Details Matter - Take the Time to Do It Right

By Stephanie Walkley, JD, BSN

The Taylor[1] family had a history of prostate cancer throughout the last couple of generations of their family tree. When Moses Taylor, age 63, received his prostate cancer diagnosis, he finally convinced his brother Malachi, age 59, and his son Martin, age 42, to see the local family medicine physician for a physical exam. Neither Malachi nor Martin were keen to go to the doctor unless they were acutely ill, which rarely happened. Reluctantly, both men scheduled appointments to see Dr. Benjamin Howard the following month.

It had been at least two years since Malachi had seen a healthcare provider, and he had never had a comprehensive physical exam. At Malachi's appointment, Dr. Howard performed a physical exam, which revealed an enlarged prostate. Dr. Howard ordered a battery of tests, including a PSA, based on Malachi's age, presentation, and family history.

A few days later, Martin went to see Dr. Howard for his physical examination. Knowing of Martin's extensive family history of prostate cancer, Dr. Howard decided to perform a prostate exam and order a PSA for this 42 year-old patient. Overall, the physical examination was unremarkable with the exception of a small palpable nodule on the prostate. Dr. Howard decided to wait until Martin's PSA results came back for review before determining whether to refer him to a urologist for biopsy.

Within a couple of weeks, the PSA results came back for both Malachi and Martin. Dr. Howard saw that each man had elevated PSA levels for their respective ages. Due to the

shared family history, elevated PSA levels, and Malachi's abnormal exam finding, Dr. Howard decided that both should be seen by a urologist for further evaluation; he referred the gentlemen to Dr. Kevin Davis.

Coincidentally, Malachi and Martin were scheduled to see Dr. Davis on the same day. They both went to their appointments as scheduled — Malachi in the morning and Martin in the afternoon. Each man had an examination by Dr. Davis followed by a biopsy of his prostate. Return appointments were made for each of them to receive their results within a couple of weeks.

Malachi was the first of the two Taylor men to have his follow-up appointment and receive his results. Much to his relief, Dr. Davis informed Malachi that his biopsy was negative. Malachi was instructed to continue seeing Dr. Howard, his PCP, for periodic monitoring of his PSA.

Martin, however, had a much more somber visit with Dr. Davis. At his appointment, Dr. Davis told Martin that his biopsy showed an unusually aggressive form of cancer. Dr. Davis discussed the need for a radical prostatectomy and offered to schedule the surgery. Overwhelmed by all of the information, Martin decided to wait on scheduling surgery so he could discuss the biopsy results and treatment recommendations with his family. Martin's father, Moses, suggested going to a major academic medical center in a nearby metropolitan area for the surgery.

Heeding his father's advice, Martin made an appointment with the urological department at the academic medical center. Three weeks later, Martin saw urologist Dr. Daniel Marsh. Based on the biopsy results, Dr. Marsh also recommended a radical prostatectomy as the appropriate surgical intervention for Martin's aggressive form of prostate cancer. Martin underwent the procedure two weeks later at the academic medical center.

While still in the hospital recovering from surgery, Martin received unexpected news. The pathology report from his surgery had returned, and his prostate showed no signs of cancer. At first Martin was elated, as this seemed to be a miracle. However, his joy and relief soon turned to confusion and anger. Martin asked Dr. Marsh how that could be possible, and Dr. Marsh could not offer an explanation.

In the days and weeks following surgery, Martin began experiencing a whole host of problems related to the radical prostatectomy, including urinary incontinence and erectile dysfunction. At his first post-operative visit with Dr. Marsh, he had many questions and concerns related to his surgery and subsequent issues.

Dr. Marsh informed Martin that he had contacted Dr. Davis about the surgical pathology results. After speaking with Dr. Davis and Martin, the decision was made to do DNA testing on Martin's original biopsy specimen. Results from the testing concluded that the prostate specimen with the aggressive cancer did not come from Martin.

Confirmation that the biopsy specimen labeled as "Martin" did not actually belong to Martin

prompted further investigation and testing. The biopsy specimen that had been labeled as “Malachi,” Martin’s uncle, positively matched a blood sample provided by Martin. Martin’s biopsy specimen had been misidentified as Malachi’s. The question now — to whom did the cancerous specimen belong?

The obvious next step was to see if the biopsy labeled as Martin’s belonged to Malachi. DNA confirmed that it did indeed. Martin had undergone unnecessary surgery, and Malachi had his treatment delayed by a couple of months. Not only did Martin have unnecessary surgery, he had severe problems related to the surgery that were getting worse, rather than better, with time. Martin and Malachi retained an attorney, and soon thereafter, Dr. Davis and the laboratory responsible for processing the biopsy specimens received letters advising them of impending litigation.

At this point, defense attorneys were retained to investigate the matter further. Meticulous accession logs and other documentation from the laboratory exonerated it from responsibility for the specimen mix-up. What came to light was a history of mix-ups and mistakes from Dr. Davis’ office – the laboratory had notified the office of problems in the past regarding matters such as incomplete labels and empty specimen boxes. There had even been a couple of occasions when specimens had been mislabeled, but the errors had been discovered due to the fact that female tissue had been labeled as “male,” and conversely, male had been labeled as “female.”

Learning from prior mistakes and proactively handling issues as they became apparent would have hopefully prevented these incidents and, at a minimum, put Dr. Davis in a more defensible position. As the facts developed during the pre-suit investigation, it became apparent that there was little in the way of a defense for Dr. Davis. The parties reached a pre-suit settlement of these claims.

Dr. Davis should have established a system for completing requisition forms, labels, and specimens. Clear guidelines were necessary to help prevent this type of error. Dr. Davis should have trained, educated, and supervised his staff more closely. The staff should have been instructed to:

1) Verify the identity of the patient and the type of specimen;
2) Check for completeness on labels and forms (date and time taken, surgeon’s name, type of specimen);
3) Use more than one identifier on every requisition and specimen (never assume that a last name or even a last name with a first initial is sufficient);
4) Label the specimen container immediately upon collecting the specimen (never pre-label specimen containers); and
5) Minimize distractions during collection and labeling.

In a high-volume clinic where there are multiple specimens going out each day, it is too easy for errors to occur if everyone is not mindful of what a profound impact an incorrect label can make. Although in this instance the patients had very similar names and happened to be related, the staff should have been “on alert” and diligent in their labeling

and processing for each and every patient.

1) The names of all involved parties have been changed.

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