Oral biopsy swap, leading to unnecessary surgery (11HDC01318, 7 March 2014)

Medical laboratory ~ Biopsy ~ Error ~ Biopsy swap ~ Pathology ~ Specialist laboratory ~ Right 4(1)

A woman had a biopsy taken by an oral surgeon. The biopsy was sent to a specialist medical testing laboratory. The biopsy was processed and the report indicated squamous cell carcinoma, a form of cancer.

The woman was subsequently diagnosed with cancer by clinicians at a district health board (the DHB) and underwent extensive surgery. Histology following surgery showed no sign of cancer. The possibility was therefore raised that the original biopsy results showing cancer did not in fact belong to the woman.

The DHB alerted the laboratory, which undertook an internal investigation. The investigation concluded that the woman's tissue sample had been wrongly labelled with another patient's name when the biopsies were being processed at the laboratory. Consequently, the woman was given the wrong biopsy result.

It was held that that, while the cause of the mix-up appeared to be human error, the laboratory was responsible for ensuring that its processes were sufficiently robust to prevent such errors from occurring. This was particularly important for a specialised laboratory, which only processes oral tissue biopsies and as a result is less able to rely on commonly used strategies to mitigate the risk of error, such as separating similar types of specimen from one another.

By giving the woman biopsy results that did not belong to her, the laboratory failed to provide services with reasonable care and skill and therefore breached Right 4(1).