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Lawsuit: Misplaced Test Result Leads to Unneeded Surgery

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May 10, 2021

Errors are inevitable, which is why good systems have built-in processes that require double-checking activities and results. But when the "double-check" gets overlooked, all of that effort can come to naught.

A woman in her mid-40s with a history of tubal ligation visited Dr OB with lower left abdominal pain after having been in the emergency department 10 days earlier. An ultrasound by Dr OB revealed an empty uterus with some fluid around the ovary. Earlier, Dr OB's office had erroneously placed a report for a positive serum pregnancy test in the woman's chart, causing Dr OB to assess a probable ectopic pregnancy.

Dr OB and the woman discussed options and agreed to proceed with surgery that day. The patient went to the emergency department to get prepared for the exploratory surgery and consented to an "operative laparoscopy for ectopic pregnancy with possible partial salpingectomy." In his note early that afternoon, the ED physician documented the patient's constant abdominal pain. Immediately following his reference to the woman's visit to her obstetrician, he noted: "Risk factors consist of pregnancy."

From a blood sample ordered at the hospital later that afternoon, however, the patient tested negative for pregnancy. Dr OB did not learn of the negative test result prior to his surgery that evening.

Medscape Editor's Key Notes:

• Develop policies and procedures that lessen the chance of putting test results in the wrong patient's file.

• When tests are ordered prior to surgery, make sure you review the results before the operation.

• Make sure staff communicates test results with the care team.

At surgery, Dr OB found no ectopic pregnancy but he did remove an ovarian cyst and performed an endometrial curettage in an effort to remove possible products of conception that might account for the original positive pregnancy test. Following surgery, Dr OB realized that the positive pregnancy test was from another patient and he explained the error to the patient.

Though there were no complications from the surgery, the patient hired an attorney to initiate a claim alleging that Dr OB failed to follow up on a pregnancy test that he had ordered before surgery, performed an unnecessary surgery, and committed a battery by exceeding her consent. The legal dispute was resolved informally.

The electronic medical record lists Dr OB as having ordered the pregnancy test at the hospital. Whether or not that was accurate, regardless of *who* ordered the test, *someone* thought it was a good idea but then failed to follow up.

For physicians, it is not enough to be respected for your knowledge; you also want to be known as the one who always dots your i's and crosses your t's. Such care will help you avoid medical errors and lawsuits.

This case comes from the "Case of the Month" column featured in the member newsletter published by the Cooperative of American Physicians, Inc. The article was originally titled "Be Sure To Check the Double-Check."

This case comes from Medicine on Trial, originally published by Cooperative of American Physicians, Inc., to provide risk management lessons from litigated case histories.