Open disclosure failure following biopsy swap
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Pathology laboratory ~ District health board ~ Biopsy ~ Biopsy swap ~ Multidisciplinary meeting ~ Breast cancer ~ Incorrect treatment ~ Open disclosure ~ Rights 4(1), 6(1)

A woman found a lump in her right breast. She underwent a number of clinical examinations including biopsies of both breasts. The biopsy result from her right breast revealed sclerotic fibroadenoma, a benign lump. That result was considered to be inconsistent with the woman's clinical presentation and, following a multidisciplinary meeting, it was agreed that the woman should undergo another biopsy. The woman underwent a further biopsy, which revealed invasive lobular carcinoma (invasive breast cancer). The woman subsequently elected to have a bilateral mastectomy.

A month later, concerns were raised that another patient, Patient Y, had had unnecessary surgery due to a biopsy swap. Internal investigations undertaken by the providers involved concluded that the woman's first biopsy, and Patient Y's biopsy of the same day, had been swapped inadvertently at the laboratory. Both women therefore received results which did not belong to them. While the district health board informed Patient Y of the biopsy swap as soon as it came to light, the woman was not informed until three months later.

Although it appears that human error led to the woman's tissue sample being swapped with a sample from another consumer, the laboratory's processes for handling late-delivery breast biopsies included unsafe practices. Those practices directly contributed to the woman receiving biopsy results that did not belong to her. By failing to ensure that its processes were sufficiently robust, the laboratory failed to provide services with reasonable care and skill and, therefore, breached Right 4(1).

Open disclosure should occur where a consumer has been exposed to possible harm, irrespective of whether harm has occurred or is immediately apparent. In this case, a biopsy swap occurred, and both consumers involved should have been informed in a prompt and transparent manner. However, the district health board did not inform the woman of the error in a timely and appropriate manner. As a result, the district health board failed to provide the woman with information that a reasonable consumer in her position would expect to receive, and breached Right 6(1).