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Mistakes that Matter

By Jonathan Saltzman
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Manuel Barros lifted his shirt in the steaming heat inside his Dorchester home to show a scar near his navel from prostate surgery he had in March. Also visible at the top of his pants was the edge of an adult diaper the 60-year-old Cape Verdean native wears as a result of incontinence, a consequence of the procedure.

Barros said he could have tolerated that side effect, as well as erectile dysfunction that resulted from the surgery, if he hadn't gotten startling news from the doctor who operated on him at Beth Israel Deaconess Medical Center soon afterward: He never had cancer.

The Beth Israel pathologist who analyzed his biopsy in November had mistaken his slides for those of another patient who did have prostate cancer, according to a report Beth Israel filed with the state.

Barros's surgery was unwarranted.

"I started crying. I was devastated by the news,'' said Barros, who takes care of medical research animals at Massachusetts General Hospital and has a second job as a custodian at Milton Academy. "I went through that surgery because I was trying to get my health back and get better.''

Andrew C. Meyer Jr., a Boston medical malpractice lawyer, filed a lawsuit Thursday against Beth Israel on behalf of Barros in Suffolk Superior Court.

Meyer filed another complaint the same day in Middlesex Superior Court against a private laboratory in Lexington on behalf of a boat mechanic from Beverly whose situation was the reverse.

Thomas Cloutman, 53, also had a biopsy of his prostate last year, and his specimen was analyzed by Strata Pathology Services. The lab results came back negative, to his great relief, he said.

About eight months later a second biopsy, examined at a different lab, revealed that he had cancer after all, he said. A Strata technician had mixed up his slides with those of another patient, according to an apologetic "letter of disclosure'' he received from Strata in November.

"Labs are a pretty important part of the whole medical thing,'' Cloutman said. "And to have them screw up a fairly simple thing like that makes me wary.''

Cloutman had surgery to remove his prostate in January at Boston Medical Center, he said, but doctors found that cancer had spread to a lymph node. Now he is weighing the possibility of radiation therapy.

Karen Steponaitis, chief operating officer of Strata, said Thursday that she was aware of the letter of apology to Cloutman but had not seen the lawsuit and could not comment on a specific patient's care because of confidentiality rules.

At Beth Israel, Dr. Kenneth Sands, senior vice president of health care quality, said in a statement that "everyone involved in Mr. Barros's care felt terrible about the mistake.'' The hospital has set a goal to eliminate such incidents, he said, "but regrettably errors still happen.''

He noted that the hospital reported the mistake to the state Department of Public Health's Division of Health Care Quality, which collects patient safety data. He added that Beth Israel had taken steps to prevent similar mistakes and hoped to "arrive at a fair and equitable resolution'' with Barros.

In recent years, hospitals have tried to reduce serious surgical errors that have made headlines, such as operations on wrong body parts and medical instruments left inside patients. But Meyer said the biopsy mix-ups illustrate that mistakes in the lab can also have devastating consequences.

"Patients give very little thought as to whether the information being given to them is accurate,'' he said. "They assume that if their doctor tells them it's accurate, it's accurate. But the reality is that the doctor is only giving them information which the doctor has been given, and the doctor may, in fact, be an innocent victim of the misinformation fed to him by either the lab or the pathology department.''

The cases of Barros and Cloutman are especially troubling, he added, given that their tissue samples were confused with those of two other men. Presumably, those men also got incorrect biopsy results that affected their medical care, said Meyer, who does not know who the other patients are.

Mixed-up biopsy tests are "not totally rare,'' said Dr. Gordon Schiff, associate director of the Center for Patient Safety Research and Practice at Brigham and Women's Hospital and associate professor at Harvard Medical School.

Schiff said such errors are more likely to be made public today than they were decades ago because of cultural shifts in medicine, which he welcomed.

"There was a time when the modus operandi in medicine was that when one of these mistakes happened, you covered it up,'' said Shiff. "You wouldn't let the lawyers know. You wouldn't tell the state of Massachusetts about it. You wouldn't want to tell the patient because they might sue and get alarmed.''

As egregious as such blunders are, he said, hospitals and labs should learn from them. One way to prevent mix-ups with biopsy tissue, for example, is to use bar codes to match specimens and slides, he said. Strata said in its letter of apology to Cloutman that it had begun to set up that kind of system when the mix-up occurred.

Barros and Cloutman underwent biopsies after routine blood tests arranged by primary care physicians revealed elevated levels of prostate-specific antigen, or PSA, which can

indicate cancer.

In Barros's case, Beth Israel took the biopsy on Nov. 19 and said he had cancer, according to the report filed with the Division of Health Care Quality.

Several days after Barros's operation on March 12, the surgeon apologetically told him that the hospital "made a big mistake,'' Barros recalled.

A pathologist had examined a dozen slides containing prostate tissue from Barros and a dozen from another patient, according to the report. The pathologist, who was not identified, inadvertently attributed the findings to the wrong patients.

To prevent similar mistakes, the hospital told the state it will take several simple steps, including requiring pathologists to initial biopsy reports to show they took a "time out'' to make sure the reports match the slides.

In Cloutman's case, a technician at Strata mistakenly took thin slices of Cloutman's tissue from tiny containers and put them on blank slides that were marked for another patient, according to the Nov. 2 letter from Strata. The technician made the same mistake with the other patient's tissue — even though, in both cases, the slides and containers had color codes and numbers to avoid such blunders.

"We are very sorry for this error,'' Dr. May Azar, medical director of the lab, wrote Cloutman. "The actions of the histo-technician involved in this mix-up violated several of our policies as well as common sense. Accordingly, we have terminated her employment.'' The letter did not identify the technician.

Several of the doctors monitoring Cloutman for the spread of cancer have told him that his eight-month delay in getting the correct diagnosis might not have made a difference in his prospects for recovery, he said. But he is still upset.

"After being cleared once and then having that thrown at you,'' Cloutman said. His voice trailed off.

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