College of Medical Laboratory Technologists of Ontario

Ethical Decision-Making Case Study: Cytology Slide Reporting Error

In 2000, Mary, an MLT working at City Lab, reported Sunita's 1st pap smear as negative to the patient's family doctor, Dr. Black. In 2004, Sunita's follow-up pap smear was reported by City Lab as negative again to Dr. Black.

In 2005, Sunita changed their last name and their family doctor to Dr. Brown. In 2006, Dr. Brown performed Sunita's pap smear test and sent the specimen to City Lab. This pap smear was reported as positive for carcinoma. A biopsy was done and confirmed the result as positive for carcinoma.

Later in the year, Mary was assigned to review the positive cases. Mary discovered that Dr. Brown did not disclose on Sunita's requisition a history of previous pap smears, and the patient had a name change. Mary reviewed all Sunita's pap smear slides and found a false negative was reported in 2000, and the 2004 pap smear was a true negative.

Mary summarizes the findings of the review to develop a plan to address Sunita's false negative report that occurred in 2000.

Year	Doctor	Reported Result	Reviewed Result
2000	Dr. Black	Normal	Positive
2004	Dr. Black	Normal	Normal
2006	Dr. Brown	Positive	Positive

Decision-making framework

1

Assess the situation

Gather and assess all available and relevant facts

2

Plan a course of action

Document the options, and the benefits and consequences of pursuing/not pursuing each option

3

Implement the plan

Carry out the plan and document the outcome

4

Evaluate the outcome

Evaluate the results of any actions

5

Share lessons learned

Practice interprofessional collaboration and share lessons learned

Scenario Breakdown

Assess the situation

This situation involves honesty and integrity. Mary reviewed positive cases at their lab and found that they reported an incorrect result in 2000 for Sunita. Patient harm may have occurred due to this error.

Plan your course of action

Mary could say nothing as it happened in 2000 and the requisition was incomplete. Mary can inform the lab manager of the reporting error and follow policies regarding incorrect results. Mary could consult her colleagues about the error.

Implement the plan

Mary decides to disclose the error and consults with the lab manager to take the following next steps:

a) Complete a risk management report
b) Issue an amended report revising the 2000 report with the correct results
c) Send reminder notice to physicians to correctly fill out requisitions

Evaluate the outcome

Mary admitted her mistake and worked with management to prevent reoccurrences. This included a risk report to ensure a record of the error is filed, issuing an amended report to communicate the error to the patient, and reminding physicians on the importance of patient information on requisitions.

Share your lessons learned

Sunita and their physician were notified of the correct test results and the reasons for the error. Mary presented this case at the next laboratory team meeting.

CMLTO resources to consider:

- Code of Ethics
- Standards of Practice
- Collaboration Guidelines
- Guidelines for Ethical Decision-Making