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Clerical Errors Can Cause Catastrophes

A wrong-site oral cancer resection reveals how one wrong clinical note destroyed lives

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Professor Bill Burnett asked us on LinkedIn:
"Could you share an example or two of real-world pre-procedure errors—and what happened to the patient and medical team involved?"

Bill, this is the story of one of two never event errors that we prepared to begin to answer your question.

The Background

Johanna had surgery to remove her jaw for a diagnosis of cancer. When she woke after surgery, she realized her surgeon had removed the wrong jaw.

How could this happen today? Let's look at how wrong-site errors continue to occur—and how **SafeStart's structured situational awareness** application helps teams detect and prevent **WSPEs (wrong-site, wrong-side, wrong-procedure, and wrong-patient errors)** at multiple points along the preoperative patient's journey.

Diagnosis Phase

Johanna's general dentist correctly documented bleeding on the **left lower gum.** The second confirmatory biopsy showed cancer—but when the pathologist phoned the result to the periodontist's office, a **non-clinical staff member incorrectly recorded the site of the cancer as being in her right jaw and even assigned the wrong tooth number near the lesion.**

Communication Confusion

As documentation moved from office to office and into the operating room, the wrong-side notation was copied forward repeatedly.

Her surgeon unaware of the error relied on the flawed record at the start of her surgery.

On the day of her operation the patient's own verbal warning to the nurses and anesthesiologist was **silenced by anesthesia that began before the surgeon entered the operating room.**

The Aftermath

When Johanna awakened from her anesthetic, she had the horrible realization that the surgeon had removed the wrong jaw. Her admonition to the nurses and anesthesia team — that it was her *left* jaw, not her right, that **should have been removed** — had been ignored.

The flawed system failed to protect her from this catastrophic error.

Key Breakdowns

The initial mis-charting of lesion location was never identified before its catastrophic surgical consequence.

- **Each subsequent provider carried the error forward never checking original source data.**
- **The patient's recognition and verbal correction in pre-op were disregarded by the surgeon.**
- **The anesthesia and nursing team voiced concern, but hierarchy trumped careful patient-safety process, corrupting error prevention.**

Lessons Learned

- Communication, verification, and system design all failed.
- This event wasn't caused by one clinician—it was the consequence of a system that allowed a small transcription error to propagate unchecked to catastrophe.

Situational awareness must be obsessive.

Continuous vigilance is not optional — it's mandatory.

Medical & Legal Consequences

- Left-side cancer remained untreated initially, requiring a **second mandibulectomy** with additional grafting.
- **Bilateral donor-site scars** and persistent **lower-lip numbness** (inferior alveolar nerve injury).
- Prolonged recovery affecting **mastication, speech,** and **psychosocial wellbeing.**
- **Consolidated claim** naming surgeon, facility, and nursing team; **settled pre-trial** with lasting human and reputational costs.

References & Media

🎧 **MedPro Minute Podcast – "Wrong Site Cancer Removal"**
https://podcasts.apple.com/us/podcast/wrong-site-cancer-removal/id1628645713?i=1000620549694

Watch Wrong-Site Surgery Narrative — Commentary by Katherine Lee, DNP, RN, CPHRM, CMPE

Expert Commentary — Katherine Lee, DNP, RN, CPHRM, CMPE

OMF Dental WSPE Case 1 Timeline (Katherine Lee, DNP, RN, CPHRM, CMPE)

| "This case illustrates how a single transcription error can cascade across multiple handoffs and providers, culminating in a wrong-site surgery. Reliable verification processes—including confirmation with the patient, direct communication between providers, and adherence to preoperative safety protocols—are critical safeguards against such preventable errors."

| "Unchecked documentation errors and procedural shortcuts can cascade into catastrophic harm. Time pressures and assumptions must never replace verification. Clear laterality markings, consistent consent documentation, and empowering staff to 'stop the line' are essential defenses against WSPEs."

| "In high-reliability systems such as aviation, a warning cannot be ignored—the process halts until the discrepancy is resolved. Healthcare must adopt the same mindset."

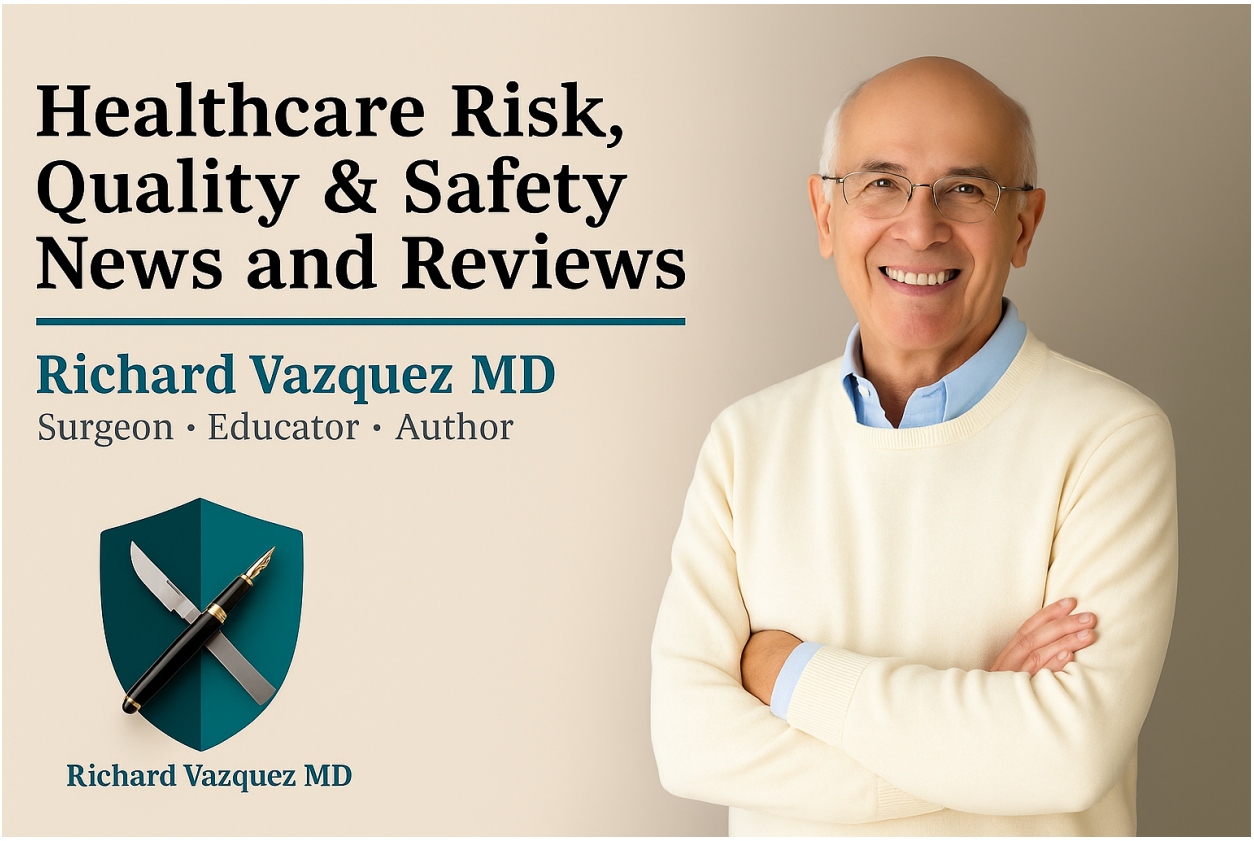
(Comments excerpted and adapted from correspondence with Katherine Lee, DNP, RN, CPHRM, CMPE, SafeStart Medical Advisory Board.)

I wish to thank **Katherine Lee, DNP, RN, CPHRM, CMPE**, and advisory board member at SafeStart Medical, Inc., for her exceptional work on this case. Her clarity and insight bring vital context to how systems fail—and how situational awareness must become habitual.

Richard Vazquez MD FACS
Founder & CEO | SafeStart Medical, Inc.

Our Mission at SafeStart Medical

To help prevent medical errors and improve outcomes through dynamic patient-provider communication.



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