PREFERRED PHYSICIANS MEDICAL
Risk Retention Group, Inc.

Anesthesia & the LAW

A Professional Liability Newsletter for Anesthesiologists **Issue 11**

Surgical Mix-Ups and Wrong-Sited Surgeries

Preferred Physicians Medical has seen a significant increase in the media attention given to adverse medical outcomes, especially those involving obvious mistakes. Recently, an Associated Press wire story featured the account of a young child in Rhode Island who mistakenly underwent a tonsillectomy, adenoidectomy and myringotomy. Upon completion of the surgery, it was discovered that the child was scheduled for an eye procedure and that she had been confused with another child with a similar name. In Florida, a surgeon was sanctioned after performing a full mastectomy on the wrong patient, a woman scheduled for a lumpectomy.

While these types of patient mix-ups are infrequent, they are certainly not rare. In fact, three such cases have been reported to Preferred Physicians Medical in recent years. One case, involving two children occurred when a child scheduled to undergo resection of a neck cyst was confused with a child scheduled for an abdominal laparotomy. The error was realized only after surgical exploration of the site. In another case, a patient scheduled to undergo a penile implant was instead brought into the operating room for a cervical laminectomy. Fortunately, the error was discovered early in the cervical laminectomy procedure and before surgery was initiated on the other patient.

In addition to patient mix-ups, a more significant number of claims involve "wrong-sited" surgeries. Preferred Physicians Medical has recorded 16 cases of this type over the last several years. Often these cases involve orthopedic surgery where confusion between left and right extremities is more likely. The most celebrated case of this type occurred in Florida following the amputation of the wrong foot. That mistake generated substantial national media attention, led to a suspension of Medicare/Medicaid reimbursement and launched investigations by the Florida licensing authorities into the actions of the hospital and its health care providers.

Given the nature of these claims, namely the expectation that such mistakes should not occur, it is not surprising that such outcomes routinely generate a firestorm of publicity and almost always result in a claim or lawsuit. While the damage in most cases is relatively minimal, resolution of this type of case can be difficult given that there can be no argument about liability. In addition, plaintiff attorneys appear to appreciate the value of negative publicity and use the media attention to help pressure hospitals to pay larger settlements than warranted by the injury.

In both types of cases, the hospital protocol designed to safeguard patients failed as a result of human error, namely the failure of an individual or individuals to follow procedural safeguards. In addition to the initial misidentification, each of the cases reported to Preferred Physicians Medical included allegations that other health care providers failed to independently recognize and correct the initial misidentification. In each case, allegations were directed against the anesthesia personnel involved. In this regard, plaintiff's anesthesia experts routinely opine that patient safety is a joint responsibility shared by the entire surgical team and that each health care provider has an obligation to independently verify that the correct patient has been identified and the designated surgical site has been confirmed. Accordingly, anesthesiologists, for their own protection, should insist that their practice facilities adopt appropriate protocols for preventing patient mix-ups and wrong-sited surgeries.❖

Risk Management Tips to Prevent Patient Mix-ups and Misidentification of Surgical Sites

Preferred Physicians Medical strongly recommends that anesthesiologists review the adequacy of their hospital protocols that address patient mix-ups and wrong-sited surgeries.

In this regard, our in-house attorneys can help you in this evaluation process and can provide resource information to assist you in the development of improved protocols.

Regarding surgical site identification, Preferred Physicians Medical has found that many hospital protocols provide only minimal safeguards. Most of the protocols reviewed to date have been extremely general statements on shared responsibility rather than providing detailed procedures for insuring proper site identification. Preferred Physicians Medical suggests that a better approach is to adopt requirements similar to the "Sign Your Site" protocol recommended by the American Association of Orthopaedic Surgeons (AAOS). The "Sign Your Site" protocol requires surgeons to specifically mark their surgical site, with participation from their patient, prior to the start of the surgical procedure. Unlike other approaches that rely solely on record checking or confirmation by other members of the surgical team, the "Sign Your Site" protocol recognizes that the surgeon and the patient are in the best position to prevent these unfortunate errors. In addition, the study conducted by the AAOS discusses the limitations of alternative approaches to site identification.

With respect to patient mix-ups, no single approach reviewed by Preferred Physicians Medical appears to effectively eliminate the risk of such medical errors. Historically, hospital protocols were more likely to place the responsibility for patient identification clearly on the hospital's nursing staff. In response to recent cases, a new trend appears to be developing; the adoption of protocols that spread the responsibility for patient identification to the entire surgical team, including the anesthesiologist. Unfortunately, this approach may simply dilute each individual health care provider's sense of ultimate responsibility and may in the end increase the likelihood of errors. Preferred Physicians Medical suspects that this new trend may be motivated in part by a hospital's desire to spread the financial responsibility for these mistakes. In several of the cases investigated by Preferred Physicians Medical, hospitals have attempted to pressure surgeons and anesthesiologists to contribute toward settlement, even where the hospital protocol clearly placed the responsibility for patient identification with the nursing staff. It should be noted that plaintiffs also have little difficulty identifying experts who will opine that patient identification is a responsibility shared by everyone on the surgical team, including the anesthesiologist.

Regardless of hospital protocol, Preferred Physicians Medical suggests that anesthesiologists adopt a few simple steps to help prevent patient mix-ups and reduce the likelihood of surgical site misidentification.

- Anesthesiologists should ***ask*** patients to tell them their names and confirm this against the chart. In several cases, especially those involving children, anesthesiologists have instead asked a patient, "are you John Smith?" only to have the patient affirmatively confirm a mistaken name. A better approach is to ask, "Would you please tell me your name?" You can also offer a small reassuring explanation such as "Would you please tell me your name, so that I can confirm that I have the correct information about your case?"
- Anesthesiologists may also ask patients to recite their surgical procedure. "Can you tell me what kind of surgery we are doing today?" This is a question even young patients may be able to answer in a manner that would help prevent errors.
- Anesthesiologists can further decrease the likelihood of mistakes by asking the nursing staff to confirm the patient's identification as well as the surgical procedure during the surgical prep and prior to initiating anesthesia. By confirming this information with the anesthesia record, the anesthesiologist can increase the likelihood that the nursing staff has in fact followed through on its obligation to properly identify the patient and to prep the correct surgical site. ❖

Resources

- American Academy of Orthopaedic Surgeons, www.aaos.org; Report of the Task Force on Wrong-Sited Surgery.
- Joint Commission on Accreditation of Healthcare Organizations, www.jcaho.org; Sentinel Event Alert, Volume Six.

Newsletter Editor
Steven R. Sanford, JD
Vice President, Claims
Preferred Physicians Medical

Anesthesia & the Law *is published by*
Preferred Physicians Medical Risk Retention Group, Inc.
7000 Squibb Road, Mission, KS 66202-3233
Telephone: 800-562-5589 Fax: 913-262-3633