Ankin Law Office LLC

Protecting the Rights of Injured Workers

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Surgical Errors Continue to Persist in High Numbers

The recent report published in the Archives of Surgery in October 2010 paints a grim picture regarding **surgical errors**. According to the report, there is a "persisting high frequency of surgical 'never events," or errors that are entirely preventable and should never occur, despite the fact that hospitals must abide by a universal protocol of procedures intended to prevent these types of mistakes. The universal protocol requires that three critical steps be performed prior to surgery: (1) a pre-procedure verification, (2) marking the correct surgical site, and (3) a "time-out" for the operating stuff just before the surgery.

Despite the procedures intended to safeguard against "never events," researchers found 25 incidents of wrong-patient procedures and 107 incidents of wrong-site treatments over a six-year span. The report was based on data drawn from an insurance database in Colorado that included more than 27,000 adverse events self-reported by Colorado doctors between 2002 and 2008.

The most drastic incident involved the insertion of a chest tube into the wrong lung, causing it to collapse and thereby killing the patient. Other incidents included surgeons removing a healthy ovary, operating on the wrong side of the brain, fusing the wrong vertebrae and performing procedures on the wrong eye, knee, foot, elbow and hand.

According to Dr. Stahel, director of orthopedics at Denver Health Medical Center and the study's author, "These data are shocking. These are catastrophic events that are unacceptable. They have been termed a 'never event' — because they should never happen."

The study's researchers found that **diagnostic errors** accounted for 56% of the operations performed on the wrong patient, and poor communication was the cause of all of the operations performed on the wrong patient.

Among operations performed on the wrong part of the body, 85% were due to errors in judgment and 72% were caused by the lack of a "time-out" as required by the universal protocol. The "time-out" is typically performed before surgery begins so that everyone present in the operating room can confirm that they have the correct patient and that they know the body part on which they are operating.

Researchers noted that while blame for these mistakes falls across the medical profession, internal medicine specialists were most frequently responsible for wrong patient errors, causing 24% of such mistakes. Clinicians involved in general medicine, pathology, urology, obstetrics-gynecology and pediatrics were each responsible for 8% of wrong patient errors.

With respect to wrong site errors, the study found that specialists in orthopedic surgery were responsible for 22.4% of the errors, general surgeons for 16.8%, and anesthesiologists for 12.1%.

As Dr. Stahel, the study's author, points out, a safety system such as the universal protocol of procedures cannot solve the problem alone if medical professionals "hide behind a safety system" and are "not mentally involved" in the procedures.

"The culture has to change to promote people speaking up when they see a safety concern and promote good teamwork," said Dr. Martin A. Makary, an associate professor of surgery at Johns Hopkins University and author of an accompanying journal editorial.

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Researchers emphasized that procedures alone will not solve the problem and that we need to move from a culture of system safety to "a culture of patient safety and accountability." According to the study's researchers, the flaws with the current medical culture are perpetuated by the fact that doctors are placed above nurses and other medical staff so that oftentimes these medical professionals do not speak up because they are intimidated by the operating room hierarchy. Moreover, those in the operating room frequently do not even know each other's names.

Trial lawyer lobbyists are using the report as ammunition in their lobbying efforts against new restrictions on **malpractice claims** – a central feature of the Republicans' plans to overhaul the new healthcare reform law by placing new limits on malpractice claims.

According to the American Association of Justice, Colorado – the state from which the data was collected – "has some of the most anti-patient laws in the country, severely capping medical negligence cases, [which] clearly has not helped patient safety."

Legal remedies are available to patients who suffer from surgical error, typically in the form of a lawsuit for **medical malpractice** or **wrongful death**, both of which require the patient to show that the doctor was negligent in administering medical care. An unfortunate result alone is not always grounds for a medical malpractice lawsuit; however, the very nature of a surgical "never event" means that negligence or intentional wrongdoing was likely present since the medical community considers the mistake to be one that should never occur.

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