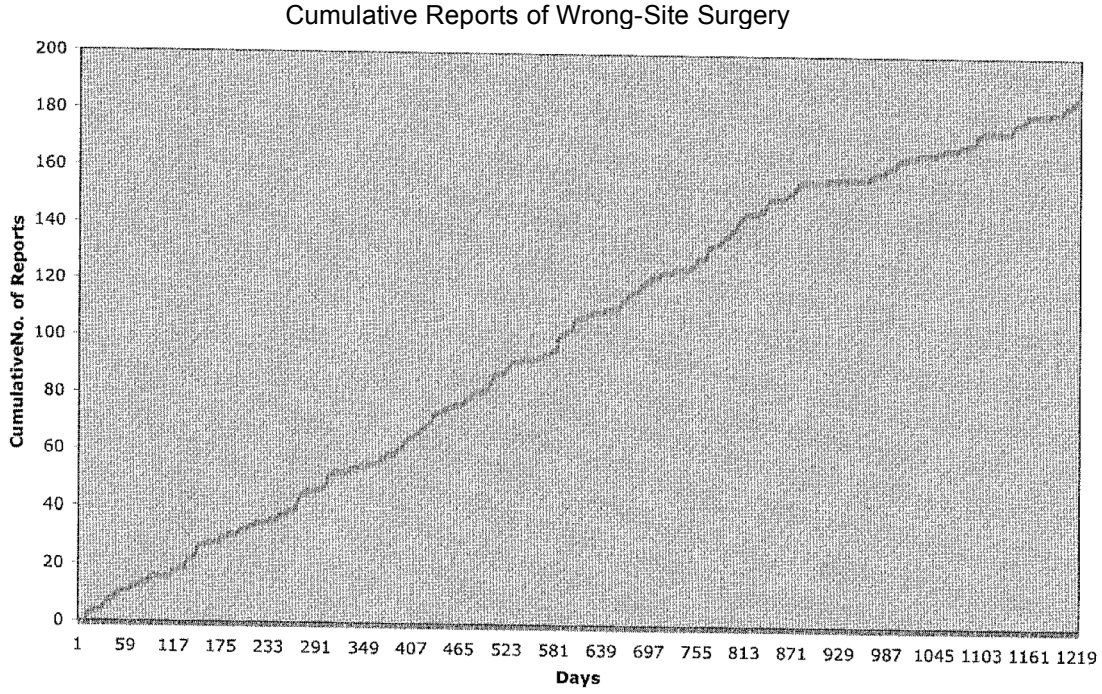
Wrong-Site Surgery

The Pennsylvania Patient Safety Authority, at its last public meeting in early December 2007, received a long and detailed PowerPoint presentation concerning wrong-site surgery. The cumulative reports of wrong-site surgery continues to grow dramatically.



Wrong Site Surgery Events Reported to PA-PSRS 7/04-10/07

PACERS is the Pennsylvania reporting system in operation between July 2004 and October 2007, created as a result of amendments to the Mcare Act in 2002, which also created the Pennsylvania Patient Safety Authority. The statistics show the increase in surgery at the wrong site.

A number of solutions have been offered to wrong-site surgery, such as preoperative verification with the patient, marking of the site, and time-out before the first incision is made. In Pennsylvania, there were 427 reports over 30 months, one every two days. Fifty-nine percent (59%) of those errors did not reach the patient. The contractor of the Patient Safety Authority has studied the factors implicated in wrong-site surgery, with “activities surgeon” in the O.R. being 53 percent, “failure of time out” being 34 percent, “activities” concerning “anesthesia

in the O.R." 17 percent, "failure to verify with consent" 13 percent, "failure to verify with patient information" 12 percent, and "failure to verify position/prep" 11 percent. Factors in successful recovery are numerous, but the patient and/or family were the biggest reason why wrong-site errors were caught in time. This militates in favor of family and patient involvement in their own care to a very great extent.

The contractor of the Patient Safety Authority concluded that a single time-out just prior to the incision is a flawed strategy that violates safety principles of redundant checks of operator-dependent critical steps and ignores the potential impact of confirmation bias. What this means is that a single time-out before the surgery is started is just not enough. In addition, it is crucial that the surgeon be involved in the time-out and that it not just be a few minutes of inactivity on the part of the nurses and staff alone. The mark on the operative site represents the patient's voice after he or she is sedated or anesthetized. There must be preoperative verification with the patient. Marking should involve an alert patient, and mark should be accurate, unambiguous and consistent with the medical documents. A surgeon is the one who must make or check the mark before any intervention.

Comparing the Patient Safety Authority reports with information obtained from the administrative courts of Pennsylvania, less than 1 percent of patient errors, near misses or serious events, ever wind up in a lawsuit being filed. This is a staggering statistic, demonstrating that very few people sue for medical errors because of the considerable burdens established by the 1996 and 2002 changes in medical malpractice laws. Clearly, the lack of accountability by virtue of a monetary or court remedy is one reason why medical errors are so out of control.

It would also be fair to note that many in the medical profession, especially academics, are very strongly committed to the eradication of patient errors. However, as one notable scientist from the University of North Carolina said at a conference held at the Medical School of the University of Pennsylvania, it is difficult to have decreases in the medical errors without the carrot and the whip provided by non-punitive medical education along with financial remedies to those injured by substandard practices.

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