When Right is Wrong – Lessons from a Wrong Site Surgical Procedure

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Since the 1998 introduction of the "Sign Your Site" campaign by the American Academy of Orthopaedic Surgeons, much attention has been directed to preventing wrong site surgical procedures. What resulted was a paradigm shift in pre-operative processes, evolving into the pre-operative procedure that is today generally accepted and implemented in most operative facilities, whether it is a hospital, ambulatory surgery center, or office setting. Today's pre-operative process involves:

1. Pre-operative verification confirming the right patient, the right surgery, and the right location.
2. Pre-operative marking of the surgical site with the patient or representative in such a way that the mark is visible after the patient is prepped and draped for surgery. SVMIC recommends marking the surgical site during discussion with the patient or

the patient's representative prior to surgery.

3. “Time Out” in the operative suite immediately before beginning surgery, with active and intentional communication among all members of the surgical team. SVMIC recommends having the relevant imaging available in the operating room for the surgeon to consult during the Time Out to verify that the correct level or side of the body is being addressed.

Without a doubt, these procedural changes have succeeded in preventing wrong site surgical errors. However, despite the development of these pre-operative procedures and the industry’s overall attention to this problem, wrong site surgical error persists. Surgery involves humans, and humans make mistakes. This article discusses one such wrong site surgical error, the legal claim that followed, and its ultimate resolution.

Ms. Johnson[1], a twenty-year-old female, presented to an ambulatory surgery center for ACL repair of her left knee. CRNA Turner administered a nerve block pre-operatively for post-operative pain control. By his own admission, CRNA Turner went too fast in his care of Ms. Johnson, got distracted, and administered the nerve block to the right (wrong) knee.

CRNA Turner quickly recognized his error. He informed his supervising anesthesiologist, the orthopedic surgeon, and Ms. Johnson what had happened. It was determined that the ACL repair of the left (correct) knee would proceed as scheduled, but without the pre-operative nerve block. Another modality would be used to address Ms. Johnson’s post-operative pain. The surgery on the left (correct) knee proceeded uneventfully, and Ms. Johnson was sent home with immobilizers on both knees. She was instructed not to attempt to ambulate on her own. Despite these instructions, Ms. Johnson tried to walk on her own at home and fell, causing pain and swelling in her right knee. Ms. Johnson reported the injury to her orthopedic surgeon, who added the right knee to the physical therapy protocol already planned for the left (operative) knee. Fortunately, the injury to the right knee was mild and resolved with physical therapy and time.

Only a few months after the surgery, Ms. Johnson decided to pursue a legal claim against CRNA Turner. She contacted an attorney, who sent a letter to CRNA Turner. CRNA Turner reported receipt of the letter to SVMIC’s Claims Department, and defense counsel was retained to assist him. After investigating the claim, it was decided that by all involved that it would be prudent to engage Ms. Johnson in settlement discussions. These discussions were productive, and a settlement was reached between the parties. The parties thus avoided a lawsuit and resolved the matter fairly quickly.

There are several lessons to consider from this wrong site surgical error claim:

1. Wrong site surgical errors are not limited to surgery itself. A wrong site error can occur at any step in the surgical process, as is demonstrated by this wrong site pre-operative nerve block. Using the three-step procedure (verification, marking, and time out) before administering the nerve block could have prevented CRNA Turner from blocking the incorrect knee.
2. Although inconvenient, it may have been prudent to cancel the surgery after

discovering the wrong site nerve block. The surgery could have been rescheduled for a later date and Ms. Johnson would have left the surgery center with only one leg immobilized. More likely than not, this would have avoided her subsequent fall, injury, and eventual legal claim.

3. "It is what it is." Once the error occurred, the only thing CRNA Turner could do was manage it well. He did this by (1) promptly recognizing the error; (2) frankly and honestly informing the supervising anesthesiologist, orthopedic surgeon, and patient; and (3) factually documenting the event in the record. "Just the facts" was what was needed in the medical record. That is not the place to explain or elaborate or make an excuse.
4. Wrong site surgical procedures are referred to as "never" events, meaning that they should never happen. It is difficult to imagine a scenario where medical negligence is not admitted in these cases. Efforts can be made to place the error in context, but, more likely than not, a defendant in a lawsuit involving a wrong site error ultimately must concede that the error was a deviation from the standard of care. Therefore, with negligence conceded, the parties are left debating what injury resulted from the error and what that injury translates to in terms of monetary damage. Fortunately, Ms. Johnson experienced only a minor injury from this wrong site error and her monetary damages were minimal, making this an easier claim to resolve. Johnson also contributed to her fall and injury by disregarding the discharge instructions, a fact that also aided the claim's resolution.
5. As to the claim's resolution, it is important to note that CRNA Turner recognized this situation early for what it was. His prompt report to SVMIC enabled the claim to be addressed, investigated, and positioned for a quick resolution, thus avoiding a lawsuit.

Significant progress has been made over the past two decades to avoid wrong site surgical errors. However, even the three-step pre-operative process is not a guarantee that this medical error will never occur. Despite all precautions, mistakes still happen. Slow down, take the pre-operative process seriously, and do your best. In the end, even if right is wrong, SVMIC is here to help you through it. Members can find extensive resources to assist with questions and issues such as the one discussed here in the Vantage® portal, by emailing us at ContactSVMIC@svmic.com, or by calling us at 800.342.2239.

[1] The names of individuals in this closed claim have been changed.

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