# A Time-out that Did Not Save the Day

**By Dan Himmelberg, JD**

Jim Logan,[1] a 54-year-old attorney and outdoorsman, had seen various providers over several years with occasional complaints of pain in one or both knees. In 2011, he injured his left knee while fishing. An MRI showed degenerative changes. Mr. Logan was initially treated with NSAIDS and pain medication. Six months later, he received a Cortisone injection in the left knee due to continued pain complaints. In early 2012, physical therapy was ordered due to bilateral knee pain. As 2012 progressed, Mr. Logan was diagnosed with bilateral osteoarthritis. His treatment, including injections in the right knee, continued. By the end of the year his right knee arthritis was assessed as mild to moderate and he started using a brace at times. This general pattern of knee pain complaints, sometimes in the left and sometimes in the right, continued through 2013 with physical therapy and other conservative care.

In November of 2013, Mr. Logan sought a second opinion and presented to orthopedic surgeon Dr. Fisher with a complaint of right knee pain. There was no mention of left knee pain. An MRI of the right knee showed moderate thinning of the articular cartilage and some bone infarctions. Dr. Fisher prescribed a Medrol Dosepak and Norco®. He recommended therapy with a different physical therapist. Mr. Logan did not return to Dr. Fisher for further care until July of 2016. He again complained of right knee pain. Plain x-rays from his PCP showed moderate osteoarthritis of that knee. Mr. Logan declined a Cortisone injection. Another MRI was ordered. This was positive for a medial meniscus tear as well as grade III arthritis. In August, Mr. Logan was seen again by Dr. Fisher. He was wearing a brace on the right knee, had an antalgic gait and the knee was tender upon palpation. In November, Mr. Logan complained that his right knee pain was interfering with his sleep and daily activities. Dr. Fisher then scheduled an arthroscopic surgery of the right knee.

When Mr. Logan presented to the hospital's surgery center, he was scheduled to be Dr. Fisher's ninth case of the day. Dr. Fisher saw him in the holding area when he was second or third in line for the OR. Dr. Fisher briefly discussed the planned surgery with Mr. Logan and marked and initialed the right leg. He wrote "Yes" and his initials on the front of the mid-leg. Dr. Fisher then continued with his other surgeries. When Dr. Fisher next saw the patient, he was prepped and draped in the OR. A time-out was called by Nurse Webber and the surgery proceeded. A partial medial meniscectomy was performed.

In the recovery room, the patient discovered that the surgery had been performed on his left knee instead of his right knee. He alerted the staff. Dr. Fisher and the staff spoke with the patient about the surgical error, although there was no clear explanation for how it occurred. Mr. Logan expressed understanding and commented that his left knee had been bothering him also. He was sent home with the plan to return in one week to evaluate the left knee and discuss surgery on the right knee. The patient was not charged by the hospital or Dr. Fisher for the wrong site surgery. When Mr. Logan returned, the left knee was healing well. He was scheduled to return in two weeks. Mr. Logan did not return to Dr. Fisher but transferred his care to another orthopedist. The new orthopedist performed a right knee replacement six weeks later.

Mr. Logan later filed suit against Dr. Fisher, Nurse Webber and the hospital due to the wrong site surgery. He asked for an award for his medical expenses related to the later surgery performed on the right knee, pain and suffering, lost earnings due to the wrong surgery and delay in recovering from the more extensive second surgery, and punitive damages. The hospital was responsible for the actions of Ms. Webber and the rest of its staff.

The co-defendants agreed it was best to try to settle this claim as quickly as reasonably possible. However, there was significant disagreement about who was responsible for the majority of any payment. While there was a clear error in performing the surgery on the wrong knee, the genesis of that error was unclear. The surgery requisition form and preoperative orders correctly stated the right knee and Dr. Fisher marked that leg. However, the wrong knee had been prepped and draped. Nurse Webber had called the pre-surgical time-out and the error was not caught. No one could recall for certain whether Ms. Webber had called out that the surgery was to be on the left or right knee, but indications were that she likely said the left knee.

Dr. Fisher’s position was that he was the only one who was known for certain to have correctly identified the right side on the day of surgery – the scheduling paperwork was correct and he marked the correct leg. Mr. Logan had taken photographs of both legs after the surgery. These showed Dr. Fisher’s markings on the right leg and the surgical bandages on the left knee. The hospital argued that the marking was “pretty useless” because it was not visible after the leg was prepped and draped. Dr. Fisher’s attorney noted that the hospital’s surgical protocols and policies did not specify how the marking was to be done and what Dr. Fisher did was the typical routine by him and others. Additionally, other surgeons continued with the same marking technique after this surgery and the hospital did not question it or change its policies. After this surgical misadventure Dr. Fisher started marking surgery sites where his markings could be seen after draping. He also started marking a large “NO” on the incorrect side as another precaution. The hospital pressed that Dr. Fisher, as the surgeon, had the most responsibility to ensure the surgery was on the correct site. Dr. Fisher had to concede that he had not looked at his surgical paperwork in the OR, including during the time-out, and did not have a copy of his imaging of the right knee in the OR.

All of the parties proceeded to a mediation. It was quickly clear that a settlement could be reached with Mr. Logan for a reasonable global amount. However, this was as much a mediation between Dr. Fisher and the hospital as between the defendants and Mr. Logan. After approximately ten hours of negotiation, SVMIC and Dr. Fisher agreed with the hospital to an apportionment of the settlement amount (with the hospital having the greater portion). While neither side was completely happy with the final outcome, the value of resolving the claim was recognized and accepted.

[1] All names have been changed for confidentiality.

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