By Tim Darragh,
OF THE MORNING CALL
March 19, 2011

LEHIGH VALLEY'S NEWSPAPER
THE MORNING CALL

'Never events' happen dozens of times a year

Pennsylvania at forefront of reporting wrong-site surgeries.

More than five times a month, every month, a doctor in Pennsylvania commits one of the medical establishment's greatest taboos — working on the wrong part of a patient's body, or even the wrong patient. Since the state Patient Safety Authority began collecting data in mid-2004, health care facilities have reported 416 "wrong-site surgeries," an average of 64 a year, the authority reported this month.

"That's one of the 'never events,'" said Pennsylvania Medical Society President Ralph Schmeltz, referring to the term Medicare has given to medical mistakes that should never occur. "The rules are there, it's just a matter of everybody paying attention."

Wrong-site surgeries have declined slightly in number, the report said, but the authority's educational efforts to remind health care professionals about such potentially grave mistakes have not produced much of a difference.

"It's frustrating," said Dr. John Clarke, clinical director for the authority, "because there are many different ways that you can mess up."

Misinformation was the cause of a mistake in 2009, when doctors at Lehigh Valley Hospital-Muhlenberg directed a beam of radiation on the wrong side of a patient's head. According to a hospital spokesman and a Nuclear Regulatory Commission record, doctors stopped when they realized the error about 47 minutes into the procedure.

Operating room personnel followed their instructions correctly, said LVH spokesman Brian Downs, noting that someone had written the error into the patient's record. The patient, who was being treated for headaches, received proper care after the mistake was realized, Downs said.

Misinformation can come from any number of sources, Clarke said. An incorrect schedule, mixed-up patient reports and faulty memories all can lead to mistakes. "Sometimes, believe it or not, the patient is wrong," when a doctor asks about the procedure to be done, Clarke said.

Misperception also causes mistakes, the safety authority has found. That can happen when a patient has a procedure planned for one part of the body and is flipped over, putting the operating site on the other side, he said.

The authority uses a strict definition of wrong-site surgery, which could include anything from numbing the wrong site, but not operating on it, to operating on the wrong patient. Among wrong-site events, operating on the wrong finger or the wrong site on the spine are the most common mistakes, Clarke said. In some cases, such as bilateral cataract operations, a medical team may work on the wrong eye first, but since both eyes needed surgery, no harm comes to the patient, he said. The incident, though, would be counted as a mistake.

Even when the harm to a patient isn't lasting, wrong-site surgery can be devastating to patients and physicians. A Massachusetts doctor last year took the unusual step of admitting in an article in the New England Journal of Medicine that he mistakenly performed wrist surgery on a woman who needed surgery on a finger. A combination of stress from an earlier procedure, delays and a change in personnel contributed to his making the error, wrote Dr. David C. Ring of Massachusetts General Hospital. "I hope none of you ever have to go through what my patient and I went through," he wrote.

Since the authority began collecting information, Clarke said he has not seen a grave permanent error, such as removing the wrong limb or vital organ, although he said non-vital organs have been improperly removed.

The report doesn't state where the mistakes occurred. Among area hospitals, Sacred Heart Hospital in Allentown said it has had no wrong-site surgeries, according to Valerie Downing, vice president of marketing and public relations. Representatives at LVH, St. Luke's and Easton hospitals declined to discuss how often wrong-site events occurred at those facilities.

Wrong-site surgeries are rare, and data on them are unreliable. The national accreditation organization, the Joint Commission, last year recorded 93 events nationwide, but reporting to the commission is voluntary. A study in 2006 by the American Medical Association estimated that they occur about once every 113,000 operations, while the state authority, the leading source on wrong-site surgery data, in 2007 came up with a rough estimate of once every 60,000 surgeries, Clarke said.

"We're unique in Pennsylvania in terms of looking at any kind of event, including near-miss events," Clarke said.

Doctors are supposed to report wrong-site surgeries to the state Health Department, but those accounts are not public. The authority additionally is prohibited by law from identifying the institutions and individuals involved in wrong-site surgeries.

In 2003, the Joint Commission developed a protocol for preventing wrong-site events, including marking the part of the body to be repaired, receiving verbal confirmations from the patient and ordering surgical teams to conduct a "time out" before work begins.

In that process, everyone on the team is supposed to stop what they're doing until they agree that they are operating on the right patient, that they'll be performing the correct procedure and how it will be done.

Giving nurses, anesthesiologists and other members of the surgical team potential veto power over a surgery required "a bit of a culture change," said Dr. Michael Pasquale, LVH's chief of trauma and senior vice chairman of the department of surgery. "The behavior has to start with the surgeons."

LVH has developed a surgical team training course to emphasize that anyone involved in the procedure is accountable. "Everyone is empowered to speak up for the patient," Pasquale said.

The health network also developed a briefing and debriefing process at LVH-Muhlenberg to prepare for, and review, surgery. That practice will be expanded to LVH's other hospitals, Pasquale said.

In all, the prep work is paying off. Pasquale recalled one timeout when a nurse contradicted a surgeon who in the past "would never have been challenged… It turned out that nurse was absolutely right," he said, adding that the doctor commended the nurse verbally and in writing for preventing "an untoward event."

The process comes with the drawback of slowing down surgery, Pasquale acknowledged. "We've noticed some delays in some of our case starts," he said.

"If the case is delayed because we did a timeout and that means we didn't amputate the wrong leg," he said, "then it was well worth it."

WHAT YOU CAN DO

•Expect that each person involved in your operation will ask for your name and other identifying information, such as your birth date.

•Allow health care providers to check your identification bracelet.

•Expect the operating team to ask you what kind of surgery you are having and the exact location.

•Make sure the information you give matches what is written on the documents. If it does not, the health care staff should double check the information. You should agree with the ultimate decision.

•If you are concerned that any of your health care providers seems unsure about what is being done to you, speak up.