



OregonLive.com

Everything Oregon

Wrong body part, wrong patient surgeries continue despite new procedures

Published: Wednesday, May 25, 2011, 9:00 AM Updated: Wednesday, May 25, 2011, 7:18 PM



Joe Rojas-Burke, The Oregonian
By



[View full size](#)

Troy Wayrynen, The Columbian

Jesse James Matlock, 4, is held by his mother, Tasha Gaul at their home in Vancouver, Wash., April 19, 2011. More surgery might be necessary to correct the wrong eye being operated on.

Before the operation for their 4-year-old son, Dale Matlock and Tasha Gaul watched the surgeon write her initials above Jesse's right eye, a safety step to prevent a surgical mix-up. In the operating room at **Legacy Emanuel Medical Center**, the surgical team performed a mandatory "time out," a final check that the correct patient is about to undergo the correct procedure on the correct site.

But during the surgery to fix his wandering right eye, **Dr. Shawn Goodman** realized she'd mistakenly operated on the healthy left eye.

"She said, 'Frankly, I was at the head of him, and I lost my sense of direction and the mark got covered up,'" Gaul told **The Columbian**

newspaper last month. "By the time she realized it was the left eye, it was all said and done."

Medical errors as extreme as operating on the wrong body part or the wrong patient are never supposed to happen. Systematic efforts to eliminate these "never events" began a decade ago, and yet such errors continue regularly in Oregon and across the U.S. The most thorough national study **estimated 1,300 to 2,700 people are harmed every year** by wrong site errors.

The frequency in Oregon appears unchanged since the state began voluntary error reporting in 2006, when hospitals listed eight wrong site or wrong patient errors. In each of the past two years, Oregon hospitals reported 10 wrong site, wrong patient, or wrong procedure errors, one resulting in a patient death. Since reporting to the **Oregon Patient Safety Commission** is voluntary, it's only a rough indicator of the numbers.

Researchers have found that it's very easy for surgeons to confuse left and right when standing over rather than facing a patient. For some procedures, such as spinal surgery, target sites are hard to distinguish from healthy sites. Identical or similar patient names cause mix-ups. Miscommunication was a factor in two-thirds of cases in Oregon last year.

The universal protocol featuring surgical site marking, time-outs, safety checklists and other steps was supposed to greatly reduce, if not eliminate wrong site errors. Since 2004, the nation's largest health care credentialing entity, the Joint Commission, has required hospitals to follow the universal protocol.

Dr. Brett Sheppard, professor of surgery at **Oregon Health & Science University** and member of the patient safety commission, said data from Oregon hospitals suggest that severity of harm from wrong site errors has decreased. The number of reported cases may reflect increased reporting, rather than a failure to reduce the true incidence, he said.

But as the Emanuel case and many others show, adopting protocols is not a failsafe.

"It has given us some pause, and a greater sense of urgency to get this right," said Dr. George Cioffi, Legacy Health's chief medical officer. Legacy is building in more safety measures, he said, including a second verification step in the operating room, using a red towel over the surgical instrument tray as a visual cue. No one can remove the towel until each team member gives the go ahead. Legacy said it will not charge for the botched procedure and will pay for medical costs made necessary by the error.

Dr. Sam Seiden, an anesthesiologist in Chicago who has studied wrong site error prevention, says protocols and checklists don't work if people fail to apply them consistently and correctly.

"A lot of times these time-outs are very much going through the motions," he said. "A huge barrier is changing the culture and getting people to really buy into this. It may be hard to prevent every one of these (errors), but if we did every step of the universal protocol how it should be done, every time, I think it would make a huge difference."

That's easier said than done considering the massive number of procedures every year and the rarity of wrong-site errors that must be caught.

"It's not easy to maintain your vigilance if you have to do it right 30,000 times a year," said OHSU's Sheppard. "If you don't change the culture, if you don't do it correctly every time, 30,000 times a year, something will sneak through."

While it's tempting to blame the surgeon, Sheppard said safety is the responsibility of a whole surgical team. "We are all frail, that's why you need to have team members that watch out for each other," he said. At the same time, he said, surgeons have to accept a leveling of staff authority in which a nurse, surgical assistant or medical student can halt a procedure if they see a safety step bypassed.

Patients have a role, too. Seiden said it's crucial for people to pay close attention to informed consent documents, medical records, test results and diagnostic images.

"Make sure it agrees with what you think the body part is. All medical records should say the same thing," he said. "If any of these pieces of information don't agree, you've got to put things on hold to sort it out."

But even patient involvement has a downside. In one study in which doctors asked patients to mark their own surgical sites, four out of 100 patients marked it incorrectly. In at least two surgical errors reported in Oregon, patients added to the problem by telling their caregivers the wrong site.

-- **Joe Rojas-Burke**

© 2011 OregonLive.com. All rights reserved.