PATIENT SAFETY BLOG

PATRICK MALONE & ASSOCIATES, P.C.
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# Wrong operation teaches surgeon the value of pre-procedure protocols

An orthopedic surgeon who performed the wrong operation on a patient now says he no longer sees any burden in The Joint Commission's (TJC) Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery. And he's gone on the record in a prominent medical journal to confess error and try to help other surgeons do it right.

TJC's universal protocol recommends that surgeons:

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1. Conduct a pre-procedure verification process.
2. Mark the procedure site before the procedure is performed.
3. Perform a time out.

The surgeon, David C. Ring, M.D., was treating a 65-year-old woman whom he had diagnosed 3 months earlier with trigger finger, a common disorder in late adulthood in which a finger or thumb snaps or locks before unlocking (like a trigger), caused by a swollen flexor tendon.

According to Dr. Ring's own account, the correct arm had been marked at the wrist by the nurse but the planned incision site on the hand was not marked. Dr. Ring performed three other carpal tunnel procedures that day, one of which was performed on a patient who became extremely agitated before and after the procedure, causing the surgeon to vow that the next procedure would be the best carpal tunnel release he'd ever performed. In addition, the patient was moved to another operating room, resulting in a change of personnel which meant the nurse who had had performed the preoperative assessment would not be in the room during the procedure.

About 15 minutes after performing the carpal tunnel procedure, Dr. Ring realized he had performed the wrong surgery. After informing staff, he told the patient about the error, apologized and offered to perform the correct procedure. The patient agreed, and the trigger finger release was performed. Later, the patient's son informed Dr. Ring that the patient had lost faith in him and would not return for followup care. A financial settlement was negotiated shortly after the event.

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Dr. Ring asked that the case be published in the Case Records of the Massachusetts General Hospital to encourage the development and following of procedures that would minimize the risk of such events occurring again.

Source: New England Journal of Medicine

You can view and download a poster of the Universal Protocol here.

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