Dynamic Chiropractic

NEWS / PROFESSION

Incorrect Body-Part Surgery Subject of Major Report

The subject of a recent Associated Press story[1] was a report from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that analyzed 126 cases of "wrong" surgery. Seventy-six percent of the cases involved operation on incorrect body parts, 13 percent resulted in surgery on the wrong patients, and 11 percent utilized unnecessary or incorrect surgical procedures.

"The know-how to create systems that prevent wrong-site surgeries has existed for years, yet the number of errors has not decreased. Even one wrong-site surgery is one too many," said JCAHO President Dennis O'Leary,MD. He noted that there were common instances of "patients with similar names," and that "...x-rays get reversed in view boxes; people are too busy or rushed to check charts; and sooner or later something happens."

JCAHO, headquartered in Oakbrook Terrace, Illinois, issued an alert to approximately 18,000 U.S. health care facilities in December 2001, citing communication gaps between surgeons, operating room personnel, patient families and patients as the cause of the phenomena.

The executive director of the American College of Surgeons, Dr. Thomas Russell, stressed the need for interaction: "It is important that there be cooperative openness between the surgeon and the nurses," he said. "The two groups must take responsibility, and if there are questions, they should stop to be sure everyone is on the same page. No one should make assumptions."

An original report was issued by the JCAHO in its *Sentinel Event Alert* of August 1998,[2] examining 15 cases reported to the organization. Thus began its database, which now includes the 126 analyzed cases. These can be broken down into the following categories:

Surgery Type	Percent
orthopedic/podiatric	41
general	20
neurosurgery	14
urologic	11
oral/maxillofacial, cardiovascular thoracic, ear-nose-throat, opthamologic, dental	14

Surgery Location	Percent
hospital-based or ambulatory freestanding	58
inpatient operating room	29
emergency department or ICU	13

Surgical Error	Percent
wrong body part	76
wrong patient	13
wrong surgical procedure	11

To their credit, 81 percent of the surgeons in the above cases reported the errors themselves, and JCAHO identified several contributing factors, including unusual physical characteristics, such as morbid obesity or physical deformity; time pressures; unusual OR equipment or settings; and multiple personnel or procedures involved. However, the New York Department of Health and the Florida Board of Medicine collected data suggesting underreporting, according to the *Sentinel Event Alert.*

The JCAHO, with the help of the American Medical Association, proposed monitoring hospitals in early 2002, and Florida's board in June 2001 instituted penalties, including $10,000 fines, five-hour risk management courses, 50 hours of community service, and lectures to "the medical community" on wrong-site surgery. A surgeon performing an operation when less invasive treatment could have been employed, could fall under the category of "wrong procedure." The medical community has essentially been put on alert that wrong-site surgeries and wrong procedures will have consequences, not only for surgeons, but for the facilities that employ them.

This is the first nationwide effort to address wrong-site surgeries. "Although the wrong-site-surgery problem has been addressed on the local level in many areas of the country, there has been no organized national effort to eliminate wrong-site surgery," said former American Academy of Orthopedic Surgeons President S. Terry Canale,MD.

"This is really an embarrassment for any place that has this happen; this is not infrequent," observed Dr. O'Leary. JCAHO's suggestions to health care professionals include using a permanent marker to label the surgical site on a patient, even initialing it as a sort of "sign-off"; oral verification by each OR staff member of the details of a surgery; and a final opportunity to double-check details through a "time-out" verification in the OR.

Dr. Dean Edell (not a chiropractic advocate), who gives medical advice on his nationally syndicated radio program, was asked about this subject as a guest on a recent radio talk show.[3] He remarked, half jokingly, that patients who go in for an amputation should mark the location with "Cut here, stupid!" In defense of his profession, he trotted out the specious analogy of being more likely to die in an auto accident than ... (in this case) being a victim of having the wrong body part removed. Of course the majority of people travel in motor vehicles every day, while only a small percentage of us have body parts removed.

References

1. Associated Press, December 5, 2001.
2. *Sentinel Event Alert,* issue 24, December 5, 2001 (http://jcaho.org/news)
3. The "Bill Handel Show" with guest host Rabbi Chaim Mentz, KFI-AM 640, December 14, 2001.

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