Asian Journal of Pharmaceutical and Clinical Research

Innovare Academic Sciences
Knowledge to Innovation

Vol 8, Issue 2, 2015

ISSN - 0974-2441

Case Report

WHEN THE "RIGHT WAS WRONG": A CASE OF "MISSED NEGLIGENCE"

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Received: 22 November 2014, Revised and Accepted: 02 January 2015

ABSTRACT

We report a case where the operation site was marked wrongly on the right side of the scalp. It was the timely intervention of a member of the surgical team that the possible mishap in the form of a negligent operation on the wrong site was prevented, hence, the term "missed negligence." The case is reported for its significance in the field of surgery as a caution and reminder that utmost care should be taken to determine and confirm the site of the surgery.

Keywords: Negligence, Res ipsa loquitur, Site, Surgery, Wrong.

INTRODUCTION

Patient care and safety are the cornerstone of good medical practice [1]. After the establishment of doctor patient relationship, doctor owes duty to provide all the necessary treatment to the patient as deemed essential to utmost care. Failure on the part of medical practitioners to act in an appropriate and expected way, causing damage to the patient amounts to medical malpractice [2].

When a patient submits to a major surgery, he/she places his/her confidence in the surgeon or anesthetist involved in the procedure. Shortly after the administration of anesthesia and until regaining of consciousness, the patient is ignorant to what had happened to his/her body. It's the surgeon and the treating team that takes the charge of the body, and act in such a way so as to decrease his pain, suffering and provide a cure to his/her condition. The patient's consent for surgery comes with a belief that the surgery and the injuries sustained there by in the process will be for the patient's benefit at large. Cases of gross negligence where there is an absolute breach of trust of the patient by the negligent doctor are included in the doctrine of "res ipsa loquitur" [3]. In this regard, performing surgery on the wrong site is undoubted lyan obvious act of negligence on the part of the surgeon.

We report a case where the operation site was marked wrongly on the right side of the scalp. It was the timely intervention of a member of the surgical team that the possible mishap in the form of a negligent operation on the wrong site was prevented. Hence, the term "missed negligence."

CASE REPORT

A 58-year-old scooter driver met with an accident when he was hit by a jeep that was overtaking it from the wrong side. He sustained multiple injuries and was rushed to a private hospital. On admission, his Glasgow coma scale was E1M3V1, pupils were dilated bilaterally and non-reactive. Computerized tomography scan showed evidence of acute left thick subdural hematoma with mass effect and midline shift. Fractures of right femur and tibia were also present. The patient was intubated, and emergency surgery was planned.

The part for surgery was prepared for craniotomy and evacuation of hematoma, and the site for primary incision was marked (Fig. 1a). Just when the surgeon was about to give the scalp incision on the right side, one of the team member realized that the surgery, in fact, should be done on the left side and yelled to stop. The surgeon realized his error due to this timely intervention and the patient in the end was operated on the side of the lesion, i.e. the left side (Fig. 1b).

Unfortunately, the victim succumbed to his injuries and autopsy was requested as per the legal requirements. It was on autopsy that the autopsy surgeon noticed the superficial mark on the right side (Fig. 1a) that was exactly similar in shape and size to the one on the left side where surgery was actually performed (Fig. 1b). This was itself a clear indication as to how a gross negligence was avoided at the last moment.

DISCUSSION

Res ipsa loquitur means "the thing itself speaks" and hence, the doctrine, in general, refers to the acts that are so glaring and obvious that they do not require any proof to substantiate the claim relating its causation [3]. Common scenario where the doctrine is applicable in the field of medicine include; giving wrong medication, leaving swabs and/or instruments in the body cavities, wrong amputations, operation or procedures on the wrong site, or on the wrong patient etc.

The incidences of wrong site surgeries occur more commonly than we can think, and occur more commonly in centers where the daily volume of procedures done is high. Wrong site surgeries reportedly are common occurrences in orthopedics followed by general surgery, urosurgery and neurosurgery [4]. A 1 year study on litigations involving surgeries on the wrong site in the year 2007 in England and Wales observed 292 such cases, 29.8% of which were related to orthopedic procedures. The proportion of wrong site surgery was estimated to be 1:105,712 cases [5].

The numbers as stated above may indicate, these events are very rare in medical practice but when occur the results are devastating for the patient as well as the doctor [4]. This may be the reason for virtually non-existence of reporting of this shameful act in the medical literature, which is a common read in the lay press [6]. Devine *et al*. [7] report in their study that 0.09-4.5 cases/10,000 surgeries are wrong site surgeries. Although rare, the consequence of this preventable incidence is difficult to measure and quantify. There are legal, social, medical and emotional implications pertaining to this issue [7].

It is only trust and confidence of the patient in his doctor that makes him voluntarily consent for the surgeries even after knowing the associated risks and danger to his/her life. "Wrong site" surgery is an uncommon and easily preventable complication in surgical practice. Wrong site surgeries are a serious cause of concern for its associated effects to the physical and mental health of the patient. Such a gross

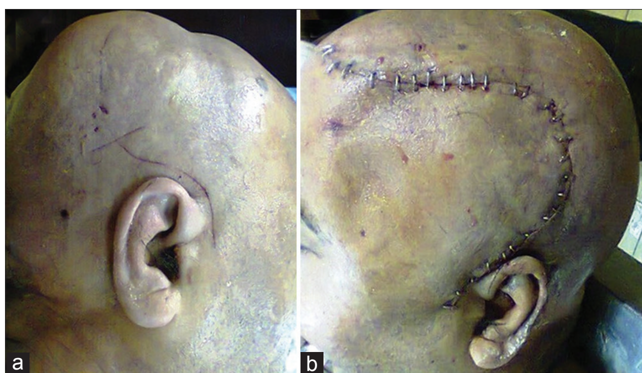

Figure 1: (a) Mark for the surgery to be performed on the right side of scalp, (b) surgically stapled wound on the left side of scalp after the actual surgery

"mistake/act of negligence" is unacceptable and unpardonable, and is often associated with serious punishments for the doctors too. Due care hence, should be taken by the medical community to prevent it from happening. Doctors should make patient's safety a top accord and an uncompromising goal [8]. The incidence of wrong site surgeries will decline to nil in any surgical specialty, once the doctors are more careful and make themselves sure about the site of the surgery and following a simple protocol of "sign your site" [9].

In the reported case, wrong marking was a clear evidence of a careless and negligent start to a procedure. Though the injury caused to the patient due to the wrong marking in itself is an act of negligence, a timely intervention prevented a surgical mishap in the form of a wrong site surgery from happening. The case is reported for its significance in the field of surgery as a caution and reminder that utmost care should be taken to determine and confirm the site of the surgery.

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