

# Editor's Notes

## Foresight Prevents Citing for Wrong Site Surgery

By Stephen Jackson, M.D., Editor



As part and parcel of our routine anesthesia practice, we are accustomed to managing issues relating to possible misidentification (checking accuracy of blood component compatibility), misinformation (charts containing another patient's lab tests, chest x-ray or ECG), or informational voids (failure to identify adverse personal or familial responses to drugs, or a Jehovah's Witness, or a DNR status). As a specialty, we have taken full ownership of these responsibilities, which rationally are integral to the practice of anesthesiology.

But, are we aware of *our mandated responsibility* for avoiding wrong site surgery? Like it or not, here in California, **"prior to commencing surgery the person responsible for administering anesthesia [, or the surgeon if a general anesthetic is not to be administered,] shall verify the patient's identity, the site and side of the body to be operated upon ..."**! This obligation is spelled out in Title 22, an easily overlooked state regulation. This "Catch 22" is found buried in Section 70223 (Surgical Service General Requirements), Division 5, Chapter 1, Article 3 (Licensing and Certification of General Acute Care Hospitals). There actually are 28 such "titles," all involving regulations adopted by state administrative agencies, many of which are almost half a century old and therein guaranteed to contain dated language.

That this onerous Title 22 regulation was in effect since 1978 was brought to my astonished attention a couple of decades ago (when I was chair of our Legislative Committee) by CSA's esteemed legislative advocate, William Barnaby, Sr., Esq. In an attempt to delete this objectionable verbiage from the State's regulations, Mr. Barnaby petitioned the Department of Health Services (DHS) to shift this regulatory obligation to the operating surgeon, clearly the more appropriate individual. With unfathomable logic, the DHS refused to alter the regulation, claiming that there was no evidence that its mandate for "verification" caused any undue practical problems for anesthesiologists.

The disturbing reality is that wrong site surgeries are not as infrequent as one might suspect. Perhaps even more shocking, there also exist numerous reported cases of wrong procedure surgery, and even wrong patient surgery! In 1998, when JCAHO became aware of such cases, this private agency with huge powers delegated to it by the federal government declared a "Sentinel Event Alert" for wrong site surgery. This prompted an inclusive, consensus-building conference that ultimately led to JCAHO's development of a *Universal Protocol* to prevent wrong site occurrences.

Of historical interest, the JCAHO's focus on wrong site surgery—as well as our concerns with Title 22 and our attempt to rescind the offending verbiage—were reported as an “alert” in our 2002 *Bulletin* by our ever-vigilant legislative advocate, William Barnaby III, Esq. (Volume 51, Number 1).

Although the ASA has endorsed the JCAHO's *Universal Protocol*, the ASA's *Basic Standards for Preanesthesia Care* (last amended in 1998) does *not* include verification of the operative site and surgical procedure, nor even patient identification as a standard of care. Given the prevalence of such misadventures and, at least in California, our responsibility to protect the patient against such events, perhaps such a standard of care should be considered for adoption by the ASA. It makes sense that patient safety involves such verification, but it might seem counterintuitive that we, seemingly alone, should have to shoulder this responsibility. At least somewhat comforting is that the *Universal Protocol*—or an institutional variant thereof—has, in fact, relieved us of sole responsibility. Therefore, all of us should be cognizant of this protocol and demand that, within reason, it be adhered to, regardless of circumstances, production pressures, personalities or other exigencies of the moment.

The essential components of this *Universal Protocol*—officially implemented into the JCAHO's accreditation process on July 1, 2004—should already be in effect in your institution and include a preoperative verification process, marking the operative site, and a “time out” procedure before initiating surgery. We now have become part of a *team* that bears joint responsibility for avoiding egregious errors of this sort. In truth, our participation in this patient safety/quality of care function is an integral element of fulfilling our ethical responsibility of always “placing the [vulnerable anesthetized] patient's interests foremost” (ASA's *Guidelines for the Ethical Practice of Anesthesiology*).

### **Even More Foresight—Beyond Katrina**

I encourage you to read the article (pages 5-8) on CSA's legendary leader and humanitarian, our erstwhile president, Tom Cromwell. As we have documented in a previous *Bulletin* (Volume 53, No. 1), Tom responded to the needs of Iraqi medicine—and especially anesthesiology—18 months ago when, in harm's way, he visited Iraq with a group of physicians. More recently, he has continued this mission by hosting several Iraqi anesthesiologists at his hospital in San Francisco, and even having them tour our CSA offices. An addendum to his unheralded but expanding list of *heroic humanitarian actions and deeds* was Tom's mission to New Orleans in the earliest of the aftermath of Katrina's wake of catastrophic destruction. The article traces the truly noble and courageous efforts of Tom and other volunteer medical colleagues in assisting Katrina's victims. But, please don't stop with that article: take the time to digest a practical accompanying report (page 9) by former CSA President, Kent Garman. He describes how we physicians can be integral to developing and participating in an organized disaster preparedness for any natural or man-made catastrophe. Kent provides us with the initial resource information to enable us to become intimately involved in very real ways with responding to emergencies that conceivably could be even greater than those induced by Katrina.