DR. WITHERSPOON

CHIEF OF STAFF

by J. M. MacDavid M.D.

Not a Clue

An orthopedic surgeon was about to start his third case, a total knee replacement. While in the holding area, the nurses reviewed the patient's paperwork and found everything in order. His H&P listed the primary diagnosis as "arthritis, right knee." The consent was signed for a right knee replacement. The vendor was ready with knee components. The patient put a mark on his right leg, as requested by the nurse. They started the prophylactic antibiotics and took him back to the OR.

He was prepped and draped in the usual manner. The OR staff did their "time out," with the circulating nurse reading aloud the consent which read "right total knee replacement." All was in order. The surgeon took the knife. The anesthesiologist noted the start time. They were underway.

But something wasn't quite right. The surgeon hesitated, knife in hand, hovering just above the skin.

"I thought this guy was a hip," he wondered out loud.

He put the knife down and asked the circulating nurse to call his office. The staff looked quizzically at each other as the nurse dialed the number.

He asked his office girl to pull the patient's chart. When she had it in hand, he asked her to read the office notes to him.

Everything in the record referenced a diseased right hip. There was not a word in the chart about his knee.

The surgeon cancelled the case.

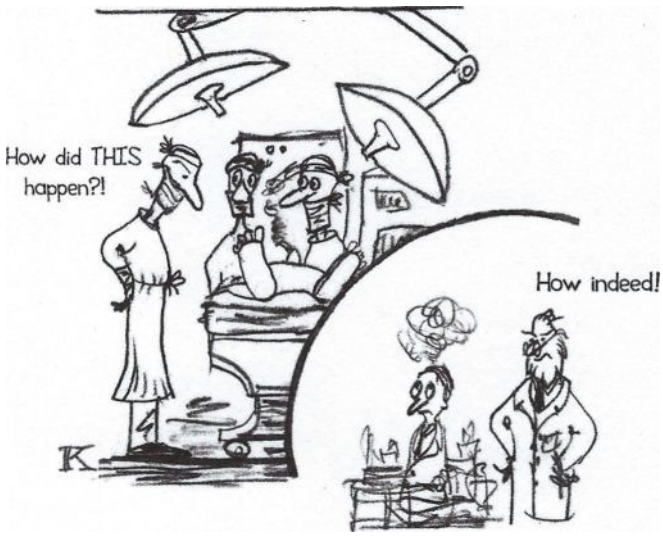
Dr. Witherspoon Says:

Sufferin' catfish! He almost whacked out a perfectly good knee.

That's as close as it gets to disaster. Everything was in order, the H&P, the consent, all of it. The only problem, it was all for the wrong operation. What happened?

The surgeon employed a physician's assistant (PA). When a patient was to have surgery, he was given an appointment with the PA who took care of all the perioperative arrangements. The PA did the H&P, filled out the consent for surgery, ordered the labs, notified the vendor, and various other details.

It was a busy practice. The PA saw patients, did pre-op work ups, assisted in surgery, was working on a computer project for the office, among other duties. It would be fair to say the fellow was pretty much getting flogged. As one might imagine could happen under such



circumstances, he had fallen into the habit of cutting comers, so to speak, now and then.

Fairly widely it seems. When this particular patient walked in the room for his pre-operative appointment the PA asked him how he was doing.

"Not too bad. My knee's hurting, though," the patient said.

Without so much as a glance at the chart or an examination of the patient, the PA wrote up an entire work-up for a knee replacement: H&P, consent, vendor notification, the works. Finally, he called the OR and scheduled him for a total knee replacement.

Now then. Before I get into the lessons to be learned from this inexcusable, almost-first-class-disaster, there are a couple of points to make.

Occasionally, hip disease will cause referred pain to the knee. This can occur in adults but is particularly true with pediatric patients. The infamous slipped capital femoral epiphysis is famous for that. Recently I had a markedly obese thirteen-year-old referred to our clinic for knee pain. As I watched him limp down the hallway, I said to the medical student standing next to me: "That's a slip."

Peds ortho pinned both hips the next day.

Occasionally this referred pain occurs in adults so the good doctor will always document a hip exam if there's any confusion about what's causing knee pain.

Remember that. Hip disease can present as knee pain, even fractures! I guarantee, if you're in this business long enough, that little axiom will rear its ugly head, usually when you're least expecting it.

Now back to this case. Lesson learned?

First of all, the generality of PA's are wonderful health care providers who do meticulous, excellent work. I'm not making excuses for this fellow but, no matter if it's a PA, neurosurgeon, or bricklayer, if overworked with an impossible schedule, inevitably, quality is going to deteriorate.

Things are going to happen. This guy did no examination and didn't even open the chart. He just shot-gunned all the paperwork based on a single comment by the patient when he walked in. Probably took him all of three minutes.

Inexcusable, to be sure. But don't overwork these guys! Put in an impossible situation with too many hoops to jump through, people are going to adapt, they'll start cutting comers, rushing through routine stuff to get to the next task, already overdue. Classic breeding ground for bad things to happen.

Next, when this case occurred, the protocol specified the patient mark the surgical site in the holding area to prevent operating on the wrong limb. That has since changed such that the surgeon himself must mark the site. Had the doctor talked to his patient in the holding area he may have discovered the error before going back to the room.

Surgeons, talk to your patients before they go back and make those marks.

Finally, why did this patient sign a consent for a knee replacement when he had been worked up for over a year for a bad hip? The doctor was known to be a bit of a fast talker. In 'n' outta there, so to speak. Are we sure his patients are getting the big picture?

It never ceases to amaze me, the number of cases we have reviewed where patients had not a clue as to what their medical problems or treatment plans were. For the millionth time, ol' "broken record" here will say it again: Doctors, educate your patients!!

If nothing else, for Pete's sake, make sure they actually know what you're gonna do to 'em when you take 'em to the OR!

Can't believe I have to say *that*.