What's New in the Patient Safety World

January 2013

How Frequent are

Surgical Never Events?

Surgical "never events" continue to occur despite a variety of patient safety interventions designed to prevent them. These include retained surgical items (RSI's) and a variety of events we classify under the term "wrong site surgery".

This month we learned from researchers at Johns Hopkins that over 4000 surgical never events occur annually in the US (Mehtsun 2012). The researchers reviewed malpractice claims and settlements reported in the National Practitioner Data Bank (NPDB) and identified cases of retained foreign bodies, wrong-site, wrong-patient, and wrong-procedure surgery. They identified a total of 9,744 paid malpractice settlements and judgments for surgical never events occurring between 1990 and 2010. But these only identify those cases in which there was actually a paid malpractice settlement or award so these are likely an underestimate of the actual occurrence of such surgical never events. Based on literature rates of surgical adverse events resulting in paid malpractice claims, they estimated that 4,082 surgical never event claims occur each year in the United States.

Importantly, the authors identified some of the demographic variables in such cases. They found that 12.4% of physicians named in a surgical never event claim were later named in at least 1 future surgical never event claim. Also 62% of the physicians were named in other malpractice claims. Surgeons in the 50-59 age bracket were more likely to be named in multiple claims than surgeons less than 40 years old. Surgeons in the age 40-49 age bracket accounted for about a third of the events overall.

In terms of patient outcomes death occurred in 6.6% of patients, permanent injury in 32.9%, and temporary injury in 59.2%. The patient age group most often affected was the 40-49 years old group.

It's pretty clear we still have a long way to go to reduce the occurrence of these surgical never events. The November 2012 issue of the Pennsylvania Patient Safety Advisory has two good articles identifying barriers to implementation of the Pennsylvania Patient Safety Authority's proposed recommendations to prevent wrong-site surgery (Clarke

2012a, Clarke 2012b). We've discussed retained surgical items in the past (see our June 12, 2012 Patient Safety Tip of the Week "Lessons Learned from the CDPH: Retained Foreign Bodies" and November 2012 What's New in the Patient Safety World column "More on Retained Surgical Items") and we will have another discussion upcoming soon.

References:

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