Case 34-2010 — A 65-Year-Old Woman with an Incorrect Operation on the Left Hand

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A Boston surgeon who operated on the wrong hand of an elderly woman has disclosed the excruciating details of his error in one of the nation's most prominent medical journals. Dr. David C. Ring, a hand and arm surgeon at Massachusetts General Hospital, described in the latest issue of the New England Journal of Medicine how a series of personal and system-wide mistakes led him to operate on the right hand instead of the left hand of a 65-year-old woman with a painful "trigger finger."

"Just imagine the worst thing that's ever happened to you and that's how it feels," said Ring, 42, of the botched surgery that occurred about two years ago. "I don't want anybody to make the same mistake I made." Ring's public admission is rare in a field that typically cloaks doctors' errors in anonymity, if not secrecy. Patient safety advocates praised Ring's seven-page mea culpa as a necessary step to reversing rising numbers of wrong-site surgeries and other errors.

"My immediate reaction was 'Bravo!'" said Dr. Helen Burstin, senior vice president for performance measures at the National Quality Forum, a safety coalition famous for pioneering a list of what were once called "never events," medical mistakes that should never occur.

"I thought it was exceptionally brave," she added

In 2008, the most recent year with complete records, 116 wrong-site surgeries, up from 93 in 2007, were recorded by the Joint Commission, a national hospital accrediting agency. Preliminary reports logged 137 wrong-site surgeries from March 2009 through June 2010. That's despite more than a decade of attention to the issue following the landmark 1999 Institute of Medicine report titled "To Err is Human."

Series of mistakes led to error

Ring, along with colleagues at Massachusetts General and Harvard Medical School, detailed the series of missteps that led to the wrong operation in the patient whose ring finger on her left hand was stiff, painful and sometimes got stuck in a flexed position, a condition known as "trigger finger."

The patient, a Caribbean native who spoke only Spanish, was the last operation on a day that included three major surgeries and three minor surgeries, Ring wrote. No interpreter was available, so Ring, who speaks Spanish, was asked to translate for her.

The correct limb was marked at the wrist, as required, but not at the surgical site. Stress was high because several other surgeons were behind schedule. As a result, the patient was moved to a different operating room at the last minute, with different staff, including the nurse who had performed the pre-operative assessment.

When the patient's arm was cleaned with alcohol in the new room, the marking was washed off her wrist. Ring spoke to her in Spanish, which was mistakenly interpreted by a nurse in the room as a "time out," the safety pause for the medical staff aimed at double-checking surgical sites, but no formal check occurred. In addition, there was a change in nursing staff in the middle of the procedure and a bank of clinical computers that diverted nurses' gazes away from the patient.

Ring performed an operation, a carpal-tunnel-release, on the patient's right hand, instead of a trigger-finger-release procedure on her left.

"About 15 minutes later, while I was in my office dictating the report of the operation, I realized I had performed the wrong procedure," Ring wrote.

Ring quickly notified the staff, the patient and the hospital's safety team and asked the patient if she wanted him to perform the correct surgery, which she did.

'Blame and shame culture'

Although he apologized to the patient, waived her fees and successfully performed surgery on the correct hand, Ring said nothing could undo the mistake. But by writing and talking about it publicly, he hoped to break the silence that still surrounds doctors' errors — and prevent them in the future.

"We're transitioning from the blame-and-shame culture," Ring said. "This is not something you sweep under the rug."

Disclosing the details of the mistake will help others learn from Ring's experience, said Dr. Peter Pronovost, a surgeon and medical director of the Center for Innovation in Quality Patient Care at the Johns Hopkins University School of Medicine.

"It's only by understanding this richness that we will be able to defend against this," said Pronovost, a renowned patient safety expert. "He should really be applauded for his courage."

Ring acknowledged that he's risking his reputation among colleagues and, more importantly, among patients."

"They will say, 'I'm glad he didn't do the wrong surgery on me," he said.

Massachusetts General Hospital officials reviewed the error, reemphasized safety protocols and coached Ring and others involved in ways to avoid specific mistakes in the future.

"I hope that none of you ever have to go through what my patient and I went through," Ring wrote to his medical colleagues. "I no longer see these protocols as a burden. That is the lesson."

As for Ring's patient? Hospital officials offered her a settlement within weeks of the event. However, her son told Ring she'd "lost faith" in the doctor and that she'd seek future care somewhere else.