KARNATAKA STATE OBSTETRICS AND GYNECOLOGY ASSOCIATION

ETHICS AND MEDICOLEGAL COMMITTEE

MEDICOLEGAL BULLETIN

Week 16:Wrong Patient, Wrong Procedure & Wrong-Site Surgery Preventing Never Events in OBGY

1. REAL LIFE CLINICAL SCENARIO

Two women with similar names were admitted to the gynecology ward on the same day. One was scheduled for laparoscopic ovarian cystectomy, while the other was admitted for diagnostic hysteroscopy. During the morning rush, the wrong patient was shifted to the operating room. Fortunately, while performing the WHO Surgical Safety Checklist, the anesthetist noticed that the consent form did not match the planned procedure, and surgery was stopped before anesthesia was induced.
Although no harm occurred, the incident was classified as a "near miss" and investigated as a serious patient safety event.

One minute of verification prevented a lifetime of litigation.

2. MEDICOLEGAL RISKS IN SUCH CASES

Wrong-patient and wrong-procedure surgeries are considered "Never Events" because they are largely preventable.
Common medicolegal causes include:

- Failure to verify patient identity
- Similar patient names on case sheets
- Incorrect case sheet or wrong consent attached
- Failure to perform surgical timeout
- Breakdown in communication between OT staff
- Inadequate site marking where applicable
- Failure to follow the WHO Surgical Safety Checklist

Even if corrected before surgery, these incidents indicate a system failure.

3. WHAT THE LAW EXPECTS

Courts expect hospitals and surgeons to have reliable systems that prevent preventable errors.
Doctors are expected to:

- Verify patient identity using at least two identifiers
- Match consent with the planned procedure
- Confirm imaging and investigation reports
- Perform the WHO Surgical Safety Checklist
- Conduct a formal surgical timeout before incision
- Ensure every OT team member participates in verification

Wrong-site or wrong-patient surgery is difficult to defend because it is considered avoidable.

4. DOCUMENTATION – THE DOCTOR'S STRONGEST DEFENSE

Correct patient identification

- Planned procedure & verified consent
- Preoperative checklist completion
- WHO Surgical Safety Checklist
- OT timeout documentation
- Team verification before incision
- Operative findings
- Postoperative verification

If a near miss occurs, document it honestly and report it through the hospital quality system. Near-miss reporting improves patient safety and demonstrates a culture of transparency.

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5. PRACTICAL SAFE PRACTICE – WHAT TO DO

- Use two patient identifiers
- Confirm procedure with patient whenever possible
- Read consent immediately before surgery
- Never skip the surgical timeout
- Encourage every OT team member to speak up
- Pause if any discrepancy exists
- Treat every mismatch seriously

Safety should never depend on memory. It should depend on systems.

6. COMMON MISTAKES TO AVOID

- Assuming patient identity without verification
- Rushing because the OT list is busy
- Ignoring incomplete or mismatched consent
- Skipping the timeout
- Poor communication during shift changes
- Failure to report near misses

Many major disasters begin with small assumptions.

7.CLINICAL–LEGAL PEARL

A thirty-second timeout can prevent thirty years of litigation.

8. REAL COURT CASE INSIGHTS (FOR UNDERSTANDING)

Wrong-patient and wrong-site surgeries have repeatedly been viewed by courts worldwide as preventable system failures.Healthcare institutions that consistently implement the WHO Surgical Safety Checklist demonstrate significantly fewer catastrophic surgical errors.

Courts generally evaluate whether accepted safety protocols were followed, documented, and actively implemented — not merely whether they existed on paper.

9.TAKE-HOME MESSAGE

Wrong-patient and wrong-procedure surgeries are among the most preventable adverse events in medicine. Patient identification, team communication, the WHO Surgical Safety Checklist, and honest documentation remain the strongest safeguards against these catastrophic errors.

Good surgeons rely on SKILL. Great surgeons rely on SYSTEMS.

Next Week's Topic:Maternal Death Review, MDR Documentation, and Medicolegal Protection of the Treating Obstetrician

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