

Opinion

Wrong-Eye Surgery: Will It Be Your Turn Next?

In my first month of residency, a wise old attending told me that surgeons who claimed never to have had a specific complication simply hadn't yet operated enough. Ever since, I've carried that aphorism in my humility handbag, where I discover it when pawing through, looking for something else. Of course, the comment assumes that all complications have a stable rate, and that it's just a matter of time before one occurs. But all surgeons expend considerable effort to push the rate ever downward with improvements in technique and procedures. It's pretty easy to demonstrate the reduction of broken capsules over time in your personal surgical experience, but it's much harder to show improvement with a complication that you've never experienced.

So it is with wrong-eye and its cousin, wrong-implant surgery. Most of us can go many years, if not an entire career, without experiencing such an event. Pretty soon, we convince ourselves that our procedures are invincible enough that it will never happen to us. And that's when it's most likely to occur.

I know, because it happened to me after 35 years in practice. A retired physician needed a glaucoma drainage device in his left eye. The Joint Commission Universal Protocol¹ was rigorously followed prior to the retrobulbar block, including the marking of the left eye and verification by all OR personnel. Subsequently, the surgical technician draped the right (wrong) eye. When

I made the first conjunctival cut, the patient said, "Ouch." So I checked ocular motility, and the eye movements were full, so we prepared a supplementary block. Only when I positioned myself to do the repeat block did I recognize it felt different, but why . . . ? Because I had blocked the other (correct) eye before!!! Thank goodness for my muscle memory. I reported the incident to medical center authorities, and a root cause analysis was undertaken. To make a long story short, my hospital system-wide now requires verification of the operative site not only before the block but also before the incision.

One paper describing a study of Ophthalmic Mutual Insurance Company (OMIC) and New York Department of Health data shows wrong-site or wrong-implant surgery is preventable.² It says that the implementation of guidelines could have prevented wrong-site or implant surgery in almost all cases, except where the error had occurred in the ophthalmologist's office preoperatively. In response to the need for ophthalmology-specific guidelines, the Academy convened a Wrong-Site Task Force in collaboration with other ophthalmic organizations. Their recommendations in a recently released protocol should be required reading for all of us, and their checklist (see page 14) is an easy reference.³

Data from OMIC indicate these cases keep appearing at a rate of 1 or 2 per month. It is my fear that surgeons

who have not experienced a wrong-site event or near miss may not be paying enough attention. Attentiveness and independent source verification from the office chart are among the most important things that the ophthalmologist can bring to the OR. Team members should not fear calling a hard stop if they have concerns. If we work together and follow the Academy's guidelines, we can reduce the incidence of these unacceptable and indefensible complications.

1 www.jointcommission.org/PatientSafety/UniversalProtocol.

2 Simon, J. *Trans Am Ophthalmol Soc* 2007;105: 513–529.

3 <http://one.aao.org/WSWIOL>.



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