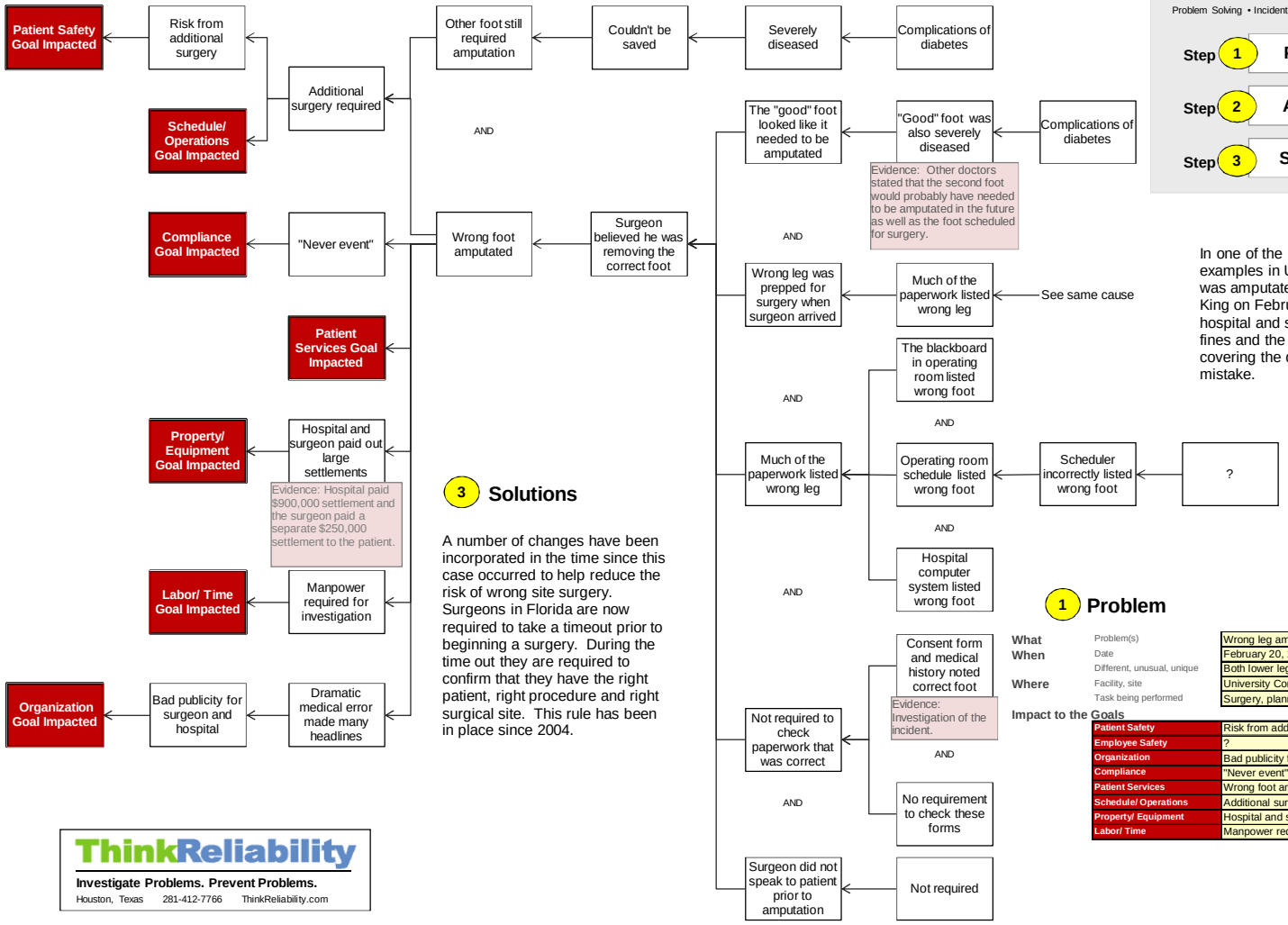
The Willie King Case: Wrong Foot Amputated

2 Analysis



3 Solutions

A number of changes have been incorporated in the time since this case occurred to help reduce the risk of wrong site surgery. Surgeons in Florida are now required to take a timeout prior to beginning a surgery. During the time out they are required to confirm that they have the right patient, right procedure and right surgical site. This rule has been in place since 2004.

Cause Mapping is a Root Cause Analysis method that captures basic cause-and-effect relationships supported with evidence.

CAUSE MAPPING

Problem Solving • Incident Investigation • Root Cause Analysis

Step 1	Problem	What's the Problem?
Step 2	Analysis	Why did it happen?
Step 3	Solutions	What will be done?

In one of the most notorious medical error examples in US history, the wrong foot was amputated on a patient named Willie King on February 20, 1995. Both the hospital and surgeon involved paid hefty fines and the media had a feeding frenzy covering the dramatic and alarming mistake.

1 Problem

What	Problem(s)	Wrong leg amputated
When	Date	February 20, 1995
	Different, unusual, unique	Both lower legs were diseased, paperwork errors
Where	Facility, site	University Community Hospital, Tampa, Florida
	Task being performed	Surgery, planned amputation of diseased foot

Impact to the Goals

Patient Safety	Risk from additional surgery	
Employee Safety	?	
Organization	Bad publicity for surgeon and hospital	
Compliance	"Never event"	
Patient Services	Wrong foot amputated	
Schedule/ Operations	Additional surgery required	
Property/ Equipment	Hospital and surgeon paid out large settlements	$1,150,000
Labor/ Time	Manpower required for investigation	
	This incident	$1,150,000

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