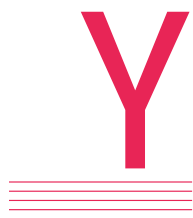


CHICAGO LAWYER

CLIFFORD'S NOTES



Years ago, two different families came into my office with a similar problem. Both had a family member who had an operation performed on the wrong side of the brain, albeit at different hospitals. This type of medical malpractice — wrong-site surgery — is a highly serious mistake.

The cases settled, but not before changes were made at these institutions and others to prevent such avoidable mistakes. Hospital personnel now mark the correct side of the body to be operated on prior to surgery. The site can then be verbally and visually confirmed by surgeons and staff, who often move too quickly from one surgery to the next.

Unfortunately, obvious errors are still regularly made. A December 2024 New York Magazine article about “never events,” or mistakes with consequences so grave that they never should occur, told the story of a man who went into emergency surgery in Florida to have his spleen removed, only to have his liver accidentally removed instead. The unintentional severing of a major artery led to his death during the procedure. Worse yet, it appears the doctor lied to the man’s widow, telling her his spleen ruptured, with a subsequent autopsy revealing the truth. As the story points out, these events often only come to light through lawsuits.

The Joint Commission, the United States’ main accrediting body for hospitals, asks facilities only to voluntarily report events that result in death or severe harm to patients. It is not mandated. Only a few states report their “never events” publicly. Illinois is not one of them.

There should be numerous checks and balances to prevent “never events,” because, as I’ve told many juries, no doctor or medical professional wakes up in the morning intending to do harm. They simply make mistakes. Even the best practitioner on any given day can be too tired, distracted or fail to follow protocol. They can have a bad day, but there are consequences for one’s actions.

And what about the doctors who make mistakes and later try to correct them, only for the patient to still suffer, possibly for the rest of their life? For example, a prominent



“NEVER EVENTS” STILL HAPPENING

Despite guardrails, tragedies continuing in ERs, doctor offices

By **BOB CLIFFORD**

orthopedic surgeon in Chicago who prided himself on never having been sued simply forgot to tighten the screws in a routine hip replacement of a 68-year-old woman. It required a revision — redoing the entire procedure just a couple of months later by reopening the foot-long scar, pulling out the artificial joint, and replacing it with a similar metal hip that required more screws and had to be held in place with larger hardware. Because the patient had to recover from two surgeries instead of just one, the physical therapy was unbearable. Was the doctor sued? No. Because any permanent injury theoretically was fixed.

What about the surgeon who killed a mother of four who was undergoing liposuction during a “tummy tuck” surgery? He had been sued several times before over prior unrelated medical errors. This time, he caused internal bleeding by cutting a muscle, and it went undetected. Then he failed to monitor the 39-year-old woman in post-op. She was transferred by ambulance from his office to a hospital for subsequent blood transfusions and surgery, but she could not be saved.

It appears many people have horror stories

of a physician making a medical mistake. They could have been prescribed an incorrect or contradictory medication, or they could have been undergoing a knee surgery that required only local anesthesia when they heard a doctor say that fateful word: “Oops.” By owning up to an error, a doctor could help their patient better deal with the subsequent healing. Instead of hiding the error, the doctor could focus on learning not to repeat it in the future. It could even help the doctor heal from their own guilt, should they have any. And hospitals might learn how to handle — even prevent — a similar situation in the future.

According to a 2010 Fierce Healthcare survey, a person will see an average of 18.7 doctors in their lifetime. Hopefully, each doctor does their best to avoid mistakes, and to treat patients with dignity and humility when errors do occur.

Those are numbers that aren’t appealing to a patient in need of care. So stay healthy! [CL](#)

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