The Willie King Case: Wrong Foot Amputated

**Problem**

- What: wrong foot amputated
- When: February 20, 1995
- Where: Tampa, Florida
- Task: surgery, planned amputation of diseased foot

**Impact to the Goals**

- **Patient Safety**: Risk from additional surgery
- **Organization**: Bad publicity for surgeon and hospital
- **Patient Services**: Dramatic medical error made many headlines
- **Schedule/Operations**: Much of the paperwork listed wrong leg
- **Property/Equipment**: Hospital and surgeon paid out large settlements
- **Labor/Time**: Manpower required for investigation

**Root Cause Analysis**

- **Problem**: Wrong foot amputated
- **Analysis**: Evidence: Other doctors stated that the second foot would probably have needed to be amputated in the future as well as the foot scheduled for surgery.
- **Solutions**: Consent form and medical history noted correct foot

**Root Cause Analysis (Cause Mapping)**

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

**Root Cause Analysis Method**

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

**Example**

- **Risk from additional surgery**: Additional surgery required
- **Additional surgery required**: Wrong foot amputated
- **Wrong foot amputated**: Surgeon believed he was removing the correct foot
- **Surgeon believed he was removing the correct foot**: The blackboard in operating room listed wrong foot
- **Operating room schedule listed wrong foot**: Hospital computer system listed wrong foot
- **Hospital computer system listed wrong foot**: Scheduler incorrectly listed wrong foot
- **Scheduler incorrectly listed wrong foot**: Much of the paperwork listed wrong leg
- **Much of the paperwork listed wrong leg**: See same cause

**Risk Mitigation**

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.

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.