## Death of Rep. John Murtha Due to Surgical Complications
## February 8, 2010

On February 8, 2010, Representative John Murtha died at the Virginia Medical Center. His cause of death was complications from gallbladder surgery. He received laparoscopic gallbladder surgery at the National Naval Medical Center in Bethesda, Maryland on January 28, 2010. It is believed that his intestine was nicked during that surgery, causing an infection which would eventually kill him.

### Timeline

| Date | Description |
|---|---|
| January 28, 2010 | Rep Murtha receives gallbladder surgery at National Naval Medical Center |
| January 31, 2010 | Rep Murtha admitted to Virginia Medical Center |
| February 8, 2010 | Death of Rep Murtha |

We begin by recording relevant basic problem information in the outline, or problem definition. We record the "what, when and where" of the incident. Because more than one date and facility is involved, it may be helpful to create a timeline of events to aid in the investigation.

Once we've recorded this information, we can define the problem with respect to the organization's goals. A patient death is our primary concern, and is an impact to the patient safety goal. An adverse event that occurs during patient care can be considered an impact to the compliance, organization, and patient services goal. Additionally, there were certainly additional costs incurred due to the additional care required, which are impacts to the materials and labor goals.

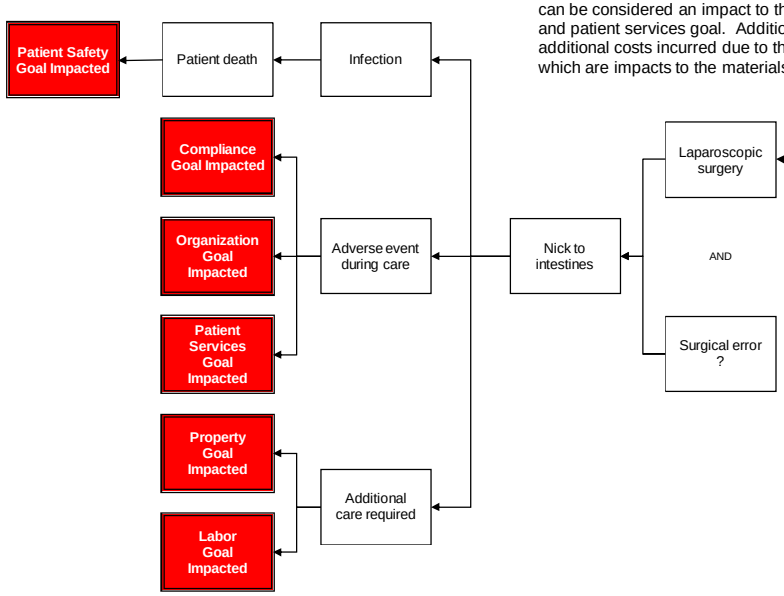
### Outline (Problem Definition)

| | | |
|---|---|---|
| **What** | Problem(s) | Death of US Representative after surgery |
| **When** | Date | Surgery - January 28, 2010<br>Death - February 8, 2010 |
| | Different, unusual, unique | Cut to intestines during surgery ? |
| **Where** | Facility, site | National Naval Medical Center (surgery)<br>Virginia Medical Center (death) |
| | Task being performed | Gallbladder surgery |

### Impact to the Goals

| | | |
|---|---|---|
| **Patient Safety** | Patient death | |
| **Employee Impact** | ? | |
| **Compliance** | Adverse event during care | |
| **Organization** | | |
| **Patient Services** | | |
| **Environmental** | N/A | |
| **Property, Equip, Mtls** | Additional care required | ? |
| **Labor, Time** | | ? |
| | This incident | ? |
| Frequency | Serious complications in < 1/1000 gallbladder surgeries | |
| | Annualized Cost | ? |

### Cause Map (Analysis)




Once we've completed our outline, we begin with our Cause Map. We begin with the impacts to the goals on the left, then ask "why" questions and fill in causes to the right. The patient death was caused by an infection believed to be caused by a nicked intestine from laparoscopic gallbladder surgery. Because not all laparoscopic gallbladder surgeries result in nicked intestines, there has to be an additional cause, but we don't know what it is. We'll just put "Surgical error ?" as a cause, and we can add more detail as more information is released.

The National Naval Medical Center has released its basic process for a quality assurance review, which is performed in the event of a patient death or adverse event during patient care. Because this process is going to be part of the solution to this issue, we can record the information we know about this process in a Process Map. Unlike a Cause Map, the Process Map flows from left to right in the direction of time to show the order of steps that should be taken. We can add this Process Map to the investigation sheet as well, for reference.

### Process Map (Quality Assurance Review)






**Why?**

Effect ← Cause

NOTE: Read the Cause Map from left to right with the phrase "Was Caused By" in place of each arrow.