CASE STUDY #1

Retained Foreign Bodies Still a Risk

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A 32-year-old female was admitted to a MLMIC-insured hospital through the emergency department with the signs and symptoms of acute appendicitis. A CT scan indicated a diagnosis of appendicitis and/or right salpingitis and a pelvic scan was normal. The insured general surgeon was called in for consultation, and he recommended that she undergo an appendectomy.

The surgeon performed the operation through a McBurney incision. A Bookwalter retractor was used in the subcutaneous tissue and also over moist laparotomy pads for exposure in the abdomen. The appendix was pointing towards the midline and there was significant inflammation around it, although it was not perforated. The peritoneal fluid was sent to the laboratory for a culture and sensitivity. The laboratory results showed no growth. The wound was packed and left open because of the operative findings. The sponge, needle and instrument counts were reported to be correct by the circulating nurse.

Postoperatively, the patient did well. Her wound packing was changed several times, and she was discharged home on the third postoperative day. She was seen in the surgeon’s office for follow-up on three occasions. Her drain had been removed and the wound was healing satisfactorily. However, she failed to keep her final appointment with the surgeon.

Four weeks following the surgery, the patient complained of right lower quadrant pain, a vaginal discharge, and prolonged menstruation. A CT scan revealed postsurgical changes in the subcutaneous tissue, with thickening of the abdominal musculature. Immediately posterior to the anterior abdominal wall, there was an 8 cm. mass with air bubbles within it. This suggested the presence of a phlegmon or abscess. A 3.4 cm. high density structure was seen in its margins. This appeared to be either a surgical change or a foreign body. The differential diagnosis was a possible abscess arising from the adnexa or the presence of an adjacent foreign body. The patient was taken to the operating room, and a laparotomy pad was removed from the site of the recent appendectomy. Following surgery, the patient did well and returned to work.

A review of the operating room nursing records revealed that only initial and final sponge, needle, and instrument counts were taken. There was no documentation of any interim count in accordance with hospital policy. The record further indicated that the surgeon was advised that all of the counts were correct.

The patient then commenced a lawsuit against both the hospital and surgeon, alleging failure to properly perform the sponge count and negligently leaving a laparotomy pad in her abdomen. The case was reviewed by a MLMIC expert, who found the case to be indefensible for the hospital. The reviewer felt that the surgeon could be defended. The case was settled on behalf of the insured hospital, since the facility’s staff nurses violated operating room policy in performing only initial and final counts. The insured surgeon was discontinued from the lawsuit and the case was resolved for $135,000.

A Legal & Risk Management Perspective

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Unfortunately, from a risk management perspective, this type of scenario is not uncommon. Pursuant to the Association of Perioperative Registered Nurses (AORN) recommended practices, the circulating nurse in the operating room is primarily responsible for accounting for all instruments, needles, and sponges. They are expected to document all of the counts and advise the surgeon.

whether the counts are correct. However, the counts must be performed in strict accordance with hospital policy and AORN standards. AORN recommends that counts of soft goods be performed: prior to the procedure (baseline); when new items are added; before closure of a cavity within a cavity (uterus); when wound closure begins; and at skin closure at the end of the procedure or when counted items are no longer in use at the end. AORN also recommends counts at the time of permanent relief of the scrub person or circulating nurse. Clearly the counts in this case did not conform to hospital policy and AORN standards, because only an initial and final count were performed and documented.

There are other problems that may arise with the performance of equipment counts which often contribute to the retention of foreign bodies. During long surgical procedures, the circulating nurse may leave the operating room for a break and another nurse may temporarily assume circulating nurse responsibilities. The relief nurse may perform the final count before the original circulating nurse returns to the operating room. However, all too frequently, the original circulating nurse returns and signs the final counts during the period after the nursing changeover, without confirming that they are actually correct. This is an extremely risky situation, since pads, needles, and/or instruments may have been added to the field during a nurse’s absence but not documented by anyone. If the final count is incorrect, but the original circulating nurse has not personally verified that the documented count is accurate, that nurse has accepted full responsibility and potential liability for counts he/she did not actually perform.

The surgeon who performs the procedure relies substantially upon the accuracy of the circulating nurse’s counts. In the past, this reliance often relieved the physician of liability. However, in a complex procedure where the operative field is quite bloody and the surgeon has required numerous additional laparotomy pads and/or needles and instruments, the physician must reassess and search the operative site for unexpectedly retained, and sometimes not obvious, foreign bodies before closing. In complex cases, when there is a question about the accuracy of the counts, the surgeon might consider having an intraoperative film taken before closure, as well as documenting that the operative site was carefully searched.

From a legal and defense perspective, retained foreign bodies are troublesome. New York State courts have consistently ruled that an object left in the body not intended for treatment purposes is a foreign body. The statute of limitations for medical malpractice, which generally runs for two and a half years from the date of the last act constituting the basis of the claim, will be extended to one year after the time when the patient either discovers the foreign body, or the date the patient has discovered facts which could lead to such discovery, whichever is earlier. Thus, if a laparotomy pad, instrument, or needle is discovered four years after surgery on an x-ray or during another procedure, the statute of limitations does not begin to run until that discovery. The patient then has one year from that date to commence a lawsuit. This often depends upon the nature and location of the foreign body and whether the patient’s body has the ability to ward off the foreign body so it does not cause symptoms or is seen on imaging which would lead to discovery. When unusual symptoms do arise close to the time of surgery, they warrant prompt investigation. If the foreign body is not discovered for a lengthy period of time, the lawsuit may be more difficult to defend. Thus, the risk of liability for the physician whose patient has a retained foreign body can be extended well beyond two and a half years.

Finally, there are difficulties in resolving a claim or lawsuit of this nature. Unless there is very clear deviation from hospital policy or negligence by the circulating nurse, as this case reveals, the hospital may seek to assign equal blame to the surgeon. The hospital may argue that the surgeon is equally liable since he/she placed the foreign body into the patient and because the surgeon should confirm that no foreign objects had been retained in the body before closing the operative site. When finger-pointing ensues between the two defendants, this clearly benefits the plaintiff.

In summary, making a reasonable effort to search the field prior to closure, ordering an intra-operative x-ray, if necessary, and documenting all of those efforts will mitigate the physician’s risk of liability in retained foreign body cases.
The patient, a 38-year-old male, came to see the internist complaining of back pain on four occasions in one month. The patient had a history of alcohol dependence, depression, and Vicodin use/abuse. The internist’s assessment of the patient’s back pain was not very detailed or adequate. He did not order x-rays, refer the patient for physical therapy, nor refer the patient to an orthopedic surgeon for treatment of the pain. Also, although the patient did have a history of Vicodin use/abuse, the internist still prescribed Vicodin for the back pain.

Several months later, after continuing to prescribe this narcotic despite no diagnosis of the source of the pain, the internist documented that the patient was addicted to Vicodin. Although he assessed the patient’s mental status as being depressed, the internist documented that the patient was not homicidal or suicidal. He then spent thirty minutes “counseling” the patient. The internist also referred him to the emergency department to be admitted to either a psychiatric unit or a detoxification unit. However, the patient declined to be admitted for inpatient treatment of his depression and addiction. Because of the patient’s refusal, the internist ordered Clonidine and Symbyax for detoxification and the patient was asked to return in two days, which he did.

The internist documented that the patient again appeared to be depressed, and further complained of insomnia and anxiety, but “denied suicidal or homicidal ideation.” The internist made an appointment for the patient to voluntarily enter a detoxification unit that day. However, the patient’s wife called the internist later in the day and told him that the patient had refused to be admitted to the hospital detoxification unit. The internist took no further action at that time.

Three days later, the patient killed himself with a gunshot wound to the head. The wife of the deceased patient commenced a lawsuit against the defendant internist for negligent treatment and failure to prevent the patient’s suicide.

The case was reviewed by an expert in internal medicine. His evaluation of the care provided was very critical. He determined that the defendant failed to adequately assess the cause of the patient’s back pain and failed to refer the patient to an orthopedic specialist to diagnose the cause of, and treat, the back pain. The expert was particularly concerned about the casual prescription of Vicodin for back pain of unknown origin. His major criticism involved the defendant’s failure to refer the patient to a psychiatrist instead of performing “counseling” and treating a severely depressed patient with various medications.

The case was also reviewed by an expert in psychiatry. He, too, was very concerned about the care provided. He criticized the defendant’s ability and attempts to treat a patient with an obviously serious psychiatric illness, rather than possibly seeking to have him voluntarily admitted for psychiatric treatment in a more timely manner. He also criticized the fact that the defendant had treated the patient, who had known depression and addictive tendencies, with narcotics for an undiagnosed condition for more than three months.

An additional very serious problem in the defense of this case was the fact that the internist rewrote his records shortly after the patient committed suicide. The rewritten records emphasized the multiple attempts of the defendant to have the patient voluntarily undergo detoxification and/or psychiatric inpatient treatment.

Because of the serious deficits found in the defendant’s care of this patient, and the difficulties in defending the defendant, the case was settled for $925,000. The age of the patient and the fact that he had a family to support contributed, in part, to the size of the settlement.

**A Legal & Risk Management Perspective**

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The defendant internist in this case was faced with a common dilemma. In a healthcare environment offering fewer
options for patients requiring mental health and/or substance abuse treatment, the defendant chose to treat his patient's mental health condition and addiction himself. As this case demonstrates, this course of action carries many pitfalls.

This patient came to the defendant with a history of alcohol dependence, depression, and narcotic use/abuse. These conditions should have raised a red flag in the defendant's mind that this patient would probably best be served by being under the care of a specialist. However, rather than immediately referring the patient to any specialist, the defendant chose to treat the patient himself. He continued the patient's controlled substance prescription for months without making any attempt to refer the patient so that the underlying cause of the patient's back pain, and resulting narcotic use, could be definitively diagnosed. So, too, even though the defendant assessed the patient's mental status as depressed, he did not refer the patient to a mental health professional, and instead attempted informal “counseling.”

It almost goes without saying that primary care physicians who have patients with mental health and addiction issues should be especially confident that they have the training and competence to manage these issues. Here, the patient's history of depression, insomnia, and anxiety, along with his longstanding narcotic dependence, should have alerted the defendant that the patient needed timely specialized care. When the patient refused to be admitted for inpatient treatment of his addiction, the defendant took it upon himself to prescribe medications for detoxification. The wife's call that the patient again refused to enter an inpatient program should have underscored the need for swift follow-up, since the patient had been compliant in keeping prior office visits.

Finally, once a medical record is shown to have been altered, it leaves the impression that the defendant's statements and version of events cannot be trusted. It is incredibly damaging to the defense of any malpractice case, and, in part, contributed to the high settlement in this case.