The Surgeon and the Nurse Share the Blame:

A case of a retained sponge (1)

By Lorne E. & Fay A. Rozovsky

The Facts of the Case

On April 19, 1982, orthopaedic surgeon, Dr. MacKenzie, operated on the 61-year old plaintiff, Frandle. A sponge was left in the plaintiff's left hip while bone from the hip was being removed and grafted onto an ankle. The sponge was not discovered until December, 1983 and was removed on January 30, 1984.

The patient subsequently sued the doctor and the hospital. The matter was heard before Mr. Justice Mackoff of the British Columbia Supreme Court. His Lordship found that both the surgeon and the nurses were responsible for the retained sponge. He found that the nurses were negligent for failing to keep a proper count and the doctor was negligent in failing to order a formal count before closing the incision.

The justice also found however, that the doctor was negligent in failing to conduct a careful search of the incision for the presence of foreign objects. He was also found negligent in failing to order an X-ray which would have revealed the sponge, since there was a radioactive marker attached to it.

In conclusion however, the trial judge placed full responsibility on the surgeon since it was he who could have prevented the consequences of the nurses' negligence and his own initial negligence.

In fact, action could not have been brought against the nurses because of the fact that the plaintiff was receiving compensation under the Workers Compensation Act which prohibited such action. However, this did not prevent the court from determining whether or not the nurses were at fault, since this would affect the responsibility of the doctor. If the facts had not involved workers compensation, the question of actual liability on the part of the nurses would have been very different.

The Court of Appeal

Dr. MacKenzie appealed the verdict of the trial judge. The plaintiff also appealed on the amount of compensation awarded.

In reviewing the decision of the lower court, the British Columbia Court of Appeal stated that it was clearly a case where the damage had been caused by the fault of two or more persons. Mr. Justice MacFarlane speaking on behalf of the the three appeal judges who heard the case said that it is clearly a case of shared responsibility between the doctor and the nurses calling for apportionment or division of fault.

His Lordship noted that the hospital made available to the doctor three methods to ensure that surgical sponges were not left at the surgical site. The first was for the nurses to conduct an informal count. The second was for the nurses to conduct a formal count upon the surgeon's request. The third was the provision of sponges with radio-opaque markers and x-ray equipment to detect them.

In this particular case, the doctor chose to rely on the first method only, that is the informal count by the nurses. The trial judge said that it was the surgeon's responsibility to order a formal count. The appeal court agreed with the trial judge's conclusion. The court said however, that it was clear that the failure of the doctor to do that did not relieve the nurses of the responsibility to take reasonable care to keep track of the sponges.

Because the doctor failed to search for and find the sponge and to confirm the absence of foreign material by X-ray, both the trial judge and the appeal judges found that the doctor's negligence was greater than that of the nurses. Considering all these factors, the Court of Appeal overturned the decision of the trial judge, and divided responsibility as 80 percent to the doctor and 20 percent to the nurses. The award of $15,000 by the trial court was raised to $25,000.

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Lessons to be Learned

From the point of view of operating nurses, what lessons can be learned from this decision?

1. The wrong-doing or negligence of a surgeon (or in fact an anaesthetist) does not excuse a nurse from responsibility for negligence or other wrongdoing.
2. The fact that the negligence or other wrongdoing of a nurse could have ben prevented, or the injury caused by the negligence could have been prevented by a surgeon and was not, does not remove the nurse from legal responsibility for any injury which may result.
3. Many risks of surgery such an the retention of surgical sponges or other foreign bodies are shared between surgeons and nurses.
4. The surgeon is not the captain of the ship nor does the surgeon take complete responsibility for everything that occurs in the operating room.
5. Nurses who suspect that something has gone wrong during surgery have a duty to the patient to bring it to the attention of the surgeon and to take whatever steps are necessary to correct it. If the surgeon attempts to prevent reasonable nursing steps to be taken, such as a sponge count, nurses should record the matter and appeal immediately to the operating room supervisor.
6. Since the problem of retained sponges, needles and other foreign bodies continues to be a problem, every hospital should have a written standard of practice established following the advice of both surgeons, operating nurses and the risk manager. The procedure should include a method by which outside assistance can be summoned if there is a medical-nursing disagreement.
7. The failure of any surgeon in following the procedure without a reasonable excuse should be reported to the appropriate medical staff committee and should be considered as a matter for privileges review.
8. The failure of any nurse in following the procedure without a reasonable excuse should be grounds for discipline and possibly dismissal.
9. Any suspicion that foreign material may have been left in a surgical patient should be immediately reported to the risk manager. No further comments are to be made on the subject to anyone without the instructions of the risk manager.
10. The risk of retained foreign material should be reviewed on a regular basis to ensure that the procedure to prevent this from occurring is being followed and is working, and that all necessary equipment to alleviate this risk is available and is effective.

(1) Frandle v. MacKenzie (1991), 5 C.C.L.T.(2d) 113 (B.C.C.A.) appld. from (1989), 47 C.C.L.T. 31 (B.C.S.C.)