Vyse vs. the Sisters of St. Joseph and Sweeney*

A case of a retained eye needle

By Lorne E. and Fay A. Rozovsky

On July 10, 1981 Dr. John P. Sweeney operated on the left inguinal hernia of Mark Vyse at St. Joseph's Hospital in London, Ontario. Following the first phase of the operation a needle count was conducted. It was found that an eyed needle was missing and a hunt was commenced. Clothing, including hats and masks, drapes and flooring were checked as well as the site of the wound. No trace could be found.

An x-ray machine was brought into the operating room to have an x-ray taken of the abdomen. The x-ray did not disclose the presence of a foreign object. A certain amount of confusion existed, however, whether the x-ray was taken of the proper area. The next day the radiologist's report identified the x-ray as being that of the chest. Over five years later the radiologist amended the report to indicate that it was an x-ray of the abdomen. This was done about two months after the patient brought a lawsuit against the surgeon and the hospital.

Unfortunately, the truth could not be discovered since the x-ray had been disposed of in keeping with the hospital's retention policy of six years. This occurred despite the fact that litigation had already been commenced.

The evidence during the subsequent trial indicated that 18 swedged needles were used and accounted for in the O.R. In addition, three eyed needles were used. Dr. Sweeney testified at the examination for discovery which proceeds the trial that he probably used an eyed needle. At the trial he stated that he did not use an eyed needle. He reached this contradictory conclusion by referring to the surgical count.

WHAT THE COURT FOUND

District Court Judge D.G.E. Thompson did not accept Dr. Sweeney's evidence, and reached the conclusion that in fact he had used an eyed needle. The judge noted that an examination of the record did necessarily justify such a conclusion. The court also concluded that Dr. Sweeney had in fact lost the needle and that it ended up in the left lower pulmonary lobe. This was not discovered until December, 1985 when the patient was x-rayed after a fall. This was the first time that Mark Vyse knew of its existence and that it had been lost during the previous operation.

Without any evidence as to what had actually happened during the operation or what part of the body had actually been x-rayed, the court concluded that the needle lost during the operation had in fact gotten into the wound and almost certainly moved to its present position by passing through a large vein to the heart, passing through the heart and then into an artery leading to the lung and then to the present position.

The action against the hospital had been dismissed previously. This left the court to determine whether the surgeon was negligent. The court was satisfied that the doctor was negligent. The judge said that this incident would not have occurred without negligence. He said that on the balance of probabili-

ties the needle would have been seen if a thorough, appropriate and accurate search had been carried out including the taking of an x-ray in the proper area.

The judge commented that he was not impressed with the evidence respecting the x-ray not disclosing a foreign object. He found it surprising that the radiologist was not called to give evidence why he changed his report six and a half years after the event. The court also found the destruction of a vital piece of evidence during the course of litigation as being highly unusual.

THE LESSONS

Malpractice cases involving the so-called "retained" sponge, needle or instrument have always been considered as among the most obvious to prove. Because of the obvious risk of a lawsuit involving the retention of a foreign object during surgery, the steps taken to prevent and subsequently handle such a situation should also be well entrenched in any surgical administration. This case illustrates that despite this awareness, some of the more obvious mistakes can still be made. Many of these could have been prevented if effective risk management measures had been used in this case.

(1) The loss of a foreign object during surgery gives the court an opportunity to infer that there was negligence, even though there is no evidence of failure to meet reasonable standards.

(2) If an object is lost during surgery, the search should not cease until reasonable efforts have been made to locate it. While the operation may have to continue in order not to place the patient at risk, the search should not be abandoned solely on the basis that it cannot be found in the patient.

(3) A standard document should be used to record missing items and the steps taken to find them. The document should record what x-rays were requested and that these x-rays were in fact taken. The documentation should reflect that reasonable and prudent efforts were made to locate the missing item.

(4) While the case against the hospital and therefore the nursing staff was dismissed, under different circumstances the court might find a hospital and its staff negligent for allowing a surgeon to leave the O.R. without the object having been found. This would include a surgeon who refuses to assist in a search or to take appropriate steps to search. A hospital could also be considered negligent if its staff gave incorrect count information to the surgeon or did not conduct a proper search on its own.

(5) If the O.R. staff could not find the object, immediate notification of supervisory authority should be given and the risk manager and claims manager involved.

(6) The patient should have been informed of the mishap which might have prevented him from taking legal action.

(7) All records involved in any incident in which there is an obvious risk of litigation should be segregated by the risk manager and should not be tampered with or destroyed either before or after litigation has been commenced. This does not prevent additional notes being made which would correct any misinformation on the records. The records as originally made should not be changed.

There is no doubt that retained foreign objects will continue to occur from time to time. A stricter control over this risk, however, might have lessened the consequences.

* Dist. Ct. Ont., July 11, 1990, London #4939/86 (unreported)

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