SURGEONS KNOCKED OUT FOR THE COUNT

by Mark A. Lienhoop

Indiana's Civil Pattern Jury Instruction, 2nd Ed., No. 23.03 provides: "In performing an operation, a doctor has a duty to the patient to remove [name the foreign object(s)] and cannot delegate that duty." The fairness of imposing this obligation on the surgeon may seem obvious on first thought but in fact it is not the standard of care practiced in the real world. For the reasons discussed below, it is no longer logical nor good social policy to uniformly put this non-delegable duty on the surgeon as a matter of law.

The standard of care actually practiced by surgeons is to delegate to operating room (OR) staff, such as nurses or surgery technicians, the responsibility to keep track of "the count." The count refers to the number of foreign objects that go into a patient during a surgery and whether those foreign objects have been removed or accounted for before the patient's incision is closed.

It is also routine for the OR facility to assume this responsibility through its OR staff's conduct, and often additionally through its policies and procedures. The OR facility typically supplies (and charges for) most, if not all, of the foreign objects used during a surgical procedure. The OR facility arranges for these foreign objects to be sterilized, present in the OR, and counted before the surgery begins. The OR facility always assigns at least one staff person to keep track of all these foreign objects used during the surgery, and to account for the removal of all foreign objects before the surgery ends. A record of whether or not the count is correct is kept by an OR facility staff member and is usually found in a separate facility nursing record regarding the operation.

In other words, the standard of care actually practiced by both the surgeon and the OR facility places responsibility for the count on the OR staff. In many, if not most, OR settings, the

surgeon has no employer, ownership, nor agency relationship with the OR facility or the OR staff responsible for the count.

For many years, standards of care regarding operating room support procedures have been defined and maintained by the Association of Perioperative Registered Nurses (AORN). Nationally accepted standards require that the OR assign a staff member such as scrub nurse, circulating nurse, or surgical technician to keep track of the type and number of all items that go into the surgical site, of all items that are removed from the surgical site, and to advise the surgeon before closing the surgical incision if the "count" of those items is correct. If the count is correct, it means there is no discrepancy between the type and number of items that went into the patient compared with the type and number of items removed. If the count is correct, the incision can be closed. If the count is not correct, then search is made in the OR for the missing foreign object. If it cannot be found, the surgeon will search inside the surgical site to the extent such would not further harm the patient. If the foreign object still cannot be found, then a STAT, or immediate, portable x-ray may be taken of the surgical site to look for the foreign object, preferable before completely closing the patient. *See* AORN's "Recommended practice for sponge, sharp, and instrument counts in Standards, Recommended Practices, and Guidelines-AORN, Inc. 2002, 205-210.

Carol Peterson RN, MAOM, CNOR, parlays clinical questions for AORN's online journal. She references the above guidelines and supports them as the standard of care in responding to different RNs' concerns about how counts are done. Peterson has written:

> [M]easures [should] be taken to ensure that no foreign objects are inadvertently left in the patient.
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> [A]ccountability for counts during a surgical procedure is the primary responsibility of the perioperative nurse.

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> Sponges, instruments, sharps, and related miscellaneous items should be counted audibly and concurrently by the scrub person and circulating nurse. Counts should include any item that is introduced during the procedure (e.g. rectal or vaginal packs, sterile towels used to pack the viscera).
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> * * *
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> [A]fter which the circulating nurse should record the items on the count board or tally sheet.

Id.

The uniform non-delegable duty of Pattern Instruction 23.03 is both unrealistic and impractical. In most non-minor surgeries, many, many foreign objects besides instruments are introduced into the operative field. These include needles, retractors, clamps, sponges, etc. Not all of these foreign objects are large nor are they kept in the surgeon's hands during the surgery. Once inserted into the surgical site, these foreign objects can become hidden as the internal anatomy is necessarily manipulated during the surgical procedure. This is especially true when the surgery is in the abdominal cavity.

For the benefit of patients, surgeons devote their full time and attention to the surgical task at hand. On a daily basis surgeons rely on anesthesiologists, nurses, and techs to each do their own jobs in the OR. Each participant has a role to play and responsibilities are assigned according to those roles. As a practical matter, the surgeon must be allowed to delegate the responsibility of the count to the OR staff because the surgeon is unable to pause the surgery, break sterile technique, get a pen, and note each item on the count sheet as it is introduced into the patient's body during the surgery. Any lay person that actually watched one non-minor surgery in the abdominal cavity would understand and agree with this.

Pattern Instruction 23.03 is analogous to the antiquated "Captain of the Ship"doctrine. *See, e.g., Miller v. Ryan*, 706 N.E.2d 244, 251 (Ind. Ct. App. 1999)(instruction properly given

that primary surgeon responsible for assistant's negligence). The Court in *Miller* noted that the general language contained in the complained of "captain of the ship" instruction was taken from *Funk v. Bonham*, 204 Ind. 170, 179, 183 N.E. 312, 316 (1932).

Interestingly, *Funk* involved a foreign body, a laparotomy or “lap” sponge, left in a patient after removing a tumor from the abdominal cavity. The defendant surgeon in *Funk* appealed a jury verdict for the plaintiff patient raising several issues. One issue was that the patient had not presented any expert testimony.

> The proposition presented by appellant upon the question of evidence would leave the matter of negligence to be decided exclusively upon the opinion of expert witnesses, as to whether or not the surgeon, in leaving the sponge in the abdominal cavity, relied upon a custom of depending exclusively upon the count of the sponges by nurses employed and furnished by the hospital.

Id., at 316. The *Funk* court held that expert testimony was not required on such an issue because the doctrine of *res ipsa loquitur* applied to a lap sponge that was not supposed to be left in the patient after the surgery was completed.

Funk is cited in the Comments to Pattern Instruction 23.03, along with *Miller*, as authority for that instruction but upon careful review, this was not the holding expressed by the court in *Funk.*

The surgeon in *Funk* argued that he could not be liable *as a matter of law* because the responsibility, and therefore the sole legal duty, for the count was on the OR staff. The *Funk* court disagreed and held that the surgeon could not as a matter of law escape liability by simply delegating this duty. However, at the same time the *Funk* Court made it clear that it was not holding as a matter of law that a surgeon could never delegate this duty. Instead, the *Funk* Court held that whether or not delegating this duty was a breach of the standard of care was a question of fact for the jury.

> And, although the proposition here contended for is supported by *evidence that good surgery practice depended upon nurses to account for all instruments and sponges used*, such expert evidence *is competent for a jury to consider in ascertaining* the fact *whether this surgeon was negligent in leaving the sponge in the cavity*. The finding of negligence under such evidence is the sole province of the jury.

Id. (emphasis added) Pattern Instruction 23.03 incorrectly takes the *Funk* decision and applies it inversely. Just because every mother is a woman does not mean that every woman is a mother.

Funk's holding that a surgeon could not as a matter of law escape liability by simply delegating the duty for the count to the OR staff is not the same as holding as a matter of law that the duty regarding the count is never delegable. The Court in *Funk* held that this was an issue of fact for the jury.

Pattern Instruction 23.03 may have provided an appropriate deep pocket for injured patients back when most ORs were in uninsured, charitable, not-for-profit or local government owned hospitals. However, it no longer serves that purpose. Hospitals and Surgery Centers advertise for business based on their quality of care. These facilities separately charge patients for the operative services they provide. These charges are for more than the use of the room, its equipment, and supplies. These charges include the professional staff of trained nurses and surgical technicians. Most facilities in Indiana with ORs are insured and have limited exposure as qualified health care providers under Indiana's Medical Malpractice Act. Ind. Code 34-18-1-1.

There is simply no longer any justification for making a surgeon responsible for everything included in the count *as a matter of law*. Instead, such delegation should be a part of the factual question of whether the surgeon, and the OR facility, met the standard of care under the circumstances of a particular case, regarding a particular foreign body.

The Indiana Supreme Court established the legal definition of the "standard of care" in

Vergara v. Doan, 593 N.E.2d 185 (Ind. 1992)(Given dissenting). *Vergara* held that a health care provider must exercise that degree of care, skill, and proficiency exercised by reasonably careful, skillful, and prudent practitioners in the same class to which the health care provider belongs, acting under the same or similar circumstances. *Id*., at 187.

It should be left to the jury to determine if the surgeon met the standard of care by delegating responsibility for the count to the OR staff. This would bring the law on this issue in line with the current standard of medical practice and with sound public policy. Responsibility for the count should not be the surgeon's duty as a matter of law, but should be a factual question for the jury as to whether leaving a particular type of foreign body in a patient during a particular type of surgery was the negligence of the surgeon, the OR facility, or both.

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