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Foreign Objects and Doctors' Liability

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COMMENTS

Foreign Objects and Doctors' Liability

Today it is highly recognized that surgeons are liable for leaving foreign objects in the bodies of their patients. Dentists are also being sued for malpractice. Statistics in 1960 showed that over 10,000 malpractice suits were filed in the United States. The number of satisfied claims increased eighty-four per cent from 1954 to 1959. These changes were reflected in malpractice insurance coverages. Medical practitioners are urged to take out malpractice insurance which generally ranges from four hundred to six hundred dollars per year.¹

The aim of this comment is to alert the public concerning doctors' liability for their failure to remove objects or substances inserted, intentionally or unintentionally, in the patient's body in the course of surgery or treatment without the intention of leaving them there permanently.

Foreign objects are often found in the bodies of patients. The fault is often that of the surgeons as well as of others. Generally, it is the physician's or surgeon's duty to remove the foreign body because inexperienced removal by another may prove to be dangerous. If it is very large, the foreign body is likely to be embedded in the large blood vessels, and removal might easily lead to hemorrhage. Removing the body might also cause the breaking off of splinters or dirt fragments which would irritate the tissues and cause swelling, and cover the foreign matter in such a way as to make the care of the patient difficult.

A physician or surgeon is held to the requisite degree of learning, skill and ability necessary to the practice of his profession and he must apply those facilities with ordinary care and diligence in every case.² One can recover against a physician or surgeon who does not exercise his best judgment, reasonable care, and diligence in the application of knowledge and skill to his patients' care. If the physician's lack of reasonable care and diligence is the proximate cause of the patient's injury, he is civilly liable for the consequences.³

These are the three common methods of preventing operating room

¹ Russel V. Lee. *The Physician* (1969).

² See *Mullinax v. Hard*, 174 N.C. 607, 94 S.E. 426 (1917); *Nash v. Royster*, 189 N.C. 408, 127 S.E. 356 (1925).

³ *Belk v. Schweizer*, 149 S.E.2d 565 (1966).

objects from being left in a surgical wound: (1) sponge or instrument counts, (2) attachments on laparotomy pads and on drains and tubings,⁴ and (3) X-rays taken at the time of the operation, sometimes made more effective by the use of radio-paque threads in sponges and pads. X-rays are also one of the post-operative methods of detecting foreign objects left in an operative wound.

The failure to follow an established procedure such as a sponge or instrument count may be evidence of negligence, but it has been held not negligent to omit a sponge count in operations where sponge counts are not customary.⁵ If a sponge count indicates that a sponge is missing and it is not found before the operative wound is closed, this may be evidence of negligence,⁶ depending on the efforts made to discover the sponge and the patient's condition.⁷ On the other hand, the fact that a sponge or instrument is missing does not in and of itself establish that the operating surgeon did not exercise due care to prevent a sponge or instrument from remaining in the operative wound.⁸

In a number of cases it has been held that even though a foreign object was non-negligently left in the patient's body the operating surgeon or dentist was liable for failing to discover or remove the foreign object within a reasonable time.⁹ Also the courts have held that where an operating surgeon had reason to suspect the presence of a foreign object in his patient's body and failed to advise that x-rays be taken for the purpose of discovering the object is evidence of his negligence.¹⁰ Even where x-rays were taken by a defendant surgeon disclosing the presence of a foreign object in the body of his patient, evidence that earlier taking of x-rays might have prevented substantial injury to the patient has been held sufficient to support a jury verdict in favor of the plaintiff. In another case it was held that where an operating surgeon leaves a foreign object in his patient's body during the operation and immediately there-

⁴ See *McLennan v. Holder*, 36 P.2d 448 (1934).

⁵ *Landsberg v. Kolodny*, 302 P.2d 448 (1956).

⁶ See *Smedra v. Stanek*, 187 F.2d 892 (1951).

⁷ *Rayburn v. Day*, 268 P 1002 (1928) wherein the court held that where an operating surgeon was told that one of the sponges was missing and the surgeon made a manual examination of the operative field for the sponge without success and closed the incision, such procedure was sufficient to sustain a jury verdict for the defendant because of the poor condition of the patient. See also *Ruble v. Busby*, 149 P. 722 (1926).

⁸ *Winchester v. Chabut*, 32 N.W.2d 358 (1948).

⁹ *Harris v. Fall*, 177 F. 79 (1910).

¹⁰ *Fairley v. Douglas*, 76 So. 2d 576 (1955); *Pasquale v. Chandler*, 214 N.E. 2d 319 (1966); *Mitchell v. Saunders*, 13 S.E.2d 242 (1941); *Hunt v. Bradshaw*, 88 S.E.2d 762 (1955).

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after discovers this fact, he is justified in immediately operating on the patient to remove the object, even without the consent of the patient or other person authorized to give such consent.¹¹

Courts apply different doctrines or rules relative to a physician's liability for not removing the foreign body from the patient's body. The doctrine of *res ipsa loquitur* is the most popular doctrine, which calls for medical evidence that pieces of the foreign body had been allowed to remain in the patient. Also one might go some steps farther by entering into evidence that if one were to leave a foreign body in a patient, sound practice dictates that x-rays should be taken some time after the operation to ascertain its location and its involvements. The moving party would have to allege that this was not done in order to hold the physician or surgeon liable.¹² The plaintiff's lawyer should, if possible, show that the plaintiff was under an anesthetic at the time of the operation, in order to explain his lack of knowledge that the foreign object was present. He should prove the effect of the foreign matter and show the defendant's prognosis after the operation, in order to demonstrate that something was wrong and that the defendant had notice of it. He should also show that the pain disappeared after the object was removed. As elements of damages, the plaintiff's attorney should show pain and suffering due to the presence of the foreign object, anxiety due to pain around vital organs, and shortening of the patient's life expectancy.

The doctrine of *res ipsa loquitur* may not be invoked merely because a patient is not cured or because aggravation follows treatment. Common experience teaches that cure is never certain and aggravation is possible even though proper care is used. A doctor is neither a warrantor of cures nor an insurer.¹³ Moreover, fright by medically warranted advice is not actionable.¹⁴ Where reasonable doubt exists as to the proper treatment to pursue, an inference of negligence is not ordinarily raised from honest mistake or errors in judgment.¹⁵

In cases where the doctrine of *res ipsa loquitur* is found inapplicable, judges have based their opinion on evidence of negligence. In *Holt v.*

¹¹ An example is *Delahunt v. Finton*, 221 N.W. 168 (1928), where the court affirmed a judgment on a verdict for the defendant and held that it was well settled that a surgeon may lawfully perform, and it is his duty to perform, such operation as good surgery demands in cases of emergency without consent of the patient.

¹² See *Cassingham v. Berry*, 168 P. 1020 (1915).

¹³ *Pendergraft v. Royster*, 166 S.E. 285 (1932); *Davis v. Pittner*, 194 S.E. 97 (1937).

¹⁴ *Kraus v. Spielberg*, 137 Misc. (N.Y.) 2d 519 (1962).

¹⁵ *Brewer v. Ring*, 99 S.E. 358 (1919).

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*Nesbitt*¹⁶ the plaintiff died as a result of a sponge becoming lodged in his trachea, while under an anesthetic, during the course of extracting several teeth by the defendant dentist. The evidence disclosed that during the course of extractions the patient suddenly became pale. It was found that nitrous oxide gas was the only anesthetic that deadened patient's gums and everything was done to save the patient. The defendant dentist was of the opinion that he had removed all of the sponges placed in the patient's mouth except a portion of one which had torn, and which was visible. Subsequently, the autopsy disclosed a large blood-soaked sponge or swab of folded gauze which completely obstructed the air passage and prevented the deceased from breathing. The defendant was held liable. Two judges held that the doctrine of *res ipsa loquitur* was applicable and the third judge held that there was evidence of negligence on the part of the defendant thereby making the application of the doctrine of *res ipsa loquitur* unnecessary. The judge who found evidence of negligence on the part of the defendant stated that

... the question arises why a prudent man, without the advantages of any special skill, should not have anticipated that the unfortunate mishap might have been caused by one of the swabs or sponges which had been used during the operation, blocking the passage of air or oxygen into the patient's lungs.¹⁷

In addition it was this judge's opinion that some effort should have been made to remove the obstacle.

An Indiana case¹⁸ is another example where the doctrine of *res ipsa loquitur* was not applied. Plaintiff brought an action against a dentist for alleged negligence in breaking a hypodermic needle and allowing it to remain in plaintiff's jaw. The court held that *res ipsa loquitur* was not applicable in the absence of evidence that the needle was defective, not of a type commonly used by dentists, that it was used in a careless or negligent manner, or that it was not used according to the usual practice of skilled dentists. There was also a total lack of evidence by lay or expert witnesses that defendant was negligent in inserting the needle into the jaw of the plaintiff.

For any act of negligence the court can find liability. A physician or surgeon is liable for the consequences if the error in judgment is so gross

¹⁶ 1 D.L.R. 671 (1953).

¹⁷ 161 S.E. 91 (1931). See *Robinson v. Ferguson*, 22 N.E.2d 901 (1939), *Hawkins v. McClain*, 79 S.E.2d 493 (1954).

¹⁸ 26 Va. L.R. 919 (1940).

as to be inconsistent with the exercise of that degree of skill and care which is his duty to apply. The failure to give needed continued care under an obligation to do so constitutes negligence or malpractice. If one could show that the physician or surgeon did not give reasonable notice or provide a competent physician in his place he could hold the doctor liable for increased pain and suffering resulting therefrom.¹⁹ In *Reeves v. North Broward Hospital District*²⁰ the jury found that the hospital employee did not exercise such reasonable care toward deceased as his known condition required. It has been stated in an article entitled "Doctor and Patient and the Law" by Lewis J. Reagon that one of the purposes for which the appellant was employed was to exercise his best judgment as to the means of relieving intense pain of the appellee, it was not only his duty to relieve that pain but necessary to do so in order to permit a determination of the cause.²¹

The courts have become more acutely aware of the need to protect an injured patient by inducing the physician to explain the reason for the injury or suffer the penalty of an adverse inference in the absence of such explanation. Generally, an inference is raised if the doctor leaves some debris in the plaintiff's body that the doctor did not exercise due care.

Another doctrine that the courts adhere to is the doctrine of common knowledge. It is a doctrine closely related to the doctrine of *res ipsa loquitur*. The doctrine of common knowledge is also used by the courts to enable plaintiffs to get their cases submitted to the jury. The effect of applying this doctrine is to allow the jury to supply the applicable standard of care and thus to obviate the necessity for expert testimony. The jury, from its fund of common knowledge, assays the feasibility of possible precautions which the defendant might have taken to avoid leaving the foreign body in the patient which caused injury to him.

If the doctor does not remove the foreign body, the court may apply either of the following rules: (1) community standard rule, (2) the customary or locality rule, or (3) the similar community rule. In nearly all jurisdictions a doctor is protected from malpractice suits if he does what his colleagues do, particularly if the non-weakening insular rule of the community standard is also applied.

The purpose of the community rule is to limit the liability of doctors by preventing the higher standards of other doctors in other communities

¹⁹ *Howell v. Jackson*, 16 S.E.2d 45 (1941).

²⁰ *See* 191 So. 2d 307 (1966).

²¹ *Id.*

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from being imposed on local practitioners.²² In *Brensden v. Johnson*²³ the plaintiff was unable to talk as a result of choking and strangling, but continued to write notes begging anyone who came into the room to please look into his throat. Expert testimony revealed that it was not common medical practice for doctors to disregard symptoms; that ordinarily in cases like the instant case a physician or surgeon would call a throat specialist within a few hours so that he would make a search for something that was causing the difficulty. The decision was based on the fact that the defendant did not use that degree of skill and diligence ordinarily administered by physicians in the community coupled with nonexpert testimony that plaintiff's symptoms were readily discernible by lay witnesses, to support a jury verdict in favor of the plaintiff.²⁴

The customary or locality rule has been bitterly attacked in much of legal literature. It is indirectly responsible for the broadening of the locality rule. *Louisiana v. Aetna Casualty Company*²⁵ is cited as dictum to show how the court treated the customary rule. Here the defendant's (radiologist) defense of customary practice was rejected by the court and the finding was for the plaintiff. The court held that to relieve a member of the medical profession from liability for injury to a patient on the ground that he followed a degree or standard of care practiced by others in the same locality was unthinkable when the degree or standard of care in question constituted negligence because it failed to meet the test of reasonable care and diligence required of the medical profession. It is believed that the results would have been the same had the defendant left a foreign body in the plaintiff. Most attacks on the customary rule are based on widening the scope of inquiry beyond the defendant's own community.

The first departure from the customary rule was a widening to include similar communities. This was partly to broaden liability, but it was mainly a forced recognition of the need to allow the plaintiff to go outside of the defendant's own home town to seek a medical witness to testify against him.

In *Delahunt v. Finton*²⁶ the court said that in order to submit a case

²² *Robert v. Young*, 119 N.W.2d 627 (1963), *DiFileppo v. Preston*, 173 A.2d 333 (1961), *Visingardi v. Tirone*, 178 So. 2d 135 (1965), *Wilson v. Scott*, 412 S.W.2d 299 (1967), *Govin v. Hunter*, 374 P.2d 421 (1962).

²³ 255 P.2d 1033 (1953).

²⁴ *Id.* at 1039.

²⁵ 144 So. 2d 544 (1962).

²⁶ 221 N.W. 168 (1928).

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of alleged malpractice to the jury, the plaintiff must produce medical testimony to the effect that what the attending physician or surgeon did was contrary to the practice in that or similar communities, or that he omitted doing something which was ordinarily done in that or similar communities, and that the jury determines and disposes of disputed questions of fact. In rejecting a contention that the trial court erred in submitting the question of what constituted malpractice, the court said that malpractice, in its ordinary sense, is the negligent performance by a physician or surgeon of the duties devolving upon him on account of his contractual relations with his patient, and the trial court's charge was in substantial conformity with this definition.

Some states such as Massachusetts have refused to allow a doctor from another state to testify in a malpractice suit.²⁷ The Nevada Supreme Court is even narrower in its interpretation than Massachusetts. However, it imposes the same locality rule and requires the witness of that locality to demonstrate his knowledge of such standards by having practiced there or by having been in that locality, apparently with an opportunity actually to observe medical standards. Most recently, this rule was reaffirmed by the Nevada Court in a case where an Oakland, California doctor was denied the opportunity to testify against a Reno, Nevada practitioner.²⁸

A few states have passed decisions which depart from the locality and similar locality rules and broaden the inquiry to a large area, geographically around certain large metropolitan areas. *Viita v. Dolan* is a leading case in this field with very liberal language to the effect that the standard may be the whole state or the entire northwest, but later cases have qualified this broad holding.²⁹ It would seem that in most of these states, limited facilities or isolation of the defendant's community may well still be taken into consideration as one, though no longer the controlling, index of the standard of care to be applied.

Few physicians are willing to state on the witness stand that a fellow physician's conduct did not meet the legal standard of care and even if the plaintiff finds such a witness, he will often be faced with an array of opposing medical experts.³⁰ In order to hold a doctor liable for not removing a foreign body one should attempt to produce a medical special-

²⁷ See *Coburn v. Moore*, 68 N.E.2d 5 (1946).

²⁸ *Lockhart v. Maclean*, 361 P.2d 670 (1961).

²⁹ *Viita v. Dolan*, 155 N.W. 1077 (1916).

³⁰ *Slago v. Leland Stranford*, 317 P.2d 170, 175 (1957), Billi, *An Ancient Therapy Still Applied: The Silent Treatment*, 1 Vill. L. Rev. 1019 (1961).

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ist to defeat any other conflicting testimony. Also in Alabama it would be advantageous to enter into evidence, if applicable to the facts, medical books to prove the truth of the statements made by the medical specialist.³¹ Another tactic is the use of the defendant's own testimony, but it is dangerous for even the proficient trial lawyer to attempt to secure damaging admissions from a confident and articulate physician who believes that his entire career depends on his testimony.

Furthermore, it has been held that a surgeon is liable to his patient for injury that results from the surgeon's negligence in connection with a foreign object other than cloth material or a surgical instrument left in the patient's arm, leg, or other extremity. In holding the evidence sufficient to sustain a jury verdict for the plaintiff, the court in *White v. Burton*³² pointed to evidence of the plaintiff's expert witnesses that in view of its size, the insertion of a beef-bone peg (which had been inserted by defendant in plaintiff's leg in an effort to maintain apposition and alignment and to achieve union in a fractured tibia) was bound to act as a foreign body and to irritate the plaintiff's leg. Also it would interfere with the function of the medullary canal, attributing deleterious effects by permitting the peg to slip out of place and into the lower fragment and remain there for some time. The court stated that this evidence, together with other evidence of plaintiff's experts, was sufficient, although it was contradicted by evidence on behalf of the defendant, to make out a case for the jury.

From the foregoing discussion, one can conclude that a physician is assumed to have the skill required by his profession and he has a duty to exercise such skill with due care in the treatment of his patients. This includes not leaving foreign objects in the bodies of his patients and removing those that are left unknowingly. Also, the physician should take precautionary measures such as sponge or instrument counts and X-rays taken before and after the operation in order to reduce the possibility of facing a malpractice suit based on negligence which could result in the physician being adjudged liable.

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³¹ 122 So. 416 (1929).

³² *White v. Burton*, 71 P.2d 694 (1937).