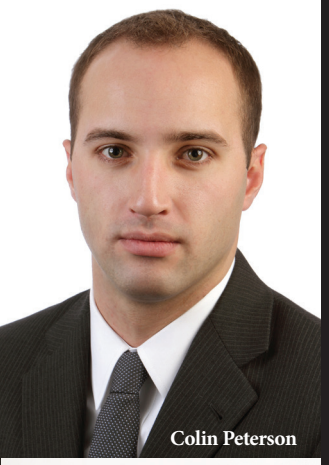
Colin Peterson


Brandon Vaughn

Hospital "Never Events": Retained Surgical Instruments and the Legal Consequences

By Brandon Vaughn and Colin Peterson

Brandon Vaughn is an attorney at Robins, Kaplan, Miller & Ciresi L.L.P. He has dedicated his entire legal career to representing individuals and families who have been injured by the wrongdoing of others. His practice focuses on helping those who have been the victims of medical negligence. He can be reached at bevaughn@rkmc.com. Colin Peterson, an attorney at the firm, represents injured plaintiffs in personal injury, medical malpractice and product liability actions. He can be reached at cfpeterson@rkmc.com.

Given the high degree of precision, accuracy, and coordination necessary to perform a modern surgical procedure, it is disturbing that surgical teams continue to fail in performing one of the simplest tasks in the OR: the instrument count.

When this count is incorrect, surgical instruments can be left inside of a patient's body after surgery. This entirely avoidable medical error is referred to as a retained surgical instrument ("RSI"). It is recognized by healthcare organizations and governments nationwide as one of 28 "never events" that should never occur in the modern healthcare setting.

The most frequent RSI is the surgical sponge but other instruments such as scalpels, clamps, scissors, tweezers, and needles are also regularly left behind. Once inside the patient's body these instruments begin to rot and fester, often leading to painful and even life-threatening complications. Bacteria and pus collect around the RSI and painful adhesions or ulcers may develop. Even when a patient is fortunate enough to discover the RSI before complications arise, the patient must still undergo an additional surgery to remove the retained instrument.

In recent years there has been a push at the state-level to establish mandatory reporting of RSI. Minnesota first pioneered this mandatory reporting system in 2003. Under that system, facilities must file a report whenever an RSI occurs and then conduct a "root cause analysis" to determine which factors contributed to the event. Roughly half of the states now employ some type of mandatory reporting system.

Despite being deemed a so-called "never event," the frequency of RSI is alarmingly high. Minnesota's reporting system identified 252 RSI cases in Minnesota from 2005-2011. And a recent study estimates these events occur 39 times per week at healthcare facilities nationwide. These estimates, however, are likely lower than the real incident rate because many RSI go unnoticed for years.

PREVENTING RSI EVENTS

In any given operating room, there can be no doubt that the primary responsibility for avoiding RSI belongs to the surgical team. But eliminating these events across the healthcare system nationwide will require a combination of improved facility protocol, patient advocacy and economic pressure.

Facility Protocol

As demonstrated by the RSI incident rates, the current instrument count protocol is failing patients. But improvements can be easily implemented. First, the surgical team should count instruments four times: when instruments are removed from the package, at the start of the procedure, when the incision is being closed, and once more before skin closure is complete. Even when the initial count appears correct, surgeons must visually inspect the surgical site carefully to ensure that nothing has been left behind. Finally, facilities should only use instruments with bar codes and radiofrequency identification so that any RSI can be quickly detected and removed before complications arise.

Patient Advocacy & Economic Pressure

National patient advocacy groups such as NoThing Left Behind® are working with various stakeholders to educate healthcare providers on how to eliminate RSI. The federal government has also incentivized hospitals to eliminate RSI by denying Medicare reimbursement for RSI procedures. Many private insurers have followed suit. That said, arguably the most important patient advocacy and economic pressure occurs in the courtroom.

Attorneys trying RSI cases must be cognizant of whether their jurisdiction will analyze the event under the typical negligence standard or whether the court will apply the most plaintiff-friendly standards of negligence per se or res ipsa loquitur. In addition, because many complications associated with RSI can take years to develop, attorneys must often overcome tricky statute of limitations issues. Lastly, as the surgical team shares the responsibility for an accurate instrument count, team members may attempt to deflect liability once litigation begins. A skilled practitioner who is able navigate these issues will obtain just compensation for an injured patient while placing economic pressure on the facility the healthcare system as a whole to avoid these inexcusable mistakes.

The modern surgical team is capable of performing some of the most complex tasks in medical history. But all too often surgical teams prove incapable of performing the exceptionally simple task of an instrument count. Fortunately, through the combination of improved protocol, patient advocacy and economic pressure, progress can be made toward making an RSI a true "never event."