Seeking responsibility for the lost swab? Search elsewhere.

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ABSTRACT

This article explores the possibility that the surgeon's control over his or her environment is not complete and that, in certain circumstances, the final swab count can be distinguished from the 'normal course of events'. We readily accept that most swabs and instruments are left inside patients simply as a result of substandard care but we cannot accept that this is invariably the case, and lessons from the common law are cited to illustrate the reasons why. We hope to persuade defendant lawyers that it might be worthwhile to tease out from surgeons under scrutiny how these factors may have influenced their practice on the day that a swab was retained.

KEYWORDS

Surgery – Never event – Litigation – *Res ipsa loquitur*

Accepted 1 August 2013

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In the last 4 years, there have been at least 322 cases of retained swabs and surgical instruments reported to the Department of Health.¹ All of these cases have been regarded as indicative of substandard care – but is that always the case?

Certainly, those who set standards for doctors assert that they are. In the definitive text for medical legal litigators, the surgical expert authority notes 'leaving a foreign object unintentionally in the peritoneal cavity represents negligence'.² Consequently, litigation in the courts over lost swabs and instruments has all but disappeared in England and Wales since in modern times, the claim has become indefensible.³ Since 2008 the National Patient Safety Agency has considered retained instruments (including swabs) as one of the original 'never events'.⁴ In so doing, the need to demonstrate a surgeon's *fault* in the retention is diminished, akin to the tortious concept of strict liability, where fault does not have to be proved in order for a claimant to succeed.

The 'lost swab' has played a key role in the development of medical law as a legal speciality. In the 1930s, the first recognisable decade of 'medical law',⁵ the majority of English cases referred to lost swabs and instruments. Consequently, during this period, cases (eg *Mahon v Osborne*)⁶ were often pleaded on the basis of the legal maxim *res ipsa loquitur* (Latin for 'the thing speaks for itself'), a claimant's device to persuade the court that from the fact that a swab or instrument had been left in situ, a presumption could be made that

the surgical care was substandard. However, this series of cases petered out through the next 30 years and there has been no record of a court report dealing with retained surgical equipment since 1961.

The retained swab or instrument is arguably the example of surgical misadventure that is most likely to conform to the requirements of the legal maxim. For *res ipsa loquitur* to apply, the accident must be an event that would not be expected to happen in the normal course of reasonable care and, in the majority of cases, the lost swab is justly indicative of substandard care. It is easy to see how a court would regard the failure to count out swabs that had been previously counted in to the abdomen as a self-evident deviation from the 'normal course of events' and we readily agree with this assertion. Nevertheless, under certain circumstances, this indicator may fail to take account of all the factors that should be considered to formulate a fair decision on the standard of care.

The first recorded English lost swab case related to Dr John Dunlop.⁷ Following a cholecystectomy and removal of gallstones in 1928, the patient returned three months later and had a second laparotomy, at which a retained pack lying amidst loops of gut was discovered. The patient, a bank manager, died a few days later, presumably of sepsis.

Dr Dunlop asserted that checking the swabs was the duty of the scrub nurse but was found negligent by the court at first instance. Dr Dunlop asked the Court of

Appeal to overturn this judgement and Professor Gamgee provided expert evidence on his behalf. The court heard that although the packs had no forceps attached to their tails, there was a great difference of opinion among surgeons as to whether this attachment was desirable. Dr Dunlop's defence was discounted and his appeal was lost. The court heard no evidence, however, as to the circumstances on the day of surgery since the defendant pleaded no such evidence, nor was it explained why the originally planned cholecystectomy became a cholecystotomy.

Soon after, the judicial approach was divided in the case of a 24-year-old labourer who died after a swab was left in his abdomen following emergency surgery for a perforated peptic ulcer.⁶ In his leading (but dissenting, on this point) judgement, Scott LJ held that the maxim *res ipsa loquitur* would not always be applicable in retained swab cases and that to apply it in every such case would be an error of law. The basis for this was the wide variety of circumstances encountered in abdominal surgery. For instance, it was argued that urgency, the operative findings, the patient's general condition, the assistance available, the efficiency of the theatre team, the surgeon's experience, the use of clinical discretion and the proximity of the patient's demise could combine to create circumstances too variable to permit a simple rule to apply.

Scott LJ's vivid depiction of the operative conditions demonstrates the difficult conditions that a surgeon in the 1930s faced during emergency surgery. The perforation in this case was the size of a three-penny piece. Solid and liquid gastric contents filled the abdomen and the movement of the intestines was '*much intensified by reason of the fact that the patient [...] was taking the anaesthetic very badly; and had great difficulty in breathing. Diaphragmatic movement was forcing the gut out of the wound, and the whole contents of the abdomen were maintained in a state of violent motion*'.⁶ The edges of the right paramedian wound were held open with Spencer Wells forceps and, in addition, 36 of these were used to control bleeding vessels. Furthermore, the court heard that 25 or 30 large swabs, each clipped, were employed in mopping the peritoneal cavity.

The sheer number of swabs and the chaos they were employed to contain clearly impressed (at least) Lord Scott. He hints that the loss of a swab in these circumstances might be understandable.

Nevertheless, Goddard LJ considered the surgeon to be 'in command' of the surgery, that swabs were not normally retained and that an explanation was called for. Despite this, in his demand for an explanation, Goodard LJ failed to acknowledge or address the surgeon's lack of control during the emergency operation or the extraordinary difficulties that he faced, as laid out by Scott LJ. Scott LJ's unusually detailed analysis of the surgical field did not help Mr Osborne's appeal, which was rejected by the majority of the court. Defendant lawyers in subsequent swab cases did not plead their cases on the basis that the clinical circumstances should be taken into account when deciding whether a surgeon falls below the reasonable standard if a swab is left behind. Perhaps they were

inclined to take the failure of Scott LJ to persuade his colleagues as an indication that such pleading would be unlikely to succeed?

In the final case (from Kenya) in the reported series, Lord Denning and his colleagues regretted that the defendant failed to plead his case fully.⁸ A swab had been retained after emergency surgery. The court acknowledged that not all mistakes amount to negligence and that the facts indicated an operation that constituted a 'race against time... they were under extreme stress'. The court speculated how blood soaked swabs might feel thin and that two together might feel indistinguishable from a bulky single, unused swab. Nevertheless, the defence provided no such evidence or alternative explanation.

On the face of it, such an omission is perplexing. Perhaps it never occurred to the defending lawyers that the operative conditions were so onerous or that the surgeon's control was, perforce, tenuous? Alternatively, the surgeon may have simply considered the operation as an everyday and unremarkable occurrence, and assumed that his lawyers would not find the circumstances of the surgery worth pleading although the judicial utterances indicate otherwise. It is also conceivable that he was reluctant to acknowledge that the surgery had been difficult since this might be seen contrary to a contemporary surgical 'creed' of steel nerves and invincibility.

There is no doubt that in some cases, it is self-evident that grounds for defence are sparse. When in *Urry v Bierer* a gynaecologist's evidence asserted that his surgical technique 'did not include' any particular effort to remind himself where he had left swabs during a Caesarean section, Hodson LJ noted that the surgeon fell 'far short' of the expected standard.⁹ It is, of course, self-evident that a careful swab count represents a minimal standard of care and, mercifully, cases such as *Urry* are rare. However, it is foreseeable that in some exceptional surgical circumstances, a swab count may not be feasible.

Absent in more meritorious cases of lost swabs is any attempt by the defendant lawyers to plead the circumstances in which these procedures were being performed or to challenge the assertion that the surgeon has complete control over the situation in an operating theatre. In the case of Dr Dunlop, one wonders whether the operative circumstances and urgency that drove him to change tack and perform a cholecystotomy might also have been sufficiently onerous to account for his failure to retrieve every swab. Regrettably, since his defence lawyers were reticent on this point, we will never know.

Safety practices in surgery are often compared unfavourably with those in the airline industry. There is no doubt that on such comparisons, surgical procedures (both peri-operatively and intraoperatively) have become far more prescriptive, ensuring that not only the identity of the patient and the proposed procedure is settled before the patient is anaesthetised but also that the correct investigations, personnel and equipment are at hand before the operation starts. Surgery in this country is safer because of these changes. Yet much more needs to be added to this core of safe perioperative management because the analogy with safe flying is not absolute and it would be

surprising (at least in the 21st century) for an operating theatre to experience the undisturbed calm that pervades the cockpit of an aircraft when isolated from the passengers on take-off and landing, and, therefore, by extension, the degree of control that the pilot enjoys.

Absent also from the analogy is the modification of process that occurs during a dire emergency. While flying 'by the book' triumphantly saved the passengers who were dunked harmlessly in the Hudson River in 2009, it seems likely that the same book may be disregarded in some circumstances. One wonders whether after instantaneous cockpit decompression due to impact, the pilots are more focused on getting out of the resultant heart stopping spin and urgently on to the ground in one piece than complying with routine.

We speculate that on rare occasions, aviation 'housekeeping' checklists are 'load shed' (ie dispensed with) to allow full concentration on saving the aircraft. To many readers, the surgical version of the heart stopping spin will not be unfamiliar. In the rare event when a life is being saved in frantic circumstances, failure to observe an undoubtedly meritorious safety routine could be seen as understandable. It remains to be seen whether the defendant lawyers might utilise the possibility of chaos in the surgical environment when defending their clients in contemporary cases.

It is quite clear that up to 1950, few defending counsel imposed any lasting impression on the court that led to consideration of the distractions that a surgeon might face while closing the abdomen after emergency surgery or Caesarean section. With the exception of *Mahon*, no mention appears of lack of or failure of equipment, or lighting or blood. There is no mention of interruptions relating to other patients requiring urgent attention or decisions that could not wait until the index procedure was finished and no mention of poor or absent surgical assistants. In summary, no reference is made to distractions that might diminish the control the surgeon has over the operation, such as the frenetic control of uncontrollable bleeding from an unpackable source.

This is despite the fact that an individual surgeon's level of performance can be affected by external stressors, which are not within his or her direct control. In a qualitative study looking at the effect of stress on surgeons, Wetzel *et al* found that excessive levels of stress subjectively impaired performance.¹⁰ Surgeons in this study identified extraneous factors that increase intraoperative stress, including problems with teamwork, distractions and personal problems.

This subjective sense of performance being influenced by external factors is borne out by objective experimental studies. It has been demonstrated clearly that background noise, exertion of time pressure and distraction all lead not only to decreased technical performance but also to an increased number of errors during a laparoscopic task.¹¹ This effect is even more marked when all three stressors are applied in combination. Others find that surgical site infections are more common in a noisy environment and speculate that noise levels are indicative of a lack of concentration by the surgeons.¹² These observations are further supported by work in the clinical environment that demonstrates a correlation between the number of surgical

errors during cardiac surgery and the number of observed 'flow disruptions', which include communication failures and external interruptions.¹³

Simulation exercises for flight deck crew inculcate reactions that may save their aircraft. As simulation becomes increasingly central to surgical education, it may be that dealing with foreseeable interruptions will train surgeons to become immured to the distraction that they cause.

There are exceptional circumstances where the evidence of negligence is so overwhelming that it may be legitimate to expect that the person responsible ought to be in complete control. This is perhaps easiest to argue in the context of manufacturing, as illustrated by this legal understatement:

*'We can imagine no reason why, with ordinary care, human toes could not be left out of chewing tobacco, and if toes are found in chewing tobacco, it seems to us that somebody has been very careless.'*¹⁴

For the patient, the retained swab may evoke similar feelings to those felt by the tobacco chewer who encounters severed toes but we suggest that the surgeon's degree of control of an abdominal swab may sometimes be less than that of tobacco manufacturers over their product. This leads us to question whether defending lawyers and sitting judges know enough about the circumstances of the operating theatre to ask the client, or the defendant, the correct questions.

Prosser concludes that to determine what constitutes the 'normal course of events' in any particular circumstances, a 'fund of common knowledge' needs to exist, with which the accident in question can be compared.¹⁵ In the early days of anaesthesia, patients frequently had injuries relating to prolonged pressure on skin and joints while on the operating table, akin to similar injuries seen after patients lie on their limbs for many hours when immobilised by intoxicants.

In the Californian case of *Ybarra*, which occurred before the importance of careful patient positioning and padding were fully understood, a traumatic nerve injury had occurred after a prolonged appendicectomy.¹⁶ The patient's injury did not constitute a departure from normal events but the court was unaware of that because the defendants failed to plead these facts. Consequently, the court found the hospital staff liable, in a policy decision designed to protect anaesthetised patients generally. Equally, a functionless hand following surgery for Dupuytren's contracture was not uncommon in the era of *Cassidy*,¹⁷ before the widespread availability of physiotherapy, and would therefore not be unusual. However, without knowing this or having heard it pleaded by the defending lawyers, it is unsurprising that the court found against the hospital.

This gap in the 'fund of common knowledge' may account for the transition that 'swab cases' have made from cases worth defending to cases that are relegated to the indefensible and that they are dealt with outside courts on the basis of automatic settlement. Such eventualities are currently couched in the term of 'never events'. The resonance that the counting in and out of swabs has with the 'normal course of events' necessary to prove *res ipsa loquitur* perhaps makes this inevitable.

Nevertheless, we would speculate that although regrettable (and perhaps on occasion unjust), this transition is irreversible. We accept readily that some (arguably, most) swabs and instruments are left inside patients simply as a result of substandard care but we cannot accept that this is invariably the case. We hope that it may yet be possible to persuade defending lawyers at least to consider the possibility that the surgeon's control over his or her environment is not total and, consequently, to acknowledge the need to tease out from surgeons under scrutiny how these factors may have influenced their practice on the day in question.

We question the assertion that a surgeon is in effective control of the operative environment since surgeons have only very limited ability to prevent interruptions and unforeseen occurrences during operative procedures. Thus, we draw a distinction between the surgeon closing the wound and the cockpit crew during the landing of an aircraft, and, more generally, the common ground on which both professional groups stand when facing a crisis. It may be that those making policy decisions with the purpose of reducing or preventing the retention of swabs should focus their attention on decreasing the influence of factors impeding the performance of the surgeon and the wider surgical team, perhaps starting by minimising interruptions during wound closure.

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National commissioning guidelines for body contouring surgery after massive weight loss

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The increasing incidence of obesity is a major health issue in the UK. Bariatric surgery, currently the only reliable treatment for obesity, leads to massive weight loss in patients. There are multiple benefits to this surgical cure for obesity. There are also some disadvantages such as hanging folds of redundant tissue. This has led to an increasing use of body contouring surgery, to manage the complex problems associated with redundant skin.

The National Institute for Health and Care Excellence recommends that a multidisciplinary team with access to plastic surgery should undertake surgery for obesity. However, the provision of reconstructive surgery on the National Health Service after massive weight loss varies across the country.

National guidelines were commissioned by the Department of Health, The Royal College of Surgeons of England, and the British Association of Plastic, Reconstructive and Aesthetic Surgeons to produce a safe and equitable care pathway for body contouring surgery. The guidelines are now available at:

<http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/body-contouring-surgery>.