How Not To Handle A Retained Sponge

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In the September print edition of *Surgical Products*, our editor, Amanda McGowan, talked about the benefits of an honest and upfront approach [1] to those surgical mistakes that, despite everyone's best efforts, can occasionally take place.

"Often, no matter how big or small the mistake, an apology is a good start to remedying the situation. Still, it seems to be human instinct to try to cover up the mistake, not talk about it or deny that it happened whenever possible," she wrote. As if to further illustrate her point, let's examine how the reaction to a retained sponge in England made a bad situation even worse.

Recently, a British woman lost part of her bowel after doctors accidentally left a surgical sponge inside her body during a routine hysterectomy. The *Daily Mail* reported that Susan Misiewicz had internal bleeding and a lot of pain after her initial surgery, and was given antibiotics. A second surgery attempted to correct the problem, but to no avail. A CT scan finally revealed the real problem – an 18" surgical sponge wrapped around her bowel. A third surgery finally remedied the error.

Misiewicz said no one is coming forward to take responsibility for the mistake. Officials at the hospital where the error occurred said the incident is still under investigation, and seeing as how treatment shifted between two different facilities, neither is willing to step up and acknowledge the obvious error.

Granted, this incident takes place in a country with a national health care system that is funded by taxpayers, so the competitive factors that propel individual hospitals to react to such matters more passionately are not in play, but should that matter? It seems in this instance ego and potential financial retribution is preventing the surgical team responsible for the initial mistake from stepping forward, especially at this point.

If a CT scan was able to pinpoint the problem several months after the initial surgery, imagine how much easier it may have been able to find it, without compromising the woman's bowel in the process, if clinicians had swallowed their pride in at least considering the possibility of a retained object. Instead, to avoid acknowledging their potential error, antibiotics and even another surgery simply prolonged the process and further alienated this patient, as well as the entire community. Now the facility is also under greater governmental scrutiny.

In the midst of this past baseball season Detroit Tiger pitcher Armando Galarraga was on the verge of one of sports most difficult accomplishments – a perfect game. This means he was able to get every single Cleveland Indian hitter out without giving up a hit or walk. On a close play at first the 27th batter was erroneously called safe by umpire Jim Joyce. This meant Galarraga would not register the elusive accomplishment and although he and his team still won the game, it would forever carry that single blemish. The reason this game garnered so much extra attention is that the "safe" call was clearly wrong. Video of the play showed the runner was clearly out.

After the game Joyce watched the replay and admitting to blowing the call, taking away Galarraga's perfect game. The response wasn't outrage towards Joyce. He's human. He made a mistake. Galarraga even said so. The public's response - let's move on.

Granted, there is no comparing the significance of outcomes between a baseball game and a surgical procedure, but there is takeaway value in a man standing up to the scrutiny of millions of people and admitting his mistake. Joyce worked in the very next game and throughout the season. He's still considered one the best, and not just for what he did, but what he continues to do at a very high level – and much of that has to do with him saying he was sorry.

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