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EDITORIAL.

AN INEXCUSABLE "MISTAKE."

Two things have combined to draw attention to the risks of patients from careless surgery: (1) the publication of a book, "Mistakes and Accidents of Surgery," by Dr. Harold Burrows, C.B.E., F.R.C.S., Assistant Surgeon at the Royal Portsmouth Hospital, which has been widely commented upon in the daily press, and in which the nursing profession by no means escapes blame; and (2) the report of an inquest at Ashton-under-Lyne, on an ex-Service man who died in the Infirmary, when the jury, recruited from ex-Service men, returned the following verdict:—

"Death from Misadventure, caused by cystitis, accelerated through negligence in omitting to remove a piece of gauze from the bladder during an operation, performed at the Ministry of Pensions Hospital, Knotty Ash, Liverpool."

The story revealed at the inquest last week was amazing.

The widow of the dead man stated that he returned from France with trench fever.

In May, 1922, he was sent to Knotty Ash Hospital for observation for possible pulmonary tuberculosis. In July, 1922, he underwent an operation, and was discharged in September. A month later he complained of something pricking him in his "stomach." He died in the Ashton Infirmary on January 9th.

Evidence was given that at Knotty Ash Hospital the man was found to be suffering from tuberculosis of the spine and bladder, and an operation was found necessary. Mr. Douglas Robert Chaplin Shepherd, giving evidence, said he assisted a leading Liverpool surgeon who conducted the operation. The patient appeared to make a good recovery.

Questioned by the Coroner (Mr. R. Stuart Rodgers) as to whether he had "any theory to account for the *post-mortem* discovery of a swab in the man," the witness made the astonishing statement that "it is a recognised accident of surgery," and added, "The Sister should count the swabs before and after they are used."

Answering the Coroner's question, "You put it down to an inexperienced error of judgment?" he replied, "I suppose, in a way, the responsibility is triple."

Dr. Hector M'Kenzie, resident surgeon at Ashton Infirmary, deposed to making a *post-mortem* examination, and finding a piece of gauze about a foot long, and, straightened out, eight inches wide. In his opinion the cause of death was inflammation of the bladder and kidney disease, accelerated by the presence of this foreign body.

The Coroner, in addressing the jury, said they might consider there was no evidence to show any gross or criminal neglect. A mere error of judgment, however regrettable, would not amount to such. If a confident operator made an accidental mistake in the treatment of a patient, whereby death ensued, he was not guilty of manslaughter.

In our view the sooner there is a penalty attached to such "mistakes" when causing the death of a patient the better. The fact that Mr. Shepherd could speak of leaving swabs in a patient's body as "a recognised accident of surgery" emphasises this necessity. We think it very regrettable that "the leading surgeon" who performed the operation was not present to give his testimony, and we note that, as so often happens, an attempt was made to place the blame on the Sister. There can be no doubt whatever that the responsible person in such cases is the operating surgeon. The best method of preventing mistakes is as follows. The swabs should be strung together in dozens, counted by the Sister and checked by the operating surgeon. It should be her duty to hand the swabs to the operating surgeon and his assistant, which when used should be placed by them in a clean bowl held by a nurse who has no other duty. Before the final closing of the wound the Sister should count all the soiled swabs and acquaint the surgeon whether they are correct or not. We have known a patient killed by careless handling of sponges, a dresser helping to dabble at an operation having cut a sponge in half, so that when at

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