

## REPORTING COMPLICATIONS ON A GENERAL SURGERY SERVICE

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Complications of medical care occur as a consequence of both the illness and the treatment. As such, we must question whether errors in the provision of care should be judged in the same light as complications attendant on the disease being treated. The use of quality assurance methods has focussed on continuing to define and decrease complications as a way of improving outcomes.

The article by Wanzel and colleagues in this issue (page xx) focuses on complications that occurred on a general surgery service. A complication was defined subjectively by the authors as “an unintended, adverse outcome that occurred after medical management or a surgical procedure, was not caused by the underlying disease and resulted in impaired health.” Complications are related to various categorized cofactors and the degree of severity (fatal, life threatening, moderate, trivial). Subjectivity was furthered by bowing to the attending clinician as to when an adverse event should be defined as a complication whenever there was disagreement between the rater and the attending clinician.

The results are not surprising. Sicker patients had more complications, and 18% of the complications were judged to be errors. Six percent of complications were not documented in the charts, and only 20% of the complications were presented at morbidity and mortality rounds.

Codman is quoted as being one of the first to suggest that medical and surgical results should be monitored.<sup>1</sup> What is not generally known is that as a result of this, Codman lost his job, thanks to the political views of the surgeons of the day!

The paper by Wanzel and colleagues joins others in the literature<sup>2</sup> in pointing out to the medical and surgical communities that it lags compared with industry in developing and maintaining standards. There is no equivalent to the International Standards Organisation (ISO) 9000 revolution that has significantly improved industrial efficiency, including those machines that we, as surgeons, use routinely on patients. Why are we so reticent as a profession to address this issue? The factors are numerous and include our traditional reluctance to

discuss errors publicly and our recognition that individual surgeons differ with respect to surgical technique, yet the outcomes are often the same. The most important factor probably is a lack of an appropriate infrastructure that allows for the orderly collection of relevant validated data, speedy analysis of the results and the communication of those results to the people most likely to influence them. This challenge must be met, and we need a “call to arms” to involve hospital administration and the payers of our medical care system to address this issue before we lose even more trust from the public we serve.

### References

1. McLendon WW. Ernest A. Codman, MD (1869–1940), the end result idea, and The Product of a Hospital. The challenge of a man ahead of his time and perhaps ours. *Arch Pathol Lab Med* 1990;114(11):1101-4.
2. Kovner C, Gergen PJ. Nurse staffing levels and adverse events following surgery in U.S. hospitals. *Image J Nurs Sch* 1998;30(4):315-21.

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