What is a reportable error in surgery?

We understand the need for accountability in surgery. We have lived with morbidity and mortality rounds, answered for mistakes during training and defended our needs to hospital administration since surgery became a specialty. Last year, however, the province of Quebec finally made reporting of errors in hospitals mandatory. I say finally because the bill to require this was passed in 2002, but became an amendment to the Act Respecting Health Services and Social Services only in 2011. The first release from Quebec's national registers of errors and accidents[1] recorded 179 000 events in about 270 facilities.[2] This is a 6-month window of less-than-full-compliance disclosure from across the province. This number certainly makes you wonder about efficiencies in the current Quebec health care system. In other provinces, hospitals are only required to disclose to the injured parties all critical events that resulted in serious injury or death. This is not as comprehensive a list as that adopted by Quebec. Quebec classifies all errors as either accidents or incidents. Accidents have a negative effect on patient outcome, whereas incidents are errors that are corrected in time with no patient consequences. Reporting of incidents, in particular, will make the number of errors reported seem very large.

The actual reporting of errors is in itself not a bad thing. My hospital has a campaign to fully report all errors in the institution. These reports are readily available on the hospital website for all to see. But it is not the obvious errors that are in question here; obvious errors need to be addressed. A recent example of this type of error would be a Quebec College of Physicians review of routine mammograms concluding that a single radiologist had failed to diagnose breast cancer in 109 women.[3] These false-negatives have huge and dire ramifications on the lives of these patients and their families.

Less clear to me is what constitutes a reportable error in the operating room. What do we need to report? What is the surgeons' responsibility and what the hospital's responsibility? There are definitely incidents that occur in surgery that should be considered part of normal treatment. For example, brisk venous bleeding during surgery for an extremity trauma may be related to the decompression of the fascial compartments. The bleeding necessitates tourniquet control, local venous ligature and a prolonged hospital stay to monitor hemoglobin levels, but no transfusion is needed. To me this is normal care, not an unexpected occurrence by any standard of surgical treatment. However, in this situation, my hospital's disclosure policy would require me to meet with the family and recount the events. The family can only see this as an error; why would the surgeon sit and talk with them about this event if it was not an error?

If during an abdominal procedure for limited hepatectomy, a partial perforation of the small bowel occurrs that is easily patched, does this necessitate reporting? When a drill bit breaks off inside a bone and the surgeon opts to leave it in place rather than excavate a large hole to remove it, does the surgeon need to report it? Certainly, there is radiographic evidence in orthopedic surgery to encourage reporting, whereas the previous small bowel perforation example, which would not be visually recorded for posterity, may not encourage reporting. If a drill bit broke because the hospital policy was to resharpen equipment rather than replace the part as per the manufacturer's recommendations, who does the reporting? When dried blood drops into the operative field from instruments that were improperly cleaned during central supply processing, who reports the error? These types of events happen too often to force the surgeons to report them. The opening of the medico-legal door targeting the deep pockets of the surgeon is too easy in these cases. We need better-defined responsibility of the institution and the government for policy implementation. The current reporting structure puts the onus on the surgeon rather than the system, and that is not right.

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