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Inside Canada's secret world of medical error: 'There is a lot of lying, there's a lot of cover-up'

By Tom Blackwell (National Post)

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Most instances of the Canadian health-care system hurting rather than healing patients are not even reported by staff internally, a Post investigation...

As Helen Church woke up one morning just before Christmas 2012, the pain that had been building for weeks behind her right eye reached an excruciating climax.

Screaming in agony, she ran around her east-end Toronto apartment before finally managing to call 911 and passing out.

For the second time in short succession, she had fallen victim to health care gone badly awry.

Just two years earlier, Ms. Church went to a nearby hospital to have an ovary removed as treatment for a painful cyst. She left hours later with the ovary still in place - and a piece of mesh embedded in her abdomen to repair a non-existent hernia.

Then, months later, a specialist replaced an artificial, cataract-correcting lens that he said had started to wear. The result: That eye was now blind and growing increasingly painful.

The ophthalmologist, another specialist told her later, had implanted the lens in the wrong position, obscuring her sight and puncturing a duct, causing a slow bleed and massive pressure.

"There was so much blood in there, it blew the eyeball out of my head. It was hanging on my cheek," said Ms. Church, a razor-sharp 83-year-old. "The blood was just dripping everywhere ... I was hysterical, the pain was so bad."

Both incidents point to dangerous breakdowns in the Canadian health-care system. But don't expect to find any public record of either apparent blunder - or of thousands of similarly harmful and sometimes deadly mistakes that occur in facilities across the country each year.

How much do we know?

In 2004 a study by Ross Baker and Peter Norton analyzed patient charts at a representative sample of Canadian hospitals and came up with estimates of the number of adverse events that occur in an average year. With a paucity of official data on medical errors at the country's hospitals, one way to get a rough estimate of adverse events is to take the Baker-Norton numbers and divide them according to provincial populations.

Most instances of the system hurting rather than healing patients, in fact, are not even reported by staff internally, a *National Post* investigation has documented.

Research suggests that about 70,000 patients a year experience preventable, serious injury as a result of treatments. More shocking, a landmark study published a decade ago estimated that as many as 23,000 Canadian adults die annually because of preventable "adverse events" in acute-care hospitals alone.

The rate of errors may be even higher today, some evidence suggests, despite the millions of dollars spent on much-touted patient-safety efforts.

Yet a tiny fraction of those cases are publicly acknowledged and usually only in the form of antiseptic statistics. For most serious treatment gaffes, not even the sparsest of details is revealed, making the vast problem all but invisible.

The *Post* has also learned there is no routine, public documentation of one common source of health-care harm - malfunctioning medical devices linked to dozens of deaths and hundreds of serious injuries every year.

"Learnings from these things, even when a good investigation is done, are going into black holes," said Darrell Horn, a "critical-incident" investigator who spent several years with the Winnipeg Region Health Authority. "They've created this perfect, invisible box to put everything in."

Manitoba is actually a rare exception to the opaqueness that shrouds medical error in Canada; single-line descriptions the province has released for the last three years offer at least a snapshot of what calamities can befall patients.

Among the 100 cases reported in the three months ending Sept. 30, 2013, was that of a new mother who had a heart attack after staff inadvertently gave her a blood-pressure-increasing medication, instead of a nausea antidote following a caesarean section.

Another patient, known to be at risk for blood clots, suffered a fatal cardiac arrest when staff neglected to provide preventive treatment after surgery.

A woman needed a second operation after an X-ray revealed a screw from a broken clamp had been left inside her during a C-section.

And, without further explanation, one patient "underwent unnecessary open-lung biopsy."

For the rest of the country, such cases occur in a vacuum, most not reported at all and virtually none described with any kind of narrative.

In fact, legislation in most provinces bars information on adverse events being released to malpractice plaintiffs or publicly divulged under freedom-of-information acts. The laws are designed - with limited success - to encourage internal reporting of mistakes.

A health-care culture still straitjacketed by an old-fashioned hierarchy, fear of legal action and a focus on punishment rather than learning from mistakes also keeps missteps bottled up, say health workers and safety experts.

A nurse at an Ontario hospital, who asked not to be identified for fear of repercussions, said she works with two surgeons whose skills are so lacking, "I wouldn't even want them to touch my dog."

British Columbia

Estimated adverse events: 24,310 events, 1,202-3,087 deaths

Reported events: Aprx. 9,800 undefined events (in other words, with no details released), no deaths reported for 2010-11

Alberta

Estimated adverse events: 21,310 events, 1,054-2,707 deaths

Reported events: No public reporting

Saskatchewan

Estimated adverse events: 5,984 events, 296-760 deaths

Reported events: 195 events, 30 deaths reported for 2013-14

Manitoba

Estimated adverse events: 6,732 events, 333-855 deaths

Reported events: 526 events, 52 deaths reported for 2011-12

Ontario

Estimated adverse events: 71,995 events, 3,561-9,143 deaths

Reported events: 29 events, six deaths reported for 2013

She filed an anonymous complaint against one several years ago, but little changed. Now, she stays mum about problems ranging from high rates of post-op infections to surgeries frequently needing re-dos.

"We do turn a blind eye and walk away," the nurse admitted. "There is a lot of lying, there's a lot of cover-up, which turns my stomach."

By contrast, preventable injury and deaths in many other arenas - from homicides to industrial accidents and road crashes - are routinely divulged by police or other authorities.

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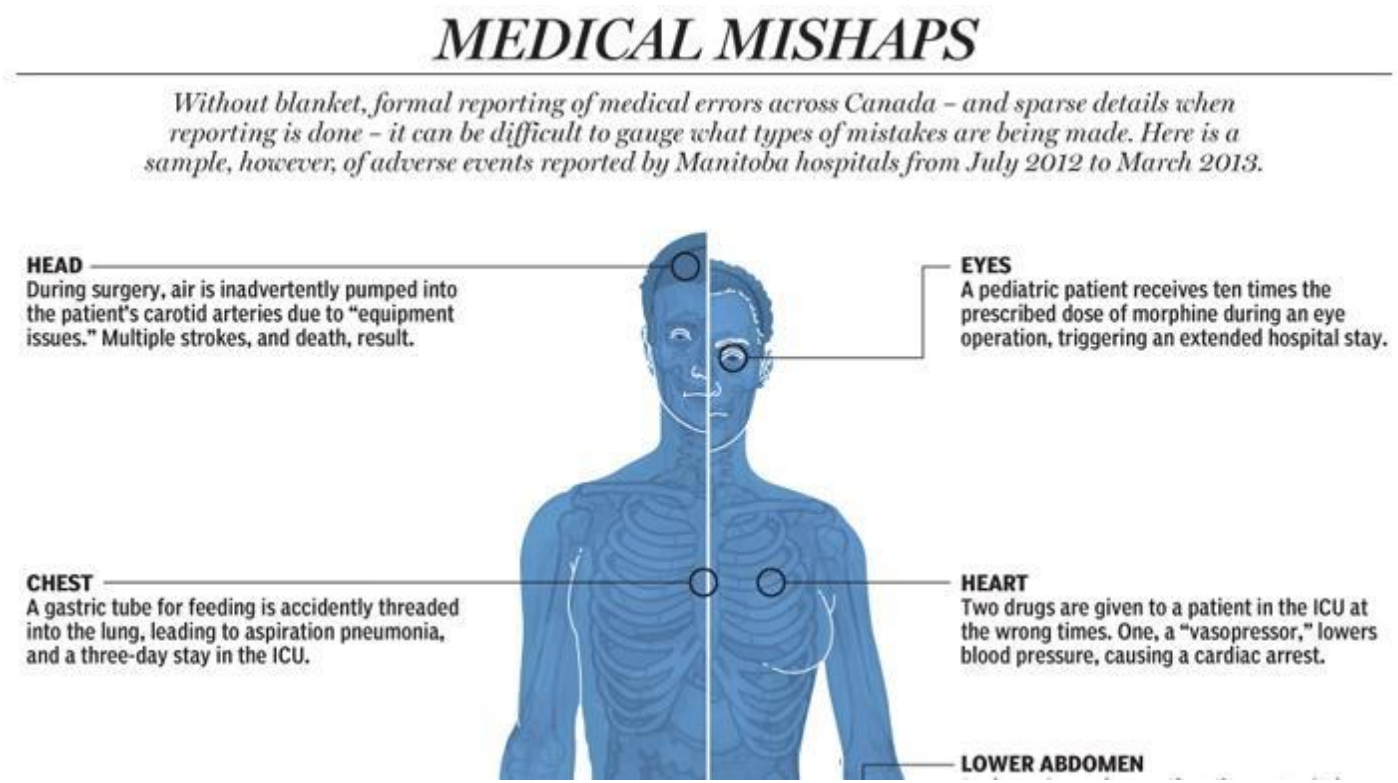
The starkest counterpoint to health care's lack of transparency around error, however, is offered by the aviation industry.

On the way to dramatically improving the safety of flying, the sector has become conspicuously open about its mishaps. Canada's Transportation Safety Board, for instance, posts details online of current investigations into everything from actual crashes to ground vehicles inadvertently driving across airport runways.

The constant, transparent exchange of safety information not only helps curb accidents, but enhances passengers' confidence in the industry, says John Pottinger, an aviation-safety consultant and former Transport Canada official.

"Where the public even thinks it is being deceived or doesn't have the whole story, then right away we get suspicious," he said.



Quebec

Estimated adverse events: 43,384 events, 2,146-5,510 deaths

Reported events: Aprx. 3,072 events, 297 deaths reported for 2013-14

New Brunswick

Estimated adverse events: 4,114 events, 203-522 deaths

Reported events: No public reporting

Nova Scotia

Estimated adverse events: 5,049 events, 250-641 deaths

Reported events: 27 events, 0 deaths reported for Jan-June 2014

Newfoundland

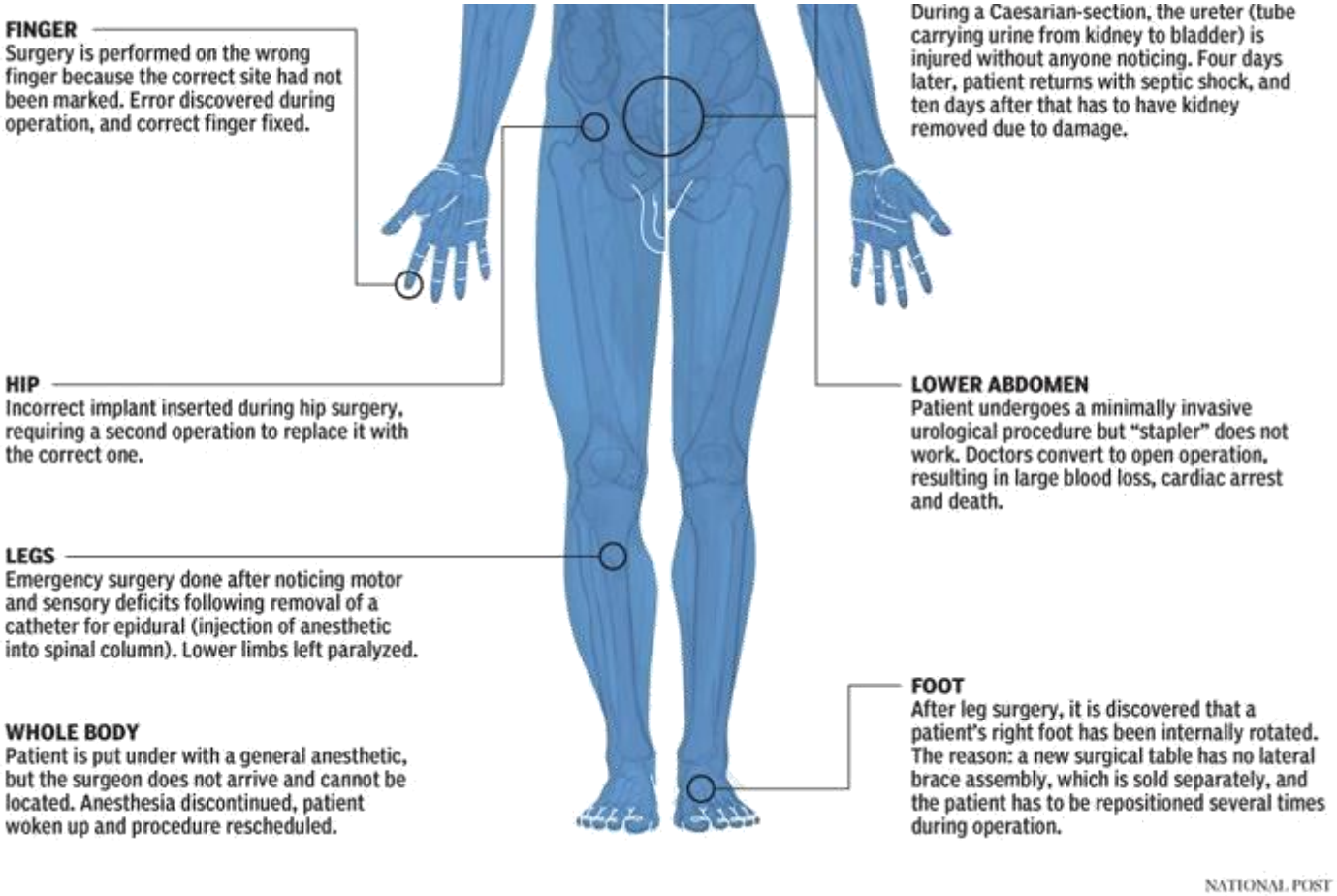
Estimated adverse events: 2,085 events, 138-356 deaths

Reported events: No public reporting

Prince Edward Island

Estimated adverse events: 748 events, 37-95 deaths [est.]

Reported events: No public reporting



The point of publicizing medical error, patient-safety experts stress, is not to shame or blame, or take away from the fact health care is replete with highly trained, dedicated professionals. Aside from a tiny smattering of true incompetents, no one comes to work expecting to dispense anything but exemplary care, says Rob Robson, a physician who led the Winnipeg health authority's groundbreaking patient safety program for seven years.

When things do go wrong, it is typically the result of a complex interplay of factors, often involving underlying flaws in the system, he added. Finding ways to prevent those mistakes is, of course, the ultimate goal and subject of intense research and numerous initiatives.

But publicity about error helps both in drawing attention to the issue and providing a well of knowledge, say safety experts.

"You have to tell people that patients are getting hurt," said Dr. Robson. "As long as the public doesn't realize that one in 13 people coming into the hospital will experience some kind of adverse event - and that's the conservative estimate - then there isn't any pressure to say, 'Listen, fix these damn things.' "

The risk inherent in hiding such information was tragically highlighted in 1997, when yet another child fell victim to a classic medical error, an error some believe still occurs.

Doctors at the B.C. Children's Hospital administered a series of drugs to Kristine Walker, a seven-year-old whose leukemia had come back. Inadvertently, they injected vincristine - meant for intravenous use - into her spinal fluid. Doctors have known since the late 1960s that using the medication "intrathecally"

triggers catastrophic, usually fatal neurological damage.

Kristine became paralyzed and died two weeks later. After her death, the hospital discovered that at least three similar incidents had occurred in other provinces in previous years, reminders of the importance of preventive measures. None were made public or even communicated within the health-care system.

"We were not able to learn from our own mistakes, nor did we have the opportunity to learn from those of our colleagues," Lynda Cranston, the hospital's president, lamented at the time.

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Procedures to avoid the error have been implemented widely, but as recently as 2012, the Institute for Safe Medication Practices (ISMP) reported the "worrisome" finding that fewer than 60% of Canadian hospitals applied warning labels on vincristine, one of three key safety measures.

An ISMP alert late last year claimed that while rare the "excruciatingly painful" mistakes still happen.

And yet, outside media reports and a journal paper about the 1997 B.C. case, there remains virtually no public documentation of any Canadian incident.

In reality, no one knows exactly how prevalent medical error is in Canada. The best approximation comes from a widely accepted 2004 study spearheaded by the University of Toronto's Ross Baker and University of Calgary's Peter Norton, now known simply as Baker-Norton.

The researchers examined patient charts at a representative sampling of 20 acute-care hospitals. They found that 7.5% of adult patients - which extrapolates to 185,000 a year countrywide - suffered a serious adverse event, almost 40% of which were preventable. Between 9,000 and 23,000 people die annually from preventable error, they concluded.

Eight years later, a similar study looked at pediatric patients, finding the rate at which children are hurt by adverse events was even higher, 9.2%. And, if anything, the numbers may have climbed since, says Hugh MacLeod, chief executive of the federally funded Canadian Patient Safety Institute.

"With the pace, the increase of new technology, new drugs, new approaches ... the probability of risk and incident has grown," he said.

Add psychiatric and obstetric patients, and residents of nursing homes and chronic-care hospitals - none of whom were covered by the two studies - and the true number of preventable deaths is likely in the realm of 35,000 annually. That's four every hour, says Dr. Robson.

> There's a bitterness, there's an anger when it's from medical malpractice, when it's preventable

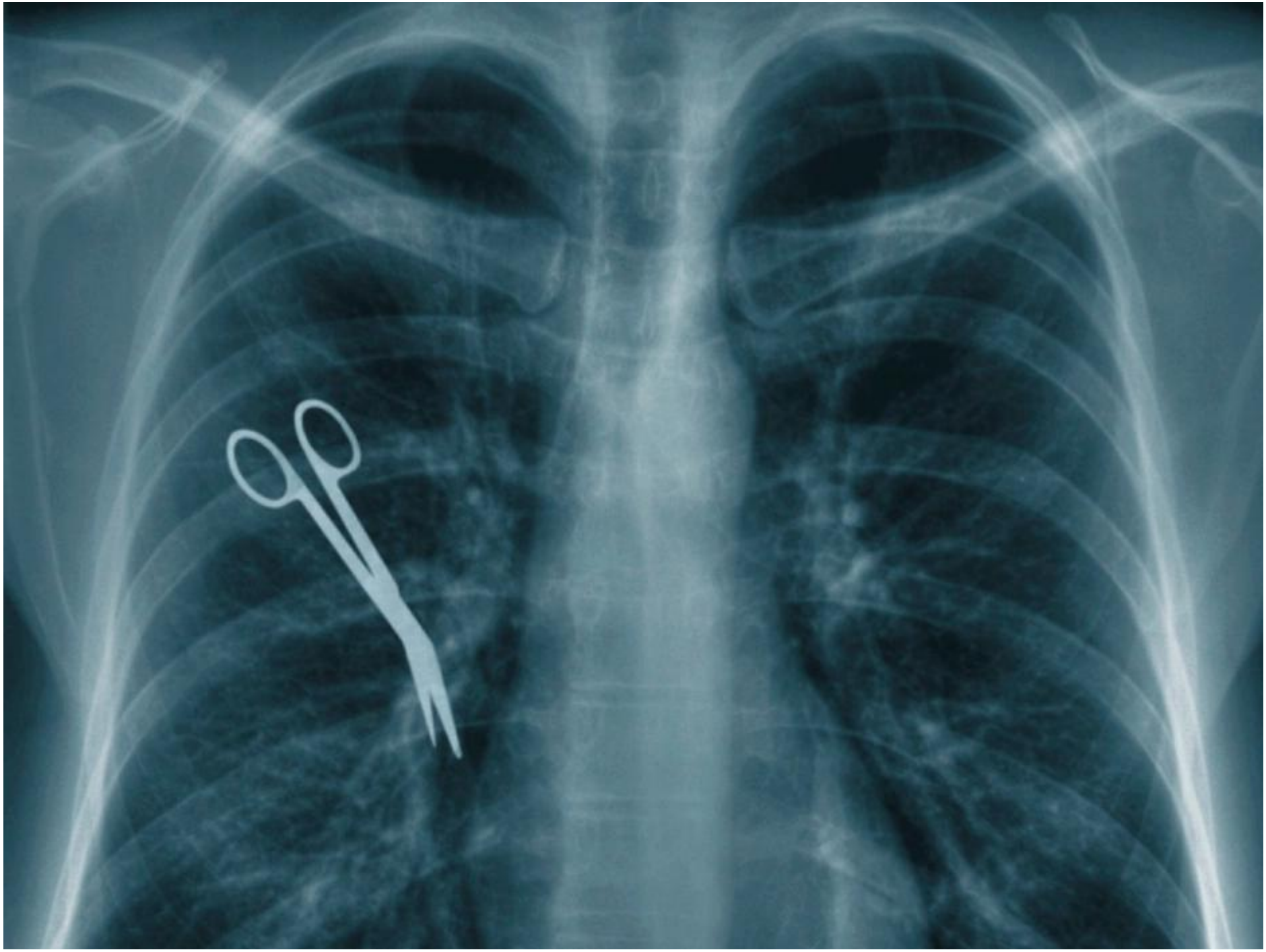
Monique Chisholm considers her son Cullan's disabilities to be a product of one of those tens of thousands of medical slip-ups.

When she checked into hospital in Antigonish, N.S., four years ago, her thoughts were predictably upbeat: She was having her first child, and the first grandchild on her side of the family. In the ensuing hours, though, a fetal-heart monitor showed "clear evidence" the baby was suffering hypoxia, a dangerous shortage of oxygen, alleges a malpractice suit the mother later filed.

Yet the nurses, overseen by a senior obstetric specialist-in-training, continued to administer pitocin, a drug designed to induce labour. This was despite signs the fetus was in distress and needed resuscitation, possibly through an emergency C-section, the suit says.

Cullan ultimately was delivered using vacuum extraction, revealing that the umbilical cord was wrapped around his neck, the statement of claim says, leaving him "seriously compromised" and, it later became clear, severely brain damaged.

The doctor



Handout An x-ray shows a surgical instrument that was left inside a patient's body after surgery. Research suggests that about 70,000 patients a year experience preventable, serious injury as a result of treatments in Canada.

responded in a statement of defence that it was only just before delivery the fetal monitor indicated an abnormally slow heart rate, and she performed generally in a "prudent, skillful and competent" manner.

Regardless, Cullan lives today with one of the most severe forms of cerebral palsy. He needs constant care and supervision, unable to feed himself or talk, and confined to a wheelchair. He is clearly well-loved, but raising the boy has been far from easy, says Ms. Chisholm.

"It's exhausting physically, it's exhausting mentally, it's exhausting on a marriage," she said. "There's a bitterness, there's an anger when it's from medical malpractice, when it's preventable ... This is at the hands of someone I trusted."

And yet, few errors of the sort Ms. Chisholm alleges are reported in facilities, shared across jurisdictions or actually publicized.

Four provinces - Alberta, New Brunswick, Newfoundland and Prince Edward Island - release no data on adverse events at all.

To give a rough picture of what is happening in the rest, the *Post* broke down the Baker-Norton figures according to the population of each province.

Paul Darrow for National Post Monique Chisholm with her son, Cullen, at the IWK hospital in Halifax, Nov. 12, 2014. Monique Chisholm considers her son Cullan's disabilities to be a product of one of tens of thousands of medical slip-ups.

Most publish statistics that encompass a much broader range of health care than the adverse-event studies, including nursing homes, psychiatric wards and the delivery of newborns. Even so, the public numbers are a fraction - from 0.004% to about 6% - of what the research indicates is occurring just in acute-care hospitals.

With some fanfare this year, Ms. Chisholm's Nova Scotia became the latest jurisdiction to divulge critical-incident data. But the total number of incidents for the first six months of 2014 was a mere 27. John McKiggan, a Halifax malpractice lawyer, says even some of his doctor friends laughed at the figure, suggesting it should be more like 27 a day.

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"It's a whitewash," he said. "They're doing it to make themselves look good, but not to effect any actual improvement in patient safety."

Releasing descriptions of incidents and lessons learned from them would be the most effective way to educate health-care workers, argues Mr. Horn, a certified "lead critical-incident investigator" who has reviewed events across Canada.

Yet doing so

Paul Darrow for National Post Monique Chisholm with her son ,Cullen, at the IWK hospital in Halifax, Nov. 12, 2014.

remains an anomaly in this country.

The patient safety institute has set up a global alert program, but only two organizations in Canada contribute cases: The Winnipeg health authority and the ISMP, which receives a smattering of reports each year. Alberta Health Services is in talks to supply its patient alerts, documents it admits are "rare."

None of the nine provinces that responded to a *Post* survey could release details of adverse events where patients had actually died, usually because they did not collect the information, or privacy or other legislation kept it under wraps. Prince Edward Island suggested filing a Freedom of Information request.

And virtually none of the provinces distribute critical-incident reports to health-care organizations outside their own borders, even confidentially.

That includes one report that recommended interventional cardiologists stop playing music in the operating room, a common practice, after a nurse misheard a doctor's instruction and the wrong-size metal stent was installed in a patient's coronary artery.

"Was that information ever shared up the street at the next hospital? No, it wasn't," said Mr. Horn, a former air traffic controller. "Because whatever happens within the hospital is a secret within the hospital. And the people who have regional authority to share information, they don't."

Some national organizations do compile data that may help illuminate health-care breakdowns. The Canadian Institute for Health Information, for instance, releases statistics that include rates of one hospital-acquired infection, adverse events in general, death after major surgery and re-admission following hip replacements, though experts debate the reliability of the numbers.

Health Canada also has an adverse drug-reaction database, cataloguing reports based on unverified suspicions. It's designed, though, chiefly to identify drug side effects, not necessarily errors hospitals or nursing homes make in dosing and administering medication.

Handout Darrell Horn, a Winnipeg-based medical error investigator, says the few reports done on incidents often end up in

It's a heavy, heavy burden to take on. Sometimes it's just easier to keep quiet

No such public registry exists at all for incidents tied to the system's myriad of medical devices, from cardiac stents to infusion pumps for delivering drugs to artificial hips.

And yet information obtained by the *Post* from Health Canada indicates the regulator receives about 10,000 reports a year of incidents suspected of being caused by devices, up to 1,000 associated with serious injury and as many as 95 linked to patient deaths.

In 2012, a flurry of emails between Health Canada staff, health-care facilities and a manufacturer revealed a disturbing trend involving one device, a lift used to move immobile patients about their rooms.

The emails, which were obtained through access-to-information legislation, detailed a string of incidents in which patients plummeted out of one brand of the machines, three of them apparently dying.

The only public acknowledgment of the episode by Health Canada, though, was a brief recall notice in July 2013, referring to "incidents at a facility in which the sling loop separated from the ... hook." What happened as a result goes unmentioned.

In fact, the department is looking at somehow increasing transparency in the medical-device reports it receives, said spokesman Eric Morrissette.

Meanwhile, Mr. Horn said he has found more information on Canadian device incidents from a British government database than he could from sources here.

Before any adverse event has even a chance of becoming public or distributed within the system, someone has to speak up internally. As the numbers reported by some provinces indicate, that does not happen often.

Why are health workers so reluctant to expose mistakes? Sometimes, they simply don't notice a breakdown in care of patients who are already severely ill, said Dr. Robson. But they also fear they will end up getting the blame if they report an error or sense that reports go nowhere when they are filed, he said.

Dr. Robson also recalls "yelling matches" with one medical department head concerned that too many adverse events were being registered for the section, and demanding the right to vet investigative reports.

Lawyers pushed back constantly at attempts to post anonymized versions of reports online, worried about lawsuits that never materialized, he says.

Andy Summers, an emergency-department nurse in Toronto for 20 years, says most hospitals still have a punitive approach and a physician-dominated hierarchy that discourage openness.

"Nurses are very, very cautious about raising issues, blowing the whistle," said Mr. Summers, who has spent the past five years as vice-president of the Ontario Nurses Association union.

"If they were part of ... the adverse incident, they are going to feel like they'll be blamed," he said. "It's a heavy, heavy burden to take on. Sometimes it's just easier to keep quiet."

In aviation, on the other hand, the culture strives at every turn to promote reporting of safety problems by Handout Dr. Rob Robson, former head of the everyone from baggage handler to flight attendant, even if it means offending the once-God-like pilot, saysWinnipeg Region Health Authority's patient- Mr. Pottinger. safety unit, says there won't be pressure to

In fact, it is those who fail to report a safety concern - rather than the whistle blowers - who face possible reprimand.

Meanwhile, for patients subject to health-care malfunctions, hidden or otherwise, the impacts can be profound.

Ms. Church, a retired consumer-relations executive at American Express, now has a prosthesis instead of her right eye, curtailing an active life that had included four rounds of golf a week.

And the pain that led to the ovarian-cyst diagnosis, which was never treated, still keeps her up at night.

"My life is entirely turned around," she said.

"I think it's abominable that these people can do this, and there is no repercussion ... I think people should know [about medical error] and people should ask, people should question."

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References

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