Preventive Measures for Medical Mistakes

by Susan McIver
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A 2012 report stated that 38,000 to 43,000 deaths occur annually in Canada in connection with health-care delivery. That is the equivalent of 80 jumbo jets crashing every year--one every five days or so.

According to the author William Charney, a veteran health and safety officer in health care and author of numerous books on health-care safety, the actual number of deaths is undoubtedly greater because of the high rates of non-reporting.

In 2009, J. O'Hagan and colleagues revealed that approximately one in six Canadians said they had experienced at least one error in the previous two years. This translated to 2.4 million adult Canadians. Not all of these reported errors caused even minor hardship, but their numbers clearly illustrate the magnitude of the problem.

An increasing awareness of and concern about medical errors in Canada and globally is driving extensive efforts to understand why and how errors occur and how to prevent them. The multitude of types of errors and the often complex reasons for their occurrence can make creating solutions difficult.

My new book, *After the Error: Speaking Out about Patient Safety to Save Lives*, tells the stories of heroic Canadians who have used their personal tragedies resulting from medical errors to prevent similar suffering in others. Their accomplishments have often come at considerable emotional, psychological and financial expense.

Robin Wyndham, a retired registered nurse, and I wrote *After the Error* not only to recognize the achievements of people affected by medical errors, but also to provide examples of what can be done to promote safe health care and to remind readers that in spite of increasing efforts to prevent errors, they continue to devastate lives.

Some heroes
The day after Terence Young's 15-year-old daughter, Vanessa, suddenly died on March 19, 2000, he began his journey to find out why. Questions and comments by attending medical professionals led him to suspect that Prepulsid, which Vanessa had been prescribed for mild bulimia, had played a role, and that he and Vanessa's mother had not been told the whole story about the drug's known dangerous, even lethal, side-effects.

Strengthened by a formidable amount of disturbing knowledge, Young successfully argued for an inquest into the circumstances associated with Vanessa's death. He established the research and advocacy organization Drug Safety Canada, launched lawsuits and wrote the book, *Death by Prescription*, an investigative journey into the world of Big Pharma. In 2008, he ran successfully for Member of Parliament for Oakville, Ontario, in order to influence federal regulation of prescription drugs.

On June 14, 2013, Young and the Honourable Leona Aglukkag, Minister of Health, announced the launch of the Plain Language Labelling Initiative. The initiative aims to improve the safe use of drugs by making drug labels and safety information easier to read and understand. "It is difficult for me to overstate the importance of this change. What the Minister is announcing today will save thousands of lives," Young said.

A particularly wrenching story is that of Heidi Klompas, 17, who died from complications arising from treatment she received in two B.C. hospitals, not from the injuries she sustained when struck by a car. Subsequently, her mother, Catherine Adamson, wrote a book, *Heidi Dawn Klompas: Missed Opportunities*, which has been widely read by surgeons and has led to improved treatment for patients with severe fractures.

Adamson is a member of the Wrongful Death Law Reform Group, a group of more than 50 families who work with other organizations such as the BC Coalition of People with Disabilities and Trial Lawyers Association of BC to bring about a Wrongful Death Accountability Act. This act contains an integrated series of statutory reforms designed to ensure that the two goals of fair compensation and meaningful deterrence are satisfied in every situation where a person is killed by the negligent conduct of another.

For several years after the sudden death of her teenaged son in 1990 from a misdiagnosed inherited cardiac arrhythmia, Pam Husband was told by members of the medical community that such deaths were rare. But upon hearing frequent mention of sudden, unexplained deaths of young people in casual social conversation, her instinct and intellect told her otherwise. Today, inherited cardiac arrhythmias are recognized as one of the leading causes of death of Canadians under 35 years of age.

In 1995, Pam Husband and Dr. Robert Hamilton of Toronto's Hospital for Sick Children decided to form a group that evolved into the Sudden Arrhythmia Deaths Syndrome (SADS) Foundation. Over the years, Husband and her colleagues have saved thousands of lives through their work to raise awareness, provide educational opportunities and support research.

Rick and Rose Lundy established Open Arms Patient Advocacy Society after Rose almost bled to death from what was presumably an uncomplicated miscarriage in the crowded emergency room of a Calgary hospital. Open Arms assists people who have experienced medical errors to navigate the complex health-care system to find answers and resolutions. "At first I felt like I wanted to replace the lost baby. Then I understood the purpose of the miscarriage was for me to help other people," Rose Lundy said.

Following the death of her mother in hospital from an astonishing series of errors, Catherine Winckler of Vancouver established a website, insisted on a coroner's investigation and used the media to tell her mother's story. Subsequently, a group of dedicated nurses launched programs to improve the care of acutely ill older adults in their homes, care facilities and emergency rooms throughout B.C.

Winckler has advice for families dealing with medical errors: separate your grief from pursuing

justice, learn about the systems involved so you can navigate them, do not rely on others and take the lead.

Staying safe
Patients must go on the defensive when it comes to their care. Below are suggestions on how to stay safe. A wealth of information is available online.

When visiting your doctor be upfront about your lifestyle and activities, what the reasons are for your visit and what you expect from the visit. Listen carefully. If you don't understand what the doctor is saying, ask for an explanation. Take notes. Take someone with you especially if bad news is a possibility. Make sure the doctor has listened carefully to you. Don't be afraid to disagree with your doctor but do so in a respectful manner.

Upon leaving the doctor's office you should have a treatment plan that makes sense to you. You may also be asked to have tests to discover more about the reason for your difficulty. Follow the plan and have the tests.

Know your medications--their names, why you are taking them, their dosage level, their possible side-effects, when you are supposed to take them. Ask the pharmacist about any possible interactions.

The best advice about hospitals is to try to stay out of them. Live as healthy a lifestyle as possible. If you need care, get it at home or on an outpatient basis, if possible.

If hospitalization is necessary, go prepared. Understand the procedure:; reasons it is being performed, potential risks and desired outcomes. Appoint a substitute decision-maker and make sure the doctor and hospital have copies of the documents.

If possible, keep an advocate at your bedside at all times. Your advocate can help keep you safe and clean, do simple tasks to assist you, and alert nurses, if something goes wrong. Your advocate can monitor nurses' and doctors' hand washing and medication administration. Your advocate should keep a diary of your care: who sees you when, what is said, what medications are prescribed, when they are given and by whom.

All caregivers who enter your room should identify themselves and ensure they are indeed seeing the correct patient. If possible, have a private room. This decreases the probability of getting an infection from a roommate.

If you think an error has occurred
The first step, of course, is to determine if an error has occurred. Not every unfortunate outcome is the result of an error. There are several crucial steps that need to be taken to determine the cause of a death or other negative outcomes. Discuss the situation with the involved physicians. A plausible explanation that satisfies your concerns may be forthcoming. If not satisfied and dealing with a death, request a coroner's investigation and an autopsy. If the coroner rejects the case, consider paying for an autopsy yourself. Establishing the definitive cause of death is crucial to any further action.

Obtain a copy of all medical records including physicians' notes, scans and laboratory tests. Have a knowledgeable friend or relative such as a nurse review the records for you. Obtain the billing records from funding jurisdictions such as British Columbia's Medical Services Plan in order to establish the date and cost of all treatments. If a journal has been kept, it may prove invaluable in highlighting significant events.

Keep in contact with physicians, hospital and health region authorities. Work with them if possible. Request that the hospital and region do reviews of the case. Lay complaints with the relevant professional colleges. Consult a medical malpractice lawyer. Even if you don't launch a suit, you may learn helpful information.

Whatever the eventual degree of your personal resolution, don't be destroyed by anger and a desire for revenge. Rather, engage in activities that promote a safer health-care system.

Susan McIver holds a PhD in entomology/microbiology and was a professor at the University of Toronto with appointments to the faculty of medicine. She served as a community coroner in B.C. and is the author of Medical Nightmares: The Human Face of Errors. *www.ecwpress.com/aftertheerror.*