Error and blame: the Winnipeg inquest

Erin Petkau, barely 4 days old, was the 12th and last child to die in 1994 after undergoing cardiac surgery in Winnipeg. The province's pediatric cardiac surgery program, reopened only 12 months earlier when Dr. Jonah Odim was recruited to be its sole surgeon, was closed by Dr. Brian Postl, head of pediatrics at Winnipeg's Children's Hospital, on Dec. 21, the day Erin died. It has not reopened.[1,2]

Associate Chief Judge Murray Sinclair's painstaking report of the inquest into the deaths was released almost 6 years after Erin's death. Over 300 of its 516 pages are devoted to precise reconstructions of the cardiac conditions and surgical events relating to each of the 12 children. Reading this work, one has the impression that Sinclair was sculpting a monument to the dead children and, as he writes in his introduction, to "the very symbol of love and life in our society: the human heart."

The public and professional view of these events focused on one easily dramatized factor: the inexperience of a surgeon whose credentials were impressive but untried. But it becomes as clear to anyone reading the report as it was to Judge Sinclair that the deaths were not due solely to a single individual. Errors occurred at all levels of the cardiac surgery program — in its hiring procedures, lack of monitoring, lack of a complaints procedure, and even in the administrative decision to develop a pediatric cardiac surgery program at a centre with a caseload too low to sustain excellence.

The simplest of surgeries on a heart the size of a plum involves thousands of integrated and sequenced actions, each of which can be improperly carried out or ill-timed. Complexity and the need for extreme attentiveness to detail characterize virtually all medical procedures, although the immediate consequences of error are not always so grave. Given this complexity, mistakes are inevitable. As Jan Davies argues in this issue, anticipation is the first step in error management[4] (page 1503).

Error, as Judge Sinclair noted in his summing up, is a human reality. And equally, we might add, is blaming. No one who has been through medical school and residency or who has been named in a malpractice claim can deny that the culture of medicine, itself perhaps just a microcosm of our larger culture, assigns responsibility and blame to individuals.

And yet, everyone who has studied problems of error in medicine agrees that the prevention of errors requires their identification and frank, nonpunitive investigation and discussion.[5] As in other complex activities such as aviation, the identification of error should be active, not passive, focusing not just on catastrophic events, but on near misses that could have been catastrophic but were not.

It is always easier to find a scapegoat than to change the culture of a working environment. But we must find the resources and muster the personal resolve to look at what we do in a systematic way, prospectively as well as retrospectively, expecting errors and developing non-blaming mechanisms for preventing them. — *CMAJ*

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