

## Apology marks new era in response to medical error, hospital says

A Hamilton hospital says the apology it issued in the wake of a girl's death is another corner turned in a medical culture that has been loathe to admit error, but the child's family remains unsatisfied.

The apology, issued by the Hamilton Health Sciences Centre following the death of 11-year-old Claire Lewis, stated: "We have identified serious care and system issues and have concluded that her death could have been avoided. For that, we offer our profound apologies."

"We are in the process of implementing a number of changes that will prevent a similar tragedy. Our commitment to you, to Claire's memory, is to follow through on every recommendation in the report [concerning the incident]. We again apologize for the length of time it has taken our hospital to conduct this review and we realize that delay has added to your grief."

The girl underwent surgery at the Hamilton General Hospital Oct. 12, 2001, to remove a benign pituitary gland tumour. The operation was successful and she was transferred to the pediatric intensive care unit at McMaster University Medical Centre.

By late afternoon on Oct. 14 her father John, a registered nurse, thought his daughter was exhibiting symptoms of increased intracranial pressure. A resident who assessed her did not take immediate action, and at 7:30 pm she

stopped breathing and was intubated. She was pronounced brain dead the following morning.

Six months later, Hamilton Health Sciences, which operates both the General and McMaster hospitals, issued the results of its investigation into the death and its apology. The hospital noted that intervention even 30 minutes before she stopped breathing "could have resulted in a different outcome for Claire."

The Lewis family, which is pursuing a lawsuit, remains unsatisfied. "There's an issue of personal accountability and responsibility in this death, i.e. physicians," John Lewis says. "I use the analogy of the drunk driver killing your child with his car and having the insurance company apologize to you — there's really no gratification in it. Personal accountability and responsibility is nowhere in the system."

However, Dr. Andrew McCallum, chief of staff at Hamilton Health Sciences, believes the hospital's apology marks a clear change in direction. "The general feeling is that it's the right thing to do," he said. "... Sometimes, it's better to say, 'You know what, there were things that happened here that we should be accountable for. Let's disclose and let's take responsibility.'"

He also believes a similar change is taking place in the legal community. "In the past, all claims were vigorously defended. Now, there's more of a trend toward saying, 'OK, this is a meritorious action. Let's work toward negotiating an appropriate settlement rather than being adversarial about it.'"

David U, president of the Institute for Safe Medication Practices Canada, says attitudes toward error disclosure are



Claire Lewis: the outcome could have been different

changing "a little bit." He lauded staff at the Children's Hospital of Eastern Ontario in Ottawa for prompt action following a recent adverse drug event (ADE).

Four-year-old Ryan Lucio died last September after the wrong data were printed on some medication orders. (He was receiving interleukin II in a clinical trial.) After the ADE, the hospital alerted the families involved in the trial and other institutions participating in it before the boy had even died.

"Organizations like ours have been advocating and promoting a good, non-punitive way to handle medical errors because the ultimate goal is to discover and reveal the problems and then address the underlying issues," U said. "If you have a culture that covers it up, then the same things happen and no one knows."

Murray Martin, president and CEO of Hamilton Health Sciences, says the apology "was the right thing to do within the context of our values as an organization."

"If we [are] to do something about medical error, we have to be able to talk openly in order to change processes and make sure [the mistakes] don't happen again."

Martin says that when cases move to litigation "the only real winners are the lawyers." — Ken Kilpatrick, Hamilton



John and Brenda Lewis: looking for personal accountability