TRANSCRIPTION

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[0:00:10] My role presently is as the president and CEO of University Health Network in Toronto. In that capacity, I am also, in my view, the chief patient safety officer of the organization. I'm a surgeon and I trained many years ago now as a cancer surgeon and worked, most recently prior to my UHN role, in the United States at the University of Texas, MD Anderson Cancer Center.

[0:00:39] I'm here to share a story that impacted me personally, a story of patient harm. My own interest in patient safety really began with a personal event at the time when I was working at the University of Texas, MD. Anderson Cancer Center as a professor of surgery. And on one day there, we were doing a very, very complicated operation for a patient who had disease in his esophagus in the swallowing tube. And we were doing a very complicated procedure where we take the patient's colon and we transplant it to replace the diseased esophagus. It's a complicated procedure. It involves multiple teams. The operation took nine hours to complete. Everything went well. And at the end of the operation, we routinely have a process where a team in the operating room does a sponge count. They check that we have not, by accident, missed a sponge. And the first count that was done was incorrect. This is actually fairly common in big operations, and I asked the nurses to repeat the count.

[0:01:42] The second count was correct, giving me some degree of comfort, but leaving me with an element of doubt. At that point in time, the operation had been going on for a long time. The patient was cold and I felt it was absolutely impossible that I could have left a sponge in the patient. And I decided instead to let the patient go to the recovery room. There was a little bit of uncertainty and I decided to get an x-ray in the recovery room that we would do, just to be sure.

[0:02:15] And as soon as that x-ray was performed, my fellow called me and said, “There's something left inside the patient.” I couldn't possibly believe that because I didn't think it was possible that I could have left something in the patient. There was nagging doubt because there were two conflicting pieces of information. I tried to reconcile first the incorrect count and then the correct count. I couldn't believe that we had possibly left something in the patient. And so I asked the fellow. We went to the bedside together. We took a different type of x-ray, this time, going across the patient. And when we did the second x-ray, we could see that definitely, there was something left inside the patient.

[0:02:57] When I looked at the two x-rays that had been done, I couldn't, for the life of me, figure out what that was. And I realized at that moment that during my surgical training, during my fellowship training, in textbooks, in exams, I had never seen x-rays of foreign bodies that had been left inside patients. And as a result, I couldn't identify that foreign body, the material that I had left inside the patient.

[0:03:23] So I went to talk to the patient's wife immediately. I said to her, “Something's not right. We've done an x-ray. I think that I've left something inside your husband.” As I left the first conversation with her, I remember vividly walking down the hallway with my head down, thinking, “How could this have happened? How am I going to figure this out? What am I going to do? What will this mean for me? Could this affect my family?”

[0:03:53] I had reached, in many ways, the pinnacle of my career. I'd been promoted to a full professor after ten years on the faculty. I was doing amazing high-end technical surgery. We were experiencing incredible success as an organization and in our group, and I was concerned that this would really adversely affect not just me personally and professionally, but would have wider implications on the organization and could, in that environment, also extend into a world of litigation and a very complicated stream of events that's very, very unpleasant for everyone involved.

[0:04:37] The fellow and I proceeded, over a period of about six hours, to x-ray every piece of equipment that we used in the operation that could possibly resemble the appearance of what we saw in the x-ray.

[0:04:46] By 2:00 in the morning, I finally realized, this has to be a sponge. We X-rayed the sponge and sure enough, that's what it was. We went then with a plan to go back the next morning and re-operate.

[0:05:02] I slept in the hospital that night. The next morning at 7:30, we went back to the operating room. I sat in the corner of the room on a stool and I looked and watched my fellows reopen the abdomen. It took them just 20 minutes. They reached inside, pulled out the sponge. The whole thing was over in about 30 minutes.

[0:05:20] And I went back out and talked to the patient's wife. And I said, “We figured out what it was. We confirmed it. We've removed it. Your husband is going to be okay.” The patient was okay. But that moment was like no other in my career.

[0:05:40] I felt horrible. I felt humiliated. I felt such grief. I could not believe that I could possibly commit an error like that. And as I began to think about this in greater detail, I began to realize that, yes, I had committed an error, but that multiple systems had failed this patient.

[0:06:00] And in my later academic life, as I went to Boston and studied patient safety at the Harvard School of Public Health, I really learned a tremendous amount about the science of human error.

[0:06:12] Much of what we have to do today is to acknowledge and recognize that in health care, we have had, historically, a culture of shame and blame and a practice, oftentimes, of covering up our mistakes and moving on to the next patient. We need to move past that, embrace principles and concepts of adjust culture, and employ systems thinking to better understand the complexity of the work environment that we have in health care.

[0:06:37] One big opportunity that we have is to adopt principles, practices, and approaches that are used by other industries. If we look at the gains that have been made in commercial aviation or in nuclear power or chemical manufacturing, those industries are often grouped together as high-reliability organizations by academics. And by adopting many of the principles and approaches that have been taken in this group of industries and taking them to health care, we can really introduce dramatic change.

[0:07:12] One of the biggest changes that we're bringing about at University Health Network is an approach and a program that we call Caring Safely. It's a program that we have designed and built and rolled out together with the Hospital for Sick Children in Toronto. It really brings about a structured approach to patient safety that begins with an effort to bring about adjust culture, to bring about an approach that encourages a process of speaking up on safety, an approach that extends not only to patients but also to employees and to workplace safety.

[0:07:47] I think patients and families do understand the complexity of medical care, the way it's delivered today. They do understand that at times things don't go the way that we plan. And the candor and honesty that we demonstrate, even the uncertainty that we convey in times when we don't know, that, in a paradoxical way, builds trust with those patients and families.

[0:08:14] Being involved in an episode like mine invokes tremendous emotions and all types of responses. Perhaps the best thing that can happen to many providers in this situation is to become safety champions, to realize that this event can spark an interest. Sometimes a change in your career trajectory can cause you to volunteer to be on a hospital committee, to read different literature, to understand that the science of human error is in fact a science, and that there's much that we have to learn, to think about the culture around safety in your organization or in your practice, and to really operate in the future as a champion for patient safety.

[0:09:07] Those champions, especially when they are physicians, have tremendous influence in the health care environment in which they work. This, in turn, can lead to saving thousands of lives.

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