In the Public Eye

Media Watch

A heartbreaking story that misses the point

Barbara Sibbald, 18 Foster St, Ottawa, ON Canada K1Y 3J4

barbara.sibbald@sympatico.ca

A 5-year inquest into the deaths of 12 babies who underwent cardiac surgery in 1994 at Winnipeg's largest hospital identified 2 culprits: systemic problems in the running of the hospital and the inexperienced Kansas-born surgeon, Jonah Odim. But the broader problems, including the hospital's insistence on keeping the prestigious program going despite an inadequate number of patients, were simply too complicated to report in 30-second news clips or 10 paragraph articles. So it is the story of Odim that has riveted the media since 1995, a story that continues to dominate reports.

Even before Odim had arrived at the hospital, its pediatric cardiac surgery program was in trouble. In 1983—a full 11 years before Odim was employed—a mortality rate of 50% and a strike by anesthetists against the cardiac surgeon forced the province to close the program. And Odim's predecessor, Dr Kim Duncan, quit after 7 years, citing mounting frustration over a lack of staff dedicated to the program and inadequate administrative support and money.

In 1994, the mortality rate among high-risk patients who required bypass (28%) was nearly triple the Canadian norm (11%), and in February 1995, the hospital suspended its cardiac program. But why did these events, and not the previous problems at the hospital, get noticed? The difference this time was that *Winnipeg Free Press* medical reporter Alexandra Paul read between the lines of the terse hospital press release announcing the program's suspension. Paul's article questioned whether pediatric cardiac surgery should ever have been performed at the hospital, and outraged parents began phoning. The province of Manitoba was forced to call an inquest. This turned out to be the longest ever in Canadian legal history, with more than 100 witnesses testifying over nearly 3 years.

Canadian inquests do not assign blame or legal culpability. Instead, they look at ways to prevent similar tragedies. The presiding judge, Murray Sinclair, quickly appreciated the larger problems and expanded the scope of the inquest to investigate the Winnipeg Health Sciences Centre Children's Hospital heart program since its inception in 1978. Sinclair, known for his thoroughness, took 2 years to write the 516-page report. Among the 36 sweeping recommendations (www.pediatriccardiacinquest.mb.ca/), released in November 2000, was a call for the program to stop handling high-risk cases. Ironically, the pediatric cardiac program had already completely shut down (patients are now referred to Edmonton or Vancouver). The report's other recommendations, including protection for whistleblowers and public access to surgeon's track records, are being studied by the province and the hospital. And the College of Physicians and Surgeons of Manitoba is investigating all 17 physicians involved in the cardiac program, including Odim, who has yet to face any disciplinary action (although a lawsuit by 4 of the families is pending).

But the underlying problem—which should have been the lead in all media coverage—was never adequately explored. The province of Manitoba, with a population of 1.1 million, simply does not have enough cases to keep surgical teams' skills sharp. The average population base for each of Canada's 11 pediatric cardiac units is 2.6 million. So why was the program kept open? Why didn't the hospital pay attention to mortality and morbidity rates a decade ago? Why didn't it listen to Duncan's complaints? Few journalists considered these crucial questions. It was far easier to zero in on the dead children and Odim.

Expert after expert testimony indicated that Odim, who now works at the University of California at Los Angeles Medical Center as a researcher and an assistant in the organ procurement team, was in over his head. This was Odim's first staff job, and he had never done many of the complex procedures alone.

Barbara Sibbald

Pediatric cardiac surgeon Jonah Odim voluntarily returned to Canada in 1997 to testify at the inquest into the deaths of 12 infants

A pediatric cardiac surgeon testified that Odim's 1 year of training in pediatric heart surgery was not adequate for the job, and a former supervisor said he "wasn't surprised" that Odim had problems.

But the testimony gradually revealed a program beset with systemic problems. A lack of clear reporting lines and poor communication left the relatively inexperienced surgeon on his own. The hospital also had shoddy hiring practices; no one checked Odim's credentials or watched him perform surgery before hiring him.

"The system allowed Odim to get in over his head," said reporter Paul, "but I don't know how you apportion responsibility. He didn't refuse cases, but neither did the cardiologists. And there were no checks or balances at the hospital. No assessment. It's shocking, given the history of the program."

There were lots of signs that the program was in trouble in 1994. After the third child died, surgical nurses alerted their superiors about Odim's difficulties with cannulation and the excessive bypass times and blood loss. They were ignored. The program was "slowed down" in May after anesthetists refused to work with Odim on high-risk cases. But it restarted in August because of "significant pressure" from the heads of the hospital. The hospital was in the midst of restructuring, and having to close this prestigious program would be an admission of failure. It had also been receiving bad press for years, including stories about decrepit buildings, flies in the operating room, and problems with cleanliness, heating, ventilation, lighting, and overcrowding. In December the program was halted again after the 12th open-heart patient died, and the head of ICU [intensive care unit] refused to refer any more patients to Odim's team.

To his credit, Odim voluntarily took the stand for 6 weeks. But the 45-year-old surgeon fanned the emotional inferno by refusing to fault his surgical technique. Instead, the Yale-educated, Harvard-trained surgeon blamed his "inexperienced" staff and said the families expected too much. He said he felt like a victim, an outsider forced to take the rap for a surgical program that was fatally flawed when he arrived. "Perhaps I should have withdrawn my services at day one," he speculated. Instead of gaining sympathy, this tactic made Odim a lightning rod for outraged parents and, by extension, journalists.

Judge Sinclair agreed with the experts, concluding that: "The program continually undertook cases that were beyond the skill and experience of the surgeon and his team."

But of the 36 inquest recommendations, only 7 concerned changes to the program itself, the rest calling for systemic changes by the hospital (15 recommendations), the provincial government (12), and the College of Physicians and Surgeons of Manitoba (2).

An on-line search through Dow Jones Interactive/Info Globe over the 6 years since the inquest was called found 198 media reports in Canada and the United States. What is remarkable is that only 8 went beyond a hard-news, blow-by-blow account of the inquest. Most focused on Odim's skills, angry parents, and vocal nurses, with only scant mention at the bottom (where it was likely to be cut) of systemic problems. But the broader picture was available to journalists in articles I wrote for the *Canadian Nurse Journal* (November 1997) and the *Canadian Medical Association Journal* (1998;158:783-789 and 1998;159:1285-1287), and articles in *The Globe and Mail*, the *National Post* and a mainstream Canadian magazine (*Elm Street*, March 1998, pp 92-99).

The story also featured as a 12-minute segment on *The Fifth Estate*, Canada's version of *60 Minutes*. I was the researcher on that segment, and a private investigator was hired in Los Angeles to follow Odim for 5 days. In the end, the producers and reporter edited out information about the underlying problems to focus on weeping parents, distraught nurses, and dramatic operating room reconstructions. These details made a more compelling story than the problems with the hospital system.

When the inquest report was released, it was front-page news across Canada. Without exception, the coverage zeroed in on the fact that at least 9 of the 12 infants might have lived had they received better care or been treated at a larger medical facility (most media got it wrong and cited 10 of the 12). Seven of those 9 deaths were attributed to surgical problems, and 2 were so complex that they should have been referred to larger hospitals. Of the remaining 3 deaths, the inquest concluded that 2 were likely not preventable and 1 death was acceptably explained.

Paul at the *Free Press*, who has written hundreds of articles about the inquest, was not surprised by the facile coverage, particularly in the electronic media. Systemic issues aren't "sexy," and the larger question of why the program was allowed to continue for 22 years was too complex.

Crown Attorney Don Slough says this is a "cautionary tale" for hospitals with low volumes that take high-risk cases. "Winnipeg's Health Sciences Centre isn't unique," he says. That story is the one that needs to be told because it contains lessons for other programs with similarly low case loads. That is the story that may prevent deaths in the future.