Twelve deaths in Winnipeg: judge must ponder 48 000 pages of inquest testimony

Features

Chroniques

Barbara Sibbald

In brief

THE WINNIPEG INQUEST into the deaths of 12 young heart patients has ended after nearly 3 years of testimony, much of which centred on a surgeon's competence. The recommendations emerging from it are expected early next year.

En bref

L'ENQUÊTE MENÉE À WINNIPEG dans l'affaire du décès de 12 jeunes patients cardiaques s'est terminée après trois ans de témoignages portant principalement sur la compétence du chirurgien. Les recommandations devraient paraître au début de l'an prochain.

Barbara Sibbald is *CMAJ*'s Associate Editor, News and Features.

CMAJ 1998;159:1285-7

After 31 months of testimony, 86 witnesses and 48 000 pages of transcripts, the inquest into the deaths of 12 children at Winnipeg's Health Sciences Centre finally ended Sept. 30. It leaves a mammoth job for Murray Sinclair, an associate provincial court judge who is expected to hand down recommendations early next year on how to prevent similar occurrences. The inquest's total cost is unknown, but Crown Attorney Don Slough says the Manitoba government alone will have spent at least $2.2 million by the time all the bills are in.

The inquest into the deaths of 12 patients being treated under Winnipeg's Pediatric Cardiovascular Surgery Program was originally slated to last 6 months (see *CMAJ* 1998;783-9). However, 14 parties, ranging from patients' parents to physicians, the hospital and nurses, obtained legal standing, and at the same time the clinical evidence grew increasingly complex. Much of the testimony centred on the competence of the pediatric cardiac surgeon involved, Dr. Jonah Odim, and on the role Winnipeg's Health Sciences Centre (HSC) played in monitoring his program. The broader question of whether Manitoba has a large enough population to support a pediatric cardiac program was also raised.

Between March and December 1994, 12 children died during or soon after cardiac surgery at the Children's Hospital in Winnipeg, which is part of the 860-bed HSC. During those 10 months, 78 cardiac patients underwent surgery and 15% of them died. Among 34 high-risk patients, the mortality rate was 29%. This rate was "clearly excessive" in the eyes of experts from Toronto's Hospital for Sick Children, who cited a mortality rate of 11% for similar procedures at their hospital.

On Feb. 14, 1995, pediatric heart surgery was suspended at the Children's Hospital. The inquest, called Feb. 28 of that year following pressure from bereaved families, officially began a year later. The early testimony revealed that Odim, 44, had little experience practising as a solo surgeon, yet the HSC hired him as associate professor of surgery and chief of the Division of Pediatric Cardiac Surgery. During his 10 months as the program's sole surgeon, he came under fire from members of the surgical team because of his surgical techniques.

Odim responded by alleging that he had to cope with hospital infighting and a lack of institutional support, and claimed that he was merely a "scapegoat" for nu-

© 1998 Canadian Medical Association (text and abstract/résumé)

Barbara Sibbald photos

Dr. Jonah Odim's technical competence was debated during inquest

merous problems at the hospital. In fact, the hospital had suspended the same program in 1983 for virtually the same reasons it was halted in 1995 — high mortality rates, low morale and communication problems. The Winnipeg program had been plagued with problems throughout its 22-year history, and this begged the question of whether the province had enough people to sustain expertise in such an élite program. The average population base for each of Canada's 11 pediatric cardiac units is 2.6 million people; Manitoba has 1.1 million residents.

Regardless of issues like that, Odim's technical skills continued to be a central issue throughout the inquest. A February 1997 report from the Pediatric Death Review Committee of the College of Physicians and Surgeons of Manitoba concluded that 4 of the 12 deaths were "possibly preventable with improved medical management" and that surgical technique contributed to 2 of the deaths.

Trained at Harvard

Odim's main clinical experience was garnered during a 1-year fellowship in 1993 at the Boston Children's Hospital, which is affiliated with the Harvard University medical school. Dr. John Mayer was 1 of 4 cardiovascular surgeons working with Odim in Boston, and they had performed 50 to 70 procedures together. When he appeared before the inquest Aug. 25, Mayer testified that he was uneasy doing anything other than relatively simple and straightforward cases with Odim because "I was not comfortable with his level of technical skill." Later he added: "[Odim] wasn't among the best people that we had ever trained. . . . I wasn't surprised that there had been some problems."

Another expert witness, Dr. Garry Cornel, reviewed Odim's training and qualifications and concluded: "I . . . do not feel that his limited experience was sufficient to undertake the appointment that he was given." Cornel, the chief of cardiovascular surgery at the Children's Hospital in Eastern Ontario in Ottawa, also stated that "1 year of this sort of training is not sufficient to ensure that a surgeon can perform all of the complex functions that are required for the achievement of excellent results in pediatric heart surgery."

He said 2 years of additional training after completing a fellowship is the normal prerequisite in this surgical specialty.

In addition, Odim was in the unenviable position of having to restart Winnipeg's pediatric cardiac program. It had lain dormant since the previous surgeon, Dr. Kim Duncan, quit in July 1993. Duncan said he was frustrated by the lack of resources and support during his 7 years in the position.

Mayer said launching a congenital heart surgery program is an "extraordinarily challenging undertaking." A young surgeon doing this should "make a very careful and critical assessment of . . . his own capabilities as a surgeon [and] as a team leader."

Yet in his report to the inquest, Cornel stated that it is not surprising that "a young man in Dr. Odim's position would not realize the extent of his limitations. . . . Having been put into such a position of authority . . . it would be difficult for him to admit of any self-doubt."

Within 2 months of starting to practise in Winnipeg, Odim attempted a complex Norwood reconstruction. [This operation, used to treat infants with hypoplastic left-heart syndrome, is considered a palliative procedure, since transplants are considered the treatment of choice for this condition. The operation has a very high mortality rate. — Ed.] When asked whether Odim should have been undertaking this procedure, Mayer said: "I guess I would have been sceptical that it would have been a successful undertaking. . . ."

Mayer also testified that no one from Winnipeg's HSC contacted him regarding Odim's candidacy for the position there. Cornel, Mayer and other surgeons found this highly unusual. Not only are former employers contacted, they noted, but the surgeons themselves are usually watched at work before a job offer is made.

Preventable deaths?

Administrative snafus like this failure to contact former employers were raised persistently during testimony. The

HSC president, Rob Thorfinnson, and several vice-presidents denied knowing of problems within Odim's program. Carol Youngson, a former OR charge nurse who has since left the profession to work as an investigator for Manitoba's medical examiner, says: "I'm astounded at how people have passed the buck. No one even now seems to know who Odim reported to.

"The problems were obvious from the beginning: the surgeon and the system. The first day I was in surgery with [Odim] I thought this guy has never done this before . . . . I found out I was right. He hadn't done anything on his own. It's nice to know I was right but it's devastating to know that all this could have been prevented."

Before going into deliberation, Judge Sinclair asked each of the 14 parties with legal standing to recommend how the program and system could be changed to prevent a similar occurrence. Youngson says the nurses are advocating clearer lines of reporting and accountability, and follow-up on concerns raised during the inquest. They also want protection for whistle-blowers and to have 2 surgeons, 1 dedicated to surgery and the second doing dedicated on-call work. They also recommended establishing 2 committees — a multidisciplinary team to monitor the program and resolve problems, and a nursing committee to help them resolve nurses' concerns.

Youngson hopes the pediatric cardiac program reopens so that patients and their families won't have to travel to Toronto or Vancouver for treatment. But if it does start up again, she says only simple and moderately complex procedures, such as atrial septal defects and Blalock-Taussig operations, should be performed. Patients needing more complex surgery, such as Norwood reconstructions, should be sent to larger centres with larger teams, such as Toronto. "We did have a good program," Youngson maintains, "and we could again."

Parents of the dead children also had recommendations. Saul Simmonds, the lawyer for parents of 6 of the 12 children who died, says they had more than 65 suggestions for Sinclair. They called for more thorough post mortems, disclosure about risks so that parents can make informed decisions and a system to establish a surgeon's credentials. The parents also called for removal of a section of the Manitoba Evidence Act that allows standards committee to withhold information regarding problems involving hospital-based physicians.

"The protection the doctors are afforded is well beyond what anyone else receives," says Simmonds. "It gives doctors the ability to hide behind this protection [and] this is not right."

Simmonds says there are 3 options for the cardiac surgery program: close it for good and refer all patients elsewhere, create a regional program for the Prairie provinces, or restart the program with proper funding. Whatever the end result, Simmonds says the parents' strongest hope is that these problems will never arise again. "Many [of the parents involved] have gone on to have healthy children," he says, "but this hasn't healed the wounds." Three sets of parents have launched a civil suit against Odim, who is currently completing a fellowship in transplantation surgery at the University of California at Los Angeles Hospital. Simmonds say these parents want "honest answers to honest questions."

Former OR charge nurse Carol Youngson says the buck has been passed

The bitterness remains

Many of the parents remain bitter that an inquest was called instead of an inquiry. The latter could have assigned blame, while the former only allows for recommendations to prevent a similar tragedy.

Margaret Feakes, whose 15-month-old grandson Ashton died after heart surgery on Nov. 11, 1994, attended most of the inquest. She is "not at all optimistic" about the final recommendations because she has seen them emerge previously and end up "being shelved."

"I'm very disappointed. The only thing that's come of it is we've learned how our kids died. It's no comfort to know how they suffered."

Donna Still, 1 of 3 parents to make final statements to the inquest in late September, lost her 5-month-old daughter after a relatively low-risk tetralogy of Fallot procedure in May 1994. "Twelve children died, yet everyone walks away untouched," concluded Still. "Everyone except the parents."