e-Appendix 3: Brief description of clinical details of adverse events occurring in 255 patients, by corresponding maximum degree of preventability*

Case	Description of adverse event†
Virtually certain evidence of preventability	
1	Acute on chronic renal failure caused by NSAIDs
2	Acute renal failure with hyperkalemia and intractable constipation with large-bowel obstruction ending in death. Lack of effect of enemas recorded in nurses' notes and results of bowel radiograph not acted upon
3	Admission because of severe anemia. The anemia had been documented in previous admission but not investigated fully, which resulted in delayed diagnosis of colorectal carcinoma
4	Delirium caused by benzodiazepines given to patient with hepatic encephalopathy
5	*Clostridium difficile* colitis following antibiotic therapy. Patient did not receive sufficient volume expansion, which led to acute renal failure and death
6	Cardiac valve replacement. Three days before discharge nurse noted wound was red, inflamed and painful, but no treatment or medical note. Nontherapeutic international normalized ratio (INR) on discharge. Readmitted at 2 weeks with a wound infection, echogenic mass on prosthetic valve and possible infective endocarditis
7	Chronic renal failure in patient taking sotalol and given increasing doses of digoxin, which led to increased QT interval, digoxin toxicity, heart block and worsening renal failure
8	Delayed diagnosis of rectal cancer in patient with long-standing rectal symptoms
9	Delayed diagnosis of uterine cancer in patient with vaginal bleeding for over a year
10	Delayed treatment of digoxin toxicity in patient with acute renal failure, diarrhea and dementia
11	Delayed treatment of pseudomembranous colitis
12	Delirium secondary to aminophylline toxicity. No measurement of drug level in clinical context of renal failure
13	Digoxin toxicity in patient with chronic renal failure possibly contributed to death
14	Drug-induced acute urinary retention and postrenal failure
15	Delirium and vomiting caused by electrolyte imbalance after chemotherapy
16	Excessive blood loss during extensive surgery resulted in anemia, which was not treated
17	Failure to follow protocol in management of acute ST-segment elevation myocardial infarction (MI). Patient readmitted after third MI 1 month after index admission
18	Multiple readmissions owing to failure to perform endoscopy or find source of gastrointestinal bleed before discharge
19	Transfer to intensive care unit (ICU) delayed because of failure to recognize and address the critical nature of the patient's illness. Respiratory failure led to death
20	Cirrhosis of the liver caused by hepatitis C transmission from transfusion
21	Inadequate investigation and post-discharge follow-up in patient with severe acute pancreatitis and probable pseudocyst
22	Recurrent infection and need for secondary surgery because of incomplete removal of nonfunctioning artificial uretheral sphincter
23	Patient with malignant coronary artery disease referred for urgent cardiovascular surgery. Treatment delayed 3 months because of misplaced films at cardiovascular case conference
24	MI following delayed transfer of patient with unstable angina because referral hospital beds were unavailable
25	Misdiagnosis for over 1 year and resulting drug therapy without adequate monitoring led to delirium and multiple admissions because of falls
26	Missed diagnosis of anemia associated with recurrent gastrointestinal bleed. Appropriate blood work not done and patient inappropriately discharged
27	Normal blood pressure and no hypovolemia, while chest radiograph showed pulmonary edema. Patient given 2100 mL of normal saline intravenously over 48 hours; when saline stopped and furosemide given, confusion and dyspnea cleared
28	NSAIDs in context of chronic renal failure and coumadin with lack of proper monitoring resulted in digoxin toxicity and hypercoagulability
29	Ovaries removed during hysterectomy; consent indicated that patient understood they would be left

30 Overmedication in context of alcohol intoxication led to unresponsive patient with possible aspiration
31 Acute renal failure in response to prolonged treatment with diuretic in patient admitted with chronic renal failure
32 Hepatitis caused by lipid-lowering drugs in patient with chronic pancreatitis and familial hypercholesterolemia
33 Patient with metastatic cancer and known hypercalcemia readmitted for intravenous therapy for recurrent hypercalcemia. Serum calcium level not measured during previous admission
34 Perforation of bladder during routine gynecological surgery in patient with no adhesions
35 Hospital stay prolonged because equipment necessary for pacemaker insertion not available
36 Pulmonary embolus initially treated as pneumonia, with no diagnostic testing for possibility of pulmonary edema
37 Worsening of renal failure because of renal toxicity related to prescription of multiple medications
38 Both cardiac and respiratory disease misdiagnosed in seriously ill patient
39 Steroid-dependent patient not given steroids in hospital, which led to adrenal insufficiency

Strong evidence of preventability

40 Abdominal surgery. Drain was intended but not available. Postoperative hematoma required 2 units of blood and another operation
41 Acute chronic renal failure secondary to drug therapy with subsequent MI, congestive heart failure and infections
42 Patient admitted because of delirium, which cleared after correction of hyponatremia and cessation of drug therapy. Lack of investigation of low hemoglobin concentration led to subsequent admission
43 Patient admitted because of gastrointestinal hemorrhage. Upper gastrointestinal endoscopy showed no source of bleeding; colonoscopy not performed. Patient readmitted several months later with recurrent gastrointestinal bleed and died
44 Patient admitted with diagnosis of pancreatic cancer and died later in palliative care. The diagnosis was not conclusively established
45 Antibiotics given for catheter-related urinary tract infection. No investigation for *C. difficile*, and patient discharged 12 days later with diarrhea
46 Delay of 3 days in diagnosing urinary tract infection
47 Acute delirium secondary to drugs or alcohol withdrawal after lung surgery. Pneumonia also developed postoperatively
48 Following diagnostic laparoscopy and endoscopic surgery, patient readmitted 3 times because of abdominal pain, diarrhea and vomiting. Diagnosis of intestinal occlusion missed
49 Acute respiratory acidosis secondary to high doses of intravenous morphine therapy following thoracotomy for repair of ventricle; hospital stay prolonged
50 Patient in emergency department day before admission and death; ultrasound at that time showed large abdominal aortic aneurysm, but diagnosis was renal colic. Patient sent home and admitted next day with ruptured abdominal aortic aneurysm
51 Inadequate monitoring of patient with hyponatremia and diuretic treatment on initial and then index admission
52 Inappropriate discharge home resulted in further fall-related injuries
53 Intraoperative complications during elective procedure led to extensive bleeding that necessitated extensive surgery and abscess drainage. Pseudoaneurysm developed as complication of arterial embolizations to stop bleeding, and abscess developed at site of embolization puncture
54 Intraoperative perforation of bowel required repair and resulted in prolonged hospital stay
55 Patient with known coronary artery disease admitted with gastrointestinal bleed and negative scope. No monitoring of hemoglobin concentration for 2 days. Hemoglobin had fallen by 60%, and patient had MI
56 Laceration of cervical vertebra (C2) during surgery
57 Misdiagnosis and then poor management of syncope secondary to aortic stenosis, with multiple falling episodes and inappropriate morphine use
58 Mismanagement of chronic constipation with inadequate and possibly incorrect medication use and inadequate instructions to patient
59 Mismanagement of diabetic patient with non-Q-wave MI, which resulted in congestive heart failure and death

60 Multiple admissions because of gastrointestinal bleed requiring transfusion, which delayed surgery in patient at high risk for cerebral infarct

61 Multiple complications pre- and postoperatively in cancer patient

62 Diagnosis of endocarditis missed on index admission, which resulted in prolonged hospital stay and readmission with same symptoms 2 weeks later, when correct diagnosis was made

63 Bradycardia and hypotension secondary to drug interaction/overmedication in patient with angina

64 Patient with atrial fibrillation not given therapeutic heparin, which resulted in cerebrovascular accident and death

65 Postcystoscopy urinary retention caused sepsis and consequent gout. Gout treated with NSAID and no cytoprotective agent; patient had gastrointestinal bleed

66 Inadequate management of postoperative complications (including biliary obstruction and neurological deficit) following exploratory laparotomy

67 Postoperative complications, including hematoma and wound infection, following knee surgery, and excessive coumadin with inadequate monitoring

68 Patient presented to emergency department with severe and suspicious headache and discharged home. Presented to index emergency department several days later with recurrent headache and found to have subarachnoid hemorrhage

69 Untreated hyperkalemia in context of acute renal insufficiency resulted in MI, cardiac arrest and death

70 Patient with urinary tract infection prescribed antibiotic therapy and discharged. Five days later culture showed drug-resistant bacteria, but therapy not modified. Patient readmitted later for urethral dilatation

71 Very-high-risk patient had postoperative acute MI and cardiorespiratory failure and died. Conservative treatment was an option

Preventability more than likely (> 50% likelihood)

72 Acute pulmonary edema in patient with chronic renal failure given intravenous fluids for dehydration

73 Patient admitted because of cellulitis of foot; β-blocker therapy discontinued, and patient had non-Q-wave MI

74 Patient admitted for management of burn secondary to radiation therapy for cancer

75 Patient admitted because of dyspnea due to pneumonia; hypokalemia developed in response to diuretic therapy with inadequate monitoring

76 Blood transfusion administered too quickly, which resulted in congestive heart failure and death

77 Cellulitis of right side of face following excision of skin lesion. Subsequent paranoia and psychosis treated with multiple drugs. Delirium workup incomplete. Evidence of untreated urinary tract infection

78 Chronic painful condition managed with intravenous morphine therapy up to 10 hours before discharge. Patient discharged with no pain medication; readmitted for pain control 24 hours later

79 Critically low hemoglobin value not communicated to physician for patient admitted because of weakness and abdominal pain. Patient did not receive transfusion and died suddenly

80 Cerebrovascular accident following cardioversion for atrial fibrillation. Anticoagulation was considered but rejected as being inappropriate

81 Delayed treatment of peptic ulcer in patient with history of untreated *Helicobacter pylori* infection and gastrointestinal bleed; patient subsequently readmitted because of anemia

82 Severe back pain and headache after epidural anesthetic, possibly due to dural tear. Also postoperative wound infection

83 Patient discharged early after coronary artery bypass grafting (CABG). Readmitted because of missed pneumonia

84 Failure of consultants to follow-up postoperative patient who went into congestive heart failure

85 Deep vein thrombosis and delay of surgery because of failure to provide adequate anticoagulation in cardiac patient

86 First syncope episode misdiagnosed, and treatment not appropriate in clinical context of congestive heart failure, low electrolyte levels and new-onset diabetes

87 Hematoma after neck surgery owing to ligature slipping off vein. Return to operating room and tracheotomy required

88 High-risk patient with advanced dementia and weakness underwent uneventful surgery for

repair of hip fracture that resulted from a potentially avoidable witnessed fall

89 Marked postoperative worsening of renal function owing to poor drug and intravenous fluid management

90 Misdiagnosed renal cell carcinoma treated as pyelonephritis

91 Mismanagement of diabetic patient postoperatively resulted in hypoglycemic episode that required intravenous glucose because of unresponsiveness

92 Missed order for necessary drug after upper gastrointestinal bleed

93 Multiple comorbidities. After surgery patient had several days of severe dyspnea recorded by nurse before pulmonary embolus finally diagnosed

94 Multiple postoperative complications, including deep vein thrombosis, ileus, severe carpal tunnel syndrome secondary to surgical positioning, and readmission for treatment of abscess

95 Patient overmedicated with benzodiazapine and had seizure after drug suddenly stopped

96 Palliative care patient had delirium secondary to drug therapy for pain and nausea. Admitted to hospital and stabilized at reduced dosages

97 Acute on chronic renal failure following coronary angiography owing to inadequate workup. Patient responded well to treatment

98 Patient waited over 1 year for elective surgery. After anesthetic induction, review of radiograph indicated significant progression of disease, and patient was rescheduled for different procedure

99 Morphine prescribed without bowel routine; confusion and constipation developed

100 Poor comunication with patient regarding medications, and inadequate follow-up to assess for infection. Digoxin toxicity secondary to renal failure led to heart block and death

101 Postoperative atelectasis due to aspiration

102 Postoperative pelvic abscess secondary to leak at anastomosis site required readmission for drainage

103 Recurrent deep vein thrombosis and pulmonary embolus secondary to discontinuation of warfarin

104 Shock secondary to alcohol withdrawal and infection. Patient restrained and sedated, and oral feeding led to aspiration pneumonia. Poor communication between staff and inadequate observation

105 Patient unable to undergo surgery to repair abdominal aortic aneurysm because of cardiac and renal comorbidities. Aneurysm rupture caused death

106 Upper gastrointestinal bleed following treatment of headaches with ASA-containing drug

Preventability not quite likely (< 50% likelihood)

107 Patient admitted because of pneumonia and experienced acute hypotension from drugs. Intubated. Acute tubular necrosis developed with residual renal dysfunction

108 Cardiac ischemia and renal insufficiency resulted in death because of severe anemia in patient refusing transfusion

109 Diagnosis of ischemic colitis later found to be perforation of small bowel at autopsy

110 Drug-induced diarrhea, NSAID-induced gastrointestinal bleed and resuscitation despite do-not-resuscitate order

111 Acute renal failure induced by contrast medium following angiography in elderly patient

112 Syndrome of inappropriate antidiuretic hormone (SIADH) developed in patient with low sodium level and prescribed diuretics with no routine monitoring

113 Missed diagnosis of MI postoperatively with inadequate investigation of patient's deterioration

114 Postoperative hemorrhage requiring 4 units of blood and reoperation for drainage of hematoma

115 Surgery for hip fracture with postoperative foot drop

116 Treatment of acute on chronic renal failure resulted in pulmonary edema and subsequent readmission to hospital

117 Unsuccessful and improper reduction of fractured humerus in emergency department and subsequent radial nerve dysfunction

118 Urinary retention after transurethral resection of the prostate required readmission, during which no urine culture was ordered

Slight to modest evidence of preventability

119 Renal failure and hepatic failure developed after shunt placement in patient with alcoholic cirrhosis of the liver

120 Patient admitted because of nausea, vomiting, diarrhea and mucocutaneous ulcerations secondary to chemotherapy

121 Pneumonia and septicemia developed in CABG patient and required prolonged postoperative intubation

122 Coumadin stopped before revision surgery in patient with history of deep vein thrombosis. Second deep vein thrombosis developed following surgery

123 Cerebrovascular accident following admission for transient ischemic attacks. Heparin was considered but deemed inappropriate

124 Delirium and dehydration following total hip replacement in elderly man

125 Drug interactions, no laboratory monitoring and sudden death

126 Emergency cardiac surgery after perforation of coronary artery during placement of angioplasty stent. Return later to operating room for athrombectomy, during which severe anoxic encephalopathy occurred

127 Postoperative enterocutaneous fistula requiring surgical revision. Septicemia secondary to subclavian intravenous catheter

128 Excessive bleed requiring return to operating room and transfusion

129 Hip fracture from fall following benzodiazepine administration for sedation

130 Following cardiac surgery patient experienced sepsis, pneumonia, urinary tract infection and acute tubular necrosis possibly due to vancomycin

131 Hydrocephalus, intraventricular bleed and delirium caused by removal of infected ventriculoperitoneal shunt

132 Leg swelling in immobilized patient given steroids and no anticoagulant; patient admitted with diagnosis of deep vein thrombosis

133 Inappropriate choice of antiarrhythmia medication for ederly patient

134 Readmission for antibiotic therapy because of urinary tract infection immediately following CABG in patient with known large prostate

135 Lung atelectasis after insertion of chest tube for hydropneumothorax

136 Bleeding after attempt to place biliary drainage tube in patient receiving heparin

137 Gastrointestinal bleed in patient treated with NSAID. Scope showed healing gastric ulcer, and biopsies negative for *H. pylori* and malignant disease. Reason for NSAID unclear

138 Delirium, likely drug induced, developed in patient with severe chronic obstructive pulmonary disease taking steroids and sedatives

139 Polyp successfully removed during second colonoscopy performed during laparotomy. Laparotomy could possibly have been avoided if colonoscopy had been repeated immediately before surgery

140 New severe weakness of quadriceps noted after hip arthroplasty

141 Postoperative dyspnea with no diagnosis. Subsequent large deep vein thrombosis and pulmonary embolus

142 Postoperative cystitis

143 Postoperative fluid management led to heart failure and acute respiratory distress syndrome

144 Hospital stay prolonged because of excessive postoperative bleeding after planned day surgery

145 Readmission because of inguinal pain after cardiac catheterization; additional surgery required after ultrasound confirmation of false aneurysm and hematoma

146 Respiratory arrest during radiological procedure in patient with multiple comorbidities

147 Seriously ill patient underwent emergency surgery. About 2 weeks later patient had sudden episode of shortness of breath with rapid deterioration and died. Pulmonary embolus suspected

148 Upper gastrointestinal bleed likely secondary to coumadin and NSAID use

149 Vertebral compression fracture in patient treated with oral steroid therapy for severe asthma

Virtually no evidence of preventability

150 Abdominal pain and fever following elective surgical procedure. Patient readmitted for antibiotic treatment

151 Acute complications following angioplasty with stent resulted in repeat angiography (x2), repeat angioplasty (x1) and prolonged hospital stay

152 Acute hypothyroidism after radiation therapy for head and neck carcinoma in patient with normal thyroid-stimulating hormone level preoperatively

153 Acute MI following prostate surgery

154 Patient admitted because of neutropenia and infection following chemotherapy; given treatment with multiple antibiotics. Discharged 2 days later. Continuation of symptoms resulted in readmission

155 Patient admitted because of gastrointestinal bleed; died of hypovolemia and prerenal volume depletion and septic shock owing to pneumonia, acute respiratory distress syndrome, staphylococcal septicemia, *C. difficile* infection

156 Adverse effects of chemotherapy resulted in veno-occlusive disease, cor pulmonale and death

157 Atrial fibrillation, transient congestive heart failure and pleural effusion developed after cardiac surgery; all treated without sequelae

158 Acute cholecystitis developed after surgery. Guide wire traversed gall bladder wall during attempted percutaneous cholecystectomy

159 Allergic reaction after third dose of penicillin prescribed for dental abscess

160 Cerebral hemorrhage following anticoagulation for atrial fibrillation. INR within therapeutic range

161 Bladder dystonia due to prolonged catheterization in post-hysterectomy patient

162 *C. difficile* diarrhea following admission for hemoptysis

163 *C. difficile* infection following antibiotic therapy

164 Cellulitis and fasciitis of abdominal wall following abdominal surgery for unsuccessful fistula closure

165 Cellulitis following bone biopsy; intravenous antibiotic therapy required

166 Chronic pain and infection following surgical repair where tissue noted to be poor and closure difficult

167 Chronic postoperative wound infection; readmission and debridement required

168 Complex case with respiratory distress following CABG; repeated intubations and eventual tracheotomy required

169 Cerebrovascular accident, confusion and antibiotic-related diarrhea following surgery

170 Hematoma following cardiac catheterization; infection following surgical drainage

171 Postoperative hospital stay prolonged because of *Pseudomonas* infection of prosthetic hip

172 Transient hypotension and angina following surgery

173 Partial tear of sigmoid colon during laparoscopic gynecological surgery; open procedure required in context of significant adhesions

174 Deep vein thrombosis, pulmonary embolus and acute renal failure following arthroscopic surgery for septic knee; dialysis required

175 Pancreatitis and pseudocyst following endoscopic retrograde cholangiopancreatography for sphincterotomy and dilation

176 Fever after discharge following surgery; readmission because of pelvic abscess

177 Probable episode of pseudomembranous colitis and delirium following bowel surgery. Result of test for *C. difficile* toxin not in chart

178 Sternal infection, dehiscence and mediastinal abscess following CABG. Return to operating room for partial resection of sternum, evacuation of mediastinal abscess and reconstruction. Readmission 3 weeks later because of new wound infection; treatment with antibiotics

179 Small-bowel obstruction following repair of abdominal aortic aneurysm; death from aspiration pneumonia

180 Anastomotic leak following surgery and subsequent pelvic abscess. Multiple admissions because of recurrent pelvic pain and fever

181 Following vaginal hysterectomy, laparoscopic treatment of adhesions and second laparascopic surgery to remove ovaries for pain control

182 Hematoma following pacemaker insertion and restarting of anticoagulant therapy

183 Hospital-acquired infection after manipulation of bladder tumour

184 Hypotension and non-Q-wave MI after laparoscopic surgery

185 Hypotension during colonoscopy in patient receiving versed and fentanyl

186 Iatrogenic heart block possibly due to calcium-channel blocker

187 Iatrogenic pneumothorax with prolonged air leak after bullectomy. Hospital stay prolonged, and readmission required

188 Infection in patient with agranulocytosis following chemotherapy

189 Inguinal hematoma and false aneurysm following femoral artery cardiac catheterization

190 Bleeding during facial surgery led to postoperative facial swelling, breathing difficulty and secondary surgery

191 Large hematoma following surgery required readmission for drainage
192 Hospital stay of liver transplant recipient prolonged because of significant intraoperative bleeding secondary to medications
193 Mismanagement of upper gastrointestinal bleed in patient with significant anemia and congestive heart failure
194 NSAID may have contributed to subarachnoid hemorrhage in patient taking coumadin with therapeutic INR
195 Patient taking coumadin for prosthetic valve had hemorrhage from fall. Coumadin maintained because of valve thrombus; re-bleed necessitated return to operating room for repeat evacuation of hematoma
196 Open reduction of fracture with inadequate attention to comorbidities in patient who had postoperative chest pain and congestive heart failure
197 Pancytopenia following chemotherapy
198 Antibiotic-induced colitis in patient admitted for treatment of severe rash
199 Atrial fibrillation and congestive heart failure 2 days following CABG with endarterectomy; reintubation required
200 Large pleural effusion following CABG; hospital stay prolonged
201 Prolonged ileus in patient receiving narcotics after surgery; relieved after acute pain service modified pain routine
202 Death from brain-stem stroke following surgery for ruptured cerebral aneurysm
203 Severe epigastric pain from presumed bleed following outpatient percutaneous liver biopsy; hospital admission required
204 Sepsis due to chemotherapy-induced neutropenia and foot drop possibly related to chemotherapy in patient with acute myeloid leukemia
205 Postoperative oxygen therapy and hospital admission following day surgery of patient with chronic obstructive pulmonary disease
206 Increased confusion and agitation following hip surgery in patient with dementia; hospital stay prolonged, with no return to baseline by discharge
207 Acute MI following inguinal hernia repair under local anesthesia in patient with severe cardiac disease
208 Pneumococcal sepsis and death following splenectomy for thrombocytopenia
209 Pneumothorax following transthoracic lung biopsy
210 Ventricular fibrillation and bleeding through sternotomy following aortic valve replacement
211 Psychotic behaviour on meperidine following appendectomy; hospital stay prolonged 2 days
212 Postoperative ileus secondary to small-bowel adhesions and overmedication
213 Postoperative bleeding after laparoscopic cholecystectomy; readmission required for drainage
214 Postoperative bleeding following CABG; repeat surgeries required and hospital stay prolonged
215 Postoperative cellulitis at saphenous vein site following CABG
216 Postoperative electrolyte anomalies and MI and congestive heart failure leading to death
217 Postoperative hypoxemic respiratory failure and admission to ICU because of undiagnosed large thoracic aortic aneurysm
218 Postoperative infection necessitating readmission and management with intravenous antibiotics
219 Postoperative nausea and vomiting due to paralytic ileus, which resolved with conservative treatment
220 Postoperative obstruction of gastroenterostomy and development of abscess requiring revision. Iatrogenic injury to duodenum during surgery; patient transferred to tertiary care hospital for reoperation
221 Postoperative pain requiring unplanned readmission
222 Drug-induced delirium and hallucinations following surgery; hospital stay prolonged by 1 day
223 Postoperative wound infection
224 Postoperative wound infection. Suicidal ideation expressed to physician not investigated before discharge
225 Postoperative wound seroma and infection necessitating hospital admission
226 Postoperative MI following surgery for fractured hip
227 Prolonged postoperative wound infection
228 Pulmonary embolism following orthopedic surgery
229 Pulmonary embolus following cystoscopy for hematuria

230 Rapid atrial fibrillation with hypoxemia following hip arthroplasty despite prophylaxis

231 Readmission because of knee effusion and pain secondary to ruptured suture from patella tendon repair

232 Readmission because of neutropenia and fever following chemotherapy

233 Readmission because of pneumonia following surgery

234 Recurrent abdominal pain following laparoscopic cholecystectomy

235 Recurrent falls possibly related to medications. Received "extra" dose of furosemide because of crackles and chest radiographic findings in emergency department following fall. Discharged home. Severe hypotension and loss of consciousness in response to nitroglycerin the following day. Admitted for 48 hours without sequelae

236 Recurrent intermittent bleeding following septorhinoplasty. No specific cause of bleeding found on reoperation

237 Significant hyperkalemia secondary to renal failure following treatment of congestive heart failure with angiotensin-converting-enzyme inhibitors in the context of diabetes and essential hypertension

238 Reoperation for fractured humerus due to migration of the pins and dislocation of head of humerus

239 Repositioning of ventricular electrode of implanted cardiac defibrillator

240 Long postoperative course of fever and elevated leukocyte counts following resection of colovaginal fistula; resolved once anastamotic leak found and repaired by colostomy

241 Replacement of defective battery required 1 day following pacemaker insertion

242 Sepsis and death due to chemotherapy-induced neutropenia in liver transplant patient with post-transplant lymphoproliferative disorder

243 Septic shock from untreated injury after a fall that led to aggressive cellulitis

244 Significant hemorrhage following dilatation and curettage for uterine fibroid. Patient had prior history of bleeding. Total abdominal hysterectomy and many transfusions ultimately required

245 Stroke following CABG

246 Syncope episode after prostate biopsy

247 Unavoidable trauma to vagus nerve during upper lobe resection for adenocarcinoma because of proximity of tumour

248 Unrecognized transient bacteremia following outpatient procedure; admission required for symptom management

249 Urinary retention and infection following surgery; repeat bladder catheterizations and antibiotic treatment required

250 Urinary tract infection and sepsis 1 day after cystoscopy and retrograde pyelography

251 Urinary tract infection treated with sulfamethoxazole–trimethoprim, to which organism was not sensitive. Hospital admission for 6 days because of severe systemic sulfa allergy. Symptoms resolved and urine culture negative

252 Urosepsis in patient with chronic urinary catheter for retention

253 Worsening of chronic renal failure in patient given diuretic

254 Wound infection following sigmoidectomy for diverticulitis

255 Wound infection with persistent draining sinus requiring excision 10 weeks after surgery

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*Physician reviewers were asked to judge the evidence of preventability of adverse events using a 6-point scale, where 1 = virtually no evidence of preventability and 6 = virtually certain evidence of preventabilty (see Box 1).

†Adverse events were defined as events resulting in death, disability at discharge or prolonged hospital stay.