TRANSCRIPTION

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Dr. Doug Cochrane
Chair, BC Patient Safety and Quality Council

[0:00:10] I'm Doug Cochrane and I am the current chair of the BC Patient Safety and Quality Council in the province of British Columbia. I also serve the Minister as the patient safety and quality officer for the province. In addition, though, I have a clinical role in I do pediatric neurosurgery at BC Children's Hospital. And I must say that over the course of my life, it's been that combination of activities that have been pretty important to me. One has a sense of balance and a sense of combination of efforts that come from treating patients directly and from trying to help make the system better.

[0:00:51] It was a number of years ago as a young neurosurgeon at BC Children's Hospital when we had a tragic event related to the administration of a medication into the spinal fluid, the fluid that normally surrounds the brain and spinal cord. It was being given to try and counter a cancer that the patient had, but the wrong medication was given in the wrong place. And as a consequence of that, despite the efforts that many of us made to try and wash out the medicine and dilute it, it had a profound effect on how the nervous system worked. And as a consequence of that, the child died. It was just a profound event to have a patient succumb as a result of the best-intended treatments, but where those treatments had failed that patient. And as an organization, the Children's Hospital at that time went through great, great deliberations. We had a courageous CEO who, at that time, Linda Cranston came forward and described what had happened to this child in a very public way. And I think it was the first time that we as an organization had taken a responsibility for the consequences of our actions where those outcomes had been tragic.

[0:02:15] As an organization, we had no idea that there was a possibility of creating this kind of injury. We thought our systems were foolproof. We thought that we had systems that were resilient and rigorous, and we had people in whom we had absolute and continue to have absolute committed trust. And yet, the system failed the patient. The system failed the organization. The system failed those individuals who were treating that patient.

[0:02:45] For me, it took me from the enthusiastic trainee who I guess had – well, I'll be really honest – the arrogance to know that what whatever we did was the right thing to do. And whenever we had patients who had poor outcomes, it was usually because of what the patient had brought to the situation. But to suddenly realize that actually, what we did mattered in very concrete ways, how we organized what we did, how we paid attention to what we were doing. And as an individual, that has had a profound effect on the way my

career has unfolded and the interests that I've held and developed in the patient safety and quality world since that time.

[0:03:35] The idea that mistakes can't happen in our health care system, you know, it's not too far from the truth when you really think about how many successful interventions, how much is happening in community care or long-term care to keep people safe, people that are being rescued from illnesses that would have taken their lives 10 and 15 years ago, over here at the Royal Alex and at the University Hospital. It is really quite amazing what people and teams and organizations can do. But we would be blind to ignore the fact that we are human and that mistakes happen. And they happen because we are human and they happen because of the way we think and the way we act and how we are. And I don't think that we can necessarily make systems mistake-proof. I just hope we can make systems that will catch the mistake before they do harm.

[0:04:41] The impact of errors that have occurred, particularly when they occur by your own hand, is profound. It does wake you up in the middle of the night. You do ask questions about your capability, your competence. “Can we do this? Can I come back and do this again tomorrow?” And I suspect there is a process that people actually have to work through to incorporate what really is a grieving loss process. It's not a loss so much in the relationship with the patient, but it's a loss in self-confidence and understanding. And I think one of the things that I have learned is that you somehow need to have an organization that is sensitive to this. Because I would never ask for help. I might be pushed to find help, probably by my wife, but I would never ask.

[00:05:50] But what would make a difference is that a colleague comes up and says, “Tell me about what happened and tell me how I can help you.” Is that important, to have closure, to have acknowledgment? Absolutely.

[0:06:08] You know, this was not the first event in my career where I've had the opportunity to recognize my own weaknesses or my own limitations and a system that wasn't on top of things. I can think of several examples, actually, where the comfort that it brought to me to be able to acknowledge this with the family or with the patient, was tremendous. I don't think it made it any easier at all for the family. It didn't make it any easier at all for the patient. And it didn't make it easier for me, but it made it different and it brought us to eventual understanding of our respective roles and where – in my circumstance, I'm thinking of a particular example where we could have been better and we weren't. And that was the royal we: me.

[0:07:17] I wanted to share this story because it is such a profound story at so many levels. Clearly, the most significant level is in the lives of the family and in the life lost in that child. But it's not just there. Children's Hospital is a different organization because of that experience. Children's Hospital takes care of its patients differently now in a way that is safer. Children's Hospital organizes and cares for its staff in a way that is different and is safer.

[00:07:52] And we've taken the approach, which I think we are obligated to, to communicate our experiences and our results to other individuals and organizations, lest they assume that they would never be subject to such an event or such an error. And I think that's actually the marvelous opportunity that has come out of this absolute tragedy.

[0:08:19] I want to be confident that people who are coming into our health system and will be our health system will be better prepared and have better understanding of the pluses and the successes of health care, as well as its limitations. And its limitations, we call issues of patient safety. The limitations are the issues that we call issues of quality. And I know they are.

[0:08:52] Actually, I'm amazed at the current set of trainees that I'm exposed to day to day. They truly up my game because they're far better prepared and have a far better working knowledge of many aspects that relate to safe care. They are more insightful about themselves, they are more understanding of their own reactions, but they are also more understanding of patients and how to treat them and families in a way that is respectful.

[0:09:21] I think we're in a good position, but I would want all of them to remember that we have an obligation. We're fortunate in Canada to have a system in which we have an obligation, not just as taxpayers, but as providers. And that obligation is to make the system better and to make it safer for all.

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