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CORONER'S REPORT

Medical system failed woman

By Paul Walton
THE FREE PRESS

A Nanaimo coroner has recommended a review of the treatment a Courtenay woman received last year before being sent to a Victoria hospital where she died.

Phuong Nguyen, 36, died April 21, 1995 after a 23-day ordeal at Victoria General and Royal Jubilee Hospitals where she was treated for complications arising from being pregnant while suffering from lupus.

Coroner Jack Harding said various factors, including a delay in sending Nguyen from Courtenay to Victoria, contributed to her death. He recommends the B.C. College of Physicians and Surgeons conduct a review of her care in Courtenay.

In Calgary the woman was diagnosed with lupus: a medical condition which can include dyspepsia, anemia, chest pain and facial rashes. She moved to Courtenay in September of 1994. Because she spoke little or no English, Nguyen was unable to explain to the doctor about having lupus when she arrived in Courtenay.

"Communication was complicated by a significant language barrier and translators were often required," said Harding.

> **"Communication was complicated by a significant language barrier and tanslations were often required**
> *- Jack Harding*

The Courtenay doctor failed to diagnose the lupus when he saw Nguyen late in 1994. Shortly after determining she was pregnant in March 1995, the Courtenay doctor diagnosed the lupus and referred Nguyen to a specialist in Nanaimo.

"Her doctor explained the problems associated with lupus to Mrs. Nguyen without the benefit of the interpreter," stated Harding.

Throughout March Nguyen's health deteriorated and she was advised to terminate the pregnancy because of the risk the lupus created. By the end of March she was suffering kidney failure, hair loss, fluid in her abdomen and coughing blood. On March 30 the fetus was found to be dead. The Courtenay doctor told Nguyen and her husband she would have to go to Victoria for further treatment.

"The husband wanted Mrs. Nguyen sent to Victoria by ambulance," stated Harding. "The family doctor suggested travel by car. As reliable transportation was not available to take her by car, the doctor then suggested bus transportation."

The couple had to go to the Ministry of Social Services to get bus fare for the trip. When they got off the bus in Victoria, Nguyen was unable to walk and had to be dragged by her husband into the hospital. She continued coughing blood.

"A specialist saw her that evening and speculated on the potential for dialysis but was unable to communicate this effectively to Mrs. Nguyen or her husband and a translator was not available," Harding wrote.

Doctors decided to remove the fetal tissue but in the following days her condition did not improve. Her immune system was severely depressed and she suffered hypertension, heart irritation and angina.

Internal bleeding also continued. Nguyen's breathing had to be assisted and antibiotics were needed. Dialysis was started but within several days a blood test found several serious infections. Within days Nguyen's condition began to deteriorate further. On April 21, the equipment which helped Nguyen breathe was shut off. Within 20 minutes she was pronounced dead.

Harding has also recommended the College of Physicians and Surgeons assess the need to provide interpreters on first visits to a family doctor for patients who know little or not English.

Amputee to get $1.3 million in lawsuit over misdiagnosis

By PHIL NEEDHAM and DEREK WOLFF

A former Williams Lake sawmill worker who had to have a leg amputated because of a doctor's misdiagnosis was awarded $1.3 million Monday.

B.C. Supreme Court Justice Lance Finch found Dr. Henry Pankratz negligent in his examination and diagnosis of Harbhajan Singh Chattu, 55.

Chattu was taken to Cariboo Memorial Hospital in Williams Lake from his home at 7 a.m. on August 20, 1986, after he suffered severe abdominal pain while bending over to brush his teeth.

It was 16 hours and two air ambulance trips later, at the third hospital he was taken to that day, before Chattu's problem was properly diagnosed as a blood clot and relieved, but it was too late to save his right leg and hip joint. He also suffered kidney failure.

Chattu had a history of back trouble and the judge found this affected Pankratz' diagnosis that a spinal disc was protruding and pressing against nerves.

Chattu's wife could not make herself understood in English and a family friend more experienced in the language talked to the doctor about Chattu's back problems. Chattu had been given medication for the pain, but told the court he indicated the pain was in his abdomen, not his back.

The language difficulty "should have made (the doctor) especially careful in conducting his physical examination and recording those findings," said Justice Finch.

Medical experts called by Chattu's lawyer, John Laxton, as well as defence experts under cross-examination, agreed Pankratz should have checked for a femoral pulse to determine if there was blood flow in Chattu's legs.

That failure, the judge found, was the negligence that caused the wrong diagnosis and amputation.

Pankratz thought the problem was neurological, and arranged for the patient's transfer by air to Kamloops Hospital, where a neurologist could examine him. There, Chattu's problem was found to involve a clot in the blood vessels.

Kamloops could not deal with the problem and Chattu was transferred to Vancouver, where it was found the abdominal aorta was blocked at the point where the major blood vessel carries blood to lower limbs.

By the time this was relieved, Chattu's right leg was beyond saving and had to be amputated at the hip.

In addition to general damages of $160,000, Chattu was awarded damages for loss of income and the cost of future care, a financial management fee for advice on the preservation of the fund, and an extra "gross-up" amount to cover the income tax on money generated by the fund.

With a family friend acting as interpreter, Chattu said Monday night that despite the settlement, he will be confined to a wheelchair for the rest of his life. "It still won't pay for the suffering I have gone through. The money cannot bring what I would have enjoyed."

Lawyer John Laxton said he was pleased with the settlement.

Overhead I.1A:TERMS

COMING TO TERMS WITH CULTURAL COMPETENCY

Culture is a set of learned and shared beliefs and values that are applied to social interactions and to the interpretation of experiences. It is shaped by factors such as proximity, education, gender and age.

Race is a sociopolitical construct, having no scientific or anthropologic basis.

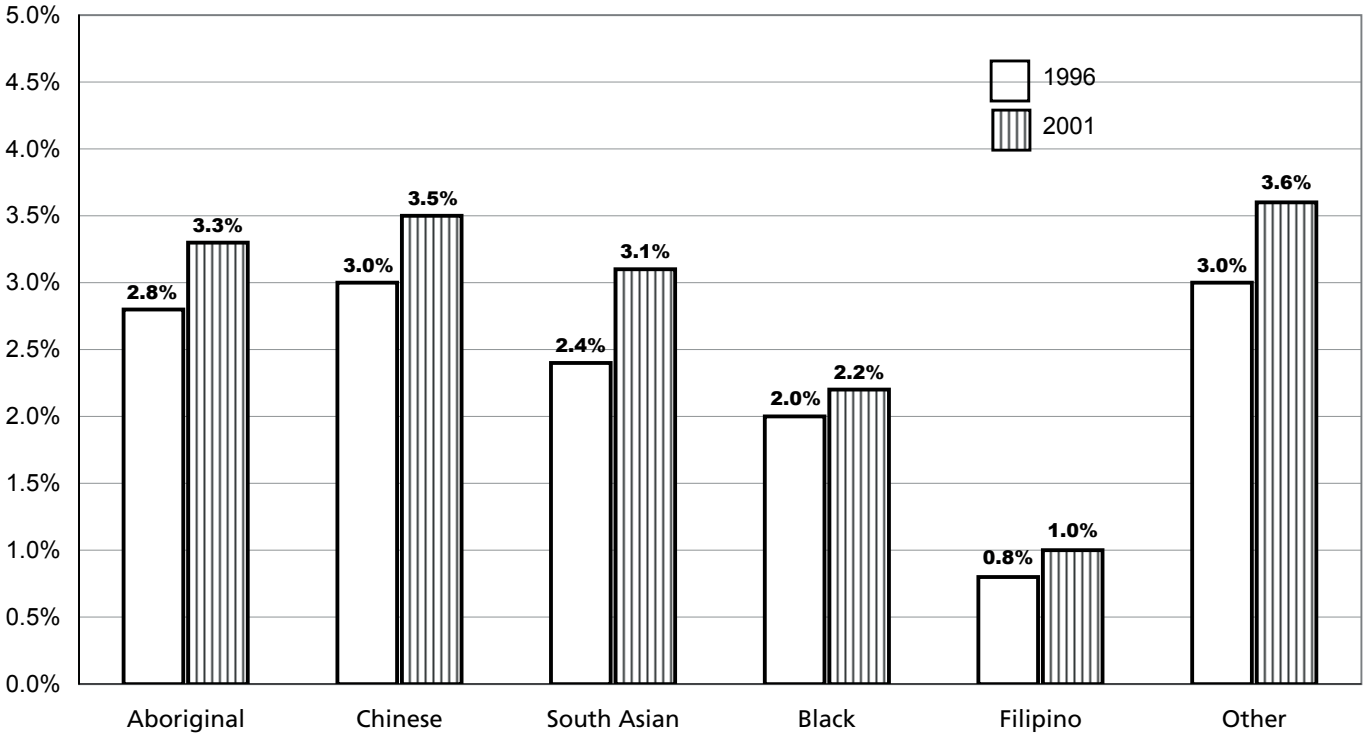
Ethnicity is self-defined and relates to one's identity with a group that shares a history, religion, nationality and/or cultural patterns.

Cultural competency is a set of skills, knowledge and attitudes, which enhance a clinician's:

- understanding of and respect for patients' values, beliefs, attitudes and expectations
- awareness of one's own assumptions and value system in addition to those of the Canadian medical system
- ability to adapt care to be congruent with the patient's expectations and preference

CHANGING DEMOGRAPHICS IN CANADA

(Percentage of Population)

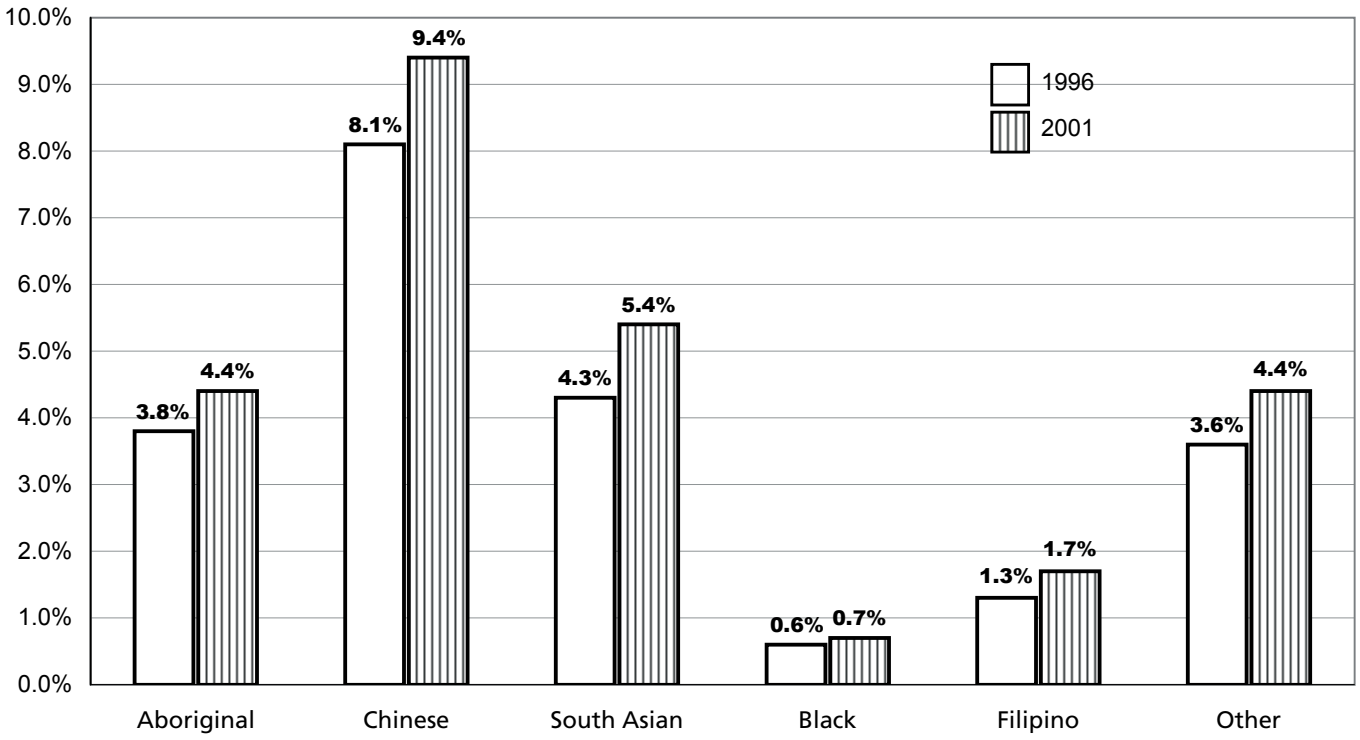


NB: Population of Whites decreased from 86% in 1996 to 83.3% in 2001.

1996 and 2001 Census Canada

CHANGING DEMOGRAPHICS IN B.C.

(Percentage of Population)

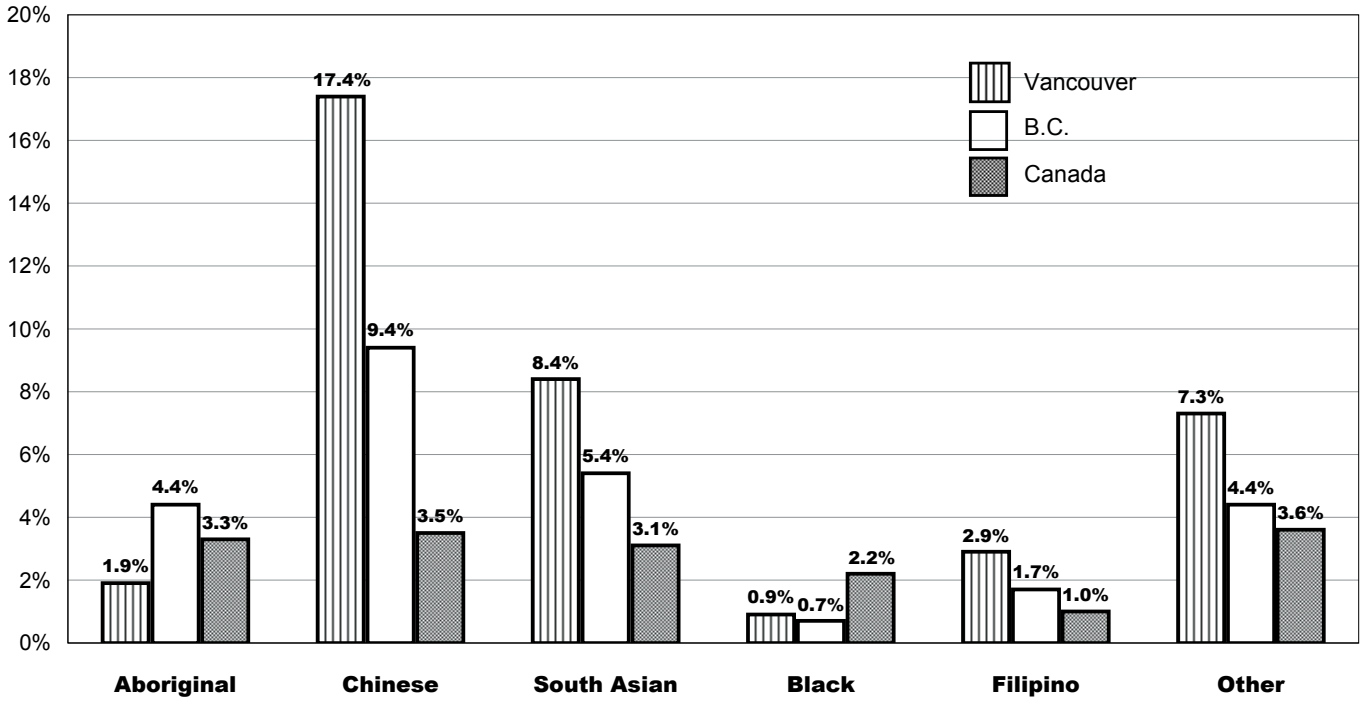


NB: Population of Whites decreased from 78.3% in 1996 to 74% in 2001.

1996 and 2001 Census Canada

COMPARISON OF DEMOGRAPHICS FOR 2001

(Percentage of Population)



Population of Whites in Vancouver: 61.2%
Population of Whites in B.C.: 74%
Population of Whites in Canada: 83.3%

2001 Census Canada

Overhead I.2D: DISPARITIES.DEF

DEFINING HEALTH DISPARITIES

Health disparities are population-specific differences related to:

- Utilization of services
- Health outcomes, including disabilities, disease and death
- Access to care
- Poorer overall health
- Social, economic, cultural and other barriers to optimal health

Overhead I.2E-1:DISPARITIES.CAN

HEALTH DISPARITIES IN CANADA

The results and conclusions of several studies:

- South Asians were found to have a higher rate of cardiovascular disease than Europeans and Chinese.

  Anand, S et al. Differences in risk factors, atherosclerosis, and cardiovascular disease between ethnic groups in Canada: the Study of Health Assessment and Risk in Ethnic Groups (SHARE). Lancet 2000; 356: 279-84.

- Ambulatory care hospitalization rates were higher and referral care sensitive procedure utilization rates were lower for northern Ontario's aboriginal residents than for non-aboriginals (even when controlled for geographic and socioeconomic factors), suggesting that "northern Ontario's aboriginal residents have insufficient or ineffective primary care."

  Shah BR, Gunraj N, Hux JE. Markers of access to and quality of primary care for aboriginal people in Ontario, Canada. Am J Public Health 2003; 93(5): 798-802.

- In the Saskatoon Health District, overall rates of gestational diabetes were found to be 3.5% for women in the general population and 11.5% for aboriginal women.

  Dyck R, Klomp H, Tan LK et al. A comparison of rates, risk factors, and outcomes of gestational diabetes between aboriginal and non-aboriginal women in the Saskatoon health district. Diabetes Care 2003; 25(3): 487-93.

- Immigrants and non-white ethnics were found "to need and use fewer services," and non-white ethnics were "associated with positive correlation with premature mortality."

  Bay KS, Saunders LD, Wilson DR. Socioeconomic risk factors and population-based regional allocation of healthcare funds. Health Serv Manage Res 1999; 12(2): 79-91.

Overhead I.2E-1:DISPARITIES.CAN

HEALTH DISPARITIES IN CANADA cont.

- Blacks were found to have an increased rate of cardiac events after MI (12% in blacks, 6.4% in whites, 4.0% in Asians).

  Nakamura Y, Moss AJ, Brown MW et al. Ethnicity and long-term outcome after an acute coronary event. Am Heart J 1999; 138(3 Pt 1): 500-6.

- "Pap smear screening rates were substantially lower among First Nations women than among other British Columbia women; older women had even lower rates."

  Hislop, TG, Clarke HF, Deschamps M et al. Cervical cytology screening. How can we improve rates among First Nations women in urban British Columbia? Can Fam Physician 1996; 42: 1701-8.

- Immigrants and other ethnic/cultural groups in Ontario were found to have lower utilization of hospital emergency departments than Canada-born Canadians, even after controlling for health status and age differences.

  Wen SW, Goel V, Williams JI. Utilization of health care services by immigrants and other ethnic/cultural groups in Ontario. Ethn Health 1996; 1(1): 99-109.

ACTS

CANADA HEALTH ACT

Made up in part by five criteria, including:

- Universality:

  "All insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions."

- Accessibility:

  "Reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers."

CANADIAN HUMAN RIGHTS ACT

Part 1: Proscribed Discrimination

3. (1) "For all purposes of this Act, the prohibited grounds of discrimination are race, national or ethnic origin, color, religion, age, sex, sexual orientation, marital status, family status, disability and conviction for which a pardon has been granted."

5. "It is a discriminatory practice in the provision of goods, services, facilities or accommodation customarily available to the general public

   (a) to deny, or to deny access to, any such good, service, facility or accommodation to any individual or

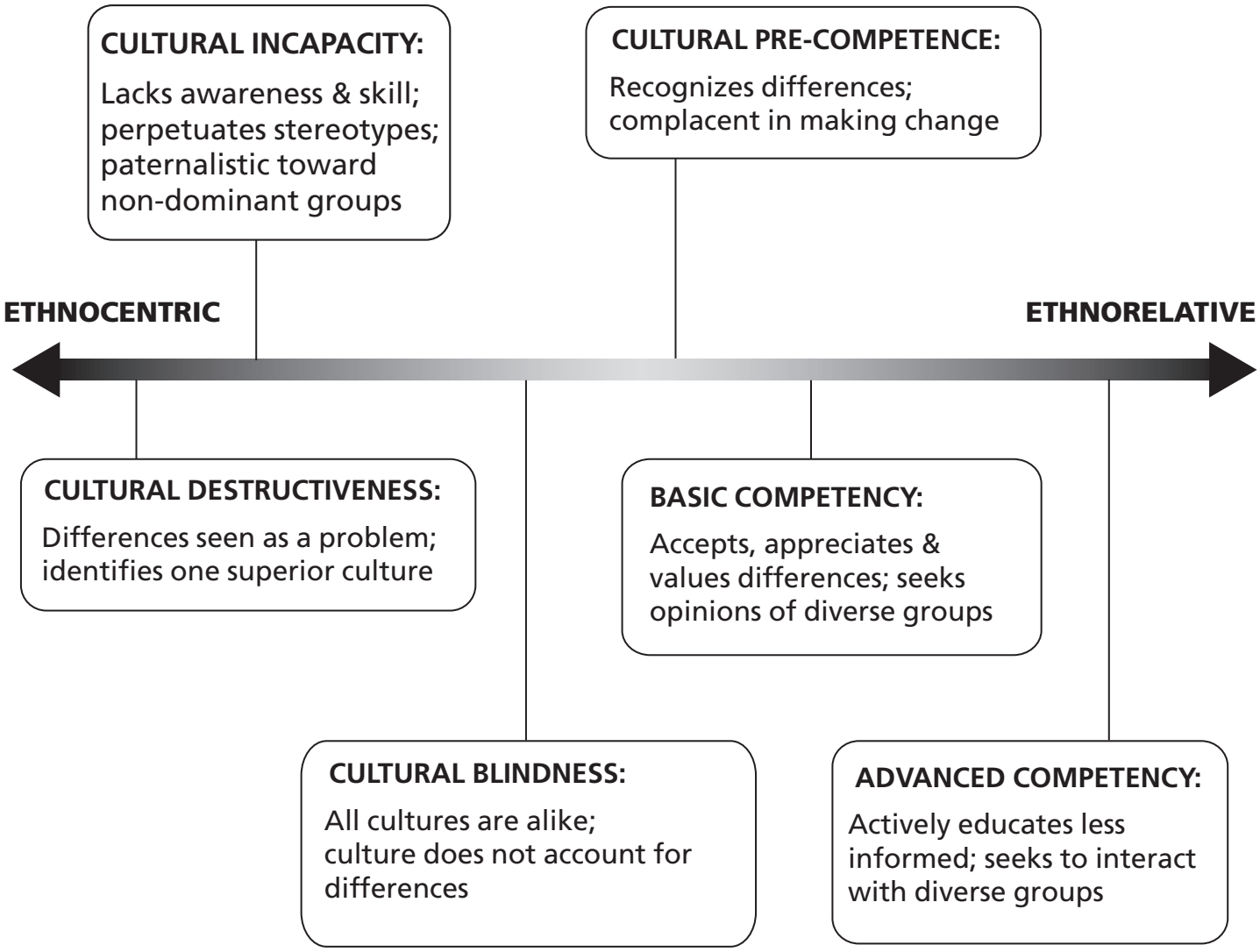
   (b) to differentiate adversely in relation to any individual, on a prohibited ground of discrimination

Overhead I.3A: MODEL

CONTINUUM OF CULTURAL COMPETENCY

Terry Cross Organizational Cultural Competency Model

Adapted from Cross, 1989.

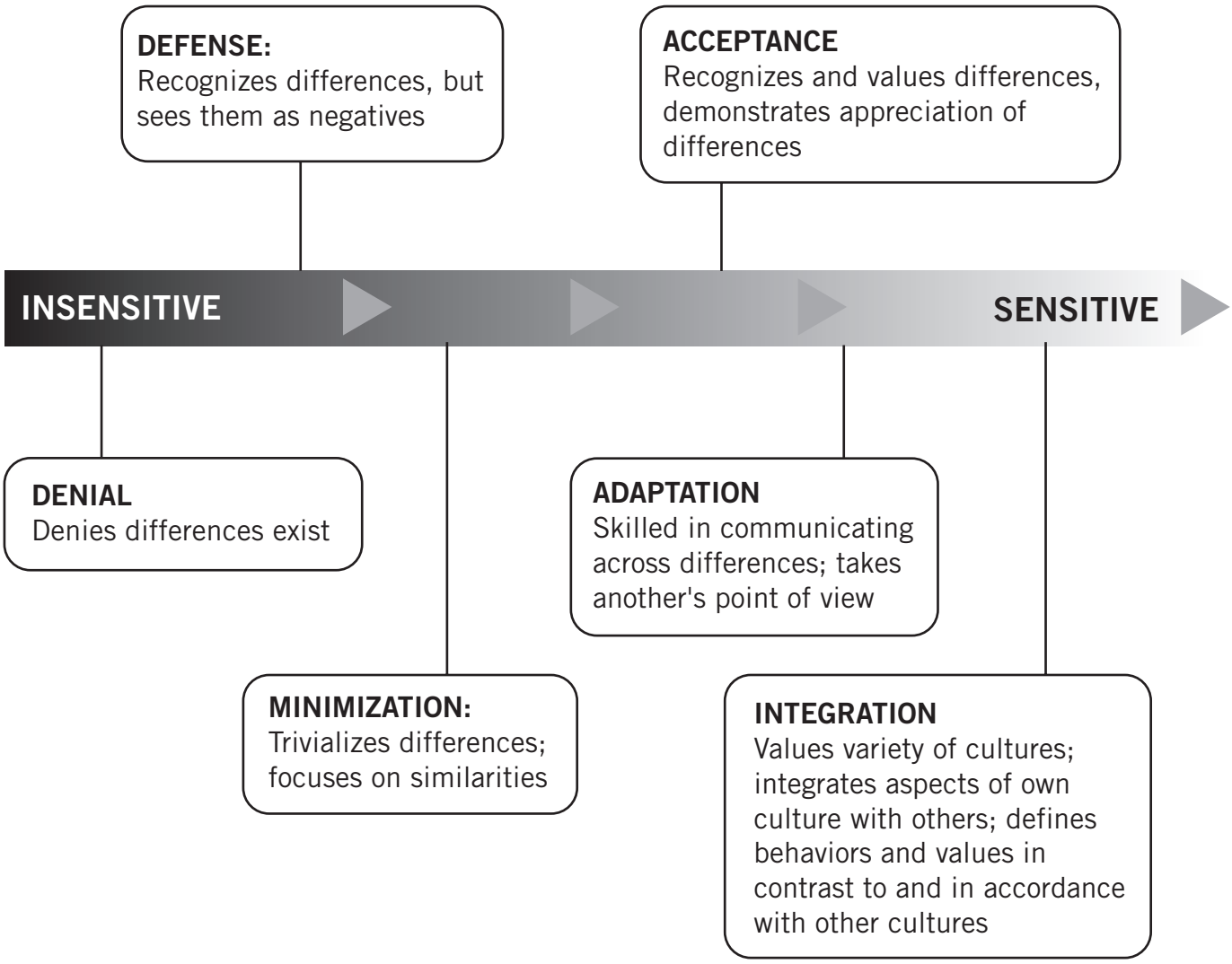


Overhead I.3B: MODEL

CONTINUUM OF CULTURAL COMPETENCY

Milton Bennett Developmental Model of Intercultural Sensitivity

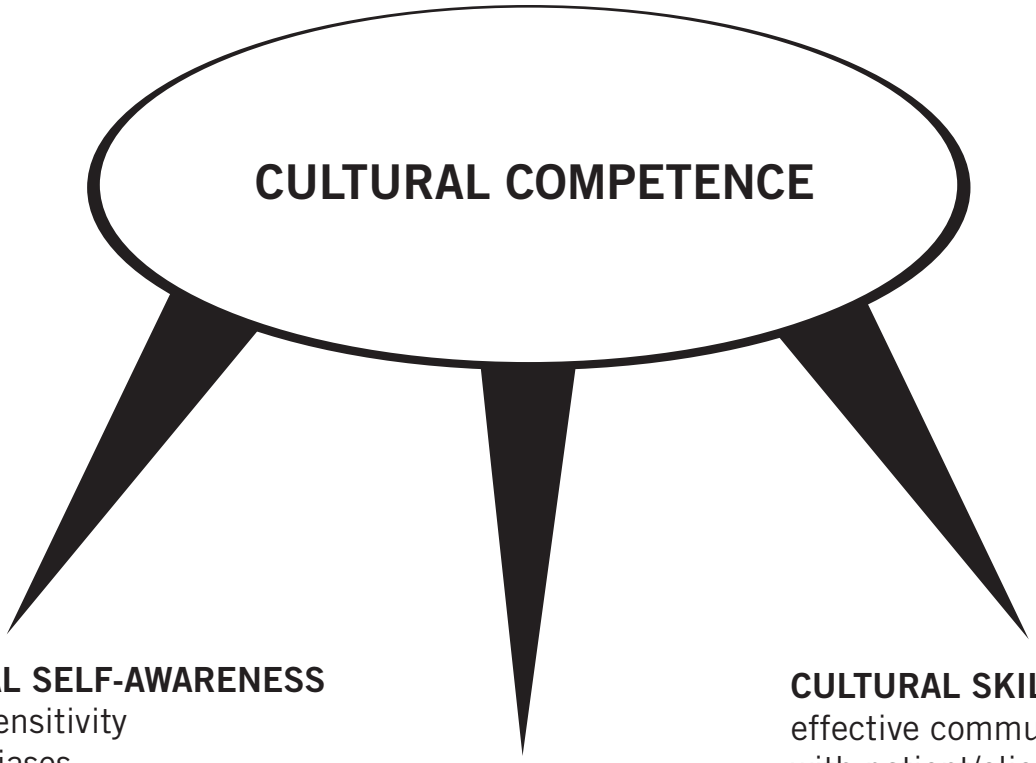
Adapted from Bennett, 1986.



Overhead I.3C: MODEL

CULTURALLY COMPETENT MODEL OF CARE

Adapted from Campinha-Bacote, 1998.



CULTURAL SELF-AWARENESS
cultural sensitivity
cultural biases

CULTURAL KNOWLEDGE
cultural world views,
theoretical and conceptual
framework

CULTURAL SKILLS
effective communication
with patient/client
effective use of professional
and non-professional
interpreters

Overhead I.4A:COMMUNICATION

VERBAL AND NONVERBAL COMMUNICATION

Adapted from Mutha S, Allen C, Welch M, Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies. San Francisco, CA: Center for the Health Professions, University of California, San Francisco, 2002.

- Language (spoken and written)
- Degree of directedness
- Facial expressions / gestures / eye contact
- Touch
- Speaking style (loudness, pitch, speed)
- Silence
- Appropriate subjects for conversation
- Status / power

Handout I.4A: WORKSHEET

CHALLENGES TO CROSS-CULTURAL COMMUNICATION

Reprinted with permission from Mutha S, Allen C, Welch M, *Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies*. San Francisco, CA: Center for the Health Professions, University of California, San Francisco, 2002.

DIRECTIONS: Check any of the following behaviors that could result in frustration or negative interactions between you and a patient/client, family member or colleague. As you read each item, jot down your typical reaction to that behavior.

- o Nodding or saying "yes" even though they do not understand
- o Speaking in a language other than English
- o Deferring to others when asked a question
- o Speaking loudly
- o Lacking nonverbal feedback (e.g. facial expression, nodding)
- o Speaking softly
- o Avoiding eye contact
- o Smiling and laughing when nothing is humorous
- o Giving a soft, limp handshake
- o Standing very close to you when talking
- o Speaking with a heavy accent or limited English
- o Making small talk and not getting to the point
- o Not providing necessary information
- o Not taking the initiative to ask questions
- o Calling / not calling you by your first name
- o Discounting, avoiding or refusing to deal with you because of your gender
- o Asking personal questions
- o Using formal titles in addressing people