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News Release

Pathology Review Update

Now Complete

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Winnipeg, MB

The review of pathology cases from a Diagnostic Services of Manitoba (DSM) pathologist is now complete.

The case review was conducted by two senior internal pathologists as well as two highly reputable international laboratories.

"Right from the start, DSM promised to be transparent throughout the entire review process. We now have the final results from the review. Being transparent is extremely important to me, especially if it is an incident that directly involves a patient or the public. We will not shy away from reporting situations," said Jim Slater, CEO of DSM.

The final results from the review include the following:

- A total of 3006 cases have been reviewed and are now complete.

- 137 total cases had a pathological discrepancy that resulted in an amended report to the patient's referring physician. In the majority of these cases the change in the pathology report did not impact patient management and treatment and the majority of these patients will have a positive outcome.

- Out of the 137 total cases that had pathological discrepancies, 5 cases were identified as a critical incident. Changes to patient care resulted in additional surgery or a change in treatment. None of the 5 individuals have died as a result of the critical incident.

Note: As critical incidents were identified, DSM immediately consulted with all Physicians associated with the affected Patient. Physicians and Patients have since consulted with each other.

By definition, a critical incident is an unintended event that causes harm to a patient, resident or client in the health care system and which does not result from the individuals underlying health condition or from a risk inherent in providing the health services. All critical incidents must be reported.

"It has been an extremely difficult time for everyone involved in the review process. Especially for the patients whose cases were reviewed and where discrepancies occurred. I would like to reiterate that we regret the anxiety that has been felt by patients and their families," said Slater.

"While we cannot promise that incidents will never happen again, we have learned a great deal from this experience and are committed to putting policies and procedures in place to avoid such critical incidents from occurring. Our priority will always be patient-safety".

Background Information:

The review was prompted by concerns identified early through DSM's internal quality assurance processes and through a routine audit required by the College of Physicians and Surgeons of Manitoba (CPSM). The completed CPSM audit and the retrospective review data confirmed that this is a pathologist-specific issue and not a systemic issue. The pathologist, a recent mid-career recruit from the United States who came to DSM in October 2010 with reputable references and work experience, entered administrative leave June 3, 2011. DSM entered into an Agreement with the pathologist, who has since resigned for personal reasons and is no longer in the employ of DSM. The terms of this Agreement are confidential and cannot be disclosed beyond the statement of fact that the Agreement exists.

DSM was created in 2002 as the not-for-profit corporation responsible for all of Manitoba's public laboratory services and for rural diagnostic imaging services. There are approximately 14.5 million tests processed in DSM labs annually.

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