

Chapter 11



CONCLUSIONS AND SUMMARY OF RECOMMENDATIONS

INTRODUCTION

The preceding chapters have reviewed the findings and recommendations of the Sinclair Report. In this concluding chapter, we present an overview of what we have learned and provide a summary of the recommendations made in the preceding chapters.

The Review Committee has learned a great deal during its four months of part-time work. We have received an enormous amount of information, presented to us both orally and in writing. All the people whom we met and others who wrote to us were generous in offering their support, encouragement and insight for what was a challenging, at times emotional, but ultimately very important task. We make special mention of the vital contribution of the families at the close of this chapter.

Even with such support and our best efforts, there are aspects of the Sinclair Report that we recognize could have been explored in more depth. Given the steep learning curve that we faced, we accept that there will be some errors of fact and questionable interpretations in our analysis. On the premise that we learn from our mistakes, the Review Committee invites readers to comment on matters where our analysis and recommendations are faulty.

Our primary aim has been to develop recommendations which if acted upon, would prevent a repeat of events similar to those which took place in the pediatric cardiac surgery program at HSC in 1994. We were also concerned with restoring public trust and confidence in the institutions which played a central role in those events.

The task of the Review Committee was different from that of Judge Sinclair in the inquest process. His focus was primarily on the 12 deaths and whether they were preventable. While he could not ignore the wider context in which those events occurred, he was not expected to make recommendations designed to improve the health care system in general. There are, in fact, important observations and lessons about the health care system contained in the Sinclair Report. But it is important to remember that he did not review

all the pediatric surgery programs, the overall functioning of the HSC or that institution's full range of relationships with external monitoring bodies. Since our mandate was to provide forward-looking advice to the Minister of Health on how to restructure the system to prevent similar events from occurring, we were drawn into broader issues.

The Review Committee sees the strong public interest and reaction to the serious and emotional events documented in the Sinclair Report as indicative of the concerns Canadians are feeling about their health care system. Surveys of public opinion tell us that health care reform is the dominant public policy issue today. While a majority of Canadians express satisfaction in terms of their own experiences with the health care system, they also express declining confidence in the future capacity of the system to meet the needs of the population at large. Canadians have more trust in their individual doctors than they do in doctors in general. Nursing care is identified in surveys as the most important factor leading to higher levels of satisfaction.

Levels of public knowledge about the health care system are low, suggesting that governments and health care providers have a communications problem they will need to address in order to restore declining confidence. Fiscal responsibility and accountability have become priority concerns for Canadians. As in other policy fields, governments are only beginning to measure the effectiveness of health care spending. There is strong public support for "report cards" on the quality of physician practice and hospital care as a means to enable individuals to make better informed decisions on how to use the system. Finally, there are growing demands for greater transparency, greater public input, greater responsiveness and strengthened accountability at all levels within Manitoba's complex and dispersed health care system. In an indirect, but powerful way, the Sinclair Report both reflected and reinforced these trends in public opinion towards the health care system.

In presenting our overview, we must begin by reiterating that there have been significant changes in the health care system and its constituent parts since 1995 when Judge Sinclair began the inquest. Other changes have been introduced or are being developed in response to the Sinclair Report. We have tried in our earlier chapters to give credit when changes seemed positive and to offer constructive criticisms and alternatives when changes fell short of what we saw as required.

The causes of the infants' deaths at HSC in 1994 were identified by Judge Sinclair as both individual and systemic in their origins. Individuals within the surgical program, within the medical and administrative structures of HSC and within the external monitoring organizations did not demonstrate the capabilities, the care, the diligence and the commitment to quality care that was expected of them. It is the view of many of the families that the key individuals responsible for the loss of their children and for the subsequent lack of timely, corrective action have yet to pay a serious price for their errors or inactions. In short, the key actors in the tragic events have not been held fully accountable. In contrast, the parents say they have already paid the huge price of losing a child and face a potential life-long emotional burden of coming to terms with that loss. The Review Committee understands the anger and the bitterness of the families. However, we were obliged to tell them that it is not our job to assign blame and liability; those issues must be pursued in other forums like the investigation and inquiry process launched by the CPSM and possible legal actions through the courts.

Beyond the ability and conduct of individuals, there were serious systemic failures involved in the events of 1994. In the health care system, there are many institutions, processes, rules, guidelines, standards, committees and monitoring mechanisms designed to promote competent, safe and ethical care. These mechanisms are both prospective and preventative, as well as retrospective and corrective. Unfortunately, the elaborate system of controls and accountability processes did not function as intended during and after the infant deaths at HSC. There was a failure to ensure the competence of the surgeon. The pediatric cardiac surgery program was restarted without adequate planning and preparation. When problems arose, the concerns raised by nurses and others were not taken seriously. Even when a series of deaths occurred in rapid succession, there was not a timely and appropriate response within the surgical team, the Child Health program, the medical and administrative structures of the HSC, the death review processes of the OCME, and the complaints/investigation processes of the CPSM. To have all the components of the system fail in the case of the death of one child would be disturbing. To have the system fail repeatedly as the death toll mounted over a short period of several months is both shocking and difficult to understand.

To the extent that we understand the breakdown of the system, the explanations are both institutional and cultural in nature. Institutional processes were clearly deficient. But even more important was a medical and health culture which stresses the need to perform flawlessly, and this error-free philosophy creates strong pressures to cover up mistakes rather than to admit them and to seek opportunities for improvement. Health professionals in all fields are intelligent individuals who have studied long and hard to make the “right” decisions and many suffer a strong emotional reaction when they make a mistake which harms a patient, the very person whom they are trying to help. And, health professionals have not always been taught or shown how to cope with this type of situation. Threats of peer review and possible sanctions contribute to the tendency to deny mistakes.

There is a need for a new professional ethos in the health field. It would consist of an acceptance of human fallibility and the inevitability therefore of error. It would involve the recognition that learning occurs not only from our successes, but also from our mistakes and failures. Within the community of health professionals, physicians, and more particularly surgeons, these individuals have been the most confident in their own knowledge and abilities, and therefore, have been the least willing to have their authority challenged. Such an attitude may be understandable, given both the lengthy and specialized education required to become a surgeon and the heroic, sometimes miraculous outcomes of surgeries. However, if the attitude persists that error is unacceptable and that the acknowledgement of mistakes is an admission of incompetence, the opportunity to learn from negative or even disappointing results will be lost. In addition, acceptance of error as a fact of all human activity would make it easier for physicians, nurses, other health care professionals and administrators to say “I am sorry” to patients and their families. Changing the deeply entrenched values of a series of separate, but related professional cultures in the health field will be a slow process, taking decades rather than years, as new generations of physicians, nurses and other professionals enter the field. The process is already underway and it must continue.

The drama and the vividness of the story of the pediatric cardiac deaths leading to the Sinclair Report have served as a “wake up” call and consciousness raising event for health institutions and health professionals in Manitoba. If the various actors within the health care system did not understand previously that

the content and dynamics of health care provision were changing, the Sinclair Report made it clear that a fundamental transformation in the relationships among governments, the self-regulating professions, the major health institutions and society was underway. Individual health care providers, health administrators and other institutional actors have been forced to question the key processes which have been relied upon in the past to ensure quality care.

Based upon the above discussion of the changes underway and the greater awareness among health stakeholders about what is at stake, the Review Committee believes that an exact repeat of the events of 1994 in any surgical program is very unlikely. However, there will always be medical errors, the need to learn from them and the need to provide patients with redress mechanisms when they complain.

In the remainder of this closing chapter, the Review committee returns to the four broad areas of concern that we identified in our opening chapter as central to the analysis found in the Sinclair Report. The four sets of concerns were:

- The treatment of the children and their families.
- The individual and collective competence and behaviour of health professionals.
- The organizational context of the hospital in which clinical programs operate.
- The responsiveness and accountability of health institutions and health providers to the wider community.

Because we want to conclude the report with a message to the families, we will discuss these four concerns in the reverse order to that presented above. Our aim is to demonstrate how the preceding chapters of analysis and recommendations represent a coherent and comprehensive response to these four sets of issues. Throughout this report and in these concluding comments, we have sought to be balanced and constructive, focusing more on what needs to be done next than on what went wrong in the past.

RESPONSIVENESS AND ACCOUNTABILITY IN THE HEALTH CARE SYSTEM

Responsiveness and accountability to patients and the public were central themes in the Sinclair Report. Many of its recommendations were intended to enable patients to make better informed choices in accessing and consenting to various types of medical procedures. Other recommendations were designed to strengthen the accountability obligations to the public for individual health care providers, for hospital authorities, for regulatory bodies and for governments.

As Chapter Two of this Report made clear, the accountability picture in the health system is inevitably complicated, blurred and confusing. Greater clarity is possible, but there are definite limits to the potential to streamline and pinpoint responsibility and accountability. In a multi-dimensional and interdependent health care system, authority will always be shared and accountability will be collective, as well as individual. Several types of accountability were identified in Chapter Two. What might appear as overlap, redundancy and a source of confusion, could also provide an extra measure of protection in the event of the breakdown of a specific accountability process since other procedures could provide a backup.

The following points capture the key areas where accountability needs to be strengthened based upon the analysis and recommendations of this report:

- the Minister of Health and the Department of Health need to focus on the strategic level of policy-making and leave operational responsibilities to the RHAs and the individual health institutions;
- to perform in its strategic role, Manitoba Health needs to develop its planning, policy advisory, standard setting, information processing, and evaluation capabilities;
- the process of regionalization, begun in 1999, needs to be completed so that the roles of the Minister/Department of Health and of the RHAs are clarified through a matrix of responsibilities which assigns different types/levels of decision-making primarily to one level;
- lines of authority and accountability have been clarified within the Program Management structure at HSC, but these structural reforms need to be supported by efforts to develop “accountability maps” and to build a culture of both individual and shared accountability;
- HSC needs to develop a formal, written internal disclosure policy to protect individuals who bring forward reasonably held concerns about various kinds of misconduct;
- over the next five years, the Government of Manitoba should monitor developments within provincial health institutions regarding internal disclosure policies and practices and examine the experience with “Whistleblowing” legislation in other jurisdictions;
- HSC has developed an improved policy on informed consent, emphasizing the three key requirements of full disclosure, the highest possible level of understanding and the voluntary nature of the consent. This policy needs to be communicated widely within the institution and could become the model for other hospitals;
- the CPSM has reformed its patient complaint process to make it more accessible and fair, but there is a requirement to create greater public awareness of the process;
- the CPSM has gathered more information on the backgrounds of physicians, but there is a need to work with Manitoba Health to develop a system of “physician profiles” as a way to enable patients and families to make better-informed choices and to promote greater individual physician accountability.

There are other recommendations in this report which will contribute indirectly to improved responsiveness and accountability in Manitoba’s health care system, a topic that is a growing public concern.

THE COMPETENCE OF HEALTH CARE PROVIDERS

The second broad set of issues identified in the Sinclair Report involved the competence and professional relationships among health care providers, particularly between physicians and nurses in the context of the delivery of multidisciplinary programs at the HSC.

The Sinclair Report was critical of the hiring process for the surgeon who lead the pediatric cardiac surgery team at HSC and of the lack of planning and preparation for the restart of the program. The Report was

also critical of the dismissal by the medical leadership of the concerns raised by the nurses and the anaesthetists. As suggested earlier in this chapter, these criticisms reflected and reinforced the growing public perception that physicians are not infallible and do not have a monopoly on the relevant knowledge and skills to deal with illness and poor health. Increasingly, a better educated, better informed and less deferential public is willing to challenge and to debate the judgement of physicians and the courses of treatment they propose.

The Review Committee makes a number of recommendations that relate to the issue of the ongoing competence of health care providers:

- develop more careful recruitment and selection processes, along with strategies to retain physicians and surgeons;
- ensure within HSC and other Manitoba hospitals a sound clinical governance model based upon a number of components that focus responsibility and accountability;
- use multidisciplinary standards committees as the pattern to be used across the province;
- strengthen critical incident reporting policies and practices within institutions;
- strengthen quality assurance and risk management processes;
- develop data bases to monitor surgical programs, beginning with the priority assigned to low volume, high-risk procedures;
- develop the emerging role of the WRHA in dealing promptly with physicians experiencing behavioural problems;
- create greater public awareness of the role of the CPSM within the health care system and the availability of its complaint process to deal with concerns about the conduct of physicians;
- develop and widely distribute a system of “physician profiles” which balance the public’s need to know with the rights of physicians to a fair representation of their records of practice;
- develop approaches to the ongoing appraisal of the performance of physicians, to the encouragement of continuing medical education and to the periodic recertification of physicians.

Achieving excellence in clinical practice is a function of many factors that go beyond the technical competence of individual physicians. Identifying deficiencies in clinical performance early and offering support to physicians encountering problems is much preferred over dealing with mistakes through the disciplinary process.

Most of the emphasis in the Sinclair Report was on the continuing competency of physicians but attention also needs to be paid to the matter of the competencies of the present and future generations of nurses. As was mentioned in earlier chapters of this Report, the inquest process revealed that nurses were not treated as full and equal members of the surgical team involved with the pediatric surgery program at HSC. Changes made to the hospital’s organizational structure in 1994 were also seen to have reduced the status of nurses within the institution. More generally, the Sinclair Report portrays nurses as occupying a subordinate position within the health care system.

The Sinclair Report was critical of the lack of formal recognition of the unique, expanded and critical role that nurses now play within the health care system. During the past several decades, nursing education has changed greatly to incorporate new knowledge and skills. The scientific, research, managerial and ethical components of nursing education have been expanded and strengthened. Advanced levels of nursing education and new fields of nursing specialization have come into existence. Many more nurses today go beyond their first degree to obtain additional education and training. As a group, nurses have placed growing emphasis on life-long learning, regular evaluation of knowledge and skills, and the duty to report on the performance of their professional colleagues. The scope of practice of nursing has widened as new fields emerge and as nurses assume duties previously assigned to physicians or other professionals. Along with these important changes, it remains the fact that nurses generally have the most contact with patients. Nurses are with patients around the clock. They are expected to develop the knowledge, skills, initiative, judgement and sense of responsibility to manage complex patient problems and to perform numerous administrative tasks.

Despite these changes to nursing education and to nursing practice, there has been reluctance by many (but definitely not all) physicians and hospital administrators to accept nurses as professional equals with a distinctive, crucial contribution to make to the care process. Formal recognition of the changed role of nurses within the structures of health care institutions has been difficult to achieve, but even more challenging has been changing long-established attitudes and stereotypes about the present and potential future roles of nurses. There is still the residual attitude that nurses should see, listen and be silent. On the basis of their professional education and career experiences, some nurses (mainly those from earlier generations) still engage in self silencing, both out of deference towards physicians and out of concern for their career prospects.

The Review Committee has made a number of recommendations to deal with the place of nurses within HSC and the broader health care system. The recommendations include: the treatment of nurses as equals on program management teams; the use of the Nursing Practice Council to obtain the input of nurses into hospital decision-making; the development of an internal disclosure policy for HSC to protect nurses when they raise legitimate concerns; the participation of nurses on standards committees; and the transformation of organizational cultures to ensure that nurses are not treated by physicians and administrators as undertrained subordinates whose concerns can be dismissed as ill-informed or emotional responses to tragic outcomes.

A further step to upgrading the place of nurses within the Manitoba health care system would be the early proclamation of the new *Registered Nurses Act* (Bill 36). The *Act* has passed all stages within the Legislature and awaits royal assent and proclamation. This is a decision which rests with the Government of Manitoba. For a number of reasons, the Review Committee believes that the process of bringing the new *Act* into force should take place as soon as possible.

Bill 36 would create a new regulatory framework for nursing in the province to replace an outdated *Act* first passed in 1980. The bill contains a great many provisions, however, only those most germane to the issues of the competencies of nurses and their place in the health care system will be mentioned here. Bill 36 would allow for the recognition of the expanded and more specialized nature of nursing roles, in part by

allowing for more flexible scope of practice guidelines. Regulations pursuant to the *Act* (were the bill to be proclaimed) would identify the legitimate practice of appropriately qualified nurses to include screening and diagnostic tests, prescribing designated categories of drugs and performing minor surgical procedures.

Corresponding to expanded responsibilities for nurses are increased accountability requirements and stronger requirements for demonstrated continuing competence. In terms of accountability, there is an emphasis on increased transparency and public representation in the hearing process involving complaints against nurses. In terms of professional competence, Bill 36 provides for the establishment of a continuing competence program for Registered Nurses. The program includes the conduct of practice audits and the requirement for members to participate in professional development programs to update their knowledge and skills. Bill 36 also imposes a statutory duty on Registered Nurses to report unfitness to practice on another member based on physical or mental condition.

The Review Committee believes that a modernization of the regulatory framework for the nursing profession is overdue and that Bill 36 strikes the appropriate balance between protection of the public interest and the recognition of the need for autonomous, responsible nursing practice. The Review Committee can only speculate on the reasons for the delay in proclaiming Bill 36, but we recommend that action be taken as soon as possible to move it into law.

The Review Committee also wishes to compliment and support the initiative of the College of Physicians and Surgeons and the Manitoba Association of Registered Nurses for the agreement reached in December 2000 titled “Guidelines for Shared Competencies and Delegated Physician Services.” This agreement between the two leading regulatory bodies in the health field is intended to assist nurses, physicians and health care institutions to make appropriate and safe decisions respecting overlapping scopes of practice and the delegation of physician services to registered nurses. This is an important step forward in terms of professional collaboration and one which will benefit Manitobans by enabling more flexible and cost effective delivery of health services.

THE EXPERIENCES OF PATIENTS AND FAMILIES

The Sinclair Report documents a disturbing story of 12 families consenting to surgery on their children without being provided full information about such crucial matters as the risks involved, the inexperience of the surgeon, the problems in the pediatric cardiac surgery program, and the fact that a suspension and review of the program had taken place. Some of the families appear to have been given the news of the death of their child in an insensitive and uncaring manner. In their moments of crisis, some parents felt all alone. Full explanations for the causes of death were not always provided. Autopsy reports arrived late and were written in language that was difficult for some families to understand. Only by hearing about it in the media did the families learn that the pediatric cardiac surgery program had been suspended, and that an inquest had been called. We repeat these facts because our meetings with 10 of the 12 families brought home to us, in a way that no report could, the deep sense of grief and betrayal felt by the parents who lost their children.

Judge Sinclair concluded his report with the following passage:

“From all the facts and evidence that has been uncovered, there is one thing that stands out, the deaths of these children were not the result of any failing on the part of the parents. There was nothing that these parents did that they ought not to have done. There was nothing that they did not do that they should have done. Faced with the situation that each of them saw, they did what they believed was best for their child and they acted on the basis of the best information they were able to obtain.” (Sinclair Report, page 502)

The Review Committee agrees. We recognize that nothing we state or recommend can erase their sense of loss and betrayal.

The Review Committee made a commitment to the families that the primary aim of our recommendations would be to prevent a repeat of anything like the tragic events of 1994. Accordingly, we have made a series of recommendations throughout this Report to provide better protection for patients and families and to ensure they are always treated with the respect and dignity they deserve. Among the recommendations which support these aims are the following:

- stricter policies on informed consent and improved physician-patient communication within the consent process;
- the publication and easy availability of physician profiles to enable patients to make better-informed choices about physicians and agreements to particular medical procedures;
- the publication of a guide to Manitoba’s health services covering the basic information needed to make use of the health system and to lodge complaints;
- the development within health care facilities of internal disclosure policies to provide protection for employees and others working in the facilities who raise reasonably held concerns about the treatment of patients;
- a strengthening of the emerging role of the Winnipeg Regional Health Authority in dealing in a timely manner with physicians with personal conduct problems;
- the development of a more visible, proactive complaint/investigation process by the College of Physicians and Surgeons of Manitoba to deal with patients’ concerns about medical practice and patient case management; and
- the development of an integrated program of financial assistance and support services for patients and families required to travel out of province to receive medically necessary treatment.

Procedural safeguards are important, but they will work well only on the basis of a health care culture which is committed to quality, the reduction of mistakes and the willingness to use untoward events to achieve individual and organizational learning.

FINAL THOUGHTS

We began this report by calling attention to the complex and dynamic nature of the health care system. If the health care system once sailed along on relatively calm waters, it now seems to face conditions of permanent “white water” involving constant review and change. During recent decades, there have been few, if any, opportunities in the health system for individuals and institutions to fully absorb one wave of change before another wave crashes down upon them.

Consideration of this report and implementation of its recommendations will absorb further time and energies of the dedicated professionals and others who work within the Manitoba health care system. There are limits, not easily specified, to the frequency, scope and speed of changes that the health care system can successfully achieve during any given time period.

There are also financial limits which require that informed choices be made and that budgetary priorities be set. We have not been as successful as we hoped we would be in identifying the costs of our recommendations. We recognize that creating an elaborate system of preventative safeguards and accountability mechanisms would have direct and significant financial implications, which the institutions involved have the expertise to calculate. Less easy to calculate are the indirect costs, such as the impacts of new controls on the motivations and behaviour of key players within the health care system. All the available reports suggest there are savings to be found within the health care system which could pay for the reforms recommended in this report. On the other hand, there are also significant unmet needs and public expectations that place upward pressure on health care spending.

Clearly, improving the quality of health care services has to be the primary goal. Spending scarce health care dollars on the prevention of mistakes and the enforcement of accountability is justified up to a point, but making a precise cost/benefit analysis is difficult and questionable from an ethical standpoint. There is also the concern that should the Government of Manitoba move ahead of other jurisdictions in establishing regulatory mechanisms like physician profiles and whistleblowing laws it may face a further disadvantage in terms of the recruitment and retention of health care professionals. The Review Committee is convinced that future changes in health care will be in the direction forecast in our recommendations and we would be pleased to see Manitoba pioneer some of those changes. But it would be more advantageous if the Province worked with other jurisdictions in adopting such reforms.

In our penultimate paragraph we wish to speak to the families who, among all the groups and individuals we met, had the most profound impact on our understanding and thinking concerning the right of all Manitobans to competent and safe medical care and to be treated with respect and dignity. We have dedicated this report to your children and to you in the hope that there will be some comfort in knowing that your great loss will potentially bring benefits to future generations of children and families who will receive the quality of health care they deserve. We would understand if some or all of the families felt that this Report was not critical enough of the people and organizations involved with the tragic events of 1994 and that the recommendations we make do not go far enough to prevent similar problems in the future. Within the mandate we were given, we have tried sincerely to uphold our commitment to honour the memory of your children and your loss.

We urge the Government of Manitoba and all the other stakeholders in the health care system to give serious consideration to the recommendations in this report and to act expeditiously on those which are considered sound. To encourage action and accountability for results, we make one final recommendation.

Within a year of the release of this report, the Minister of Health, with the support of the Department of Health, prepare a status report on actions taken to date within the various institutions to implement the recommendations. This status report should be made public and be tabled in the Manitoba Legislature.

A summary of the recommendations of the Review and Implementation Committee and of the Pediatric Cardiac Surgery Inquest Report follows.

SUMMARY OF COMMITTEE RECOMMENDATIONS

The Review Committee recommends that steps be taken to expedite and better coordinate the physician recruitment and selection process among the organizations involved so that promising candidates are not lost.

The Review Committee recommends that contracts and letters of appointment of physicians should require a notice period for departures and that any breach of this requirement be included in letters of reference for positions elsewhere.

The Review Committee recommends that formal search committees be used for all hospital hirings. Such search committees should be multidisciplinary including physicians, nurses and other relevant health personnel.

The Review Committee recommends that a number of strategies be used in the recruitment and selection process to determine the willingness and demonstrated capacity of physicians and surgeons to work in a team context.

The Review Committee considers the proposal to observe all surgical candidates at work to be impractical in terms of time and expense. The Review Committee recommends that “junior” surgeons “shadow” their senior colleagues and that formal mentoring relationships be developed.

The Review Committee recommends that Manitoba Health identify anomalies in the fee schedules for physicians and surgeons that do not support provincial health priorities and seek approval for a bargaining strategy to correct those anomalies in advance of fee negotiations with the Manitoba Medical Association.

The Review Committee recommends that all health care institutions in the Province have written orientation policies and programs and that participation in such programs be mandatory for all new personnel, including physicians.

The Review Committee recommends that Manitoba Health and the WRHA review the staffing levels for pathologists at HSC in light of the issue of timely autopsy reports raised in the Sinclair Report. This recommendation must be acted upon in conjunction with the recommendation in Chapter Seven on possible changes to the death review process conducted by the OCME.

The Review Committee recommends that each Program Management division develop an “accountability map” which designates responsibilities and traces the lines of reporting back to the Chief Operating Officer of HSC.

The Review Committee recommends the further implementation of the Program Management model at HSC through the clear assignment of costs and the generation of performance information along program lines.

The Review Committee recommends that on a cyclical basis, the HSC evaluate the performance of its program teams to ensure that they are functioning on the basis of shared leadership and the full utilization of the disciplinary expertise of all members.

The Review Committee recommends that the HSC examine means to encourage more physicians to participate in courses on teamwork and conflict management. This would involve, in part, examination of alternative remuneration arrangements for physicians.

The Review Committee commends HSC authorities for the creation in January 2001 of the Nursing Practice Council and recommends that the Council become a key source of advice on nursing practice issues throughout the institution.

The Review Committee recommends that the leadership of HSC give serious and sustained attention to changing the climate and culture of the institution as a more prominent part of an integrated strategy for organizational change.

The Review Committee recommends that part of the cultural change process within HSC involve a recognition of the inevitability of medical errors and other untoward events and an acceptance of the need to learn from such developments.

The Review Committee was impressed with the new critical incident reporting policy within HSC. We recommend that the policy be strengthened by including protection against reprisal for individuals who raise legitimate, reasonably-based concerns.

The Review Committee believes that the current structure for quality assurance within HSC – which combines line responsibility with corporate promotion and monitoring – offers the best potential for ensuring quality concerns are integrated into everyday decision-making. The Review Committee recommends that the HSC, working with the appropriate WRHA staff, develop a multi-year cycle of quality audits of specific clinical and support service areas.

The Review Committee supports and recommends funding for the proposed Child Health Program Quality Initiative.

The Review Committee believes that the elements of a sound risk management system exist at HSC. The Review Committee recommends that stronger risk management strategies and better information on different types risk be developed.

The Review Committee recommends that HSC authorities explore ways to make the patient experience less intimidating and more supportive.

The Review Committee recommends that the Patients' Representative Office at HSC should be more visible, should act as a neutral intermediary between patients and hospital personnel, should track patient complaints over time, and should report directly to the Vice-President and Chief Nursing Officer.

The Review Committee recommends that the accountability of the Chief Operating Officer of HSC to the WRHA Board of Directors be reviewed to ensure that the Board is setting broad policy direction for the hospital and is providing sufficient scrutiny of hospital operations to assure itself that competent, safe, effective and ethical care is being provided.

The Review Committee commends HSC authorities for their continuing efforts to improve its informed consent policy and to educate employees about its content and requirements. The Review Committee recommends that the informed consent policy at HSC become the model for adoption within RHAs and/or health facilities throughout the Province.

The Review Committee does not support the concept of a Handbook of Patients' Rights for the reasons stated in this chapter. Instead, the Review Committee recommends that Manitoba Health should produce and distribute "A Guide to Manitoba's Health Services." The proposed guide would contain information such as: the principles of *The Canada Health Act*, a listing of the health services which are insured and not insured within the Province, the right of patients to informed consent, the provincial policy on out-of-province travel for medically necessary care, an outline of the delivery structure for health care services and an office location, telephone number and web site where additional information and answers to questions can be found.

The Review Committee recommends that all RHAs and/or facilities produce a similar guide to services and a contact point for questions and complaints.

The Review Committee endorses the development and publication of physician profiles that balance the public's right to know with protection against unfair damage to the reputations of physicians.

The Review Committee endorses performance measurement and performance reporting on surgical and program outcomes. However, it cautions that there are inherent analytical problems with such activities and significant financial costs involved in creating the computer-based information structures required. Manitoba Health should play a lead role in collaborating with other stakeholders in the health system to establish priorities in this area.

The Review Committee recommends that the proposed “Guide to Manitoba’s Health Services” indicate clearly that travel out-of-province to receive medically necessary services is not an unqualified right. The Guide should provide a contact location for information on conditions of eligibility and the nature of the financial support for out-of-province travel.

The Review Committee recommends that HSC and other hospitals in Manitoba develop policies on internal disclosure as part of a broader strategy to promote cultures and climates of openness and creative-problem solving in which individuals can raise legitimate and reasonably-based concerns without fear of reprisal.

The Review Committee recommends that Manitoba Health monitor the development of internal disclosure policies and their operations within hospitals and the experience with whistleblowing laws in other jurisdictions. If after five years, there are continuing problems and complaints involving a lack of responsiveness by hospitals to concerns raised by their staff, Manitoba Health should at that point consider the adoption of a *Whistleblower Act* for the health field or the public sector in general.

The Review Committee recommends that Manitoba Health through the RHAs should direct hospitals to notify the OCME of “significant changes” to programs and of program reviews prompted by hospital-related deaths.

The Review Committee supports the OCME efforts to improve tracking of hospital-related deaths, but that further steps in this direction should be integrated with the development of a computer-based information infrastructure for the overall health system.

The Review Committee recommends a review of the role, number and location of MEIs based upon the outcome of the current fee dispute between the Department of Justice and the Manitoba Medical Association representing the MEIs.

The Review Committee recommends no change in the employment status of pathologists.

The Review Committee endorses the recommendation that the OCME develop guidelines for pathologists on the conduct of autopsies to ensure that all relevant perspectives are included.

The Review Committee recommends that the OCME conduct a process analysis of the steps involved with its investigations and autopsies to determine whether a “re-engineered process” could maximize productivity and expedite the autopsy process.

The Review Committee recommends that the CPSM adopt a more pro-active education strategy to promote public awareness of the role that the College plays within Manitoba’s health care system, including its role in dealing with complaints about physician behaviour and its disciplinary powers.

Such a strategy would include more widespread distribution and more prominent display of brochures describing the College’s role and the rights of patients under its Complaints/Investigation procedure. It

would involve College Officers appearing in educational forums, before community groups, at conferences, on the media and in other venues to describe and explain the role of the College.

The Review Committee recommends that the CPSM Code of Conduct be modified to include a duty on the part of physicians to inform patients and others about the role of the College and the availability of the complaint process.

The CPSM Code of Conduct has sections dealing with the responsibilities of physicians to the profession, to the College and to society, but there is not a duty to promote public awareness of the College and its procedures for handling complaints. The other responsibilities imply a duty to inform patients about the College and this should be recognized in the Code.

The Review Committee recommends that the CPSM work with Manitoba Health and other interested groups to develop a system of “physician profiles” describing the education, experience, training, awards, disciplinary history and other information deemed relevant for each physician practising in Manitoba. In the context and format for physician profiles, a balance must be found between the public’s right to know and easy access to information with the right of physicians to a measure of privacy and to an accurate, balanced and fair interpretation of their history of medical practice.

Several questions could be raised about the recommendations that the CPSM play a larger role of public education. The profession might see this as more appropriately the responsibility of Manitoba Health and perhaps of the Regional Health Authorities. However, the CPSM is not the Manitoba Medical Association, the professional organization which represents doctors. The CPSM has been endowed with public authority to allow physicians the privilege of self-regulation and with this authority comes an obligation to promote public awareness of its role. This educational role will be shared with other bodies in the health system and there should be discussions with Manitoba Health and others about coordinating and perhaps cost sharing in the field of public education.

The Review Committee recommends that the CPSM proceed to develop a more formal program of Continuing Medical Education for its members.

The Review Committee recommends that the CPSM adopt the Physician Achievement Review process used in Alberta to incorporate both peer review and patient input into the evaluation of physician performance.

The Review Committee recommends that the CPSM, in consultation with Manitoba Health, develop over the next five years a program for the periodic recertification of doctors as a means of ensuring quality practice and maintaining public confidence and trust in the profession.

The medical profession today definitely faces a more challenging environment than in the past. There are pressures for more direct patient and public involvement and for more accountability for physicians, both individually and collectively. The process of professional self-regulation has been reformed, but more needs to be done to ensure timely responses to identified problems in clinical practice. In addition to ensuring

physicians are qualified to practice at the beginning of their careers, the CPSM must strengthen its commitment and support for the concept of lifelong learning. Identifying and tackling serious or persistent clinical problems in a timely manner should be emphasized over dealing with problems after they enter the complaints process.

The Review Committee recommends that for the immediate future, there should be no restart of the pediatric cardiac surgery at HSC. Pediatric cardiac surgery programs are costly to support in terms of programming funding. Fiscal resources that would be utilized for a Manitoba pediatric surgery program should be redirected to support the WCCHN.

The Review Committee recommends that the Province of Manitoba continue to support and play a lead role in the development of the WCCHN as basis for providing high-quality pediatric cardiac surgery to Manitobans.

The Review Committee recommends that in the development of the WCCHN that attention be paid to the needs of families in terms of the concerns raised above. Patient experience and patient satisfaction should be a larger component of the formal in-depth evaluation scheduled to take place several years after the launch of the program.

The Review Committee recommends that the WCCHN be seen as a possible model for extension of collaboration with pediatric surgical programs in Eastern Canada and for other specialty programs where Manitoba could benefit from participating in interprovincial programs.

The regional model adopted in 1997 delegates significant authority, resources and managerial direction of health care service to the 12 RHA Boards and the Chief Executive Officers who report to them.

The Review Committee recommends that the regionalization process be completed to include all health facilities.

There remain areas of overlap and duplication between the provincial policy determination, standards setting and monitoring role that reduce efficiency and blur accountability.

An initiative is underway to more clearly align responsibilities within the provincial-RHA relationship.

The Review Committee urges the completion of this initiative to serve as the basis for clearer direction and sounder accountability framework within the regional health care model.

Manitoba Health is in transition, moving away from a significant role in the direct management of service delivery and towards a new role that focuses on policy frameworks, provincial-wide planning, standards setting, performance measurement and evaluation as a basis for ensuring that all Manitobans have fair and consistent access to competent and safe health care.

To perform in its new role, Manitoba Health needs to be reorganized and to develop new kinds of knowledge and skills among its employees.

The Review Committee supports recent actions and further proposals for reform put forward to the Government of Manitoba by the Minister of Health and the Deputy Minister of the Department.

Meaningful accountability in the complex and decentralized structure of regional health care requires the generation and flow of valid, reliable, timely and relevant health care data among stakeholders at all levels within the system. This requirement will involve significant investments in the creation of information technology infrastructure linking the various parts of the health system. It will also require a transformation of the “culture” of the health care system to ensure the greater utilization of data to guide decision-making, with less reliance being placed on political calculations, institutional rivalries and the use of “crises” to leverage additional resources.

The Review Committee supports the work of the provincial taskforce developing a health information technology strategy as a basis for the creation of an information rich context for better informed policy-making, management and risk avoidance.

Within a year of the release of this report, the Minister of Health, with the support of the Department of Health, prepare a status report on actions taken to date within the various institutions to implement the recommendations. This status report should be made public and be tabled in the Manitoba Legislature.

THE PEDIATRIC CARDIAC SURGERY INQUEST REPORT

CHAPTER 10 — FINDINGS AND RECOMMENDATIONS

SUMMARY OF REPORT RECOMMENDATIONS

Page 469

#1

It is recommended that: The Health Sciences Centre establish a medical staff recruitment process for senior or specialized positions within the hospital that has as its main priority the creation of a mechanism that results in the best possible candidate being hired or appointed.

Page 470

#2.

It is recommended that: The Manitoba government and the Manitoba Medical Association adjust the Manitoba Doctor's fee schedule to allow for the payment of compensation to pediatric cardiac surgeons that does not stand in the way of the effective recruiting of, and maintenance of, pediatric cardiac surgeons in Manitoba. The fee schedule should reflect the fact that pediatric cardiac surgeons are as highly trained as adult cardiac surgeons; that because of lower case load, pediatric cardiac surgeons will perform fewer operations than adult cardiac surgeons; and that the operations that pediatric cardiac surgeons perform will be just as, if not more, complex than adult cardiac operations.

Page 471

#3

It is recommended that: If a Pediatric Cardiac Surgery Program is re-established at the Health Sciences Centre, it have clear written lines of authority and responsibility. Efforts must be made to ensure that program members understand these lines of authority. This is of particular importance in a multidisciplinary program.

Page 472

#4

It is recommended that: If a Pediatric Cardiac Surgery Program is re-started at the Health Sciences Centre, overall supervision for the program should be the responsibility of a single Department Head – logically the head of Pediatrics. The head of Pediatrics can more easily supervise a program that has as its focus pediatric cases. Staff providing service to any revamped Pediatric Cardiac Surgery Program should be primarily assigned to the program and be accountable to the head of Pediatrics through their appropriate department head or line manager for their performance. In particular the head of Pediatrics should also have responsibility for monitoring the surgical performance for of the pediatric cardiac surgeon through the assistance of the head of Pediatric Surgery and the head of Pediatric Cardiology. The head of Pediatrics should ensure that the surgeon, the head of Pediatric Cardiology and the head of Pediatric Anesthesia have a plan to phase in the surgical program. In addition, the program should be monitored closely, with regular reports going to the head of Pediatrics.

Page 475

#5

It is recommended that: The Health Sciences Centre develop protocols for providing orientation and support to all new staff and staff moving into new positions. This should be done even when the appointment is to an Acting position.

Page 475

#6

It is recommended that: Any re-established Pediatric Cardiac Surgery Program involve all units that would be affected by the program in the development of appropriate protocols. Such protocols should include a requirement that the entire team, including those individuals responsible for post-operative care, be fully prepared before the program moves to higher-risk cases or new procedures.

Page 476

#7

It is recommended that: Any restart of the Pediatric Cardiac Surgery Program be initiated only after the relevant department heads jointly review staffing levels and assure themselves that they are appropriate to avoid overwork and fatigue and maintain appropriate skill levels. This applies to every discipline involved in the program.

Page 478

#8

It is recommended that: The Health Sciences Centre restructure its Nursing Council to allow nurses to select its membership and to give it responsibility for nursing issues within the hospital. The Nursing Council should have representation from on the hospital's governing body and be responsible for monitoring, evaluating, and making recommendations pertaining to the nursing profession within the hospital and for nursing care. The Council should also serve as a vehicle through which nurses could report incidents, issues, and concerns without risk of professional reprisal.

Page 479

#9

It is recommended that: The Health Sciences Centre establish a clear policy on how staff is to report concerns about risks for patients. This policy must ensure that there is no risk to the person who is making the report. It should be clear that every staff member to whom they are to present such reports.

Page 479

#10

It is recommended that: The Province of Manitoba consider passing "whistle-blowing" legislation to protect nurses and other professionals from reprisals stemming from their disclosure of

information arising from a legitimately and reasonably held concern over the medical treatment of patients.

Page 481

#11

It is recommended that: The Department of Health of the Manitoba Government prepare a patient's rights handbook that among other things, deals with the issue of informed consent. That handbook should clearly set out that a patient and a parent acting on behalf of a minor have a number of rights, including, but not limited to:

- The right to be fully informed before giving consent to medical treatment;
- The right to information about a surgeon's experience in performing a particular procedure, as well as the experience of the hospital and/or surgical team;
- The right to a second opinion;
- The right to an out-of-province referral in certain circumstances, including where the patient or parent chooses to have a procedure performed by a surgeon or institution with more appropriate experience and where the surgeon or institution in Manitoba lacks the same experience; and
- The right to have an out-of-province surgeon perform the procedure in Manitoba, provided that there is a surgeon willing and able to do the procedure here.

Page 481

#12

It is recommended that: The Department of Health direct Manitoba hospitals to require that, as part of their obligation to obtain informed consent from a patient, hospitals have a positive obligation to provide to a patient, or parent on behalf of a minor, information about:

- The right to information about a surgeon's experience in performing a particular procedure, as well as the experience of the hospital and/or surgical team;
- The right to a second opinion;
- The right to an out-of-province referral in certain circumstances, including where the patient or parent chooses to have a procedure performed by a surgeon or institution with more appropriate experience and where the surgeon or institution in Manitoba lacks the same experience; and
- The right to have an out-of-province surgeon perform the procedure in Manitoba, provided that there is a surgeon willing and able to do the procedure here.

Page 481

#13

It is recommended that: The Health Sciences Centre review its policies on consent and communication with families. All information that is germane to a child's care or to decisions that must be made about a child's care should be provided to those from whom consent is being obtained.

In particular, the policy on consent must make it clear that the medical staff treating a patient must be forthright and truthful in disclosing all relevant information to the patient or representative before the procedure in question. The fact that the surgeon has not performed a particular surgical procedure on his or her own in an unsupervised setting in the past must be disclosed.

Page 482

#14

It is recommended that: The Government of Manitoba establish a policy for the payment for counsel for families granted standing at inquests, taking into account the following factors:

1. The length of proceedings.
2. The complexity of the issues.
3. Whether or not the costs of family involvement in the proceedings would be prohibitive to the applicant.
4. Whether or not the presiding judge so recommends on application by the family.

Page 483

#15

It is recommended that: The Government of Manitoba pay the entire legal costs of the families involved in these proceedings.

Page 486

#16

It is recommended that: The Office of the Chief Medical Examiner develop a protocol requiring hospitals to inform that Office of significant changes in the delivery of medical services, such as program slowdowns and shutdowns, as well as any hospital-related deaths that cause the hospital to undertake a program review.

Page 486

#17

It is recommended that: The Office of the Chief Medical Examiner maintain a database of hospital deaths, which would track in-hospital deaths and causes of death on a weekly and monthly basis.

Page 486

#18

It is recommended that: As part of their investigation into a patient's death, the Chief Medical Examiner's Investigators conduct a preliminary interviews of nursing and medical staff who had been involved in the patient's death.

Page 486

#19

It is recommended that: For CME cases the Chief Medical Examiner arrange to have autopsies performed by a pathologist not affiliated with the hospital where the operation had been performed, unless it is unreasonable or impossible to do so due to distance, time, or expenses.

Page 486

#20

It is recommended that: The Chief Medical Examiner develop guidelines for pathologists to follow in obtaining information before performing an autopsy in CME cases. These guidelines should not place over-reliance on anyone whose involvement might have contributed to the death of the patient.

Page 486

#21

It is recommended that: The Office of the Chief Medical Examiner establish reasonable timelines to complete autopsies, prepare and forward preliminary results and complete the final reports, including the completion of necessary laboratory work.

Page 487

#22

It is recommended that: The Office of the Chief Medical Examiner insist on compliance with reasonable timelines for the preparation and delivery of autopsy results.

Page 487

#23

It is recommended that: The HSC and other hospitals amend their autopsy consent forms. The forms should make it clear that the hospital might wish to retain organs and other specimens from the bodies of deceased patients. Families should have the option of withholding such consent, while still consenting to the autopsy itself.

Page 498

#24

It is recommended that: The Province of Manitoba consider legislation that requires hospitals throughout Manitoba to establish appropriate quality assurance and risk-management programs that accord with the principles and suggestions contained in this report, and that legislative protection be granted to the discussions that form part of those processes, provided that the right of patients and their families to full disclosure of what has occurred to them during the course of treatment is not compromised.

Page 498

#25

It is recommended that: The HSC, in conjunction with the Winnipeg Regional Health Authority, develop a quality assurance and risk management program employing the principles and suggestions contained in this report.

Page 498

#26

It is recommended that: The HSC exclude doctors who have been involved in a case that is under review by any of the hospital standard committees from participating in the decision-making process relating to such a review.

Page 498

#27

It is recommended that: The HSC Department of Surgery develop an appropriate database for all surgical procedures, but particularly for pediatric cardiac surgical operations. The database should include information such as cross-clamp times, cardiopulmonary bypass times, total circulatory arrest times, amount of blood products used and such other relevant information as would allow for the proper monitoring of surgical trends within a given program or for a particular surgeon.

Page 498

#28

It is recommended that: Pediatric cardiac surgical data be collected in a way that makes it possible to compare Winnipeg procedures with those preformed in other centres.

Page 498

#29

It is recommended that: The HSC establish a clear policy on how staff is to report concerns regarding risks for patients. This policy must ensure that there is no personal or professional jeopardy to the person who is making the report. It should be clear to every staff member to whom they are to present such reports.

Page 498

#30

It is recommended that: The HSC Administration ensure that all staff members are made aware of their responsibility to use incident reports and fully chart problems with the process of delivery of care and any complications in the outcome of care.

Page 500

#31

It is recommended that: The HSC, the Winnipeg Regional Health Authority and the Manitoba Department of Health pursue discussions with provinces in Western Canada for the development of a Western or Prairie regional Pediatric Cardiac Surgery Program.

Page 500

#32

It is recommended that: A provincial Pediatric Cardiac Surgery Program be developed at the HSC that is limited to undertaking lower and medium-risk procedures, but can undertake more complex procedures in conjunction with a regional pediatric cardiac surgery centre.

Page 500

#33

It is recommended that: The Province of Manitoba develop a financial assistance package for families required to travel out of province for surgical treatment of family members. The package should ensure that family members are in no worse a financial position than if the treatment had been provided in Manitoba.

Page 500

#34

It is recommended that: As a part of any planned restart of the Pediatric Cardiac Surgery Program, the post-operative care of pediatric cardiac patients be centralized in a single intensive care unit.

Page 501

#35

It is recommended that: The College of Physicians and Surgeons of Manitoba revamp its policies and procedures so that in the future investigations and disciplinary proceedings no longer depend on whether or not a formal complaint has been filed with the College.

Page 501

#36

It is recommended that: The College of Physicians and Surgeons review this report to determine if there are grounds for undertaking disciplinary proceedings against any of the medical professionals involved in the care of any of the 12 children whose deaths were the subject of these proceedings.