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| <p style="text-align: right;">Page 1</p> <p>1 MR. CAULFIELD: 2 Q. I'm Tim Caulfield, I'm a law professor from 3 the University of Alberta. And I am the 4 Director of Research, I've had the opportunity 5 to be the Director of Research for this 6 Inquiry and really for this part of the 7 Inquiry. 8 I know that this has been a very 9 challenging issue for Newfoundland, an issue 10 that has truly been a tragedy for many 11 families and has touched the lives of people 12 throughout Newfoundland and Labrador, and 13 really, throughout Canada. So it is a 14 challenge. 15 Over the next couple of days we are going 16 to hear from legal and ethical, media, really, 17 social policy experts and they really truly 18 are a renowned group of individuals, so I see 19 this as a really wonderful opportunity to talk 20 about the issues that may allow us to look 21 forward. 22 Now, I would like to emphasize that that 23 is the goal of this event. We don't want to 24 talk too much about the specifics of the 25 Inquiry, the specifics that led us to create</p> | <p style="text-align: right;">Page 3</p> <p>1 things forward and look forward. 2 So let me give you some process and 3 procedure. The presentations will be 25 4 minutes long. And I'm going to be strict, you 5 guys. I'll give you guys a warning around 20 6 minutes. Then we'll have time for perhaps one 7 or two quick questions for the first speaker. 8 Then we'll have the next speaker, again, 20, 9 25 minutes. And then an opportunity for 10 discussion. Now, we will, hopefully we'll 11 have lots of discussion. As I said, I want 12 this to be an open dialogue. And then at the 13 end of next--end of tomorrow there will be 14 about an hour and a half for a really open 15 discussion where we'll bring all the 16 panellists up and hopefully that'll allow us 17 to get some closure on some of the issues that 18 have come up throughout the day and a half. 19 I encourage our speakers to be--to speak 20 freely, to speak their mind, hopefully to 21 speak with passion and on really any topic. 22 There are--given that this is an inquiry and 23 there are some very delicate issues at play, 24 the one thing we have to be careful about is 25 issues that are direct to, perhaps, liability.</p> |
| <p style="text-align: right;">Page 2</p> <p>1 an inquiry, but rather to explore the norms, 2 to explore the legal background, to explore 3 the international trends that will hopefully 4 allow us to look forward to inform the 5 Inquiry's actions and allow Justice Cameron to 6 have informed recommendations. So that's the 7 goal, that's the goal of today. 8 We have, as I said, a truly remarkable 9 faculty who have had the opportunity to write 10 wonderful background papers which are on the 11 web site. I hope some of you have had the 12 opportunity to read them, at least some of 13 them. And they really are an amazing team. 14 And I'm not--this isn't hyperbole when I say 15 that we have managed, we've managed to put 16 together a group of individuals that have 17 spent a good part of their career studying the 18 issues around patient safety and it's a 19 tremendous opportunity for us to pick their 20 brains, to ask them questions about what may 21 be relevant to recommendations for Justice 22 Cameron. So I hope that what we can do today 23 is set a tone of open discussion, I hope we 24 can set a tone that allows us to scratch below 25 the surface and hopefully really move, move</p> | <p style="text-align: right;">Page 4</p> <p>1 But beyond that, beyond that I hope we can 2 speak very freely. 3 I am going to have very, very short 4 introductions for our speakers. Their long 5 bios are on the web site if people want to 6 explore a little bit about them, but I don't 7 to take up precious time introducing them. 8 Take my word for it, they are remarkable. 9 It has been a true pleasure to work with 10 Justice Cameron and the entire Inquiry team. 11 They really are a wonderful team and I know 12 that they've been working very, very hard. I 13 get e-mails at weird times, so that's always 14 an indication that people are work strange 15 hours and working very, very hard. 16 And but also before I begin I think it's 17 important for me to disclose something. I 18 have a magical ability over Newfoundland. 19 I've been here over half dozen times, as my 20 good friend, Daryl Pullman, knows and I've 21 never seen precipitation. Now, I understand 22 that it does snow here and it does rain here 23 and it's not always blue skies, but it's 24 apparently an ability--I have never seen it. 25 So let's hope that this beautiful weather that</p> |

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1 we're having, the sunny skies, will help to
 2 set the right tone and help us to look
 3 forward.
 4 So, thanks very, very much and I look
 5 forward to introducing Justice Cameron, who is
 6 going to give us a few words about what
 7 brought us here. Justice Cameron.
 8 THE COMMISSIONER:
 9 Q. Thank you, Tim. Good morning and welcome.
 10 Tim has asked me to say a few words about the
 11 Commission and our task. I suspect most of
 12 you in the room know all too well what we're
 13 about, but for those few who are either not
 14 from the immediate area or perhaps are tuning
 15 in for the first time via the media, let me
 16 just say a few words about the task.
 17 The Commission was established in July of
 18 last year. There are six terms of reference,
 19 four of those look to the past, one looks to
 20 the present and one looks to the future.
 21 Essentially the Commission is to find out
 22 what happened to cause a high rate of
 23 conversion on retesting and whether those
 24 problems could have been determined earlier.
 25 I am directed as well to determine whether the

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1 systems now in operation are reflective of
 2 best practice. Those terms can be said to
 3 deal with testing practices for estrogen and
 4 progesterone within the health care system.
 5 The Commission is also to examine
 6 communications about ER/PR, as we've come to
 7 know it, retesting with affected patients,
 8 with the public and with others within the
 9 health care system. As those of you who may
 10 have been following the Commission proceedings
 11 will know, we have chosen to begin with the
 12 issue of communications.
 13 The final term of reference invites me to
 14 make recommendations. When considering how to
 15 go about doing this, I knew I needed the
 16 assistance of experts in the field of patient
 17 safety and in communications. I would not be
 18 making findings of fact which those in my
 19 profession are accustomed to doing dealing
 20 with the past in the context of making those
 21 recommendations. I would be trying to
 22 discover and articulate recommendations which
 23 will make a better system in future. Thus,
 24 the theme of the symposium is "Looking
 25 Forward." However, I also concluded that a

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1 traditional hearing, the process which is
 2 already ongoing, as most of you would know,
 3 was perhaps not the most beneficial way to
 4 obtain the information I needed. I preferred
 5 a dialogue where perspectives of different
 6 disciplines would be expressed and different
 7 opinions could be discussed. That is where
 8 Tim Caulfield came in and joined our team.
 9 I am most grateful for his assistance and
 10 encouragement in pulling together this group
 11 of presenters which, as he has noted, I think,
 12 is remarkable in the sense that we have been
 13 able to gather together so many on the one
 14 occasion who are in a position to give us so
 15 much information. Six of our presenters have
 16 prepared papers which you, as Tim has already
 17 noted, would find on our web site, and I
 18 recommend all of those papers to you.
 19 Some of you will have observed that we
 20 have included some traditional legal analysis
 21 in the mix that includes principles relating
 22 to tort law. That is not to suggest that I or
 23 the presenters intend to engage in an analysis
 24 of civil or criminal liability as it relates
 25 to ER and PR retesting. That is outside the

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1 Commission's mandate, as I have said often.
 2 For me, however, the legal obligations
 3 respecting communications are a part of the
 4 context which must be examined to enable me to
 5 make recommendations for the future.
 6 I'm very much looking forward to the next
 7 day and a half and the discussion which will
 8 take place. A transcript of the presentations
 9 and the discussions will be available on our
 10 web site early next week for those of you who
 11 don't wish to take notes but sometime in the
 12 future have the thought that you might want to
 13 think again about something that was said
 14 here.
 15 For those persons who do not have
 16 standing, that is, those of you who are beyond
 17 about the fifth or sixth row here, you are
 18 reminded that if you wish to do so, you may
 19 make written submissions to the Commission
 20 regarding matters such as communications with
 21 patients and how that should be handled in the
 22 future. We have set May 15th as the deadline
 23 for the submission of briefs by members of the
 24 public. I want to assure those members of the
 25 public who may be considering submissions of

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1 briefs that I very much welcome that and would
 2 look forward to seeing your perspective on the
 3 issues related to patient safety and
 4 communications to patients.
 5 So without further ado, Tim.
 6 MR. CAULFIELD:
 7 Q. Thank you, very much, Justice Cameron. Well,
 8 we're already ahead of schedule, which is
 9 always a good sign when you're organizing a
 10 conference. I do have a few more details to
 11 say, important things like where the washrooms
 12 are. I did a little reconnaissance and they
 13 are to the left and then to the left again.
 14 So go through the double doors and then
 15 through another set of double doors. Also,
 16 please try to keep your cell phones on vibrate
 17 or perhaps even, best of all, turn them off.
 18 And other than that, as I said, I hope that we
 19 can have an open discussion.
 20 Now, we're lucky, we're going to start
 21 now with our first speaker, who is going to
 22 lay the groundwork regarding patient safety
 23 generally, talk a little bit about the patient
 24 safety trends and things that the community
 25 have been talking about, the academic

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1 community in relation to patient safety. And
 2 we have Dr. Peter Norton. He--as I said, I'm
 3 going to keep these introductions very short.
 4 He is a professor at the University of
 5 Calgary. He is an expert in patient safety
 6 issues. I know he's spoken all over the world
 7 on these topics and he's written on these
 8 topics extensively and he's also a professor
 9 of family medicine. So, over to you, Peter.
 10 DR. NORTON:
 11 Q. I have to get this thing on because my wife
 12 tells me I wander all the time away from the
 13 podium, so. How is that? Have I got sound?
 14 Hello. Can you hear me now? Yeah, okay.
 15 Well, thank you very much for having me
 16 come. I always enjoy coming to Newfoundland.
 17 It's one of my favourite parts the country
 18 right after the Rocky Mountains, and today
 19 it's even better because the Rocky Mountains
 20 are covered in snow and you can't move around.
 21 So it's really delightful to be here as spring
 22 comes to this province.
 23 Tim asked me if I would talk a little bit
 24 about how things were going in patient safety.
 25 And as I prepared this, I realized it was a

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1 personal view, so I hope you'll enjoy it.
 2 It is reasonable to say that modern
 3 patient safety began with the publication of
 4 what's called "The Harvard Medical Practice
 5 Study" which was published in 1991. This was
 6 a study undertaken in New York State to
 7 determine if no-fault insurance was a viable
 8 option for them, and so they were looking for
 9 potentially events which potentially would
 10 cost money to the insurance system. They
 11 looked at a lot of charts and in a
 12 retrospective way determined iatrogenic
 13 injury. They published this paper saying that
 14 probably 180,000 people a year were dying from
 15 iatrogenic injury. They cited this famous
 16 quote that this was the same as three jumbo
 17 jets crashing every two days and this was met
 18 in the United States and around the world with
 19 astounding silence, except in Australia where
 20 Ross Wilson and his colleagues read this and
 21 said, "We want to find out what's going in
 22 Australia."
 23 They published their work in 1995. They
 24 studied 28 hospitals in two of the states of
 25 Australia and they looked at 14,000 admissions

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1 retrospectively, looking at the charts. They
 2 used the same methods that the Harvard Medical
 3 Practice Studies used, but they refined the
 4 definition of an adverse event to not just be
 5 things which had to do with the legal/medical
 6 interface, but also to deal with the quality
 7 interface. And redefining it was an important
 8 part of the patient safety movement. They
 9 shows 16.6 percent of Australians admitted to
 10 their hospitals, adult Australians, had an
 11 adverse event and 51 were considered highly
 12 preventable and that there was a huge burden
 13 on the system, as well, with extra hospital
 14 days being used. This happened, when the
 15 report was just ready to be released, hadn't
 16 yet finished its peer review, the minister of
 17 health in Australia stood up in the
 18 legislature and announced the number and
 19 caused a turmoil in Australia that took about
 20 five years to settle down. Nothing happened
 21 except fighting between the various players.
 22 The next major event occurred in 1999
 23 when the institutes of medicine in the United
 24 States published this book called "To Err is
 25 Human, Building a Safer Health Care System."

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1 They really reviewed the Harvard Medical
 2 Practice Study and reflected on the quality of
 3 care in the United States. It was released on
 4 what has been called by many people as slow
 5 news day in the States and so made front-line
 6 headlines in the Tribune, the Chicago Tribune,
 7 the New York Times and so on. This produced
 8 an immense effect in the States, even though
 9 they were reporting on something that we knew
 10 for almost ten years.

11 And there was a ripple effect in Canada
 12 and one of the things that happened was Health
 13 Canada asked if someone would understand the
 14 state of safety in Canada, patient safety.
 15 And Ross Baker and I, Ross is a colleague who
 16 I've worked with for many years, received
 17 funding from Health Canada to undertake a
 18 study of the Canadian system to give an
 19 overall picture of where we were in Canada and
 20 whether we needed to be doing anything and
 21 what was actually going on. We used a complex
 22 set of methodologies, but the main one was to
 23 talk to key informants and then ask them who
 24 else we should talk to, what's called a
 25 snowball technique in most of the stakeholder

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1 groups. And we completed that report and
 2 listed it--and published it in, or sent it to
 3 Health Canada in 2002. It's posted on their
 4 web site still. And it really is--has, I
 5 think, had an effect in where we've gone in
 6 Canada.

7 We had made four major recommendations in
 8 this report: That there was a necessity to
 9 build awareness and set priorities in patient
 10 safety; that we needed better reporting
 11 systems so that we could learn from events;
 12 that we needed to create organizational and
 13 policy supports for patient safety efforts;
 14 and we had to build skills, disseminate
 15 knowledge and implement systems to improve
 16 safety.

17 What I want to do is reflect in just six
 18 brief years where we've gone with these
 19 recommendations.

20 The first was to build awareness and set
 21 priorities to improve safety. The first, I
 22 think, major event was the Canadian Adverse
 23 Events Study. This study was funded by the
 24 major federal funding agencies, the Canadian
 25 Institutes of Health Research and the Canadian

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1 Institute of Health Information. They put out
 2 a call for someone to do this research and
 3 Baker and I were lucky enough to receive the
 4 funding. You'll be hearing from two of the 40
 5 folks that were involved in getting this
 6 report, study and report done today; Phil
 7 Hebert and Ed Etchells were both on the study
 8 team. This was an effort to replicate the
 9 Harvard and Australian studies in Canada and
 10 it was funded very generously at about
 11 \$875,000. We also had about \$200,000 to work
 12 on dissemination so that people were ready for
 13 the results.

14 It's important for me to just step back
 15 and tell you what an adverse event is
 16 according to the way we did it in this study.
 17 And this actually comes from Ross Wilson, the
 18 Australian I was telling you about. Thumb
 19 nailed is an adverse event is a bad outcome of
 20 care, but we have a very specific definition
 21 in this. So first of all, it's an unintended
 22 injury or complication. That's important
 23 because in our care we often injure people and
 24 we know the injuries are going to happen. You
 25 give--there are people down in the surgery

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1 suite at the hospital at the moment who are
 2 being injured, they're being cut open.
 3 That's, we're doing that because the risk of
 4 being cut open is small compared to the
 5 benefit of having surgery for the condition.
 6 So an unintended injury or complication. The
 7 second thing about this is it has to have an
 8 important result. Either--and this is focused
 9 now on the acute care setting, but either
 10 disability at the time of discharge or death
 11 or prolonged hospital stay. So you've got
 12 this unintended injury causing something and
 13 resulting in something and it has to be caused
 14 by health care management, not the patient's
 15 underlying illness.

16 It's a complex definition and hard to
 17 understand. And to make it a little clearer I
 18 thought I'd go through this diagram. So
 19 errors, we all understand errors. They're
 20 slips, misses, things we do wrong. People
 21 make them all the time and I think Ed'll talk
 22 a bit about people making errors. And then we
 23 have this adverse event, these things I just
 24 described. And here's three little stories
 25 about things that happen in hospitals and

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1 let's just go through them.

2 Looking up at the upper right-hand

3 corner, a patient is admitted--no. Let's

4 start with--yes. Let's start with the red

5 one. Patients admitted is never--is asked by

6 the admitting physician, "Are you allergic to

7 Penicillin?" "No." The patient is admitted,

8 Penicillin is the right drug, the drug is

9 given, the patient has a severe allergic

10 reaction with bad consequences. This is

11 clearly an adverse event. There's an

12 unintended injury caused by the medical

13 treatment with a profound effect. However,

14 there was no error in care here. So this sits

15 in the adverse event box but not in the error

16 box.

17 The second one is down at the bottom.

18 Same patient is admitted, the Penicillin is

19 ordered at 250 milligrams, four times a day

20 and the patient actually gets, through many

21 things that went wrong in the hospital, 500

22 milligrams. Now, Penicillin is a nice drug,

23 that's why docs like it, because it doesn't

24 hurt you much if you get 500 or 250. It's got

25 what's called a large therapeutic range. So

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1 there's really no consequence here except for

2 a few cents to buy another Penicillin tablet,

3 instead of giving one, you give two. So this

4 is clearly an error, things didn't work right,

5 the system slipped, but it's not an adverse

6 event because there was no injury. And so it

7 sits in that box.

8 The one at the top talks about the

9 patient is admitted, the medical student takes

10 the history and writes down on the chart,

11 "Patient allergic to Penicillin." The patient

12 gets to the floor and somebody writes an order

13 for Penicillin and then many things go wrong

14 in the hospital, all the checks and balances

15 we have in place to make sure this doesn't

16 happen break. The pharmacist misses it, the

17 nurse misses it, the physician misses it. The

18 patient gets the Penicillin, they have a

19 severe allergic reaction. It's clearly both

20 an adverse event and probably a series of

21 slips and misses. So it sits in this area.

22 Now, these areas are all important as we

23 try to work to make a better system. First of

24 all, the area at the top that the red box is

25 in tells us about, sorry, tells us about the

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1 kind of things that happen that we have no

2 control over, but we can do things about

3 those. If that's happening all the time in my

4 hospital, if I'm having a lot of people

5 getting Penicillin and getting bad reactions,

6 I can change the formulary and say "We're not

7 going to give Penicillin in my hospital any

8 more." or I can go to the basic scientists and

9 say, "I need a better test for Penicillin

10 allergy." That's a basic science question.

11 So that's an important area for us to

12 understand.

13 The area at the bottom, the errors that

14 aren't adverse events are really important

15 because they're what we might call near

16 misses. The system didn't work but nobody got

17 hurt. But next time the system doesn't work,

18 we give a different kind of drug, a drug that

19 you can't get away with doubling the dose on

20 without causing harm, we're going to have harm

21 to a patient. We don't want that. So this

22 area is very good for us to study as we try to

23 improve the quality of the system.

24 The intersection, the centre, is the

25 really important thing. Those are preventable

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1 adverse events, those are the things we should

2 be hoping in the future to get to zero.

3 That's about the quality of the system.

4 So the Canadian Adverse Events Study was

5 studying adverse events. We started it in

6 2002, we completed it in the fall of 2003.

7 Some people have said this is the largest

8 health service research project even

9 undertaken in Canada. We used the methods, as

10 I said before, of the Harvard Medical Practice

11 Study and Australia and we were trying to find

12 out how many adverse events occurred to

13 patients and how many of them were

14 preventable. We studied the--oh, the paper

15 was published in 2004 in May. It really had

16 quite an impact. It was downloaded 25,000

17 times in the first four days, an all-time

18 record for the CMAJ still and Ross Baker and I

19 within two months had 43 national and regional

20 media contacts about the paper.

21 Here are the key numbers that we found:

22 The overall Adverse Events Study in adults in

23 Canada in fiscal year 2000 was 7.5 percent.

24 7.5 percent of adults admitted to our acute

25 care hospitals had one or more adverse events,

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1 one in 13. The confidence intervals are
 2 small. And about three percent had a
 3 preventable adverse event. This is the number
 4 we want to push to zero, about half, a little
 5 under half.

6 These numbers are the same as the numbers
 7 that are in almost every study that's been
 8 done and is being done around the world. The
 9 number is around 10 percent of patients, plus
 10 or minus two percent everywhere. And I just
 11 listed a few of the places, the UK, New
 12 Zealand, Spain, Holland, Denmark, Australia,
 13 Brazil. More recently since I've got this
 14 I've seen the data from three of the Arab
 15 countries, they're coming in in the same
 16 range, and two Sub-Saharan countries. This
 17 number seems to be a pervasive number, which
 18 is an interesting fact. I told you this was -

19 So the second part, remember I'm talking
 20 about our 2002 report, and the second point I
 21 wanted to make was about setting priorities
 22 and improving safety was that the Canadian
 23 Patient Safety Institute was established in
 24 2003. It's funded for \$50 million for the
 25 first five years. It's to coordinate this

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1 effort across Canada. And putting a national
 2 organization in place, within funding, to move
 3 this ahead has been an important and, I think,
 4 foundational piece of work as we try to move
 5 to make a safer system in Canada. We just
 6 heard two weeks ago that their funding has
 7 been extended for another five years, which is
 8 very good news.

9 The second thing Baker and I asked--
 10 recommended in the report, asked for, that's a
 11 bit much, was to develop better reporting
 12 systems. There's something can CMIRPS,
 13 Canadian Medication Incident Reporting and
 14 Prevention System. This had been touted as
 15 the first really national reporting system for
 16 adverse events. It'll report adverse drug
 17 events, which are a big part of adverse
 18 events. This development has occurred much
 19 more slowly than we would have hoped, and it
 20 still is not in existence, although money
 21 continues to flow to it. We would hope it
 22 gets up. The Canadian Patient Safety
 23 Institute has taken a major lead with CIHI,
 24 Canadian Institutes of Health Information, in
 25 the next four or five years to try to get

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1 something going first in drugs and then across
 2 the country.

3 But provincially we've seen some amazing
 4 movement in this area. For example,
 5 Saskatchewan changed their regulations to
 6 allow all critical incidents to be reported to
 7 Sask Health where they're anonymized and then
 8 sent back out to all their regions. So if
 9 something bad happens in one place, they
 10 investigate it and they then, after sufficient
 11 confidentiality concerns, send it to every one
 12 of their health regions and say "All of you
 13 work on this." So I think that it--and
 14 there's some others here. This is occurring
 15 at the provincial level, we just haven't got
 16 the federal stuff in place yet.

17 Third point was to create organizational
 18 and policy supports for patient safety
 19 efforts. All the provinces have introduced
 20 some legislation concerning protection, legal
 21 protection around investigation of adverse
 22 events at this point and the legal experts
 23 will probably talk more about that.

24 Disclosure is moving ahead, it's either
 25 mandated or suggested or supported at various

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1 levels in each province, and I know there's
 2 going to be a lot of discussion with
 3 disclosure. And CPSI, Canadian Patient Safety
 4 Institute, has just recently released a
 5 national framework to help each institution,
 6 province, region accelerate their work in
 7 disclosure.

8 And finally, in 2005 our accreditation
 9 council for hospitals has began increasingly
 10 to demand organizational practices during
 11 accreditation directly related to improving
 12 safety. And their web site will show you a
 13 lot of stuff about that. So there's been a
 14 fair amount of work in this area.

15 And finally, build skills, disseminate
 16 knowledge and implement systems to improve
 17 safety. So the first three, if you like, are
 18 the framework to make us somewhere and this
 19 one says now let's do something.

20 One of the places where, in my
 21 estimation, we haven't done enough is in the
 22 educational form for new health professionals.
 23 The penetration of the safety information into
 24 the curriculums has really been quite slow and
 25 I think is accelerating but not as much as we

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1 should have done. However, we have lots of
 2 professional development opportunities
 3 available, we've funded a lot of demonstration
 4 projects, there's been significant, 5 and a
 5 half million dollars worth of funding from the
 6 federal government toward doing research. And
 7 the involvement of the public has--
 8 understanding the public have to be part of
 9 the solution, posing the questions, moving us
 10 to a safer system. We're seeing some of the
 11 health regions in the country, Winnipeg is the
 12 one I picked here, take a real leadership role
 13 in engaging the public in a new way to make
 14 the system safer.

15 However, now we get very personal because
 16 I'm part of this story I'm going to tell you.
 17 We're doing another major thing to improve the
 18 system, and this is called "Safer Health Care
 19 Now." And I wanted to spend a little time
 20 telling you about this national initiative
 21 because I think it's a hopeful thing that we
 22 can actually do something. So here's the
 23 story.

24 December 14th, 2004 Jack Davis, who you
 25 see on the left, who's the CEO of the Calgary

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1 Health Region where I work, was at a meeting
 2 in Florida where Don Berwick, who is
 3 international, "the" international leader in
 4 patient safety said he was impatient, nothing
 5 was changing, safety wasn't getting better.
 6 He, as was announced in the paper, threw down
 7 the gantlet and said the Americans were
 8 launching a campaign to save 100,000 lives in
 9 the next 18 months. Well, Jack, being an
 10 Alberta, said, "Well, that's good. If they
 11 can do it, we can do it, right." And Ward
 12 Flemons, who I couldn't find a picture of, who
 13 is the vice president of safety was sitting
 14 beside him, so Jack leans over to Ward and he
 15 says, "Ward, I think we'll do this in
 16 Calgary." Ward comes back and phones me and
 17 says, "Peter, Jack wants to do this in
 18 Calgary." I said, "Well, I'm not doing it in
 19 Calgary, Ward, I'm only going to do it if we
 20 do it in Canada." And so that lead me to get
 21 Ross involved and we established Safer Health
 22 Care Now.

23 Now, we didn't call it 100,000 lives
 24 campaign. We had some feelings that it was
 25 more Canadian to say Safer Health Care Now,

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1 let's get on with it, let's do it. But we've
 2 certainly borrowed much from the Americans.
 3 They've helped us with this, they've been our
 4 allies. We've taught them things and we've
 5 learned things. And I want to tell you what
 6 we've done.

7 Remember, this is now Christmas of 2004.
 8 So we decided we had to Canadianize the
 9 American approach, you know, you couldn't
 10 possibly follow it directly, and we would
 11 align Canadian experts in quality improvement
 12 and clinical areas as faculties to assist
 13 front-line teams, the doctors, nurses,
 14 pharmacists and therapists who are actually
 15 taking care of patients to improve their care.
 16 That was the idea. And we would do it in six
 17 targeted low-tech areas where we had good
 18 evidence that there was a gap, we weren't
 19 providing as good care as we could, and we're
 20 going to give them the tools to make them able
 21 to provide the care they wanted. We assumed
 22 anyone could come at any level, you didn't
 23 have to be, you know, a teaching hospital in
 24 downtown Toronto, you could be a small
 25 hospital in Baie Comeau, you could be up in

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1 Nunuvik, you could be on the rock. And we
 2 were going to do this together, we were going
 3 to form communities of practice across the
 4 country and all work and learn from each
 5 other. Those were the fundamental principles
 6 we set down. There were six key
 7 interventions, these are directly from the
 8 Americans. I'm not going to go through them.
 9 You can read them on the Safer Health Care Now
 10 web site. But none of them are really high
 11 tech.

12 And I'll come and discuss just one, the
 13 prevention of surgical site infections as an
 14 example. So what would happen is a team from
 15 a hospital would pick one of these and work on
 16 it and we would support them with quality
 17 improvement and clinical knowledge.

18 How did we get the funding? We scraped
 19 it together, CPSI gave us some, the provinces
 20 put some money in, the provincial quality and
 21 safety organizations did, we had a variety of
 22 sources and we launched it, notice, in four
 23 months with four regional nodes. Now that was
 24 a good idea, you know, because Canada just
 25 loves to compete and if I can say, you know,

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1 Ontario is ahead of the west, the west gets a
 2 lot of excitement going, so part of it was
 3 that, because it's a Canadian thing to do. We
 4 had a national coordinating group, we had the
 5 faculties which are both clinical experts and
 6 quality experts and we produced what are
 7 called "Getting Started" kits which were,
 8 they're all posted on the web, but they're
 9 explicit details about both the evidence for
 10 improving practice, the ways to measure where
 11 your practice is at and improvement
 12 techniques. We had a goal to enrol 100 front-
 13 like teams by December, 2006, that was our
 14 goal.

15 The western node, just so you understand
 16 the depth of staff, for dealing with the four
 17 western provinces I have a secretary, two
 18 quality staff advisors, the team director and
 19 me. The first four get paid and I don't. Lot
 20 of people doing unpaid work here. This
 21 campaign is probably costing Canada about 2.3
 22 or 4 million dollars a year, plus
 23 contributions in kind from the hospitals and
 24 regions who send teams and support teams so
 25 they can do the work. And there's a national

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1 measurement team and we have learning
 2 meetings, national learning meetings and
 3 teleconferences and web conferences and use
 4 all the modern educational techniques that we
 5 can.

6 Well, here's the enrolment starting from
 7 September, 2005 and you'll notice by October
 8 we had done a little better than 100 teams,
 9 789 teams working across the country in those
 10 six initiatives. It's now over 850 teams.
 11 That in itself is impressive, there are that
 12 many doctors, nurses and pharmacists who
 13 actually say we're going to work together on
 14 this and we're going to work together close to
 15 the patients at the bedside.

16 So I thought I'd just explain surgical
 17 site infection and show you their results.
 18 Surgical site infections were the most
 19 frequent adverse event in the Canadian
 20 adverse--were among the most, it says were the
 21 most, were among the most. Surgical site
 22 infections were very prevalent in the Canadian
 23 Adverse Events Study. A recent Quebec study
 24 showed about two percent surgical patients
 25 have a surgical site infection. These are not

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1 just little things on the surface, these are
 2 bad infections, deep inside you that require
 3 either re-operation or--and complicated
 4 antibiotics. You're sick. And there's
 5 timely--there's very strong evidence, 20-year
 6 evidence that if we give antibiotics within 60
 7 minutes of surgery starting, the cut, we can
 8 substantially reduce these, substantially
 9 reduce them. You want a lot of antibiotic
 10 around so when you go through the skin,
 11 bacteria die if they try to go into the
 12 surgical site. Get the idea?

13 When we--and so there were four things
 14 that the teams were going to try do. The
 15 first is easy. Don't shave the skin, clip the
 16 hair, because when you shave, you make little
 17 cuts and the bacteria can get inside the skin
 18 before the operation, and now they're not,
 19 they're closer to the site. You think that
 20 sounds easy, you think that all you have to do
 21 is not buy more razors, well, that costs more
 22 money, so you have to convince the chief
 23 financial officer not to do that, but in
 24 addition you got to go and find all the razors
 25 that are hidden all over the hospital. True.

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1 The second is to make sure that
 2 antibiotics are given and stopped on time,
 3 these prophylactic antibiotics, you got a 60
 4 minute window. Now, that sounds like it's
 5 easy, right? The trouble is the patient's
 6 down in the ward, and it says on the list,
 7 "Surgery will start at 10:30" so at 9:30 the
 8 antibiotic is given, but of course, the OR is
 9 not running on schedule, never is, and the
 10 floor doesn't know the time, so you've got to
 11 change the system to make it work differently.
 12 And then you've got to control blood sugar
 13 during cardiac surgery and body temperature
 14 during abdominal surgery. Very simple.

15 We've known these things should happen
 16 for 20 years. Every surgeon, every
 17 anaesthesiologist, every OR nurse wants these
 18 to happen all of the time. Yet, when we
 19 began, for example, with hair removal, across
 20 Canada, that's the baseline measure, the teams
 21 were averaging around 66 percent. Two thirds
 22 of the time they were clipping the hair, but
 23 one third of the time they were shaving it.
 24 However, working together as teams across the
 25 country by 11 months out, 100 percent and

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1 holding. So you can actually change
 2 something.
 3 Receiving the antibiotics, the right
 4 antibiotic by the right room at the time, when
 5 we started across the country the surgeons and
 6 anaesthesia guys were shocked when they
 7 actually measured it, because the system
 8 doesn't give us these kind of measurements.
 9 Forty-five (45) percent of the time we were
 10 getting it. The goal here is not quite 100
 11 percent because some people are very allergic,
 12 sometimes you have to do crash surgery,
 13 there's some reasons not to get to 100 percent
 14 clinically. But look at the gain, look at the
 15 gain. We have the teams 90 percent of the
 16 time, and that's holding, as well. So this is
 17 a demonstration that we can do something, we
 18 don't have to spend a lot of money, but we
 19 have to enable people to change the system
 20 they work in and reflect on it.
 21 Here's some comments about, I just picked
 22 a couple, about participating in Safer Health
 23 Care Now from hospital leaders. These are a
 24 couple from other provinces. "To not
 25 participate is not an option." "Finally

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1 someone is giving us the tools to change
 2 things." "Safer Health Care Now has provided
 3 us with leadership and coordination in all the
 4 intervention."
 5 We've just launched new initiatives in
 6 Safer Health Care Now. In the last month in
 7 addition to the first six, preventing falls in
 8 long-term care, preventing harm from these
 9 terrible antibiotic-resistant organisms,
 10 preventing clots in your legs, in your tummy
 11 during surgery and after surgery, high-risk
 12 medications in paediatrics and getting the
 13 medications right in home care when people are
 14 admitted.
 15 We're sort of nibbling away at the edges
 16 and sometimes you might want to get
 17 discouraged about this. But, you know, I sort
 18 of have to think about this and I just put up
 19 a couple of very old quotes, "The journey of
 20 1000 miles begins with one step" said Lao. He
 21 was a contemporary of Confucius. I think
 22 we've actually done more than one step, but
 23 it's a long journey and we're not going to get
 24 there.
 25 Where's Tim? Can I go--can I do five

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1 more? Okay.
 2 So why is this journey so hard? And I
 3 just want reflect on this, this one last
 4 point. I want to talk about hospitalization.
 5 And one of the things people keep saying is,
 6 "Well, if we can get airlines right, how come
 7 we can't get hospitals right?" "If we can get
 8 the oil rigs right, how come we can't get the
 9 hospitals right?" I think that's really
 10 unfair. Hospitals are complex places that
 11 deal with a product line, if you like to talk
 12 about business, the patients are all
 13 different, they're vulnerable, they're sick.
 14 We make big risks in taking care of them.
 15 It's a very complex system.
 16 And if you're going to say "Are hospitals
 17 good or bad?" you should say, "Well, what
 18 happens if we close all the hospitals
 19 tomorrow?" That's really the comparison.
 20 What are hospitals doing for us? And let me
 21 tell you, if we close all the hospitals in
 22 Newfoundland tomorrow and your nephew goes out
 23 and plays hockey and gets boarded badly and
 24 ruptures his spleen, he will die. If the
 25 hospitals are open, he won't die. Or if your

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1 niece gets a red rash and a bit of a stiff
 2 neck and the hospitals are open, she has a 70
 3 percent chance of living through her
 4 meningitis and if there were no hospitals, she
 5 wouldn't. So let me tell you, I am absolutely
 6 convinced that hospitals make a huge gain
 7 overall on the quality of Canadian life.
 8 However, having said that, I will now
 9 compare hospitals to other industries in
 10 Canada. And I have to thank Phil Hebert for
 11 this work. This diagram is an important
 12 diagram, it's a safety diagram. The first
 13 thing I'd point out is these scales are both
 14 logarithmic, they get big very fast, so they
 15 go 1, 10, 100. Up that side is how many lives
 16 are lost a year in Canada by various
 17 activities and this is the number of
 18 encounters needed for one person to die at
 19 that activity. And the lines are important.
 20 The safety scientists break us into three
 21 kinds of activities; dangerous activities,
 22 regulated activities and ultra-safe activities
 23 based on those lines. And the important thing
 24 here is from the safety sign is to cross one
 25 of those lines you have to fundamentally

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1 change the system. You don't get that--you
 2 can move inside an area by little things,
 3 moving across is a big thing, and I'll show
 4 you that.
 5 So here's commercial airlines in Canada,
 6 they're very safe. They're ultra-safe, we
 7 never worry much about getting on an airplane
 8 in Canada. There's, this is an Alberta thing.
 9 You can fire guns a lot of times before you
 10 kill anybody in this country. And we're
 11 pretty interested in that in Alberta, as you
 12 can imagine, anyway. I won't say more about
 13 that. Here's some of our sports activities.
 14 Phil has a funny sense of humour, you'll see
 15 later on today. That's the scuba diving. And
 16 of course, the bungee jumping here, this is
 17 Canadian bungee jumping which is done at
 18 places like the national exhibitions. We
 19 don't jump into canyons like the New
 20 Zealanders and Australians. Their bungee
 21 jumping might be a bit later--lower. And the
 22 rock climbing, 25 hours of rock climbing is
 23 pretty dangerous activity, but we let people
 24 do that in Canada. And my colleagues who work
 25 in the emergencies close to the foothills see

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1 these people all the time.
 2 Here's some of our industries, primary
 3 industries. And I want to just talk about
 4 coal mining for a second. 100 years ago coal
 5 mining was down in the dangerous area and it
 6 got up into the regulated area. And how did
 7 they do that? They fundamentally changed the
 8 way we coal mine in Canada. Back then they
 9 were mining underground, now they're above
 10 ground. That's a fundamental change. And
 11 that's how you move. There's driving, we all
 12 do it every day. And if you average all that,
 13 that's about where we are. That's what
 14 Canadian acceptable risk is. And that's where
 15 hospitalization is. That's where
 16 hospitalization is in Canada, based on the
 17 Canadian Adverse Events Study.
 18 So my goal when I talk to people like
 19 yourselves or anyone else is to say, "Well, we
 20 want to go across the line. It's going to
 21 take a lot of change and it's going to take a
 22 generation or two, but you got to start, you
 23 got to make the first part of the journey."
 24 Churchill said, "Every day you make some
 25 progress, every step will be fruitful, yet

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1 there are stretches before you, an ever
 2 lengthening, ever ascending, ever improving
 3 path. You know you'll never get to the end of
 4 the journey, but this is not discouraging. It
 5 adds to the joy and glory of the climb." And
 6 that's the climb we're on. Thank you.
 7 MR. CAULFIELD:
 8 Q. We have, now have some time for a discussion,
 9 obviously. I have many questions myself. It
 10 would be great if we could concentrate some of
 11 our discussion on the general topic of patient
 12 safety and perhaps some of the framework
 13 issues. So I have some questions myself, I'd
 14 be happy to start, but let's open it up to the
 15 group first. Does anyone have some questions
 16 they'd like to dive in on? Yes.
 17 UNKNOWN SPEAKER:
 18 Q. I'd like to ask Dr. Norton whether he knows
 19 offhand how many participants there are from
 20 the Province of Newfoundland and Labrador in
 21 these Safer Health Care Now initiative?
 22 DR. NORTON:
 23 Q. I believe that we have teams from every region
 24 of the province. I don't know the exact
 25 number. I'm sorry, I should have looked that

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1 up, I do have it. It's posted on the web
 2 site. If you Google "Safer Health Care SHN!"
 3 you'll find the web site and we have all the
 4 enrolment figures. But the campaign in the
 5 Atlantic Provinces, the Atlantic Provinces
 6 form a node, just like the west. So the nodes
 7 are Ontario which, of course, assumes its the
 8 biggest node; and then the west, which knows
 9 its the biggest node; and then the Maritimes,
 10 which is doing an excellent job and has the
 11 highest penetration; and Quebec, which came on
 12 late because it took them longer to join. So
 13 that's a very Canadian thing. Alberta is--I
 14 mean, Alberta, here we are, the western node
 15 is responsible for the Arctic. It's really
 16 very exciting to go to the meetings. I can't
 17 tell you how exciting it is to see that many
 18 clinicians. Like, we had a meeting in
 19 Winnipeg, of all places, three weeks ago, and
 20 we had 400 clinicians and quality improvement
 21 people come to talk about getting better.
 22 MR. CAULFIELD:
 23 Q. Daryl?
 24 DR. PULLMAN:
 25 Q. Thank you for your very interesting talk. I

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1 am curious, most of the data that was
 2 presented and so forth has to do with errors
 3 in treatment, and I'm curious whether there--
 4 whether there are statistics kept on
 5 diagnostic issues because many of the issues
 6 that we're dealing with here have to do with
 7 diagnosis and errors in diagnosis, which seem
 8 to be slightly different. And I wondered if
 9 there's work being done in that area and
 10 recommendations in that respect, as well?
 11 DR. NORTON:
 12 Q. Let me say two things. First of all, we did,
 13 there were 255 patients out of 4000 charts who
 14 had one or more adverse events in the study.
 15 And when one of these errors was found, these--
 16 -not these errors, these adverse events was
 17 found. The doctors and nurses who were
 18 reviewing the charts wrote quite extensive
 19 notes. These were quite painful for the
 20 reviewers to look at, many because you can see
 21 yourself doing these things, being involved.
 22 And we've done an extensive analysis, what's
 23 called a qualitative analysis trying to
 24 understand those stories and put them
 25 together. Seventy percent of them sit in

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1 three categories.
 2 The first category is misdiagnosis, but
 3 this is not misdiagnosis exactly in a way you
 4 say. Here's a typical example of that. First
 5 it's either missing another illness. The
 6 patient has two illnesses which are
 7 contributing to their condition, both are
 8 active. It's not what's called a co-
 9 morbidity. So the patient might have
 10 pneumonia and congestive heart failure but the
 11 clinicians only understand the pneumonia and
 12 they treat the pneumonia but after a few days
 13 they realize they've got to treat congestive
 14 heart failure, which is water in the lungs, as
 15 well, and so there's a prolonged hospital
 16 stay. The other thing is just plain having
 17 the wrong diagnosis, so you think it's
 18 pneumonia, but it's just congestive heart
 19 failure. So that's the most common thing we
 20 saw. Those are not quite lab diagnostic
 21 errors, those are different. I'll come back
 22 to that.
 23 The second most common thing are errors
 24 in drug and fluid management. So having two
 25 drugs together that shouldn't be together,

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1 having a drug present when the patient is
 2 intolerant, having a drug present which
 3 doesn't deal with the condition, the condition
 4 of the patient.
 5 And the third is the fact that organ
 6 failure is occurring and it's not recognized.
 7 Typically treating a person with congestive
 8 heart failure, the pump failing, we push their
 9 kidneys pretty hard and sometimes the kidneys
 10 start to fail and the clinicians may not see
 11 that happening early enough and the patient
 12 gets into trouble because of renal failure as
 13 well as their underlying condition. And those
 14 account for 70 percent, one or more of those
 15 is present in 70 percent of cases.
 16 I use that with my residents, I tell
 17 them, you know, when you walk around and
 18 someone's not behaving the way you'd expect
 19 them to on the ward, sit down and say, "Let's
 20 do a quick review, let's--the whole team,
 21 let's review this. Let's say, have we got the
 22 diagnosis right, are the drugs and fluid okay,
 23 but if we aren't sure let's get a pharmacist
 24 here to help us. Let's not assume doctors and
 25 nurses can do that. And, you know, have we

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1 checked all the vital organs, are they all
 2 functioning okay. If not, let's get the tests
 3 done."
 4 In terms--I'm not an expert at all in
 5 quality at the lab end. There are lots of
 6 people in Canada who are. I've been much more
 7 interested in the sharp end where the
 8 clinicians meet the patients. I know that, I
 9 mean, you're hearing a lot about that here at
 10 this Inquiry both from--but there is a lot of
 11 work that's been done, I know, in the
 12 biochemistry about quality assurance, but I'm
 13 not really an expert, so I did have to tell
 14 you about the other part of diagnosis, though.
 15 MR. BROWNE:
 16 Q. Yes. (Inaudible - not at microphone) is there
 17 any tracking of what type of resources, the
 18 amount of resources is necessary (inaudible)
 19 implement these roles in the end.
 20 DR. NORTON:
 21 Q. The Safer Health Care Now stuff? Well, -
 22 MR. BROWNE:
 23 Q. (Inaudible) always an issue in health care.
 24 DR. NORTON:
 25 Q. Yeah, yeah. No, I want to be honest about

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1 this. I beat myself up about this because I
 2 should have, if we weren't--excuse me. If we
 3 weren't in such a rush to get it started, we
 4 would have put a better evaluation in place,
 5 and so we're cobbling together an evaluation
 6 at the moment. It is pretty easy for us to
 7 get the direct costs, the costs of hiring
 8 those people and moving them around the
 9 country. What is hard to get is how much is
 10 being put in by the health regions, because
 11 those teams are not supported by the campaign.
 12 If your hospital here has a team working on
 13 surgical site infection, we know that for that
 14 team to be successful they've got to release
 15 maybe about a half a day of staff time to do
 16 some of the team meetings and things and then
 17 you've got to get people to come to meetings,
 18 so there's a real cost for them and we have no
 19 good way of capturing that. We have some
 20 surrogates for it, so--because we are in
 21 discussions with health care, with Health
 22 Canada right now about sustaining this program
 23 and how it should be sustained and where it
 24 should be put. And I don't have the data I
 25 should have had. So that's sort of a long

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1 answer to say I didn't do a good job.
 2 MR. CAULFIELD:
 3 Q. I want to jump in with a question, if you
 4 don't mind, and then we'll go directly with
 5 you. I'd like to open this one up to the
 6 entire panel. You spoke about the 1999
 7 report, the IOM Report and of course we've
 8 known about these issues for so long, and you
 9 kind of touched on this at the end of your
 10 presentation. Could you give some specifics
 11 why you think change is just--we've known
 12 about this. Why has it taken so long, what
 13 are the actual kind of barriers? Maybe you
 14 can give a couple of examples. We've know a
 15 change is required and it just has taken so
 16 long to happen. I know it's a complex system,
 17 but I wonder if you could just push--and
 18 that's--I'm curious what Ed thinks about that,
 19 also. Ed, sorry.
 20 DR. ETCHELLS:
 21 Q. Well, I think you have to put it in context.
 22 I think the best context is aviation, so the
 23 aviation safety movement really came to the
 24 forefront during and just after World War II
 25 and it took that many decades to reduce

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1 accidents and errors in aviation to its
 2 incredibly safe level now. For example, in
 3 the '40s and early '50s pilots complained that
 4 you shouldn't standardize cockpits because it
 5 takes away the art of being a pilot. And this
 6 is just the sort of thing that you start to
 7 hear in health care now is that we don't want
 8 to over standardize health care because it
 9 takes away from the art of clinic medicine.
 10 So I think it just takes a long time to do
 11 these sorts of things.
 12 What are some of the barriers? I think
 13 that if I could pick the biggest barrier for
 14 me as an internal medicine, hospital-based
 15 specialist, it's lack of coordinated
 16 information flow. So it is virtually
 17 impossible for me at two in the morning on a
 18 Sunday to figure out what a patient has had
 19 done to them in the past, what medications
 20 they might be taking, what doctors who saw
 21 them on Friday might have been thinking. That
 22 lack of coordinated information really makes
 23 it very difficult to provide safe continuous
 24 care, which, so I've started to get more
 25 interest in that particular area. There are

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1 many others, but that's the first one that
 2 jumps in my mind. I don't know if -
 3 DR. NORTON:
 4 Q. I just happen to have a slide, Tim.
 5 MR. CAULFIELD:
 6 Q. This wasn't planned.
 7 DR. NORTON:
 8 Q. It's about the history of medicine, at least
 9 part of it. Modern medicine emerged, I think
 10 this is very easy to argue, somewhere between
 11 1860 and 1910. During that period we
 12 developed new standards for clinical
 13 education, the Flexner Report is the big one.
 14 Strict requirements for professional licensing
 15 in Canada back in 1850. Anyone could say they
 16 were a doctor. There were no rules, there
 17 weren't a regulatory system. The beginning of
 18 clinical practice being founded on scientific
 19 research. And we organized the hospitals. We
 20 essentially haven't changed the hospitals
 21 since then. This is a very interesting quote
 22 from a noted medical historian saying "In 1912
 23 was the first time that a random patient
 24 attending a random physician had a better than
 25 50/50 chance of getting a benefit." But,

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1 after that it started accelerating. When I
 2 think about my own clinical practice, I take
 3 care of frail elderly people with pneumonia in
 4 the community because I have in my
 5 armamentarium powerful antibiotics. Before
 6 those existed, if you go back to 1940, if
 7 those people weren't admitted, they died. So
 8 I think that the system is based--we haven't
 9 taken the structural part of our system and
 10 moved it along as quickly as the care has.
 11 And it's very hard for us to catch up now
 12 because we can't just shut the hospitals down
 13 and redesign them.

14 MR. CAULFIELD:
 15 Q. Gerald, did you want to get in on that
 16 question?

17 ROBERTSON, Q.C.:
 18 Q. No.

19 MR. CAULFIELD:
 20 Q. No. You're good. I'm sorry, sir, you had a
 21 question.

22 CROSBIE, Q.C.:
 23 Q. It sounds like if you could start with a blank
 24 sheet of paper and a very fat budget, you
 25 could do much better?

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1 MR. CAULFIELD:
 2 Q. Good question.

3 DR. NORTON:
 4 Q. Maybe. If you look carefully at the effect of
 5 the hospital sector, which is what I talked
 6 about mostly, on the health of Canadians,
 7 sometime around 1970 you see an accelerated in
 8 major public health indicators, an
 9 acceleration which you can--an improvement
 10 that can be attributed to hospital care. It's
 11 around the time when we started doing cardiac
 12 surgery and then accelerated into more other
 13 highly technical procedures. And you'd have
 14 to--it would be, I think, complex to redesign
 15 the system on a blank sheet of paper. And I
 16 think that's one of the reasons that some of
 17 the efforts in the '80s and '90s where we were
 18 talking about some of the industry things, the
 19 radical redesign kind of stuff, sort of didn't
 20 take off was because we weren't sure we knew
 21 what to do. People that work in organization
 22 theory talk about this being the most complex
 23 system that they see, much more complex than
 24 flying airplanes and building cars and stuff.
 25 So I don't know, it would be an interesting

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1 exercise. I wouldn't want to sacrifice the
 2 health of Canadians for it, though. So
 3 that's the balance. I don't know, Ed, do you
 4 -

5 DR. ETCHELLES:
 6 Q. Yeah, I don't think it would be any easier to
 7 start on a blank sheet. I think the other,
 8 one other barrier that we run into in the
 9 hospital setting is the lack of measurement of
 10 value of our care. So in the hospital we have
 11 a very good knowledge of how much money is
 12 being spent year to year, that's very
 13 accurate. We have very little sense of the
 14 value that we get from spending those dollars,
 15 what adverse events are occurring not in 2002
 16 in chart reviews, but this week, last week,
 17 last month, where the inefficiencies were, the
 18 good things, we don't have a sense of that so
 19 it's very hard to make wise decisions about
 20 what's working and what isn't. I think that's
 21 an investment that has to be made. Good
 22 businesses know what value they're getting out
 23 of their work. We need to get a better sense
 24 of that.

25 MR. CAULFIELD:

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1 Q. Can we make sure we speak into the microphone
 2 so everyone can hear?

3 DR. ETCHELLES:
 4 Q. Yeah. Sorry.

5 MR. CAULFIELD:
 6 Q. No, that wasn't you.

7 DR. NORTON:
 8 Q. When I was saying that the surgeons couldn't
 9 believe those 40 percent figures, they really
 10 couldn't, but no one had measured it for them
 11 in a systematic way. So this evaluation
 12 component of the system is--and it gets worse
 13 as you move away from hospitals. For example,
 14 if you're working in community-based mental
 15 health, you have very little feedback
 16 available about the efficacy of your
 17 treatment, except on a case-by-case basis,
 18 which is not good enough to understand. I
 19 mean, I understand--and so when we talk to
 20 clinicians, they say things like, "Well, of
 21 course I gave good care to every patient."
 22 But it's the sum, right, and is there an
 23 opportunity to move the mean and narrow the
 24 standard deviation along. I don't think that--
 25 Ed said communication is the--I mean, I

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1 would--is necessary and communication is a
 2 thing that can really help. Moving the
 3 information with the patient through the
 4 system is really important. But feedback to
 5 clinicians and to hospitals and to regional
 6 health authorities of real data about the care
 7 they provide will allow them--I mean, it isn't
 8 that people don't want to get better, it's
 9 that they don't know they have to get better,
 10 I think, I think a lot of the time.

11 MR. CAULFIELD:
 12 Q. That's a really interesting point because--and
 13 you touched on this in your talk, also, of the
 14 difficulty of measuring outcomes, and I think
 15 we're going to touch on this throughout the
 16 day. Is there any evidence that things are
 17 getting better? I mean, again, 1999, IOM,
 18 we've instituted some kind of framework
 19 changes. What's the data tell us about how
 20 we're doing, are some areas getting better?

21 DR. NORTON:
 22 Q. Do you want me to say something? Okay. I'll
 23 tell you two anecdotes where things really
 24 have gotten better. One of the interventions
 25 on there is called Central Line Infections.

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1 Central lines are lines that we put in through
 2 the major arteries and veins into the body to
 3 get access, very quick, big access into the
 4 vascular system. So when you go into an ICU,
 5 you see people with lines in here and here and
 6 in their legs and all over the places. I
 7 don't know that kind of--I'm a family doc, you
 8 know, but they put these lines in. And of
 9 course, because you've--the skin is a
 10 wonderful protection against infection, I was
 11 sort of talking a bit about that, but once you
 12 put a hole through it, infection can creep in.
 13 And the central line infection is a bunch of
 14 very simple things that you can do to reduce
 15 the risk of infection in these lines. So you
 16 can imagine if the bacteria crawled down one
 17 of these lines and they're into your heart or
 18 something, you're in big trouble, right. You
 19 don't want bacteria in your heart or lungs or
 20 any of those places. And the--I won't go into
 21 the protocol but it's proper cleaning and
 22 proper changing of the lines, things we've
 23 known about for a long time. The 16
 24 paediatric hospitals in Canada, we have 16
 25 specialized paediatric hospitals, took that

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1 on, they were part of the teams to do that.
 2 And we knew, we know from other work that
 3 every time a child in a paediatric intensive
 4 care unit in one of those hospitals gets a
 5 central line infection, the mortality rate is
 6 30 percent and the cost is around \$30,000.
 7 It's easy to remember because they're both
 8 30s. I like the number. We have--and they
 9 were averaging about two central line
 10 infections per 100 patient days. This is a
 11 complex measure, but, and six of them--seven
 12 of them had six months without one, as of
 13 December last year. That's a real gain. I
 14 mean, we saved a lot of money, we saved a lot
 15 of kids' lives.

16 A second example is about another one of
 17 those called ventilator-acquired pneumonia.
 18 Ventilator-acquire pneumonia means when you're
 19 in a ventilator in the ICU again, you can get,
 20 the bugs can creep down the tube into your
 21 lungs and you get a ventilator-acquired
 22 pneumonia, because we've breached the system,
 23 all the nature defences. And the intervention
 24 is quite simple, you sit people up at an angle
 25 so that the bugs have--it's harder for them to

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1 go down and you put them--you don't let the
 2 stomach acid come up and things like that.
 3 We've been running contests across Canada to
 4 see who can get the one-year reward. Don't
 5 have one for a year. I would have said five
 6 years ago it was impossible for an ICU
 7 anywhere in this country to make a one-year
 8 award. We've had about ten of them.
 9 Furthermore, we now are able to show that
 10 people that institute this protocol 100
 11 percent of the time have lower mortality,
 12 adjusted for all the other factors, in their
 13 ICUs.

14 So the answer is, yes, you can change
 15 things but they're small and I just have to go
 16 back and say Lao said you got to start by
 17 walking. I mean, that's where we are.

18 CROSBIE, Q.C.:
 19 Q. Okay. That was a valuable discussion, but it
 20 wasn't actually the question I got on my feet
 21 to ask.

22 DR. NORTON:
 23 Q. I'm sorry.

24 CROSBIE, Q.C.:
 25 Q. The overall theme of today and tomorrow is, of

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1 course, disclosure. And I wonder if you could
 2 relate your remarks about the state of safety,
 3 you didn't put it this way, but I guess you
 4 could say, or what I took out of what you said
 5 is that hospital safety is in a relatively
 6 primitive stage of development, relative to
 7 where we are in other industries such as
 8 aeronautics or even driving our car to work.
 9 And you used the analogy of coal mining 100
 10 years ago, which is kind of a vivid analogy.
 11 Can you relate all that to the role of
 12 disclosure of adverse events, errors,
 13 whatever, the taste these days I think is to
 14 call it adverse events, and make it a little
 15 more concrete? So, for example, in the case
 16 at hand that sparked this symposium and the
 17 Commission of Inquiry, we've learned that
 18 there was an outside reviewer report or
 19 reports into ER/PR pathology testing and there
 20 was a court argument about whether they should
 21 be disclosed to the Commission and the public
 22 and the judge ordered that they should be. I
 23 won't go into the complexities of that. We've
 24 also learned that they were held very closely,
 25 when they were prepared, by the hospital

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1 authorities and I think there were only four
 2 copies given to the hospital. And it's not
 3 clear to my mind, but it may be that there
 4 were only four copies ever, ever made. So, I
 5 know it's a broad topic, but we've just been
 6 told by Sir Winston up there that you can turn
 7 exquisite complexities into exquisite
 8 simplicities. Could I ask you to comment on
 9 disclosure of adverse event and what role that
 10 has and relationship does that have to the
 11 patient safety movement generally and
 12 achieving greater safety?
 13 DR. NORTON:
 14 Q. Yes, I can't speak specifically to the
 15 Newfoundland situation. But many of us
 16 believe that an important--that the journey to
 17 the safer system requires three components.
 18 It requires first leadership and the
 19 leadership must exist at multiple levels from
 20 the leadership at the provincial ministry to
 21 the leadership at a nursing unit. So
 22 leadership is an important component. The
 23 second important component is the one we've
 24 reflected on, evaluation, the ability for us
 25 to understand how our performance is and get

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1 feedback and have mechanisms to act on that
 2 feedback and improve our processes of care.
 3 And the third important component is culture.
 4 And without the three components being aligned
 5 and aligned toward a safer system we probably
 6 won't make the changes we need. And the
 7 culture one is the one that I think is so
 8 critical, and I think that things like
 9 disclosure and--are part of the cultural
 10 dimension that we must move along and improve.
 11 So I look at, from my perspective, the legal
 12 people will have a different cut on this to
 13 some extent, but to my perspective adopting
 14 and implementing and facilitating a disclosure
 15 policy is an important step in developing a
 16 culture of safety which is one of those three
 17 components that goes together to allow us to
 18 accelerate the changes toward a safer system.
 19 MR. CAULFIELD:
 20 Q. Other questions? I see a couple.
 21 MS. NEWBURY:
 22 Q. Just two questions. You had a danger graph
 23 and hospitalization was shown to be in the
 24 dangerous part of that graph. Does that take
 25 into account, you know, the underlying disease

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1 or illness that brought the person to the
 2 hospital?
 3 DR. NORTON:
 4 Q. The underlying illness?
 5 MS. NEWBURY:
 6 Q. Yeah, obviously if someone is going to
 7 hospital, then they have some -
 8 DR. NORTON:
 9 Q. No, I mean, that was my whole point about it,
 10 it was really unfair because I think that I
 11 was comparing hospitals to organizations that
 12 don't deal with things like complex ill
 13 patients. And so it--I do that slide more to
 14 pin to your mind the fact that it will require
 15 a fundamental change to really produce the
 16 next level of safety. And we know to make
 17 those kind of changes it's generational, it
 18 won't happen tomorrow, so we've got to be on
 19 this journey. So that's really what it's
 20 about. And as I said, I think it's unfair to
 21 put hospitals in those comparisons, but people
 22 tend to do it. And I think that we must
 23 reflect as a balance that most of the people
 24 who enter a hospital today, if we didn't have
 25 hospitals, would have very much worse outcomes

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1 than they do with hospitals. Having said
 2 that, there's lots of things we can do better.
 3 We can reduce infection rates, acquired
 4 infection rates, you know. We can make sure
 5 that the clinicians know what their practice
 6 is. There's lots things we can do.
 7 MS. NEWBURY:
 8 Q. A second question that I had, is there any
 9 room for including the patient in the patient
 10 safety movement by, you know, explaining to
 11 them the benefits of having hand washing or
 12 maybe patients if they're not, you know,
 13 unconscious or too ill could help to monitor
 14 drugs, for example, especially when they
 15 return home after hospitalization?
 16 DR. NORTON:
 17 Q. I think that the--it's not going to happen
 18 until we engage patients as active partners.
 19 So my answer, my big answer is yes. And but
 20 there are complex cultural issues involved
 21 with that. And if I could tell a brief story,
 22 I don't know, Tim, can I tell? So we thought
 23 that we--let me talk about NICUS, neonatal
 24 intensive care units. Many of you have had,
 25 been to one of those. The little wee babies

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1 with lots of tubes in them, pretty scary
 2 places. And they're not very safe places.
 3 And one of the places where they have a lot of
 4 trouble and they work really hard on this is
 5 getting the drug doses right for those little
 6 kids because they're very small and they don't
 7 have much tolerance to not having exactly
 8 right, and making sure they're given at the
 9 right time when--because the child has to
 10 clear the drug before the next drug is given.
 11 And it seems to me, it seems to me in my
 12 naivety that putting an extra check in the
 13 drug system would be a useful thing. And so
 14 we, as a pilot, devoted a bunch of clinical
 15 pharmacology time, clinical pharmacists time
 16 to educating the family members to be able to
 17 help the nurses and pharmacists make sure that
 18 the right drug was given to the baby in the
 19 right dose at the right time. And we were
 20 doing this as a pilot, which was one of our
 21 good things we did. And so you can educate
 22 people and they can understand the drugs. And
 23 then we found out that nobody liked it after
 24 they tried it for awhile. And so we did what
 25 good researchers do, we did qualitative

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1 analysis, how come you didn't like this. So,
 2 from the nurses there was--when you could get
 3 them away so they could talk about it, they
 4 felt they were losing some of their
 5 professional--professionalism was being
 6 questioned. And so I would reflect that back
 7 and we've got to train our next generation of
 8 health professionals differently. I mean,
 9 those are embedded cultural beliefs they have.
 10 But for the families the reason they didn't
 11 like it was they weren't sure that there
 12 wouldn't be a bad consequence if they
 13 questioned the nurse or the pharmacist when
 14 they weren't there. Will my child get the
 15 same care when I'm not there. And so it just
 16 struck me that if we naively say we could do
 17 it without talking about the cultural
 18 dimensions and how we fit together the
 19 patients and the system and don't pay
 20 attention to that, we're not going to make
 21 that part of the journey. We have to pay
 22 attention to that. But we have to have the
 23 patients there. The only thing I can think to
 24 make the NICUS safer is have the families as
 25 active partners. One of the things about

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1 being an active partner, to me, is that the
 2 accountability has to change. If you have
 3 more--if you're more active, you have to have
 4 more accountability for what happens. And,
 5 you know, we've lied--well, maybe I should say
 6 I've lied in terms of we'll take care of you,
 7 the health care system, instead of let's work
 8 on your care together. So we've produced a
 9 culture that sort of says to you you don't
 10 have to be part of it, we'll just take care of
 11 it. And that's going to be, that's going to
 12 be a bit of a journey for us. And that's a
 13 long answer, I hope it was okay.
 14 MS. NEWBURY:
 15 Q. Thank you, very much.
 16 MR. CAULFIELD:
 17 Q. Sir?
 18 MR. RITTER:
 19 Q. I have a question about the issue of human
 20 factors. It's something that we've been
 21 struggling with for a very long time and it's
 22 very much, I think, at the core of some of the
 23 issues we're dealing with here in our
 24 province. You were saying that it's not
 25 always appropriate to compare industries, but

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1 in the aviation industry I think there are
 2 some lessons to be learned and I think there's
 3 a reason why we don't have two 747s crashing
 4 every day. And I think one of the reasons is
 5 that there are standards that recognize the
 6 frailties of human error and the risks of
 7 human error. And the standard that I'm
 8 thinking about is the standard where they
 9 establish certain set time frames for how many
 10 consecutive hours you can work, what your
 11 cycle ought to be, you know, what's the
 12 maximum hours you ought to be working within a
 13 given time frame, and I believe that that has
 14 a lot to do with why their risk is so
 15 diminished. I was wondering, of course, in
 16 the health care world it's a difficult
 17 challenge given, you know, the supply and
 18 demand issues and so on and the cost
 19 implications. Do you have any advice or
 20 thoughts about what can be done in the health
 21 care sector in terms of managing the human or
 22 engineering the human error situation with
 23 respect to those kinds of standards?
 24 DR. NORTON:
 25 Q. Yeah, I think Ed's going to speak more to

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1 that. But let me just say that we've seen
 2 some very promising stuff about the fatigue
 3 issue which you raised. The residents and
 4 interns across Canada now do not subject
 5 themselves to what my generation did and
 6 they're not going to go into practice
 7 expecting to have to work that way. And that
 8 was really lead by the anaesthesiologists in
 9 '80s when they said, "Well, if you worked
 10 overnight, you had to go home the next day."
 11 And so we're making progress.
 12 There are other areas where we've made
 13 progress. It is increasingly common in Canada
 14 for surgeons to do time outs prior to surgery
 15 and that's right out of aviation. So what
 16 they do is the team stands there, and
 17 depending how you run it, you say, "Okay,
 18 let's review the operation, let's make sure
 19 the kit's right." This is just like the pilot
 20 walking around the airplane before you start
 21 the flight, I mean, this is common sense. And
 22 they usually say "What can go wrong today?"
 23 The good teams say, "What can go wrong today?"
 24 Let's think of all the things that can go
 25 wrong and are we ready for them."

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1 We're using similar sort of checklist
 2 technology in many of the ICUs in Canada where
 3 during the rounds, I mean, it's complex, lots
 4 of stuff going on, much like--and rapid,
 5 needing rapid response. And so ICU guys are
 6 doing that thing about saying, "Okay, we've
 7 just reviewed Mrs. Smith. What can go wrong
 8 with Mrs. Smith today?" Let's anticipate it
 9 because we know whether it's human or her
 10 biology and physiology something can go wrong
 11 and let's be prepared as far as we can for
 12 it." So we're taking -
 13 And the third thing I should talk about
 14 is the communication. A guy called Mike
 15 Leonard in the States has looked at
 16 communication in the airline industry where
 17 they have special rules about how you talk in
 18 the cockpit and stuff. And we're taking those
 19 down to some of the areas in the hospital.
 20 It's called ESPAR (phonetic), and it's very
 21 interesting. But it's a structured
 22 communication that helps us convey information
 23 quickly when there's a need to get it quickly
 24 conveyed. So structure it more, make it work
 25 better so that we really understand what is

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1 needed at that moment. It isn't probably the
 2 way we should deal with the whole person
 3 medicine when--but if the person's failing and
 4 we need to do something, we need to get the
 5 information around the team quickly, and
 6 that's what that does.
 7 So I think while I say we shouldn't
 8 compare them in a sense, we can learn from
 9 every one of those other industries and we
 10 should.
 11 Don Berwick, who I mentioned briefly,
 12 says "Steal, steal shamelessly and don't let
 13 anybody who owns something that'll make care
 14 safer hold onto it or patent it. Get it out
 15 there, spread it across the country." That's
 16 what we're trying to do with Safer Health Care
 17 Now. The teams talk about things, they share
 18 their forums, they share their ideas.
 19 MR. RITTER:
 20 Q. I guess one of the concerns I have is that you
 21 don't always have the luxury of a time out.
 22 If you've got a team of people that let's say
 23 is inadequate for supply and demand reasons
 24 but the workload is there, are you better off
 25 taking the time out or seeing more patients

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1 than you ought to because, you know, someone's
 2 got to see them and you don't want the wait
 3 times to get any longer than they already are.
 4 So those are the kinds of dilemmas I think we
 5 all face, but they're certainly very much at
 6 play here in our province these days, and I
 7 think we're going to have to wrestle with
 8 those issues.

9 DR. NORTON:
 10 Q. Yeah, I think a lot of those really aren't
 11 issues for the health professionals, they're
 12 issues for society, at least we need society
 13 involved telling us or the citizens telling
 14 us. But there are things we can do. Ed and I
 15 were talking this morning about how the system
 16 rewards failure, almost. So if make something
 17 not work too well, then you have to see the
 18 patient again, so you get another fee. What
 19 other industry would tolerate that? Think
 20 about that for awhile.

21 MR. CAULFIELD:
 22 Q. One more question, perhaps? Yes, please.

23 DR. KEARNEY:
 24 Q. Just a comment. Just we are at the university
 25 here and there's 20 projects across Canada

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1 promoting interprofessional collaborative
 2 patient-centred practice, so that is happening
 3 at the education level. And there is evidence
 4 emerging that when there are professionals
 5 working in teams that not only know about each
 6 other's scope of practice but really respect
 7 that and allow all members of the team to
 8 practice the full scope that there is better
 9 quality care, less risk, less liability
 10 concerns. The Conference Board of Canada just
 11 said that. The Canadian Protective Medical
 12 Society just came out and said that, as well.
 13 But, and this is not a reflection on the
 14 speakers this morning, but when we continue to
 15 say medical care and the doctor who admitted
 16 the patient and the resident who took the
 17 history, then we're still falling back on the
 18 old way that we used to practice or that we
 19 are still practising but we need to move
 20 forward to talk about full scope of practice
 21 so that other members of the team can have
 22 equal, as appropriate, care for the patient
 23 and role in the system.

24 DR. NORTON:
 25 Q. Yeah, I agree with you. But the reality of

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1 2000 when the study occurred was that it
 2 wasn't that way. I would point out that David
 3 Bates, who is at Harvard Brigham and Women's,
 4 has shown that the single cheapest
 5 intervention to produce improved quality and
 6 safety in an internal medical ward is to put a
 7 clinical pharmacist on as a full-time team
 8 member and to empower that person to
 9 essentially manage the drugs. So there's an
 10 example of moving away from the physician who,
 11 you know, gets 20 hours of training on drugs
 12 to someone who gets four years of training. I
 13 mean, it just makes sense, right. And it
 14 isn't like we don't--we have enough docs or
 15 enough nurses or enough anything. We don't
 16 have enough anything, so let's put the right
 17 people in the right jobs and make the team
 18 work as a team. I agree.

19 MR. CAULFIELD:
 20 Q. Okay. I can see we have lots to talk about
 21 today and I see that you guys aren't shy for
 22 asking questions, which is wonderful. After
 23 our break we'll be moving into focus more on
 24 disclosure, a point that was made by one of
 25 our--one of the questions. And that really

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1 will be much of the focus.
 2 I want to make sure, can everyone hear?
 3 I know there's some problems with people who
 4 are--any problems hearing, everyone? No,
 5 okay. So all the speakers please speak
 6 clearly into the microphones so everyone at
 7 the back can hear clearly.

8 I said at the beginning that we had a
 9 wonderful faculty and I think you can see
 10 already the tremendous knowledge base that we
 11 have in the room. So let's exploit it over
 12 the next day and a half and let's thank again
 13 our panel.
 14 So let's meet back at quarter to.
 15 Thanks.

16 (RECESS)

17 MR. CAULFIELD:
 18 Q. We'll now begin the next session and we'll
 19 have two speakers. And this one is called
 20 "Medical errors and the providers disclosure
 21 obligation." Now, we're going to start with
 22 Ed Etchells. You've already heard him speak a
 23 little bit. He is an internist from the
 24 Sunnybrook Health Science Centre in Toronto.
 25 So he's a clinician, he does have a practice,

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1 but he's also been extremely involved in
 2 patient safety. He's published, again,
 3 published in the area. And as I understand
 4 it, he also do a lot with information
 5 management, which obviously is very relevant
 6 to the discussions that we are having here
 7 today and tomorrow. So Ed, I turn things over
 8 to you.

9 DR. ETHELLES:
 10 Q. Thank you and good morning. I was honoured
 11 when Tim asked me to speak with you today, but
 12 I felt that he had made perhaps an error in
 13 sending the e-mail because I felt I probably
 14 wasn't qualified to speak with you. I'm an
 15 internist at Sunnybrook. All of my work is
 16 related to the in-patient care of mostly
 17 elderly patients with medical problems and
 18 really my expertise is in medication error.
 19 But Tim reassured me that I was a reasonable
 20 choice for the job, so I spent the last few
 21 months convincing myself that he was correct.
 22 And I think I want to start by saying
 23 that although I'm going to be talking about
 24 medication errors, what I hope to leave you
 25 with is a way to improve the system beyond

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1 just medications. I want you to know that,
 2 you know, myself and my family, we've all
 3 experienced illnesses, we know how important
 4 it is to feel trust in the health care system.
 5 We know that when there are errors, that they
 6 cause wounds that take a long time to heal.
 7 So with that introduction, I'm going to start.
 8 I'm going to talk about two cases. These
 9 are real cases. The first is a patient who
 10 got too much Morphine. Morphine, as you know,
 11 is a narcotic. If you get too much, it slows
 12 your breathing down or stops your breathing
 13 and is quite a dangerous medication if given
 14 in excess. And in the second case a patient
 15 who is in the midst of a medical emergency,
 16 the intern was giving the patient medications
 17 through the intravenous line but the
 18 medications kept leaking all over the bed
 19 leading to some delays in the patient getting
 20 their medication.
 21 What I'm going to do is try and give you
 22 an approach to improving safety and I'm going
 23 to bring that approach back to how we've
 24 looked at these two cases and made what I
 25 think were useful improvements.

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1 So whenever there's an error that either
 2 caused harm or may cause harm to a patient,
 3 there are really four steps in the management.
 4 The first is you have to take care of the
 5 patient and do whatever you can to make them
 6 better immediately. I'm not going to get into
 7 those details today. Second, which is part of
 8 my job, is to figure out what happened. And
 9 third, reduce chances of it happening again.
 10 I'm going to spend much more time on item
 11 three and less time on item two, although I'd
 12 be happy to get into that in the discussion.
 13 And the fourth point is telling the patient
 14 and the family what happened and what you're
 15 doing. Also extremely important, part of what
 16 we're here about, here to talk about today.
 17 I'm not going to talk about in any deal in
 18 this specific presentation, but three other
 19 speakers today and one other speaker tomorrow
 20 are going to be talking about those details.
 21 And again, I'll be happy to discuss it in the
 22 discussion.
 23 So I'm going to focus on what can we do
 24 to prevent these sorts of things from
 25 happening again. That is the core activity of

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1 the patient safety movement learned from the
 2 past to improve the future.
 3 So in my presentation I'm going to try
 4 and accomplish three things. First, I'm going
 5 to outline the three steps to improving
 6 patient safety. That will take me a couple of
 7 slides. Next I'm going to explain the systems
 8 approach to patient safety, which is really
 9 the philosophic and scientific cornerstone to
 10 the patient safety movement. And finally, I'm
 11 going to demonstrate a few safety change
 12 principles. These are things that are proven
 13 concepts from other industries that can
 14 reliably improve safety.
 15 So I'm going to start by telling you what
 16 the three steps to safety are. So the first
 17 step is really a philosophic one, which is you
 18 have to believe in what I'm going to call the
 19 Swiss cheese model, and I'm going to explain
 20 what that means and I'm going to refer to it
 21 many times in this presentation. And I hope
 22 at the end that you too will believe it in. I
 23 believe in it. And if you don't believe in
 24 it, it's very hard to make patient safety
 25 improvements.

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1 If you believe in the Swiss Cheese model,
 2 obviously the analogy is that there are holes
 3 in the system, so then the next step is to
 4 study those holes. You have to understand why
 5 they're there before you can fill them. And
 6 that's step three.

7 So I'm going to just step to the side
 8 here. You can read at the back? All right.

9 Okay, so this is the Swiss cheese model.
 10 The concept here is that in health care, in
 11 other industries, there are layers of defences
 12 and each layer is imperfect and has holes in
 13 it. For example, in the context of the
 14 patient who got too much Morphine, we would
 15 often conceptualize that the last safety layer
 16 in a patient in the hospital in getting a
 17 medicine would be the nurse because the nurse
 18 is generally who administers medications. So
 19 we might conceptualize this last layer of the
 20 Swiss cheese model as the nurse, and nurses
 21 are imperfect and may make errors. We might
 22 consider this to be a pharmacist, we might
 23 consider this to be a doctor, we might
 24 consider this to be a ward manager and so on
 25 and so forth. The number of layers of cheese

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1 in health care is countless. This is just a
 2 simplified model.

3 Now in the discussion we heard last time
 4 prior to the break, you might actually re-
 5 conceptualize this and say the last layer is
 6 the patient. A well-informed patient who
 7 feels empowered to speak up and ask questions
 8 might be a very effective safety mechanism but
 9 still might be imperfect and might not ask the
 10 right questions or might be unable to defend
 11 themselves.

12 So the concept here is that each layer
 13 has weaknesses. Most of the time the
 14 weaknesses or the holes don't cause any
 15 trouble. So here is an arrow, that represents
 16 an error that just didn't cause any trouble.
 17 We know from very good studies of medication
 18 errors that there have to be 100 medication
 19 errors in hospitalized patients before one of
 20 those errors causes harm. So we get away with
 21 it 99 times out of 100, which is why
 22 individuals tend not to react to errors,
 23 because they tend not to cause harm. In one's
 24 personal experience, you don't see it as a big
 25 problem until it happens to you or one of your

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1 patients.

2 The concept here, this arrow is awful
 3 close to the patient but a vigilant nurse who
 4 happened to double check something caught it
 5 just before it got to the patient. That's
 6 what we call a near miss, and that's something
 7 that Peter alluded to in his talk. So we know
 8 again from very good medication literature
 9 that there are seven near misses and these are
 10 situations where patients were very close to
 11 being harmed, but they weren't harmed just
 12 because of good luck or random vigilance,
 13 someone just happened to catch it today, but
 14 tomorrow could well have been a different
 15 story. There are seven of those for every one
 16 preventable harm caused by drugs.

17 That's the Swiss cheese model. The
 18 concept is that there are many errors in the
 19 system. We only pay attention when they all
 20 line up. We have to start paying attention to
 21 the situations where they don't line up. We
 22 have to start filling these holes so that
 23 patients can't be harmed. If we only focus
 24 our attention at the last layer of cheese,
 25 that mistake that the nurse might have made or

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1 that the pharmacist might have made or that
 2 the doctor may have made, we're not going to
 3 improve the system. We have to systematically
 4 look at every hole, pick the biggest ones,
 5 pick the most dangerous ones, and hammer away
 6 at those.

7 Oh, I don't have to walk over there,
 8 okay. All right. So now I've outlined the
 9 three steps to safety and I've told you what
 10 the systems approach is--the Swiss cheese
 11 model is. I'm going to extend the Swiss
 12 cheese approach to the systems approach.

13 So this is the key philosophic slide in
 14 my presentation and I'm going to back it up
 15 with one study that's referenced because I
 16 think it's really important to show you that
 17 this isn't just philosophic. So the systems
 18 approach is as follows: Preventable adverse
 19 events. That means harms caused to patients
 20 by errors. Whoops, I didn't do that. Are
 21 caused by interactions between two things:
 22 unavoidably imperfect humans and flaws in the
 23 working environment or the working system. So
 24 in the Swiss cheese model the unavoidably
 25 imperfect humans are represented by certain

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1 layers of cheese with holes in them, but the
 2 imperfectly designed system represents many
 3 other layers with many other holes. If we
 4 focus only on the unavoidably imperfect
 5 humans, we're not going to get very far.
 6 I think I just said that, so I'm not
 7 going to say it again. To make patients
 8 safer, to reduce adverse events we have to
 9 build a system that does one of two things,
 10 either reduces error, so even though humans
 11 are unavoidably imperfect, there are things we
 12 can do to reduce human error. For example, we
 13 know that interns who work 85 hours a week are
 14 six times more likely to make serious
 15 diagnostic errors than interns who work 64
 16 hours a week, therefore I would rather be
 17 taken care of by a 64 hour per week intern and
 18 so would you. We need to fix that.
 19 Second, we can never eliminate error
 20 because humans, the very things that make us
 21 creative people who can make brilliant
 22 diagnoses, come up with brilliant treatments,
 23 be very caring at the bedside are the same
 24 things that make us prone to random slips and
 25 lapses. So we will never eliminate error,

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1 rather we need to build a system that prevents
 2 those errors from causing harm.
 3 I actually don't mind making medication
 4 errors. I only mind if they hurt my patients.
 5 Which is why it's much nicer to be a doctor
 6 than it is to be a nurse or a pharmacist
 7 because there are very good studies to show
 8 that doctors make just as many mistakes as
 9 nurses, the only difference is that our
 10 mistakes get caught by nurses and pharmacists,
 11 whereas nurses mistakes don't because there's
 12 no systematic double check in place for nurses
 13 like there is for doctors. So let's build the
 14 systematic double checks in so that any errors
 15 that are left over can't hurt patients.
 16 Now, if we just focus on the unavoidably
 17 imperfect humans using the name, blame and
 18 shame approach, that means Etchells, you made
 19 a mistake, you gave too much Morphine, you
 20 need to be either educated, disciplined or
 21 punished, depending on whether we like you or
 22 not, that will not make things better for
 23 patients. All it will change is that next
 24 week we'll have the same set of holes, same
 25 layers of Swiss cheese that are imperfect and

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1 the same events will happen again, there'll
 2 just be different patients and different
 3 health care personnel involved next time.
 4 Now, this isn't just random musing, so I
 5 think it's very important to present this
 6 study to you. This is a study that was
 7 published about 13 years ago in the Journal of
 8 the American Medical Association. This is a
 9 prospective study of 264 preventable adverse
 10 drug events or close calls, near misses,
 11 situations where the patient experienced a
 12 medication error that could easily have caused
 13 harm even though in that particular case harm
 14 was avoided. So what they did in this study
 15 is systematically looked at those events and
 16 looked for the errors that lead to those
 17 events. They identified 334 obvious human
 18 errors and then tried to pin it on a person or
 19 a team and they were unable to do it. These
 20 were 334 random cognitive human failures that
 21 lead to harm to patients. We need to build a
 22 system that traps those errors rather than
 23 just focusing on the 334 people who made those
 24 mistakes. If we just focused on the people,
 25 we would have 334 people either in classes or

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1 undergoing discipline. We'd have to get
 2 another 334 people in to work and they'd
 3 experience exactly the same problems.
 4 Now the doctor--I don't know why this
 5 keeps advancing, but okay. That's a
 6 systematic error, which I can't fix right now,
 7 although it has happened before.
 8 The doctor who did this work repeated
 9 this work in the paediatric setting and found
 10 exactly the same result.
 11 And I think it's important to say that
 12 there was an exception where there was a
 13 physician who had notoriously bad handwriting
 14 and this did lead to several errors related to
 15 dosing in paediatrics and so the appropriate
 16 response in that case was to focus on that
 17 physician's individual performance. So I'm
 18 not saying that it's a mindless blinkered
 19 approach where personal accountability is
 20 completely thrown to the window, but rather,
 21 the most important thing is to focus on
 22 systematic improvements rather than individual
 23 errors.
 24 And I think I just said that, but I'm
 25 going to say it again. I want to reemphasize

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1 that this is not a message that is saying let
 2 us throw personal responsibility out the
 3 window, but it is rather saying let us
 4 reemphasize the focus away from individual
 5 performance, because we know it is flawed, and
 6 rather shift our focus to system. We're
 7 really only interested in making sure patients
 8 get highly reliable safe care. That's the
 9 goal, that's what we want to do and the way to
 10 do it is to embrace the systems approach.
 11 There are certain situations where the best
 12 response is to focus on individuals, but
 13 that's only right probably one to five percent
 14 of the time.
 15 So what I'm going to do now is talk to
 16 you a little--I'm going to go back to the
 17 Swiss cheese model, I'm going to go back to
 18 the two case that I presented at the beginning
 19 and show you some of the holes in this Swiss
 20 cheese that we found and then how we tried to
 21 fill them.
 22 So just to remind you, the first case was
 23 a patient who got too much Morphine. And
 24 again, we wanted to go to the staff, and they
 25 need to believe that when you come and say,

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1 "What happened"?" that they're not going to
 2 get in trouble for an honest mistake. It's a
 3 key cultural issue which by the systems
 4 approach is not just a scientific issue, it's
 5 a philosophic and cultural issue. If people
 6 don't believe that you're coming to ask them
 7 what happened in order to make improvements,
 8 they're not going to want to talk to you. So,
 9 you know, we try and send this message at
 10 Sunnybrook, the system focus is what we're
 11 interested in so that people are more willing
 12 to talk to us about preventing future similar
 13 events.
 14 So the patient got too much Morphine.
 15 Obviously the nurse--actually, what happened
 16 was the nurse took the wrong drug out of the
 17 carton and brought it to the doctor, the
 18 doctor was treating the patient at the bedside
 19 in a medical emergency, didn't double check
 20 the dose, and the patient got the wrong dose.
 21 So it would be easy to just focus on those two
 22 holes. We wanted to look a little bit
 23 further.
 24 And this is what we found when we looked
 25 in the narcotic drawer. So just so you know,

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1 narcotics have to be kept in a special cabinet
 2 on units in locked drawers because narcotics
 3 are controlled substances. So nurses carry
 4 the lock--sorry, the key to the lock. When
 5 you open the drawer, this is what you see, a
 6 whole bunch of different narcotics stored in
 7 there. Now, there are many problems with this
 8 drawer, which I won't bore you with, but you
 9 can see that it's rather full and it would be
 10 very hard to know what you were selecting if
 11 you tried to get anything from this side.
 12 In this case they were looking for
 13 Morphine ten or Morphine two. Those are
 14 actually pretty good labels, but unfortunately
 15 the nurse picked this one which had been torn.
 16 And this is what she got out. And I'm just
 17 going to ask you--I'm just going to tell you
 18 that one of these is a two milligram per
 19 millilitre dose and the other is a ten
 20 milligram per millilitre dose and they are
 21 virtually identical. They're not identical,
 22 but they are virtually identical. And the
 23 nurse believed that she had pulled out a two
 24 and once you've made that substitution error,
 25 you're doomed, you're never going to catch it.

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1 And this was not enough of a signal to catch
 2 it. I don't think I brought pictures of the
 3 vials, but they're, you can see, you can't
 4 even see what the dose is. You'd have to be
 5 very astute to see a two there and a ten right
 6 there, which I can't see, so you probably
 7 can't, either. So that's a hole that we
 8 thought needed to be fixed. It was
 9 systematic. If we let that go, then next week
 10 it's going to be a different nurse, different
 11 doctor, same problem.
 12 Now, I would also add that if I had to
 13 have ten milligrams of Morphine or two
 14 milligrams of Morphine be given to me, I would
 15 want that nurse to give it to me because that
 16 nurse is going to be the most expert nurse on
 17 the choosing between two and ten milligrams of
 18 Morphine in the hospital. So there's no point
 19 in punishing her, we need to punish the
 20 drawer. All right.
 21 Now, so I'll get back to how we fix that
 22 in a second. But I just--the purpose of that
 23 is to show you why you need to look beyond the
 24 human holes, into the system holes.
 25 Okay, now the next case as a patient who

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1 was getting medications and they leaked all
 2 over the bed as they were trying to squirt the
 3 medicines into the intravenous port.
 4 So what happened here is the intern told
 5 me that he thought that the syringes were not
 6 working properly. And so, and the nurse also
 7 had concerns. Without boring you with the
 8 details, as they were going to attend the
 9 patient, they went to pick up some syringes to
 10 give the patient the medications. So this is
 11 the--where the syringes are stored. And the
 12 intern told me that he didn't know which ones
 13 to pick, so he just grabbed a whole bunch and
 14 kind of threw them on the table to see what he
 15 had. If you read them carefully, there are
 16 bar codes there and there are some labels
 17 there. I can tell you they're virtually--they
 18 provide no useful information about what
 19 you're getting. So this is what the intern
 20 picked up. They don't really--they don't give
 21 a useful signal. And what the intern then did
 22 is he just turned it over and he said, "You
 23 know what, I need to give this patient some
 24 medicine. I need to draw the medicine up with
 25 a needle first and then take the needle off

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1 and hook it up to the intravenous and inject
 2 it into the patient, so I'm going to pick this
 3 one because this is a syringe with a needle
 4 already attached." Perfectly logical.
 5 Probably what I would have done, too.
 6 Unfortunately, it was the wrong thing to do
 7 because if you read, this is the same product,
 8 if you read it very carefully it says, "BD
 9 integra syringe with retractable precision-
 10 glide needle" and in the small print it's for
 11 subcutaneous and intramuscular injection only.
 12 It actually isn't compatible with the
 13 intravenous ports. All the other ones are,
 14 that one isn't. So that was the hole there,
 15 all right.
 16 So what I'm trying to take you through is
 17 we believe the Swiss cheese model. We talked
 18 to these people. We allowed them to give us
 19 information which helped us understand what
 20 the holes really were.
 21 And again, that intern is now an expert
 22 in syringes and needles at the hospital. He
 23 could probably teach a course on it. There's
 24 no point in getting mad at him.
 25 All right. So the next issue is filling

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1 holes. And I think one of the questions in
 2 the--before the break was related to human
 3 factors. Human factors to me means something
 4 slightly different. There's a whole
 5 discipline of reliable design of work
 6 environments, sometimes called ergonomics,
 7 sometimes called human factor science. Part
 8 of human factor science is the frailties of
 9 the human mind, like fatigue, lack of
 10 caffeine, something I'm suffering from right
 11 now, but also many other disciplines as well.
 12 And really, in my opinion human factors
 13 science is really the way to fill holes
 14 smartly. So the idea is to work smarter, not
 15 to work harder. Don't create new holes as you
 16 fill old ones. I call that moving cheese. So
 17 it doesn't make sense to tell someone to work
 18 harder in one area, because it means by
 19 definition they are not working harder in some
 20 other area. You've now created a different
 21 hole, you're going to have a different adverse
 22 event next time. The other analogy is that's
 23 swatting mosquitos instead of draining the
 24 swamp, okay.
 25 So the game here is to fill holes without

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1 creating new ones. Obviously more resources
 2 would be nice. And I'm not against more
 3 resources, but you still need to use those
 4 resources wisely and efficiently whether you
 5 have a small amount of resources or a larger
 6 amount and human factor science is the way to
 7 do that.
 8 So let's go back to the cases again.
 9 What did we do? So, human factors design
 10 concept number one is hazard removal. You
 11 can't pick something up that isn't there. So
 12 the real question is not why did the nurse
 13 pick up the ten milligram instead of the two,
 14 the question is why is the ten milligram there
 15 to be picked up at all. Now, on some units
 16 there's actually a very good reason to do
 17 that. If I worked on C-3, which is our
 18 oncology unit where patients are getting very
 19 high doses of narcotics, they use this dose
 20 regularly and that needs to be there. On our
 21 unit, which is mostly frail patients, the
 22 average age is over 80, they're not used to
 23 getting these sorts of drugs, they rarely
 24 would get that dose. And in fact, we looked
 25 at the use of that dose over the preceding two

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1 months and found that it had only been used
 2 once. So we said the best way to prevent this
 3 from happening again is to get rid of it, so
 4 we took it out. It is impossible for a nurse
 5 to pick up ten milligrams by mistake on our
 6 unit any more because it's not there. Now, if
 7 you really need it, you have to ask for it.
 8 That doesn't happen very often.

9 We also did some work redesigning the
 10 drawers. This all basic human factors
 11 concepts. We've grouped them into logical
 12 areas. So these are all intravenous, these
 13 are all short-acting pills, these pink labels
 14 tell you that they're long-acting drugs, you
 15 only need to take them one or two times a day
 16 and you should never crush them, and a bunch
 17 of other things. Note that we didn't add any
 18 new labels because that just tends to create
 19 confusion because people invariably put them
 20 in the wrong drawer. We've taken a lot of
 21 other products out that people weren't using
 22 and they were just getting in the way. And we
 23 proved that not only did this probably make
 24 patients safer, but it actually made it faster
 25 for the nurses to do their day-to-day work, so

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1 it had an efficiency gain, as well.

2 We also let ISMP Canada know. This is
 3 the same group that runs the Canadian
 4 Medication Incident Reporting Program. They
 5 sent out an alert a couple of years ago now.

6 I got to take this slide out because it
 7 tells you how old my case is, but it's such a
 8 good case.

9 And they actually, the company was
 10 excellent and redesigned the packaging within
 11 three months. It was completely redesigned
 12 and quite distinct. So that was a good story.

13 Okay, second case, the patient who got
 14 the wrong medicine. Same concept. Here's the
 15 nasty syringes. Why are they there? First
 16 question is always why are they there. And
 17 the answer is they're there because that's--
 18 because, because the people bring it up from
 19 stores and that's where they put it. There's
 20 no compelling logical reason for it, it's just
 21 the way things are. It's just a hole that was
 22 created for no good reason. So we got rid of
 23 them. That was easy.

24 Of course, you have to--they are there
 25 for a reason and they're there for nurses to

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1 give subcutaneous intramuscular injections, so
 2 we said, well, where do the nurses do that
 3 work? And we turned our eyes over there and
 4 the nurses told us that, "Well, actually, we
 5 do all that work over about eight, ten feet
 6 from there at our medication cart."
 7 Just to orient you again, this is where
 8 the narcotics are that I showed you
 9 previously. This is where all the syringes
 10 are kept, and this is where all the patients'
 11 drugs are kept. And the nurse will take the
 12 drug out of there, put it up there and they
 13 need a syringe. So actually they were wasting
 14 time walking backwards eight feet to go and
 15 get a syringe when really it needed to be on
 16 the drawer, so we just put it there and now
 17 all -

18 The major intervention that was really
 19 required was talking to the guys who brings
 20 the stores up from downstairs. Turns out, no
 21 one ever talked to that guy. He was actually
 22 quite interested in the whole case and now he
 23 is one of our biggest converts. He's gone
 24 around to all the other people he works with
 25 telling them that they need to be more careful

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1 and talk to their nurses and doctors and
 2 pharmacists about where things are stored.
 3 And so even though technically it's not quite
 4 within union rules, because you're not
 5 supposed to--they're not allowed to put things
 6 anywhere else, he never puts them on the cart
 7 and he comes to a nurse and says, "Where would
 8 you like these to be put?" and the nurse shows
 9 him where to put them. So excellent example
 10 of interdisciplinary teamwork that was also a
 11 key topic.

12 All right. So I think I'm finished. And
 13 my main message is that the role of safety
 14 improvement is to prevent things from
 15 happening again, and the way to do that is to
 16 believe the Swiss cheese model, to study the
 17 holes and to fill the holes using human
 18 factors science.

19 And Tim isn't even standing up yet, so
 20 that's good because this is my last slide.

21 So I hope that I've outlined the three
 22 steps to safety. Swiss cheese approach,
 23 understand the holes and fill the holes. I've
 24 explained the systems approach to safety,
 25 which is a shifting of focus away from

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1 individual error to system-induced error while
 2 still maintaining an appropriate balance for
 3 individual responsibility. And I hope I've
 4 just given you a flavour for the important
 5 discipline of human factors science. Thank
 6 you, very much for inviting me today.

7 MR. CAULFIELD:
 8 Q. That was wonderful, Ed. We've now had two,
 9 two talks that sort of set the foundation, the
 10 clinical foundation. We started very broadly.
 11 Ed gave us a little bit more of a narrow,
 12 narrow focus on the clinical experience and
 13 the kinds of things that can be done in the
 14 clinical setting. Do we have any questions?
 15 Just a couple short ones for Ed before we move
 16 on?

17 MR. CROSBIE:
 18 Q. It's axiomatic that our health care systems
 19 and hospitals are resource constrained and
 20 time constrained. I'm just wondering how--who
 21 made the time to, because it took some time,
 22 I'm not sure how much time, to think about the
 23 problem and make these relative obvious, at
 24 least in hindsight, changes? Because
 25 physicians often are on fee for service, they

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1 don't think they're getting paid to do that.
 2 In your institution, at least, how did that
 3 work?

4 DR. ETCHELLS:
 5 Q. Yeah, so Sunnybrook in 2002 funded something,
 6 it was originally called the "Error Management
 7 Unit" but I suggested that wasn't the best
 8 title for it, but we now call it "The Patient
 9 Safety Service". It's a hospital-funded
 10 program staffed by physician and nurse, a
 11 pharmacist and closely allied with our quality
 12 program. And essentially we do this kind of
 13 work, but we are a dedicated resource. Our
 14 time, our professional time is dedicated
 15 towards this and we have other duties. And I
 16 think it doesn't happen easily on its own, it
 17 does require time, effort, communication,
 18 patience.

19 MR. CAULFIELD:
 20 Q. It was suggested to me that when people ask a
 21 question, perhaps say their name and say where
 22 they're from, if they'd like, unless they want
 23 to stay anonymous and also please remember to
 24 speak clearly and into a microphone. And
 25 perhaps one more question for Ed before we

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1 move on? No? Okay, excellent. Thanks again.
 2 Now the next speaker is going to now move
 3 us into a legal analysis, talk about the legal
 4 norms. And we're going to start with a
 5 discussion about the basic legal norms as they
 6 relate to obligations of health care providers
 7 in the context of disclosure, which of course
 8 is very, very relevant to what's happened here
 9 in Newfoundland and with the subject matter of
 10 the Inquiry. So we are moving a little bit
 11 more into specifics. And Gerald Robertson, a
 12 colleague, a very good, close friend, a mentor
 13 from the University of Alberta is in an ideal
 14 situation to provide this opening into the
 15 legal realm. Gerald is again, a renowned
 16 health law expert, internationally renowned
 17 and author of many relevant publications. So
 18 I'll turn it over to my friend, Gerald
 19 Robertson.

20 ROBERTSON, Q.C.:
 21 Q. Thank you, Tim. As you can see, the focus of
 22 my presentation is the legal duty of
 23 disclosure, and specifically the physician's
 24 duty of disclosure. If a physician makes a
 25 mistake which harms the patient or which has

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1 the potential to harm the patient, does the
 2 physician have a legal duty to disclose that
 3 fact to the patient?

4 I think a number of themes will become
 5 clear during my presentation, and the first is
 6 that the legal duty of disclosure is well
 7 established, beyond question, but secondly, a
 8 number of aspects of that duty, its precise
 9 scope are not clear and await further
 10 clarification. I think it's also important to
 11 point out that this is an area which has seen
 12 a lot of activity, a lot of developments in
 13 recent years and there is every reason to
 14 expect that that pace of development will
 15 continue. This is very much a hot area from a
 16 legal point of view and other points of view,
 17 as well.

18 Let's start with the duty and the well-
 19 established duty. It is well established that
 20 if a doctor makes a mistake which causes harm
 21 to the patient or has the potential to cause
 22 harm, the physician has a legal duty to
 23 disclose that fact to the patient. As I said
 24 at the outset, that is well established,
 25 beyond question, that that legal duty is

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1 imposed on the physician.
 2 These are some of the cases which
 3 establish that legal principle. As you can
 4 see, the first case to establish it is an
 5 Ontario case, Stames and Davies, a decision of
 6 Mr. Justice Creever involving a case in which
 7 a physician performing a lung biopsy punctured
 8 the patient's spleen, did not reveal that to
 9 the patient, simply said that the biopsy
 10 results were not what he had expected because
 11 we didn't get what we wanted. The patient
 12 said, "Well, what did you get?" The physician
 13 said, "Something else," but did not
 14 specifically explain to the patient that he
 15 had biopsied the spleen and not the lung.
 16 Justice Creever held not only was the
 17 physician negligent in puncturing the spleen,
 18 but the physician was also negligent in
 19 failing to disclose that fact to the patient.
 20 As you can see from the list there, a
 21 number of cases involving surgeons performing
 22 the wrong operation, so performing the
 23 operation on the wrong disc. Again, a duty to
 24 disclose that fact to the patient.
 25 The Vasdani case, second on the list, is

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1 a particularly important case because of the
 2 physician's reasons for non-disclosure. In
 3 Vasdani the surgeon operated on the wrong part
 4 of the back, did not realize his mistake, but
 5 discovered that fact one year later. By then
 6 the patient was no longer the doctor's
 7 patient. The patient had moved on to the care
 8 of another physician. And for that reason the
 9 doctor decided not to disclose that fact to
 10 the patient. And the Ontario court held that
 11 that was no excuse. The fact that the patient
 12 is no longer your patient by the time you
 13 discover the error is no justification for
 14 keeping silent.
 15 The Quebec case of Kiley and Nikkel
 16 involving a pathologist there, patient who was
 17 mistakenly diagnosed with breast cancer
 18 because of a pathologist's error. The
 19 pathologist discovered the error and informed
 20 the surgeon who said, "I will let the patient
 21 know," but didn't, and six years elapsed
 22 before the patient was finally told that she
 23 did not have breast cancer. The surgeon again
 24 was held to have been negligent in failing to
 25 disclose that fact to the patient.

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1 The last case, the most recent, Shobridge
 2 and Thomas, retention of abdominal roll during
 3 surgery. The surgeon discovers that fact,
 4 again, fails to disclose to the patient. The
 5 court held the doctor was negligent in failing
 6 to disclose that to the patient.
 7 These, along with several other cases,
 8 make it beyond question that there is a legal
 9 duty of disclosure imposed on physicians.
 10 Why? Why does the law impose a duty of
 11 disclosure on physicians? Generally speaking,
 12 civil law and particular law of tort does not
 13 require confession. For example, if I'm
 14 playing baseball in my back yard with my son
 15 and I hit the ball over the fence and it goes
 16 through my neighbour's window, the law does
 17 not require me to go to my neighbour and say
 18 it was me. Even if my neighbour comes to me
 19 and asks, I have no legal duty to tell him.
 20 So in order to impose a duty of
 21 disclosure there has to be some principal
 22 basis for making the exception to the general
 23 rule that there is no duty of confession or
 24 disclosure. And these are the three, or at
 25 least the first two, the two basis that have

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1 been used by our courts to justify imposing a
 2 duty of disclosure on physicians.
 3 The first is the concept of informed
 4 consent, the patient's right to know. And
 5 that may seem odd to use informed consent,
 6 which we tend to think of as something which
 7 arises before the treatment is performed. How
 8 can informed consent be a principal basis for
 9 saying that after the treatment is performed
 10 the physician has a duty of disclosure if
 11 something goes wrong in the course of that
 12 treatment? And the justification and the
 13 reasoning, I think, is cogent, and that is if
 14 the patient has a fundamental right to be told
 15 what may go wrong with a treatment, then
 16 surely the patient has an equal right to be
 17 told what, in fact, has gone wrong in the
 18 course of the treatment.
 19 The informed consent basis was the one
 20 that was used initially by courts to justify
 21 duty of disclosure, but then courts started to
 22 talk more in terms of fiduciary duty. The
 23 physician/patient relationship is a
 24 relationship of utmost faith, it's a fiduciary
 25 relationship and according to several courts

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1 that fiduciary relationship brings with it an
 2 obligation of disclosure if the physician has
 3 made an error.

4 The third basis that I've put on that
 5 slide is not one that courts have yet used,
 6 but I think there is reason to believe that
 7 they will begin to use it, and that is the
 8 ordinary duty of care which a physician owes a
 9 patient. Physicians must act with reasonable
 10 care, a physician must act as a reasonable
 11 physician would do in similar circumstances.
 12 Because disclosure has now become the norm,
 13 both in terms of the legal duty of disclosure
 14 and more and more now in terms of hospitals
 15 protocols, disclosure has become the norm,
 16 it's what reasonable physicians are expected
 17 to do and therefore we might conclude simply
 18 as a matter of the ordinary duty of care which
 19 a physician owes the patient to act as a
 20 reasonable physician would do in similar
 21 circumstances, that includes disclosing error
 22 to patients.

23 Let me talk briefly about the legal
 24 consequence of not disclosing, what legal
 25 consequences may flow from failure to

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1 disclose. And by that I don't mean if the
 2 patient does not obtain necessary treatment.
 3 That's obviously one of the most serious
 4 consequences of failing to disclose. If the
 5 patient, because of the error, requires
 6 additional treatment and is not told about
 7 that, then clearly damages could be awarded
 8 for the failure to obtain treatment. But
 9 aside from that, some of the things that the
 10 courts have talked about in terms of the legal
 11 consequences are first of all, damages for the
 12 anxiety and stress in not knowing the truth.
 13 So, for example, the Quebec case that I
 14 mentioned, the pathologist's error, the
 15 patient who thinks she has breast cancer and
 16 suffers great anxiety over the course of six
 17 years worrying that the cancer may come back
 18 when all along she doesn't is entitled to
 19 damages for that needless distress and
 20 anxiety. But linked to that, aggravated
 21 damages associated with knowing that your
 22 doctor was not truthful.

23 In some of the cases the last one that I
 24 mentioned, the Shobridge case, the patient
 25 there received damages for the distress that

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1 she claimed to have suffered when she realized
 2 the truth and when she realized that the
 3 physician whom she trusted had not been
 4 truthful with her.

5 Some cases have even gone as far as to
 6 award punitive damages. It's fair to point
 7 out that those cases involved more than simply
 8 failing to disclose where a physician takes
 9 active steps to cover up the mistake and to
 10 try and insure that the patient does not find
 11 out. For example, altering the hospital chart
 12 as in one case or in telling nurses to keep
 13 quiet and not to chart what, in fact,
 14 happened, steps, active steps like that may
 15 result in punitive damages.

16 The last point is the question of
 17 fraudulent concealment which is related to the
 18 running of the limitation period. Failure to
 19 disclose has been held to be fraudulent
 20 concealment for purposes of spawning the
 21 running of the limitation period.

22 Let me add one other item to that list,
 23 the legal consequences of non-disclosure, and
 24 that is increasing your chances of being sued.
 25 There are many barriers to disclosure, there

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1 are many reasons why physicians and others do
 2 not disclose even although there is a legal
 3 and an ethical duty to do so, and one of the
 4 reasons that is often cited for failure to
 5 disclose is fear of being sued. If I tell the
 6 patient what has happened, is that not simply
 7 inviting them to sue? Whereas the literature
 8 indicates the exact opposite, that failure to
 9 disclose increases the chances of being sued.
 10 Open and candid disclosure, far from inviting
 11 lawsuits, according to the literature, tends
 12 to diminish the chance of being sued.

13 Let me move on to some of the areas that
 14 are not clear. I mentioned at the start that
 15 the existence of the duty is clear, but many
 16 of its aspects are not so clear. And this is
 17 the first area that's not clear, when does the
 18 duty arise specifically? Does it apply or
 19 does it arise only in cases of harm? The
 20 Canadian Medical Association Code of Ethics
 21 talks about a disclosure in cases of harm and
 22 so also do the Canadian Patient Safety
 23 Institute guidelines which came into being
 24 earlier this year, it too talks about harm.

25 What about cases of future harm or

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1 potential future harm, cases where harm may
 2 arise in the future? I put a quote there from
 3 the CPSI Canadian Disclosure Guidelines, "The
 4 need to disclose when there is no immediate
 5 harm but the potential for harm exists is
 6 influenced by the future likelihood of severe
 7 consequences, the severity of possible
 8 consequences and the potential to prevent,
 9 identify or mitigate future harm through
 10 clinical testing or treatment. When uncertain
 11 of whether harm has occurred, it is
 12 recommended that disclosure take place."
 13 What about cases of possible harm where
 14 you're not sure of whether the patient has
 15 suffered harm or, indeed, whether they will
 16 suffer harm but there is the possibility that
 17 that has happened? There are cases on that
 18 and the Pittman case is perhaps the best
 19 example where a patient may have been
 20 transfused with HIV contaminated blood. In
 21 fact, he had been, but the physician and the
 22 hospital did not know that for certain, but
 23 they knew that there was a possibility that
 24 that had happened. And according to the court
 25 that created a duty of disclosure, a duty to

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1 inform the patient that there was a distinct
 2 possibility that he had received HIV
 3 contaminated blood.
 4 Indeed, depending on how you define harm
 5 it's possible to say that the cases say there
 6 is a duty to disclose even in the absence of
 7 harm. These two cases both involving the
 8 patient whose surgeon operated on the wrong
 9 part of the back. As I say, depending on how
 10 you define harm, could you say that these
 11 cases the patient wasn't harmed, they just had
 12 the wrong operation which didn't improve their
 13 condition, but did they suffer harm? Some
 14 might suggest no, but, yet, in both these
 15 cases the court said there was a duty to
 16 disclose that fact to the patient. And the
 17 justification for that, and this is very
 18 important, is the idea of the, one of the
 19 basis for the duty of disclosure may be linked
 20 to the idea of informed consent, the patient's
 21 right to know. And if that is the basis of
 22 the duty of disclosure, then our cases tell us
 23 that when you ask what has to be disclosed,
 24 you ask the question what would a reasonable
 25 patient want to know. And if this is

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1 something which a reasonable patient in these
 2 circumstances would want to know, then there
 3 is a duty to disclose it. And that may go
 4 beyond cases of actual harm or even potential
 5 harm, it may indeed even include cases of near
 6 misses. If a reasonable patient in these
 7 circumstances would want to be told what
 8 happened, then arguably there is a duty to
 9 disclose it.
 10 The timing of disclosure, again, is
 11 something that's not entirely clear, although
 12 the cases do indicate that we're talking about
 13 immediate disclosure. The BC case, Shobridge,
 14 talks about disclosure as soon as reasonably
 15 practicable and the Canadian Patient Safety
 16 Institute refer to disclosure at the earliest
 17 practical opportunity and preferably within
 18 one or two days after discovery of the adverse
 19 event.
 20 What has to be disclosed? The cases are
 21 fairly clear that disclosure, that a legal
 22 duty of disclosure is a disclosure of fact.
 23 There is no duty to disclose opinions, there
 24 is certainly no duty to disclose that it was
 25 your fault. And indeed, the guidelines, most

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1 of the protocols say that fault should not be
 2 used, the term "blame" the term "fault" should
 3 not be used. This is not a disclosure of
 4 fault, it's a disclosure of fact.
 5 Some of the cases also say there is no
 6 obligation to disclose evidence. It's facts,
 7 not evidence. But where you draw the line
 8 between fact and evidence is perhaps less
 9 clear.
 10 Who has this duty? Well, first of all,
 11 the cases make clear that it is a delegable
 12 duty. A physician does not necessarily have
 13 to disclose this information personally. A
 14 physician has to take reasonable steps to
 15 ensure that it is disclosed, but doesn't
 16 necessarily have to do so personally. One
 17 area where the law is not clear is whether
 18 other individuals aside from the physician
 19 also have a duty of disclosure. The Shobridge
 20 case, the BC case in which the patient, an
 21 abdominal roll was left inside the patient, in
 22 that case the court held that the nurses, who
 23 were well aware of what had happened, had no
 24 obligation to disclose that fact to the
 25 patient. And this arises in two settings,

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1 it's really dealing with two questions here.
 2 The first is, if someone other than a
 3 physician, such as a nurse, makes an error, do
 4 they have a duty to disclose that fact to the
 5 patient? And second, if other individuals are
 6 aware that the physician is not disclosing to
 7 the patient, do those other individuals then
 8 come under a duty to disclose? As I say, the
 9 only case that touches on that suggests there
 10 is no duty on other individuals. This is a
 11 physician's duty only. I would think that is
 12 unlikely to remain the law. There is every
 13 reason to believe that as we continue to
 14 emphasize the team approach to health care
 15 there is every reason to expect that our
 16 courts will begin to say this is not an
 17 individual duty imposed only on the physician.
 18 This is a duty that is imposed on other
 19 members of the health care team and, indeed,
 20 the institution itself.
 21 That's the conclusion that I put in the
 22 last paragraph of my paper. Canadian courts
 23 have taken a very expansive and very broad
 24 interpretation of the patient's right to
 25 informed consent and the physicians' duty,

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1 fiduciary duty. And both of these, as I've
 2 explained, underlie the duty of disclosure.
 3 For that reason there is a reason to expect
 4 that as our courts revisit this area, that
 5 they will broaden the duty of disclosure both
 6 in terms of when it arises, in terms of what
 7 has to be disclosed, and perhaps most
 8 importantly of all, in terms of who had this
 9 duty. So far our courts have focused very
 10 much on the physician, have seen the
 11 physician, as it were, as the captain of the
 12 ship who has this duty and they alone have
 13 that duty. That is unlikely to remain, in my
 14 opinion that is unlikely to remain the state
 15 of the law for very much longer. Other
 16 individuals clearly should have this duty of
 17 disclosure, including the institutions, as
 18 well as other individual health care members.
 19 I'm going to stop there, but I would
 20 welcome any questions that you may have.
 21 MR. CAULFIELD:
 22 Q. Excellent. Thank you, very much, Gerald. So
 23 now we're getting to the heart of things.
 24 Does anyone want to start with a question?
 25 Comment? If not, I have a starter question

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1 for Gerald. Gerald, I wonder if you could
 2 comment on apology legislation a little more
 3 fully? It's something that you hear a lot
 4 about and it's something that Newfoundland
 5 does not have. Some jurisdictions do and some
 6 jurisdictions are considering it. I wonder if
 7 you could talk a little bit about the
 8 justifications behind it, the presumptions
 9 behind it, and perhaps the role it plays in a
 10 medical/legal setting? And then I'm also
 11 curious what both our other panel members
 12 think about apology legislation. So, Gerald?
 13 ROBERTSON, Q.C.:
 14 Q. Okay. Three provinces, BC, Manitoba and
 15 Saskatchewan have all introduced apology
 16 legislation. It applies not only in the
 17 health care context, but in all context, and
 18 briefly it says that the fact of an apology is
 19 not an admission of liability, nor can it be
 20 introduced into evidence as an admission of
 21 liability. I think the reasons why that
 22 legislation was introduced are very important
 23 and I think they relate to what I said earlier
 24 about the misconception that many people have
 25 that if I disclose, then I will be sued, and

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1 likewise, many people have felt that if they
 2 apologize, they run the risk of that apology
 3 being used in evidence against them. There is
 4 no evidence of that happening. There is no
 5 case that I'm aware of where an apology has
 6 ever been used as evidence of an admission of
 7 liability against the health care profession,
 8 yet clearly there is that perception that it
 9 might be, hence, those provinces have
 10 introduced apology legislation and many other
 11 provinces are actively considering doing
 12 likewise.
 13 ROBERTSON, Q.C.:
 14 Q. Ed, for you?
 15 DR. ETCHELLES:
 16 Q. Yeah, I think the issue of apology is
 17 important. If you read the Globe and Mail
 18 about a month ago when the Canadian Patient
 19 Safety Institute disclosure guidelines were
 20 released and the headline said something along
 21 the lines of, "Guidelines fall short of
 22 requiring doctors to say they're sorry," or
 23 something along those lines, I think it's
 24 because people aren't clear on what they're
 25 saying sorry about, so you know, in some cases

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1 you're just saying sorry that the patient is
 2 sick, not doing well. And why would you ever
 3 have any question about saying that? Of
 4 course you're sorry. That's not what you're
 5 all about. You want the patient to be getting
 6 better. So I always tell people you should
 7 always say that because you are sorry because
 8 they're not doing well. If there's clearly a
 9 mistake in care, that's where the--the issue
 10 is around disclosing mistakes, so the first
 11 step is figuring out whether--you have to
 12 decide whether there's been a mistake or not.
 13 And I'll be frank with you, sometimes it's not
 14 so clear and there's judgment involved. If
 15 you're not sure that there's been a mistake,
 16 you shouldn't apologize for a mistake, but if
 17 it's obvious that there's a mistake, I mean, I
 18 don't understand the issue of the wrong site
 19 surgery, to me that's an obvious mistake and
 20 there's no two ways about it. You should
 21 apologize because there's just no two ways
 22 about it. In other complex things where it's
 23 not clear whether there's a mistake that's
 24 been made, all I can say is you're sorry for
 25 the patient's current condition. For example,

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1 the patient developed an infection in the
 2 hospital, it's not clear whether that was
 3 related to a mistake or not, but you're
 4 certainly sorry the patient is sick and has an
 5 infection and you should say so.
 6 MR. CAULFIELD:
 7 Q. Peter?
 8 DR. NORTON:
 9 Q. We train our residents very aggressively to
 10 say they're sorry when these things happen and
 11 often focusing on we're sorry your mother is
 12 sicker, because we are sorry and we hurt. We
 13 did some very interesting work with panels of
 14 Albertans asking them about how complaint and
 15 the system dealt with complaints and injuries
 16 and it is striking to look at transcripts
 17 about the amount of pain that we cause when we
 18 don't say we're sorry, and long-term
 19 psychological effects. I think we have to say
 20 we're sorry, because we are, so it's just
 21 being honest about our own thing, and that
 22 helps people. This is horrible for families
 23 and patients and this is a step to help them
 24 heal.
 25 DR. HEBERT:

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1 Q. Philip Hebert from Toronto. A related
 2 question. How--what do you think about the
 3 right of hospitals or physicians or programs
 4 to look back analysis and find mistakes in
 5 quality of care and there's some jurisdictions
 6 which have prevented those from legal
 7 discovery, from taking part in? So this is
 8 going beyond the apology, this is when you're
 9 actually doing a look-back program, finding
 10 mistakes in quality of care, you want to
 11 inform patients about that. Do we have any
 12 reassurance that that's not an area of legal
 13 jeopardy for physicians and their
 14 institutions?
 15 UNKNOWN SPEAKER:
 16 Q. You do first.
 17 UNKNOWN SPEAKER:
 18 Q. That was a legal question.
 19 ROBERTSON, Q.C.:
 20 Q. A legal question so I'll give it a legal
 21 answer.
 22 DR. ETCHELLS:
 23 Q. By the way, he's a speaker this afternoon, so
 24 you can get back at him.
 25 ROBERTSON, Q.C.:

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1 Q. That's not fair.
 2 UNKNOWN SPEAKER:
 3 Q. (Inaudible).
 4 ROBERTSON, Q.C.:
 5 Q. I know Bernard Dickens will be touching on the
 6 institutional obligation. But if we were to
 7 say that the institution has an obligation of
 8 disclosure, then you're right, we then have to
 9 deal with the issue what happens to look-back
 10 programs, quality assurance programs where
 11 institutions discover that errors have been
 12 made. How do you deal with that? Do you say
 13 that there is a duty of disclosure in those
 14 circumstances or do you protect that with the
 15 same protection that's given to quality
 16 assurance? I'm sure Dr. Dickens will be
 17 dealing with that when he speaks this
 18 afternoon.
 19 DR. NORTON:
 20 Q. Phil will remember this. During the work for
 21 the adverse events study, of course, we had to
 22 deal with this. We went through 40 ethics
 23 reviews across the country to carry that study
 24 out. And we were seriously concerned about
 25 not the fact we'd find adverse events, but we

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1 might find cases where there was clear
 2 liability in a health care professional. And
 3 the ethics committees were very worried about
 4 that. And you may know that in most
 5 jurisdictions health professionals who know
 6 someone else was liable are required to report
 7 that to the regulatory college. And we spent
 8 a long time talking to the ethics group about
 9 how to handle it. What was finally done to do
 10 the study was to establish a panel, a wise
 11 panel, at arm's length from the researchers
 12 who would, if a health professional became
 13 aware of a case where they thought there had
 14 been serious impropriety by a health
 15 professional, one of our reviewers could
 16 contact that panel. The procedure was roughly
 17 if a reviewer saw something that was
 18 disturbing and they thought they should report
 19 it but weren't sure, they reported it to the
 20 provincial site coordinator who was an MD in
 21 all case. If they couldn't make a decision,
 22 it was referred to the study team who would
 23 refer it to this panel. The panel consisted
 24 of an eminent legal, medical/legal person and
 25 eminent clinician and a public advocate. We

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1 only had one case that was sent forward and
 2 they dealt with it effectively. But that
 3 handled the ethical considerations about
 4 trying to do this look-back kind of work. It
 5 is very important, as we talked earlier, that
 6 we can do it so that we can learn from things,
 7 but we have to protect--it's a complex issue,
 8 I think, is what I would say, Bernard and
 9 Gerald.

10 MR. CAULFIELD:
 11 Q. I have a question, I don't want to jump in if
 12 there's one that is pending. But I'm curious
 13 about the perceptions that--I know there's a
 14 lot of health care providers here. The
 15 perception that the health care providers
 16 themselves have about their obligation in the
 17 context of disclosure. I'm not aware of any
 18 empirical research and I'm curious if the
 19 panel members are, of their own perception of
 20 disclosure. My own experience working with
 21 health care providers is perhaps there is a
 22 lack of clarity out there. So my question, I
 23 guess, would be, and I'm curious what the
 24 audience thinks, the health care providers out
 25 there that experience this day to day, what

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1 they--how they perceive their own obligations
 2 and if there is some work to be done on
 3 explaining those obligations and I guess the
 4 specific question is, is there any empirical
 5 research about those perceptions?
 6 DR. ETCHELLS:
 7 Q. I can start. I mean, I think, I don't think
 8 there's a lot of debate about the requirement
 9 to disclose adverse events. I think the grey
 10 area falls into disclosing potential for harm
 11 events or close calls, because that does
 12 require judgment and that judgment will be
 13 biased by your own view on the case, so I
 14 think that's one place where people struggle.
 15 Once a decision has been made that disclosure
 16 should occur, I think the hard parts are, you
 17 know, who should be doing it, how should it be
 18 done, where should it be done, when it should
 19 be done, those are really tough decisions. I
 20 think the hardest is the who should be
 21 involved. If we're going to embrace this
 22 systems approach and this team approach to
 23 patient safety on one hand, which I think is
 24 the only way to go, yet on the other hand
 25 we're hearing--I appreciate that you modified

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1 your comments to say it's going to change, but
 2 right now it seems to be the physicians' duty
 3 to disclose. I have a problem with that. It
 4 doesn't really mesh with the systems approach
 5 at all. I think, you know, from a hospital
 6 point of view we have to figure out a way to
 7 present the hospital as taking responsibility
 8 for its performance along with the front-care
 9 providers. I don't think we've figured out
 10 how to do that perfectly at Sunnybrook, but
 11 we're trying. It doesn't make sense to me to
 12 just leave it to the physician who probably
 13 doesn't even understand all the holes. How
 14 could you possibly know that? The analogy to
 15 me is asking the Air Canada clerk why your
 16 luggage got lost. How is that -
 17 UNKNOWN SPEAKER:
 18 Q. Do that all the time.
 19 DR. ETCHELLS:
 20 Q. - person possibly going to know? But the
 21 mechanism by which that occurred and the way
 22 to prevent it from happening in the future is
 23 something that person couldn't possibly
 24 answer. So you know, the physician's job may
 25 be to initiate the process, but there's a

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1 whole subsequent process of investigation,
 2 iterative communication with the family, this
 3 is what we've learned over the last few weeks.
 4 It takes a lot of time and a lot of effort
 5 that requires active management, it requires
 6 commitment of resources and people with
 7 expertise in these really delicate
 8 communication matters. I know the University
 9 of Michigan in US has done a very good job not
 10 just with the proactive disclosure but really
 11 committing resources and expertise to doing
 12 this well and their experience was written up
 13 in the New England Journal of Medicine two
 14 years ago. Interestingly, a co-authored
 15 article by Barack Obama and Hilary Clinton,
 16 which is the only article that I think they've
 17 ever written together.
 18 MR. CAULFIELD:
 19 Q. They're not going to be doing a lot together,
 20 I don't think, in the near future.
 21 DR. ETCHELLS:
 22 Q. Yeah. So it's worth a read. But it was
 23 around their health care tort reform
 24 legislation which didn't go anywhere in the
 25 United States. So I think there's a problem

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1 with the entire process of disclosure. It's
 2 not just the doctors saying they're sorry and
 3 you're sick, there's a lot more to it than
 4 that, and I don't think that's being worked
 5 out.
 6 MR. CAULFIELD:
 7 Q. Gerald.
 8 ROBERTSON, Q.C.:
 9 Q. I was just going to add, I think it's
 10 understandable why the law has developed the
 11 way it has. The duty has to be imposed on
 12 some entity. I think it's understandable that
 13 that entity would be seen to be the physician
 14 initially. And so I don't find it surprising
 15 that the law so far as focused on the
 16 physician as being the one who has the duty of
 17 disclosure. But equally, as I said in my
 18 comments, there is every reason to believe
 19 that the next logical step is to say that that
 20 duty is not the physician's duty alone, it is
 21 an institutional duty.
 22 DR. ETCHELLS:
 23 Q. Can I have one other comment? In Ontario I
 24 believe as of July 1st of this year all
 25 Ontario hospitals will be required to

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1 demonstrate that they have a process in place
 2 for disclosing what are called critical
 3 incidents, which I would think are just really
 4 bad adverse events, under the Public Hospitals
 5 Act, which is the act that allows you to
 6 continue to keep your hospital open and it's--
 7 so it's a pretty important act and CEOs and
 8 VPs pay very close attention to it. So I
 9 suspect over the next year a lot of Ontario
 10 hospitals will be fretting over this and
 11 developing procedures to really manage this
 12 properly, which is a good thing.
 13 UNKNOWN SPEAKER:
 14 Q. Do you have a comment to make?
 15 DR. NORTON:
 16 Q. You asked for some evidence. In the study
 17 that Baker and I did that ended up with the
 18 2002 report that I discussed, one of the
 19 things we asked was about the health
 20 professionals was about disclosure. We had
 21 hypothesized that the fear of litigation was a
 22 major deterrent and it appears in the
 23 qualitative data that it is a deterrent.
 24 However -
 25 MR. CAULFIELD:

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1 Q. It is?
 2 DR. NORTON:
 3 Q. It is. However, there is a much bigger
 4 deterrent and that is losing your standing in
 5 the profession. The health professionals are
 6 more worried about not being a nurse, not
 7 accepted as a nurse, a therapist, a pharmacist
 8 after they have disclosed an error. And the
 9 pain that physicians carry and nurses carry
 10 and pharmacists carry from these things is
 11 immense. And we have been very, very poor as
 12 health professions at helping our colleagues
 13 find places where they can discuss this and
 14 express it. And there aren't that many health
 15 professionals, so we must take care of them.
 16 We carry out some very interesting--well, I
 17 have to go back a bit. A colleague I met from
 18 South Africa talked about using traditional
 19 healing circles to help people discuss, health
 20 professional discuss their experience with
 21 this. And we, using Blackfoot techniques,
 22 have carried those out with health care
 23 learners in Alberta. So healing circles have
 24 some rules that you can only speak when you
 25 hold the totem. In the Blackfoot case, of

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1 course, it's an eagle feather. That there is
 2 a facilitator essentially who makes sure that
 3 it passes. And it's astounding--and
 4 furthermore, everything that's said in the
 5 circle, stays in the circle. So there's some
 6 rules that we put on. It's astounding the
 7 anger and the pain that health, young health
 8 care professionals in their training
 9 experience because of being close to these.
 10 So we have some things to do about that with
 11 disclosure. A final thing I should tell you
 12 is work we've done in Alberta through the
 13 Health Quality Council asking both physicians
 14 and--well, first asking the public who do they
 15 want to disclose. There's no question, they
 16 want docs, they don't want anyone else at the
 17 present time.

18 MR. CAULFIELD:
 19 Q. They want doctors?
 20 DR. NORTON:
 21 Q. Doctors, doctors, doctors. "What if it was a
 22 pharmacy error?" "I want the doctor to tell
 23 me." That is consistent. These are focus
 24 group work. It just, it's true, at the moment
 25 in Alberta. So as you were saying, there's

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1 some distance, I think, to go. The second
 2 thing is when we ask patients, citizens, what
 3 they want disclosed, they want everything
 4 disclosed. Harm is not--if they got two
 5 Tylenol tablets and there was one ordered,
 6 they want know about it.

7 MR. CAULFIELD:
 8 Q. I think that's, the last points are
 9 interesting. I hope we can come back to that
 10 because I think that that, the perceptions of
 11 what need to be disclosed, I think, and again,
 12 it's something that's very relevant to the
 13 Inquiry. We had a question here. And perhaps
 14 your name and where you're from?

15 MR. SIMMONS:
 16 Q. Sure. My name is Dan Simmons. I'm one of the
 17 lawyers involved in the Commission of Inquiry
 18 here. And I do have a question about the
 19 timing of disclosure, when the obligation
 20 arises. The presentation deals pretty
 21 directly with what the obligations are once
 22 it's known that an adverse event has occurred.
 23 But you can have a situation where a suspicion
 24 has arisen that there may be an adverse event
 25 and there's going to be some opportunity to

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1 investigate or take some steps to determine
 2 if, in fact, there has been an adverse event
 3 involving a patient. And I'm wondering if
 4 there's any guidance or if you have any
 5 comments on what the nature of the disclosure
 6 obligations may be in that circumstance?
 7 ROBERTSON, Q.C.:
 8 Q. I can't give you any guidance in terms of what
 9 the case law says because as far as I'm aware,
 10 it doesn't deal with that specific issue, what
 11 if you suspect that there may have been an
 12 error but want to take steps to inquire
 13 further. My own view is that if that
 14 determination can be made quickly, then I
 15 would see it as justifiable to delay
 16 disclosure pending that determination so when
 17 the disclosure is made, it can be made more
 18 fully and on a more informed basis. But
 19 again, I emphasize, if that determination can
 20 be made quickly. And if it cannot, if it's
 21 going to be involve a period of time to make
 22 that determination, then my own view is that
 23 there could well be situations where the
 24 people who may have been affected would want
 25 to know that they may have been affected and

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1 that steps are being taken to determine
 2 whether they have been affected by an adverse-
 3 -again, I go back to this idea that if we take
 4 our guidance from would a reasonable person
 5 want to be told that, would a reasonable
 6 person in these circumstances want to be told
 7 that there is the possibility that an adverse
 8 event has occurred, we are taking steps to
 9 determine if one has occurred and, if so, who
 10 may have been affected, would a reasonable
 11 patient want to be told that. I think there
 12 are circumstances where you might well
 13 conclude a reasonable patient would want to
 14 know about the possibility of an adverse event
 15 having occurred.

16 MR. CAULFIELD:
 17 Q. We have a couple of questions over here. Do
 18 you mind if he goes first, sir?
 19 DR. GALLAGHER:
 20 Q. Tom Gallagher from University of Washington.
 21 I just wanted to circle back to this issue of
 22 evidence and what we know about health care
 23 workers' attitudes. And there are actually
 24 several good sources of information about
 25 health care workers' attitudes about

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1 disclosure, including Canadian health care
 2 workers. I was pleased to work with Wendy
 3 Levinson, who is chair of medicine at the
 4 University of Toronto, on a survey of a few
 5 thousand physicians in both the US and in
 6 Canada asking about their attitudes about
 7 disclosure and how they would respond to a
 8 variety of disclosure situations. So there is
 9 that large data set that does support that
 10 health care workers and physicians, in
 11 particular, really endorse the concept of
 12 disclosure but struggle with its
 13 implementation. We did a second study where
 14 we watched surgeons disclose errors to
 15 standardized patients and analyze those tapes
 16 qualitatively. And then Sherry Espin, who is
 17 one of the other presenters, has done some
 18 really nice work watching and talking with
 19 operating room teams about disclosure. So
 20 there are several sources of empiric evidence
 21 available about health care workers in Canada
 22 and their attitudes about disclosure.

23 MR. CAULFIELD:
 24 Q. Thanks, Tom.
 25 MR. RITTER:

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1 Q. I have a couple of observations and questions.
 2 The first one, what I could gather from the
 3 presentation today and from some of the
 4 material that I'd had a chance to read in
 5 advance of the meeting is that a lot of the
 6 work in disclosure from a legal perspective,
 7 from an ethical perspective is in many respects
 8 still maybe not in its infancy, but certainly
 9 in its adolescence and hasn't quite matured
 10 yet. And as much as we have--we look to you
 11 for answers you also have presented us with
 12 still many outstanding questions. And I guess
 13 the observation or question I would ask is,
 14 you know, with the sort of the revolution on
 15 privacy that's boomed in the last number of
 16 years, we've created a new discipline called,
 17 you know, privacy and you have privacy
 18 directors and privacy managers. I'm just
 19 wondering, I'm thinking, you know, in terms--
 20 I'm trying to empathize with the physicians
 21 who are busy enough as it is trying to be
 22 clinical people and do clinical work. You
 23 know, these questions that we're asking
 24 without very clear, precise guidelines, you
 25 know, are not easy questions to answer, and

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1 I'm sure that often times physicians find
 2 themselves very conflicted. And I wonder
 3 whether hospitals now are considering or
 4 whether you're recommending the creation of
 5 disclosure consultants where people can turn
 6 or physicians or nurses or anyone can turn and
 7 say, "Here's my situation. How do I deal with
 8 it?" The second observation I just wanted to
 9 make, if I may raise the issue of aviation
 10 once again, my son is an airline pilot so I
 11 get into this stuff, but the issue of near
 12 misses and the need to disclose close calls
 13 and near misses, my understanding is, and I
 14 think I'm right, that in aeronautics when
 15 they'd have near misses, they investigate them
 16 but they don't necessarily publicize them, and
 17 I think for obvious reasons. And I would be a
 18 little concerned in the area of close calls
 19 and near misses--I agree totally that they'd
 20 need to be investigated. The amount of work
 21 and the potential alarm that that could create
 22 I think really needs to be examined carefully
 23 because it may well do more harm than good.
 24 That's just an observation open for debate.
 25 DR. ETCHELLS:

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1 Q. I'll speak to the second point. Around--it's
 2 really an issue of the threshold for
 3 disclosure and we've struggled with this. I
 4 think the right answer is asking yourself
 5 first whether the error reached the patient,
 6 and we've defined reached in two ways. Either
 7 the patient actually received care that was
 8 unintended, for example, they got the wrong
 9 medicine, it might just be a laxative that
 10 probably causes no harm, but we feel because
 11 it entered the patient's body, they actually
 12 received it, they should be told, and not
 13 speculating whether it may cause harm or not.
 14 We just think that's being truthful. The
 15 second form of reach the patient is if they
 16 did not get something that was intended. So
 17 if a medication was ordered but not given, we
 18 also feel the patient should be told that.
 19 Obviously harm is speculative there; it
 20 depends on what wasn't give. But we think
 21 they should know and then it gives you an
 22 opportunity to tell the patient what care is
 23 intended and they have an opportunity to speak
 24 up if things aren't happening correctly the
 25 next day, so it has some advantages. Moving

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1 backwards then, if it's an error that's
 2 visible but did not reach the patient, I just
 3 think it's kind of polite and silly not to
 4 comment on it. So I've had situations where
 5 we've gone in the room and we've been about to
 6 do something and then we've said, you know
 7 what, this is the wrong person or it's just
 8 the wrong thing or we're in the wrong place.
 9 You might as well just apologize and move on.
 10 Even though there is no--there might be some
 11 psychologic harm from that and you should
 12 assume that there is. But then all other
 13 things we feel there's no real value in
 14 disclosing to the patient and it would
 15 probably cause more harm than good, so errors
 16 that do not reach patients, that are not
 17 visible to patients, it's our job to fix them,
 18 but not necessary to disclose them. It's not
 19 the patient's job to worry about them. And
 20 that's kind of how we've drawn the line.
 21 MR. CAULFIELD:
 22 Q. And I want to clarify, so you're saying if
 23 it's an error that reaches the patient, the
 24 default is disclosure?
 25 DR. ETCHELLS:

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1 Q. Absolutely.
 2 MR. CAULFIELD:
 3 Q. Regardless of whether it necessarily has harm
 4 -
 5 DR. ETCHELLS:
 6 Q. Because you don't know, you can't--it's so
 7 speculative whether harm could occur.
 8 MR. CAULFIELD:
 9 Q. Yeah.
 10 DR. ETCHELLS:
 11 Q. Plus it's just polite.
 12 MR. CAULFIELD:
 13 Q. Gerald, I don't know if you wanted to comment
 14 on that in the context of the legal obligation
 15 and would a reasonable patient want to know
 16 being (unintelligible).
 17 ROBERTSON, Q.C.:
 18 Q. Well, as the questioner pointed out, there's
 19 certainly very good reason for internal
 20 disclosure of a near miss, for purposes of
 21 investigation, to minimize the chance of it
 22 happening again. But in terms of whether
 23 there is a legal duty to disclose to the
 24 patient they almost suffered harm, personally
 25 I doubt it. Because, you know, even if we, as

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1 I've said many times, even if we look to the
 2 hypothetical reasonable patient to answer that
 3 question, is this something that a reasonable
 4 patient would want to know, as has been
 5 pointed out, studies tell us that patients
 6 want to have a great deal of information, so
 7 it might well be that most people would want
 8 to know about the near miss that almost
 9 reached them. That doesn't necessarily mean
 10 that the law should impose that duty. You
 11 know, if we move out of the health care
 12 context and look at the obligations that the
 13 law imposes on the legal profession, lawyers
 14 equally have a well established ethical and
 15 legal duty to inform their clients if they've
 16 made a mistake that has the potential to cause
 17 harm, financial harm to the patient (sic).
 18 But I think it's pretty farfetched to say that
 19 if I almost forget to file the statement of
 20 claim before the limitation period expires and
 21 at that last minute I remember I haven't filed
 22 it and so I run off to the courthouse and just
 23 in time I file it, I think it's pretty
 24 farfetched to say I have an obligation to tell
 25 my client that I almost missed the limitation

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1 period. They might be interested in knowing
 2 that, but to say that the law imposes that
 3 duty on me as a lawyer I think is a bit
 4 farfetched.
 5 MR. CAULFIELD:
 6 Q. You can tell all the lawyers in the audience
 7 because they're laughing, because they've all
 8 experienced that.
 9 ROBERTSON, Q.C.:
 10 Q. So why isn't it farfetched to say that, you
 11 know, a physician has a duty to disclose near
 12 misses?
 13 DR. NORTON:
 14 Q. The issue of what to investigate, which you
 15 brought up, is a critical one. The academics
 16 who are now thinking about the adverse event
 17 rate that you find by the method I described,
 18 which is retrospective chart audit, structured
 19 retrospective chart audit, would probably
 20 today say that finds approximately a quarter
 21 to a third of the adverse events. So that
 22 means in Canada one in four, one in three
 23 patients are having an adverse event. Most of
 24 those are rather minor. It may be as the case
 25 where Ed said, they got the laxative by

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1 mistake and they have diarrhoea so they have a
 2 one-day extended health care episode at the
 3 hospital. We can't afford too many of those
 4 given the stressed resources, though. So
 5 there's a lot. And if you add near misses to
 6 that, you end up with rooms full of reports.
 7 And so we need to define strategies, develop
 8 and use strategies to sort out the ones that
 9 give us the maximum benefit. So it's clear if
 10 it's something to do with the product, if the
 11 amount of harm, and I don't just mean personal
 12 harm, it can be system-based harm, times the
 13 frequency, that should indicate when we
 14 investigate and start patching the holes. And
 15 we haven't done a lot of work in that area
 16 yet.
 17 MR. CAULFIELD:
 18 Q. Um-hm.
 19 DR. NORTON:
 20 Q. We tend to spend a lot of time on the big
 21 events and not very much on the small grinding
 22 things, which may in the end have a bigger
 23 impact on the health of the population. So I
 24 think it's a very interesting question that I
 25 don't think we know how to handle at the

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1 moment.
 2 DR. ETCHELLS:
 3 Q. Can I just jump in on the -
 4 MR. CAULFIELD:
 5 Q. Please, please.
 6 DR. ETCHELLS:
 7 Q. We've spent years trying to get people to
 8 agree on the definition of near miss, and I
 9 gave up, precisely because of these sorts of
 10 discussions. I actually try not to use the
 11 term any more and I go back to error that
 12 reached patient and caused harm, error that
 13 reached patient but did not cause obvious
 14 harm, error that was visible to the patient
 15 but did not reach them. I actually find it
 16 makes the conversation more clear in terms of
 17 disclosure and investigation because I can't
 18 anyone to agree what a near miss is. To me
 19 any time a patient gets the wrong medication,
 20 doesn't matter whether it's a laxative or a
 21 beta blocker or insulin, like, something's not
 22 working. Thank God it was a laxative because
 23 then they're probably not going--they're going
 24 to be okay, but why did that happen is really
 25 the big issue, so but it reached the patient,

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1 so they should be informed. If the nurse
 2 picked up the laxative in the cart, said,
 3 "This isn't for Mr. Jones," that's an error
 4 that did not reach the patient, but certainly
 5 had the potential to cause harm and some
 6 people call it a near miss. I don't care what
 7 you call it, but it's an error that did not
 8 reach the patient, so it does not require
 9 disclosure; had the potential to cause harm to
 10 the patient, therefore it requires
 11 investigation. I don't know if anyone's come
 12 up with a better definition for near miss.
 13 Love to hear it.
 14 MR. CAULFIELD:
 15 Q. Did you have a comment, Peter?
 16 DR. ETCHELLS:
 17 Q. It just drives me crazy.
 18 DR. NORTON:
 19 Q. I just had Ed reminded me of one other thing,
 20 and that's in this discussion we need to
 21 clearly differentiate three things. There's
 22 first of all the obligation of the health
 23 professionals to tell each other and tell
 24 their organization that something's happened.
 25 MR. CAULFIELD:

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1 Q. Um-hm.
 2 DR. NORTON:
 3 Q. That's an obligation. And I don't--maybe
 4 Bernard can say what the law says about these.
 5 Then there's the obligation to tell the
 6 patient's family that something has happened.
 7 But thirdly, and I haven't heard any
 8 discussion yet, there's also the obligation, I
 9 think, maybe not be legal, it's certain moral,
 10 of the organization to inform this is at large
 11 what happened. And if we don't sort of
 12 separate those out, we sometimes get confused
 13 about what we're talking about here. We
 14 worked very hard in Calgary to try to separate
 15 those and have a different track, understand
 16 the timing and the level of detail that's
 17 needed in each of those disclosure activities.
 18 But they are separate and I think that we need
 19 to think about them. I don't know if you -
 20 MR. CAULFIELD:
 21 Q. Daryl.
 22 DR. PULLMAN:
 23 Q. Daryl Pullman from Memorial. It's clear that
 24 this is an evolving environment in terms of
 25 disclosure and, you know, a more open

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1 environment that's developing here and we're
 2 still trying to work out, you know, what needs
 3 to be disclosed, when and how much and so
 4 forth. But it goes back again to the earlier
 5 question that I asked around, you know, these
 6 diagnostic labs and so forth where we know
 7 around certain kinds of tests and so forth
 8 that there's an error rate of, you know,
 9 significant error rates in certain respects.
 10 And so when--I mean, you can tell that to a
 11 patient when they're going for a test, say,
 12 "Well, you know, nine times out of ten this is
 13 okay, but, you know, sometimes it's a false
 14 positive." Patients tend not to hear that
 15 kind of thing. Their expectation is that
 16 their result is going to be correct. I'm just
 17 curious about from both a legal and a sort of
 18 clinical perspective where our duty comes in
 19 in that respect, do we just tell people up
 20 front and then it's their responsibility to
 21 follow up and see, "Are you sure that's my
 22 result?" and so forth? Because it seems the
 23 further we go down this road, which we have to
 24 go down, and as you pointed out, you know, it
 25 just becomes more and more complex all the

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1 time about, you know, who--what do we
 2 disclose. And the other part is what does the
 3 patient actually understand when they've been
 4 told, you know. Around this ER/PR stuff, you
 5 know, patients have been calling, they've got
 6 a negative result on that and some of them
 7 have interpreted that meant that they didn't
 8 have cancer. Well, no, it didn't mean you
 9 didn't have cancer, but they heard, well, it's
 10 a--you know, you did a test and it was
 11 negative, you know, and it--so again, it goes
 12 to that standard of information disclosure
 13 which, I mean, a reasonable person for sure,
 14 but once you move that the duty of the
 15 disclosure from the physician to the team, to
 16 the institution and then it's, well, how far
 17 do we have to go to insure that this patient
 18 who, you know, doesn't have, you know, for
 19 whatever reason doesn't understand or
 20 appreciate this, you know, just a lot of
 21 different questions around that kind of thing.
 22 MR. CAULFIELD:
 23 Q. Comments from the -
 24 DR. NORTON:
 25 Q. I could speak clinically to this, in my day-

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1 to-day practice. So let me suppose you were
 2 my patient and you were coming in and you're
 3 at the right age to have some screening done
 4 for cancer of the colon. And I have to have a
 5 very complex discussion with you about how
 6 accurate the two tests that are available, one
 7 called faecal occult blood, meaning you give
 8 us some stool samples and we find out if
 9 there's minuscule amounts of blood in it
 10 versus colonoscopy, which has some small risk
 11 and some people dislike that, some people
 12 dislike the other test. And I have to try to
 13 explain to you small margin benefits for those
 14 two things and how many times do you miss the
 15 cancer if you use each of them. And I think
 16 it's very hard and I don't think it--I work
 17 really hard with my patients to make sure they
 18 make an informed choice. I think my duty is
 19 to do that, but I'm not sure I can do it.
 20 MR. CAULFIELD:
 21 Q. Gerald?
 22 ROBERTSON, Q.C.:
 23 Q. Comment from a legal point of view. As a
 24 questioner pointed out earlier, although it's
 25 true to say that the legal duty of disclosure

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1 of error is in its infancy or adolescence, the
 2 idea of disclosure and disclosing information
 3 to patients has been around for a long time.
 4 There's a lot of case law dealing with the
 5 obligation of disclosure in terms of
 6 disclosing risk. And one of the most
 7 important developments in that area in recent
 8 years is the emphasis, the shift in emphasis
 9 away from disclosure to understanding. And
 10 case law now makes it very clear that the
 11 obligation on physicians in terms of
 12 disclosing risk to patients is not simply a
 13 disclosure of information, it includes a duty
 14 to take reasonable steps to insure the patient
 15 actually understands the information that's
 16 being disclosed. And if that emphasis on
 17 insuring patient understanding continues and
 18 begins to crop up in the area of disclosure of
 19 medical error, you'll see the same thing, that
 20 it's not simply--it's not good enough simply
 21 to disclose the information, you have to take
 22 steps to insure that the patient actually
 23 understands the implications of what is being
 24 disclosed.
 25 DR. NORTON:

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1 Q. Can I ask if it's this, the risk, is it risk
 2 of if I don't explain carefully enough to a
 3 patient their risk of cancer and why they
 4 should have this test, would I have
 5 obligation--have not met my obligation?
 6 ROBERTSON, Q.C.:
 7 Q. No, what I'm saying is that -
 8 DR. NORTON:
 9 Q. I'm saying the omission, does the omission and
 10 the commission work the same way?
 11 ROBERTSON, Q.C.:
 12 Q. I think they do. I think if you're dealing
 13 with a situation where you have reason to
 14 believe that this patient does not understand
 15 that there is a ten percent chance of a false
 16 positive, then you have to take steps not only
 17 to disclose that to the patient, but to insure
 18 the patient actually understands the
 19 implication of what you're telling him.
 20 MR. RITTER:
 21 Q. Can I just make a quick observation in
 22 response to that? And I agree and accept what
 23 you're saying, but the reality is, again, if
 24 you look at, for instance, an oncologist or a
 25 team of oncologists that at the present time

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1 are working--are seeing about 40 percent more
 2 patients than the national standards would
 3 dictate, suddenly are sort of confronted with
 4 having to explain, not just to disclose but to
 5 explain in a way that the patient truly
 6 understands, if they have to do that with 1000
 7 patients, I would say from a purely practical
 8 perspective, to really get them to understand
 9 you're probably looking at a couple of hours
 10 per patient, maybe more. The dilemma is an
 11 operational dilemma. Do you immediately start
 12 dealing with all that at the expense of all
 13 the people who are waiting to see you and have
 14 potential malignancies and whatnot? How do
 15 you deal with it? You know, it's a push and
 16 pull situation that's really very delicate and
 17 very conflicting, especially for the
 18 physicians.
 19 MR. CAULFIELD:
 20 Q. That's a tough one, so maybe we'll leave that
 21 one hanging. Good point.
 22 DR. WARD:
 23 Q. Steve Ward, UBC. Peter, I want to pick you up
 24 on your talk about the three levels,
 25 particularly disclosure to citizens, general,

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1 which is, I agree, I think this Inquiry, it's
 2 a huge issue for this Inquiry. At what point,
 3 at what time is there a duty on the part of
 4 health professionals or institutions to go
 5 public, what the content of that communication
 6 should be and also do the arguments for
 7 disclosure and certain criteria such as
 8 reasonable patient test, informed consent, do
 9 those justifications for going to the citizens
 10 extend over into the public realm, in other
 11 words, or do we move on to different arguments
 12 for disclosure to the citizens separate from
 13 the justifications for telling patients, such
 14 things as public trust in the system, such
 15 things as accountability of public
 16 institutions. Have your colleagues looked
 17 into that, these issues at all?
 18 DR. NORTON:
 19 Q. Well, we have a nascent policy about that in
 20 Calgary, which is available on our web site,
 21 you can read it. But I must say that the
 22 debate is not finished, I think, about that.
 23 I personally believe that the public trust is
 24 best served by the institutions, the regions
 25 or the hospitals being honest about these

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1 things. Clearly, there clearly is a different
 2 time because I think the story has to include,
 3 in most cases, what you've done to remove it,
 4 because you need to show that and it tends to
 5 get lost otherwise, they aren't linked enough.
 6 But I don't think I know, I'd be very
 7 interested in your feeling about it because of
 8 your perspective, whether you're going to say
 9 that today or tomorrow, on what you think
 10 about that. But it is a separate step, I
 11 think, from telling the involved individuals
 12 that we need to consider.
 13 MR. CAULFIELD:
 14 Q. I think this is an interesting question that I
 15 think will come up perhaps in Bernard's talk
 16 and certain tomorrow morning. I have a
 17 question I want to get in for sure before the
 18 lunch break, which is an e-mail question. And
 19 it has to do with the tension between privacy
 20 that you brought up, and I don't think we
 21 actually touched on this, privacy and the
 22 obligations that you have to an individual
 23 which is a fascinating question, particularly
 24 in a situation like this where you may have
 25 not 10, not 100, but perhaps even thousands of

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1 people could be implicated. So how you play
 2 that tension between the obligation obviously
 3 to respect patient confidentiality, to
 4 disclose information only with explicit
 5 consent and this sort of broader, broader
 6 disclosure obligations that may not just be
 7 disclosure to individual patients on a broad
 8 scale but disclosure to society. So you
 9 really have some interesting tensions. I
 10 don't know if anyone wants to comment, Gerald,
 11 maybe the legal obligation and then others on
 12 how that may play out in a system level?
 13 ROBERTSON, Q.C.:

14 Q. Well, in terms of disclosing to the public at
 15 large, I would imagine in most circumstances
 16 that could be done without disclosing details
 17 which would breach patient confidentiality.
 18 Obviously the identity of the patients would
 19 not be revealed. But, you know, there may
 20 well be circumstances where the public's need
 21 to know might be paramount and might supplant
 22 the individual patients' right to
 23 confidentiality, but I can't see why that
 24 would necessarily be a concern. I would think
 25 in most circumstances, it would be possible to

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1 discharge the obligation to the public so the
 2 public has information and is aware of what
 3 has happened without endangering individual
 4 patient's right to confidentiality.
 5 MR. CAULFIELD:

6 Q. So you're saying that not--this is actually--I
 7 think you touched on it a little bit in your
 8 paper, Sherry, the idea--do you really think
 9 in a legal perspective there could be any
 10 situation where either the institution or the
 11 physician or the health care provider is
 12 justified in releasing confidential
 13 information without disclosure for the good of
 14 the system or society? And perhaps
 15 practically this won't be an issue because you
 16 can deal with it within the bounds of the
 17 legal obligation, but let's just say
 18 hypothetically, can you ever see that playing
 19 out so the patient doesn't want anything
 20 disclosed but would say for the good of the
 21 system, we're going to disclose this error?
 22 PROFESSOR ROBERTSON:

23 Q. Well, certainly, if you're talking about
 24 public safety, if it were a situation where
 25 the public needed to know this because there

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1 were issues of public safety, then it's well
 2 established in those circumstances, the
 3 individual's right to privacy might have to
 4 take a backseat to the public's interest in
 5 public safety, but it would be difficult to
 6 conceive of a situation where the public's
 7 right to know, because this is a matter of
 8 public interest, would be seen to be more
 9 important than the patient's, individual
 10 patient's right to confidentiality. There
 11 might be, but you know, I just find it
 12 difficult to conceive of a situation where
 13 that would arise.
 14 DR. ETCHELLS:

15 Q. I can't think of a scenario where there'd be
 16 an issue of public health importance where you
 17 would need to identify the name of the patient
 18 involved in the hospital. I can't think of
 19 one. The public health issues with -
 20 MR. CAULFIELD:

21 Q. You could see a public health scenario, but I--
 22 I'm with Gerald. It's hard to see a
 23 situation where it's a system error problem
 24 that would require a disclosure, but--Gerald,
 25 Bernard, I'm sorry.

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1 PROFESSOR DICKENS:

2 Q. Bernard Dickens, Toronto. We had a case of
 3 this with the SARS outbreak in Toronto where a
 4 woman flying back from China was infected and
 5 the family agreed that her details should be
 6 disclosed. She died of the condition, so did
 7 her son, who she infected, and the family
 8 agreed that it was in the public interest to
 9 identify this person by name so that her
 10 family members and neighbours would know, so
 11 that the flight that she was on would be
 12 identified, so that other passengers would
 13 know. The challenge would have arisen had the
 14 family said that they didn't want her identity
 15 to be disclosed.
 16 MR. CAULFIELD:

17 Q. But in some respects, that's different, right,
 18 Bernard, because the public health norms kick
 19 in. Infectious disease kind of traditional
 20 norms kick in, and it's a very interesting
 21 question whether those kinds of norms and
 22 ethical standards sort of morph now into
 23 patient safety questions. So I don't want to
 24 beat this to death with five minutes to go and
 25 lunch to come, so I'm going to turn it over to

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1 you.

2 MS. NEWBURY:

3 Q. Thanks. Jennifer Newbury, I'm one of the

4 lawyers involved in the Inquiry. I have a

5 two-part question. Number one, has there been

6 or is there still a real legal or policy

7 debate about whether or not wrong site surgery

8 causes harm? I'm not sure--that was raised, I

9 think, by Dr. Etchells during the

10 presentation.

11 DR. ETCHELLS:

12 Q. Legally, to me, there's no issue. I mean,

13 obviously if the patient got the wrong

14 procedure, the error reached the patient and

15 at a minimum, caused them unnecessary

16 discomfort and suffering, and at maximum, they

17 still have the condition that they were

18 supposed to get treated and it's still there.

19 I don't see any issue about disclosing that at

20 all. I've never heard anyone argue about

21 that, to be honest with you.

22 MS. NEWBURY:

23 Q. Okay, that's what I was curious about.

24 DR. ETCHELLS:

25 Q. I think it was just that specific legal case.

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1 MS. NEWBURY:

2 Q. The second issue, and it deals with that

3 generally, have there been any protocols built

4 in place to take into account potential bias

5 by people deciding whether or not there has

6 been harm or some event that should be

7 disclosed to a patient? And I'm thinking, you

8 hear about research bias or specialist bias,

9 you know, there tends to be a thinking, you

10 want a certain outcome and because you want a

11 certain outcome, then you might be bias to

12 interpret that outcome, and of course, I

13 assume that no physicians or other health care

14 providers ever want harm to be caused by a

15 patient. So is there any concern about

16 whether that decision maker having to look

17 back at his or her own work might have a bias

18 wanting to conclude there hasn't been any

19 harm?

20 DR. NORTON:

21 Q. This is a big issue in the retrospective chart

22 reviews, and essentially to determine if

23 there's an adverse event, the chart reviewers

24 have to look at the three conditions I put

25 down: was there an injury, unintended; was

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1 there consequences, which I outline death,

2 disability and prolonged hospital stay; and

3 was it caused by medical management. And in

4 the Canadian study, we did some very careful

5 work to try to see how reliable, i.e. how much

6 bias those three decisions were, and I must

7 say, this is done in a very structured way.

8 You can't make the decision without answering

9 a bunch of questions first to frame it, each

10 of those three questions. The agreement on

11 the first, was there an injury which was

12 unintended or a complication, the agreement

13 among reviewers is quite acceptable. It's a

14 complex statistic, but it doesn't really

15 matter, it's acceptable. The agreement on the

16 second issue, did the injury cause death,

17 disability or prolonged hospital stay, is

18 still in the acceptable range, from a

19 scientific point of view, but the reviewers

20 would agree about 75 percent of the time. The

21 agreement on the third issue, was it caused by

22 medical management and not the patient's

23 underlying condition, drops down to about 60

24 percent. It's the highest that anyone's got

25 in those studies, but it still leaves open to

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1 me the question of even if you're not involved

2 with the case, how objective can you be? Now

3 let me say when you are involved in the case,

4 your objectivity gets shot in the foot, and in

5 fact, people, in my experience dealing

6 primarily with learners who've been in bad

7 situations, is that they over call this. They

8 over call it, and I think that's true with

9 professionals as well. So that an objective

10 person moving back says "actually, no," but

11 they're very sensitive. You teach, Ed, do you

12 find that as well?

13 DR. ETCHELLS:

14 Q. Yes, I think there's just when one is

15 reflecting on one's own work, the bias is as

16 much to be overly critical as it is to be

17 overly positive, but it's going to depend on

18 the personality as much as anything. One

19 trick we tried to use in a different

20 retrospective chart review study I was

21 involved with is after the reviewers had done

22 all their work, we then said, okay, imagine

23 that the patient did perfectly well, would you

24 still have any concerns about the processes of

25 care? And that's the control for the problem

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1 of hindsight bias. You always tend to take a
 2 dimmer view of things when the outcome was
 3 unfavourable. That seemed to be helpful to
 4 the reviewers because they were focused on the
 5 processes of care, not the outcomes initially
 6 and that was a useful question.
 7 MR. CAULFIELD:
 8 Q. Excellent question. Next please? I'll give
 9 you the last one before lunch.
 10 MR. SINGLETON:
 11 Q. Great. Rick Singleton, I work in Pastoral
 12 Care and Ethics with Eastern Health. Just
 13 want to take a moment. Most of your examples
 14 and so on speak to individual cases, and a lot
 15 of the papers did as well, but I just want to
 16 ask about the domain of ethics in the issues
 17 and the decisions about disclosure and so on.
 18 A lot of what we've heard this morning
 19 pertains to the law and the kind of legal
 20 obligations which would be on the floor level
 21 at which we have to start off, but it seems in
 22 some ways that the discussions kind of make
 23 the floor to ceiling, that you know, if there
 24 isn't a legal obligation, then it doesn't go
 25 much beyond that. I'd like you to address the

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1 kind of scope of ethics that might happen and
 2 one example that was used, it wasn't really--
 3 it was to make the point about, you know,
 4 someone breaks a window next door with a ball.
 5 I guess if you owned the window next door,
 6 you'd like to know who broke it, and you'd
 7 have a kind of expectation and whether or not
 8 there is a legal obligation to say you broke
 9 the window, are there other considerations
 10 that would lead you to consider that? But the
 11 flip side of it being are there ethical
 12 considerations as well about not disclosing
 13 that in some cases would challenge--especially
 14 when we look into the domain of broader
 15 issues, things that are more complex than the
 16 individual cases of individual patient with an
 17 individual physician and a specific team and
 18 specific times and places. Are there ethical
 19 issues and considerations and frameworks that
 20 might inform us about what would be the
 21 appropriate thing to do and the extent of
 22 legal obligation and the extent of moral
 23 obligation? It's 12:30, so you know, a ten-
 24 second answer would be adequate, I'm sure.
 25 MR. CAULFIELD:

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1 Q. So brief, efficient, accurate responses.
 2 PROFESSOR ROBERTSON:
 3 Q. Well, let me start. The Canadian Medical
 4 Association amended its code of ethics in 2004
 5 to explicitly provide for a duty of disclosure
 6 on physicians if they cause harm. It's my
 7 understanding that other health care
 8 professionals, including nurses, also have a
 9 similar ethical duty of disclosure in their
 10 codes of ethics. So the ethical position is
 11 as clear as the legal position. There is a
 12 duty of disclosure.
 13 MR. CAULFIELD:
 14 Q. And we will be hearing about this more from
 15 future speakers. Okay, it's a wonderful time
 16 to stop. I'd like to again thank our panel
 17 and we'll start back at 1:30 sharp. Thanks to
 18 everybody.
 19 (LUNCH BREAK)
 20 MR. CAULFIELD:
 21 Q. Good afternoon. I hope everyone had a nice
 22 lunch, and you're rearing to go for another
 23 set of great talks. We started the day
 24 talking about patient error, patient safety in
 25 a broad sense. We moved into a clinical

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1 perspective. We then started talking about
 2 specific legal obligations for health care
 3 providers, and now we're going to talk--open
 4 up a little bit again and talk about how--what
 5 the obligations are of other entities, of the
 6 system, of regional health authorities,
 7 politically, and to lead us through that
 8 discussion, we're going to start with
 9 Professor Bernard Dickens who is a law
 10 professor from the University of Toronto, and
 11 I think it's fair to say, and all the health
 12 law lawyers in the room I'm sure will agree
 13 with me, is truly one of the fathers of health
 14 law, not just in Canada, but around the world.
 15 He really is a seminal figure in this field
 16 and it's a great honour to have him here. My
 17 friend, Bernard Dickens.
 18 PROFESSOR DICKENS:
 19 Q. Thank you, Tim. The real honour is to have
 20 been invited to participate in this
 21 stimulating discussion, clearly based on the
 22 most regrettable of circumstances, but if it's
 23 an ill wind that blows no good, the good for
 24 this for me is the opportunity to become
 25 involved in some of the details and in

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1 particular, the broader principles, and I
 2 really am going to be dealing with the
 3 setting, a number of the background
 4 circumstances that have conditioned the more
 5 detailed inquiry. I'm also indebted to Tim
 6 for having invited me here and I'll be even
 7 more indebted if he keeps me to a good time
 8 discipline, because this is fascinating and
 9 I'm disposed to ramble on, and a time will
 10 come when I have to stop. There was an
 11 occasion once, admittedly chaired by a friend,
 12 who not very discreetly pushed a little note
 13 to me, simply said "shut up and sit down
 14 already," and this is a variance of the two-
 15 minute warning, I think.

16 The background with the provincial health
 17 authorities and the government lies in the
 18 conditioning of the Canada Health Act. The
 19 Canada Health Act doesn't impose obligations
 20 on provinces. It empowers the federal
 21 government to make contributions, increasingly
 22 modest, to reimburse provinces for their
 23 expenditures, and the provinces equip
 24 themselves to receive federal grants by
 25 conforming to the Canada Health Act, and the

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1 Act essentially has two preconditions for
 2 payment.

3 The first is that there is eligible for
 4 coverage and coverage is relatively
 5 comprehensive, would have reasonable access.
 6 That's not necessarily immediate access. It's
 7 not necessarily local access. It is, in
 8 whatever the circumstances are, reasonable
 9 access to medically necessary services, and
 10 although we speak about the Canada Health Act
 11 and in the Province of Ontario, for example,
 12 we have the Health Insurance program. It's
 13 only covering medical health. It doesn't
 14 cover general dental health. It doesn't cover
 15 a variety of services that we would regard as
 16 meeting the World Health Organization
 17 definition of health, a state of--the WHO
 18 definition uses the word "complete, physical,
 19 mental and social well being." The health
 20 plans, as we call them, are simply medical
 21 plans and under particular circumstances. So
 22 we're looking at medically necessary. They
 23 have to medical and they have to be necessary.
 24 We've seen that in recent litigation involving
 25 autism where the treatment, if not medically

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1 advised, was not given by physicians and a
 2 number of Courts have concluded that the
 3 provinces equipping themselves to be
 4 reimbursed don't have to cover autism
 5 treatment because it's not medical and it's
 6 not clear that it's necessary. Of course,
 7 families would disagree quite fundamentally on
 8 that.

9 The government powers, and I apologize
 10 for those who've done anything on civics, to
 11 say nothing of first year constitutional law,
 12 but governmental powers tend to be divided
 13 into three, and we speak about doctrines of
 14 the separation of powers: the power to make
 15 law that is vested in the legislature; the
 16 power to discharge the functions of
 17 government, that is the executive function;
 18 and the judicial function, and of course,
 19 judicial independence of government and of the
 20 legislature becomes quite important.

21 The history of the separation of powers
 22 are really we shouldn't go into, but we see a
 23 contrast between countries from the Anglo-
 24 Canadian tradition, if I'd call it that, and
 25 the United States. It has a more strict

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1 separation of powers in that in the United
 2 States, the secretaries of state, the
 3 ministers of the executive, are not part of
 4 Congress and not part of the legislature. In
 5 Canada, we have a parliamentary executive,
 6 that is the government is the government
 7 because it can control a majority vote in the
 8 legislature, and that means that the policies
 9 it proposes, it has a fair chance of
 10 implementing because it has the persuasiveness
 11 within the legislature. Really then, we have
 12 interactive powers and it's the way these
 13 different powers intersect that we have to
 14 deal with.

15 The Courts are independent. They, of
 16 course, have to interpret legislation. They
 17 have to see how legislation fits within the
 18 background law, that is does the legislation
 19 change the background law, which is has the
 20 power to do, or does it consolidate, does it
 21 codify the background law. Is it subject to
 22 the background law? A number of our laws, for
 23 example, dealing with adolescence right to
 24 medical treatment, the Courts have interpreted
 25 to accommodate the common law, the customary

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1 law principle of the mature minor. So though
 2 the legislation may say that people below the
 3 age of 16 need a written parental consent, the
 4 Courts may interpret that and sometimes the
 5 legislation will specifically provide that
 6 this is subject to the maturity of the
 7 individual, the mature minded doctrine. So
 8 the Court, though independent of the
 9 legislature, interpret what the legislature
 10 has done. If the legislature doesn't approve
 11 what the Courts have done, it's open to the
 12 legislature to change the legislation, and
 13 whether the new legislation consolidates
 14 previous judgments. If, for example, the
 15 legislature approves of the interpretation the
 16 Courts have given, they may reenact the
 17 provision in identical language and that locks
 18 in the interpretation the Courts have given.
 19 If the legislature disapproves of the
 20 interpretation by the Courts, then they will
 21 use different language and different concepts,
 22 and although we've been accustomed to the
 23 concept of legislative supremacy, legislative
 24 sovereignty, that of course is now subject to
 25 the Charter, the Canadian Charter of Rights

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1 and Freedoms, which doesn't bind you and me as
 2 individuals. It only binds government and
 3 those discharging governmental functions, but
 4 government is subject to the Charter, which
 5 the Courts will interpret. It came as a great
 6 surprise to many Canadians in January 1988, in
 7 the Morgentaler decision, when the Courts
 8 declared provision of a criminal code on the
 9 very sensitive issue of abortion as
 10 inoperative, and many people didn't understand
 11 that that was an implication of the Canadian
 12 Charter enacted in 1982.
 13 So really, we have to deal with the way
 14 the different powers of government interact
 15 with each other. The executive power vested
 16 in a minister primarily, but also back-bench
 17 members, and of course, we're aware that back-
 18 bench members, if successful in the lottery,
 19 can introduce private members bills that may
 20 attract a majority support in the Legislative
 21 Assembly. The minister will propose law.
 22 This is what the executive does. The
 23 legislature may enact the law. If a minister
 24 proposes legislation that doesn't attract
 25 majority support, that could mean that the

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1 government falls. If it is deemed to be a vote
 2 of confidence in the government, a government
 3 that cannot govern loses its credentials to
 4 claim to be the government.
 5 The legislation then will represent, not
 6 just the wishes of the minister, but the
 7 wishes of the Parliament, which includes, of
 8 course, non-governmental members of the
 9 government party, members of the official
 10 opposition, members of other parties, and the
 11 Courts have to interpret the intention of the
 12 legislature, which is not necessarily the
 13 intention of the minister.
 14 So the involvement of government in
 15 implementing its policy becomes a matter that
 16 has political and legal dimensions. That is
 17 the government is accountable to the
 18 legislature politically, but it can also be
 19 sued in Court, that is, is accountable to the
 20 judiciary.
 21 A contrast has been recognized with the
 22 abolition of historical claims of governmental
 23 immunity. This is based on the rather
 24 pedantic proposition with the supremacy of the
 25 Royal Courts among other courts in the United

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1 Kingdom and England that the monarch could not
 2 be sued in the monarch's own courts. And we
 3 still have retentions of governmental immunity
 4 from legal liability, but the Courts have
 5 recognized that with the involvement of
 6 government in so many matters affecting
 7 individuals, affecting families, affecting
 8 communities, that a claim that the government
 9 cannot be liable in the courts simply is
 10 intolerable. There has to be a level of
 11 governmental accountability to law, and the
 12 Courts have recognized the contrast between
 13 policy decisions and operational decisions.
 14 Now there's a permeable barrier between
 15 what is policy and what is operational, and
 16 functions of advocacy become relevant here.
 17 That is an advocate has to persuade a court,
 18 if defending the government, that it's a
 19 policy decision for which the government is
 20 politically accountable, but not accountable
 21 to the Courts, and advocates for those
 22 asserting governmental liability will say
 23 "this is not policy. This is the
 24 implementation of policy. This is
 25 operational." And this is a contrast that

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1 becomes quite important.
 2 In my paper, I've given an example that
 3 had arisen quite recently and I'm sorry, this
 4 is quite parochial, in Ontario, and in
 5 particular, in Toronto, the question of
 6 garbage disposal, toxic garbage, and there was
 7 an intention to take it out of the province,
 8 to ship it elsewhere, to the United States, to
 9 other areas, and dispose of it in contrast to
 10 incinerating it. And whether one goes for an
 11 incineration policy or whether one goes for an
 12 exportation policy is a question that
 13 governments have to decide. If we disapprove
 14 of their decision, then we could take account
 15 of that in the next election, and to that
 16 extent, if governments make policy decisions,
 17 the Courts will not scrutinize them for their
 18 wisdom, for their economic implications.
 19 Governments make policies and they're
 20 politically accountable and that's why we vote
 21 them into office and vote them out of office,
 22 on the basis of their promises and on the
 23 basis of their record.
 24 In contrast are the way that decisions
 25 are actually put into effect. That is if a

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1 decision is made that there will be
 2 incineration of toxic products, then that
 3 could cause a nuisance, a public nuisance,
 4 that could be subject to litigation, a private
 5 nuisance in some circumstances, and the Courts
 6 may review how the incineration process
 7 operated, not whether it was a good policy or
 8 not, but whether it was operationalized with
 9 due respect to individual interests.
 10 If we accept that the contrast, we then
 11 have to ask whether operational decisions
 12 involve private law duties of care and Joan
 13 Gilmour is going to be addressing duties of
 14 care in much more detail.
 15 We had an instance of the Ontario
 16 government again, I apologize for the
 17 parochialism of this. In Canada, you can't
 18 criticize decisions for being provincial in
 19 quite the way you can in the United Kingdom.
 20 In the United Kingdom, to be provincial is
 21 very negative. In Canada, it's perfectly
 22 legitimate.
 23 There was a government proposal on how to
 24 deal with West Nile virus. There was an
 25 instance of infection and family members of

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1 the infected person sued the government saying
 2 that the government should have been more
 3 active in promoting its policy. The action
 4 failed on the basis that whether and how
 5 policies developed with regard to this onset
 6 of infection is a policy decision and it
 7 didn't create rights of litigation for
 8 individuals. That is, the general assessment
 9 was that at most this is a policy. The Court
 10 found that in fact it wasn't even policy. It
 11 was simply a proposal for those at the
 12 municipal level who wanted to implement it.
 13 It imposed no duties. But the Court said that
 14 had it been a question of policy, then that
 15 would be in the political realm, not the
 16 legal, and it wouldn't give rise to successful
 17 litigation.
 18 But if we actually look at the background
 19 jurisprudence, we find that the Courts are
 20 entitled to take account of policy factors,
 21 even at the operational level, and an example
 22 of that, or two examples, come first of all
 23 from the evolution of legal concepts of
 24 vicarious liability, in particular, in master
 25 servant relationship. If a servant employed

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1 by a trucking company drives negligently, is
 2 the company liable for that or is it a
 3 liability simply of the truck driver? There's
 4 a matter of policy. The Courts have said that
 5 if there is to be justice, if there's to be
 6 any prospect of compensation for those who
 7 have suffered injury because of careless or
 8 negligent driving, then to require the
 9 plaintiff to sue against the resources of the
 10 truck driver would create little prospect of
 11 compensation. The truck driver is employed to
 12 promote the interests and the commercial
 13 profits of the trucking company. The trucking
 14 company makes the profits. They pay the truck
 15 driver an employment wage, perhaps modest.
 16 The company would have insurance for its
 17 trucks and therefore, as a matter of policy,
 18 the Courts have said that within a
 19 master/servant relationship, if in the course
 20 of discharging the functions of the master,
 21 the servant creates liability, then the
 22 liability vicariously is borne by the
 23 employer. That is the agency better equipped
 24 for protection, better equipped to pay
 25 compensation, and to have insurance for legal

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1 insurable interests.
 2 We've also found policy coming into the
 3 operation of the Charter. The Canadian
 4 Charter of Rights and Freedoms provides a
 5 number of entitlements, for example,
 6 protection against discrimination, and also
 7 protection of rights to life, liberty and
 8 security of the person. But this is also
 9 subject to Section 1 of the Charter and a
 10 crude paraphrase of Section 1 is that those
 11 governed by the protection of the Charter have
 12 all of the rights and freedoms embodied in the
 13 Charter unless they don't, and they don't if
 14 it is demonstrably justifiable in a free and
 15 democratic society that they don't have those
 16 entitlements. So if there is no Charter
 17 breach, the issue doesn't have to be
 18 addressed. But if the Court finds that there
 19 has been a breach of one of the protections of
 20 the Charter, protections perhaps against
 21 discriminatory behaviour, then the Courts have
 22 to see whether that discrimination is
 23 demonstrably justifiable in a free and
 24 democratic society, and although that invites
 25 international comparisons, it essentially

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1 turns on the free and democratic society that
 2 Canadians enjoy. And the Courts have to make
 3 an assessment, and sometimes they say this is
 4 demonstrably justifiable; in other cases, not.
 5 A leading case on this establishing that
 6 hospitals, as such, are not actually governed
 7 by the Charter was the case from Vancouver,
 8 Stoffman against the Vancouver General
 9 Hospital. That was allied with cases
 10 involving the University of Guelph and the
 11 University of Toronto on the question of
 12 mandatory retirement. People were entitled to
 13 employment up to the age of 65 and after 65,
 14 they were not entitled. And the claim was
 15 made that this is a violation of
 16 (unintelligible) discrimination on grounds of
 17 age. And the Court said three things. They
 18 need only have said the first thing, that this
 19 is a Charter claim against the Vancouver
 20 General Hospital, and although it has
 21 essentially public funding, it is a private
 22 corporation. It's not government and
 23 therefore the Charter doesn't apply.
 24 The case was in the early years of
 25 Charter litigation and therefore the Court

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1 went further and said that if the Charter did
 2 apply, then this would be discrimination on
 3 grounds of age. But third, the Court said
 4 this discrimination on grounds of age is
 5 demonstrably justified in our free and
 6 democratic society because what doctors have
 7 in hospitals are called privileges, and within
 8 the university setting, faculty have the
 9 protection of tenure, and there comes a point
 10 when the people at the top of the ladder can
 11 be required to leave. It is justifiable that
 12 privileges not be permanent, that they
 13 eventually have to yield. Those who have the
 14 protection of tenure must give way to the
 15 students they are responsible for training to
 16 replace them, and if there is to be any
 17 progress on the ladder, if those seeking a
 18 place in the lower rungs are to be
 19 accommodated, it has to be that those at the
 20 top leave. And so the Court said, if this was
 21 a Charter case, this would be discrimination
 22 on grounds of age, but demonstrably justified
 23 in a free and democratic society.
 24 In a subsequent case, also involving
 25 British Columbia, the Eldridge case, the Court

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1 went back to its language in Stoffman and
 2 interpreted it more explicitly. There were
 3 provisions in the Stoffman judgment that a
 4 number of people, and I say including myself,
 5 didn't pay special attention to, and the
 6 primary judge who drafted the Stoffman
 7 judgment went back to his language in Eldridge
 8 and said that although public hospitals, being
 9 private corporations, are not themselves a
 10 branch of government in their policies of
 11 hiring and firing and contracting for
 12 services, when they are discharging
 13 governmental functions, then they are bound by
 14 the Charter because governments can't evade
 15 their Charter responsibilities by delegating
 16 functions to other agencies, and the
 17 functions, in particular, concern the supply
 18 of health care. Governments are not licensed
 19 to practice medicine, nor are hospitals, but
 20 hospitals employ, under various contractual
 21 terms, doctors who are licensed to practice
 22 medicine and that is a function that
 23 governments have taken responsibility for
 24 under the provisions of the Canada Health Act.
 25 This is a governmental function and

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1 governments can't evade their Charter
 2 responsibilities by delegating the discharge
 3 of them to private agencies.
 4 So in Eldridge, it was found that there
 5 was discrimination on grounds of hearing
 6 disability in that case, and the Charter did
 7 apply, and again, we can see the policy
 8 implications of that.
 9 Legal liability can be established in
 10 accordance with a variety of different
 11 principles. Liability for failure to meet the
 12 standard of care is the key issue and again,
 13 Joan Gilmour is going to be dealing with that.
 14 Standards of care are set by the Courts and
 15 although they have to meet a criterion of
 16 adequacy, they don't necessarily have to be
 17 excellent. Courts will set the standards.
 18 Clearly if agencies could themselves set the
 19 standards that would measure their liability
 20 for negligence, they would have self-
 21 protective incentives to set very modest
 22 standards. So the standard of care is
 23 determined as a matter of law by the Courts.
 24 It needn't be cutting edge. It is essentially
 25 one of adequacy in the circumstances, not

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1 necessarily the best, but good enough.
 2 There can also, of course, be liability
 3 for error, but we've heard this morning that
 4 not every error is a consequence of
 5 negligence. There are wide categories of non-
 6 negligent error and whether the error was
 7 negligent or not is what litigation will
 8 essentially focus on.
 9 There can also be liability for
 10 misfeasance of public officers, and this is a
 11 tort that has come to recognition relatively
 12 over recent times and the Courts are still
 13 working through the more detailed juris
 14 prudence of it.
 15 Litigation, whether for negligence, for
 16 misconduct in public office, can be pursued by
 17 class actions and the Courts will certify by
 18 legislative criteria whether the case is
 19 appropriate for a class action suit or not,
 20 and there can also be non-delegable duties of
 21 care. That is, if hospitals delegate their
 22 functions to doctors who are not servants of
 23 the hospitals, in some circumstances, they may
 24 be, if they're salaried or they may be
 25 analogous to servants. Many doctors are what

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1 are described as independent contractors.
 2 That is, they will contract what services they
 3 will deliver, but they deliver them in
 4 accordance with their ethical and legal duties
 5 as doctors. Servants are represented by
 6 nurses. Nurses are told what to do and how to
 7 do it. Doctors agree what they will do, but
 8 they do it as doctors, as the qualified
 9 physicians and medical scientists they are,
 10 governed by their code of ethics. And if
 11 hospitals delegate functions to doctors who
 12 are not servants, it's not obvious that
 13 hospitals will bear vicarious liability, or
 14 for that matter, health authorities will bear
 15 vicarious liability for the negligent errors
 16 and other legal wrongs, breach of fiduciary
 17 duty, for example. But the Courts will
 18 recognize some categories of non-delegable
 19 duties and in those circumstances, even if the
 20 person discharging that duty is an independent
 21 contractor, so the ordinary rules of vicarious
 22 liability won't arise, the Courts may say that
 23 this is an area of direct liability because
 24 the function is not delegable. Now again,
 25 whether the Courts will say that is a legal

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1 issue.
 2 To come to ethics. Ethics sometimes
 3 coincide with law. The concept of fiduciary
 4 duty comes not from the historic or customary
 5 law of the Anglosaxon community. It is a
 6 product of equity; a product of the course of
 7 conscience, and individual conscience is often
 8 guided by ethical considerations. So many
 9 duties, fiduciary duties, ethical duties could
 10 coincide or could show a coincidence of ethics
 11 and law. But ethics often requires more than
 12 law. The law will sometimes say what must be
 13 done and the other side of that, of course, is
 14 what must not be done, but frequently, the law
 15 is simply empowering. The law says that
 16 things may be done, but don't necessarily have
 17 to be done, and whether one uses one's legal
 18 powers or not is an ethical choice.
 19 We've had a number of instances, the case
 20 involving a woman who was sterilized without
 21 her consent in Alberta, under legislation, the
 22 Meil (phonetic) case, was a good example of
 23 the Government of Alberta recognizing
 24 liability, not defending on the merits,
 25 conceding that what was done was wrong, even

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1 at the time it was done, and simply dealing
 2 with what compensation to award. And the
 3 Court said that although the wrong conceded by
 4 government was compensable, they were not
 5 going to award punitive damages because the
 6 government had done the decent thing. The
 7 Court said that government had a watertight
 8 defence under the Limitation Act. The action
 9 was commenced out of time and it would have
 10 been certainly within its legal powers of the
 11 government to invoke the limitation period
 12 saying the action is brought too late, end of
 13 case. The Government chose not to do that and
 14 that was an honourable, just thing to do.
 15 That was an ethical exercise of a legal
 16 discretion, the discretion not to use legal
 17 powers, and the Court recognized that in
 18 saying this is not a case for punitive
 19 damages. The government has behaved very
 20 decently. It did not invoke a defence to
 21 which it had entire legal access, but is
 22 undertaking compensation. Whether Alberta
 23 taxpayers would see the issue in the same
 24 light is a political question.
 25 The major ethical principles tend to be

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1 reduced to what's often called the Georgetown
 2 mantra. This is a somewhat humourous, not
 3 necessarily, denigrating description. It goes
 4 back to a report of the U.S. Government on
 5 research in medical and biosocial sciences,
 6 the so-called Belmont report. Many of the
 7 authors came out of the Georgetown University
 8 Kennedy Institute of Ethics. So it was called
 9 the Georgetown mantra. It has either three or
 10 four principles. I'd prefer to identify it as
 11 four principles.
 12 The first is respecting people, and the
 13 governing principle is the autonomy of
 14 individuals. The autonomy principle is so
 15 dominant in the United States that many
 16 citations, recitations of the Georgetown
 17 mantra call the first principle autonomy, but
 18 it actually fits within the broader context of
 19 respect for persons. That is the autonomy of
 20 people capable of exercising autonomy, but
 21 also due protection of those who are
 22 vulnerable, those who are incapable of
 23 exercising their full autonomy, and there are
 24 circumstances in which each one of us is
 25 vulnerable, in particular, when we're sick and

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1 go to doctors and hospitals for care. So this
 2 is a principle that has a double aspect, but
 3 of course, the precondition for autonomy, the
 4 precondition for exercise of one's own choice
 5 is that one receive appropriate information
 6 and Gerald Robertson touched on that this
 7 morning, saying that disclosure of error can
 8 fit within this important concept of informed,
 9 free and informed consent, and that's a major
 10 feature of autonomy.
 11 The second principle is the duty to do
 12 good, and in Belmont, that folds within it the
 13 third principle, which I prefer to isolate,
 14 the principle that historically going back to
 15 the Hypocractic environment, was taken as the
 16 primary duty, to do no harm. The fancy
 17 philosophical language is non-maleficence, in
 18 the same way that the duty to do or to
 19 maximize good is beneficence. But doing good
 20 and avoiding harm are important values and the
 21 two don't necessarily coincide.
 22 The fourth principle is the ethical
 23 principle to which the law claims to devote
 24 itself, the ethical principle of justice.
 25 That is to treat like cases alike and this, of

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1 course, is the root of the legal preoccupation
 2 with precedence and that if cases are like
 3 each other, they should be governed in the
 4 same way. The other side of that, of course,
 5 is to recognize ethically significant
 6 differences. That is if treating the like
 7 cases differently is unethical, it could be
 8 equally unethical to treat different cases as
 9 if they're alike, subordinating one to the
 10 other.
 11 And the principle that the health
 12 agencies are very much concerned with is the
 13 duty sometimes described as distributive
 14 justice. That is the fair allocation of
 15 burdens and benefits. We see this in the
 16 research context. One population group should
 17 not be exposed to unproven treatment to
 18 develop therapies from which different
 19 population groups will benefit. That is those
 20 who bear the risks, those who bear the
 21 burdens, should have equitable ethical
 22 entitlement to appropriate benefits.
 23 But we've had developments of the
 24 Georgetown mantra into the modern
 25 administrative ethic and a lot of this is

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1 associated with the writing of Norman Daniels,
 2 a philosopher, historically at Tuft's
 3 University, recently transferred to Harvard,
 4 who emphasizes, and this is relevant to
 5 governments, accountability for
 6 reasonableness. That is the decision should
 7 be made reasonably on the basis of evidence,
 8 not just doctrine, not just ideology, but
 9 there has to be an empirical basis for
 10 policies, to show that they are factually
 11 reasonable and they have to be transparent.
 12 They have to be adequately explained to those
 13 affected by them, which is the broader public
 14 in general, and particularly individuals. And
 15 the result of this concept of accountability
 16 for reasonableness is that although
 17 governments are not necessarily at fault for
 18 making bad decisions, in good faith, they may
 19 pursue policies that seem appropriate that
 20 worked disastrously. So there may not be
 21 accountability for making bad decisions, there
 22 can be accountability for making decisions
 23 badly. That is not based on evidence and not
 24 adequately communicated.
 25 Tim has stepped forward very ominously

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1 and I'd be foolish to disregard that. Let me
 2 come to the final issue then that we're very
 3 much concerned with, the disclosure of
 4 information and of course, this is an issue
 5 that was explored, not exhausted, but well
 6 explored this morning and that we're going to
 7 be very much concerned with for the rest of
 8 today and tomorrow.
 9 It's clear that the public has a right to
 10 information of error in a general sense. In
 11 fact, there is a recently developed Canadian
 12 institute, the Canadian Institute for Health
 13 Information, that will publicize data of
 14 infection rates, of treatment rates, not
 15 specifying individual hospitals or health
 16 facilities, not identifying individual health
 17 care providers, clearly not identifying
 18 individual patients, but presently global data
 19 for the public at large.
 20 We have to remember though, and this is
 21 relevant to the shift that Gerald Robertson
 22 touched on this morning of the Courts
 23 emphasizing the patient should not simply be
 24 given information, but should be given an
 25 opportunity to understand it, that not all

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1 data will be informative. That is we have
 2 sometimes incomprehensible data. We've got
 3 findings, but we don't know what they mean.
 4 We don't know how they fit into a wider
 5 context. And in that sense, simply producing
 6 data will not necessarily be informative and
 7 much research is promoted, is propelled by the
 8 need to understand how particular findings of
 9 an individual case or a pattern fit into a
 10 wider framework. Simply giving data won't
 11 mean anything unless it's put in a broader
 12 context. If, for example, you're told that
 13 the recording here is calculated, it
 14 quantifies at 18, 18 out of 20. 18 out of 20
 15 is low. 18 out of 40 is middling, but to say
 16 the finding is 18 doesn't mean anything unless
 17 it's put into a wider context. If that wider
 18 context hasn't been researched and doesn't
 19 exist, the data will not be informative. So
 20 what has to be disclosed is information and
 21 data will not necessarily constitute
 22 information.
 23 Clearly, if patients ask for information,
 24 they have a right to be given it truthfully
 25 and the Courts have established that. A 1992

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1 case of McNarney and MacDonald made it clear
 2 that patients have a right, not necessarily to
 3 raw data, but to have their medical records
 4 interpreted to them by a medium that they have
 5 confidence in.
 6 Whether patients have a right to their
 7 own information is the issue that we began
 8 exploring this morning. If patients are
 9 affected by the error, then clearly they have
 10 to be informed of it. Again, Gerald Robertson
 11 put it primarily in the context of informed
 12 consent. If an error requires a patient to
 13 have additional treatment or have treatment
 14 managed in a particular way, in consequence of
 15 the error, then the patient is entitled to
 16 know that this has been necessary. This is
 17 not indicated or recommended because of errors
 18 that were previously made, and that would
 19 explain how the subsequent management is being
 20 undertaken, in the framework of informed
 21 consent.
 22 Whether the patient ought to be disclosed
 23 or ought to be informed of near misses, if Dr.
 24 Etchells will let me use the expression, is a
 25 question of judgment and if I could just take

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1 a minute to respond to the invitation of
 2 Professor Robertson. If hospitals undertake
 3 techniques of risk management or quality
 4 assurance to see how safe and effective their
 5 therapists have been by retrospective file
 6 examinations, they may find that mistakes were
 7 made, either negligent or non-negligent, but
 8 errors were found, and plaintiffs' lawyers
 9 will want evidence of that in litigation. As
 10 a matter of policy, the Courts, not
 11 invariably, but generally, say that on policy
 12 grounds, this information ought not to be
 13 admissible because it could have the harmful
 14 effect of discouraging agencies from
 15 undertaking quality assurance and monitoring
 16 the safety and efficacy of their procedures.
 17 That is if those that have the integrity and
 18 the conscientiousness to check safety and
 19 efficacy will have those records used against
 20 them, but those who don't bother to check
 21 adverse outcomes will not be vulnerable, then
 22 this provides a road for disregard of patients
 23 legitimate interests.
 24 So Courts generally will say that records
 25 of quality assurance, records of inquiries

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1 into adverse events will generally not be
 2 admissible. But this falls into wider
 3 questions of policy and this is subject to
 4 legislation. If on grounds of policy,
 5 governments decide that there ought to be
 6 required disclosures or there ought to be
 7 principles of legal admissibility, then they
 8 can enact it and the Courts will interpret it.
 9 Good. Thank you for your attention.
 10 MR. CAULFIELD:
 11 Q. Thank you, Bernard. I didn't have the guts to
 12 put a "shut up" sign up, so I thought my
 13 presence might. But thank you, that was
 14 superb and I'm sure there's many, many
 15 questions. What I'm going to do is ask people
 16 to hold them so we can hear from Joan, so
 17 we're sure to have time to have lots of room
 18 for discussion.
 19 Now Joan also is a renowned health law
 20 expert, an individual that I've had the
 21 opportunity to work with many times, and we're
 22 actually capturing Joan at a perfect time in
 23 her career, because she has just spent I guess
 24 a little over a year, right, Joan, doing an
 25 analysis of patient safety issues, and she's

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1 starting a research release in the fall on the
 2 very issues that we're discussing. So we're
 3 capturing an expert at an expert moment in her
 4 career. So perfect. Over to you, Joan.
 5 PROFESSOR GILMOUR:
 6 Q. Thank you. Now I may be an expert in health
 7 law, but I'm not so much an expert in
 8 technology. So I need to get out of Bernard's
 9 and into mine. And just as I'm getting under
 10 way, I want to thank the Commission and Tim
 11 Caulfield for the opportunity to think about
 12 these issues in more depth and in particular,
 13 in a context that I had spent less time on,
 14 that being the background of laboratory
 15 testing that has given rise to this inquiry,
 16 and when we think--my topic today is the duty
 17 of care and standard of care and it brings us
 18 to think about not just the nature of error
 19 more generally, but also what flows from it in
 20 law, and how we establish what is owed to
 21 people, in terms of the care that they are
 22 entitled to and the care that must be taken
 23 and also how we establish what the standards
 24 are that must be met.
 25 Duty of care and standard of care, though

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1 they have larger meanings, arise particularly
 2 in connection with negligence law as part of
 3 what someone who is suing, a plaintiff, has to
 4 prove in order to establish negligence. And
 5 although I'm not going to be dwelling on
 6 negligence itself as a whole, I did want to
 7 just set out what the analytical framework is.
 8 So in a negligent suit, the plaintiff has to
 9 prove, on a balance of probabilities, that the
 10 defendant, so the person being sued: owed the
 11 plaintiff a legal duty of care; the defendant
 12 breached the standard of care that is required
 13 by law; the defendant's breach caused the
 14 plaintiff injury or loss, so damages; and that
 15 the plaintiff's damages are not too remote as
 16 a matter of law to be recoverable. And then
 17 the burden of proof is on the defendant to
 18 establish any defences, for instance,
 19 compliance with approved practice or that it's
 20 too late to start a law suit.
 21 In terms of duty of care, the doctor-
 22 patient relationship is really a long
 23 established, well recognized category in law
 24 in which a duty of care is owed, and so
 25 generally, the existence of a duty of care is

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1 not a question at all. The scope of that duty
 2 of care, what in fact is included within it,
 3 may give rise to more contention. And the
 4 duty of care will extend beyond acting in ways
 5 that will avoid harming patients to include a
 6 requirement that health care providers take
 7 affirmative steps to protect their patients as
 8 well.

9 When we refer to standard of care,
 10 standard of care that is required of health
 11 professionals is an obligation to take
 12 reasonable care to avoid a risk of foreseeable
 13 injury to patients, and in determining the
 14 standard of care that is to be met, they are
 15 held to the standard of a reasonably competent
 16 member of their profession. So a physician
 17 would be held to the standard of a reasonably
 18 competent physician. If someone is a
 19 specialist, they would be expected to have a
 20 higher level of care, higher standard of care.

21 A laboratory technologist would be held to the
 22 standard of a reasonably competent member of
 23 that profession. So it applies to other types
 24 of professions as well.

25 One thing to remember about the standard

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1 of care, and Bernard Dickens was commenting on
 2 this as well, is that the standard expected is
 3 not a standard of perfection. So it's not a
 4 guarantee of the patient's safety.

5 When we think about how we establish
 6 whether or not the standard of care has been
 7 breached, generally in order to assess the
 8 standard that's required, you're going to need
 9 expert evidence. So expert evidence that the
 10 practitioner did or didn't comply with
 11 generally approved practice in questions of
 12 treatment and care, and if it is a situation
 13 where the common practice is divided, where
 14 there's a difference of opinion in terms of
 15 what might be appropriate care and what would
 16 be inappropriate care, it would not constitute
 17 negligence if the practitioner had followed a
 18 body of thought that was accepted by a
 19 reasonable and competent sector of the
 20 profession, even if that is a minority sector.

21 However, our Courts have held that if the
 22 standard of care is, as it's termed, fraught
 23 with obvious risks, such that anyone is
 24 capable of finding it negligent without the
 25 need for clinical or diagnostic expertise,

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1 then a Court can find an approved practice and
 2 the defendant who followed it to be negligent,
 3 and there's a case from Manitoba that gives us
 4 an example of that. It arose in the context
 5 of laboratory testing and in that case, a
 6 physician and a hospital were held liable when
 7 they failed to ensure that proper systems were
 8 in place to follow up on abdominal test
 9 results, and that had decreased the patients
 10 chances of survival, that would have followed
 11 on an early diagnosis. That was a case in
 12 which the Manitoba Court of Appeal noted that
 13 this failure to provide for a reasonably
 14 effective follow-up system on the part of the
 15 physician and on the part of the hospital that
 16 had no system to make sure the test results
 17 ever got to the doctor who ordered them was an
 18 obvious and reasonable precaution that was
 19 readily apparent to the ordinary finder of
 20 fact.

21 Now it's important to remember, and as
 22 Bernard Dickens had pointed out, that an error
 23 in judgment is not necessarily going to equate
 24 with negligence, nor will it give rise to
 25 liability. And that's the case, unless the

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1 error is such that a reasonable health care
 2 provider would not have made it in similar
 3 circumstances, and so what that means is that
 4 sometimes it can be difficult to distinguish
 5 between what would simply constitute an error
 6 in judgment, which does not amount to
 7 negligence, and what has gone beyond that and
 8 actually constitutes negligence.

9 When assessing the care that has been
 10 provided, the assessment is conducted
 11 effectively trying to take one's self back to
 12 the point at which these events, acts or
 13 omissions occurred. So the timing of the
 14 assessment is--and the standard by which the
 15 practitioners are to be judged, is the
 16 standard that applied at the time that these
 17 acts or omissions occurred. The advances in
 18 medicine are rapid and there are lots of them
 19 and not thought to be fair or appropriate to
 20 be judging what has occurred sometimes years
 21 in the past by what we now know.

22 Now with respect to the duty of care that
 23 is owed by physicians, when we think about
 24 what that includes, commonly and I take this
 25 actually from Gerald Robertson's book that he

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1 has co-authored with Ellen Piccard on the
 2 legal liability of doctors and hospitals, the
 3 most common components of the doctors' duty of
 4 care would be the duty to attend, to diagnose,
 5 to refer, to treat, to instruct. That's,
 6 however, not an exhaustive list, nor did
 7 Gerald mean it to be so, and there are other
 8 aspects to the duty of care as well. It's
 9 also important to note that physicians and
 10 other health care providers can rely on each
 11 other to discharge their professional
 12 responsibilities in a non-negligent manner.
 13 In other words, if we expected health care
 14 providers to be always checking up on each
 15 other, the health care system itself wouldn't
 16 be able to carry on for very long. That said,
 17 there will be circumstances that arise that
 18 perhaps should have twigged a health care
 19 practitioner to the fact that there is
 20 something potentially wrong here, and in those
 21 instances, it may be, and it would be
 22 dependent on the facts, that the health care
 23 provider should have been alert to that
 24 possibility.
 25 Let me see where I am here. In terms of

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1 the duty of disclosure that both Gerald
 2 Robertson and Bernard Dickens have spoken of,
 3 I would agree that this is an aspect of the
 4 duty of care that is owed by the health
 5 professional, certainly when a patient has
 6 been caused harm or there is a potential that
 7 the patient will suffer harm from the care
 8 that has been provided or that has not been
 9 provided, and I'd agree that the basis for
 10 that duty are several. One would be the duty
 11 of obtaining informed consent. Another would
 12 be fiduciary duty that is owed to the patient,
 13 that kind of duty of loyalty that brings with
 14 it a duty of candour, and also the duty to
 15 disclose risks and to warn the patient of
 16 risks that may be ongoing.
 17 Now Gerald Robertson, having spent
 18 considerable time on that this morning and
 19 that being the subject of his paper, I'm not
 20 going to dwell more on it at this point,
 21 though I'm happy to take questions.
 22 Turning to the issue of laboratory
 23 testing and the standard of care. One thing
 24 to bear in mind is that the standard of care
 25 to which laboratories would be held will be

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1 affected by the nature of lab testing and also
 2 limits on its reliability. So there are some
 3 types of laboratory testing that will involve
 4 an inherent element of subjectivity, so that
 5 staff interpreting those results may
 6 legitimately differ in their conclusions. So
 7 that may mean that then there is an error rate
 8 that occurs in the testing and it may not
 9 indeed involve negligence.
 10 However, where the error rates in a
 11 particular laboratory are considerably in
 12 excess of what might be anticipated in the
 13 normal course, with proper procedures in
 14 place, that could be indicative of substandard
 15 practices.
 16 In New Zealand, several years ago now,
 17 there was a committee of inquiry appointed to
 18 look into instances in which screening of PAP
 19 smears that women had undergone was conducted
 20 because a particular laboratory had missed
 21 diagnoses of cancer that should have been
 22 apparent on the slides that were examined, and
 23 the committee of inquiry in that case
 24 identified a number of both errors on the part
 25 of the individual laboratory and systemic

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1 errors in the system that had contributed to
 2 the errors occurring.
 3 And in terms of how the analysis is
 4 conducted, the analysis of whether or not
 5 there is a breach of the standard of care, I
 6 referred here to an English case, Penney and
 7 East Kent. That also involved a case where
 8 the screening for cervical cancer had missed
 9 cases in which women had cancer and they sued
 10 the health authority, and the English Court of
 11 Appeal examining this case, in talking about
 12 how you decide whether or not there was a
 13 breach of the standard of care, said that
 14 there really were three questions that had to
 15 be answered.
 16 The first would be what did the slides
 17 show. The second, at the relevant time could
 18 the screener, exercising reasonable care,
 19 because remember that is the standard of care
 20 to which one is held, fail to see what was on
 21 the slides. And third, could a reasonably
 22 competent screener, aware of what a reasonably
 23 careful screener would see on the slide, treat
 24 this slide as negative. So those were the
 25 three questions that in that case the Court

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1 considered to be the ones that had to be
 2 determined in order to decide whether or not
 3 there was a breach of the standard of care,
 4 and as I'd indicated, the first of those
 5 questions certainly involved a question of
 6 fact, but the second two involved questions of
 7 fact and opinion, some of those being
 8 obviously matters on which expert opinion was
 9 needed.

10 In the end result, the Court concluded
 11 that there was negligence in that case because
 12 the abnormalities that were apparent on the
 13 slide should have been seen by a reasonably
 14 competent screener at the time.

15 Turning to the duty of care and standard
 16 of care expected of hospitals and health
 17 authorities, they are determined essentially
 18 in the same way that it would be with respect
 19 to an individual and in terms of assessing the
 20 direct liability, and that's liability for
 21 their own deficiencies of a hospital or a
 22 health authority, plaintiffs essentially have
 23 to prove all of the elements of a negligence
 24 action.

25 The responsibilities of a hospital or

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1 health authority, and I'm just using those
 2 terms interchangeably because it would depend
 3 on what responsibilities have been assigned to
 4 them and what responsibilities they have
 5 assumed to patients, but the responsibilities
 6 certainly will include selecting competent
 7 staff and monitoring their competence, and
 8 also establishing the systems that would be
 9 necessary for the safe operation of the
 10 hospital, and that is a duty that has been
 11 interpreted increasingly expansively over
 12 time, but that obligation to ensure safe
 13 systems within a hospital may encompass
 14 everything from proper maintenance of
 15 equipment to making sure that nurses have been
 16 scheduled such that they can still get a
 17 coffee or a lunch break without leaving
 18 patients in unsafe situations. And so, an
 19 example of that would again be the Manitoba
 20 case that I referred to earlier, Braun Estate
 21 and Vaughn, in which one of the reasons that
 22 the hospital was held liable was because it
 23 didn't have any system in place to make sure
 24 that test results were actually going to get
 25 to a physician who had ordered them.

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1 Now Bernard Dickens has already spoken
 2 about vicarious liability and non-delegable
 3 duties of care, and so I just want to touch on
 4 those areas very briefly. As he indicated,
 5 hospitals can be held vicariously liable and
 6 vicarious liability doesn't depend on any
 7 deficiencies on the part of the hospital or
 8 health authority itself. What vicarious
 9 liability flows from is the relationship
 10 between that entity for whom it is responsible
 11 and someone who was deficient in their care.
 12 Most commonly, it would be in the case of an
 13 employer and an employee. So that the
 14 employer would be vicariously liable for the
 15 substandard care that an employee provided
 16 that in fact injured a patient.

17 Generally, vicarious liability is not
 18 imposed on the principal, as between a
 19 principal and an independent contractor, as
 20 opposed to an employee, and most often doctors
 21 who are not employees are considered to be
 22 independent contractors to whom the hospital
 23 has granted privileges, and so there certainly
 24 are cases, probably the longest standing
 25 authority would be one called Yepremian and

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1 Scarborough General Hospital where hospitals
 2 have been held not liable for the negligence
 3 of non-employed physicians.

4 The characterization of the relationship
 5 will depend on all of the circumstances, and I
 6 think it's fair to say that recent
 7 developments in judicial analysis of the
 8 vicarious liability may support an expansion
 9 of hospital and other health care
 10 organizations liability to include
 11 responsibility for the negligence of non-
 12 employed physicians. But, as I say, from
 13 existing juris prudence that would, at this
 14 point, amount to an expansion of what is
 15 commonly understood.

16 Now Bernard Dickens had also commented on
 17 non-delegable duties of care, and so those
 18 would be instances in which defendants have
 19 been held liable on the basis that the nature
 20 of the defendant's relationship with the
 21 plaintiff means that the duty of care the
 22 defendant was under was non-delegable. It
 23 couldn't be delegated to somebody else. The
 24 duty on the defendant is to ensure that care
 25 was taken. There are some non-delegable

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1 duties of care that are quite well recognized
 2 in the area of health care. However, non-
 3 delegable duties of care have also been
 4 undergoing an expansion in other areas of the
 5 law and they too are an area where there may
 6 be some expansion of liability for non-
 7 delegable duties of care as well.

8 Now, one of the things that flows from
 9 this potential--and I'm speaking in legal
 10 terms, as opposed to ethical or practical
 11 policy terms, but one of the things that may
 12 flow from an expansion of hospital liability
 13 is that in many ways it can accord more with
 14 how care is actually delivered in a hospital.
 15 And we've heard this morning, both from the
 16 speakers and some of the questions that were
 17 put, that care is much more delivered in a
 18 team environment and it may not be really
 19 possible to evaluate someone's actions or
 20 omissions without looking at the environment
 21 and the people with whom they were practising
 22 and what they did or didn't do and what
 23 constraints the environment imposed on them as
 24 well. So in that sense, expanding liability
 25 in that way to include the organization makes

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1 some sense, and I think it would also respond
 2 to advances in our understanding of how errors
 3 and adverse events in health care occur, and
 4 we have heard already how frequent errors are
 5 and how frequent the adverse events that
 6 result are, and we have also heard from this
 7 morning's speakers about the importance of
 8 moving away from at least a sole focus on
 9 personal responsibility for health care
 10 providers because, in many cases, in fact in
 11 most cases, it may well be the institutional
 12 systems within which health care providers
 13 operate that cause the harm. So we've already
 14 heard speakers talk about the importance of
 15 broadening the focus from the sharp end, where
 16 you've got the people who actually deliver the
 17 care, to the blunt end, where you've got
 18 regulators, policy makers, funders, technology
 19 suppliers, people who determine what the
 20 number of workers will be on a particular
 21 shift, people who determine things like is the
 22 work force casualized and this person hasn't
 23 been on this service for a long period of
 24 time. And I think that those are all
 25 important initiatives.

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1 So we ask ourselves then, well, can the
 2 law accommodate that? Certainly the
 3 traditional focus on the law has tended to be
 4 on personal responsibility of those who are
 5 involved, but I think it certainly can. Our
 6 courts have long recognized that most things
 7 don't have just one cause, that there are many
 8 causes that will contribute to harm occurring.
 9 So it certainly seems to me then that existing
 10 legal analysis could take into account the
 11 importance of systemic factors and systemic
 12 causes. That said, it often doesn't because
 13 the focus tends to be on who precisely was
 14 involved in what had gone wrong in the system.
 15 But it could do so. It does, I think, require
 16 though an openness to and an awareness of the
 17 important role that systemic factors play.

18 Then finally, looking forward, yes, legal
 19 analysis can accommodate an acceptance of the
 20 role played by multiple causes and that may
 21 more accurately reflect what the causes of the
 22 injury were. But I think it's also important
 23 that we make sure, through whatever processes,
 24 and they're certainly not limited to law suits
 25 as the very fact of this Commission of Inquiry

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1 points out, we need to ensure that there is
 2 both accountability in the system and
 3 accountability for making the system better as
 4 it moves forward. That accountability then
 5 is, in important ways, systemic as well as it
 6 is individual and as some of the earlier
 7 speakers were saying, if we don't pay
 8 attention to that, well, you may fix what went
 9 wrong with this patient and that physician,
 10 but you won't have made things better for the
 11 future and you don't want to end up with the
 12 same things going wrong again.

13 Thank you.

14 MR. CAULFIELD:

15 Q. Okay. Wonderful. So we've had two very legal
 16 discussions. You're now all experts on the
 17 relevant law. Questions to start, I certainly
 18 have some I would like to put forward. I see
 19 one right away.

20 MR. PETER BROWNE:

21 Q. I'm interested in the panel's analysis on
 22 quality assurance protections vis-a-vis
 23 individual patients' incidents versus systemic
 24 incidents, and I see a big distinction there
 25 in some of the comments and wondering whether

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1 you see a distinction there as well.
 2 PROFESSOR GILMOUR:
 3 Q. Can I just ask if by quality assurance
 4 protections you mean protection from
 5 disclosure to either -
 6 MR. PETER BROWNE:
 7 Q. Yes
 8 PROFESSOR GILMOUR:
 9 Q. - the patient or the--so that type of
 10 privilege.
 11 MR. PETER BROWNE:
 12 Q. Peer review protection type of thing.
 13 PROFESSOR GILMOUR:
 14 Q. I have a bit of a mixed response on this, and
 15 I did do an extensive patient safety study for
 16 Health Canada and it was an international
 17 study, so in addition to Canada, looked at the
 18 United States and Australia and England and
 19 New Zealand, where they have a no-fault
 20 system, and what became very apparent to me
 21 was that even in jurisdictions where there was
 22 legislated protection from disclosure, there
 23 was a great deal of non-disclosure. So in
 24 other words, if you are protecting from
 25 disclosure, the idea of that is to get more

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1 information out. As we've heard this morning,
 2 it's important to surface the information so
 3 that you know what you're trying to fix. So
 4 the problem was that even with the legislated
 5 protection, there wasn't a whole lot more
 6 disclosure and that may be particularly
 7 because the American environment is especially
 8 worried about litigation. But it wasn't a
 9 sure thing that if you had this kind of
 10 protection from disclosure that the
 11 disclosures would increase.
 12 That said, I do think that it is really
 13 important to get more disclosure. I think
 14 that it is absolutely crucial to get this
 15 information so that you know what to fix, and
 16 so in that sense, there's a balancing. And so
 17 in the report that I did, one of the things
 18 that I recommended is that if you're going to
 19 have legislation that expands this qualified
 20 privilege as we become aware of the need to
 21 share among institutions and so on, that
 22 perhaps we should include an incentive for
 23 disclosure in it. So that perhaps we could
 24 include something like a sunset clause, use it
 25 or lose it. If we aren't getting disclosure

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1 here, then maybe this isn't a privilege that
 2 we should continue because when you keep
 3 relevant information from being disclosed,
 4 that also has costs, right, and I don't mean
 5 financial costs. It has costs in terms of we
 6 don't get at things that we're used to getting
 7 at in a law suit. We don't get at other
 8 information available to the public and so on.
 9 So I'm not against that kind of legislation,
 10 but I think that we need to establish that
 11 it's working or increase the incentive so that
 12 it works.
 13 MR. CAULFIELD:
 14 Q. Interesting. Bernard?
 15 PROFESSOR DICKENS:
 16 Q. To approach it initially from the ethical
 17 perspective, quality assurance perhaps an
 18 aspect of risk management, clearly fits the
 19 goal of beneficence. It is a good thing to
 20 learn from errors. The United States
 21 Institute of Medicine's report on errors was
 22 titled Learning From Errors. That requires
 23 that they be disclosed to those who can learn
 24 from them. That is individual physicians
 25 ought to be encouraged to disclose among

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1 colleagues the errors that have occurred,
 2 negligent or non-negligent, so that one could
 3 learn from them, and minimize, if not entirely
 4 avoid their repetition. And of course, that
 5 fits into the related ethical principle of
 6 non-maleficence, that is reducing the incident
 7 of repetition of errors.
 8 Equally, there has to be disclosure to
 9 the hospital administration. There had to be
 10 disclosure, on occasion, to licensing
 11 authorities to see whether individuals are in
 12 need of retraining. So clearly the duty to
 13 maintain, conscientiously and effectively, a
 14 system of quality assurance, quality securing
 15 is within an ethical framework. One could go
 16 beyond saying this is ethically justified to
 17 say that it's ethically required.
 18 The question of legal admissibility fits
 19 into the policy framework that I've mentioned,
 20 that if those who undertake identification of
 21 errors, including negligent errors, are going
 22 to make themselves legally liable to pay
 23 compensation and those agencies that don't
 24 undertake this don't provide that evidence
 25 against themselves, then there's a negative

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1 incentive, an incentive not to follow up.
 2 At the level of clinical care, in the
 3 doctor-patient relationship, although we have
 4 clear demonstration of the legal requirement
 5 of adequate disclosure to achieve informed
 6 consent, there is a narrow margin of so-called
 7 therapeutic privilege that is the duty--not
 8 the duty, the power that the physician has not
 9 to disclose information that would be counter-
 10 therapeutic and the incentive of the courts,
 11 for obvious reasons, is to keep a so-called
 12 therapeutic privilege of non-disclosure in a
 13 very narrow range because of the risk, as the
 14 courts have said, that this so-called
 15 privilege could overwhelm the duty of
 16 disclosure and destroy it.
 17 In the context of disclosure to
 18 individual patients of errors from which they
 19 were not harmed, we get back into exploring
 20 the discussion that we launched this morning
 21 of whether it would make patients anxious and
 22 worried to know that there was a near miss,
 23 whether there was a failure of the system.
 24 And of course, if one actually has systems to
 25 check errors so that the pharmacist gets back

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1 to the doctor and says "I'm not clear from
 2 this prescription whether you're prescribing
 3 2.5 milligrams or 25 milligrams," and the
 4 doctor said "2.5" and the pharmacist said "but
 5 the document here could be understood as 25,"
 6 then that is a check that has worked
 7 effectively. That is the system has worked.
 8 Is it beneficial to tell the patient,
 9 "gee, there could have been an error that we
 10 avoided." Is that reassuring? Does the
 11 passenger--just to go back to the airplane
 12 analogy, getting on the plane or close to
 13 schedule, landing safely on schedule and going
 14 about his or her business, need to be told
 15 that as you were coming in to land there was
 16 another plane within a prohibited distance of
 17 your plane, and there could have been a
 18 disastrous collision, but there wasn't, so
 19 you're fine. Do you really want to know that?
 20 And if one doesn't need to know, as one walks
 21 out of the airport that you could have been
 22 carried out in a coffin, is this something
 23 that the public at large is entitled to know?
 24 Now I think one could make a case for the
 25 latter. That is, and again this is consistent

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1 with the Canadian Institute for Health
 2 Administration, publicizing data. One knows
 3 that there will be errors, negligent and non-
 4 negligent, in the system. One shouldn't
 5 suppose that there is a record of perfection.
 6 One shouldn't anticipate perfection. This is
 7 part of education of the public at large that
 8 mistakes occur. Bad stuff happens, and that's
 9 simply a reality check, and this is something
 10 that I think there's a legitimate case to
 11 present to the public in quantified terms, if
 12 need be, that one in thirteen patients going
 13 into hospital is at risk of suffering or will
 14 suffer an adverse event. Whether individual
 15 patients ought to be told is an area, I think,
 16 of more clinical judgment. That is if it
 17 makes patients anxious about any repeat
 18 treatment, then it well could be that this is
 19 a dysfunction and this was something that was
 20 touched on this morning.
 21 In the context of informed consent, and
 22 this is a very narrow instance, if a surgeon
 23 made a mistake and the surgery has to be
 24 repeated, then the patient may have an
 25 interest in not having the surgery undertaken

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1 by that same surgeon who made the mistake.
 2 That itself could be an error.
 3 If I could just comment on experience in
 4 the United Kingdom, the idea of publicizing
 5 hospital mortality rates and mortality rates,
 6 adverse events specific to individual
 7 surgeons, this has been recommended. But it
 8 risks the dysfunction that the really
 9 difficult cases will be sent to the major
 10 hospital through referral hospitals and they
 11 will have the deaths rather than the local
 12 community hospital that doesn't want to take
 13 the chance. There is evidence, and this is
 14 something that perhaps Peter Norton could
 15 comment on, that the hospitals with the least
 16 impressive looking mortality rate and adverse
 17 incident rate will in fact be the better
 18 hospitals. But this is a question that could
 19 be resolved by some evidence.
 20 DR. ETCHELLS:
 21 Q. Perhaps I could speak to that (inaudible).
 22 MR. CAULFIELD:
 23 Q. Sure.
 24 DR. ETCHELLS:
 25 Q. There is no relationship between hospital

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1 mortality rates and quality of care in the
 2 literature right now. So it's not a good
 3 (inaudible) cardiac surgery.
 4 MR. CAULFIELD:
 5 Q. Does everyone hear that? Turn around and say
 6 it loudly.
 7 DR. ETCHELLS:
 8 Q. There's no relationship between hospital
 9 mortality rates and quality of care.
 10 MR. CAULFIELD:
 11 Q. No relationship between mortality rates and
 12 quality of care.
 13 DR. ETCHELLS:
 14 Q. That doesn't mean mortality is not important.
 15 MR. CAULFIELD:
 16 Q. Mortality is important.
 17 MR. ROB RITTER:
 18 Q. I have two related questions. First of all,
 19 in the work that you're doing, Dr. Gilmour,
 20 are there issues in terms of defining an
 21 employee-employer relationship or is there a
 22 standard definition that can be used in the
 23 work that you're doing? The second piece of
 24 my comment, then question, is in cases where
 25 we're talking about non-employed or non-

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1 salaried physicians, people who have
 2 privileges with an institution, in the context
 3 of the privilege, is there not some kind of
 4 implicit contractual or an inherent
 5 contractual element that the institution
 6 that's granting the privileges for that
 7 physician to do their work, whether it's in a
 8 laboratory or in an operating room, is being
 9 provided with, you know, high quality
 10 equipment, adequate support staff, adequate
 11 professional staff and so on? Is that not
 12 part of an implicit contractual arrangement
 13 that in a way might preclude the need to have
 14 an employee-employer relationship in order for
 15 the vicarious liability to remain with the
 16 institution, as opposed to the professional?
 17 Is that confusing or does that make -
 18 PROFESSOR GILMOUR:
 19 Q. Okay. If I'm not clear in my answer on the
 20 second one, in particular, we'll see if we can
 21 work this forward.
 22 In terms of whether or not there's a
 23 standard definition of who is and who isn't an
 24 employee, usually there is and usually it's
 25 quite clear whether somebody is an employee.

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1 Nurses, for instance, are generally employees
 2 of hospitals. There have been cases where the
 3 status has been a little more questionable.
 4 For instance, an intern or resident who may be
 5 considered both an ongoing student of the
 6 university and a hospital employee and so on.
 7 And there have been enough cases in which, for
 8 the most part, someone like an intern or
 9 resident has been held to be an employee and
 10 therefore the institution is vicariously
 11 liable for their negligence and there have
 12 been also other types of physicians, like some
 13 anaesthetists, not all anaesthetists, who have
 14 been held to be in an employment relationship.
 15 So you need to look at the particular
 16 relationship between whoever it is you're
 17 considering.
 18 When it comes to the question of
 19 privileges, and it used to be that it was just
 20 doctors who got privileges and then dentists
 21 for some sorts of things, and now midwives in
 22 some provinces and so on. We can expect, I
 23 think, that that will continue to expand as
 24 the recognized health professions and their
 25 relationships with hospitals continue to

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1 expand.
 2 You were talking first in terms of is
 3 there a contract relationship. This is not
 4 consistent across all provinces, but in most--
 5 in a number of provinces, that relationship of
 6 the hospital grants privileges to the
 7 practitioner actually isn't considered to be
 8 one of contract. So it's an odd duck in the
 9 law. There are some jurisdictions where it
 10 is, and so you need to look at a particular
 11 jurisdiction. But in terms of what's required
 12 in the relationship of well, doesn't that mean
 13 the practitioner will get high quality
 14 equipment and all, certainly the hospital has
 15 its own responsibilities and as I said when I
 16 was speaking, part of its responsibility, much
 17 more towards the patient, is to make sure that
 18 safe systems are in place for the patient, as
 19 well as selecting competent staff and
 20 monitoring their competence. Part of ensuring
 21 safe systems are in place is to ensure that
 22 the facilities are appropriate for the care
 23 that is being provided and that is much more
 24 of an obligation that flows to the patients
 25 who are being treated.

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1 That said, we recognize that there are
 2 financial realities and that the whole health
 3 care system is working under those
 4 straightened financial circumstances that will
 5 sometimes mean the reality of the care that's
 6 being provided isn't the very best one could
 7 think of, because of that reality.

8 CROSBIE, Q.C.:

9 Q. Professor Gilmour, Ches Crosbie. I'm one of
 10 the legal counsel involved in the Inquiry.
 11 Two questions which may possibly be related to
 12 each other. First is, and it may be just that
 13 I missed what you said or I didn't read your
 14 paper carefully enough. Have we arrived at
 15 the point in Canadian law where there is a
 16 positive or affirmative duty now imposed on
 17 hospitals to promote safety? And I guess the
 18 second question would be, to the extent that
 19 it's in the public interest to promote the
 20 focus for safety promotion purposes to be on
 21 systems, would it be a good thing to shift the
 22 focus when litigating liability from
 23 individuals, for example, doctors, onto the
 24 enterprise, namely the hospital, which I think
 25 is more the case in the United Kingdom?

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1 MR. CAULFIELD:

2 Q. Actually, that was my question too I was going
 3 to pose to you.

4 PROFESSOR GILMOUR:

5 Q. Okay, just a second. Okay. First, is there
 6 an affirmative duty or a positive duty on
 7 hospitals to promote safety, and I don't mean
 8 to dance away from the question, but that's a
 9 very big term, promote safety, and so I think
 10 you'd need to give some content to that. What
 11 hospitals do, I think, have a duty to their
 12 patients to do is to provide safe systems and
 13 to then take steps within the hospital to make
 14 sure that those systems are safe, and I think
 15 that that is a duty that has not been worked
 16 out in detail yet, in terms of what in
 17 particular circumstances that's going to
 18 require of a hospital. So my answer is
 19 somewhat narrower than promoting safety to
 20 providing systems that are safe.

21 Your second question, I think, is should
 22 we shift focus from individual liability to
 23 some form of enterprise liability. There's a
 24 couple of ways that can be done, so I was
 25 certainly talking about the importance of

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1 moving from recognizing that an individual may
 2 be at fault to also paying attention to
 3 systemic factors that have contributed to the
 4 result, and I think that of the ways that
 5 could be achieved, one is to say we're only
 6 going to focus on the enterprise, and in fact,
 7 the enterprise is liable for everybody who's
 8 working there, whether they're there as an
 9 employee or with privileges or whatever else,
 10 and we're just looking at the enterprise.

11 Another way to do it is to maintain both
 12 a focus on an individual and on the
 13 enterprise. If you think about someone who is
 14 recognized now as a employee, like a nurse,
 15 right, a nurse working in a hospital might be
 16 sued for negligence, but the hospital would be
 17 maybe sued as well and it may be sued for not
 18 providing safe systems in which she worked.
 19 It may be sued as being vicariously liable for
 20 that nurse's negligence. So it doesn't seem
 21 to me that those two are mutually exclusive.
 22 In other words, you could have a system in
 23 which you are looking at individual liability
 24 as well looking at the systemic factors that
 25 the organization could be held liable for. So

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1 both.

2 PROFESSOR DICKENS:

3 Q. The last two questions weren't directed to me
 4 and I'm not claiming to answer them, but they
 5 do raise some interesting features in the
 6 context of looking forward. One is moving
 7 doctors from a fee-for-service to a salary
 8 basis. Some hospitals, I know, have done
 9 that. Health ministers like it because fee-
 10 for-service is very open-ended. That is if
 11 instead of a doctor saying you should come
 12 back following today's treatment in six months
 13 and twelve months, if a doctor says come back
 14 in four months, eight months and twelve
 15 months, then on a fee-for-service basis, the
 16 doctor's income has increased 50 percent from
 17 treating that patient. So health ministers
 18 like salaried doctors because they know in
 19 advance what doctors are going to cost them.

20 One legal effect of this is that if
 21 doctors are not being paid on a fee-for-
 22 service basis, there's no contractual
 23 relationship between them and the patient.
 24 You're still a contractor even if the fees are
 25 not freely negotiated, and even if the payment

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1 isn't coming from the patient, it's still a
 2 contractual relationship. If doctors are paid
 3 on a salaried basis, then the contractual
 4 underpinning of the doctor-patient
 5 relationship is gone, and perhaps one
 6 consequence of that is the courts elaborating
 7 the fiduciary duty that binds the doctor to
 8 the patient when there's no contractual duty.
 9 It also means, of course, that hospitals,
 10 if found vicariously liable, will want an
 11 indemnity from the doctor, and even if the
 12 doctor isn't sued by the patient, the hospital
 13 may sue the doctor through third party
 14 proceedings or independently. One consequence
 15 of this is that some hospitals, again within
 16 my experience, will contribute towards
 17 doctors' membership for the Canadian Medical
 18 Protective Association so that if the hospital
 19 is liable for what the doctor has done, the
 20 hospital can then claim against the doctor
 21 with some likelihood of there being funds to
 22 meet the perhaps high damages. If one takes
 23 mismanagement in neonatal care, child may live
 24 as an adult three score years and ten, but
 25 require 24-hour-a-day nursing and this could

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1 run into tens of millions of dollars. So
 2 hospitals will require members of their
 3 medical staff to be members of the Canadian
 4 Medical Protective Association or a comparable
 5 professional self-defence organization and may
 6 contribute towards their membership fees.
 7 The other issue beyond encouraging
 8 doctors to move, requiring doctors to move to
 9 a salary basis is the recommendation of the
 10 Krever Commission, dealing with contaminated
 11 blood supply, where Krever recommended a shift
 12 to no-fault liability. If it happens, there's
 13 compensation. Not for vast amounts of pain
 14 and suffering, the difficult to quantify
 15 claims, but claims for prompt recovery and
 16 full recovery of expenses actually incurred.
 17 This built on the recommendations of an
 18 earlier commission set up by the federal,
 19 provincial and territorial governments, the--
 20 what would I call it, the Prichard report,
 21 recommending that an option of no-fault
 22 liability. That is if it happens, then you're
 23 covered for costs actually incurred, again
 24 modest payment for pain and suffering, but
 25 out-of-pocket expenses fully and promptly

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1 reimbursed, and Prichard recommended that
 2 those who claim injury can either opt for
 3 prompt full payment of expenses incurred or
 4 they can invest in what Prichard called the
 5 forensic lottery. That is you can sue with
 6 the chances of losing and being liable for
 7 your own costs and the other side, or you may
 8 be awarded some monumental sum, including
 9 aggravated and punitive damages going beyond
 10 the injuries actually incurred.
 11 Krever recommended the option--I beg your
 12 pardon, Krever recommended against the option
 13 saying there ought to be mandatory no-fault
 14 coverage for medical mal-occurrences and that
 15 would mean that having to prove fault, having
 16 to prove negligent error or other wrong would
 17 be no more part of the system.
 18 There is some experience of this in New
 19 Zealand that others here may comment on. I'm
 20 not certain the New Zealand experience adds
 21 any special encouragement to the
 22 recommendation of moving to no-fault insurance
 23 because that hasn't reduced litigation in New
 24 Zealand. In New Zealand, one now litigates
 25 about whether the injury occurred within the

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1 no-fault compensation scheme or outside it.
 2 So there's still work for lawyers in this, but
 3 this is something that perhaps one might think
 4 as part of a broader frame of reference.
 5 MR. CAULFIELD:
 6 Q. Lawyers always seem to be able to find work.
 7 MS. JENNIFER NEWBURY:
 8 Q. Thank you. Professor Dickens, I believe you
 9 surmised in your paper that a decision to
 10 cease to monitor quality of a program could be
 11 construed either as a policy decision or an
 12 operational decision, based upon perhaps the
 13 circumstances or the advocacy. If a decision
 14 were made to downsize or cease to monitor
 15 quality of a program, would you see that
 16 there's a duty to notify: A. the patient who's
 17 availing of those services; or B. the public
 18 at large? And I'm thinking that a patient
 19 might choose, in light of that information, to
 20 perhaps travel to a larger centre or to seek a
 21 second opinion, and the public might want to
 22 perhaps lobby government for more money for
 23 the services. And a third aspect of that
 24 question, would there also be any sort of
 25 obligation, in light of the fact that it's a

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1 policy decision, to explore other
 2 alternatives, any checks and balances to make
 3 up for the fact that, for whatever reason, the
 4 particular type of monitoring couldn't be
 5 afforded by the institution?
 6 PROFESSOR DICKENS:
 7 Q. Yes, clearly one wants some follow-up
 8 information of decisions, both of policy and
 9 of the implementation of policy. Whether
 10 governments will accept evidence that their
 11 policies were misguided is a much wider
 12 question, but clearly this is a matter of
 13 legitimate public and political interest.
 14 If there are failures at the level of
 15 operation, again, I think this is something
 16 that is properly within the realm of public
 17 disclosure. This is something that ought to
 18 be communicated and it ought also to come from
 19 agencies with sufficient independence of the
 20 operators to be credible. We know that when
 21 agencies are disclosing information that could
 22 implicate their own fault, they could put a
 23 favourable spin or emphasis on it. Whether
 24 this is something that feeds into litigation,
 25 I think will turn on the merits of individual

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1 cases. But in principle, I think there ought
 2 to be, as Norman Daniels puts it, there ought
 3 to be transparency in decision making and
 4 transparency in follow up data.
 5 MS. NEWBURY:
 6 Q. Thank you.
 7 MR. CAULFIELD:
 8 Q. Thank you very much. Now remember everyone
 9 that we have an hour and a half at the end of
 10 tomorrow, the morning session, to tackle any
 11 questions. So if you do have questions that
 12 haven't been answered and you want to make
 13 sure that they get on the table, please write
 14 them down and make sure that you get a chance
 15 to air them tomorrow.
 16 So now we're going to have a break, but
 17 before we break, I'd again like to thank our
 18 panel members. So let's try to start back on
 19 time at as close to quarter past as we can.
 20 Thank you.
 21 (BREAK)
 22 MR. CAULFIELD:
 23 Q. (Mic not turned on).
 24 DR. GALLAGHER:
 25 Q. Can everybody hear okay? It really is a

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1 pleasure to be here today and I think we're
 2 really at an exciting time when it comes to
 3 the issue of disclosure of unanticipated
 4 outcomes and harmful errors to patients. I
 5 think there's a strong awareness that there's
 6 a gap between the expectations for disclosure
 7 that you've been hearing about and the actual
 8 clinical practice, and I think that gap is
 9 somewhat surprising to people. There are some
 10 folks who look at the issue of disclosure and
 11 they think, well, what can be so hard about
 12 that? All you need to do is go tell the
 13 patient the truth. Right, but I think the
 14 clinicians in the audience know that
 15 disclosure is much more complex than that and
 16 at the same time, the implication is well, the
 17 way to improve disclosure is sort of through
 18 exhortation. We remind health care workers
 19 that disclosure is sort of an ethical mandate
 20 and the implication is well, you should just
 21 sort of pull yourself up by your boot straps,
 22 kind of screw up your moral courage and go in
 23 and do the right thing. I think there's a lot
 24 more to disclosure than that, and there are a
 25 lot of exciting programs internationally that

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1 get at what I think is the real gap, which is
 2 the challenge of turning the general
 3 principles of disclosure into actual practice.
 4 We're seeing accelerating interest in
 5 disclosure in a variety of settings. There's
 6 growing experimentation with different
 7 approaches to disclosure at the level of
 8 different countries. Different health care
 9 organizations are trying difference
 10 approaches. Even different malpractice
 11 insurers are coming up with disclosure
 12 programs. There are new standards, that I'll
 13 touch on briefly, in this area that are trying
 14 to help bridge this gap between principle and
 15 practice. You've heard some about some state
 16 laws on disclosure and apology that I'll
 17 mention very briefly. Plus this all sort of
 18 fits in with a growing emphasis on
 19 transparency in health care generally, and I
 20 was interested to see that the issue of
 21 medical errors had made it to Reader's Digest,
 22 although truth be told, I was curious to know
 23 first why is it that sex only gets better, but
 24 we're still a little bit distracted and wanted
 25 to know who are those daredevil stunt sisters.

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1 But I collected myself and got back to the
 2 main article, Fatal Hospital Mistakes and How
 3 to Avoid Them. Turns out this was about
 4 nosocomial wound infections, many of which are
 5 not due to errors, but again dramatizes how
 6 this has hit the public's consciousness.
 7 As I mentioned, not only are people
 8 increasingly interested in disclosure, we're
 9 increasingly aware that there's a disclosure
 10 performance gap. Harmful errors are frequently
 11 not disclosed. The best estimates that we've
 12 seen in the literature are roughly a third of
 13 harmful errors are disclosed to patients, and
 14 when disclosure does take place, we know that
 15 it frequently falls short of meeting patient
 16 expectations for what these conversations are
 17 to be like. Part of the problem is that
 18 there's really relatively little prospective
 19 evidence about what specific disclosure
 20 strategies are effective, and for the
 21 clinicians in the trenches, this makes it
 22 really difficult to know. So how do we turn
 23 this general theory of disclosure into
 24 specific words that I'm going to say to this
 25 patient.

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1 In addition, there's very little evidence
 2 about the impact of disclosure on outcomes,
 3 and the debate continues to rage about the
 4 impact of disclosure on litigation. As you've
 5 heard, there's some suggestive evidence that
 6 there might be a positive effect, but I think
 7 it's a little bit more complex story than that
 8 and that uncertainty, I think, really makes it
 9 hard for health care workers and organizations
 10 to know what to do, and this leads to
 11 disclosure strategies that you might describe
 12 as counterproductive. Here's a doctor who's
 13 taking the musical approach. He's got his
 14 guitar coming out of the operating room and
 15 sings "Listen up my fine people and I'll sing
 16 you a song about a brave neurosurgeon who done
 17 something wrong." Well, this is one approach
 18 that you could take. Hopefully we can think
 19 of more productive approaches to disclosure,
 20 and what I wanted to do is talk about how
 21 disclosure is rolling out internationally.
 22 We're going to start with the United
 23 States, in part because that's the environment
 24 I'm most familiar with, but also because, as
 25 you've heard, the malpractice climate in the

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1 United States is particularly onerous and I
 2 think programs that might work in the United
 3 States have an even better chance of working
 4 in environments where the litigation climate
 5 might not be quite so problematic.
 6 I'm going to talk a little bit about one
 7 particular standard, one adopted by the
 8 National Quality Forum, just to give you a
 9 flavour for what some of these policies are
 10 looking like.
 11 We'll talk very quickly about a very
 12 interesting development that takes disclosure
 13 and tries to move it forward to include not
 14 just the disclosure conversation, but
 15 disclosure and compensation, to integrate the
 16 response to the error and move beyond the
 17 disclosure process itself.
 18 And we'll talk a little bit about state
 19 apology and disclosure laws, and then we'll
 20 move very quickly through what the apology and
 21 disclosure programs are looking like in a few
 22 other key countries, including Australia, talk
 23 very quickly about the UK, a little bit about
 24 Canada, although I'll leave that mostly to
 25 Sherry Espin who will be talking tomorrow.

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1 Hint very quickly at New Zealand, and then
 2 think about where we're going next.
 3 So first, U.S. disclosure policies.
 4 Well, as you've heard, the expectation for
 5 disclosure has been a part of professional
 6 norms for a long time in many countries and
 7 the U.S. included. It wasn't until the Joint
 8 Commission, which is the organization in the
 9 U.S. that accredits hospitals and health care
 10 organizations, adopted a policy in 2001 on
 11 disclosure that the formal policy ball really
 12 got rolling, and this was a very minimalistic
 13 standard. The Joint Commission standard just
 14 said hospitals are to inform patients about
 15 all outcomes of care, including unanticipated
 16 outcomes, period. That was the extent of the
 17 standard. Didn't specify who, what, where,
 18 when, why, how, right, but this was important
 19 because it was the first attempt to articulate
 20 a policy and it had some teeth, because it was
 21 tied to hospitals accreditation status. And
 22 in response, the vast majority of hospitals
 23 and health care organizations have adopted
 24 some sort of disclosure policy in the U.S.
 25 Those policies range very widely. Some of

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1 them just restate the Joint Commission
 2 standard. Others outline a very elaborate
 3 disclosure policy.
 4 The next important development in the
 5 U.S. was in 2006 when the Harvard Working
 6 Group on Disclosure released their report that
 7 was entitled "When Things Go Wrong." This was
 8 particularly important for a couple of
 9 reasons. One was that it really pushed
 10 forward the importance of accepting
 11 responsibility and apology in the disclosure
 12 process. Now the Joint Commission standard
 13 doesn't say anything about talking about
 14 preventability, error, apology, much less
 15 accepting responsibility. So the Harvard
 16 Working Group statement was really the first
 17 organization to come right out and talk about
 18 a broader process of disclosure.
 19 This was followed up in 2007 by the
 20 National Quality Forum which adopted a new
 21 safe practice on disclosure. I was involved
 22 in the adoption of this, and let me tell you a
 23 little bit more about it, because I think it's
 24 a very interesting model where things what
 25 might be headed.

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1 What are the NQF safe practices? Well,
 2 they're basically a set of thirty consensus
 3 based standards for safe health care that were
 4 adopted and harmonized across a variety of
 5 organizations in the U.S. that are involved in
 6 health care. Disclosure was one of two new
 7 safe practices that came out in 2007. The
 8 other was discharge management.
 9 The final report where this was issued
 10 was in March of 2007. They're in the midst of
 11 rewriting the standards and a new set will be
 12 out or a revised set of safe practices
 13 probably sometime this summer.
 14 What's so interesting about the NQF safe
 15 practices is that they're used in pay-for-
 16 performance programs through the Leapfrog
 17 group and they're used in public reporting
 18 efforts, and so hospital-specific scores for
 19 these safe practices are available on the web.
 20 So if you go to the internet right now and put
 21 in my home zip code, Seattle, up pop four
 22 hospitals within ten miles of that and you see
 23 a variety of scores on CPOE, do they have an
 24 intensivist in the ICU, etcetera. So for
 25 example, if you look at University of

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1 Washington, we get a quarter of a circle for
 2 CPOE. I'm not quite sure how we got a quarter
 3 of a circle. I think you get a quarter of a
 4 circle if you think that CPOE is a good idea,
 5 but we haven't done anything more than that.
 6 Somehow we merited a quarter circle. But the
 7 interesting part is when you get to the safe
 8 practice score column, if you click on that
 9 button, you actually get a list of all 30 safe
 10 practices for an individual hospital. You can
 11 go down here and see patients notified of
 12 problems in care delivery. So this is
 13 University of Washington Medical Centre. You
 14 can see we've got a long ways to go. Out of
 15 the 25 possible points, we got about a quarter
 16 of those.
 17 Now so if you're a consumer and are
 18 interested in these things, for any hospital
 19 that participates in the Leapfrog process, you
 20 can pull up these safe practice scores for all
 21 30 safe practices and actually compare them
 22 across hospitals. Is this going to drive
 23 consumer behaviours? Are consumers going to
 24 look at this and think "wow, University of
 25 Washington, not doing so well on disclosure.

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1 I don't know if I want to go there?" Hard to
 2 tell. But it is an important internal
 3 motivator of prompting change.
 4 So what's in the safe practice? Well, it
 5 emphasizes transparency as a core value, where
 6 the risk management implications of disclosure
 7 are important but they're secondary. The
 8 other important parts of the safe practice is
 9 it links disclosure with performance
 10 improvement. This is really important and it
 11 goes in both directions. So the safe practice
 12 envisions disclosure as feeding the
 13 performance improvement process. You've heard
 14 about partnerships with patients. The
 15 disclosure process can generate information
 16 about the event. You can then feed into the
 17 performance improvement process. I'm
 18 especially interested in the opposite
 19 direction, which is using performance
 20 improvement tools to actually enhance
 21 disclosure. We know that there's a gap
 22 between practice and policy in disclosure and
 23 in no other area of the hospital would we see
 24 this performance gap and not try to start
 25 measuring how is this practice going. But at

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1 the moment, I would be shocked if any of the
 2 hospitals you're affiliated with measure, in
 3 real time, how is disclosure going, right.
 4 This is what performance improvement really
 5 calls for. When a disclosure happens trying
 6 to see how did this go from the patient's
 7 perspective. How did this go from from the
 8 doctor's perspective? And then using that
 9 information to drive performance improvement
 10 on disclosure.

11 It talks a lot about the process of
 12 disclosure and it details an institutional
 13 support system for disclosure. This is
 14 important because lots of people, as I hinted
 15 at at the beginning, have sort of implied that
 16 transparency is something that resides within
 17 the individual health care worker, right, and
 18 that if you have high moral fibre and are
 19 disposed to transparency, you'll be a good
 20 discloser. That's not right. Disclosure and
 21 transparency are system properties, right, and
 22 so hospitals and health care organizations
 23 need to put the processes in place to support
 24 disclosure and transparency. The safe
 25 practice lays out what some of those might be,

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1 including background education, just in time
 2 coaching. So when you're at a hospital that's
 3 participating in this program, you can get a
 4 hold of someone 24/7 who's a disclosure expert
 5 to help you in real time with your disclosure
 6 decisions.

7 So very quickly, the content of
 8 disclosure includes empathic communication of
 9 the facts of the event and its preventability.
 10 The "and its preventability" part is huge,
 11 because as you'll see, this is an area of lots
 12 of debate and discussion across the world,
 13 right. When we're talking about disclosure,
 14 do we focus on the adverse event? Do we focus
 15 on the error? Do we tell the patient this was
 16 preventable? The safe practice comes right
 17 out and says you need to tell them about the
 18 unanticipated outcome and whether it was
 19 preventable, an expression of regret for all
 20 unanticipated outcomes, and a commitment to
 21 investigate and prevent recurrences.

22 Well, here's what they mean by the facts.
 23 An explicit statement about what happened, an
 24 explanation about why the event occurred and
 25 its preventability to the extent known and

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1 then an explanation of the consequences of the
 2 event for the patient's future health. This
 3 notion of providing information about results
 4 of analysis is an important part of the safe
 5 practice. It calls for patients being told
 6 about the results of the investigation
 7 relevant to the unanticipated outcome are
 8 communicated to the patient, including whether
 9 the unanticipated outcome resulted from an
 10 error or system failure, in sufficient detail
 11 to support informed decision making by the
 12 patient. We could have a very interesting
 13 conversation about how much of the analysis
 14 should you share with the patient. This used
 15 an informed decision making standard to try to
 16 guide that.

17 An apology including an expression of
 18 regret for all unanticipated outcomes, so an
 19 expression of regret is "I'm sorry this
 20 happened," right, whereas a more full apology,
 21 "I'm sorry that you were harmed by our error,"
 22 is appropriate when analysis shows that there
 23 was a clear cut error or system failure.

24 I mentioned the support system. It
 25 really is key, providing emotional support,

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1 providing disclosure education and providing
 2 disclosure coaching around the clock. But
 3 even with all of those things in place,
 4 disclosure can still be difficult. So this
 5 health care team has come to the patient and
 6 says "this probably isn't going to mean much
 7 to you, but we took your brain out and
 8 misplaced it." The patient's looking,
 9 understandably, a little bit confused about
 10 all of this, and so people have been trying to
 11 think "well, what else can we do to promote
 12 disclosure?"

13 One thing that's happened in the U.S.,
 14 and as you've heard in other countries, are
 15 adoption of apology and disclosure laws, 35
 16 states in the U.S. and the District of
 17 Columbia have adopted some form of an apology
 18 law. The important thing to recognize about
 19 these, and this is true across the world, is
 20 that the protection varies widely. In most of
 21 the countries in the U.S. that have--excuse
 22 me, most of the states in the U.S. that have
 23 adopted these have adopted a very limited form
 24 of an apology law that just protects the
 25 expression of regret. So it protects the "I'm

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1 sorry," but does not protect any expression or
 2 admission of liability that's within the
 3 disclosure statement itself. So the "I'm
 4 sorry" is protected. The "about what
 5 happened" may not be protected, and even for
 6 those, there are four states in the U.S. that
 7 protect the entire disclosure and apology
 8 statement, it doesn't mean that you can't be
 9 sued because of the disclosure and that would
 10 happen if the disclosure or apology is what
 11 alerts a patient to an event that they would
 12 have otherwise been unaware of. Seven states
 13 actually mandate the disclosure of serious
 14 unanticipated outcomes. Usually the
 15 disclosure burden falls to the institution,
 16 although in Florida, I think it also--the
 17 health care worker is mentioned individually.
 18 We're really not sure, given these
 19 limitations. These are useful public policy
 20 endorsements of transparency, but how much
 21 effect they're really going to have on the
 22 conduct of disclosure, I think is uncertain.
 23 So now let's switch quickly and talk a
 24 little bit about some of these disclosure and
 25 offer programs. You heard a little bit about

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1 the University of Michigan program. They
 2 combine disclosure and an offer of
 3 compensation and reported pretty impressive
 4 results. So in the five years since
 5 implementation, here's what their litigation
 6 costs went down, three million to one million,
 7 and the timed resolution and number of claims
 8 really cut significantly down. Now there were
 9 also temporal trends in the same direction in
 10 Michigan as a whole. So this is not
 11 randomized clinical trial level data, but at
 12 least it suggests that at one institution,
 13 they adopted this policy of disclosure and
 14 full and early compensation and the sky did
 15 not fall in.
 16 COPIC is the other example I wanted to
 17 talk about, and it's important because it's a
 18 large Colorado malpractice insurer that
 19 insures mostly private practice physicians. A
 20 lot of these disclosure programs have
 21 germinated in academic centres that are self
 22 insured. The individual providers aren't on
 23 the hook for buying their own malpractice
 24 insurance. The private practice environment
 25 in the U.S. is a little bit different. COPIC

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1 insures mostly private--or all private
 2 practice physicians in Colorado and they
 3 developed what they call their three R's
 4 program in the late 90s. This is a program
 5 that seeks to promote disclosure and early
 6 offers of compensation to patients. It's a
 7 no-fault program. There are some exclusions:
 8 so patient death is an exclusion; attorney
 9 involvement, a very controversial exclusion;
 10 complaint by the patient to the Board of
 11 Medical Examiners; or a written demand for
 12 payment from the patient. So these are sort
 13 of moderate level events, not super serious
 14 events. But because the patients are not
 15 asked to sign a waiver of their right to sue
 16 and because this is a payment that's not made
 17 in response to a written demand letter, these
 18 are not payments that are reportable to the
 19 National Practitioner Databank, which is an
 20 entity in the U.S. where all payments made on
 21 behalf of providers need to be reported. And
 22 so from the provider perspective, these
 23 attributes make the three R's program very
 24 attractive, because they can compensate
 25 patients without having to report the provider

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1 to the databank.
 2 So how does three R's work? The event
 3 gets reported and as you'll see, this hinges
 4 on a very active and open culture of early
 5 event reporting at COPIC. The physician and
 6 COPIC need to decide whether it's appropriate.
 7 The doctor tells the patient about the
 8 program. The doctor gets some coaching and
 9 COPIC then will pay the patient up to \$30,000
 10 for lost income and other out-of-pocket
 11 expenses for the program. And let's a little
 12 bit of data from COPIC on how this works. We
 13 had a little bit more up-to-date data in our
 14 New England Journal article. Basically, there
 15 were five--roughly 4600 reported events in the
 16 50 month period. That's a lot of events, a
 17 lot of doctor reporting to this program.
 18 Roughly half of them met the criteria for the
 19 three R's program. 1600 of them were closed
 20 with no payment to the patient, which COPIC
 21 interprets as full disclosure and apology were
 22 sufficient, right. You could test that
 23 hypothesis empirically, but that's COPIC's
 24 interpretation that we disclosed it and the
 25 patient said "that's good. I don't need any

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1 money." Of the 500 events closed with
 2 payment, the average payment was only \$5600.
 3 So it suggests that if you provide these types
 4 of payments, patients are not going to try to
 5 max out the system, and none of these events
 6 has proceeded to a full jury trial.

7 So COPIC's experience with this has been
 8 positive. There are other things that make
 9 the Colorado environment particularly amenable
 10 to such a program, but I think we're really
 11 seeing this notion of coupling disclosure and
 12 compensation as one that has potential
 13 benefits. But there are also some potential
 14 problems, so here the health care team is
 15 coming to the patients and say "first the good
 16 news, we're not going to charge you anything,"
 17 and this cartoonist thinks this is a time to
 18 worry, right. Where does compensation fit in
 19 this disclosure process? What sorts of events
 20 would you compensate, for how much? There's a
 21 lot of unanswered questions in this area.

22 So now let's quickly move and look at a
 23 couple of programs across the country.
 24 Australia was actually in the Vanguard of
 25 developing a program for open disclosure and

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1 adopted its open disclosure standard in the
 2 year 2003. It focuses on adverse events. In
 3 fact, you really have to look long and hard
 4 throughout the whole standards to see the word
 5 "error" anywhere. It really is a focus on
 6 adverse event exclusively. They divide events
 7 into high and low level events and have
 8 different disclosure responses for the low
 9 level versus the high level events. It calls
 10 for an expression of regret, but does not call
 11 for a formal apology after these sorts of
 12 events, and Australia, like the UK that we'll
 13 talk about in a minute, really has done a
 14 great job of developing educational resources.
 15 So very extensive set of educational material
 16 that individual states in Australia can use to
 17 implement this open disclosure standard, and
 18 there is a little bit of pilot data coming
 19 out. So individual states were supposed to
 20 adopt a policy consistent with open
 21 disclosure.

22 Queensland is probably the state that's
 23 gone the furthest in this area. They have a
 24 pirate report on their website that you can
 25 download in detail, and the results of the

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1 pilot project show a couple of things. First,
 2 there's this ongoing tension between
 3 transparency and medical legal concerns and
 4 particularly, and this theme has already
 5 surfaced today, this issue of protecting the
 6 root cause analysis results versus sharing
 7 this information with the patient. It's
 8 really caused a lot of problems in Australia,
 9 trying to figure out how much of the root
 10 cause analysis can we share with the patient
 11 and does that eviscerate the legal protections
 12 for the root cause analysis.

13 The pilot results also highlight other
 14 challenges regarding implementation of this
 15 open disclosure standard. So balancing timely
 16 disclosure with the need to really conduct a
 17 thorough investigation. You'll see on the
 18 site, they report the results of, I think, 23
 19 patient interviews and this was a pretty
 20 common complaint. It took a long time for
 21 them to get back with me with results about
 22 what happened, and I think that when you read
 23 the report, it has lots of surveys of
 24 patients--excuse me, lots of surveys of health
 25 care workers, key informant interviews.

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1 There's very, very, very little data from
 2 patients. And I think the concern has been,
 3 in Australia and elsewhere, that if we start
 4 asking patients about how disclosure is going,
 5 maybe bad things will happen, right. It's a
 6 little bit like, you know, the concern that if
 7 you ask a depressed patient whether they're
 8 suicidal, they'll think "well, I weren't
 9 before, but now that you mention it, that does
 10 sort of sound attractive to me." I think
 11 people worry that if you ask a patient about
 12 their satisfaction with disclosure, they'll
 13 say "oh well, now that you mention it, I
 14 really don't think Dr. Gallagher told me the
 15 whole truth," right. So that's inhibiting, I
 16 think, our efforts to learn how is the
 17 disclosure process actually going.

18 The UK developed its Being Open policy
 19 that was published in 2006 and really drew on
 20 the Australia open disclosure standard as a
 21 starting point, but in the UK policy, apology
 22 is really front and centre. So the policy
 23 reads "patients should receive an apology."
 24 Remember, in Australia didn't even use the
 25 word "apology" right. "Patients should

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1 receive an apology after the patient's safety
 2 incident has occurred and staff should feel
 3 able to apologize on the spot. Saying sorry
 4 is not an admission of liability and it is the
 5 right thing to do."
 6 There's been some pilot evaluation
 7 ongoing in the UK as well, after extensive
 8 educational efforts were undertaken, but we,
 9 again, know relatively little about how are
 10 these events, how are these disclosures being
 11 experienced from the patient perspective.
 12 So Canada took all that information from
 13 across the world and launched some very
 14 impressive guidelines in 2008 on disclosure,
 15 and I'll let Sherry tell you more about them
 16 tomorrow. I think what's particularly
 17 interesting about them is that they really
 18 highlight this tension between transparency
 19 and litigation and accountability and error,
 20 right, and the guidelines come right out and
 21 encourage open disclosure, but they say these
 22 guidelines purposely avoid the use of the term
 23 "error" and go on to describe a number of good
 24 reasons why the term "error" can be
 25 problematic, but it leaves health care workers

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1 in this sort of difficult position. We're
 2 supposed to tell patients the facts about what
 3 happened, but we're not supposed to use the
 4 word "error" and so what do we say and how do
 5 we say it? Similarly, apologies are allowed
 6 in some circumstances, but what those
 7 circumstances are and what the wording of the
 8 apology is is ambiguous, which may be good.
 9 It's nice to have some discretion and
 10 latitude, but I think this is a fundamental
 11 hurdle that we're going to need to overcome.
 12 I don't know if the NQF policy is the
 13 right approach, that just comes right out and
 14 says you need to tell the patient what
 15 happened and whether it was preventable,
 16 right. Is that the right approach? I don't
 17 know, but I know that that's information that
 18 patients would like to hear, but they may not
 19 need to know all of the details, but what
 20 happened and was it preventable I think is
 21 information that patients want to hear about.
 22 So lastly, New Zealand. New Zealand is
 23 particularly interesting to me because it
 24 highlights the disconnect between the medical
 25 legal climate and disclosure. As you heard

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1 earlier, New Zealand has adopted an
 2 essentially no-fault environment around
 3 compensating medical injuries. They have a
 4 very vigorous complaint system. It's not like
 5 litigation has gone away, but it's basically
 6 a--it's sort of as attractive a tort
 7 environment from a physician perspective as
 8 you could imagine would exist anywhere in the
 9 country, and yet, New Zealand's disclosure
 10 programs, even though they're right next door
 11 to Australia, right, are relatively early in
 12 their development. So New Zealand has
 13 endorsed disclosure, but their expectations
 14 are that district health boards need to have a
 15 disclosure policy in place by 2010. So
 16 compared with lots of countries in the world,
 17 really less well developed approach to
 18 disclosure even though the tort and
 19 malpractice environment, I think, is a little
 20 bit more favourable.
 21 So looking across and thinking about
 22 moving forward, what do I think we can
 23 conclude? I think we can conclude that
 24 support for the concept of disclosure is high,
 25 but that there are important implementation

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1 challenges that people are facing and that
 2 implementation at present is really uneven.
 3 We know very little about how disclosures are
 4 currently taking place, and I think if we have
 5 any hope of closing this gap, we're going to
 6 need to start to figure out how can we take
 7 the performance improvement tools that we're
 8 used to using in other settings and start to
 9 apply them to the process of disclosure
 10 itself.
 11 The malpractice environment, I think, is
 12 an obstacle, but I do not think it's the most
 13 important obstacle to open disclosure. I
 14 think things like clinician shame and
 15 embarrassment, lack of communication skills,
 16 are much more important. This is not to say
 17 that doctors do not worry about malpractice,
 18 but in the study I mentioned earlier during
 19 the questions, comparing U.S. and Canadian
 20 physicians' attitudes about disclosure, even
 21 though the malpractice climates in the two
 22 countries are pretty different, U.S. and
 23 Canadian doctors' attitudes about disclosure
 24 were almost indistinguishable. This is
 25 embedded in the culture of medicine and the

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1 way we train health care workers, and so is
 2 going to take a long time for us to try to
 3 fix.
 4 Some of the legal barriers to disclosure
 5 turn out to be enacted from within health
 6 care, right. We need to sort out how are we
 7 going to deal with this issue of sharing the
 8 results of error analyses with patients.
 9 Patients really care a lot about knowing how,
 10 what did you find out about how this happened
 11 and how you're going to prevent recurrences.
 12 But you also heard there are very compelling
 13 reasons why this information ought to have
 14 some legal protection. We need to resolve
 15 that balance, and I think ultimately it's
 16 reasonable to say we're sort of at the
 17 beginning of the beginning of this process of
 18 trying to turn this general principle of
 19 disclosure into a system that really works to
 20 effectively disclose these events to patients
 21 all of the time.
 22 Thank you very much.
 23 MR. CAULFIELD:
 24 Q. Thank you very much, Tom. Do we have any
 25 questions for Tom, before we move on to our

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1 final speaker? Yes, please, your name and go
 2 ahead.
 3 MR. SIMMONS:
 4 Q. Sure, Dan Simmons. One question. The
 5 presentation that you've given us, I take it
 6 to be addressed towards the question of
 7 disclosure to individual patients of adverse
 8 outcomes in the course of their care and it's
 9 a good review of the state of disclosure
 10 policies in various places. Has there been
 11 similar work done, and is it available, to
 12 address the issue of disclosure to the general
 13 public when there's been adverse events?
 14 DR. GALLAGHER:
 15 Q. And not that I'm aware of. You know, some of
 16 the principles might apply, but I think as
 17 you've heard good group discussion about how
 18 there might be important differences in those
 19 two circumstances, I think it's in part
 20 because the instances of disclosure to an
 21 individual patient are much more common than
 22 what I would call these group disclosures.
 23 Although when you look across the world, there
 24 have been a number of instances similar to the
 25 one that prompted this commission, where

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1 considerations had to take place about what
 2 are we going to say to a broader group of
 3 either patients or the general public. But as
 4 far as I know, other than a few individual
 5 institutions, there's no expectation, for
 6 example, in accreditation standards.
 7 Hospitals in general, maybe they developed a
 8 communication policy, but they don't think
 9 about it in the same way as they think about
 10 disclosure to an individual patient.
 11 MR. SIMMONS:
 12 Q. Thank you.
 13 MR. CAULFIELD:
 14 Q. Are there some other quick questions? If not,
 15 we'll move on to our final speaker. Always a
 16 tough spot, last speaker of the day, but I
 17 know that Philip Hebert is ideally suited for
 18 this. Now Philip is a clinician, but also a
 19 bioethics expert from the University of
 20 Toronto. He has been involved in patient
 21 safety issues for a very long time, in fact
 22 has coauthored some work with other speakers
 23 here. So over to you, Philip.
 24 DR. HEBERT:
 25 Q. Thank you very much. Can everyone hear me all

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1 right? Is the microphone okay? Thank you for
 2 the invitation to this important event.
 3 My task is to talk about some of the
 4 ethical issues and policy issues involved in
 5 disclosure of error, and so I'm going to
 6 address some of the issues that other speakers
 7 have addressed, perhaps from a slightly
 8 different perspective.
 9 I want to talk about the traditional
 10 ethos of medicine. Deception is never far
 11 from physician's hearts and medicine has had a
 12 hard time historically with telling the truth.
 13 I'm going to talk about the evolving standards
 14 over the past 50 years and these are still
 15 under evolution, the increasing openness with
 16 patients. I want to look at the intimate link
 17 between truthfulness and trust,
 18 trustworthiness of institutions and
 19 practitioners, and then I want to look at some
 20 policy implications as well.
 21 So doctoring the truth, isn't that a
 22 wonderful phrase? Captures one of the ways in
 23 which physicians typically have exerted their
 24 power over disease and illness, doesn't it?
 25 By making things appear better to patients

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1 than they in fact are; by making them appear
 2 as if somehow a cure of their illness is
 3 somewhat magical, not purely scientific. But
 4 it also some rather bad connotations as well,
 5 to adulterate, sophisticate and to cook, and I
 6 don't know about you, but to me that's not
 7 what you should with data, but that's what
 8 physicians are well known for.

9 Now, you know, there's--you can find this
 10 in many writings prior to the 20th century as
 11 well. This is--Oliver Wendall Holmes is a
 12 well-known physician writer. I love his--
 13 there's such pithy phrases, right. They're
 14 wonderful. Truth is only safe when diluted.
 15 Isn't that great? I mean, that's true. You
 16 know, we don't tell people the truth all the
 17 time. We don't tell everybody the truth all
 18 the time. We do make allowances for tact and
 19 for telling things carefully in social
 20 situations, and why should physicians or
 21 health care professionals be any different? I
 22 say physicians, but really what I say applies
 23 to any health care professional. I don't
 24 think one profession is more suited to truth
 25 telling than others. I don't think dentists

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1 are better than doctors, are better than
 2 nurses and so on and so forth. So I think we
 3 all suffer from this. And I like this other
 4 one, I guess when you're riding your horses,
 5 you have your saddlebags. Your patient has no
 6 right to tell the truth than the--to the true--
 7 all the truth than he has to all the medicine
 8 in your saddlebags. He should only get so
 9 much as is good for him. Of course, the
 10 assumption there is there is something about
 11 medicine that requires a certain aspect of
 12 deception, and the trust involved--put into a
 13 physician or health care professional could
 14 not be there were not an aspect of deception.
 15 And of course, that's probably not surprising
 16 because medicine, up until this century,
 17 really could do very little for patients
 18 anyway. So if you were going to get better,
 19 you had to hope you were going to get better.

20 Why was deception advised? Well, I think
 21 it had to do with attitudes and beliefs about
 22 patients. The belief--and of course, these
 23 are true to some extent today as well. I
 24 mean, you ask physicians why you didn't tell
 25 patient the whole truth about the situation or

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1 a better approximation to the whole truth, if
 2 not the whole truth itself. They will say
 3 things, well, patients can't really
 4 understand. I'll be there all day explaining
 5 things, you know. So they tend to exaggerate
 6 the difference between patients and
 7 physicians, even in these days of lots of
 8 information providing, and they think that
 9 patients are only capable of understanding or
 10 accepting so much of the truth. The truth is
 11 a harsh reality and patients are like children
 12 and they have to be treated in that kind of
 13 way when it comes to information practices.
 14 And then physicians engage in all sorts of
 15 protective behaviour, vis-a-vis patients as
 16 well. And this is just one study from
 17 sometime ago, not that long ago, 60 years ago,
 18 published in JAMA was a survey of physicians
 19 who wouldn't, at that time, disclose a
 20 diagnosis of cancer to patients, and why?
 21 Well, not surprisingly, there wasn't much
 22 treatment for cancer, even at that time, and
 23 there was also worries about the effect the
 24 truth would have upon patients, deny them any
 25 hope, and they'd give up and they'd die

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1 sooner. And you still find these attitudes.
 2 The view is that the truth, the uncomfortable
 3 truth is really unbearable for patients and
 4 part of the job as a physician as being a
 5 healer, is not to do harm to patients and to
 6 protect them from these uncomfortable truths,
 7 and the Courts sometimes accepted this. They
 8 went along with this.

9 This is a case I found when I was looking
 10 through an old BMJ journal for 1950s, and the
 11 patient had--a physician had left a large
 12 needle inside the patient's perineum. Not
 13 supposed to do that. And the physician didn't
 14 want to tell her about this because that would
 15 cause her excessive worry, and the Court
 16 agreed. The Court went along with the
 17 physician, said that was all right. Said, I
 18 cannot (unintelligible) any abstract duty to
 19 tell patients what's the matter with them. It
 20 depends on the circumstances, a patient's
 21 character, health and social position, and so
 22 on and so forth. Well, we're not talking
 23 about patients generally, we're talking about
 24 what about this patient. Anyway, he got away
 25 with it. Of course, you wonder is this

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1 deception really for the good of the patient
 2 or is for the good of the practitioner.
 3 So I mean, at this time in medicine, and
 4 I think this is still why it's so difficult
 5 sometimes for physicians or health care
 6 practitioners generally to hear this message.
 7 We still have this belief that do no harm is
 8 the most important principle. Of course, I
 9 think everything we do in medicine has some
 10 risk of harm. So if you're going to try to do
 11 no harm, you'd probably do nothing in
 12 medicine. Of course, that involves risks too,
 13 right? So in the middle of the road, you may
 14 get run over in both directions.
 15 But this is a prioritization of the
 16 patient's wellbeing over the information
 17 provided to the patient that the view is the
 18 truth won't do much good and if it won't do
 19 much good, why would we tell, especially if
 20 there may be some harms. So you could argue
 21 there is an argument from tact here.
 22 Deception is helpful because it prevents these
 23 uncomfortable truths from being known to
 24 patients. And of course, this is much
 25 influenced by the meagre impact of therapy at

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1 that time upon disease. Just because we
 2 couldn't do very much, why would we tell
 3 patients about this? There's no good will
 4 come from the truth.
 5 So sea-change (phonetic) began in the
 6 late 1960s, influenced by many things.
 7 Certainly a big element was the improvements
 8 in care. We could actually do things that
 9 made a difference to patients. We could
 10 actually improve their care, improve their
 11 length of life. There were options they could
 12 choose between. There was no--just one way of
 13 proceeding. There was different ways of
 14 proceeding and so some difficult decisions had
 15 to be made. You had to make risk balance
 16 assessments and you could actually perhaps
 17 help patients, but more importantly, I think
 18 there are also social trends as well towards
 19 greater democratization in society generally
 20 and a greater interest in autonomy and
 21 wellbeing. Wellbeing is defined from the
 22 patient's perspective, so there's no longer a
 23 physician-based perspective. It was
 24 increasingly expected you'd incorporate the
 25 patients' perspective into decision making and

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1 of course, if a patient is going to make
 2 decisions, then they need information for that
 3 decision making, and if you didn't provide
 4 them with it, then they couldn't make informed
 5 choices or informed about what care they could
 6 receive.
 7 Patients generally have not been shy of
 8 wanting to know the truth. Studies going back
 9 before the Oken study, and this is just a
 10 couple of studies from sometime ago, one from
 11 the late 1950s, that showed that most patients
 12 and their families wanted to know the
 13 diagnosis of cancer. These are American
 14 studies, of course. The U.S. President's
 15 Commission on Ethical Problems in Medicine in
 16 1982 commissioned a number of papers and they
 17 found at that time too that many patients want
 18 to know the diagnosis of cancer. So the
 19 attitude towards truth telling was important
 20 for patients and has always been important for
 21 patients, hasn't required the therapeutic
 22 rationale physicians seem to want.
 23 Now this is a sea change. It's not a
 24 wall. It's not a tsunami. It's not all of a
 25 sudden everything changed in medicine.

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1 Nothing changes that quickly. Some fields of
 2 medicine have been more open and more able to
 3 adopt patient-based decision making. Others
 4 have been less able to do so, and certainly
 5 some parts of the world are more comfortable
 6 with this perspective, and you'll still find
 7 the paternalistic kind of doctor knows best
 8 perspective in many parts of the world. And
 9 then there's parts of medicine which have less
 10 direct patient contact, such as radiology and
 11 pathology, which has typically not been
 12 involved in the disclosure process and
 13 probably should be and will be in the future.
 14 I'm going to talk about that in a few minutes,
 15 but in the past, they really have been free
 16 from, as it were, the autonomy principle of
 17 medicine.
 18 So I think there's a revolution in
 19 medicine around information providing that is
 20 still spreading. It's not finished, and it
 21 will take some time to undergo, but we're
 22 still in the process of seeing this principle
 23 of truthfulness through, and just a survey the
 24 changes in American physicians again attitude
 25 towards truth telling, here's 20 years after

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1 the Oken study, again another diagnosis. This
 2 time physicians are quite prepared to tell
 3 patients the diagnosis of cancer. So there's
 4 almost a complete reversal in how physicians
 5 approach at least this diagnosis.
 6 So what do patients want? Well, I think
 7 many studies show that patients want to be
 8 informed, not necessarily to make the
 9 decisions themselves. In fact, there's some
 10 evidence that if you try to get patients to
 11 make decisions that may raise their anxiety
 12 levels and so on, but at least when it comes
 13 to information providing, most patients want
 14 that, if they don't necessarily want to make
 15 the decision themselves. And they also want
 16 to feel supported. Who can I rely upon? Who
 17 can I trust? Who can I fall back upon if
 18 things don't go well? And trust goes along
 19 with information provision.
 20 What does trust in medicine require?
 21 Does it require that uncomfortable truths be
 22 hidden, which was true in the past? That
 23 patients be protected from negative emotions,
 24 is that what disclosure is all about? I don't
 25 think so. Or should, as Cabot said, a

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1 physician in the early part of the last
 2 century, professionals should strive to create
 3 a true impression in their patient's mind. So
 4 not necessarily telling the patients the whole
 5 truth, but creating a true impression in the
 6 patient's mind, and that's what disclosure is
 7 all about. And we'll find this in modern
 8 ethical codes as well, the British Medical
 9 Association. Relationship of trust depends
 10 upon reciprocal honesty between patient and
 11 doctor. Canadian Medical Association
 12 emphasizes in its code of ethics about the
 13 requirement for disclosure to patients where
 14 it may have a bearing upon medical decision
 15 making. Some would argue truth telling goes
 16 beyond that, it's not just medical decision
 17 making. It's how patients want to live and
 18 how they see their life in the world as a
 19 whole, so really probably truth telling goes
 20 beyond what's in the CMA's code of ethics.
 21 And they must communicate that information in
 22 a comprehensible way.
 23 So truth and trust go together. Trust is
 24 necessary for the therapeutic relationship.
 25 Patients, if they don't think that physicians

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1 are going to be entirely honest with them or
 2 open with them about what's going on, they're
 3 less likely to share intimate details of their
 4 life with physicians, health care
 5 practitioners generally. So it's important
 6 for that therapeutic relationship to take
 7 place that there be this relationship of truth
 8 between patients and health care
 9 practitioners. They really are inseparable
 10 and truth telling has been defined as not
 11 necessarily telling patients everything or
 12 telling patients everything, but as Cabot
 13 suggested, trying to create a truth impression
 14 in the minds of patients, intending not to
 15 mislead or to deceive, and that may be quite
 16 different than medicine in the past.
 17 The primary ethical principle, of course,
 18 these days is respect to persons. I think
 19 that is--that's not the only ethical principle
 20 by any means, but it is a primary one these
 21 days in western medicine, and the patients are
 22 adults, they're not children. They need to
 23 be treated like adults and information is
 24 important for adults to make decision, and
 25 while in the past it might have been said how

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1 can the patient stand being told, the new
 2 principle is now how can the patient stand not
 3 being told. So the assumption is that
 4 disclosure should be this default position and
 5 non-disclosure only the exception to this.
 6 The role of truth telling has--there's
 7 many ethical rationales for truth telling
 8 disclosure in medicine and Bernard mentioned
 9 these principles already, but to see how they
 10 capture--fit into the scheme of truth telling.
 11 Obviously the most important thing is that it
 12 enables patients to live their lives as they
 13 see fit. That's what decision making is all
 14 about. It's not about making--having patients
 15 make the right decisions or having information
 16 that's not going to upset them. It's about
 17 helping them to see their lives as they truly
 18 are, if they want to know that, of course, and
 19 to help them make informed decisions is a
 20 secondary part of that. Not just to make
 21 decisions about their lives, but to make
 22 decisions about therapy and information may be
 23 important for that.
 24 Another reason is from the principle of
 25 beneficence, that truth telling fosters good

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1 decision making, improves clinical outcomes.
 2 There have been many studies showing this,
 3 some which I detail in my paper, and
 4 encourages better, which now call it
 5 concordance between doctor and patient, not
 6 compliance, not patient compliance, but
 7 concordance, agreement between the physician
 8 and the patient.
 9 And the last issue is one really of
 10 justice (phonetic) or maybe also the principle
 11 of autonomy as well. Patients, when asked why
 12 do you want to know? Well, they say why do I
 13 have to tell you why? There's no reason. One
 14 study in multiple sclerosis patients say "why
 15 should I have to explain why. I just want to
 16 know." Not necessarily they're going to do
 17 anything with all that information, but they
 18 just want to know what their diagnosis is or
 19 what their problem is. Whether they can do
 20 anything with that information is up to them
 21 to decide. So there's really a right to know
 22 there which comes, you can say is an element
 23 of natural justice or maybe respect due
 24 persons.
 25 So the many worries in the past about

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1 psychological harm or the harms caused by
 2 disclosure haven't been borne out by studies.
 3 Most people want to know. There is, however,
 4 ten to twenty percent of patients who don't
 5 want to know the truth. I think that's
 6 important for any decisions about how to
 7 proceed in this matter. It's particularly
 8 difficult when there are populations at risk,
 9 when it's not just one patient you need to
 10 tell, but a group of patients. There may be
 11 some people in that group who don't want to be
 12 informed, who don't want to know the truth,
 13 and what do you do about that? I think it's
 14 hard to answer that question generally, but to
 15 say you have to have good information sharing
 16 practices. I'm going to talk about those--can
 17 minimize the harm to those patients who
 18 perhaps don't want to know.
 19 It's not just important for trust. Truth
 20 is not just important for trust between
 21 patients and health care providers. It's also
 22 between patients and institutions, and
 23 patients will experience a betrayal of trust
 24 if they think that institutions of medicine
 25 aren't acting in ways that are solely

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1 conducive to a patient's interest. In other
 2 words, if they think the institutions are
 3 acting in self-protective and deceptive ways,
 4 it will undermine their trust in the medical
 5 system, which of course undermines the health
 6 care system generally.
 7 So faced with hazardous situations, what
 8 are the responsibility of institutional
 9 officials? I want to give you a little case
 10 here, which I'll--it's difficult for you to
 11 read, but this case comes from an article
 12 written in the 19th century by a
 13 mathematician. It's actually the only paper
 14 he ever wrote. I'm getting dry. While you're
 15 reading, I'll drink some water. I thought it
 16 was particularly (unintelligible)
 17 Newfoundland since it concerned a ship.
 18 But he had this ship, he used it many
 19 times to ferry immigrants from somewhere in
 20 Europe to North America, and he knew there had
 21 been problems raised about the ship. The ship
 22 not that well made in the first place, needed
 23 repairs, and some doubts were raised about its
 24 safety, and he managed--and he thought about
 25 this and was worried about it, whether it cost

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1 great expense to overall this ship and he
 2 managed, through thinking about this, to
 3 realize, well you know, the ship has sailed
 4 many times. You know, doubts have been raised
 5 before. They've not been realized, and he
 6 managed to convince himself prior to the ship
 7 sailing that everything would be okay. That
 8 it sailed every other voyage, why wouldn't it
 9 sail in this one. The passengers are eager to
 10 go anyway. Everybody was willing to go, why
 11 would he say no to the ship going forward, and
 12 he decided, as we see in the last sentence
 13 there, in the last few sentences, he acquired
 14 a sincere and comfortable conviction that his
 15 vessel was thoroughly safe and seaworthy and
 16 watched her departure with a light heart and
 17 benevolent wishes for the success of the
 18 exiles in their strange new home that was to
 19 be, and he got insurance money when she went
 20 down mid ocean and told no tales.
 21 So what the writer wrote at the time is
 22 that really what are the ethics of that
 23 belief? What are the ways in which--was this
 24 a right judgment, a proper judgment in the
 25 shipowner's case? And Clifford said no, it

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1 wasn't. He had no right to that belief. He
 2 should have looked at the evidence and
 3 explored it more carefully and not simply
 4 accept--the fact that he believed, genuinely
 5 believed the ship was safe was not grounds for
 6 allowing that ship to go forward. He should
 7 have examined the basis of the doubt, examined
 8 his evidence and Clifford said that he had no
 9 right to believe in such evidence before--and
 10 that's sort of an interesting statement, when
 11 you think about it. What are the ethical
 12 aspects of belief and statements in truth?
 13 And I think we can make some--a jump from that
 14 to suggesting there are certain duties of
 15 trustees or people who look after institutions
 16 is that they have to exercise appropriate
 17 supervision, to act reasonably and to prevent
 18 harm and when doubts arise, ignore them at
 19 your and your patients peril. So you should
 20 take those doubts carefully into account and
 21 not assume that everything is going to be okay
 22 because everything has been okay in the past.
 23 So adverse events in disclosure, just to
 24 end on this. We've heard about how common
 25 errors are. Really the problem for patients

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1 isn't so much the occurrence of errors,
 2 although that is clearly a problem when they
 3 get harmed by it, but it's the attitude to
 4 error that upsets patients the most, when they
 5 feel that they're not taken seriously, then
 6 the public is dismayed by lack of
 7 accountability, and the secretativeness around
 8 some of these events. So I think that's a
 9 disservice to patients and the public. It
 10 isn't the errors themselves, but how we deal
 11 with them.
 12 Critical incidents aren't as harmful to
 13 patients. They do cause harm to patients.
 14 They're also a threat to our institutions as
 15 well. They can undermine public confidence in
 16 the institutions and really it should be
 17 looked at as kind of an medical emergency, as
 18 it were. Not emergency just from the
 19 patient's perspective, making sure they get
 20 better, but also seeing them as potential
 21 threats to the acceptability of our
 22 institutions and if we don't deal with these
 23 openly and honestly, that will undermine that
 24 institutional legitimacy on which so much
 25 depends and especially medicine depends.

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1 So there are certain things that--yeah,
 2 so there are certain things can be said about
 3 truth telling, in terms of policy, developing
 4 policies in this area, and basically, these
 5 policies help assure the public that we take
 6 these events seriously and they also allow us
 7 to outline what a timely response to these
 8 events might be and to prevent harms to future
 9 patients, and the general policy here would be
 10 the more serious the harms or potential harms
 11 to patients, the more thorough going and the
 12 faster the response should be from people
 13 responsible for those incidents.
 14 Individual institutions must notify any
 15 affected at risk patients. Again, when you do
 16 that depends upon your definition of
 17 timeliness, but the more serious event, the
 18 quicker that notification must be. So as soon
 19 as after the event has been identified, most
 20 policies suggest there should be a time
 21 element here, relatively rapid notification,
 22 especially in the occurrence of serious
 23 events. It's best done in person with
 24 adequate time in a comfortable, private
 25 setting which allows the empathic relationship

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1 between patient and health care providers and
 2 also encourages that trusting relationship,
 3 and there are other ways which you can
 4 communicate this information to patients,
 5 which I think indirectly is probably less
 6 acceptable because they don't provide that
 7 support that often patients or families need,
 8 and certainly, if you phone patients up or
 9 families up about these events, I think that's
 10 the least helpful ways in which--one of the
 11 least helpful ways in which communication can
 12 be done because it's so impersonal, and the
 13 patient and their family may not know who's
 14 calling anyway. Media notification happens in
 15 some cases, but I think this is less
 16 acceptable as well because--unless all other
 17 means of contacting patients have been
 18 exhausted.
 19 Disclosure is clearly a process and I
 20 don't think you should wait for definitive
 21 answers. I think that's come up more in the
 22 presentations already. Answers are important
 23 and it's important for patients and families
 24 to know that "we understand the complaint.
 25 We're looking into it. Here's what we know so

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1 far. Here's what we need to find out," and
 2 where there are serious events, the disclosure
 3 should take place as quickly as possible.
 4 So I think honesty is the best policy,
 5 and not everybody is convinced, and these
 6 folks think "okay, what's the second best
 7 policy?" My view is you don't settle for
 8 second best. The first policy is the only one
 9 you need.
 10 So just in conclusion, patient safety is
 11 the responsibility of all health care
 12 professionals, whether they're directly
 13 involved in patient care or not.
 14 Professionals and institutions must have a
 15 system in place for which hazardous findings
 16 and incidents can be communicated to patient
 17 and all the treating team, and this may apply
 18 to other specialities that may not have direct
 19 patient care, such as radiology or pathology,
 20 which comes up with abnormal results are
 21 hazardous findings. They need to make sure
 22 that there's some ways in which patients may
 23 find out about these events.
 24 And lastly, the public's trust in health
 25 care requires transparency and truthfulness.

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1 Thank you very much.
 2 MR. CAULFIELD:
 3 Q. Thank you, Phil. So we have about a half hour
 4 for a final set of questions, if people have
 5 them. I know I have a couple, but I'd like
 6 to--oh, good, go ahead.
 7 DR. ETCHELLS:
 8 Q. My question is directed to Dr. Gallagher and
 9 it speaks to the issue of judging
 10 preventability. So I'm going to give you a
 11 case, and I'd be interested to hear your
 12 thoughts because I find it very difficult. So
 13 suppose a patient has cardiac surgery. They
 14 have an infection in their breast bone after
 15 the surgery. Clearly that's an adverse event,
 16 and on review of the chart, the sternum was--
 17 the hair was clipped. The antibiotics were
 18 given about 30 minutes late because of a
 19 variety of delays. The blood glucose was
 20 elevated above ten twice and the body
 21 temperature was kept normal throughout. So my
 22 question is, is that a preventable adverse
 23 event? I think it's very difficult for a
 24 clinician to judge that when a statistician
 25 can't even judge that. How do you go about

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1 disclosing those sorts of complex, non-
 2 specific outcomes to patients and putting a
 3 label of preventability on it?
 4 DR. GALLAGHER:
 5 Q. One of the reasons that I said I thought we
 6 were at the beginning of the beginning is, you
 7 know, we talk about disclosure using these
 8 paradigm cases where the preventability is
 9 clearly known and medicine, as you all know,
 10 lives in the grey areas, you know, and that's
 11 a perfect example, you know, and you can
 12 extend that example to the compensation side
 13 of things. So if the patient has an
 14 additional two weeks in the hospital because
 15 of this sternal wound infection, does the
 16 hospital need to cover all the costs and pay
 17 for their lost wages? I think it's terribly
 18 difficult to know. You know, it's this very
 19 difficult balancing act between timeliness of
 20 disclosure and providing accurate information,
 21 and we actually, you know, are--the policy at
 22 UW tends, in part, to put the brakes on the
 23 disclosure process a little bit. We see a
 24 variety of different errors in error
 25 disclosure. The one that people think about

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1 the most is what we call hypo disclosure. We
 2 need better terms for this, by the way, so if
 3 you have good ones, I'm open to your ideas.
 4 So hypo disclosure, not saying enough
 5 information. But there's clearly hyper
 6 disclosure, telling the patient way more
 7 information than they wanted to know or, I
 8 guess, mal-disclosure, misdisclosure, telling
 9 them information that, on later reflection,
 10 turns out to be wrong. How does that happen?
 11 Oftentimes, junior physicians feel terrible
 12 about an event. They rush into the patient's
 13 room and say "I made a terrible mistake. I'm
 14 so sorry about this," and then when the dust
 15 settles and patient safety analysts have had a
 16 chance to look at this, it turns out it wasn't
 17 preventable, or even worse, we don't know
 18 whether it was preventable, right, and then as
 19 the risk managers say, you're in the
 20 unenviable task of having to "unring the
 21 disclosure bell." Go into the patient and say
 22 "we thought this was an error. It turns out
 23 it's not an error." If your credibility was
 24 not high before, now it's, you know, now it's
 25 zero, zero.

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1 I think the issue you raise of so what do
 2 you do when you're uncertain, I think it's a
 3 great area for collaboration. Do you share
 4 that uncertainty with patients? We do in the
 5 informed decision making process sometimes,
 6 and other times, we keep the uncertainty to
 7 ourselves.

8 MR. CAULFIELD:
 9 Q. I'd like to get a question in because I think
 10 it's a great topic, and it's one that both
 11 Philip touched on and I'm curious how the
 12 legal experts think. It's when there's a
 13 group of patients that may or may not want to
 14 know and it builds on what you were just
 15 talking about, with sort of an added
 16 complexity. Over lunch, we were talking about
 17 the experience in Alberta with mad cow
 18 disease, CJD and blood products being exposed
 19 and this is a completely theoretical risk and
 20 did the public want to know. Well, it's
 21 interesting because there was threats of legal
 22 action, both from individuals that weren't
 23 told and from individuals that were told.
 24 You've made me worry when I didn't--shouldn't
 25 have had to worry. So what do you do, both

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1 from a legal perspective and from a system
 2 policy perspective with that uncertainty,
 3 particularly when there may be groups of
 4 individuals that don't want to know?

5 DR. HEBERT:
 6 Q. I think that's an area of fertile discussion
 7 at this time. I think most of us would say
 8 that when--I mean, I guess when you're
 9 relatively certain an event has happened or
 10 you are certain an event has happened, the
 11 more certainty the better, it does put the
 12 onus upon disclosure and non-disclosure would
 13 only be the exception. When it comes to
 14 groups of patients as a whole, I think you
 15 want to apprise the community of risks to
 16 their health. If you know a specific group
 17 of--are you talking about a specific group of
 18 individuals or some more general threat to the
 19 population?

20 MR. CAULFIELD:
 21 Q. Well, both, and I think that there may be a
 22 situation--I'm curious what the group thinks,
 23 the legal scholars think. Can a person say,
 24 "look, I don't want to know about risks?"

25 DR. HEBERT:

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1 Q. Well, an individual can say that though when--
 2 if there's implications for other people, I
 3 think it less--it would sit less well. The
 4 greater the risk to those other people would
 5 be. So that would be my general statement.
 6 So the more patent the risk is to individuals,
 7 then the more--the less, and the greater the
 8 threat is to other people, the less you can
 9 reign in that disclosure to people at risk.

10 DR. GALLAGHER:
 11 Q. Yeah, I think it's a real challenge in a
 12 variety of ways. You know, when we videotape
 13 surgeons, including Canadian surgeons,
 14 disclosing hypothetical events to standardized
 15 patients, there seem to be sort of three basic
 16 approaches. One was what we call sort of the
 17 nuclear bomb of disclosure. The doctor would
 18 go in and just sort of tell the patient
 19 everything they know in one fell swoop, kind
 20 of (unintelligible - making sound) and just
 21 dump it all on the patient and the patient
 22 kind of had the hair blown back look, like
 23 they'd just gotten way too much information.
 24 Some of the doctors their disclosure skills
 25 were so poor, we had designed the cases, we

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1 couldn't even tell what they were talking
 2 about. But there was this middle group of
 3 doctors who took the sort of graded approach
 4 to disclosure, where they would start with a
 5 little information, wait to see what the
 6 patient said, provide a little bit more
 7 information, wait to see what the patient
 8 said, and I think that approach makes a lot of
 9 sense. Physicians want to customize these
 10 conversations based on what they know of their
 11 patients preferences. The down side of that
 12 though is that if physicians don't accurately
 13 predict their patients preferences for
 14 information in other areas, right, so if you
 15 studied patients--physicians, do they
 16 accurately predict patients preferences for
 17 information about end of life care, you might
 18 as well flip a coin. Doctors think they know,
 19 but they don't. That's why I think it would
 20 be helpful to have some basic guidelines or
 21 standards about what information needs to be
 22 conveyed, and if you get there all at once or
 23 if you get there in a conversation gradually,
 24 I think that doesn't matter as much.

25 For example, patients, I think, need to

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1 know was this preventable, if we know, right,
 2 and I think you can get there lots of
 3 different ways, but to not get there at all
 4 because you think "oh, the patient wouldn't
 5 want to know this," I think is potentially
 6 problematic.
 7 MR. CAULFIELD:
 8 Q. I think that's a really good point and it ties
 9 in with Gerald and others were talking about
 10 with if the standard is what a reasonable
 11 person in the patient's position would want to
 12 know, how can you make that judgment, and
 13 likely should err on the side of, obviously of
 14 disclosure. So other comments? I know it's
 15 been a long day.
 16 MR. RITTER:
 17 Q. I have a corollary that I want to introduce
 18 here. We've been talking a lot about adverse
 19 events and how we report when an adverse event
 20 occurs. We also talked this morning about
 21 preventing adverse events, and we also talked
 22 about the evolution or the growing
 23 consciousness about the systemic side of
 24 things, rather than the individual side of
 25 things. So within that particular frame of

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1 reference, when a professional person or when
 2 someone in an institution recognizes a hazard
 3 or a risk, what is their obligation to
 4 disclose? There are obviously internal--I
 5 mean, within current institutions, there are
 6 mechanisms where people are supposed to report
 7 up the system. Sometimes what happens is a
 8 professional may report it to the system, but
 9 the system sort of sits on it for a while,
 10 sometimes for a long while. I think we seen
 11 this happen many places. What is the
 12 obligation of, let's say a physician, and what
 13 kind of protection in the form of whistle
 14 blowing or something along those lines should
 15 be available for them?
 16 I know that at the present time, there's
 17 some activity going on in our province with
 18 respect to physicians signing non-disclosure--
 19 you know, signing confidentiality agreements
 20 and they're not totally clear, and there could
 21 well be a bit of, sort of, suppressing of
 22 certain kinds of information, apart from, you
 23 know, patient confidentiality type things. So
 24 I'm just wondering whether there's been any
 25 discussion within the community of sort of

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1 medical safety and disclosure experts on this
 2 particular subject.
 3 DR. HEBERT:
 4 Q. I think in particular, there's--certainly, if
 5 you're talking about a harm to a particular
 6 patient, if a physician becomes aware of that,
 7 then I think he/she has some obligation to act
 8 upon that, to ensure the patient safety and
 9 wellbeing is looked after first and foremost.
 10 Now how that takes place will depend upon the
 11 institution. I mean, there may be a perfectly
 12 good mechanism within the hospital to do that,
 13 but there have been several cases, I know more
 14 American than anywhere else, where say, for
 15 example, a radiologist who hasn't--who noticed
 16 some abnormality on an x-ray, a serious
 17 abnormality and for whatever reason, the
 18 ordering physician never gets the original
 19 report, the patient never finds out about it
 20 until it's too late to help them, and there
 21 have been a number of cases where physicians
 22 are found liable for fail--radiologists have
 23 been found liable, even though they're not
 24 doing direct patient care, because they didn't
 25 ensure the patient was cautioned about this.

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1 Now you know, this creates some controversy
 2 because radiologists aren't directly
 3 responsible for the patient. Why should they
 4 suffer any legal consequences? Well, I think
 5 there can be a strong ethical argument there,
 6 where you know someone is at risk of serious
 7 harm, you don't do what you could have done to
 8 have made that person aware of it. Not that
 9 it's necessarily your duty to do so first and
 10 foremost, It may be (unintelligible) someone
 11 else's, but if you can't reach the ordering
 12 physician or the patient's x-ray has not been
 13 acted upon, you bear some responsibility for
 14 that. But it's hard to figure out how that
 15 would actually work in reality. Does that
 16 mean radiologists have to phone every patient
 17 with a serious diagnosis to make sure it was
 18 acted upon?
 19 So the limits of that duty are quite
 20 unclear at this time, but I think there is
 21 some ill-defined obligation to act upon that
 22 information. If it's a hazardous situation,
 23 such as, you know, ill run laboratory or
 24 something like that, then again, there's a
 25 hazard to a group of patients. An institution

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1 has to do something about that, but again, if
 2 the institution doesn't act upon it, there is-
 3 -there is whistle blowing legislation actually
 4 in the UK to protect people against who report
 5 a hazardous situations, because there's a
 6 number of disasters in the UK where people had
 7 tried to warn hazardous situations and they
 8 suffered job consequences. I don't know
 9 whether that whistle blowing legislation has
 10 been very effective or not, but there is
 11 legislative protection now in some
 12 jurisdictions.

13 DR. GALLAGHER:
 14 Q. We had a paper in health affairs a few months
 15 back about physicians attitudes about
 16 reporting systems. I use reporting for
 17 informing the institution about these events
 18 and physicians, we didn't include the Canadian
 19 physicians in this paper, but their attitudes
 20 were relatively similar to the U.S.
 21 physicians. They had very low confidence and
 22 awareness about hospital reporting systems.
 23 They wanted reporting systems that were fast
 24 and easy to use, that were voluntary and
 25 confidential. The most important thing they

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1 wanted was feedback. They wanted to know that
 2 if I report something into this system, I see
 3 that it drives performance improvement and I
 4 hear back what was--what came of it. I think
 5 one of the earlier speakers mentioned this
 6 sort of reporting fatigue that we've seen at a
 7 number of institutions where systems have been
 8 set up that generate mountains of reports, way
 9 more than any institution could analyze, and
 10 this is counterproductive because the health
 11 care workers get frustrated and stop
 12 reporting.

13 MR. RICK SINGLETON:
 14 Q. I'd be interested in hearing a few comments
 15 about the situation--some of your comments and
 16 the earlier panel has spoke of some of the
 17 ethical frameworks and principles and so on
 18 that apply to disclosure, but my sense of it
 19 is that most of the comments have been
 20 addressing individual situations, and they're
 21 interesting and informative, but I'd like to
 22 hear a few comments about the situation that's
 23 really relevant to why we are here and what's
 24 going on in our local community where, for a
 25 lot of reasons, and complex reasons that

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1 requires a commission of inquiry to try and
 2 figure it out and make recommendations, that
 3 in itself indicates the size of it and the
 4 scope of it and that in many ways, the
 5 beginning of the beginning is kind of what's
 6 happening here, that this is a whole new field
 7 to be on to try and figure out how to move
 8 forward.

9 Now particularly what I'm interested in
 10 hearing your comments on is that there are
 11 ethical frameworks that you've described that
 12 apply to individual situations, but I'm
 13 thinking in the--I'm asking about situations
 14 where there are many patients and many complex
 15 issues and unfortunately, and I think we would
 16 all acknowledge unfortunately, things have
 17 slipped along that it isn't handled face to
 18 face, at the bedside, clinician to patient and
 19 so on. It has become bigger than that and far
 20 more complicated than that, and I think in
 21 some ways, to my observation, I'd say that the
 22 Commission of Inquiry itself even has become
 23 part of disclosure now, at least in terms of
 24 public disclosure, but in some cases as well,
 25 it seems that the people who have been

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1 personally connected and impacted, there's
 2 kind of an element of disclosure that's
 3 happening through the Commission itself and
 4 through the way that it is publicized and the
 5 comments and the scrums and all of the things
 6 that are happening. People are finding out
 7 things that are very relevant to their own
 8 lives and things that are relevant to the
 9 community and to, you know, our public health
 10 system and what have you.

11 With all of that said and done, my
 12 question is, is there or ought there be a more
 13 specific ethics consideration of things as big
 14 and as broad and as complex as the situation
 15 we are in here now and the public disclosure
 16 piece that is happening along with, if not
 17 through or because of the Commission of
 18 Inquiry? And I'm thinking specifically of
 19 things such as, you know, the issues around
 20 harm or the potential for harm that comes from
 21 the new complications or the intensified
 22 complications that we have in our province
 23 around recruitment and retention, adding of
 24 course, also to the issues of trust and those
 25 things that are important to the maintenance

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1 of an already very stretched and strained
 2 health care system. I know my question is -
 3 DR. HEBERT:
 4 Q. Well that's a bit of a--yes, well, could you
 5 rephrase the question?
 6 MR. SINGLETON:
 7 Q. No, no, no.
 8 DR. HEBERT (phonetic):
 9 Q. I see where you're going. Are you saying does
 10 the system and even inquiries like this need
 11 to consider the broad system impact of
 12 disclosure, the broad social impact of
 13 disclosure, and the way that it unfolds and
 14 having a complicated inquiry such as this, you
 15 have to be even more sensitive to its long-
 16 term ramifications, both in the individual
 17 level, at the system level and at the social
 18 level.
 19 MR. SINGLETON:
 20 Q. It's the long term and the immediate. I mean,
 21 this is having day-to-day fall out on people.
 22 We see it in the media each day, you know, how
 23 people are distressed and who are, you know,
 24 on leaves and what have you, and that's having
 25 an impact on client care and what have you.

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1 So I think in the short term and in the long
 2 term and I doubt that there's very much in the
 3 literature to go to and that's why, you know,
 4 people like yourself might cast a bit of light
 5 on it for us because it is evolving. We are
 6 at the beginning of the beginning, so it's an
 7 opportunity probably to make some corrective
 8 adjustments as we move on through this.
 9 DR. HEBERT:
 10 Q. Well, whether system based or individual
 11 based, I think that anybody who deals with
 12 these problems of adverse events in health
 13 care want to do it in a facilitative kind of
 14 way. We don't want to do it in a way that
 15 undermines other people's ability to do their
 16 work and, you know, I think especially with
 17 these kind of events, we know they're not
 18 individually based failures. There are all
 19 sorts of systemic reasons why that happened,
 20 and we would hopefully have a mutual
 21 understanding and approach to these things
 22 that doesn't set out one person or one group
 23 of people and say what a nasty job you done.
 24 Rather look at the kind of--the system factors
 25 that allow this situation to take place and

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1 hopefully do it in a way that is supportive of
 2 those people, not undermining their work,
 3 because nobody goes to work in health care
 4 wanting to know who they can harm that day.
 5 (Unintelligible) did these--you know, these
 6 harms happened for any reasons of intention.
 7 So you're trying to figure out in the best
 8 possible way and the most systemic way
 9 possible what happened, and I guess some
 10 people may experience that as stressful. Some
 11 people may see it as an attack upon them or
 12 their position, but I guess that is a risk of
 13 sometimes making these things public. But on
 14 the other hand, I think there's much greater
 15 risks to the health care system if you don't
 16 deal with these things openly and it's just
 17 left to fester.
 18 DR. GALLAGHER:
 19 Q. Sorry, Philip, I didn't mean to cut you off
 20 there.
 21 DR. HEBERT:
 22 Q. That's okay.
 23 DR. GALLAGHER:
 24 Q. I think this is--it's really complex and I
 25 think in part, it has to do with trying to at

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1 least start to resolve the underlying tension
 2 between disclosure as informed consent and
 3 disclosure as a fiduciary obligation/right to
 4 know truth telling, you know, because they
 5 lead you in somewhat different directions. If
 6 the focus is really around harm and decision
 7 making, then I think the framework that we
 8 heard earlier that was sort of a public health
 9 framework of sort of what's the likelihood
 10 that this information--that disclosing this
 11 information would allow patients to avoid
 12 future harm, how severe is that harm,
 13 etcetera, makes a lot of sense. If this is
 14 really about a fiduciary responsibility and
 15 truth telling and right to know, that might
 16 have different implications. But what I've
 17 been impressed by is how helpful sort of a
 18 public patient advisory panel can be in making
 19 some of these determinations because when
 20 we've looked at disclosure to individual
 21 patients, doctors and patients are on
 22 different pages on this issue, i.e. doctors
 23 really think about the informed consent
 24 implications of disclosure because if the
 25 information "wouldn't matter" maybe we don't

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1 need to tell the patient. Patients really
 2 downplay the informed consent dimensions and
 3 they think much more about disclosure as this
 4 is my body. I have a right to know. You need
 5 to tell me. Who cares what I'm going to do
 6 with the information. But so I think given
 7 that bias that's built into health care to
 8 prefer informed decision making rationale over
 9 fiduciary truth telling rationale, having a
 10 relatively sort of neutral group that can
 11 guide some of these decisions, I think helps a
 12 lot.

13 UW had a similar, thankfully a little
 14 less severe, incident a few years back where
 15 there was a breakdown in sterilizing
 16 endoscopes, where six or seven hundred
 17 patients were affected and there the problem
 18 was the risk was thought to be infinitesimally
 19 low of patients being infected, but ultimately
 20 the medical centre thought "well, we really
 21 need to let people know about this and make
 22 testing available to them and set up a
 23 hotline," and I think the sense was that this
 24 disclosure was probably the right thing to do
 25 on the public trust and honesty and integrity

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1 side. It may have led to a hit to UW's
 2 reputation in terms of providing competent
 3 medical care. So trust has more than one
 4 dimension, right, trust and competence, trust
 5 and honesty and integrity, and for a fair
 6 number of patients, it generated a lot of
 7 anxiety, and some patients, a ton of anxiety.
 8 You know, they kept calling, were very
 9 concerned, wanting to be retested over and
 10 over and over and over again, and so there was
 11 clearly some harm to a group of patients that
 12 came with this public disclosure.

13 Now the situations are not exactly
 14 comparable to the situation under
 15 consideration here, but I think the mix of
 16 benefits and burdens is complex and I think
 17 having someone neutral to help sort some of
 18 these things out is helpful.

19 MR. CAULFIELD:
 20 Q. Excellent, and perhaps a good way to end the
 21 day, unless there's any other pressing
 22 questions? No. Well, let's give this panel a
 23 round of applause.

24 Now we're going to start at 9:00 tomorrow
 25 and we're going to be exploring things like

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1 disclosure processes and also the involvement
 2 of the media in disclosure, which has been
 3 very interesting, both in this context, but in
 4 the broader context, and then we're going to
 5 have a panel discussion. We're going to
 6 invite all the panellists up and this is also
 7 a warning to the panellists. I'm going to ask
 8 you for your one sentence key message for
 9 looking forward and if you have any questions,
 10 really any questions, anything that you want
 11 answered, anything that you would like on the
 12 table, please bring them tomorrow morning and
 13 we'll try to address them. So thanks very
 14 much and have a very nice evening everybody.
 15 (UPON CONCLUSION AT 4:36 P.M.)

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1 CERTIFICATE
 2 I, Judy Moss, hereby certify that the foregoing is
 3 a true and correct transcript of the Inquiry on
 4 Hormone Receptor Testing, Part II, Symposium, heard
 5 on the 22nd day of April, A.D., 2008 at the
 6 Memorial University of Newfoundland and Labrador,
 7 St. John's, Newfoundland and Labrador and was
 8 transcribed by me to the best of my ability by
 9 means of sound apparatus.
 10 Dated at St. John's, Newfoundland and Labrador
 11 this 30th day of April, A.D., 2008
 12 Judy Moss

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