


Since Then: Recommendations Or Regulations

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Main Messages

- Inquests/Inquiries
 - mainly legal processes
 - complex social and psychological processes
- There is “politics” involved with the creation and impacts of inquests/inquiries
- Inquests/inquiries represent
 - “defining moments”
 - “windows of opportunity”

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Review and Implementation Committee (1)

- The Sinclair Report
 - released in November, 2000
 - six years after the events at HSC
- In January, 2001, the new Minister of Health appointed a three person Committee to assess the merits and practicality of the 39 inquest recommendations, including their affordability and relevance to the wider healthcare system
- The Thomas Committee
 - given four months to complete its report

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Review and Implementation Committee (2)

- Minister
 - committed to make the Committee's Report public
 - agreed that there would be an annual public report on the fate of the Sinclair/Thomas recommendations
- We established an advisory committee
 - representatives from seven key stakeholder groups
 - to gain the necessary expertise
 - no research commissioned: done mainly by Chair
- Committee working support
 - One professional administrative support person

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Review and Implementation Committee (3)

- Approach
 - no public hearings
 - collaborative, non-adversarial
 - first group we met with were the 12 families at a neutral location
- Developed a set of 14 evaluative criteria
 - asked organizations to provide assessments of the Sinclair Report based on those criteria
- Visited a number of sites and groups

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Thomas Report

- Committee very concerned about feasibility of recommendations
 - available policy knowledge
 - prevailing practices
 - organizational capacity & financing
 - potential support or opposition (including at the political level)
- The 52 recommendations
 - seen by the families, their lawyers and some advocacy groups as less critical and bold than the 39 recommendations in the Sinclair Report

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Some key initiatives in Manitoba since Sinclair/Thomas

- Creation of the Western Canada Children's' Heart Network
- Improved informed consent procedure
 - first in the WRHA & then across the province
- Creation of the Manitoba Institute for Patient Safety
- On-line physician profiles
- Critical incident reporting and investigation
- "It's Safe To Ask" campaign for vulnerable populations
- Apology Act
- Integrated Patient Safety Strategy in the WRHA

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Lessons Learned (1)

- Full blown inquiries
 - should be the last resort
- No shortage of laws, rules, codes, guidelines, oversight bodies, etc.
 - The greater need is for cultural change
- Need to shift from a legalistic, individualistic and blaming approach
 - to a cultural, collective and learning approach to accountability

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Lessons Learned (2)

- Difficult for judges or others who lead inquiries
 - to acquire depth of expertise in a short time
- Unclear if a "pure" report calling for "fundamental" reforms leads to more progress
 - than a "pragmatic" report based on calculations of feasibility which lead to more incremental changes
- Need to look for "windows of opportunity"
 - to move the patient safety agenda forward.

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