

SYMPOSIUM PROGRAM

Presented in collaboration with



October 23-25, 2008

Lead sponsor



Platinum sponsors



The Canadian Healthcare Safety Symposium 8

The Winnipeg Convention Centre / Winnipeg, Manitoba

A PROVOCATIVE FORUM FOR LEADERS TO ADVANCE SAFETY, CULTIVATE RELATIONSHIPS, AND SHAPE THE FUTURE OF HEALTHCARE

Healthcare and the Law

Program at a Glance

All sessions will take place in Rooms 1 to 3 (1st Floor) unless otherwise noted

Thursday, October 23, 2008

7:00 am – 9:00 pm	Registration	Foyer (1st Floor)
7:00 am – 4:30 pm	Pre-Symposium 1	Rooms 1 to 3 (1st Floor)
7:00 am – 4:30 pm	Pre-Symposium 2	Rooms 2G to 2H (2nd Floor)
6:00 – 7:30 pm	CPSI Funded Research Presentations	Rooms 2G to 2H (2nd Floor)
7:30 – 9:00 pm	Opening Reception and Poster Viewing	Foyer, Rooms 4 to 8 (1st floor)

Friday, October 24, 2008

7:00 am – 5:30 pm	Registration	Foyer (1st Floor)
7:00 – 7:45 am	Breakfast	Room 2F to 2H (2nd Floor)
8:00 – 8:30 am	Symposium Opening	
8:30 – 9:30 am	Keynote Presentation <i>Healthcare safety and judicial inquiries – Justice Murray Sinclair</i>	
9:30 – 10:00 am	Break and Poster Viewing	Foyer, Rooms 4 to 8 (1st Floor)
10:00 am – 12:00 pm	Theme 1: Inquests & Inquiries <i>Since then... recommendations or regulations – Paul Thomas</i> <i>The Bristol Inquiry: then and now – Sir Ian Kennedy</i> <i>The Inquiry into Pediatric Forensic Pathology in Ontario – Justice Stephen Goudge</i>	
12:00 – 12:45 pm	Lunch	Rooms 2F to 2H (2nd Floor)
12:45 – 1:30 pm	Poster Viewing	Rooms 4 to 8 (1st Floor)
1:30 – 3:30 pm	Theme 2: Litigation and Compensation <i>The impact of litigation – case load, financial, social & emotional – Gerald Robertson</i> <i>Patient safety and tort litigation: two solitudes? – Joan Gilmour</i> <i>Appropriate Dispute Resolution and No-Fault Compensation: ideas whose time has come? – Rob Robson</i>	
3:30 – 4:00 pm	Break and Poster Viewing	Foyer, Rooms 4 to 8 (1st Floor)
4:00 – 5:15 pm	Theme 3: Can we Regulate Safety? <i>Regulating for safety in aviation: what works and what doesn't – Jonathan Aleck</i> <i>The need for regulation to ensure safe, high quality care – Bill Runciman</i>	
5:15 – 5:30 pm	Rapporteurs at the End of Day 1 <i>Justice Horace Krever & Alan Forster</i>	
5:30 – 7:00 pm	Reception and Poster Viewing	Foyer, Rooms 4 to 8 (1st Floor)

Saturday, October 25, 2008

7:00 am – 3:30 pm	Registration	Foyer (1st Floor)
7:00 – 7:45 am	Breakfast	Rooms 2E to 2H (2nd Floor)
8:00 – 9:40 am	Theme 4: Apologies and Adverse Outcomes Keynote Presentation <i>Medical encounters and everyday life: why apologies heal – Aaron Lazare</i> <i>Apology legislation in Canada – George Derwin</i>	
9:40 – 10:00 am	Break and Poster Viewing	Foyer, Rooms 4 to 8 (1st Floor)
10:00 – 11:30 am	Theme 5: Responsibility & Accountability: Discussion & Debate Introduction: Steven Lewis, Moderator <i>Family member / citizen: 'Rights and responsibilities' – John Lewis</i> <i>Hospital administrator: 'Day-to-day operations' – Maura Davies</i> <i>Regulator: 'Sanctions and safety' – Dennis Kendel</i>	
11:30 am – 12:15 pm	Lunch	Rooms 2E to 2H (2nd Floor)
12:15 – 1:00 pm	Poster Viewing	Rooms 4 to 8 (1st Floor)
1:00 – 3:00 pm	Theme 6: Crime and Punishment <i>Criminal negligence and patient safety – Alan Merry</i> <i>A Crown Prosecutor's view – Gordon Wong</i> <i>The media view – André Picard</i>	
3:00 – 3:15 pm	Rapporteurs at the End of Day 2 <i>Justice Horace Krever & Alan Forster</i>	
3:15 – 3:30 pm	Closing	



HALIFAX SYMPOSIA

Organizing Committee

Co-chair:

Jan Davies MSc MD FRCPC

Professor, Department of
Anesthesia, Faculty of
Medicine, University of Calgary

Co-chair:

Laurie Thompson RN MN

Executive Director, Manitoba
Institute for Patient Safety

Ross Baker PhD

Professor, Health Policy,
Management and Evaluation,
Faculty of Medicine,
University of Toronto

Paula Beard ACP

Director of Operations,
Canadian Patient Safety
Institute

**Sharon Caughey
MD FRCSC FACOG**

Assistant Professor,
Department of Obstetrics
and Gynaecology,
University of Ottawa

**Doug Cochrane
MD FRCSC FAAP**

Chair, British Columbia Patient
Safety Task Force, Provincial
Health Services Authority

Pat Croskerry MD PhD

Professor, Department of
Emergency Medicine,
Dalhousie University

Philip Hassen MPH FCCHE

Chief Executive Officer,
Canadian Patient Safety
Institute

Carolyn Hoffman RN MN

Director of Critical Care,
Emergency and Trauma,
Royal Alexandra Hospital,
Alberta Health Services –
Capital Health

**Gerald Robertson
QC LLB LLM**

Professor, Faculty of Law,
University of Alberta

Rob Robson MDCM FRCPC

Chief Patient Safety Officer,
Winnipeg Regional Health
Authority

Paul Thomas PhD

Duff Roblin Professor of
Government,
University of Manitoba

Jewel Buksa MBA

President, BUKSA Conference
Management and
Program Development

Letter of Welcome

On behalf of the host organizations, welcome to Winnipeg and the Halifax Series: The Canadian Healthcare Safety Symposium 8!

As efforts continue to improve healthcare safety, healthcare professionals, administrators, and regulators find themselves increasingly caught in a web of public expectations, as well as legal and regulatory standards and rules. At the same time, because legal frameworks have a significant effect on improving healthcare safety, many members of the legal profession are experiencing a greater exposure to health system issues.

Halifax 8 will delve into the relationship between healthcare safety and the law. For example, the concepts of responsibility, accountability, and disclosure – all which have legal ramifications - play a central role in interactions between providers and patients, and within healthcare teams. By bringing healthcare professionals and members of the legal profession together in one room, we hope to gain a greater understanding of the perspectives of each group, who are both ultimately interested in improving healthcare safety for patients, their families, and members of the general public.

We hope that Halifax 8 will provide you with a unique opportunity to network with our outstanding speakers and with other delegates, and that the meeting will give all of us more awareness about how the healthcare and legal professions interact and can work together.

As the venue for Halifax 8, Winnipeg has a great deal to offer. You will find exciting museums, restaurants, shopping, and history throughout this great city. Please take time to enjoy Winnipeg and its surrounding areas!

We look forward to meeting with you. Again, welcome to Winnipeg!

Jan Davies MSc MD FRCPC
University of Calgary
Co-chair
Canadian Healthcare Safety Symposium

Laurie Thompson RN MN
Manitoba Institute for Patient Safety
Co-chair
Canadian Healthcare Safety Symposium



The Halifax Symposia



The Canadian
Healthcare
Safety
Symposium 8

The Halifax Series has evolved into Canada's flagship event in healthcare safety. Participants from previous meetings have consistently remarked about the meeting being innovative, cutting edge, and intellectually challenging.

The meeting is different by design. In developing the early programs, the founders of the Halifax Series sought inspiration within healthcare and in other industries around the world for different ideas, knowledge, skills and attitudes that would present opportunities for the improvement of healthcare safety in Canada. The Halifax Series Organizing Committee has diligently continued this approach.

Halifax Symposium attendees can expect:

- A challenging learning opportunity, designed for senior leaders and clinicians in healthcare
- A program that allows every registrant to participate in every session, and that contains no profession-specific sessions
- Themes that are academic in focus, and that examine issues from a variety of perspectives
- Speakers who are selected for their expertise, and not because they represent a discipline, a profession, or an organization
- Sessions that explore the safety experiences of other industries
- A conference that has limited capacity, so as to preserve the intimacy of the interactions among delegates and speakers

The Halifax Series was founded in 2000 by Dr. Pat Croskerry of Dalhousie University. In 2004, a consortium of Alberta organizations (Calgary Health Region, Capital Health, College of Physicians and Surgeons of Alberta, and Health Quality Council of Alberta) agreed to assume responsibility for the event. After organizing the next three meetings, the Alberta consortium transferred stewardship to the Canadian Patient Safety Institute. The organization of the meeting is governed by the principles established by the founder and the Alberta consortium, and the Canadian Patient Safety Institute.

Mark your calendars!



Montreal, Quebec
October 22-24, 2009



Halifax, Nova Scotia
October 21-23, 2010

Healthcare and the Law

Conference objectives

At the end of this Symposium, participants will be able to:

- 1 Summarize the facets of apology and describe the impact of apology legislation on patient safety
- 2 Outline the emotional, financial and workload impact of litigation on patient safety
- 3 Describe the challenges in healthcare accountability relationships, the potentially conflicting points of view, and the impact of differing views on efforts to improve patient safety
- 4 Explain how different legal frameworks and legal instruments aim to find the balance between demands for accountability, learning, and restoration for the patient and the health provider
- 5 Identify lessons learned for healthcare and the law from international examples of inquiries and inquests, and identify their potential impact on improving patient safety and preventing future system breakdowns
- 6 Describe the major points in the debate between the relative effectiveness of legal, institutional, regulatory, and individual patient-driven mechanisms to ensure responsibility and accountability in healthcare
- 7 Compare and contrast examples of criminal negligence cases and identify the potential impact on improving patient safety and outcomes for systems, providers, and patients and their families
- 8 Summarize current evidence related to whether or not legal mechanisms that affect patient safety are actually effective in improving patient safety

MAINTENANCE OF CERTIFICATION (MOC)

Attendance at this program entitles certified Canadian College of Health Service Executives members (CHE / FCCHSE) to 7.5 Category II credits + 2.75 for the pre-symposium for a total of 10.25 MOC II credits toward their maintenance of certification requirement.



Canadian College of
Health Service Executives
Collège canadien des
directeurs de services de santé

Halifax Series Secretariat

BUKSA Conference Management and Program Development
Suite 307, 10328 – 81 Avenue NW, Edmonton, AB T6E 1X2
Phone (780) 436-0983 x233
Fax (780) 437-5984
Email halifax@buksa.com
www.buksa.com/halifax



Symposium Moderator:
Steven Lewis, President,
Access Consulting,
Saskatoon

Healthcare and the Law Program

All sessions will take place in Rooms 1 to 3 (1st floor) unless otherwise noted.

Thursday, October 23, 2008

- | | | |
|-------------------|--|-----------------------------------|
| 7:00 am – 9:00 pm | Registration | <i>Foyer (1st floor)</i> |
| 6:00 – 7:30 pm | Implementing Patient Safety Research Results:
 CPSI funded research presentations | <i>Rooms 2G to 2H (2nd floor)</i> |
| | <i>Moderator: Ross Baker, Toronto</i> | |
| | <i>Discussant: Rick Roger, Victoria</i> | |
| | Opening and Closing Remarks – <i>Ross Baker, Toronto & Rick Roger, Victoria</i> | |
| | <ul style="list-style-type: none"> ■ Developing and Implementing an Effective Method for Independent Double Checking of High Risk Clinical Procedures – <i>Anthony Easty, Toronto</i> ■ An Examination of Documented Fall Risk and Compliance to Fall Prevention Interventions in Ontario Long-Term Care (LTC) Facilities – <i>Laura Wagner, Toronto</i> ■ The TOCSIN Project: Organization Chart for Monitoring and Follow-up of Nosocomial Infections/ Le projet TOCSIN: Tableau Organisationnel de Contrôle et de Suivi des Infections Nosocomiales – <i>Régis Blais, Montreal</i> ■ The Impact of Sleep Deprivation, Circadian Misalignment, and Sleep Inertia on Patient Safety in the Intensive Care Unit – A Patient Simulator Study – <i>Najib Ayas, Vancouver</i> | |
| 7:30 – 9:00 pm | Opening Reception | <i>Foyer (1st floor)</i> |

Friday, October 24, 2008

- | | | |
|-------------------|--|--|
| 7:00 am – 5:30 pm | Registration | <i>Foyer (1st floor)</i> |
| 7:00 – 7:45 am | Breakfast
Poster Viewing | <i>Rooms 2F to 2H (2nd floor)
Rooms 4 to 8 (1st floor)</i> |
| 8:00 – 8:30 am | Opening Ceremonies
Welcome | |
| | <i>Honourable Theresa Oswald, Minister of Health, Government of Manitoba</i> | |
| | <i>Laurie Thompson, Co-chair, Symposium Organizing Committee</i> | |
| | <i>Philip Hassen, Chief Executive Officer, Canadian Patient Safety Institute</i> | |

8:30 – 9:30 am

KEYNOTE PRESENTATION

Healthcare safety and judicial inquiries

Justice Murray Sinclair, Winnipeg

Justice Sinclair will start by describing briefly the Manitoba Pediatric Cardiac Surgery Inquiry, as well as the Aboriginal Justice Inquiry. He will reflect on the role of these inquiries, including why we need them. Through examining the process of inquiries, he will consider if there are better ways to conduct them, using as an example the role and operation of the Manitoba Inquest Office. Finally, he will discuss whether or not inquests and inquiries actually help improve healthcare safety, and if inquiries can help minimize the probability of the next Winnipeg, Bristol, or Walkerton.

9:30 – 10:00 am

Break and Poster Viewing

Foyer, Rooms 4 to 8 (1st floor)

THEME



10:00 am – 12 noon

INQUESTS & INQUIRIES

Since then... recommendations or regulations

Paul Thomas, Winnipeg

Paul Thomas will discuss the 'politics' of implementation of patient safety reforms in the aftermath of the Pediatric Surgery Inquiry in Winnipeg. He will reflect on how the committee assigned to review the Sinclair Report sought to ensure that its recommendations were not ignored by the Government of Manitoba and the various healthcare institutions. He will provide an overview of developments in patient safety in Manitoba since the presentation of his report in 2001 and what is left undone.

The Bristol Inquiry: then and now

Sir Ian Kennedy, London

The Bristol Inquiry broke new ground in its approach. The report offered an analysis of the National Health Service and modern healthcare, which has played a significant role in the agenda for reform. Professor Kennedy describes the Inquiry, discusses the report, "Learning from Bristol," and the question, "How much have we learned?"

The Inquiry into Pediatric Forensic Pathology in Ontario

Justice Stephen Goudge, Toronto

In this presentation, Justice Goudge will describe the events leading up to the Inquiry, the process followed, the facts canvassed, and the issues explored. He will also discuss ways in which issues might be addressed.

12 noon – 12:45 pm

Lunch

Rooms 2F to 2H (2nd floor)

12:45 – 1:30 pm

Poster Viewing

Rooms 4 to 8 (1st floor)

THEME



1:30 – 3:30 pm

LITIGATION AND COMPENSATION

The impact of litigation – case load, financial, social and emotional

Gerald Robertson, Edmonton

Gerald Robertson will focus on the impact of health malpractice litigation, both on the patient and on the healthcare provider. He will examine a range of impacts, including

emotional, professional, and financial. He will also discuss whether or not those impacts (particularly financial) might act as a deterrent to those who wish to sue a healthcare provider.

Patient safety and tort litigation: two solitudes?

Joan Gilmour, Toronto

The debate about patient safety has been reframed to reflect a new understanding that much patient harm is the result of systemic factors and to promote a 'systems-oriented' approach to error reduction. This understanding and approach fit uneasily with tort (negligence) law, in which recovery is premised on individual fault-finding. Law is a major factor in shaping the healthcare environment and affects uptake of the patient safety approach. Joan Gilmour reports on the results of a five-country study examining tort reform and compensation systems for patient injury that determined whether or not and how the law has been changed in response. She recommends reforms that can be implemented within existing tort law, and to the tort system itself, in order to foster conditions to better enhance patient safety.

Appropriate Dispute Resolution (ADR) and No-Fault Compensation (NFC): ideas whose time has come?

Rob Robson, Winnipeg

Rob Robson will provide an historical and present-day Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of Alternative or Appropriate Dispute Resolution (ADR) and No Fault Compensation (NFC). He will then use this SWOT analysis as the basis for a discussion of better ways to address patient and family concerns following adverse events causing harm, as well as providing compensation when appropriate.

3:30 – 4:00 pm

Break and Poster Viewing

Foyer, Rooms 4 to 8 (1st floor)

THEME



4:00 – 5:15 pm

CAN WE REGULATE SAFETY?

Regulating for safety in aviation: what works and what doesn't

Jonathan Aleck, Canberra

In aviation, as in other fields, concepts and practices of safety regulation can be fraught with controversy. Much of the debate about air safety and its effective regulation, however, proceeds on a remarkably uninformed basis. Jonathan Aleck will discuss the ways in which the political realities of regulatory processes tend to trump rational, objective analysis far more often than the vagaries of the law, and how some progressive legal models hold real promise for the achievement of optimal safety outcomes.

The need for regulation to ensure safe, high quality care

Bill Runciman, Adelaide

Healthcare as a profession is expected to 'self-regulate.' However, there is now overwhelming evidence that regulation must be improved, as shown by the high incidence of adverse events and enormous variations in practice. Effective regulation is impossible without clinical standards. Bill Runciman describes an urgent need for the development and maintenance of standards for clinical tools, for their implementation and maintenance, and for basing credentialing of individuals and accreditation of services on objective evidence, using transparent, explicit processes.

5:15 – 5:30 pm

RAPPORTEURS AT THE END OF DAY 1

Horace Krever, Toronto & Alan Forster, Ottawa

Our rapporteurs will present a collection of "What I've heard that I'm going to do differently over the next year."

5:30 – 7:00 pm **Reception and Poster Viewing** *Foyer (1st floor)*
Sponsored in part by the Canadian Patient Safety Institute

Saturday, October 25, 2008

7:00 am – 3:30 pm **Registration** *Foyer (1st floor)*

7:00 – 7:45 am **Breakfast** *Rooms 2E to 2H (2nd floor)*
Poster Viewing *Rooms 4 to 8 (1st floor)*

THEME



8:00 – 9:40 am **APOLOGIES AND ADVERSE OUTCOMES**

KEYNOTE PRESENTATION

Medical encounters and everyday life: why apologies heal

Aaron Lazare, Boston

The importance of apologies in medical practice emerges from the growing international interest in apologies in all walks of life, beginning in the mid 1990s. Aaron Lazare will focus on 10 to 12 specific healing factors in the apology process. The analysis is important because different people require different healing factors in response to various offenses. Although all apologies have much in common, each apology is a unique transaction between two parties.

Apology legislation in Canada

George Derwin, Winnipeg

In this talk, George Derwin will describe and review the status and effects of Canadian apology legislation with respect to healthcare. While the effects are not quantifiable, the overall result has been positive, helping to change the way people think about the legal aspects of adverse events.

9:40 – 10:00 am **Break and Poster Viewing** *Foyer, Rooms 4 to 8 (1st floor)*

THEME



10:00 – 11:30 am **RESPONSIBILITY & ACCOUNTABILITY:
DISCUSSION & DEBATE**

Introduction by the moderator, Steven Lewis

The terms “responsibility” and “accountability” are often used, and often equally confused. What do they mean? Do the definitions depend on whose point of view is taken? Not only are there different definitions, there are also different mechanisms for attempting to ensure responsibility and accountability in healthcare. What works? What doesn’t work? What makes a difference? What is the relative effectiveness of each of these mechanisms? Do any of them increase healthcare safety? Is the ‘best’ mechanism the ‘internal sense of responsibility’ that each healthcare worker must bring to his or her work? Would employing more proactive tools make a difference? What about the individual versus the collective?

Participants

Family member / citizen: 'Rights and responsibilities' – *John Lewis, Hamilton*

Hospital administrator: 'Day-to-day operations' – *Maura Davies, Saskatoon*

Regulator: 'Sanctions and safety' – *Dennis Kendel, Saskatoon*

11:30 am – 12:15 pm

Lunch

Rooms 2E to 2H (2nd floor)

12:15 – 1:00 pm

Poster Viewing

Rooms 4 to 8 (1st floor)

THEME



1:00 – 3:00 pm

'CRIME AND PUNISHMENT'

Criminal negligence and patient safety

Alan Merry, Auckland

In some countries, notably the UK, there has been a marked increase in criminal charges being laid against healthcare workers after unintentional patient deaths arising from a series of simple errors. Alan Merry discusses how the inappropriate use of criminal law is an integral part of an overall failure to address systemic deficiencies in healthcare that predispose to such disasters. Everyone concerned – healthcare workers, healthcare funders, and the legal profession – needs to work together urgently, to find effective ways of addressing the currently unacceptable levels of risk in healthcare. At the same time, we need to address legal and cultural attitudes. The overriding goal must be patient safety.

A Crown Prosecutor's view

Gordon Wong, Calgary

When can a healthcare professional be criminally charged for his or her actions in regard to a patient? What is the dividing line between civil liability and criminal liability? Gordon Wong will examine the law as it relates to criminal negligence causing death or bodily harm. He will also discuss the public policy reasons that justify charges of criminal liability.

The media view

André Picard, Toronto

A veteran health journalist, André Picard reviews how the media portrays adverse events. Journalists are quick to pass judgement about 'medical errors' and often lead the charge in calling for punishment and retribution. How can reporters be educated about the complexities of the issues?

3:00 – 3:15 pm

RAPORTEURS AT THE END OF DAY 2

Horace Krever, Toronto & Alan Forster, Ottawa

3:15 – 3:30 pm

Closing

Laurie Thompson, Co-chair, Symposium Organizing Committee

Healthcare and the Law Faculty

Jonathan Aleck BA MA JD PhD

Head of the Legal Services Group,
Civil Aviation Safety Authority,
Canberra, Australia

**Maura Davies BSc BEd MHSA
FCCHSE**

President and Chief Executive
Officer, Saskatoon Health Region,
Saskatoon, Saskatchewan

George Derwin BA LLB

Brock Derwin Barristers & Solicitors,
Winnipeg, Manitoba

Alan Forster MD FRCPC MSc

Scientist, Associate Professor, OHRI,
Clinical Epidemiology Unit,
University of Ottawa, The Ottawa
Hospital, Ottawa, Ontario

Joan Gilmour BA LLB JSM JSD

Associate Professor, Osgoode Hall
Law School, York University, Toronto,
Ontario

**Justice Stephen Goudge BA MSc
LLB QC**

Commissioner, Inquiry into Pediatric
Forensic Pathology in Ontario,
Toronto, Ontario

Philip Hassen MPH FCCHSE

Chief Executive Officer, Canadian
Patient Safety Institute, Edmonton,
Alberta

Dennis Kendel MD FCFP

Registrar, College of Physicians &
Surgeons of Saskatchewan,
Saskatoon, Saskatchewan

**Sir Ian Kennedy KBE FBA LLB
DSc(Hon) DM(Hon) FRCP(Hon)**

Chairman, Healthcare Commission,
London, United Kingdom

**The Honourable Horace Krever
BA LLB LL.D**

Retired Justice of the Ontario Court
of Appeal, Toronto, Ontario

Aaron Lazare MD

Professor, Chancellor & Dean
Emeritus, Department of Psychiatry,
University of Massachusetts Medical
School, Boston, Massachusetts

John Lewis RN BScN

Hamilton Health Sciences, Hamilton,
Ontario

Steven Lewis

President, Access Consulting,
Saskatoon, Saskatchewan

**Alan Merry MRCS LRCP MBChB
DipObst FFARACS FANZCA**

Professor of Anaesthesiology,
University of Auckland, Auckland,
New Zealand

André Picard

Public Health Reporter, Globe and
Mail, Montreal, Quebec

Gerald Robertson QC LLB LLM

Professor, Faculty of Law, University
of Alberta, Edmonton, Alberta

Rob Robson MDCM FRCPC

Chief Patient Safety Officer,
Winnipeg Regional Health
Authority, Winnipeg, Manitoba

Bill Runciman MBBS PhD FRCP

Professor, University of Adelaide,
Adelaide, Australia

**Justice Murray Sinclair LLB LL.D
QC**

Court of Queens Bench, Winnipeg,
Manitoba

Paul Thomas PhD

Duff Roblin Professor of
Government, St. John's College,
University of Manitoba, Winnipeg,
Manitoba

Gordon Wong QC

Chief Crown Prosecutor,
Calgary Crown Prosecutor's Office,
Calgary, Alberta

1

Pre-Symposium 1 **Partnering for Patient Safety IV: Disclosure**

Life can only be understood backwards; but it must be lived forwards.

Soren Kierkegaard, Danish philosopher (1813 - 1855)

Program Overview

In the spring of 2006, an interdisciplinary team of Canadian healthcare stakeholders came together to form the Disclosure Working Group. CPSI provided secretariat and funding support to enable their work. The guidelines are intended to assist and support healthcare providers, interdisciplinary teams, organizations and regulators in developing and implementing disclosure policies, practices and training methods across Canada.

Although development of the Guidelines is complete, the next step is to support and facilitate understanding and local adaptation across Canada. This workshop will attempt to bring to life the Canadian Disclosure Guidelines, with presentations from international experts and members of the group responsible for drafting the document. Additionally, two interactive panels will be convened. The first will focus on a specific adverse event and the subsequent disclosure experience, from the perspectives of the family, their lawyer, and the health region. The second panel will feature local actors presenting several vignettes highlighting difficult circumstances requiring disclosure, for comment from an expert panel and the audience.

The workshop promises to be lively and thought-provoking, with opportunities for audience participation throughout the day. As moderator, Martin Hatlie will provide his perspective as an international leader who models the concept of partnering for patient safety in myriad ways.

Learning Objectives

At the end of this workshop, participants will be able to:

- 1** Understand the Canadian Disclosure Guidelines and the implications for professional and organizational responsibilities
- 2** Learn more about different perspectives on disclosure
- 3** Articulate strategies for enabling open and honest disclosure



Moderator:
Martin Hatlie, President,
Partnership for Patient Safety,
Chicago

Pre-Symposium 1 Program

All sessions will take place in Rooms 1 to 3 (1st floor) unless otherwise noted.

Thursday, October 23, 2008

7:00 am – 4:30 pm	Registration	<i>Foyer (1st floor)</i>
7:30 – 8:15 am	Breakfast	<i>Room 2F (2nd floor)</i>
8:30 – 8:45 am	Welcome and Introductions <i>Paula Beard, Co-chair, Edmonton</i> <i>Martin Hatlie, Moderator, Chicago</i>	
8:45 – 9:30 am	KEYNOTE PRESENTATION <i>Thoralf M. Sundt, Rochester</i> <p>A cardiovascular surgeon at the Mayo Clinic, Thoralf Sundt speaks about his personal experience with critical incidents and the challenges of disclosure conversations with the family members, the quality improvement process that ensued, his reflections on the good things that resulted and what he wished might have been done differently.</p>	
9:30 – 10:15 am	Journey to consensus: the Canadian Disclosure Guidelines <i>Trevor Theman, Edmonton</i> <i>Brent Windwick, Edmonton</i> <p>This session will provide an outline of the Canadian Disclosure Guidelines and their implications for healthcare professionals and organizations. Our speakers will offer a glimpse into how two very different disciplines – healthcare and legal - came together to shape this document. Brent Windwick, a lawyer, was Chair of the Disclosure Working Group of the CPSI that developed the guidelines. Trevor Theman, a physician and regulator, was a member of the Disclosure Working Group.</p>	
10:15 – 10:45 am	Refreshment break	<i>Foyer (1st floor)</i>
10:45 am – 12 noon	Panel presentation: perspectives on disclosure <i>Valli Elmgren, Edmonton</i> <i>Luane Wagner, Saskatoon</i> <i>Reginald Watson, Regina</i> <i>Jim Hornell, Swift Current</i> <p>This panel presentation will focus on a single adverse event, and will provide three distinct viewpoints on that case: the patient’s family members, the family’s lawyer, and the current CEO of the health region in which the event took place.</p>	
12 noon – 1:30 pm	Lunch	<i>Room 2F (2nd floor)</i>

1:30 – 2:45 pm

Open and honest communication: simple concept, complex reality

Through the use of live scenarios, two different examples of disclosure will be analyzed by our panel, and audience feedback invited. Commentary will be provided by a lawyer, a representative of the Canadian Medical Protective Association, and representatives from the “Patients for Patient Safety” Canadian advocacy group.

Panel commentary:

Reginald Watson, Regina
Gordon Wallace, Ottawa
Donna Davis, Carievale
Deborah Prowse, Calgary

2:45 – 3:15 pm

Refreshment break

Foyer (1st floor)

3:15 – 4:00 pm

Closing presentation

Rob Robson, Winnipeg
Alan Katz, Winnipeg
Gale Hume, Winnipeg

Gail Hume, a respected professor of nursing and colleague to many, experienced the loss of her husband as a result of an adverse event in a Winnipeg hospital. Ms. Hume and physician, Alan Katz, have presented during grand rounds and to medical and nursing students about their experience. Rob Robson, Chief Patient Safety Officer for the Winnipeg Regional Health Authority, will join them to reflect on their learnings in the disclosure process and provide their recommendations for ensuring open and honest communication following an adverse event.

4:00 – 4:30 pm

Wrap up: thoughts and impressions

Martin Hatlie, Chicago

Pre-Symposium 1 Faculty

Donna Davis LPN

Co-Chair, Patients for Patient Safety
Canada, Carievale, Saskatchewan

Valli Elmgren RO RCLP

Managing Optician, Edmonton, Alberta

Martin Hatlie JD

President, Partnership for Patient
Safety, Chicago, Illinois

Jim Hornell BA BEd MEd

Chief Executive Officer, Cypress Health
Region, Swift Current, Saskatchewan

Gale Hume MEd BA

Teaching Assistant, Faculty of Nursing,
University of Manitoba, Winnipeg,
Manitoba

Alan Katz MBChB MSc CCFP MMSF

Clinical Research Professor in
Population Medicine, Associate
Professor, Departments of Family
Medicine and Community Health
Sciences, University of Manitoba;
Associate Director, Manitoba Centre for
Health Policy, Winnipeg, Manitoba

Deborah E. Prowse MSW LLB

Patients for Patient Safety Canada,
Calgary, Alberta

Rob Robson MDCM FRCPC

Chief Patient Safety Officer, Winnipeg
Regional Health Authority, Winnipeg,
Manitoba

Thoralf M. Sundt MD

Adult Cardiac Surgeon, Mayo Clinic,
Rochester, Minnesota

Trevor Theman MD FRCSC

Registrar, College of Physicians &
Surgeons of Alberta, Edmonton,
Alberta

Luane Wagner

Saskatoon, Saskatchewan

Gordon Wallace FRCPC

Director of Education, Risk
Management Services, Canadian
Medical Protective Association, Ottawa,
Ontario

Reginald A. Watson QC

Lawyer, Balfour Moss LLP, Regina,
Saskatchewan

Brent Windwick QC LL.M. (Cantab.)

Partner, Field Law LLP, Edmonton,
Alberta

Planning Committee

Co-chair**Paula Beard ACP**

Director of Operations, Canadian
Patient Safety Institute

Co-chair**Carolyn Hoffman RN MN**

Director of Critical Care, Emergency
and Trauma, Royal Alexandra Hospital,
Alberta Health Services –
Capital Health

2

Pre-Symposium 2

Decision Making and Judgement in Healthcare and the Law

Program Overview

Decision making is a critically important part of the provision of everyday healthcare but is rarely taught effectively and not well understood. Interestingly, those who work in the legal system encounter many of the same problems as do healthcare providers. Both need to understand context, resource and expertise availability, fatigue, and cognitive and professional bias. In addition, when cases are discussed after the event, reviewers should consider the context in which the decisions were made, as this is not the same as the context of the classroom or the courtroom.

Learning Objectives

At the end of this workshop, participants will be able to:

- 1** Describe how physicians and nurses, and other healthcare professionals, learn how to make better decisions.
- 2** Distinguish the differences in their decision making processes
- 3** Summarize how the legal world views healthcare judgement and decision making
- 4** Describe alternate approaches to decision making
- 5** Identify some common pitfalls when making decisions and how to avoid them
- 6** Learn how to engage patients and their families effectively when making decisions

Pre-Symposium 2 Program

All sessions will take place in Rooms 2G to 2H (2nd floor) unless otherwise noted.

Thursday, October 23, 2008

7:00 am – 4:30 pm	Registration	<i>Foyer (1st floor)</i>
7:00 – 7:45 am	Breakfast	<i>Room 2E (2nd floor)</i>
8:00 – 9:00 am	“Context is everything” or “How could I have been that stupid?” <i>Pat Croskerry, Halifax</i> Pat Croskerry will open the day with an explanation of why decision making is integral to every situation, and why the context under which decisions are made can never be separated from the decisions themselves. He will provide an overview of decision making models and how they affect different professions within the healthcare and legal systems.	
9:00 – 9:15 am	Questions	
9:15 – 9:30 am	Refreshment Break	<i>Foyer (2nd floor)</i>
9:30 – 10:15 am	Clinical decision making and judgement in nursing <i>Carl Thompson, United Kingdom</i> Carl Thompson will illustrate the kinds of choices that nurses face, the limitations on the quality of the decisions reached, how error is unavoidable, and the impact of factors such as time and guidance on decisions and judgements. He will argue that nursing needs to move away from ‘woolly thinking’ and superficially-based concepts such as ‘holism,’ and move towards more evidence-based decision making.	
10:15 – 10:30 am	Questions	
10:30 – 11:15 am	Shared decision making <i>William Godolphin, Vancouver</i> Informed and shared decision making in the doctor-patient encounter has become widely encouraged and espoused, and has been called the crux of patient-centred care. Yet this type of care rarely takes place. William Godolphin poses and then answers several questions. How do we know that it is a ‘good thing’? Why is shared decision making so difficult to teach and to learn? What are the barriers to shared decision making and what is being done, might be done, or should be done to overcome them?	
11:15 – 11:30 am	Questions	

11:30 am – 12 noon

Rational Experiential Inventory testing

Delegates will have the opportunity to complete the Rational Experiential Inventory test, which will then be scored, with results revealed during the afternoon session.

12 noon – 1:15 pm

Lunch

Room 2E (2nd floor)

1:15 – 2:00 pm

Thinking about thinking

Kathryn Montgomery, Chicago

Clinical medicine – a learned, rational, science-using practice – is labeled a science even though physicians have the good sense not to practice it that way. In this presentation, Kathryn Montgomery discusses how this misdescription of physicians' thinking – "how we think they know what they know" – has ill effects on medical education, the patient-physician relationship, and our expectations of the profession. Clinical judgement remains an essential intellectual strength, even as evidence-based medicine improves the information with which physicians work.

2:00 – 2:15 pm

Questions

2:15 – 3:00 pm

A view from the bar

John Martland, Calgary

John Martland will discuss the process by which Courts review medical decisions and arrive at a legal judgement. He will address the problem of analyzing a medical event in the isolation of the Courtroom where the larger context of the circumstances in which the adverse event occurred may be lost. He will discuss the difficulties lawyers and judges, who are not medically trained, face when presenting and understanding evidence concerning a complex, circumstantial medical situation. Specifically, he will address the legal challenge of appropriately considering outside contextual factors such as resources, other ongoing events, and ever-changing medical practices with the passage of time.

3:00 – 3:15pm

Questions

3:15 – 3:30 pm

Break

Foyer (2nd floor)

3:30 – 4:30 pm

Wrap-up

REI results, group discussion, and summation

Pat Croskerry, Halifax

Sharon Caughey, Ottawa

Pre-Symposium 2

Faculty

Pat Croskerry MD PhD

Professor, Department of Emergency Medicine, Dalhousie University, Halifax, Nova Scotia

William Godolphin PhD

Professor Emeritus, Faculty of Medicine, University of British Columbia, Vancouver, British Columbia

John Martland QC

Senior Counsel, Bennett Jones LLP, Calgary, Alberta

Kathryn Montgomery PhD

Professor and Director, Medical Humanities and Bioethics, Northwestern University, Chicago, Illinois

Carl Thompson DPhil BA RN

Senior Research Fellow, Head of Programme, MSc Evidence Based Practice, Department of Health Sciences, University of York, York, United Kingdom

Planning Committee

Chair

Pat Croskerry MD PhD

Professor, Department of Emergency Medicine, Dalhousie University

Sharon Caughey MD FRCSC FACOG

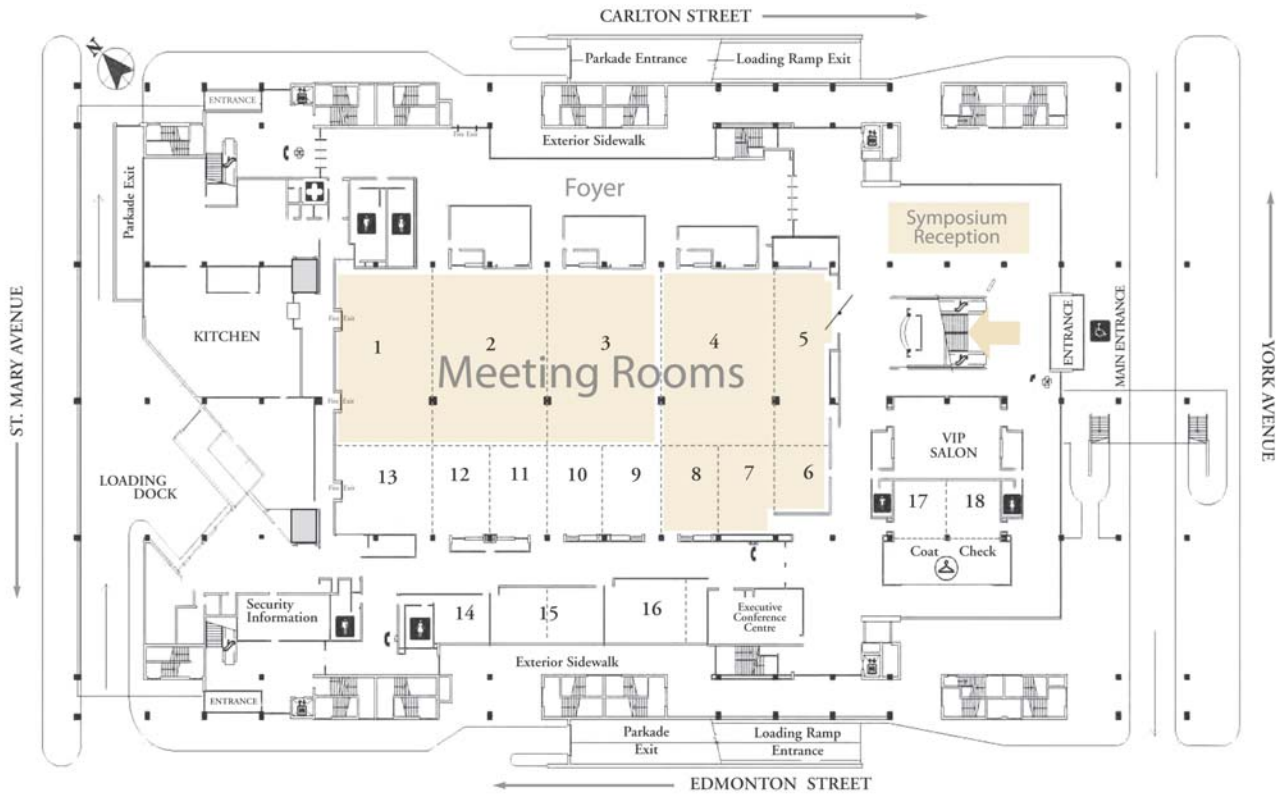
Assistant Professor, Department of Obstetrics and Gynaecology, University of Ottawa

Jan Davies MSc MD FRCPC

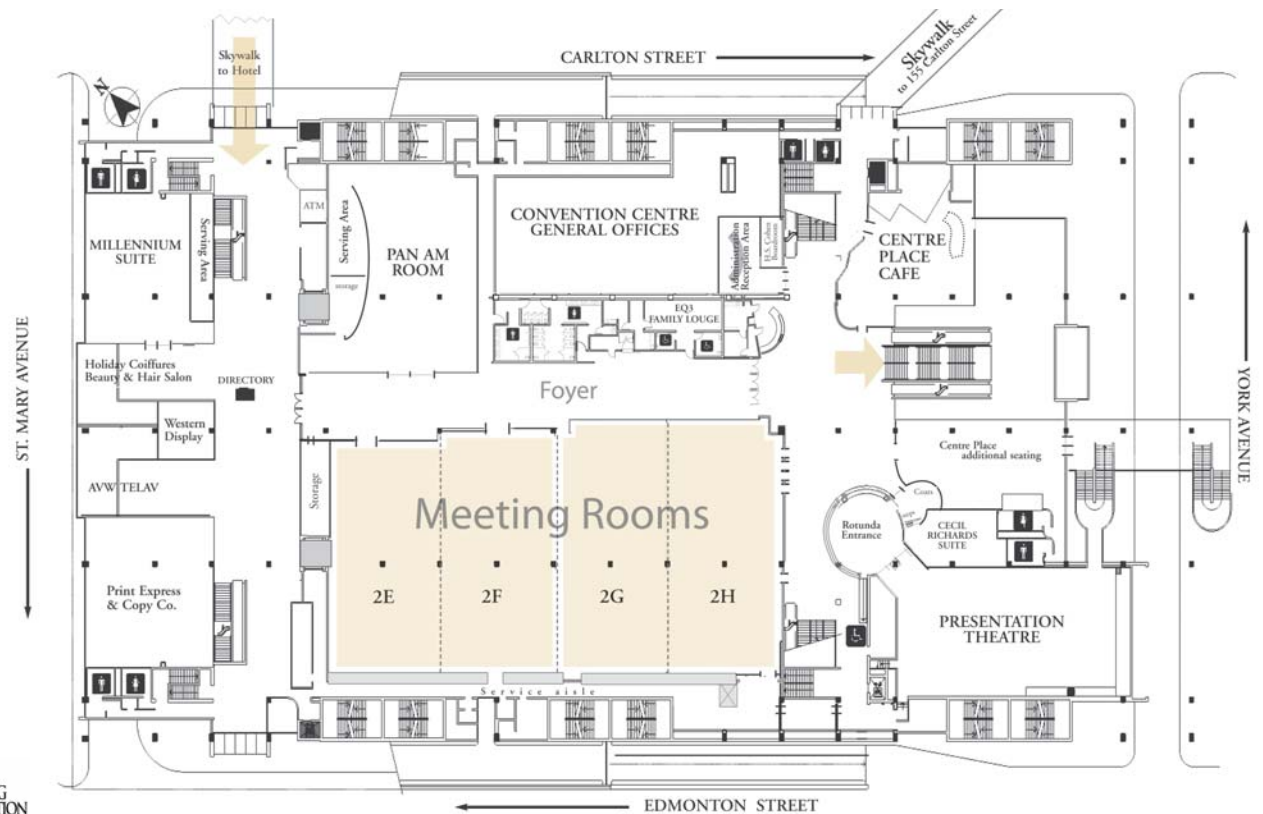
Professor, Department of Anesthesia, University of Calgary

Winnipeg Convention Centre

1st level



2nd level



Healthcare and the Law Symposium Sponsors

Lead Sponsor



Platinum



Gold



Silver



Bronze



Canada's Research-Based
Pharmaceutical Companies



Les compagnies de recherche
pharmaceutique du Canada

