

Chapter 4



THE HEALTH SCIENCES CENTRE

ESTABLISHMENT OF THE HEALTH SCIENCES CENTRE

The events that are the subject of this Inquest occurred at the Children's Hospital during 1994. The Children's Hospital is part of the Health Sciences Centre (HSC), which is Manitoba's largest hospital. Through its affiliation with the University of Manitoba, the HSC is also Manitoba's primary medical teaching facility.

The HSC came into existence in February 1973, when *The Health Sciences Centre Act* (see SM 1998-99 c.41) was proclaimed, incorporating the Winnipeg General Hospital, the Women's Pavilion, the Children's Hospital of Winnipeg, the Manitoba Rehabilitation Hospital and the D. A. Stewart Centre (Respiratory Hospital) into one administrative and legal unit. The purpose of the merger was to produce global hospital planning, uniting these facilities under a single administration. A separate affiliation agreement was signed with the Manitoba Cancer Treatment and Research Foundation.

Until the amalgamation, the Children's Hospital had been a stand-alone institution, complete with its own corporate structure, board, budget and administration.

Under *The Health Sciences Centre Act*, the Women's Pavilion became known as the Women's Centre, the Winnipeg General Hospital became the General Centre and the Children's Hospital became the Children's Centre. The medical staff of the Children's Hospital was reorganized as the Department of Pediatrics and Child Health within the HSC, and the head of the Children's Hospital became the Head of Pediatrics and Child Health.

Despite the amalgamation, however, the Department of Pediatrics and Child Health and the Children's Centre are still referred to as the Children's Hospital (or simply the Children's). Those references will occur throughout this report, but it must be kept in mind that, during the period under discussion, the Children's Hospital was not a stand-alone institution.

This chapter outlines the overall structure of the HSC during 1994, with a particular focus on those units and departments associated directly or indirectly with pediatric cardiac surgery. Changes to the hospital's organizational structure that occurred during 1993–94 are discussed, along with their implications for the pediatric cardiac program. This chapter also highlights a number of committees and procedures that relate to the monitoring and maintenance of medical care.

In some sections a certain degree of ambiguity and confusion regarding lines of authority and responsibility will be apparent. During the course of hearings, witnesses gave differing accounts of what the responsibilities of various staff appointees were. Indeed, in some cases the appointees or staff people themselves expressed uncertainty about the full range of their own responsibilities and obligations. These matters will be dealt with in subsequent portions of the report. This chapter is meant to be an overall guide to the HSC's structures.

THE 1994 HSC REORGANIZATION

During 1993–94 the HSC undertook a major organizational review. Throughout this period, lines of authority were shifting. In June 1994, a major structural reorganization occurred that, among other things, saw the number of vice-presidents reduced from seven to four and a dramatic alteration in reporting lines. This reorganization was part of a larger reorganization that had been initiated by the Manitoba government in the early 1990s. At that time the government had hired the American Patient Management group (APM) to undertake a review of the operations of a number of Winnipeg health-care institutions. The review was headed by U.S. health-care consultant Connie Curran. One of the major thrusts of this review was to reduce health-care costs.

The restructuring involved the establishment of a number of 'patient improvement teams' (PIT teams) throughout the hospital. Each team was given a dollar figure goal and expected to find ways to reduce spending by that amount in the team's area. The Inquest was told that the team examining the in-patient budget (the amount spent treating patients in the hospital) was expected to find between \$10 and \$15 million worth of savings, approximately ten per cent of the total in-patient budget.

The review process began in the summer of 1993 and continued until the end of the year, with a staged implementation commencing in 1994. Many people who appeared before this Inquest indicated that the review process consumed a great deal of their time and energy during that period. The review naturally created serious anxieties for many hospital personnel. Their concerns were justified. The in-patient review that was expected to save \$10 million looked almost solely at staff and service-delivery areas. In other words, the changes that came from its recommendations involved either altering people's jobs or eliminating positions.

ADMINISTRATIVE STRUCTURE

THE BOARD OF DIRECTORS OF THE HOSPITAL

The board of the HSC in 1994 had 19 members. Five members were appointed by the Manitoba Government, two by the University of Manitoba Board of Governors, one by the Manitoba Cancer Treatment Centre and Research Foundation, one by the Children's Hospital Research Foundation and eight by the board itself. In addition, by virtue of their offices, the Dean of Medicine of the University of Manitoba and the President of the Medical Staff (representing doctors) sat as full voting board members. No active member of the hospital nursing staff sat on the board.

THE PRESIDENT

In 1994, the President of the Health Sciences Centre was the Chief Executive Officer of the HSC and was responsible for the proper management of all aspects of the hospital's activities. The President was appointed to his position by the board. The President's job description set out the following principal functions:

The President is responsible for developing and maintaining a suitable organization structure and employing competent executive staff. He assists and guides the Board of Directors in setting the strategic direction for the hospital and ensures that objectives are met. He is the principal trustee of the hospital's financial and physical resources.

The President sets the standards and principles which determine how the hospital is to conduct its affairs. He ensures that the hospital is in compliance with all relevant statutes and regulations and is the principal management contact for external agencies, organizations and companies. He is responsible for the development and maintenance of a sound image of the hospital in the general public. (Exhibit 375)

Although not a board member, the President attended all meetings of the hospital board, and was responsible for ensuring that the board was kept informed of matters that were within its purview. The hospital's vice-presidents and senior managers reported to the President. During 1994, the period when the 12 deaths under investigation occurred, the President of the HSC was Rod Thorfinnson. An experienced administrator, Thorfinnson was not a doctor.

THE VICE-PRESIDENTS

The HSC's vice-presidential structure was significantly altered by the corporate reorganization of June 1, 1994. Not only was the number of vice-presidents reduced, but the portfolio system that had been in place was eliminated and replaced by a system of program management.

Vice-presidents and portfolios before June 1994

Before the reorganization, the HSC had seven vice-presidents, each with a specific portfolio or area of responsibility. The portfolios were:

- Corporate planning
- Medical
- Nursing
- Operations
- Finance
- Human resources
- Communications and information systems (This Vice-President reported to the Senior Vice-President for Corporate Planning.)

Some of these portfolios, such as Medicine and Nursing, were known as clinical portfolios, while others, such as Finance or Operations, were known as non-clinical portfolios. There was also a vice-presidential hierarchy: four vice-presidents were titled senior vice-presidents. Under this system a person would hold a position with a specific title, such as Senior Vice-President, Medicine; or simply Vice-President, Communications and Information Systems. All but one of the vice-presidents reported directly to the President and all were appointed by the board.

The significant portfolios before June 1994 in terms of the issues under consideration by this Inquest were the Senior Vice-President Medical (a position held by Dr. J. B. (Ian) Sutherland) and the Senior Vice-President Nursing (a position held by Susan VanDeVelde-Coke). Under this structure, Sutherland also chaired the Medical Advisory Committee (an important hospital committee that will be discussed later).

Before discussing the 1994 reorganization, it is useful to outline the structure of these two portfolios (Medical and Nursing) before their elimination in June 1994.

The medical portfolio

The Senior Vice-President (SVP) Medicine was responsible for the Medical Portfolio. This portfolio supervised services delivered by the hospital's medical staff. (In this context, medical staff included doctors, dentists and scientists). The Medical Portfolio was subdivided into departments, each with its own head or chief, who was appointed by the board. Before June 1, 1994, all department heads reported to the SVP Medicine. All doctors with HSC medical appointments would have an appointment to one of the medical departments.

The medical departments at the HSC were:

- Anaesthesia
- Clinical Chemistry
- Clinical Microbiology
- Community Health Sciences
- Emergency

- Medicine
- Obstetrics and Gynaecology
- Ophthalmology
- Otolaryngology
- Pathology
- Pediatrics and Child Health
- Psychiatry
- Radiology
- Surgery

The three key departments for the purposes of this Inquest were Anaesthesia, Pediatrics and Child Health, and Surgery. The structure of these departments will be discussed later in this chapter.

The nursing portfolio

Before June 1, 1994, the Senior Vice-President Nursing was responsible for the Nursing Portfolio. This portfolio was responsible for the provision and management of all nursing services in the hospital. The portfolio was divided into six smaller divisions, each with its own director. All directors reported to the SVP Nursing.

The Nursing Divisions at the HSC, before June 1994, were:

- Surgical Nursing
- Medical Nursing
- Psychiatric Nursing
- Pediatrics and Child Health
- Adult Ambulatory Care
- Obstetrics and Gynaecology

The SVP Nursing was also responsible for Nursing Education and Research. The key divisions for the purposes of this Inquest were Pediatrics and Child Health Nursing and Surgical Nursing.

The rationale for the reorganization

The portfolio system had long been criticized because people working side by side in a ward or medical unit often fell within vastly different administrative lines of authority and accountability. Doctors, nurses, medical technicians, residents, therapists and administrative personnel, working on the same ward and dealing with the same patients, reported to different managers and responded to different managerial priorities. Unit personnel could easily fail to develop a team approach to the management of the issues that occurred in the unit. This sometimes resulted in conflicts over the medical management of patient care that required the involvement of senior managers for resolution.

The reorganization sought to break down these barriers by creating lines of authority that grouped the individuals who worked together on the same ward or in the same program into management units that reported to the same vice-president.

Vice-presidents and portfolios after June 1994

In June 1994 the system changed to one where there were only four vice-presidents, each of whom had both clinical and non-clinical responsibilities and reported to the President. The seven portfolios, including the Medical and Nursing portfolios, were eliminated. Of the four vice-presidents, the three of interest to this Inquest from June 1994 onward were Sutherland, Helen Wright and VanDeVelde-Coke.

The new structure sought to bring units together under one line of authority. No longer did all medical departments report to a single vice-president. The same was true of nursing divisions, which were renamed patient service divisions. Under the new structure, program teams were created, led by three managers with equal and joint responsibility for overseeing the program of which they were a part.

Medical departments and patient services divisions were clustered into program teams. The head of Pediatrics and Child Health and the director of Patient Services for Pediatric and Child Health were part of the Child Health Program Team and reported to Vice-President Helen Wright. (The third member of the Child Health program team was the director of Support Services, an administrative officer.)

Medical departments that were interdependent reported to the same vice-president. For example, the two other medical departments key to this Inquest, Anaesthesia and Surgery, reported to VanDeVelde-Coke.

Program teams were responsible for patient care teams. In the case of the Child Health program team, the significant patient care teams for this Inquest were those for Surgery, Pediatric Intensive Care and Neonatal Intensive Care. Patient care teams were meant to bring together front-line and administrative staff. These teams were to be made up of a section head (a senior doctor responsible for a medical service), a unit manager (usually a senior nurse) and an administrative official.

The hospital's bylaws were not updated at the time of the reorganization. As a result, the bylaws continued to refer to the responsibilities of non-existent positions, such as Senior Vice-Presidents.

Issues raised by the reorganization

The positions of Vice-President Medicine and Vice-President Nursing had always been held by persons with medical and nursing backgrounds respectively. The elimination of these positions caused some concern among staff that medicine and nursing—and nursing in particular—would lose status. Therefore, Thorfinnson gave a written commitment that there would always be one vice-president with a nursing background and one vice-president who was a doctor. (Other issues relating to nursing and reorganization will be discussed later in this chapter.)

MEDICAL DEPARTMENTS

For the purposes of this inquest, the three key medical departments were Anaesthesia, Surgery, and Pediatrics and Child Health. During all of 1994, Dr. Douglas Craig was the Clinical Head of Anaesthesia and Dr. Robert Blanchard was the Clinical Head of Surgery. Until June 1, 1994, Dr. Agnes Bishop was the Clinical Head of Pediatrics and Child Health (and therefore the head of the Children's Centre). She left on that date for a position with the federal government. For the summer months of 1994, the position rotated among various medical staff, including Dr. John Bowman. On September 15, 1994, Dr. Brian Postl became Clinical Head of Pediatrics and Child Health.

Before June 1, 1994, these three heads all reported to Sutherland. After that date, the heads of Anaesthesia and Surgery reported to VanDeVelde-Coke, while the head of Pediatrics and Child Health reported to Helen Wright.

According to the medical staff bylaws, department heads had the following responsibilities:

- To develop and maintain high standards of patient care, teaching and research within the department;
- To supervise the work of departmental members in all matters relating to patient care;
- To prepare a departmental budget when called upon to do so and maintain expenditures within that allocated budget;
- To develop departmental policies in consultation with the Department Council;
- To act as the official channel of communication between the administration and the department;
- To report to their respective VP on the work of the department when called upon to do so;
- To conduct investigations of departmental members, or assign such investigations as required within medical staff disciplinary procedures;
- To recommend to the Board, through the Medical Advisory Committee, the appointment, reappointment, delineation of privileges and other changes in status of departmental members;
- To recommend to the Board, through their respective VP and the President, the appointment, reappointment or termination of section heads.
- To immediately suspend, or otherwise limit, the privileges of a member of the department, for a period of up to 10 working days, for conduct that the department head reasonably believed might negatively affect patient care or which constituted a serious breach of ethical standards, or breached Centre policies and procedures; and
- To exercise such other powers and perform such other duties as might from time to time be conferred by the Board.

Surgical sections

There were a number of sections within the Department of Surgery. They all reported to Dr. Robert Blanchard, the head of surgery in 1994. Each section had its own section head, and each subsection also had a subsection head. For the purposes of this Report, the primary section of interest is the Section for Cardiovascular and Thoracic Surgery and the Pediatric Cardiac Surgery service within it.

Cardiovascular and Thoracic Surgery

The Department of Surgery had a section known as Cardiovascular and Thoracic (CVT) Surgery, with a section head. During 1994 the acting head of the CVT section was Dr. Helmut Unruh. The pediatric cardiac surgeon, Dr. Jonah Odim, reported to Unruh, who reported to the head of surgery. Odim was referred to as a service chief for Pediatric Cardiac Surgery. A service in a hospital consists of a group of doctors providing the same kind of medical service. Each service is usually assigned a number of residents, interns and medical students who are posted there for a period of time. However, the pediatric cardiac surgical service headed by Odim was not so fortunate. For all intents and purposes, Odim was the only member of the pediatric cardiac surgery service and had no residents assigned to him for training as pediatric cardiac surgeons. However, residents did occasionally provide assistance at pediatric cardiac operations.

Odim's contract specified that he was being offered a position as associate professor in the Department of Surgery of the Faculty of Medicine, University of Manitoba, as well as a position on the medical staff of the Health Sciences Centre. In the former position, he was responsible to the head of the Department of Surgery. The contract stated that in relation to his duties on the medical staff:

You will undertake the responsibilities of Service Chief, Pediatric Cardiac Surgery at the Health Sciences Centre . . . and other duties as assigned by the Section Head, Cardiothoracic Surgery, under the Surgeon-in-Chief, HSC. (Exhibit 178)

Odim's job description included the following passage:

1. Title: Service Chief, Pediatric Cardiac Surgery
2. Responsible to: Section Head, Cardiovascular & Thoracic Surgery
3. Description of area of responsibility
 - a. General Purpose of Program

To provide the citizens of Manitoba with a high standard of care and specialty expertise in the area of pediatric cardiothoracic surgery. This program is partly supported by the Variety Children's Heart Centre which is primarily an ambulatory service providing consultations on a referral basis, to pediatricians and family practitioners throughout the Province of Manitoba and Northwestern Ontario; occasional referrals are received from the eastern part of Saskatchewan. Children with significant heart lesions are followed on a regular basis before and after heart surgery.

As the surgical component of the service expands there is increasing hospital involvement, although as a rule the in-hospital commitment is in consultation on the wards and Intensive Care Unit of the Children's Hospital. Other nurseries and pediatric units in city hospitals are visited in consultation on occasion.

Nursing staff and technologists work both in the Heart Centre itself and in the heart catheterization laboratory (which is located in the Radiology Department of the Children's Hospital), as well as providing services on the wards of the Children's Hospital. There is considerable after-hours activity, with physicians, nurses and technologists providing 24 hours hospital coverage, seven days a week.

The Heart Centre itself incorporates examination rooms and the non-invasive laboratories, where electrocardiography (ECG), echocardiography (echo) and exercise testing is performed. A 'drop-in' service for ECG's is provided for city practitioners, otherwise these laboratories support only the clinical activities of the Heart Centre staff.

b. Area of Responsibility

Responsible to organize and direct a broad spectrum of pediatric cardiac services and to promote a high standard of patient care, teaching and research activities. The Service is also responsible for directing the surgical component of the Variety Children's Heart Centre. (Exhibit 178)

Odim also held a secondary hospital appointment in the Department of Pediatrics. However, the Pediatric Cardiac Surgery Program was primarily a surgical (as opposed to a pediatric) program.

Pediatric sections

There were also a number of sections within the Department of Pediatrics and Child Health that reported to the head of that department. For the purposes of this report, the sections with which we are most concerned are Pediatric Cardiology, Pediatric Surgery, Pediatric Intensive Care and Neonatal Intensive Care.

Pediatric cardiology and the Variety Children's Heart Centre

Pediatric Cardiology services were delivered through the Variety Children's Heart Centre. In 1994, the acting medical director of the VCHC and the acting section head of Pediatric Cardiology was Dr. Niels Giddins.

According to a job description dated October 1993 and prepared by the previous VCHC medical director, Dr. George Collins, the medical director of the VCHC was required to:

Provide overall supervision of the medical diagnostic and therapeutic activities occurring at Variety Children's Heart Centre and Children's Hospital, ensuring the highest possible standard of care

With the Surgical Director [of the VCHC], and Directors of the Cardiac Catheterization and Non-Invasive Laboratories:

Develop and maintain appropriate guidelines for pre-operative evaluation, perioperative care, and post-operative management of children referred for congenital and acquired heart disease

Maintain free and open communications with other sections (i.e. Neonatology, Intensive Care) and departments including (i.e. Anaesthesia, Radiology) within Children's Hospital, Health Sciences Centre, and the University of Manitoba

Oversee staffing assignments within VCHC

Establish standards for staff safety and conduct. (Exhibit 71)

Pediatric surgery

Pediatrics and Child Health also had a section known as Pediatric Surgery. Dr. Nathan Wiseman was the head of Pediatric Surgery during this period. He reported to the head of Pediatrics, as well as to the head of Surgery (Exhibit 296). His responsibilities consisted primarily of co-ordinating the surgical services provided by the Children's Centre, ensuring that the scheduling of cases occurred in an appropriate manner and that the operating rooms at the Children's Hospital were properly used.

Wiseman's job description stated that he was "responsible to: Department Head, Department of Surgery and the Department of Pediatrics and Child Health." Under the heading of "Description of Area of Responsibility," the job description stated:

To provide the citizens of Manitoba with a high standard of care in areas of Pediatric Surgery.

b) Area of Responsibility

Responsible to organize and direct a broad spectrum of pediatric surgical programs and to promote a high standard of patient care, teaching and research in the field of Pediatric Surgery. Overall, Pediatric Surgery includes Pediatric Ophthalmology and Pediatric ENT as it impacts on Pediatric Surgery.

c) No. of physicians:

CVT 3, Dentistry 11, Plastics 3, Urology 3, Neurosurgery 5, General Surgery 4, Ophthalmology 8, Orthopaedics 5, Otolaryngology 12. (Exhibit 296)

Under the heading of “Personnel,” it stated that the head of Pediatric Surgery:

Coordinates the selection process and recommends to the Department Head office the appointment of and reappointment of staff who are adequately qualified to deliver a high standard of care, research and education in the different specialty areas. (Exhibit 296)

Pediatric Intensive Care

Pediatrics and Child Health had a section known as pediatric intensive care. This section was always referred to as the pediatric intensive care unit (PICU). The head of the PICU in 1994 was Dr. Murray Kesselman. The doctors who worked in the unit were referred to as intensivists and specialized in the treatment of intensive care for children from the age of six weeks to 18 years. The other intensivists who worked in the unit during 1994 were Dr. Fiona Fleming, Dr. B. J. Hancock and Dr. Jo Swartz. Hancock also worked in the Department of Surgery as a pediatric surgeon and Swartz was also an anaesthetist and was a member of the Department of Anaesthesia.

A description of the services provided in this unit is found in Chapter Three.

Neonatal Intensive Care

Pediatrics and Child Health had a section known as neonatal intensive care. This section was always referred to as the neonatal intensive care unit (NICU). The doctors who worked within it were referred to as neonatologists and had been trained in the special care of newborn children aged up to six weeks. In 1994, the head of this section was Dr. Molly Seshia. The other neonatologists were Dr. J. Belik, Dr. R. Caces, Dr. O. Casiro, Dr. R. Alvaro, Dr. H. Rigatto, Dr. C. Fajardo, Dr. G. Cronin and Dr. R. Savani.

A description of the services offered by this section is found in Chapter Three.

Anaesthetic sections

The Department of Anaesthesia was responsible for providing anaesthetic services within the hospital. The head of the Department of Anaesthesia was Dr. Douglas Craig. The department had two sections, one for adult anaesthesia and one for pediatric anaesthesia. Both sections reported to the head of Anaesthesia.

Pediatric anaesthesia

The head of the section of pediatric anaesthesia was Dr. Suzanne Ullyot. The section provided anaesthetic coverage for all surgical and some diagnostic procedures involving pediatric patients in the hospital. There was also a pediatric cardiac anaesthesia subsection.

Pediatric cardiac anaesthesia

The subsection of pediatric cardiac anaesthesia was responsible for providing all anaesthetic coverage for pediatric cardiac patients at Children's Hospital during 1994. The subsection did not have a subsection head until May 16, 1994, when Dr. Ann McNeill was appointed to that position. She reported to Ullyot. Four specialists provided pediatric cardiac anaesthetic care during 1994: McNeill, Dr. Jo Swartz, Dr. Heinz Reimer and Dr. Harley Wong.

MEDICAL STAFF

Health-care professionals, such as doctors, were appointed to the HSC's medical staff. As such they were not employees, but were professionals with a hospital appointment. They had hospital privileges, which meant that they were allowed to work in the hospital. As will be seen later in this report, professionals with a hospital appointment enjoyed a degree of autonomy that employees such as nurses did not enjoy.

Every member of the medical staff was appointed to a specific department. However, staff members could have more than one appointment. In such cases, the member had a primary appointment and a secondary appointment.

The medical staff was governed by the HSC's medical staff bylaws. (Exhibit 41) According to these bylaws, the medical staff were responsible:

- for ensuring the provision of optimal medical care to patients at the Centre, of a standard commensurate with the resources available and the state of medical science;
- for ensuring an environment conducive to scholarly inquiry and research at the Centre;
- for ensuring the provision of medical education programs to support the aim of a high standard of care; and
- for advising the Board on medical matters relating to the mission, role, goals and objectives of the Centre.

To accomplish this, the medical staff was expected to maintain an effective system for making recommendations for the appointment, reappointment and the delineation of privileges. In addition, the bylaws stated that the medical staff should:

Maintain an acceptable quality assurance programme for the Medical Staff through the establishment of standards of medical care in the Centre, the monitoring of performance, the identification of problems, and the undertaking of corrective action in relation to the conduct of medical practice in the Centre. (Section 3.2.2.2)

In short, the medical staff were responsible to the board for the “quality of patient care, education and research.” (Section 4.1.11)

Members were appointed and reappointed to the medical staff on the basis of the recommendation of the Medical Advisory Committee. This committee made its decision based on applications submitted to it by the appropriate department head. According to the medical staff bylaw, Section 5.2.2.1,

All medical practitioners shall be qualified to practice in the Province of Manitoba and shall be registered and hold a current license with the College of Physicians and Surgeons of Manitoba.

In addition, the board, when deciding on an application, considered past performance in quality of patient care, ability to work with colleagues and staff, and contribution to administration and committee work.

Members of a department were responsible to the section head and the department head for meeting standards of patient care, performance of teaching and research duties, performance of administrative responsibilities, and appropriate attendance at meetings.

Each department was expected to have its own Department Council to act as a forum for communication and discussion between the department head and members of the department. As well, the Department Council could:

Establish such standing or ad hoc committees as it deems necessary each operating within specific terms of reference. Such Committees shall include a Credentials and Privileges Committee and a Standards Committee. [Section 6.6 (e)]

The Department Council comprised all members of the department (except for honorary and educational members) and persons who the council believed might be appropriately included in membership because of their association with the department.

Medical Staff Council

The Medical Staff Council was composed of the medical staff at the Centre and was intended to represent the interests of the medical staff. The council consisted of members of the active staff, members of the provisional staff and members of the scientific staff.

Medical Advisory Committee

The Medical Advisory Committee was the senior patient care committee responsible for advising the board on all matters concerning medical policy and issues.

According to the HSC bylaws, the main duties of the Medical Advisory Committee included:

- advising the board on all matters concerning patient care policy and issues;
- establishing and maintaining standards of medical practice;
- through the President of the Medical Staff Council informing the medical staff of business transacted at meetings of the Medical Advisory Committee;
- making recommendations to the board concerning the qualifications required for appointment to the medical staff;

- making recommendations to the board on the appointment and privilege delineation of each member of the medical staff; and
- recommending to the board policies and procedures relating to disciplinary matters.

The Medical Advisory Committee's membership included a Senior Vice-President, who acted as the chair. (Both before and after June 1, 1994 this position was occupied by Sutherland.) Other members included the President of the Medical Staff Council, three other officers of the Medical Staff Council, the department heads of the various medical departments and the Dean of the School of Medicine. The committee's non-voting members included the President of the HSC, the Senior VP of Operations, Senior VP of Nursing, Senior VP of Corporate Planning, the HSC Director of Research and the Director of Medical Administration. The Medical Advisory Committee met at least ten times a year.

Remuneration

HSC medical staff received their income in a variety of ways, besides the payment they might receive from the University of Manitoba for their academic duties. Department heads, section heads and subsection heads were paid by the HSC. In addition, they were entitled to bill the Manitoba government for medical services that they performed in the hospital. Surgeons, anaesthetists and other doctors similarly received a combination of direct payments and fee-for-service payments.

The members of the section of pediatric anaesthesia had established an arrangement with the hospital that introduced an element of income sharing to the manner of their remuneration. Essentially, members of the section performed their services and each was paid on the basis of the earnings received by the entire section (less an administrative fee).

NURSING

The greatest impact of the administrative changes that occurred at the HSC in 1994 was with respect to nurses. Up until June 1994, as noted above, there was a Nursing Portfolio with a number of divisions. Each division had its own director, each of whom reported to the Senior Vice-President Nursing.

Under the June 1994 reorganization, Nursing as a separate portfolio disappeared. In the new system the nursing divisions were renamed patient service divisions, and the directors of these divisions reported to different vice-presidents. For the purposes of this Inquest, there was one significant nursing division or, after June 1, patient service division. That was the Division of Pediatrics and Child Health Nursing, which became the Patient Service Division (Pediatrics and Child Health).

The Division of Pediatrics and Child Health Nursing – Patient Service Division (Pediatrics and Child Health)

Isobel Boyle was the Director of Pediatrics and Child Health Nursing at the Children's Centre before June 1, 1994, when her title changed to Director of Patient Services (Pediatrics and Child Health). Whereas

before June 1, 1994, Boyle had reported to Senior Vice-President Nursing VanDeVelde-Coke, after the reorganization she reported to Vice-President Wright, who also had responsibility for the Medical Department of Pediatrics and Child Health.

Through 1994 Boyle was responsible for 450 nursing positions. Because part-time employees filled many of these positions, the Director was responsible for between 600 and 700 people.

Nursing assignments were organized into units, each with a unit manager (formerly called the head nurse). While unit managers continued to perform most of the roles carried out by head nurses, the job (at least as formally described) was now refocused away from nursing to patient services and management responsibilities.

The training that nurses received emphasized the importance of dealing with any concerns they might have about medical quality through the appropriate channels. This would involve raising the matter with their unit manager, who was expected to take the concern to the next level.

Nurses from the following areas were involved with the Pediatric Cardiac Surgery program in 1994:

Nurses at the Variety Children's Heart Centre

Two nurse clinicians worked at the VCHC. Lois Hawkins, the senior nurse clinician at the VCHC, reported to Isobel Boyle.

Operating room nurses

Karin Dixon was the head operating room nurse until June 1, 1994. From that date forward, she was referred to as the unit manager. She reported to Isobel Boyle.

Carol Youngson was the senior nurse in charge of cardiac surgery. Youngson was responsible for ensuring that all supplies and equipment were ordered and for co-ordinating the surgical schedules of the other cardiac nurses. She reported to Karin Dixon.

Anaesthetic nurse

The only anaesthetic nurse was Irene Hinam. She reported to Boyle before June 1, 1994. After the reorganization she reported to Dixon.

Pediatric intensive care nurses

Until July 1994, Donna Feser was the PICU acting head nurse (and after June 1, 1994, the unit manager). In July, Evelyn Link returned from leave and resumed her position as unit manager. Both Feser and Link reported to Boyle.

Neonatal intensive care nurses

Sybil Russell was the head nurse and then the unit manager in PICU during the period under discussion. She reported to Boyle.

The Nursing Council

Before the change of June 1, 1994, there had been a Nursing Advisory Committee in place at the hospital that oversaw nursing issues. The VP Nursing sat on the Committee, which had significant status and authority within the hospital over the regulation of the nursing profession. For example, the Nursing Advisory Committee had a quality assurance subcommittee, which addressed quality assurance issues from a nursing perspective. With the changes brought about on June 1, the Nursing Advisory Committee was eliminated.

As noted above, the restructuring also removed the word “nursing” from the hospital’s formal organization and vocabulary. Directors of nursing became directors of patient services, while head nurses became unit managers. Under the new structure, the hospital did not have to have nurses in any position above the level of clinical resource nurse (formerly called a senior team leader), which is one level below a unit manager. The doctors continued to be recognized organizationally through the Medical Advisory Committee. In response to these concerns, a Nursing Council was established at the hospital.

The Nursing Council was charged with:

- Facilitating the growth of professional nursing at the HSC;
- Ensuring that patient care provided by nursing services was consistent with the HSC Mission Statement and Philosophy of Nursing;
- Fostering consistency in application of nursing policies and procedures;
- Setting directions for nursing education, research and clinical practice; and
- Facilitating communication between clinical programs.

The committee’s membership comprised the six directors of patient services, two nurses from each of the clinical programs, and one representative each from the School of Nursing, and Nursing and Education Research, Nursing Systems. In addition, the chairs of the Educational Advisory Committee, the Nursing Practice Committee, the Nursing Policy and Procedure Committee and the Nursing Research Steering Committee were members of the council. The President of the Hospital was an *ex officio* member. The Nursing Council met once a month and was responsible for addressing issues of professional practice, education and research. (Exhibit 312)

PERFUSIONISTS

Perfusionists are the technicians who run the cardiopulmonary bypass machine. Perfusion Services was a technical department that reported to the head of surgery, and provided perfusion services for adult and pediatric surgery. Michael Maas was the head of Perfusion Services at the HSC. He and three other perfusionists (Chris McCudden, Todd Koga and David Smith) provided perfusion services at both the HSC and St. Boniface General Hospital.

STAFF DISCIPLINE

The HSC board had the right to appoint, suspend or remove all medical and other staff and employees.

The board required that complaints alleging misconduct against a member of the medical staff be in writing and detail the specific misconduct alleged. Complaints were to be sent to the President or the appropriate vice-president. These complaints could be forwarded to the appropriate department head for informal resolution. If the complaint involved the department head, the Senior Vice-President Medical would deal with it.

Where the informal process failed or the complaint was deemed to be of a serious nature, the complaint was handled by the complaints committee of the Medical Advisory Committee. The committee investigated the complaint and, if it deemed necessary, struck a hearing panel. The panel's report was forwarded to the board, which decided on the course of action to be followed.

In addition, a department head had the right at any time to immediately suspend, or otherwise limit, the privileges of a member of the department, for up to 10 working days, for conduct that the head reasonably believed might negatively affect patient care or would constitute a serious breach of ethical standards (Exhibit 41, section 9.5.51).

In such a situation, the department head was required to initiate a complaint and inform the SVP.

COMMITTEES WHOSE ACTIVITIES TOUCHED UPON THE EVENTS OF 1994

The HSC had a dense committee structure, and the following is not an exhaustive listing of the HSC committees. However, it does outline a variety of institutional committees that either became involved in the events of 1994 or might have been expected to become involved in those events.

THE PEDIATRIC OPERATING ROOM COMMITTEE

The HSC had a Pediatric Operating Room Committee that was responsible for dealing with day-to-day operating room problems as they related to the smooth and efficient operation of the operating room and its environs. Matters that related directly to nursing, anaesthesia and surgery were to be dealt with primarily by those departments, but where co-ordination and interaction between the disciplines was an issue, the Operating Room Committee was expected to address such problems directly (Exhibit 309).

The committee was made up of the OR head nurse, the head of Pediatric Surgery, the head of Pediatric Anaesthesia, a pediatric surgeon elected by the Pediatric Surgical Council and the Administrator of Children's Hospital. The committee was to meet on a monthly basis.

THE CHILDREN'S HOSPITAL MANAGEMENT ADVISORY COMMITTEE

This Committee existed to provide a forum for patient care teams to discuss common issues, advocate for needed resources, approve standards and guidelines, and co-ordinate activities. The committee's members comprised the clinical director, director of patient services, the director of support services, one representative from each of the patient care teams and one representative each from Medical Information, Radiology and the Family Advisory Committee. One of the committee's responsibilities was to ensure quality monitoring for the child health program.

QUALITY ASSURANCE

The HSC, as a large medical institution, made use of a variety of committees and practices to review quality assurance issues, such as patient care and patient outcomes. The following list outlines the main committees that were or might have been expected to become involved in the events of 1994.

QUALITY ASSURANCE COMMITTEE

The HSC had a Quality Assurance Committee that was required to meet at least four times a year. The members were appointed by the board and included the Chairman of the Medical Staff Council. Non-voting members of the committee include the President and three vice-presidents.

The committee was charged with ensuring that:

- A quality assurance program was established and met the requirements as set out in the Canadian Council on Hospital Accreditation Standards Manual;
- Standards for patient care delivery were defined;
- Established standards were appropriately monitored;
- Quality assurance activities were recorded and outcomes reported; and
- Adequate resources were allocated to undertake the activities of the program.

The committee was required to report monthly to the board. The quality assurance program was meant to deal with broad issues on a retrospective basis, rather than deal with specific problems in specific units.

MORBIDITY AND MORTALITY (M & M) ROUNDS

Morbidity and Mortality Rounds were meetings at which incidents, particularly deaths, would be given a detailed review. Pediatric cardiac surgery Morbidity and Mortality Rounds were to be conducted once a month to address surgical issues. The meetings were open to everyone in the hospital in addition to the surgical team and other professionals involved in the case. The CVT surgery section also conducted its own monthly M & M Rounds.

INCIDENT REPORTS

When there was an untoward event at the HSC, according to the bylaws of the hospital, staff members who had been involved in the event, witnessed the event or were advised that it had taken place were under an obligation to report the event by completing an incident report.

An incident was defined in the HSC Corporate Policy and Procedure Manual as:

a patient care-related or non-patient care-related event which:

2.1.1 is normally not anticipated under usual circumstances and may adversely affect patient care, the provision of service, or the assets or reputation of the centre; or

2.1.2 has the potential to result in litigation. (Exhibit 107)

If the incident involved a patient, it was to be documented in the patient's HSC medical record, along with a description of the injury and the treatment. The incident report itself, however, did not become part of the patient's hospital record. Departments were expected to develop lists of reportable incidents and categorize them as being of Minor or No Consequence, Moderate Consequence or Major Consequence.

Staff were expected to take immediate remedial action, report the event to the appropriate supervisor and then fill out an incident report. This could be a general incident report, a medication discrepancy incident report, a fire and false alarm report, or a security incident report.

Supervisors were expected to investigate the incident and take the appropriate follow-up measures. Department heads were to be informed of incidents with major consequences and incident report forms were to be forwarded to department heads.

Department heads were required to take steps to prevent the recurrence of such incidents and to contact any other departments that were involved in the incident. In the case of incidents with major consequences, the department head was expected to notify the appropriate vice-president. In the case of patient-care related incidents, the head was expected to provide a copy of the report to the director of the Medical Information Department. The director of medical information was then responsible for notifying the Health Sciences Centre insurance adjuster and the hospital's legal counsel, securing the medical records, coordinating meetings, collecting information, photocopying records and corresponding with relevant parties.

There was no requirement to inform the patient or the patient's family that such a report had been filed or to provide them with a copy of the report. The patient or patient's family might be informed that an incident report had been filed. A copy of the incident report was not kept as a part of the patient's chart.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

The College of Physicians and Surgeon of Manitoba (CPSM) is the licensing body for physicians and surgeons in Manitoba. Pursuant to the provisions of *The Medical Act* (RSM 1987, c. M90), and various regulations and bylaws thereunder, the College of Physicians and Surgeons created a Medical Standards Committee for the Province of Manitoba. The College also established a standards committee, the Pediatric

Death Review Committee, to review all cases of pediatric deaths in the province. This committee met approximately six times a year.

The College also designated medical standard committees for each of the hospitals and/or regions of Manitoba. The Health Sciences Centre had a Medical Standards Committee (referred to as the Centre-Wide Committee) created under its bylaws. This committee oversaw medical standards for the entire hospital, including the Children's Hospital, General Centre and Women's Centre. The College had recognized the Centre-Wide Committee as the Medical Standards Committee for the Health Sciences Centre.

There also existed a Children's Hospital Standards Committee that reported to both the Centre-Wide Committee and the College's Paediatric Death Review Committee. In 1994, Dr. Milton Tenenbein chaired this committee. The Children's Hospital Standards Committee had approximately 12 members, some of whom were on the committee by virtue of their office, while others were appointed. Each committee member was a doctor who worked at Children's Hospital.

A panel of three surgeons, each of whom was appointed by the Department of Surgery, reviewed all surgical deaths at Children's Hospital. A surgical death was defined as a death of a child who had had surgery immediately before death or was admitted to hospital and died under the care of a surgeon. In 1994, Dr. Nathan Wiseman chaired this panel. The other two members of the committee were Dr. Odum and Dr. Postuma. The panel's finding would be reported to the Children's Hospital Standards Committee by Wiseman, who was also a member of the Standards Committee.

The Standards Committee would receive the panel's report and then discuss the case. In doing so the panel members might make use of personal information, information in the patient's chart, or information that had been brought forward from the panel. It was not the committee's practice to hear testimony or evidence from non-members.

Following the discussion, Tenenbein would summarize the case and forward it to the Paediatric Death Review Committee. He would also prepare a generic report that did not identify specific cases. This summary would be forwarded to the Centre-Wide Committee. From there the summary would be circulated to department heads as a part of the Centre-Wide Committee's report.

In 1994, Dr. Michael Moffat was the co-ordinator of the Paediatric Death Review Committee. He reviewed the reports from the Children's Hospital Standards Committee and other reports (such as police and child welfare reports) that may have been filed on the child's death. He then would summarize the case for the Paediatric Death Review Committee. That committee (which included in its membership not only Tenenbein, but also Wiseman and the HSC's chief pediatric pathologist, Dr. Susan Phillips) would then review the case.

The role of the hospital Standards Committee included the assessment of medical practice through peer review, analysis and education to improve, rather than to discipline. In his testimony, Tenenbein said that the Standards Committee was the only specific mechanism or program for quality assurance within Children's Hospital in 1994.

The Standards Committee filled an educational purpose in the sense that the committee investigated incidents to determine if there was anything to be learned from them. If the committee concluded that there was something to learn from a death, the chairperson then communicated the committee's conclusions to

the individual, along with a recommendation either for a change in procedure or in how similar cases should be handled in the future, or for upgrading of skills.

The committee could issue a more public statement to the profession to alert it to a particular issue. The committee could also communicate with a department or the hospital about its findings, and might also communicate with the government. In all such cases, the communications were of a general nature, without specific reference to a particular patient and without identifying any of the persons involved.

Members of the general community and members of the hospital staff could also bring a particular matter to the attention of the Standards Committee. While the committee would investigate matters brought to its attention in such a manner, it did not normally communicate its results and findings back to the source of the question.

THE MANITOBA ASSOCIATION OF REGISTERED NURSES

The Manitoba Association of Registered Nurses (MARN) is the regulatory and professional body for registered nurses in Manitoba. It derives its mandate from legislation, *The Manitoba Association of Registered Nurses Act (RSM 1987 c. R40)*. The Association deals with issues relating to registration, regulation, professional conduct, health policy, education, research and nursing practice. MARN has a responsibility to protect the public from unsafe, incompetent and unethical nursing practice.

THE OFFICE OF THE CHIEF MEDICAL EXAMINER

Deaths in the HSC and other hospitals in Manitoba fell under the jurisdiction of the Office of the Chief Medical Examiner of Manitoba (CME). When a child died, the death had to be reported to the Medical Examiner's office. In the case of a hospital death, a Medical Examiner's Investigator (MEI) would go to the hospital and conduct an initial investigation. Deaths were categorized under five classifications that the CME used: natural, accidental, suicidal, homicidal or undetermined. Under the policy of the Chief Medical Examiner's office, autopsies were to be ordered when children died either during or immediately following operations. The CME's office did not order an autopsy if it had been informed that the hospital's Department of Pathology intended to perform one.

In those cases of surgical death where the cause of death was known and the parents were opposed to an autopsy being performed, the CME could agree to waive the requirement for an autopsy. For this reason, autopsies were not performed in the case of two children whose deaths were under investigation. The MEI's chief source of information in such cases was the attending surgeon.

A further investigation, conducted by a medical examiner (who must be a doctor), could be ordered. This was invariably the case when the CME's office ordered an autopsy. These were then referred to as medical examiner's cases.

An autopsy involves the examination of a dead body and its structures and organs to determine the cause of death. An autopsy is meant to observe the effects of aging and disease, and determine the evolution and mechanisms of disease processes. Doctors who have been trained in pathology carry out autopsies. The pathologist usually dissects the body and examines its internal organs.

The findings are then recorded and balanced against one another, in an attempt to tell the specific story in the form of a sequence of events that led to a patient's death. The pathologist can, but does not always, list an immediate cause of death, which is considered to be the one lesion without which death would not have occurred, as well as an underlying cause of death. The underlying cause of death is the specific disease or injury that started the course of events that led to the immediate cause of death. In addition, the pathologist may report other conditions that pre-existed or co-existed and contributed to the patient's death, but did not result in the death. (In a death certificate, there is usually a list, which starts with the most recent condition and then goes back sequentially in time, with each earlier condition causing the later condition.)

The pathologist may not always be able to give an immediate cause of death and may express some degree of uncertainty by the use of words such as 'presumed' or 'probable'. Like many other aspects of medicine, cause of death is, in essence, a concept or opinion based on all available information. As such, this opinion may be subject to differences in interpretation.

During 1994, the Chief Medical Examiner maintained a process to assist his office in determining if and when to order an inquest. Following a medical examiner's investigation the case could be referred to the Children's Inquest Review Committee. This committee included representation from the police, the Justice Department, the College of Physicians and Surgeons and family service agencies, and met approximately eight times a year. The committee advised the CME as to whether or not an inquest should be called, although the CME could order an inquest without the committee's input. Inquests were called when, in the public interest, it appeared that there were preventable aspects to a death and if the CME perceived a trend in deaths in a particular hospital or industry. Inquests were also called to allay public concerns and make known the circumstances surrounding a death.

BUDGETING

The three major sources of income for a hospital are government grants, revenue from medical services provided on a fee-for-service basis and donations.

The Department of Health provides grants to medical institutions on an annual basis, although sometimes grants are committed over a period of time. Negotiations occur between the hospital and the Province for those annual grants.

The Department of Health and the HSC had an arrangement whereby the Province provided an annual grant to the HSC that allowed the HSC to decide how to divide the money among its various departments. This was called global budgeting.

Under global budgeting, the various HSC departments negotiated with hospital administrators and committees for a share of the money. As with any such process, decisions were made in a manner that some saw as unfair. Those involved in pediatrics often felt that the lion's share of funding at the HSC was given to the

adult side, leaving pediatrics with less than its fair share. This situation was said to arise because of the inordinate influence that those on the adult side seemed to have over the process of the distribution of money.

One would also have to recognize that the amount of money spent on services to adult patients would tend to reflect the fact that the numbers of adult patients at the HSC greatly outnumbered the pediatric cases. Additionally, adult patients provided a greater source of income from fees for service than did pediatric patients. This was not only because of the greater number of adults but also because the fee schedule, the basis for payment for those services, seemed to pay more for adult procedures than it did for those involving children.

It is difficult to describe with any degree of certainty the extent to which this tension between the adult and pediatric communities within the hospital might have played a role in the events surrounding the Pediatric Cardiac Surgery Program at Children's Hospital in 1994. Nonetheless, where it has been raised or may possibly have been an issue, mention will be made in this report.

THE RELATIONSHIP BETWEEN THE HSC AND THE FACULTY OF MEDICINE

The HSC is a teaching hospital. It maintains a close working relationship with the Faculty of Medicine of the University of Manitoba. Students in the Faculty of Medicine receive a portion of their training on the wards in the hospital. The Faculty of Medicine, in fact, is located next to the HSC.

Many of the hospital's senior medical staff also held positions in the faculty as assistant, associate or full professors, so that they could assume academic responsibility for the education of medical students within the hospital. While such medical staff might have been called upon to provide classroom instruction, much of the teaching that went on at the HSC occurred on the wards. Staff with dual appointments were paid for their medical duties by or through the hospital and received a small stipend for their educational duties from the University.

The hospital's bylaws and policies designated which positions were considered dual (i.e., requiring both a hospital and a faculty appointment). For such positions, both the university and the hospital had to approve the candidate's appointment. For the most part, the heads of medical departments and medical sections in the hospital held dual appointments, including the heads of the departments of Anaesthesia, Pathology, Pediatrics and Surgery.

Heads of the sections of pediatric surgery, cardiothoracic surgery, and pediatric anaesthesia were also dual appointees. Individual medical staff may also have had dual designations. In these proceedings, some of the pediatric anaesthetists and the pediatric cardiac surgeon involved in the deaths under review held dual appointments.