July 11, 2015

Copy

Dr. Trevor Theman,
Registrar
College of Physicians & Surgeons of Alberta
2700 - 100020 100 Street NW
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Re: Response of the College of Physicians & Surgeons of Alberta to the Health Quality Council of Alberta Continuity of Care Recommendations, sent to the Honourable Fred Horne, Minister of Health

Dear Dr. Theman,

Thanking you for providing us, Greg's family, a copy of your letter to Minister Horne.

We would like to provide our own perspective on your response to the HQCA's analysis and recommendations.

HQCA Recommendation #3 - While we can understand some of the concerns expressed about Doctors not being kept in the position of being the singular decision maker, it is clearly evident that there are instances of considerable urgency (referred to as time-sensitive in the report), when the doctor involved is not available and delays in actually making contact and getting action taken can cost the patient their life. We encourage you to quickly move forward with the development of solutions for the patients at greatest risk and work back from there, rather than taking an idealist position when the system and the proven response of some doctors is far from ideal.

HQCA Recommendation #5 - We would characterize this recommendation as one setting out the need to insure "who is in charge, and who is accountable" for each patient's care 24/7. The position taken by the CPSA that everything that should be in place in the standards of practice exists today, and that where "responsibilities should be clear to the patient and other physicians (and other providers)" is in our view a position that does not recognize the gravity of the current situation at all. The general statement indicating the belief "that a process to ensure that a physician practice is compliant with current requirements is more likely to be successful" not only lacks detail for us to gain any confidence in the odds of success but there is nothing to show that this is the immediate priority it should be.

Recommendation #6 - Definition of "time sensitive" in order to insure specific physician commitments to patients to be available and responsive to patients... The CPSA's response we view is one that chooses to ignore the need and instead puts up issues with the ability to get different specialty groups to agree on a definition. So where is the patient in all of this? We know Greg was left to fend for himself not just once or twice but too many times to survive. We expect the CPSA to come forward with solutions.

Recommendation # 8 - After-hours compliance by members to the CPSA's Standards of Practice. Again, this is a long-standing issue. It appears that there will be more process put in place to first, make sure that "members are aware of" the Standards, and then some form of "a formal inspection of members' practices". The description so far, lacks the detail for us to see how what can only be described as a very poor compliance level will be dramatically and quickly be dealt with.

We are very disappointed that for the most part, the CPSA's response is one that follows a well-worn path of explaining that things are complicated and that there are concerns with potential infringement on the responsibilities given to members of your profession. We read that it is understandable that

members don't comply with the College's Standard of Practice given that some don't even know that they exist are and others choose not to comply for a variety of reasons. Your letter essentially suggests that maintaining the status quo appears to be acceptable as long as there is a bit of effort to tinker with a few potential improvements.

The overall message we took from the HQCA's report and recommendations is that there must be an answer to the question of who is in charge, responsible and in the end accountable for each and every patient, one by one, who needs health care in this province.

As you know, while our family has been seeking to support a major positive change in the way patient care is handled in this province, we have been told of many instances where other families have suffered greatly from their experiences with what we call system failures. Individual members of your organization have told us how sad they are with Greg's tragedy. They tell us it should not have happened. Many have also told us that Greg's experience is not unique and that there are many "near misses" occurring. The "Swiss cheese" analogy has been explained to us and that disaster occurs when the holes in the system line up. Nurses and other health care delivery people told us of cases involving close friends or members of their family that "were lucky" that a terrible direction of care was changed and the patient survived.

In any other sector where a business or organization is responsible for the care and safety of people, this characterization of the delivery of their responsibilities would be described as a failure. Indeed, it simply would not be tolerated. Let me ask a few questions to help make the point.

How many of your members would venture into a building, or onto a construction site where it was clearly known that the health and safety standards for that location had the low level of compliance with the basic standards that you know and have reported publicly exist with your membership? (OHSA would not allow work to continue to be done there, nor would OHSA itself be allowed to tolerate this level of non-compliance.)

How many members would choose to purchase and consume food with their family, from a production and processing company whose level of meeting safety standards and practices for the production and processing of that food matched physicians' level of compliance with the College's standards? The Canadian Food Inspection Agency would not allow the company to operate at all without full and complete compliance with its standards.

In fact there is a recent example of this. It involved a multi-billion dollar Alberta company that was shut down for an extended period, putting thousands out of work when some people (less than 20) got ill as a result of a combination of less than full compliance of standards, and the substandard monitoring and inspection of practices and processes. The product recall involved millions of pounds of meat. No one died. That business could not re-open until the CFIA was satisfied and the responsible Federal Minister himself was personally convinced the food would be safe and that proper oversight and inspection activity was in place.

In the closing comments of your letter you state that the HQCA report and recommendations "has had a profound influence within Alberta and nationally." We know of a number of and have participated in some discussions, and indeed we agree that all of this has raised the issues to a higher level but in terms of tangible significant positive action being taken, there is a long way to go. We believe there must be a dramatic change in how things are done. There must be a change in the practice and in the approach to patient care in so many areas. Reacting to Greg's death by saying that physicians and other providers *should* be clear about their roles and responsibilities for and with the patient, that

current standards *should* be sufficient to have physicians act as they *should,* is simply not acceptable. Greg's death is proof that what should happen, doesn't. Current practice is dangerous and deadly. It must change and change quickly. More than six months have already passed since the HQCA report was provided to the Minister and made public.

It is our view that in order to expect a different behavior, and an acceptable (complete) level of compliance by all members to their own professional standards, strong action must be taken when non-compliance is found or even suspected (via complaints or peer reporting or indeed whistle blowing). Strong action in every other sector's case is suspension of the duties and responsibilities of those involved, pending investigation. In the case of physicians it would mean suspension of their license to practice or the facility's operating license right from the first alarm until the investigation was completed to the satisfaction of the CPSA and appropriate corrective action had been completed. This corrective action at both the individual level and at the policy/procedure level must have as its goal the elimination of the risk identified. If you feel more study is needed, you must take the offending members out of the game while you develop how to close the gaps. To say that this can't be done or patients will suffer is simply not true. Arrange for other capacity to cover this adjustment whether it is in another practice, or clinic, hospital or indeed, province or country. Alternatively, if necessary and more practical, bring capacity here for the time needed. The argument that this approach could not be taken in Alberta because the potential level of disruption in care would be overwhelming, would clearly verify that the magnitude of the problem is much larger than is being admitted! If this is true, it further elevates the need for prompt and strong action, not the avoidance of it.

Where gaps in the continuity of care, or the potential to expedite the process of investigation and care, have been identified by the HQCA or anyone else for that matter, we encourage the College to actively shoulder the responsibility on behalf of all of the care providers, and quickly develop solutions. The College has been given the public's trust for the safety and care of patients treated by your members in this province. Explanations of the difficulty of the task and questioning the need, given what "*should*" take place, does not fix anything. What is actually happening today is not acceptable. You know that and we know that. As my father often said to us "you are either part of the solution, or you are part of the problem".

We believe that the College has done much more work than has been referred to in your letter to Minister Horne and we encourage you to tell us all more about what can and will be done over a short and clearly defined period of time.

We also want to encourage you to take a strong leadership position to pursue the vision of bringing Alberta's health care sector into the modern world of the use of electronic data and reporting and processing systems (HQCA Recommendation #2). This is absolutely foundational to the future of patient care here. Over the last six months, we have heard from many senior health care people that universal electronic medical records has been talked about and considered for years. What exists today is a hodgepodge of disconnected and expensive pieces that can't or won't work with each other. You have indicated you support e-referral and I know that the College has done good work in this whole area. Put forward a set of criteria that must be met (such as; universal for all patients, accessible by all players including patients, and effective in not only communication but in tracking referrals and facilitating application of best practices) and then invite world wide service providers from all sectors to compete to develop what you want and patients need. The current process is terribly flawed not only from a quality of service to those that need it, but also it is fully exposed to the monopolistic tendencies of certain local players and to opportunistic politics on many levels.

I would like to close by saying that I have appreciated the willingness of you, Dr. Theman, to meet with me and to discuss how we can all work together to move things forward. We certainly want to do that and our comments are intended to insure that everyone appreciates the gravity of the situation. We lost Greg to a non-existent "system" or at best a system that is clearly failing. It is the memory of him, his integrity, and his tenacity that keeps us on the path to help fix things any way we can. We want to eliminate the chances of another family experiencing the tragic, premature loss we have.

Thank you again and we look forward to stronger actions being taken and to any opportunity where we can work together to ensure change in our pursuit of safe, continuous, collaborative, patient centred care for all Albertans.

Yours sincerely,

Dave Price

On Behalf of Greg Price's Family

Cc Honorable Fred Horne, Minister of Health, Ms. Patricia Pelton, Acting CEO, HQCA, Dr. Tony Fields, Board Chair, HQCA, Dr. Ward Flemons, Senior Medical Consultant, HQCA, Dr. Verna Yiu, AHS, Dr. Lyle Mittelsteadt, AMA, Alberta Society of Radiologists