

The Report from the DSM Review Committee

**Submitted to
The Chair of the Board of Directors
Diagnostic Services of Manitoba (DSM)**

regarding an

**Undated complaint filed by
The Complainant, received November 17, 2009**

and titled as

***“Abuse of Finances, Workers, and The Public Trust at
Diagnostic Services of Manitoba (DSM) Inc
from 2007-2009”***

To:

Arlene Wilgosh, Chair
DSM Board of Directors
Room 327, Legislative Building
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Winnipeg, MB R3C 0V8

From:

Sharon M. Macdonald, MD, FRCPC
Chair
DSM Review Committee

February 10, 2010

1.0 EXECUTIVE SUMMARY

In the last week of November 2009, I was requested by the Chair of Diagnostic Services Manitoba (DSM) to chair a committee to review allegations that had been brought forth about the DSM organization by a pathologist working at the Health Sciences Centre, Winnipeg. By December 1, 2009, the DSM Review Committee had been constituted.

I was joined by Mr. Denny Kells, retired labour lawyer and Dr. Rosemary Henderson, a Pathologist from Prince Edward Island. Our work began immediately and was completed by February 10, 2010.

This DSM Review Committee was not a committee of inquiry and did not have the power to require individuals to come forward. The Review Committee held one open meeting with pathologists and another with Pathology Department (HSC site) technicians, technologists and other staff and related union representatives. Input was invited at these two meetings and contact information for the Review Committee was posted. A letter was also circulated to each pathologist employed by DSM based on a list provided by DSM.

Early in December, I was in contact with the Complainant, _____ to arrange an interview. Before he accepted an appointment to talk with us, he raised his allegations in the political arena. Hence, the issue was reported in the Winnipeg Free Press and on TV media on December 10-11, 2009. This was unfortunate as it raised concerns and fears that the issues would be considered without regard for privacy and protection of persons wishing to come forward. The threat of going to the media was used again by the Complainant in the course of the Review.

The Complainant spent the first two and one-half years of his career as a pathologist working for DSM. He developed some good working relationships. He contributed the enthusiasm of his youth and training in pediatric pathology to the organization, colleagues and families. He is described as a caring person. He left feeling appreciated. So we are left to investigate his concerns.

During the course of our review, interviews were held, e-mails were received, documents were reviewed and site visits were undertaken. In all, we spoke with or received written communication directly from 51 people. We undertook 43 interviews, received 8 written submissions plus a block of another 18 written submissions. Represented were DSM pathologists, DSM management, various DSM staff, clinicians, and other senior administrators. Ninety percent of interviews were face-to-face. As the focus was on the pathology services at the Health Sciences Centre (HSC) in Winnipeg, the majority of respondents worked in those services at that site. We did a tour of the Pathology Department at HSC.

Individuals who came forward to offer information presented their views, ideas and suggestions for improvements. They expressed pride in their work and commitment to ensuring that patients and doctors receive timely and accurate pathology reports. Recognizing the importance of their contribution to the diagnosis of disease and its management, the workforce presented a professional and caring intent to provide the best pathology services possible.

The need to provide quality pathology services to support patient care and safety was a common theme. The Complainant raised a concern in regards to patient safety in one specific circumstance. That was addressed by DSM. It is also addressed in this Report.

While there were no imminent threats to patient safety identified, there was consensus that there must be a commitment at all levels in the organization to understanding the work being done and to pay attention to detail. This means, at minimum, addressing the human resource shortages; funding and pursuing quality assurance activities; being rigorous in investigating critical incidents so that needed systemic changes can follow; maintaining a respectful workplace; fostering a culture of inquiry and professionalism; and encouraging openness to input from staff and clinicians. In these regards, there is work to be done.

DSM is a relatively new organization. Its early development brought improvements in equipment, addressed workplace safety and health issues and stated a commitment to quality assurance exemplified by its intent to participate in accreditation at HSC and St. Boniface General Hospital (SBGH) through the College of American Pathologists (CAP). However, DSM also brought a matrix structure that has its strengths, but is not always understood by its workforce. Decision-making is thought to be highly centralized and not transparent. DSM senior management needs to communicate its mission and values more clearly to and be visible to the DSM work force. It needs to seek out and utilize feedback from its constituents including patients, doctors, regional health authorities and other health service organizations.

DSM is responsible for services that are critical to patient care. There is an opportunity to be more transparent about the challenges it faces; its approach to recruitment of staff; how issues are identified and problems solved; and how to get accurate and timely results back to patients and doctors. These are issues faced not only in the pathology services here but also across Canada.

DSM has the challenge of continuing to bring together numerous, complex, diverse and province wide services. Maintaining communication and visibility, seeking input, establishing common operating procedures and developing quality assurance activities across Manitoba requires the use of all types of strategies. While there are newer communication modalities available, nothing is quite like a site visit to improve one's understanding and commitment to services outside of Winnipeg.

Transparency, effective communication, clear accountability, clarity around decision-making and inclusion of staff's ideas for improving services are not new or original ideas. But they are critical to the success of an organization and engagement of its workforce. Regular meetings, open communications, listening to staff input and enhanced problem solving would address many of the issues raised by employees of DSM.

DSM needs to be transparent about its interactions with the private laboratory sector, for with staff shortages, a lack of information has led to assumptions and rumour. Changes in hospital based services have presented challenges to the pathology departments at various Winnipeg sites, particularly when the impact on the pathology services was not fully considered. These are problems that can be rectified without putting new mechanisms in place. The processes for identifying near misses and critical incidents and implementing change need to happen now.

The workplace environment will benefit from addressing the issues of accountability, communication, and transparency. Strengthening quality assurance will provide confidence to patients, DSM staff, and all the users of DSM services; as will thorough and timely review of near misses and critical clinical incidents. The importance of teamwork with clinicians cannot be overstated as a mechanism to improve patient care.

There have been positive developments through the establishment of DSM. We have received feedback from DSM staff that good leadership and openness to ideas will contribute to ensuring quality pathology services in Manitoba. There is willingness amongst those who presented their ideas to this Review Committee to contribute their best. This reveals a deep interest in providing excellent services. The opportunity is there; a solid foundation exists upon which to build.

My sincere thanks are extended to Denny Kells and Dr. Rosemary Henderson for their work which is reflected in this Report. Thank you to each of you who contributed to this Report by speaking up in interviews and through written submissions, with the hope that doing so would make a difference.

Sharon M. Macdonald, MD, FRCPC
Chair, DSM Review Committee
February 10, 2010

2.0 SUMMARY OF THE REVIEW COMMITTEE'S FINDINGS AND RECOMMENDATIONS

This summary details the DSM Review Committee's findings and recommendations. The Report is written in sections. The numbering below corresponds to the relevant section of the detailed report.

Section - 3.1 The Complaint, the Complainant and the Committee's Approach

The Complainant's disruptive conduct in the workplace and the allegations that he made in pursuit of his stated effort to expose what he viewed as egregious conduct within DSM and among its management have had a deleterious impact on those that he accused.

The Committee believes that many of the Complainant's actions were inappropriate and that many of the allegations that were made with respect to the integrity of other employees or managers were based on assertions that the Complainant would have known were at least partly untrue. The Committee has however found that there was substance to some of the Complainant's allegations.

It should be said that the conduct of the Complainant, while relevant, was not the focus of the Committee's investigations. The Committee focused on the Complainant's allegations rather than his conduct. The Committee was mandated to look into the types of issues that were referenced in the Complaint. In pursuing that mandate, it examined the broader issues of workload and workload assignment, fee-for-service and assignment of fee-for-service cases, quality monitoring and reporting, patient safety and Critical Incident Reporting, and matters related to issues of communication or the lack thereof. As will be seen from the Committee's conclusions, there is much work that needs to be done by DSM in many of these areas.

There are cross cutting themes that need to be addressed. They include a commitment to seeking out the truth, transparency, significant improvements in communication, clear accountability, improved service to clients and establishment and maintenance of a healthy workplace.

Section - 3.2 Allegations Regarding Work Volumes of a Named Pathologist

The Complainant alleged that a fellow pathologist had assumed unsafe work volumes that impacted her ability to perform pathology functions in a safe manner. He also alleged that DSM management were aware that the circumstances that he described were unsafe but nevertheless permitted the pathologist to continue to engage in unsafe work volumes, thereby putting patient safety at risk.

The specific instances that the Complainant referenced in the complaint as regards this pathologist did not establish that she was working in an unsafe manner.

The Committee does however have the following recommendations:

1. DSM should consider requiring pathologists to fully disclose the time commitment associated with any additional work or professional activities performed outside of DSM, with this being done on a quarterly or annual basis.
2. DSM should monitor its fee-for-service work on a continuing basis, with the expectation that a discussion regarding the pathologists practice would ensue where the additional work exceeded a particular level.
3. The matter of workload limits needs to be addressed in consultation with the pathologists as a group.

Section - 3.3 Allegations Re: Use of Immunoperoxidase Stainer at

The Complainant alleged that the two full time DSM pathologists at the have been permitted to use this DSM equipment for the purpose of improperly facilitating work done by private laboratories with which they are associated.

The Committee has concluded that there is no evidence that either of the two full time DSM pathologists at the received any benefit from the tissue processing arrangements between DSM and the private laboratories. Any suggestion of wrongdoing with respect to this issue on the part of DSM or the two pathologists is without foundation.

The Committee does however have the following recommendation:

1. Given that DSM is providing services to private laboratories, it must do so in a manner that is both transparent and understood, particularly by employees who may be directly or indirectly involved in the work being performed.

Section - 3.4 The Issue of Workload Standards

The Committee has examined this issue as part of its larger mandate.

The existing work measurement system was designed to establish average annual workloads for pathologists. Work is to be transferred to other sites (or distributed for completion on a fee-for-service basis) when the workload exceeds a defined limit. An analysis of workload statistics suggests that pathologists at the St. Boniface and Westman Laboratory (Brandon) sites are being assigned a workload that exceeds these limits.

The Committee's recommendations are as follows:

1. There are clearly misunderstandings underlying the existing work measurement system and the purpose for which it was designed. The limitations of the system as a

measure of individual workload need to be clarified. Concerns regarding perceived inequities need to be addressed through a defined mechanism or procedure. The Pathology Executive Committee should be given a formal mandate, part of which would include consideration of concerns related to workload weighting or allocation. Consideration should also be given to having the consultant who conducts the annual PCU survey, based on a selected period, report through to this Committee. The process must be transparent.

2. The pathologists in Brandon need to be given an opportunity to work more closely with senior pathologists to ensure consultation on difficult cases. This needs to be implemented immediately. The means chosen must be established in consultation with the Brandon pathologists. This will address professional isolation and contribute to patient safety.
3. A process should be developed to re-distribute work from pathologists who devote significant professional time to "non-bench-work activities" (such as quality assurance) to those pathologists who elect to focus only on production. As matters now stand, those who focus almost solely on production can, with the availability of fee-for-service work, earn much more than those who exhibit a greater overall commitment to all aspects of their position.
4. Specific consideration needs to be given to issues that might arise as a result of DSM shifting its assignment of work from more of a generalized basis to a subspecialty basis.
5. Consideration needs to be given to the issue of whether the present system can be refined or modified to better measure individual workload in a more precise manner and if so, whether steps should be taken to move in that direction. The Pathology Executive Committee should examine options to purchase or develop a program that can be used to assign workload (both regular and additional cases) at and between sites.
6. DSM must engage its autopsy pathologists in a process that will establish a mechanism for effectively measuring autopsy workloads. Autopsy pathologists need to be consulted and arrangements need to be adopted to address excess workload in the short term.

Section - 3.5 The Issue of the Fee-For- Service Remuneration

The existing fee-for-service arrangements enable DSM to meet pathology workload requirements by allocating excess cases to pathologists who are willing to complete such work on that basis. The Complainant advanced several allegations, all of which were found by the Committee to be without foundation.

The Committee's findings are summarized as follows:

1. *Allegation - Utilizing a "fee-for-service" mechanism to address excess workload is a "bad practice".*

There is, in the Committee's view, no basis to conclude that "piecework" is a "bad practice". While concerns can be identified, they can also be addressed.

2. *Allegation - Given that cases are not presently tracked at the Health Sciences Centre site, it is "not entirely ethical for [a pathologist] to say, "I have done my work now pay me for every additional case I do"- because this cannot be proven".*

The Committee finds that there is no evidence to suggest that DSM pathologists are being paid for work not done.

3. *Allegation - In the case of one pathologist, the performance of excessive piecework "resulted in [an] unsafe practice that culminated in serious harm to a patient".*

This allegation has been dealt with elsewhere in this Report and the Committee's recommendations to better address the underlying concern have also been set forth in Section 3.2.

4. *Allegation - The ^{Medical} Director improperly manipulated the Table of Workload Values (i.e. the Pathology Complexity Units (PCU) weightings) in order to obtain a personal advantage.*

This assertion appears to have been advanced simply to attack the character and credibility of the person named. After examination of the issue, the Committee finds that there is no basis to this aspect of the Complaint.

5. *Allegation - The piecework or fee-for-service mechanism was being abused by the ^{Medical} Director*

The Committee concludes that there is no basis to this aspect of the Complaint. Moreover, the Committee does not accept the Complainant's assertion that the Health Sciences Centre (HSC) practice of assigning products of conception cases to one pathologist results in recent graduates having to perform a higher percentage of complex malignancies than would otherwise have been the case. Nor does the Committee accept the Complainant's assertion that this practice deprived him and the other pediatric pathologist of the opportunity to fully utilize their expertise. These are uncomplicated cases that had routinely been examined by other pathologists as part of their normal case load.

Despite its findings, the Committee has concluded, as part of its larger mandate that consideration needs to be given to several issues related to fee-for-service work:

1. An ongoing fee-for-service commitment for procedures such as products of conception will have a cost rather than a savings during any period where the regular capacity of DSM pathologists exceeds the regular workload (for at such times, these cases could simply be assigned at no cost as part of the regular workload). Given the recent shortage of pathologists, there is no reason to conclude that the costs have at this point outstripped the savings. Nevertheless, this concern bears examination.
2. Although other pathologists have not sought to take on the products of conception cases, the current arrangement can certainly create a perception of impropriety. If DSM elects to continue the practice of treating these cases as falling outside of the normal case assignment process, then consideration must be given to making this additional work available to other pathologists on a similar fee-for-service basis. In making this recommendation, the Committee recognizes that these cases must be handled on a daily basis and that DSM should be able to expect that any pathologists who wish to take on this work would provide a commitment to do so on a continuing basis.
3. The PCU value for products of conception cases needs to be re-examined in a timely manner. If the cases are to be assigned as part of a pathologist's regular workload, then credit should be given having regard to the generally acknowledged fact that these cases are much simpler than a regular small case. Such an assessment would also provide guidance as to the adequacy or appropriateness of the payments that are presently being made
4. As discussed under the section of this Report dealing with workload, the removal of very simple cases from the regular workload increases the complexity of the cases that remain. These concerns have frequently been raised by pathologists at various worksites; for if the average case complexity increases, then one should be able to expect that fewer cases would be assigned. Despite the fact that DSM has conducted an annual assessment to determine whether there have been changes in the average site complexity, they appear to have decided to ignore these legitimate concerns. That cannot be allowed to continue.

In a similar vein, DSM needs to determine whether the cases that are being handled on a fee-for-service basis are generally less complex than cases that are being retained. Where such is the case, then adjustments in the case complexity factor (and the number of cases assigned) need to be made to reduce the average PCUs to an acceptable level.
5. The Committee believes that DSM needs to re-examine and rationalize the fee-for-service payments that are currently being made, for at present, the differing amounts that are paid at each site are not based on the complexity of work that is emanating from that site.

6. DSM needs to establish guidelines that would serve to monitor and perhaps limit the amount of additional work that pathologists can accept on a fee-for-service basis. This recommendation is discussed in greater detail elsewhere in this Report.

Section - 3.6 Critical Incident (CI) Policy and Procedures at DSM

DSM is required by law to report Critical Incidents to Manitoba Health within three days of identification of the incident. The Complainant made a reportable error but DSM did not report it to Manitoba Health until approximately three and one-half months after the error was discovered. The report was made following an altercation between the Complainant and DSM's Chief Medical Officer. The Complainant alleged that the incident was reported in order to punish him and tarnish his reputation.

The Committee was unable to conclude that the Critical Incident review involving the Complainant was established for malicious reasons. However, the investigation and follow-up of the CI was incomplete and there were undue delays in the process. A timely review process with feedback to the Complainant might have avoided the scenario that emerged.

The Committee has the following recommendations with respect to the issue of Critical Incident (CI) reporting:

1. That DSM revises its critical incident policies and procedures to ensure that "unknowns" (such as whether the incident resulted in patient harm) do not delay immediate reporting of the incident; that designation of CIs occur in a reasonable timeframe; and that all possible CIs be declared as CIs so that the Critical Incident review Committee (CIRC) investigation can occur; that a designated person, if not the Chief Medical Officer, no less than a senior member of management is charged with full responsibility for the CI investigation and the implementation of its recommendations. If the investigation is to be led by the Quality department personnel, then other resources need to be accessible to them in order to conduct timely and thorough investigations;
2. That DSM ensures training of its staff in quality assurance to ensure that the process of investigating critical incidents is transparent and timely;
3. That DSM ensures training is provided to its pathologists so that they can participate fully in identifying, reporting, and investigating CIs;
4. That DSM implement a process to support a cultural change for staff and management so that unusual occurrences and near misses can be identified, discussed, analyzed and resolved in order to reduce the potential for critical incidents;

5. That DSM in its accreditation preparation for reporting occurrences and near misses considers developing a reporting form that is directed towards a laboratory setting rather than a clinical setting.

Section - 3.7 The Workplace

The Complainant alleged that members of DSM's management frequently mistreated employees. This mistreatment was said to include bullying, screaming and other instances where management exhibited disrespect for both pathologists and support staff.

The Committee has examined the Complainant's allegations regarding the disrespectful manner in which some employees have been treated. The Committee has found these allegations to have been somewhat substantiated.

The Committee has therefore made the following recommendations:

1. That DSM engage an external Human Resources (HR) consultant group to work with DSM to begin a phase that might include evaluating management, healing relationships and improving feedback mechanisms between DSM pathologists, staff and senior management.
2. That vigorous recruitment is ongoing to replace retired or departing pathologists and persons working in the laboratories or related service areas.
3. That decision making and accountability be transparent and that the communication and feedback loops are improved.

Section - 3.8 Quality and Patient Safety

The Committee has examined this issue as part of its larger mandate. Significant work has been accomplished with respect to laying the foundation of a well organized and well documented quality management system. This is a work in progress, with the improvements to be made at various levels being in part dependent on adequate resources being made available for the work. Gains in pathologist and non-pathologist satisfaction could be made by a commitment to improved communication, both within the wider DSM pathologist community and between the pathologist and technologist communities.

The Committee has the following recommendations:

1. That the composition of the DSM Board is reviewed and that representation from patients or patient advocacy groups, and physician end users is considered;
2. That Reports to the Board from the Patient Safety Committee continue to be refined in such a way as to include a focus on problem areas (with complete, objective data when appropriate), and that the Patient Safety Committee composition includes individuals with specific laboratory expertise;

3. That DSM develops a plan to systematically and proactively assess client (primarily physician) satisfaction with their services.
4. That pathology manpower and workload analyses take into account explicit allocation for quality assurance activities at each site at which pathology services are provided; and that additional or re-allocated resources be pursued with some vigour to meet the goal of CAP accreditation so as to alleviate staffing issues related to these increased demands;
5. That additional pathology manpower be allocated in support of the Anatomical Pathology Quality Assurance (AP QA) Committee;
6. That the effectiveness of the Quality Specialist - Pathology be evaluated after a suitable period of time, to determine the adequacy of support at the 1.0 EFT level;
7. That clerical support be provided to the AP QA/ Standards Committee;
8. That a Quality Assurance module compatible with the DSM computer system(s) be purchased or developed, in support of Quality Assurance activities.
9. That DSM establish turnaround times (TATs) having regard to recognized benchmarks and thresholds to address the issue of real and/ or perceived lengthy TATs;
10. That DSM efforts toward monitoring and reporting of TAT be continued and enhanced, such that site specific TAT and TAT by specimen groupings (e.g. biopsies, rush specimens, large specimens, etc.) be made available and posted on the DSM website.
11. That DSM communicates with its end-users if limitations in infrastructure, process efficiency and/or pathologist numbers (or some combination of these factors) preclude meeting the targets; and identified ways to remedy the deficiencies.
12. That minuted meetings of DSM pathologists with Senior Leadership (CMO, CEO, COO, Pathology Medical Director, Pathology Technical Director) occur on a regular basis (e.g. quarterly);
13. That the Pathology Executive Committee clarify its role vis a vis the Pathology Working Group; that it develop formal terms of reference, clarify its quality focus and develop a communication plan to further inter-institutional communication and accountability for shared quality issues;
14. That DSM reviews the effectiveness of middle management-pathologist communication with respect to the identification and resolution of technical and clerical problems.