Thompson, Robert

From: Thompson, Robert
Sent: Wednesday, March 12, 2008 4:30 PM
To: Gregory, Deborah; Power, Glenda; Pritchard, Rolf
Subject: Draft Release
Attachments: Draft Release.doc

Glenda:

In order to help things along, I have composed a draft release inclusive of the bits I previously sent to you. Feel free to rewrite as necessary, but all the things we have to offer are there.

I have asked Rolf and Debbie to review as well.

Robert

Ross Wiseman, Minister of Health and Community Services, provided an update today on matters relates to the ER/PR testing issue as a follow-up to his press conference of February 22, 2008.

1. Changed Results among Deceased Patients

There have been several requests from the media for the number of deceased patients whose ER/PR test results had changed upon retesting at Mount Sinai Hospital. There are two ways to report "changed " results:

- Using similar categories to define a "changed result" as were used by Eastern Health in its May 2007 media briefing, including the assumption that a "changed result" measures change in estrogen receptor tests only (not including the results for progesterone receptor tests), the number of deceased patients whose test results changed is 108 out of 322 deceased patients, and the number of living patients whose test results changed is 275 out of 691 living patients.
- If "change" takes into account the results for both estrogen and progesterone receptor tests, the number of deceased patients whose test results changed is 90 out of 322 deceased patients, and the number of living patients whose test results changed is 194 out of 691 living patients.

To understand these numbers, it is essential remember that a changed ER/PR test result is not necessarily an indicator of delayed or inappropriate cancer treatment. Nor do these statistics mean that there is a relationship between an inaccurate ER/PR test and the cause of death. As well, the data source for mortality statistics includes "all causes" of death and does not specify whether the cause was cancer or some other reason.

2. Contact with Patients

On February 22, 2008 the Minister reported that there were 35 living patients whose tissue samples had been sent for retesting but had never been contacted about the retesting process. The Centre for Health Information has provided additional information which indicates there are [17] more living patients who, while they received an initial contact about the retesting process, may not have been contacted with their results. None of these patients had changes in their test results. All of these patients are now being contacted.

The Minister stated that he regrets that this new contact information was not available for release on February 22nd, but the information had not been extracted from the ER/PR database at that time. While the continued release of new information may be disconcerting, the Minister noted that there are no additional issues on which the Department has asked the Centre for Health Information to report, and now the Commission will use the database as it determines best in support of its work.

Overall, the database exercise has been extremely useful in identifying people who needed retesting but had not been sent, people who had not

been contacted about the resting process and results, and the actual extent of changed results. The database also allowed the government and health authorities to identify early lessons learned so that funding could be made available to provide solutions.

3. Task Force Terms of Reference

On May 30, 2007 the provincial government announced the creation of the Task Force on Adverse Health Events to "examine how the health system identifies, evaluates, responds and communicates in regard to adverse events in the health system which may compromise the health of patients in Newfoundland and Labrador." Robert Thompson, the Secretary to Cabinet (Health Issues) was appointed to head up the Task Force.

The Task Force serves a different role than the Commission of Inquiry on Hormone Receptor Testing. The Commission of Inquiry has been mandated to look at ER/PR testing, and determine what went wrong, did officials respond appropriately, and whether best practices now exist to address the issues raised by situation. The Task Force is mandated to examine more generally how the health system responds and communicates when an adverse event occurs. The Terms of Reference are included as a backgrounder to this release. The Task Force will invite release further information about its workplan in the coming weeks.

Q/A [It may be asked why the task force has not been more public to date. The answer is that my role also includes preparing government for full and open participation in the Commission of Inquiry. Given the demands as DM of Health until November 6, the subsequent need to review disclosure documents, and oversee the ER/PR database, the work of the Task Force moved slowly. Now that the Commission hearings are about to start, the work of the task Force will ramp up as well.]

Q/A [Given the delayed start, June 30 is not a lot of time to do a report. We have some background work done, but it may need another month or so.]

Q/A [Questions may be asked about the Health Council. This was a commitment of the government (that it be established) so given the close alignment between the Task Force mandate and the health council, it seemed appropriate to merge the foundational work on it into the Task Force work.]

4. Clarification of Minister's comment

During the February 22, 2008 press conference, one of the Minister's answers to a question from the media implied that the mandate of the Commission of Inquiry might extend to examining the circumstances of individual patients. For purposes of clarity, Mr. Wiseman wishes to clarify that the mandate of the Commission of Inquiry does not include the circumstances of individual patients.

Backgrounder:

Terms of Reference for the Task Force on Adverse Health Events

- The Task force will be a one person Task Force headed by Robvert Thompson, Secretary to Cabinet (Health Issues).
- The Task Force will

  1) examine and evaluate how the health system identifies, evaluates, responds and communicates in regard to adverse events within the health system;
  2) examine relevant best practices in other jurisdictions;
  3) propose a mandate, structure and budget for the establishment of a "health quality council" in Newfoundland and Labrador, and
  4) make such recommendations as may be appropriate.

- The Task force will consult directly with health authorities and experts; establish a committee of health authority "safety/quality" officials to assist its work; invite submissions from the public; hold meetings as necessary with relevant shareholders; and hold a symposium on adverse health events.

- The report deadline is June 30, 2008.