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Jeudi 14 décembre 2006

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Ministry of Health
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STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Thursday 14 December 2006

Jeudi 14 décembre 2006

The committee met at 0945 in committee room 1, following a closed session.

2006 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.06, hospitals—management and use of diagnostic imaging equipment.

The Chair (Mr. Norman W. Sterling): Good morning, ladies and gentlemen. My name is Norman Sterling. This is the public accounts committee of the Legislature of Ontario. This meeting was called with regard to section 3.06 of the auditor's report, dealing with the consideration of hospitals—management and use of diagnostic imaging equipment. This report was issued on December 5, one week and two days ago.

We have with us the deputy minister for the Ministry of Health and Long-Term Care, Mr. Ron Sapsford. We also have with us the president and chief executive officer of the Ontario Hospital Association, Hilary Short. I'd ask Hilary if she would like to occupy a seat at the front as well. I believe both the deputy minister and the president will have an opening statement, and then we will go to questions by the committee. Mr. Sapsford?

Mr. Ron Sapsford: Thank you, Mr. Chair. Good morning. I'm pleased to be here today on behalf of the Ministry of Health and Long-Term Care. I want to thank the standing committee on public accounts for providing me with this opportunity to address some of the issues in the Auditor General's report on hospitals—management and use of diagnostic imaging equipment.

Let me state at the outset that the ministry fully supports and appreciates the work done by the Auditor General in completing these important hospital value-for-money audits. This audit constitutes the first value-for-money audit of the broader public sector, including the hospital sector; as you are aware, it was enabled by an expansion of the mandate of the Office of the Auditor General of Ontario. I should add that it's been an interesting learning experience for the Ministry of Health and Long-Term Care and, I believe, for his part, the Auditor General as well. Overall, the ministry supports the recommendations of this report and recognizes their significance for the health care system.

In responding to the report, I believe it is important that we understand the responsibilities and accountabilities as set out in the statutes that govern the health care system in Ontario. Make no mistake, I take seriously the ministry's accountability for the broader health system and the delivery of health care to Ontarians, and I'm committed to the goal of providing timely and equitable access to MRI and CT services to all the residents of Ontario. And the ministry appreciates the need for appropriate standards, guidelines, best practices and an adequate supply of human resources—all recommendations of the Auditor General.

However, to move forward with the agenda to improve access and reduce wait times for MRI and CT services, the ministry recognizes that this requires working closely with our partners: hospitals, health professionals, and their colleges and associations. Within the current health care system, there are multiple entities with their own specific roles and responsibilities under Ontario's legislation, and the accountabilities for each of those entities is clearly set out.

I want to turn for a moment to the legislative framework that governs the roles and responsibilities of the various players in the health care system because it will set the context of the manner in which the ministry will address the recommendations in the Auditor General's report.

The Ministry of Health and Long-Term Care Act sets out the duties and functions of the minister and, through him, the ministry. These are to oversee and promote the health and the physical and mental well-being of the people of Ontario, and to be responsible for the development, coordination and maintenance of comprehensive health services. This includes a balanced and integrated system of hospitals, long-term-care facilities, laboratories, ambulances and other health facilities in Ontario.

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The Public Hospitals Act of Ontario sets out the responsibilities of the boards of directors and the medical advisory committees regarding the quality of care provided in the province's hospitals.

A hospital's board of directors is ultimately accountable for the quality of patient care provided in each hospital. The legislation also requires every board to pass bylaws setting out the duties of the medical staff, including the establishment of medical staff committees to assess credentials, medical records, patient care, infection

control, the utilization of hospital facilities, and all other aspects of medical care and treatment in the hospital.

While the Public Hospitals Act places the ultimate accountability for patient care with the board, the act recognizes that physicians and other professionals are the people with the expertise to supervise and assess the quality of care being provided to patients, and, accordingly, requires every board to establish a medical advisory committee. The mandate of the medical advisory committee includes making recommendations to the board concerning the quality of care provided in the hospital by the medical staff and other specified health professionals. The committee also is responsible for supervising the practice of medicine and the other specified health professionals.

In summary, the Public Hospitals Act places the ultimate accountability for patient care in the hospital with the hospital's board.

The profession of medicine is governed by the Regulated Health Professions Act and the Medicine Act. Under these acts, the College of Physicians and Surgeons of Ontario is the self-regulating body for physicians in the province.

The profession of medical radiation technology is governed by the Regulated Health Professions Act and the Medical Radiation Technology Act. Under these two acts, the College of Medical Radiation Technologists of Ontario is the self-regulating body for medical radiation technologists. For clarification, a medical radiation technologist, or MRT, is the qualified professional who uses radiation or electromagnetism to produce diagnostic images of a patient's body or who administers radiation to treat patients for certain medical conditions, on the order of a physician.

The colleges are to protect the public through the regulation of the practice of the profession and its members. The colleges are required to develop, establish and maintain standards of qualification for entry to practice; programs and standards of practice to measure the quality of the practice in the province; standards of knowledge and skill and programs to promote continuing competence; and standards of professional ethics.

The colleges administer quality assurance programs to promote the continuing competence of members. They also maintain complaint, investigative and discipline processes in relation to reported concerns about the practice or conduct of members.

I have laid out this legislative framework to clarify the role of the ministry in relation to the specific areas raised by the Auditor General's report.

As I have said previously, the ministry takes its role and responsibility seriously in setting the system's strategic direction and administering the province's health system. But we cannot overlap legislated boundaries. As a ministry, we must work within the legislative framework and at the same time in collaboration with our partners to deliver the best possible care to patients.

Let me turn now to where we are in relation to the Auditor General's report on hospitals and diagnostic medical equipment, as was outlined in the table that I believe was provided to you. I'm pleased to report to you that significant changes have been made since the Auditor General's review of the three hospitals involved in May of this year.

I first want to address the recommendations related to the wait time strategy.

With respect to the recommendations related to workplace health and safety patients, let me start by saying that the ministry believes that all Ontarians should have timely access to MRI and CT services, with medical need determining the priority of their case. To that end, the wait time strategy team worked with experts in the field to develop four levels to prioritize patient access to diagnostic equipment. This information was posted publicly on the website in December 2005 and was available for hospitals to implement. A formal communication to those hospitals funded through the wait time strategy, requiring them to implement these prioritization guidelines, was forwarded in September 2006. Accordingly, at the time of the auditor's report, these priority levels were relatively new and not fully implemented. Today, all hospitals participating in this strategy are required to use these levels when booking patient appointments, includeing appointments for WSIB patients, and when reporting prioritized wait times.

For your information, the four levels which form the ministry benchmarks for the provision of MRI and CT services are outlined. Priority 1, emergency, is service provided on an immediate basis. Priority 2 would be inpatients or urgent outpatient cases, the benchmark being service to be provided in 48 hours. Priority 3 is semi-urgent, which includes cancer staging, and this should be provided within 10 days. Priority 4 would be all non-urgent cases, the benchmark being within four weeks.

This leads me to another recommendation of the Auditor General: as was quoted, "misleading" waiting time information. Unfortunately, this description of the wait time information was picked up by the media even though this was not in the Auditor General's report.

In October 2005, the government announced a website that provides current waiting times for hospitals across the province of Ontario for five key health services. Ontario is a leader in Canada in providing this information on a public basis. I'd like to point out that only five provinces currently report MRI and CT waiting times publicly: Prince Edward Island, Nova Scotia, Manitoba, Alberta and Ontario. None of these provinces differentiate on their public websites between inpatients and outpatients.

More important for the committee to understand is that Ontario is the only province that reports the average, the median and the 90th percentile wait times. Recently, to improve the public's understanding and enhance the usefulness of the information, the ministry chose to redesign the website to focus on the 90th percentile of the wait time. This statistic reflects the date by which 90% of Ontarians waiting for a procedure receive the procedure. This means in real terms that anyone can go to the

website to find out the time that it will likely take to receive the procedure. This number is not the average, it's not the shortest, but the time that it takes for 90% of patients to receive their care. So I argue that rather than misleading the public, the ministry is being fully transparent with respect to the waiting times. We are seeing improvement and we will continue to see improvement, not only of the waiting times themselves but in the reporting of them.

Since the time the Auditor General conducted his review, we have begun to make significant improvements to the data that is reported on our public website. At the time the Auditor General undertook his work, the data reported on the website was what is termed exit data; that is, hospitals reported the key indicators, including the decision-to-treat date and the date the procedure took place, at the time of the procedure. This collection process was therefore retrospective and the data quality checks were performed on a monthly basis.

Today, as I speak to you, the data collection system has been fully automated with computers and networks now all the way back to surgeons' offices, so that the wait time data is entered and calculated from the date the decision is made to treat, and the information is uploaded electronically within 48 hours to the Ministry of Health and Long-Term Care at each milestone. As we further develop this data collection system, we expect to have even more current information on the public website beginning in the spring of next year.

We are more confident of the data accuracy using this new system. It has built-in systems that automatically check for data validity and errors. Currently, the wait time data from August to September 2006 that is available on the public website is a combination of this old—or retrospective—data, and the new data collection systems. We expect that by spring of next year, the wait time website data will include only the information collected through this new reporting system.

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The website also includes educational information on wait time issues, an update on the wait time strategy, information on understanding wait times, myths about wait times, frequently asked questions, and questions for patients to ask their physicians.

As with any other new initiative, we are constantly looking for ways to improve the system as it evolves. As you are aware, the minister recently announced that Senator Kirby will be independently reviewing the Auditor General's concerns on how the province measures and presents or reports on its wait time strategy and will provide advice for additional improvements. The ministry is looking forward to working with Senator Kirby, and upon receiving his report we will consider his recommendations for additional improvements and changes.

In developing the wait time strategy and wait time reporting process, the ministry took a leadership role and set the strategic directions. Ontario involved, sought and implemented advice from nationally and internationally renowned health information experts as well as the regulatory colleges, professional associations and clinical experts.

The ministry convened the expert panel on MRI and CT in October 2004 to recommend a plan to provide Ontarians with access to MRI and CT in a timely and appropriate manner. The panel was asked to make recommendations on the provision of quality health care to promote efficient management practice in this particular part of the system.

The panel consulted with the Canadian Institute for Health Information, the Institute for Clinical Evaluative Sciences and other provincial leaders who are dealing with similar issues; for example, the Saskatchewan surgical wait times project. The panel also conducted research into how patients and providers use this kind of information and how they would like to use this information.

The first report was released in April 2005 and identified operational and utilization targets and benchmarks, such as minimum standards for the hours of operation per day and time per procedure. The report also identified the priority rating system and set the standard for the minimum data to be reported, which I've described to you.

The panel's second report has just been provided to the ministry and is expected to make recommendations related to future capacity, such as the location of new machines.

As well, the ministry has commissioned the Institute for Clinical Evaluative Sciences to conduct an audit of hospital data to determine clinical indication and appropriateness of MRI and CT scans performed in the province. Their report is due to be delivered to the ministry in the new year and is expected to provide insight into the appropriateness of ordering practices, which was referred to in the auditor's report.

In keeping with the ministry's oversight role and responsibility for strategic directions, the ministry consistently consults with and carefully considers the advice of the clinical experts.

While our wait time strategy focuses on these priorities immediately, the overall agenda for transformation will improve the public's access to health services and how the ministry and health providers manage that access.

With respect to the Auditor General's recommendation related to radiation exposure and that hospitals, in conjunction with the ministry, should develop and implement standardized patient CT-radiation exposure protocols, I would like to refer back to the legislative framework that I initially set out for you. The setting of patient CT-radiation exposure protocols is a clinical decision that rightly belongs in the hands of the health professions and their colleges. Having said this, the ministry has been working with our partners on many of the issues identified in the Auditor General's report through the following committees: the Ontario health technology advisory committee, the diagnostic services committee, the

diagnostic imaging safety committee, and the wait time MRI and CT expert panel.

The diagnostic imaging safety committee, established in September 2006, is developing recommendations for minimizing the impact of radiation exposure for patients and hospital personnel. This committee's work is progressing very well, and the ministry anticipates that it will have completed its review and it will be presented by February 2007.

As well, I have convened a series of meetings with the Ontario Hospital Association, the College of Physicians and Surgeons of Ontario and the College of Medical Radiation Technologists of Ontario to identify existing best practices and guidelines; for example, the Canadian Association of Radiologists guidelines and those used at the Hospital for Sick Children. These organizations have committed to ensuring that all guidelines will be distributed to their members and will be part of the education and training that they provide.

The ministry has provided funding as well for comprehensive research on national and international best practices. This information will be used to inform the guideline work being completed by the diagnostic imaging safety committee. As well, it will be made available to the Ontario Hospital Association, the College of Physicians and Surgeons of Ontario and the College of Medical Radiation Technologists of Ontario.

As well, last week I spoke to Hilary Short, president and CEO of the Ontario Hospital Association, Dr. Rocco Gerace, registrar of the College of Physicians and Surgeons of Ontario, and Sharon Saberton, registrar of the College of Medical Radiation Technologists, to advise them that I was requiring all hospitals to review their CT practices to ensure that patient safety is not being compromised, and in particular with respect to the radiation levels used for children.

At my request, the Ontario Hospital Association forwarded a bulletin to its members recommending that all Ontario hospitals performing CT and MRI scans review their policies and practices, especially with respect to paediatric protocols, to ensure compliance with recommended manufacturer settings for their equipment.

With regard to the Auditor General's comment that children have received an adult dosage of radiation, I must tell you in honesty that this statement has generated considerable discussion within the Ministry of Health and with others. Given that the report is short on the specifics of these occurrences and tends to generalize the results that have been reviewed, it's difficult to assess whether this is a systemic issue, a hospital-specific problem or a case of individual professionals not practising within their own norms. So the appropriate remedy is more difficult to discern. I have raised this question directly with each of the colleges to see what can be done further with respect to each hospital. More specific information is needed than is provided in the public report, and I will be raising this question with the Auditor General directly. To that end, I am calling meetings with each of the hospitals mentioned in the Auditor General's report to review in detail the results of the report and audit for their hospitals to determine if further action is required. I hope that the foregoing has demonstrated some of the ways in which the ministry's work plans align with those recommendations of the Auditor General's report.

Once again, I wish to thank the public accounts committee for this opportunity to discuss the report and how we intend to work even harder in the future to ensure that Ontario's health care system will continue to provide the best possible care for all Ontarians.

As Deputy Minister of Health and Long-Term Care, I am grateful for the Auditor General's report. Productive feedback is an important part of an effective system, and continuous improvement is the key to every successful activity; and effective improvement depends upon useful feedback.

The Ministry of Health and Long-Term care views the Auditor General's report as an important help in improving Ontario's health system. It gives us knowledge and direction, both of which are vital to the government's ongoing plans for innovation in public health care, building a system that delivers on the three priorities of keeping Ontarians healthy, reducing wait times and providing better access to health professions.

Thank you, Mr. Chair.

The Chair: Thank you very much, Mr. Sapsford. I'd also like to draw attention to, and place on Hansard an acknowledgement of, your response to the committee dated December 12, where you provided the committee with your response to the eight recommendations which the Auditor General put forward on December 5. We appreciate the up-to-date response. Of course, that document is a public document as well, and I would like to indicate on Hansard that if anybody wants access to that, they can apply to the clerk of the committee or the Clerk of the Legislature in order to obtain that.

Next we have Ms. Hilary Short, president and chief executive officer of the Ontario Hospital Association. I might add, Ms. Short, as Mr. Sapsford indicated, that this is a new process, and you are actually the first witness under this new process where we are going out and beyond the deputy minister in responding to the auditor's report. So you're making history today. Welcome.

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Ms. Hilary Short: Thank you, Mr. Chair. I'm very honoured to be the first person to have that honour. Thank you for the opportunity.

Joining me today at this hearing are two experts in the field of CT and radiation: Judith Reid and Dr. Paul Babyn. Judith is a radiation protection technologist at both the University Health Network and Mount Sinai in Toronto. She holds a degree in physics and mathematics from the University of Toronto, and her professional responsibilities include auditing radiation protection standards in these facilities; suggesting changes in policy in response to audit results; and educating administrative staffs on evolving standards at the provincial, federal and international levels. She had the opportunity to work with one of the Auditor General's associates for three weeks

when they were preparing this report, so she is very knowledgeable.

Dr. Paul Babyn is the radiologist-in-chief at the Hospital for Sick Children and an associate professor at the University of Toronto's department of medical imaging.

Both Ms. Reid and Dr. Babyn will be available to answer questions that committee members may have with respect to computerized tomography, or CT, scans.

I would like to thank again members of the standing committee on public accounts for inviting the OHA to participate in today's hearing. We understand how rare it is; that's what I have written in my script. I didn't realize I was actually the first.

We understand that it is unusual for a non-governmental organization to be given such an opportunity, and your invitation demonstrates how committed legislators from every party are to ensuring that the public fully understands issues around the management, use and safety of diagnostic medical equipment. And can I say too how much we value the Auditor General's report for having raised some very important issues for the hospitals.

Earlier this year, the Auditor General reviewed the magnetic resonance imaging, or MRI, and CT scanning protocols and practices in use at three of Ontario's 158 hospitals. In his 2006 annual report, the Auditor General commented on his findings regarding these protocols and practices and made eight recommendations meant to strengthen them. I'll use my time this morning to comment on a few of these findings and recommendations.

The Auditor General's report examined the way patient wait times are measured and reported in the province of Ontario. He identified two major issues: first, that the audited hospitals used different starting points when measuring wait times, and that this practice could distort the length of time that patients actually wait; and second, that there may be issues with how the Ministry of Health and Long-Term Care reports wait times on its website.

With respect to the audited hospitals using different start points, this is a legitimate issue, but one which may well be resolved through the widespread implementation of the wait times information system. This system is currently being implemented at hospitals participating in the Ministry's wait times strategy. We understand that this process will be completed by the summer of 2007.

You've heard the deputy minister speak about the report times on the government's website, and I won't go into that matter. And I have read, as you have, that Minister Smitherman has asked former Senator Kirby to review how wait times are measured and reported and look forward to hearing his conclusions and recommendations.

But let me be clear: The fact that we can now have a debate about how and whether wait times are being properly measured and reported shows, in my view, just how far we have come on this important file in a very short period of time.

The OHA has strongly supported the wait times strategy since its creation in 2004, because only by measuring wait times can we most effectively direct or redirect the resources needed to shorten them. This was simply not possible prior to November 2004 because we did not have the capacity to measure wait times in any organized fashion. The OHA believes that the wait time strategy has been, and will continue to be, of enormous benefit to Ontarians. We look forward to working with the ministry, with our partners, to ensure that this valuable program continues, grows more accurate and expands into more areas.

I'd like to touch briefly on the issue of the treatment of Workplace Safety and Insurance Board—WSIB—patients in terms of access to diagnostic imaging. In his report, the Auditor General stated that the WSIB directly pays hospitals approximately $1,200 per patient for MRI tests and that these patients appear to bump patients on normal waiting lists without regard for medical need.

I cannot speak specifically to the practices used at the audited hospitals with respect to WSIB patients, but what I can say is the following: Through their annual accountability agreements, hospitals are provided with a certain amount of funding by the Ministry of Health and Long-Term Care. In return, hospitals agree to provide a set number of specific services.

For example, a hospital may be given the mandate and funding to provide 1,000 MRIs in a given year and may find itself able to meet that obligation running their MRI machines five days a week between 9 a.m. and 5 p.m., 52 weeks a year. Emergency cases and in-patient cases, as you've heard from the deputy, would take priority, as they should; standard outpatient cases would be done on the basis of medical need within the service mandate and funding envelope the hospital was given. WSIB patients would only be processed outside of the normal ministry-funded operating hours at this hospital. To be clear: In our view, WSIB patients could not bump other cases at this hospital because the other patients would not have been seen outside of the funded hours.

I'd also like to note that many hospitals reinvest the revenue generated by processing WSIB cases into diagnostics, which allows them to complete more procedures than perhaps they otherwise could, which could, in turn, ultimately lead to shorter wait times. That said, the OHA of course takes the Auditor General's recommendations in this regard very seriously, and we understand that the ministry and the audited hospitals are certainly going to review them very carefully.

I'd like to now turn to the section of the Auditor General's report regarding diagnostic imaging. Let me just provide a little context. Diagnostic imaging—by MRI, by CT scan, by X-ray and by ultrasound—is incredibly important to the practice of modern medicine. Diagnostic imaging provides physicians and other health professionals with vital, often life-saving, information. In 2005-06, approximately 10.6 million of these valuable tests were conducted in Ontario's hospitals.

In his report, the Auditor General made a number of important comments about CT safety, particularly with respect to patient radiation exposure. Exposure to radiation from CT scanners and other diagnostic tools is an emerging international issue, one that has only been addressed through guidelines in the United States in the relatively recent past and is currently under examination in the United Kingdom and the European Union.

Dr. Babyn and Ms. Reid, who are with us today, are just two of the individuals in Ontario who monitor the research and the progress of the discussion all over the world on this topic. Again, I'd like to stress that I'm not a clinician. If you have technical questions, we'd certainly be willing to bring others to the table to answer them.

As I understand it, one of the reasons that guidelines or standards don't exist yet in more places is because there remains a great deal of debate about what these standards should be. A myriad of factors, such as patient size and weight, and radiation levels, can all impact on CT scan image quality. But, as I mentioned, we do have the ability to answer your specific questions.

The Auditor General outlined a number of issues relating to the use of existing pediatric protocols for CT scanning in use at two Ontario hospitals. Unfortunately—and judging from his published comments, I believe the Auditor General would agree with me—a number of misconceptions regarding the safety of CT scans have arisen since the release of his report.

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First, it has been reported by the media that CT scans are not a safe diagnostic tool because they use radiation that puts patients, particularly children, at immediate risk of developing cancer. This is simply not the case. CT scans have been, and remain, a safe and extremely effective diagnostic tool for both adult patients and children in the province of Ontario. Nowhere in his report did the Auditor General state that pediatric patients in Ontario are at immediate risk of developing cancer as a result of undergoing a CT scan. What he did raise were certain important and very fair points:

—that these machines do use radiation;

—that anyone subjected to repeated exposure to high levels of radiation may, over time, be at increased risk of developing cancer; and

—that physicians, health professionals, the government and hospitals must do all they can to ensure that every CT scanner in Ontario continues to be used as safely as possible.

In fact, we were glad to read that in the December 8, 2006, edition of Peterborough This Week, the Auditor General himself remarked that he "wouldn't think twice" about taking his child to any hospital in Ontario for a CT scan and that the media had drawn and reported "factually incorrect" conclusions about his observations and recommendations.

Second, it has been reported that no standards exist with respect to the use of CT scanners. While it is true that uniform guidelines for the use of CT scanners have not been set in Ontario, this does not mean that hospitals or radiologists are not guided in their work by certain practices and principles. I speak specifically of what is known as the ALARA, or the "as low as reasonably achievable" principle, which states that medical imaging professionals should always seek to use the lowest levels of radiation possible. The Auditor General acknowledged that all of the hospitals he visited had general radiological policies based on the ALARA principle.

Third, it has been reported by the media that pediatric patients received higher-than-necessary doses of radiation because the pediatric protocols preset on the CT scanners by the manufacturers were not used by radiation technologists. What the Auditor General stated on page 150 of his report is that radiation technologists at two of the three hospitals he audited had adjusted or had the discretion to modify the pediatric protocols that were preset by the scanner's manufacturer in order to obtain an image of sufficient quality. As the Auditor General noted, "Staff at one hospital indicated that the modified protocol would often expose a child to less radiation than the manufacturer's preset protocols."

The Auditor General also noted that, while the modified pediatric protocol used in less than half of the tests might have exposed patients to more radiation than they would have received had the manufacturer's presets been used, there may have been unique circumstances in these cases. A unique circumstance may have been the size or body mass of a particular child, although I would encourage you to seek additional clarification, should you require it, from Dr. Babyn or Ms. Reid.

Finally, it has been reported that the Auditor General recommended that immediate action be taken to address the issue of CT scan radiation levels. Again, this is not the case. What the Auditor General, on page 154 of his report, did recommend was that relevant parties "develop and implement CT-radiation-exposure protocols, based on international and national best practices, that would ensure that the patient's radiation exposure is as low as reasonably achievable and is consistent among hospitals, and monitor adherence to these protocols through a quality assurance program." The OHA and Ontario's hospitals strongly support this recommendation.

In September 2006, the Ministry of Health and Long-Term Care established a diagnostic imaging safety committee, or DISC, made up of clinical experts to develop specific recommendations regarding how CT scanners can be used safely, effectively and in keeping with the ALARA principle. The OHA is working closely with this committee, and we expect a full report to be released in February 2007.

As with all issues related to the health of patients, the OHA believes that we have a responsibility to utilize a thoughtful fact- and evidence-based approach such as this to resolving important clinical issues, rather than an ad hoc, back-of-the-napkin approach.

We believe that the DISC will, in short order, develop protocols that every Ontarian can have confidence in. Once these protocols are developed, the OHA will, along with our partners, use all the resources at our disposal to

disseminate these protocols and any other relevant best-practice information to Ontario's hospitals.

Specifically, we will also offer any assistance we can to the College of Physicians and Surgeons of Ontario—the body that, according to statute, regulates the medical profession—to ensure that Ontario's physicians are familiar with the latest in diagnostic imaging best practices.

I would like to note that, once the Auditor General's report was released, the OHA, as the deputy said, advised its members to review both the report and their own policies and protocols around the use of CT scanners to ensure that these are being used as safely as possible. We will be developing any necessary educational programs so that hospital administrators and trustees will have the tools they need to implement and monitor the protocols.

One of our core mandates at the OHA is to seek out partnerships wherever possible to improve the quality and safety of patient care in this province. To that end, we will also continue working with our partners in government and in the health sector to identify ongoing or emerging issues, such as this one. We believe that these are appropriate roles for an association like ours that, unlike the College of Physicians and Surgeons of Ontario, does not possess specific statutory or regulatory authority over its members.

We would like to reassure patients, their families and the public that their safety is a top priority for Ontario's hospitals and that continuing quality improvement is key. CT scans have been, and remain, a safe and valuable diagnostic tool, and we plan to work with our partners to ensure that they are used even more safely in the future based on the best knowledge we can gather from around the world.

I would just like to close my remarks with some brief comments about hospitals and public perceptions. As you know, hospitals are trusted public institutions. People turn to hospitals for help—for themselves or for their loved ones—because they trust that the professionals working in hospitals will know what needs to be done and that what will be done is safe.

As with any trust relationship, the bond between hospitals and the patients they serve can take many years to build but only a short time to lose. Allow me to illustrate this point with a brief, relevant and unfortunate example from the media. In one community, a local radio station, on the basis of media reports that overstated the risk of CT scans to children, ran a programming segment asking listeners whether their children had had a CT scan in the last year. The follow-up question was whether these children had developed any negative side effects. This prompted over 40 worried parents to contact the local hospital, asking whether their children were at imminent risk of developing cancer.

This kind of situation helps no one. It diminishes public faith in hospitals and our highly skilled medical professionals, it worries patients and their loved ones unnecessarily and it misconstrues and devalues the many important and useful recommendations made by the Auditor General.

This example also shows that hospital practices need to be accurately reported on, that an abundance of caution should be used by all who choose to comment on them, that temperate language must be the vehicle for informed debate and that any solutions to issues raised must be developed on the basis of facts and evidence.

I would like to personally thank the Auditor General for his important report. I can assure him and this committee that Ontario's hospitals and the OHA take these recommendations very seriously and will work on them very diligently.

Finally, I would, through you, Mr. Chairman, like to thank you again for the invitation to attend this committee. We have appreciated the opportunity and look forward to answering any questions that you may have. Thank you again.

1030

The Chair: Thank you very much. We'll go to questions now. Shelley Martel from the New Democratic Party, do you have some questions?

Ms. Shelley Martel (Nickel Belt): Thank you both for being here and to the other folks who are here this morning as well. We appreciate your participation. I want to deal with the protocols around radiation, especially for pediatrics.

The auditor noted on page 154: "The Ontario health technology advisory committee was also examining the use of CT equipment, including patient radiation exposure, CT imaging standards, and patient shielding practices, and expected to make recommendations to the ministry in the summer of 2006."

I would assume they would have been looking at protocols. Did they actually make recommendations to the ministry in 2006, or was that delayed? I don't know if you have the answer to that off the top, Deputy.

Mr. Sapsford: As I'm aware, it was delayed. We have not yet received that specifically.

Ms. Martel: It has not been received.

Ms. Short: There is a report by OHTAC on the website, but I don't think the recommendations have come yet.

Mr. Sapsford: That's the OHTAC report on CT you're referring to? Can you refer me to the page?

Ms. Martel: I'm looking at page 154 at the top left-hand corner, the very first paragraph.

The Chair: Mr. Sapsford, I think we're referring to the OHTAC recommendation which we were given as part of our source materials by OHTAC, which was issued in—

Mr. Jim McCarter: We think this was issued in August 2006, but if I could just get the clerk to give you a copy of it. I think that's the one.

Mr. Sapsford: That would be helpful.

Ms. Judy Reid: Judy Reid. Basically, the report listed a number of recommendations. Part of that recommendation asked for creation of committees and review of practices elsewhere to ensure that everything that needed to be done was being done. So the recommendation was

basically to create the committee and move forward on that basis.

Ms. Short: That led to the creation of DISC, and that's what the work is on now.

Ms. Martel: I appreciate that answer. Let me then ask about what would have been available in Ontario previous to this report that might have given hospitals doing pediatric scanning some indication of what appropriate exposure levels were. I'm assuming—and I'm going to get an answer here, I'll bet—the Hospital for Sick Children would have had some useful information in this regard. I'm assuming Sick Kids does; we'll get an answer to that. My questions are the following. What, if any, effort was made by anybody to share your protocols with other hospitals to ensure that the best protocols at the time were in place with respect to radiation levels for children and what the settings were with respect to pediatric scans?

Dr. Paul Babyn: Paul Babyn. I'd like to thank the committee for the opportunity to come forward today. The issue of radiation in pediatric use has certainly been an ongoing concern, one that was highlighted for us from some data that was established in 2001. Since that time, there has been extensive development of resources and publications within the literature to address the issues about pediatric protocols. Ontario is not unique in this regard in the differences between institutions and use of pediatric-relevant protocols, and that has been recognized amongst other institutions and in the medical literature itself.

At the Hospital for Sick Children, where we obviously take these issues very seriously and are directly involved continually with them, we have developed protocols for our unique equipment. We review on an ongoing basis studies that come to us done on children from other institutions. We provide the information that we are quite willing to share with those outside institutions when we come across individual situations where we see some improvement could potentially be made.

Ms. Martel: When you say "outside institutions," can I just get clarification on "outside institutions"? Is that other Ontario hospitals?

Dr. Babyn: Yes, wherever the site is that has referred outside imaging to us.

Ms. Short: From the OHA's point of view, the whole question of the dissemination of best practice is an ongoing challenge. How do you get best practice implemented in any field? It doesn't matter whether it's CT—we happen to be talking about that. But it is an ongoing challenge to make sure that new knowledge or developing knowledge is shared as quickly as possible. That is just a fact of life. As physicians learn more, we need to spread that knowledge between physicians and also between organizations. Obviously, the useful purpose of this report is that this area has been focused on.

For the OHA, in the field of patient safety, that is a challenge too. How do you learn from experiences and transfer knowledge of best practice on an ongoing basis? That is the challenge hospitals have.

Ms. Martel: You have guidelines, though, in other jurisdictions. Doctor, you're probably in the best position to tell us about the relevance of those or if you agree with them or not. We've got some information, certainly in the United States, about protocols. We were given to understand that there were protocols already developed in the UK, although there has been some information this morning that would suggest those are still under review.

My question is this: If we have another jurisdiction where experts have looked at this matter, especially with respect to pediatric CT exams, why would we not be moving to implement those right now and then make any modifications that may be necessary through the committee that was established in August? What is the problem about doing that?

Dr. Babyn: Let me just comment. I am also a member of the diagnostic imaging safety committee. Certainly, we are currently considering the variability of CT dose among institutions and the need for age-related dose parameters to be used in CT as well as the recommendations regarding the introduction of diagnostic reference levels.

You can appreciate that there has been extensive literature and ongoing debate within many nations and jurisdictions. We would like to ensure that Ontario takes a leadership role in this and provide the information to the ministry that will allow them to put the best, not just the most expedient, solution forward.

There is also consideration in the emphasis on the role of radiologists as gatekeepers in promoting the optimal use of imaging modalities. We need to recognize that CT is one of the most powerful tools for medical imaging that we have and is unique in its capabilities in many situations.

In other situations, CT is not unique and can be substituted for effectively using other imaging modalities that do not use ionizing radiation, such as ultrasound or MR. We need to be ever vigilant that we have the appropriate capability and access to allow those situations that may not need CT to be done with other imaging modalities.

I think the committee is considering a lot of the concerns that have been raised and is looking to address them in a thoughtful manner and move forward as expeditiously as we can.

Ms. Short: In the interim, we have encouraged all of our members, as the deputy said, to review their policies and practices and also, if they don't have pediatric protocols, to certainly use the ones developed at Sick Kids and CHEO. That's what is being done in the interim.

Ms. Martel: That was going to be my next question. If there are concerns about the international literature and reasons for not implementing it right now—which I still feel like I don't have a clear answer on. I'm not trying to undermine you; I'm just not sure clearly why we wouldn't move to that as a first step right now and then the second choice, obviously, would be what is going on at Sick Kids.

Was that a conscious decision, then, made by the committee or the ministry: to forgo, for the moment, the international protocols and at least ask hospitals that do pediatric scanning to use Sick Kids' protocols?

1040

Dr. Babyn: Just to answer that, certainly we have been more than willing to—and have—disseminate our protocols to whomever has asked us, and we are looking to put them forward on the Web. There are sites that have these protocols already available, as you mentioned, so people can have access to that. We disseminate our information, and, you can imagine, over the last several weeks we have had a flurry of activity in that regard. But we only have one particular type of scanner; we don't have all the scanners. There are different protocols for the different equipment. People need to recognize that there is variability amongst equipment so that they can make sure they're using as low a dose as possible for that particular equipment.

Ms. Martel: In respect of the OHA sending a message or communiqué encouraging hospitals to use Sick Kids' guidelines and protocols, I appreciate that.

I guess my other question would be flowing from that. What are the mechanisms to compel that until such time as we have a more established protocol from the committee? The committee may well put in its recommendations by February. I think, given the public attention on this issue, that's absolutely going to happen. I don't know what the delay would be between the time of their recommendations to the ministry and the ministry's accepting of guidelines. For the interim—the communiqué has certainly gone out. Deputy, what can you do to compel that?

Mr. Sapsford: In fact, when I met with the two colleges and the OHA last week, that was one of the first questions: On an interim basis, could a reference be made to Hospital for Sick Children standards, at least for the pediatric? We're now developing a specific response and work plan, and that is one of the questions that we'll be addressing very quickly.

I think you have to remember that all hospitals are working with some form of guidelines. There are a number of references—the Canadian Association of Radiologists, the Sick Kids—that have been adapted from their own use of their machines. So, even in saying, "Well, let's use Sick Kids," I'm not too sure how directly applicable that would be to another hospital with a different machine and different manufacturer's standards.

But we're working very specifically on that question, to see if we can get the support of the two colleges to in fact make some reference to a working interim while the committee completes its work.

Ms. Martel: Can I ask another question on this? I'm sorry, is that all right?

The Chair: There's lots of time.

Ms. Martel: I have just one more question, then. With respect to your own protocols at Sick Kids, I appreciate that of all of the hospitals—maybe with the exception of CHEO—you are going to have the most specialized equipment. It's clear that that's not going to be applicable to a number of other hospitals. However, could you tell the committee, with the protocols that you do have, would they be applicable to essentially any Ontario hospital that is doing a scan?

Dr. Babyn: Certainly I would suggest that there are several avenues that can be brought forward to do this; the first is to deal with the vendors. There are only a limited number of the vendors of CT scanners within Ontario. All of the vendors have a particular interest and focus on dose reduction. I would suspect that they would all have individual access to their protocols and best practices for those individual pieces of equipment. As well, we can certainly provide some general guidelines that can be used by any institution to minimize the risk of radiation exposure in children. We'll be happy to provide that as soon as we can.

The Chair: Okay. Mr. Hardeman.

Mr. Ernie Hardeman (Oxford): Thank you very much for the presentation; we much appreciate it.

My questions are not as well versed in the medical field as your answers are, I'm sure, because I don't understand how the system works. I'm more interested in what the auditor says—and he's also not a medical expert—about what's wrong with the system.

My concern, mostly, is in two areas in the presentation done by the deputy: the wait times, but the biggest concern is the radiation levels for children. Though the auditor pointed it out, there really isn't enough information to make a good judgment on what the real situation is because of the overlapping or the division of responsibilities between the ministry, the OHA and then the practitioners who are actually providing the service.

But in very simplistic terms, if there is evidence—and there appears to be in the report—that there are images being done when the setting is not appropriate for the person whose image is being taken, that, to me, is not an issue of a new protocol. If the auditor can find out that it was wrong with the evidence that he found, it would seem that somebody under the present structure wasn't doing the job right. Somewhere in the system there must be something that says, "This is the level of radiation you should use for this type of patient." Now, if there's evidence that that isn't happening, wouldn't we be moving forward not with another study but to send a direction to everyone who is doing it to make sure that you do it to everyone this way, period?

I'm not sure how we're getting into this. We're looking for all kinds of new solutions and new protocols, but the auditor's report says some of them are being done wrongly according to today's standards. That's why I think we're meeting here today. It's very important that this problem doesn't become part of a study, but that the child who's going in for an X-ray today, a CT today, does not stand any greater risk than they need to to have that CT completed. I want to know what we're doing to deal with it now.

The Chair: Can I just intervene here briefly? I'd just like the auditor to explain the process he went through in

order to identify this problem. I think it's only fair to the hospitals because they were really the ones who discovered that there were—

Mr. Hardeman: Mr. Chairman, I appreciate that. My problem is not how it was done. My problem isn't even whose fault it is. My problem is, what are we doing today to make sure that it doesn't happen tomorrow?

The Chair: Mr. Sapsford?

Mr. Sapsford: Well, perhaps I'll start. I think the complication from my perspective is that many of the decisions around radiation exposure are professional decisions. As the deputy or as the ministry, it's impossible for me to write a line that directs all professionals in the province to practise this way. Those are professional decisions. The difficulty from my point of view, although I acknowledge it's a responsibility for the ministry to follow up and make sure, as you're suggesting, what ought not to happen doesn't happen, is that I can't simply write a letter and say, "Do it this way." That's where the ministry must of necessity rely on the judgment and advice of the experts in the system.

My first appeal to hospitals was to say, "Review what you're doing." I know, as deputy, they work in a professional environment that says the lowest dose that's possible to get an effect. That's my working assumption as to how the professionals work and practise in Ontario. Now, when there's evidence that it isn't happening that way—that's what our debate is about today—the question is, who responds and how?

The first response, in my view, is from professionals themselves. They have to ask the question: "Is what we're doing, the way we're practising, right?" I suspect that as a result of the auditor's report, those questions are being asked.

The second response is, in my view, from the hospital, "Is the way we're organized and is the operating procedure that we're using in this hospital according to a standard? What is the standard? Is it up to date?" as the doctor has said.

Then the third response, from my perspective, is: What does the ministry have to do to ensure that those responsibilities and accountabilities in fact are taken seriously, they're followed up? That's how I've tried to characterize the ministry's response.

So who responds and how? Each part of the health care system has to respond, and I would argue that you can see that response occurring in an appropriate way, and fourth, where does the responsibility lie?

In my view, when we cross into questions of clinical practice—how much dose, the height and weight, what's the condition, what kind of a picture do we need, what part of the body, how much radiation—those are all clinical decisions that lie in the hands of professionals. I know the doctor can expand on that.

1050

Mr. Hardeman: If I could just go further because, like I say, my concern isn't a ministry concern. I think it is the providers of the service. As we're looking at things that need to be improved and things that need to be done better, I'm sure that the direction that a radiologist has as they're performing the test—I'm sure there's nothing in it that says, "Don't worry about the level of the radiation." It says that there's a certain standard for the different type of patients they're doing. Children get less radiation than a grown person. I'm sure that's presently the practice. The auditor's report says there are cases when that setting is not being properly done when it goes to kids. The college would have some responsibility, I think, as I read in the standards they're responsible for, to monitor, educate and direct the appropriate practising of that exercise. What are we doing if that is happening and we don't know who is doing it and who isn't? Did we notify all these people to say, "This is important. It's not something that sometimes we forget"? Why would it be happening that they're doing it wrong?

Ms. Short: Changes and improvements, though, happen in all parts of the health care system all the time, as you learn new knowledge. I will say that, but I'd ask Dr. Babyn to comment on a couple of things that you've said.

Dr. Babyn: The recognition of the variation between patients and the requirements for doses is something that has been emerging over the last several years. The capabilities of the equipment and improvements that have been made with the automatic dose reductions are again things that have only been brought forward over the last few years, so there is definitely a change for the better and a recognition of these potential capabilities that we can now do. So that is the starting point.

The other is disseminating the information and making sure that each and every time the study is obtained that the lowest dose possible is used. There's a lot of variation between patients, by their size, by their age etc. that we take into consideration and others take into consideration. It's just a question of making sure and being vigilant all the time that each individual patient is considered as an individual and not just a standard that is known and being used because it will produce very decent images.

You have to recognize that for CT, it's sort of like how much light do you need in this room. The question is the light that you may need for a full committee hearing is going to be a different level than if you just need to know if the blinds are open or any other thing. It's very easy with CT to use too low a dose and then you don't get the appropriate medical information, and that is the consideration. It's much more difficult to tell that you used too high a dose for that individual patient. We're trying to find the compromise in the middle of using the right dose for that patient to provide the right information that's needed at that time for that individual patient.

Mr. Hardeman: I have one more on that same topic just so I understand it, because I read the auditor's report and it doesn't say all children are receiving too much radiation for the cause, it just points out that this is happening. The next step, of course, is to reassure the public that every child who has had a CT has not been over-radiated with it; it's just rare cases. I want to know, if we are aware that it's only minimal cases—it just

happened, we found the ones where it was happening—how come we can't find out what caused that to happen? If it's that high a dose, it isn't just making the decision of how much we should use and then finding out that we were a little too high or a little too low. This seems to be that people are not vigilant in rationalizing the use and the patient, and balancing that out.

Have we done anything to point that out to them? This is rather important. I know the people in Oxford county who saw this in the paper have great concerns. The people in this room have great concerns. Do all the people running the CTs have the same concern? Have they been informed that the problem is there, that they need to be more vigilant than they were two months ago?

Mr. Sapsford: Yes, I believe they all share the concern. And as I said in my remarks to your question about this being isolated or not, that's one of my questions. To that end, I'm making sure that we meet with those hospitals to understand in a little more detail what the significance of the results of the audit are for those hospitals. I think at that point, the ministry would be in a better position to judge whether this is more isolated or whether we need to do further work. But that's precisely why I want to have a more detailed discussion with the hospitals about their specific results.

Mr. Hardeman: Just very quickly, Mr. Chair, on the wait times: I can't understand how a patient in a hospital—obviously this is a difference of opinion between the auditor and the ministry—who gets an MRI and is never on a wait list could become part of the wait time.

Mr. Sapsford: Well, the mechanism that—yes, they would be on a wait list. Emergencies, like emergency scans, are obviously not on the wait list, but they're not included in the calculation. For in-patients in hospital, who would be in the next criteria—in other words, the scan has to be done before deterioration—the wait or the benchmark is two days. It's a very short wait, I grant you that, but what we're trying to do is not classify by "in" or "out" but by the clinical necessity of getting the scan in order of priority. Generally speaking, hospital in-patients are sick and hence need access to the diagnostic equipment, not because they're an in-patient but because they need the diagnostic work. That's taken into account in terms of calculating the average, but that's what an average is: We take the full population of patients being scanned and calculate the average. I think what we're reporting publicly, though, is the 90th percentile, which in my view more than compensates for the concern that was expressed about short versus long, meaning an average. We're now reporting the 90th percentile, so that means that this is the time people have to wait until 90% of everybody who's waiting gets access to the scanner, which I think is—

Mr. Hardeman: That's the other half of the question: the 90th percentile. When I'm looking on the website for a place to get the treatment sooner, since I'm looking, is it not almost automatic that I'm in the 10%?

Mr. Sapsford: No. Well, the last 10%—I don't want to get into a statistical discussion necessarily, but the reasons that the last 10% of people wait often has to do with their condition or they're not available or there's a change in the clinical decision about the necessity of it. There are individual reasons. So in terms of the efficiency of this system, which we're trying to measure with this, the accepted standard is to look at the 90th percentile as being those who are truly waiting, with no other intervening factor. This is a reasonable estimate. So it moves away from the argument—I mean, I agree there's an argument about the average, but an average is an average, and we use that in health care a great deal to measure the performance of systems. So it's not so much on any day what that number is, but how that number changes over time. That's really what we're tracking. To give a reasonable representation of the wait time for the public, as I've said, we've chosen to move to the 90th because that does come closer to what's the longest period of time you're likely to wait, as opposed to the shortest period.

1100

The Chair: That was an interesting "one more question." We'll come back to Ms. MacLeod in the next round.

Mr. Patten.

Mr. Richard Patten (Ottawa Centre): Thank you for your presence and your report today. As you rightly identified, the committee did feel that it was important to follow up immediately because of the possibility of public confidence and misrepresentation in the media of what the auditor actually said and what he identified as being of import to continue to run down and track. One of the questions that was raised at our meeting was—first of all, the auditor was reviewing a small number of public hospitals, and he did say, "However, there are some important indicators to follow up on." That's what he said.

I used to work for a children's hospital, as you probably know, at CHEO, as the head of the foundation. I was concerned, so I phoned CHEO and said, "What's the reaction?" They said, "Well, we've had a number of calls from parents being concerned about this." My assumption is that in the area of pediatric excellence, obviously most of that is going to be—that's not to say anything disparaging about the pediatric divisions of general hospitals. But you would expect that the attraction for those who are doing research, because both CHEO and Sick Kids are teaching hospitals—that that's where the expertise is. My suggestion was, "Why don't you offer to the other general hospital pediatric divisions at least your experience heretofore in terms of the range of what you deal with?" My assumption would be that that's where the greatest body of knowledge is, and indeed the indication was that CHEO and Sick Kids were working with the OHA to offer that opportunity and to bring together some of those who—that's number one. I didn't hear anybody comment on that, but it was suggested to me that that's the sort of thing that was going to be happening.

Number two, I had suggested that CHEO might want to do something in its own community if they felt that there was some kind of a questioning of confidence because it would flow over to all the hospitals, particularly for CHEO. Of course, they value their own reputation in that community, and this could get out of hand. I know some of the talk shows love to play this kind of thing up. They can raise doubts in the minds of people unnecessarily.

My question is somewhat related to Mr. Hardeman's and Ms. Martel's, which is that in the immediate case, I can see the ongoing evolution of knowledge and learning with technology, which I appreciate, and that there is a group that's looking at this at periodic points in time. There's some reporting as to, "Okay, now here's what we're going to upgrade," but that's always in evolution, and I do appreciate that. But I guess our immediate concern is what kinds of things can be done to allay the misconceptions and to provide some confidence in the public that we're on to this, we've got the overall picture, and we're doing some things immediately to engender some confidence in the general public.

Ms. Short: I appreciate those comments. That's certainly something we've tried to do through the OHA, and individual hospitals may wish to do that too. But I can assure you that the protocols from Sick Kids and CHEO have been made available. As Dr. Babyn said, that offer has been accepted and they've moved immediately, as the deputy said as well. But perhaps you're right: Maybe more needs to be done by our association or individual hospitals to reassure the public that despite there always being a need to improve, those scans are still an important part of diagnosing illnesses and so on.

The Chair: Are you finished, Mr. Patten?

Interjection.

Dr. Babyn: I'd like to comment that certainly, since the release of the Auditor General's report and as part of our ongoing activities that had already been established amongst the Ontario Children's Health Network and pediatric MRI and CT wait time activity, we have expanded that to make sure that we include the dissemination of information for CT as we move forward in that regard.

All the Ontario Children's Health Network institutions currently have protocols that are pediatric-adjusted. Those are some institutions that certainly do the large bulk of imaging for pediatrics in Ontario, so we can be confident in that. All of them have been willing to disseminate information to their local communities as needed for pediatric adjustment of protocols.

Ms. Monique M. Smith (Nipissing): This is kind of a follow-up to Mr. Patten's question. As we've heard from all the members, there has been a great deal of concern raised, especially around the children's CT question. I know that the auditor has tried his best to control some of that concern with some other interviews where he has pointed out the limitation of the review. But I just wondered—and Ms. Short, you talked about the radio exchange and people getting agitated—where can just normal citizens who have concerns and who have questions about safety and accountability get information? What kind of communication can hospitals do, the ministry? Or where can we point, in our case, constituents who are calling with questions? We'll reassure them as best we can, but where can we point them to as well?

Ms. Short: That's a very good question. These are actually excellent questions. Obviously, Sick Kids and CHEO have always been very good at sharing information. They're very proactive at sharing information. I'm not sure right now whether that kind of information is on the website; I just don't know. We can certainly look at that and do what we can in terms of encouraging hospitals or finding places where the general public can go, which would be the best ones to refer on that issue. So I don't have an answer for you, but I can say that it has raised good points in my mind. Certainly I know that the hospitals themselves are good points of information, but they may not have specific information on this point readily available on their websites at this point, so we'll look at that.

Mr. Sapsford: Advice to individuals: In my view, the first response, where there's a concern about care and treatment that either they or family have received, should be back to their professional, their physician; in the second instance, if it's a concern more broadly about care in an institution, then to the hospital directly. Where it's an individual clinical concern, where someone is concerned about the practice of a physician, then the recourse would be to the College of Physicians and Surgeons of Ontario, the college of medical radiation or, in the final analysis, the ministry fields a lot of questions and concerns to make sure that people are being directed to the right source to get those kinds of questions answered. But if they're concerns about clinical care, generally speaking, information is generally provided by the professional community or, as Ms. Short has said, from the hospital or from the institution where the care is provided.

Ms. Smith: Thanks. Just as a follow-up question, perhaps, Ms. Short, the OHA could look at disseminating some information to all your members that could be posted in the radiology departments or something so that if people come in with their child and have a question, then there is some readily available information there.

Ms. Short: Yes, we could do some Qs & As that could be put on people's websites and so on. Then, as the deputy says, if people have specific issues about what has happened to them during the course of their treatment, I guess they'd have to ask their own individual physician. But people are very used to websites, we find, these days. We'll certainly look at that.

Ms. Smith: Thank you very much.

The Chair: Are there any other questions from the Liberal caucus? Thanks very much. Ms. Martel?

Ms. Martel: Are you next?

Ms. Lisa MacLeod (Nepean–Carleton): You go ahead.

1110

Ms. Martel: Actually, I want to follow up from where Ms. Smith was going, for this reason. We had some constituents who called us and said their children had had CT scans at our local hospital. They called the hospital to ask whether or not they should be concerned and the hospital said, "We weren't part of that report, so don't worry." I thought it was a rather poor way to respond to a family who, I think, is representative of a number of families who have some concerns. I'm not talking about hysterics by any stretch of the imagination, just someone saying, "How can we find out if our child was overexposed?"

My question is, at what point should parents be concerned? I don't know if you can answer that, Dr. Babyn, but if it was one scan, should they be concerned or not? If there have been a number of scans, should they be concerned? Even if their hospital wasn't the one that was highlighted in this report but is a hospital that's providing scans, what kind of information can they get and what can they do? I'm not a medical expert. I have no sense, except from what the auditor reported about, of how challenging this could be, but I would really like to get some information along the lines of, at what point should we be concerned, should parents be concerned, and then where do we go from that?

Dr. Babyn: When you ask individual questions related to a particular family and child, I think you have to look at it from the point of view of what the individual benefits are as well as the individual risks. As we know, all medical procedures, therapeutics, interventions and imaging have risks and they have benefits. Certainly for the individual, the benefits of an appropriately indicated examination far outweigh the future risk, and it is a potential risk to that individual child.

If you look at what we're saying, we have immediate risks from trauma, from whatever the medical condition is that the child required the scan for, to the potential risk 50 years from now that they may have an excess incidence of cancer of one in 2,000, one in 4,000, whatever the dose is. And even if they had a slightly higher dose than expected, there is still a risk. We know that no matter what level of radiation you give, there is a risk for that level of radiation. The higher the dose that you have, so the more examinations you have—it is a higher risk, but at the same time we need to balance that and say the medical benefit from that examination and the potential information that's gleaned from that examination is more than likely in that individual patient to far outweigh the risk in the future.

Ms. Short: And I think it goes back to that point. We will try and gather some pieces of information that we can make readily available using the expertise that we have to give families the best information we can under the circumstances that would reassure people. We will try and do that because I think it has raised so many concerns.

Ms. Martel: I think the issue is not just the benefits versus the risks for parents making that decision. It's also where the decision's already been made because the child has already had the scan.

Ms. Short: Yes, that's right. So we want to put the best information—

Ms. Martel: What does this mean if the scanner was set too high? Actually, that is the nature of the calls that we're getting. I don't know if there is a way to respond to that.

Dr. Babyn: We'll elicit medical physicist help in assessment of risk. But again, it's a relative increase in risk from a very low level to a slightly higher level, and the question is, how do you quantify that? Can you? I don't think there's going to be a satisfactory response for that individual itself.

Ms. Martel: Just with respect to the other hospitals—and the deputy said this is the question, of course, that you were thinking of—is this isolated or not? Did the auditor find the two hospitals where there might be a problem, or did he just find evidence that this is probably more systemic? You did mention that you were going to be meeting with the two hospitals about the specific results and then would decide what to do next. I just wonder if I could get some clarification. What are you looking at when you're talking to those hospitals and how is that more broadly applied with respect to other hospitals that also may be doing pediatric scans? I recognize, Doctor, you talked about the children's network and those institutions doing the bulk of pediatric scans. I don't know what that represents in the system. I don't know how many hospitals that is and how many hospitals outside of that might have been doing scans and whether or not you have that information, and secondly, how relevant that information also is.

Mr. Sapsford: I don't have that offhand, but I can certainly find that out.

In response to your question, I think the ministry needs to know more about the methodology that was used in the actual results. I know that the hospital staff gathered a lot of the information and produced it for the auditor. I'm more interested in what the hospital's response to the results is with respect to their own analysis of what the issue is here. Is this an issue of, "We have a standard but nobody uses it," or is it, "No, we didn't have a standard. Individual professionals make their own decision." I want to understand more about the process in that hospital itself—and that isn't clear in the auditor's report—and then come to some conclusions about whether further examination needs to go beyond that.

Again, I still work with the assumption that all professionals are working within their own expertise to set up norms and standards that are appropriate for that practice. So the question for me is, is this a practice issue, is it an organizational issue, or is it a much broader issue where there's lack of information or knowledge that needs to be filled in.

Another example in the auditor's report is staff not wearing dosimeters. I don't understand that. I don't understand how that would be, based on the practice as I understand it. So it's those kinds of questions that I need

to get more information on in terms of the response and the rationale—what's really going on—because I don't think dosimeter problems is a widespread systemic problem. I do not believe that.

Ms. Martel: I appreciate that work and I appreciate the concern about the professional intervention and are people responding to that appropriately. I do think having some protocols that everyone says are established would go a long way, so I encourage those as soon as possible.

I would appreciate some information around which hospitals do scans. Maybe, Doctor, you can just describe to the committee or to me what the relevance of that would be. If the bulk of these scans were done within the children's network and most of them were using some established protocols, either Sick Kids or CHEO, would that significantly reduce the potential exposure that might have gone on? I don't know if you're in a position to answer that, because I don't know how many hospitals involve the network and what the bulk of the scans would be.

Dr. Babyn: The Ontario Children's Health Network consists of five institutions: the Children's Hospital of Eastern Ontario, the Children's Hospital of Western Ontario, Sick Kids, McMaster as well as Kingston. So those institutions certainly have established protocols for pediatrics. I'm not aware of what percentage of children is done outside of those institutions. I can't comment on that directly. I would imagine that the majority of the younger patients who require more specialized expertise are done within those institutions, and the others are more likely to be adolescents, where the relative risk is reduced and more comparable towards adults. But I can't specifically comment on that further.

Ms. Martel: Those are my questions on those ones.

The Chair: Ms. MacLeod?

Ms. MacLeod: I'd like to welcome both Ron and Hilary to the committee, as well as their colleagues. Thank you very much for today. I know it was short order, because the auditor's report was just released, so I do appreciate you coming under such fire today.

I also want to say thank you to my colleague Shelley Martel. Her line of questioning was very similar to what I was going to ask.

I just wanted to shift gears a bit with respect to both of your deputations, and you in particular, Mr. Sapsford. It's a little confusing. We're talking about different legislative frameworks and who's responsible for whom, and it's very unclear to me who is ultimately responsible for health care in this province. Would you like to clarify that? Because I'm looking at hospitals and clinicians, and at some point the buck has to stop somewhere. One would assume, as a legislator, that it would stop with you and the minister. Would you be able to clarify that for me?

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Mr. Sapsford: The relationship of responsibility and accountability is for the role performed. In this province—well, not this province—in this country, in North America and the western world, the concept of professional practice—an independent practitioner making clinical decisions—is a keystone of our health care system. And so where clinical decisions are being made and treatment applied, it is the professional's responsibility. That's simple and clear. How that practice is then regulated on a professional basis is where our legislative framework through the colleges in the province describes their responsibilities. So where people feel that their diagnosis and treatment is not appropriately managed, then the role of the college takes over.

The responsibility of the ministry is in the framing of how all this legislation works together and in ensuring that it's effectively administered and followed up.

Ms. MacLeod: With respect, I think the Auditor General's report uncovered to myself, as well as to my colleagues and many Ontarians, that the system doesn't seem to be working all that well, when you're getting some children in some hospitals—I just want to quote the auditor's report: "Staff at the two hospitals we visited that performed pediatric CT examinations indicated that, in close to 50% of the selected cases, the appropriate equipment settings for children were not used."

My question to you then becomes: How can this committee and how can this Legislative Assembly ensure that the protocols are being met? Do we have to change laws? Do we have to put in place regulations?

I know that this can be a bit emotional, and I really appreciated the anecdote you were talking about, Ms. Short, with respect to the radio announcers asking parents and getting them all worked up. I'm a parent myself, as is Ms. Martel, Mr. Qaadri and many others here. You get a little bit worried because we're talking about children, and maybe that's why you're getting more media reports and people asking more questions.

As a legislator here, my question is, how do we improve upon this? How, as a Legislative Assembly and as a committee, do we ensure that the proper protocols are put in place?

Mr. Sapsford: Thank you for your question. I hope today that you at least have the beginning of how that response will occur. We're working very closely, as indicated, with hospitals. We need to follow up on the audit report to get more information about whether this is professional, organizational or systemic. I've committed to doing that, because it's not an easy answer, based on what I've seen in the auditor's report.

Whether other legislative intervention is required is a question that's on the ministry's mind. In the discussion with the College of Physicians and Surgeons and the College of Medical Radiation Technologists, that question was laid on the table: What are the colleges going to do in the face of this report? We asked questions such as: Should the colleges go into these hospitals and do more of a professional review?

Their current mandate is really with respect to individual professionals. The auditor's report didn't name people and say, "This person's practice isn't acceptable," so it's difficult for the college to see immediately what their response is.

I don't dispute with you that our system is complicated; I don't dispute any of that. I think the auditor's report has raised a number of issues that we're actively looking at to see what is a better way to respond to some of these questions. I think that's where I see, as deputy, the value of the report, because it's raised questions in a novel way, if I could put it that way. Now we're having to respond to make sure that the system is following up appropriately.

There is a question about the role of the—

Ms. Short: Healing arts radiation commission.

Mr. Sapsford: —healing arts radiation commission around their role with respect to CAT scanning.

The current regulatory framework does not include inspection of CAT scanners. That's a regulatory question, and we're actively looking at that particular part.

I agree with you: We have to do more work to see if there's better follow-up so that our system can work better together. We're looking at this as an opportunity to look for improvement.

Ms. Short: Can I just add something to that? Changing standards and continuing improvement occurs in every aspect of hospitals all the time. It doesn't always occur in the glare of the light of publicity that we've seen as a result of the auditor's report. In surgery, in infection control, in patient safety, for example, hospitals try to improve all the time, working with their practitioners. Today's standards are not yesterday's and they're not tomorrow's. They change all the time. This is a very important area that we have to focus on. Because of public concern, we have to talk more about it and help people understand it. But it occurs all the time. It is complicated but physicians, hospitals, all the partners in the system do try to improve all the time.

If I could answer your question, I think we have a shared responsibility as hospitals, practitioners and the ministry. We try to work together to improve all the time. That's why we take this all very seriously and we're going to try to work our way through it. But it's just one of a myriad of examples where we need to be ever vigilant and to use new knowledge to improve all the time.

Ms. MacLeod: I'd like to go back to the deputy minister's comments where we're not quite clear yet if it's a systemic or an organizational issue. On page 135 of the auditor's report, the auditor cites, "A recent survey of referring pediatricians in the Toronto area found that 94% underestimated the radiation exposure for children from CT examinations." To me, that's one example, right there, of a problem. Do you need this to see the report?

Mr. Sapsford: I remember the statement.

Ms. MacLeod: That is disconcerting to me. I wonder, what steps are you taking right now to ensure that referring pediatricians across the province of Ontario are up to speed on acceptable radiation levels?

Dr. Babyn: Perhaps I can answer that. There was a survey conducted by a member of my staff, Dr. Karen Thomas. As that has just been recently published, we are disseminating that information to all the survey participants, who really are all the pediatricians within the greater Toronto area. Certainly that information can be made available even more broadly throughout Ontario. So we are taking steps to educate our referring physicians and trying to ensure that they have the best understanding of the risks involved.

We are not unique in Ontario for that. This echoes some studies done in adult institutions regarding the understanding of radiation risks and changes over the last few years. The best that we can do to try to educate the upcoming generation of physicians, as well as those who are locally referring to us, is what we're trying to do.

Ms. MacLeod: Just before one final question, I would encourage you to make sure that happens throughout all of Ontario, not just the GTA.

Finally, moving just from referring doctors, what about patients and parents? The auditor's report found that, "Hospital staff indicated that patients were not specifically informed about the radiation risks of CT scans." I'm just wondering, how can a parent or a patient find out about the radiation risks?

Dr. Babyn: You raise a very valid question and one that is being considered as the issue of informed consent. Clearly, as we understand more of the risks of procedures, I think we have an obligation, for example, in CT, to not only discuss the risks of contrast material that may be infused during the study but also the potential risks of radiation.

We have done a survey of institutions and that is not yet standard practice, really, anywhere. It is something that is being developed moving forward and from today, one that we're going to strongly look at implementing for ourselves. But I think informed consent is one of the considerations for that so that parents have an understanding, as well as the children themselves, of what the potential benefits are as well as the risks.

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Ms. MacLeod: Okay. Thank you very much.

The Chair: Can I just ask a supplementary on that? If a child has had a CT scan in the past, is it possible for the parent to find out what the radiation dose was?

Dr. Babyn: I think that is going to depend in large part on when the study was done. There has only recently been the capability for the individual recording of the particular dose on the scanner itself and having that information available, and not all institutions currently record that information. That's something that I know the committee is looking at for the diagnostic imaging safety committee, as to whether that information should be recorded and reference levels established and utilized to make sure that we're in the range.

To answer your question, I can't really say for each individual site, "Yes, it's possible." For certain sites it's certainly possible, but there are a lot of factors that go into what the actual dose is for that individual child, not just the equipment's standard.

Ms. Short: In the future, the electronic health record may help in that regard, but again, it would be patchy right now.

The Chair: But the patient or the guardian of the patient is entitled to that information if they ask for it; correct?

Ms. Short: Yes, absolutely.

Dr. Babyn: Oh, yes.

Ms. Short: Whatever's in the record can be accessed.

Mr. Sapsford: Mr. Chair, just on that question, one of the three hospitals is now giving that information to parents.

The Chair: Good. The auditor had a question here.

Mr. McCarter: I was going to go at the end, but I could ask it now. Dr. Babyn and Ms. Reid, thanks for being here and taking the time. We were interested when we talked to Sick Kids—Sick Kids actually was very proactive. When they would get a CT scan from a referring hospital, if they noticed that the dosage level looked high, they had pretty good packages that they sent out to the referring hospital saying, "You should have a second look at your dosage levels."

My question is directed at getting a feel for the extent of this. I don't know if you have any feel for this, but how often, when you get scans from a referring hospital, would you have a situation where your people would look at it and they'd say, "You know what? This looks higher than the protocol we would use"? Would it be one in 10, one in five, one in 20? Do you have any feel for the range that this would be happening in, where you would be going back to the referring hospital and saying, "Here's some useful guidance that might be helpful"?

Dr. Babyn: We first established this process back in 2001, and since that time we've noticed a steady decline in the number. I don't think that there have been significant numbers in the recent ones that we've seen, so I can't give you an exact number myself.

Mr. McCarter: Okay.

The Chair: Mr. Sapsford, can I ask you when you received information that this was a problem in two hospitals?

Mr. Sapsford: When?

The Chair: Yes. When were you first made aware of that particular problem?

Mr. Sapsford: The process that was used was, the audit draft was completed. It was shared with the hospitals, the hospitals responded, and then it was shared with the ministry. We were given about a week I think, seven days, to respond in general terms to what we saw. It would have been late October—oh, no, it was November.

Mr. McCarter: It might have been late September, perhaps.

Mr. Sapsford: Somewhere around there.

Mr. McCarter: We had finished all of our work at the hospitals and basically had their responses before we provided the draft document to the ministry.

Mr. Sapsford: I have the end of October.

Mr. McCarter: Once again, the auditor is corrected.

The Chair: Did you take immediate action at that point in time to tell the hospitals to deal with the matter? Did you communicate with the rest of the hospitals in Ontario that would be giving children CT scans to improve their practices?

Mr. Sapsford: At that point?

The Chair: Yes.

Mr. Sapsford: No. The first response to hospitals was at the release of the audit report.

The Chair: Why wouldn't you take action right away?

Mr. Sapsford: I think this is an issue around some of the process around the audit itself. Our understanding in the ministry was that the audit was not to be shared publicly until it was released, and so discussion with the individual hospitals was not undertaken until after that. The ministry's response and the way we were approaching it at that point was through the diagnostic safety committee, as we've already outlined.

The Chair: Do we have any further questions? Ms. Martel.

Ms. Martel: It's on a different issue from radiation.

The Chair: Sure. Go ahead.

Ms. Martel: I want to ask some questions about the wait time concerns that were raised by the auditor. I'll be candid with you, Deputy. When I saw the announcement that Senator Kirby was going to be independently reviewing the Auditor General's concerns, I took from that that the ministry either didn't trust or didn't agree with what the auditor had to say. So I'd really like to hear from you as to what it is that Senator Kirby is looking at that may be different from what the auditor actually recommended in terms of next steps.

Mr. Sapsford: Well, it's certainly not to redo the audit. I think our concern is around the measurement itself and the presentation of the measurement, to get an external view from the public perspective as to the adequacy of the measure, how it's calculated and its presentation. With wait lists and the manner in which the information is collected, the rules around it and so forth, we're into statistical techniques that are sometimes difficult to communicate clearly. So it's really around the presentation and to ensure that if there are improvements we can make in that as well as the measurement tool itself, to consider those recommendations and to move forward.

Ms. Martel: Can I just clarify that? I'm not sure that I'm understanding when you were talking about the measurement tool and the presentation. Is it that you disagree with his concerns about the mixing of in-patient and outpatient data. Is that the concern? Is it a concern with the second item that he raised, which was that the starting point for measuring wait times was different even in the hospitals that he was in? When you talk about the presentation and the measurement, what is it that you're referring to specifically?

Mr. Sapsford: I think the overall approach that we're using to reporting waiting times. Typically, you report these kinds of statistics on an average basis. The auditor took some issue with that in terms of whether that is an accurate representation. As I've already said, the ministry had already moved to looking at 90th percentile as a

better way of representing wait times. So it's really simply to review the whole process of public reporting of wait times, the measurement tool itself and the method of presentation.

Ms. Martel: Okay. You referenced what other provinces are doing, that other provinces use averages and that's fine. Maybe that's not the correct—maybe they shouldn't be using averages either; that would be the flip side of the argument for me. So is the ministry going to continue the in-patient-outpatient, or do you think that moving to the 90th percentile as a different measure is going to respond to the concerns that the auditor noted?

Mr. Sapsford: In my view, it does respond to the concerns the auditor has raised, in large measure, because now we are reporting the point at which 90% of the people waiting have in fact received their scan, which is a better representation of the actual time of the wait. So at the 90th percentile, 90% of the people waiting have received their procedure and 10% will wait longer than that. As I've already said, there are a number of factors that go into the wait. There are issues around patient choice, the condition of the patient. Sometimes scans or procedures are booked as routine follow-up beyond the 90th percentile, but those numbers are included as well. Sometimes it's treatment complexities, so the wait is related not to the procedure not being available, but other resources needing to be brought around it, other treatment modalities. All of those factors are embedded in the calculation of it, and, all things considered, reporting at the 90th percentile represents that best.

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Ms. Martel: The second issue: the starting point for measuring wait times.

Mr. Sapsford: The starting point, as it's defined, is the time the decision is made to proceed. In the case of diagnostics, it's when the radiology department receives the order and there's agreement that tests be done. In the case of surgical procedures, as I mentioned, the information system is being put all the way back to surgeons' offices. When they see a patient in their office and make a decision to do the surgical procedure, the surgeon's office is then able to include it on the waiting list from that date. So we've got the earliest possible date: the date of decision that treatment should proceed.

Ms. Martel: Are these new—maybe the word is "definitions"—standard protocols? Or is the problem that you're still getting hospitals doing different things?

Mr. Sapsford: At the time of the auditor's report, as I've said, we didn't have the computer system available. It's only been implemented over the course of the summer. At this point, it's something like 55 or 57 hospitals, representing 90% of the volume. So it's not all hospitals in the province but those that are producing the significant volume. All of those hospitals are now online.

I believe the definitions were there, so it was how it was recorded, because we were doing it essentially when the procedure was done and the original date of booking was included as part of that submission. I believe it's probably, to some degree, errors in reporting or just the way the process had been set up in individual hospitals. But with this new system, a lot of that reporting error should be gone.

Ms. Martel: Let me deal with one other concern that he raises. I think it was 33—he'll correct me if I'm wrong—hospitals that have CT scans and MRIs that don't have to report at all. Was it 33?

Mr. McCarter: I have to check.

Ms. Martel: If you have hospitals that still have the machinery and are actually doing the work and don't have to report, doesn't that skew your numbers?

Mr. Sapsford: You raise a good point. We have started with the hospitals that are receiving additional funding to increase their volumes, and that's the group of hospitals that are being monitored. On the surgical side, as I've said, that's over 90% of the volume. The volume of CT/MRI: I'm not so clear. I can get that information for you, if you wish. But that's where the focus has been, where we achieve the greatest volume of service. The large hospitals that have large volumes is where we've started.

Bear in mind, we've started this process from scratch and we're building this component by component over time. So we've started with the five surgical procedures and CT/MRI in those hospitals where we're providing additional resources to increase those volumes. But we've designed the information system in a way that we can extend it to all surgical cases in all hospitals. It takes time to implement the program, so that would proceed over a period of years until we have a comprehensive reporting system on all surgical waiting times.

Ms. Short: I have to stress again, as I did, that this is a huge step forward that we've embarked on here in Ontario, and a lot of progress has been made in a short space of time. It's immensely complicated. If the committee just remembers that before this time, there was no wait list because all of the individual physicians across the province kept their own wait lists in their own office. There was no ability to compile any wait lists at all. So the fact that we're having this discussion is really about how we can continue to improve the reporting, get better at it and broaden it. I think it's a huge step forward that will be of benefit.

So the glass is half empty, yes. We haven't got it right yet, but there is a great deal of progress being made, which I consider to be very exciting. We need to look at how we do it best, how we get everybody to report consistently and get it all online. But really, at the end of the day, it's a huge step forward and it's a big task we're embarking on together.

Mr. Sapsford: I think another point I'd raise in terms of the data itself is that the ministry has started its own audit process on things like definitions and compliance with it. So as this new information system comes into place, the audit triggers and trails are being established as we go.

Ms. Martel: That audit process will apply to those hospitals that are online right now. When will that start,

an actual group of people who are doing that work, or has it started now?

Mr. Sapsford: No, I don't believe we've done an occasion yet, because many of them are still implementing it, so I would suspect during 2007.

Ms. Martel: I have one final question. When do you expect Senator Kirby to provide you with his report? What's your timeline?

Mr. Sapsford: I would expect a few months. It won't take a great deal of time.

Ms. Martel: I know the auditor told the committee already that he's had a call from Senator Kirby. I'm assuming that whatever he finds is going to go back and forth not just to the ministry, but to the auditor for review as well. Is that the undertaking?

Mr. Sapsford: I don't believe that undertaking has specifically been given, but it's an interesting—

Ms. Martel: How would you like to make that undertaking, Deputy?

Mr. Sapsford: Would you allow me a little time to consider that? But I'll respond to the question.

Ms. Martel: I don't want to undermine anybody, but I've been on this committee for a long time. I usually take what the auditor has to say—both the previous auditor and this current one—with a lot of seriousness. So I was, and I remain, concerned about another review of his work and where that leads. It gives me the impression that someone didn't believe his work.

Mr. Sapsford: If I could help, this is not about redoing the auditor's work. It is a measure of the concern from the auditor's report that the ministry make sure that in its public reporting of wait times, we're doing it in an appropriate, thorough and effective way. It's from the report and the concerns that were identified that the minister decided to do a third party review of the work that we're doing. So I want to make it clear: We're not redoing the auditor's report.

Ms. Martel: I don't think I was suggesting that you're redoing it. It's the implication about whether or not you agree with recommendations or trust the recommendations. I hope that, as Senator Kirby does his work, he's going to continue to have an ongoing relationship as well with the auditor to have these things clarified.

Mr. Sapsford: Fair. I'm not trying to be defensive about this at all. This is a very important program for the ministry and we want to make sure that it's done with public confidence. This is a very serious and honest attempt to ensure that access to these services improves, that the citizens of Ontario have effective access to these and that we have an effective measurement system to monitor it. So it's from the ministry's concern that this is seen to be effective, reliable and valid that we're doing this extra level of due diligence, not from the perspective of, "Oh, we don't agree with the auditor and we need a defence to the auditor's report." I can assure you it's not from that perspective, although I would be happy to debate the meaning of the word "average," what that means and what it doesn't mean. But there's serious intent here.

Ms. Martel: Thank you, Deputy.

The Chair: Can I ask for clarification on your statement, Deputy? The benchmarks for the provision of MRI and CT services: You mentioned priorities 1, 2, 3 and 4. When was that established?

Mr. Sapsford: That was established, I think, late in 2005. This comes partly from the federal-provincial agreement between the provinces and the federal government. Provinces were required to agree to benchmarks in December 2005, and it was at that point that Ontario established, for the five procedures, those categories.

The Chair: Ms. Short, I would like to ask you a question. You were given, as I understand it, a copy of the auditor's report as well, before December.

Ms. Short: Yes.

The Chair: Now, when you saw this particular remark with regard to the radiation levels with children, did your association take any action?

Ms. Short: Absolutely not. We were very pleased to be given the report several days in advance of its release so that we could look at it. We very clearly understood it was confidential. This is the first time, of course, that hospitals have been involved. Hopefully we'll learn from that, and if there are ways we want to do things better, we can do that, but—

The Chair: That's why I mention this.

Ms. Short: We certainly were under the impression that it was to be released on a particular date and it was confidential until then. So if the auditor or you wish to see things done differently, we can do that, but no, we didn't.

Mr. Sapsford: In fact, Mr. Chair, I think—I haven't made any comments today about it because I wish to take it up with the auditor. I think there are some learnings from this first audit of broader public sector institutions and ways that we might improve the overall process and the relationship between all the parties in the future. But I would intend to take that up directly with the auditor and start to talk about next year and the year after that.

The Chair: Any further questions from the committee?

Thank you very much for coming on such short notice, and thank you, Deputy, for the update, in particular with regard to where you stand on each of the recommendations.

The committee continued in closed session at 1152.

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