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A systemic deconstruction of the Canadian tainted blood tragedy

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" the system can have outcomes that no agent in the system intended"
Lant Pritchett

Introduction

In the first installment[1] of this report, we presented, in a very stylized way, the mechanisms at work in modern complex socio-technical systems that might explain why irrational responses to mishaps often transform crises into tragedies, tragedies into scandals, and scandals into miscarriage of justice. We argued that this is what happened in the case of the Canadian tainted blood tragedy.

In the second installment[2], we showed that the four accusations levied against Dr Perrault and colleagues as a result of the Canadian blood tragedy events were ill-founded. Dr Perrault was fully exonerated by Justice Benotto in 2007 of the fourth charge, and the other three accusations were withdrawn, as a result of this acquittal, by the Solicitor General of Ontario. However this left somewhat unresolved the whole issue about the responsibility for this tragedy.

This third installment aims at proposing a systemic explanation of the sources and causes of the Canadian blood tragedy. It builds on a point that we underlined at the end of the second installment about the fact that social scientists and media analysts are not very good at thinking about systems problems. Because they know mostly about objects and agents, they tend to anthropomorphize and personalize systems problems, and to reason as if a system were an agent. This, we propose, has been at the basis of many miscarriages of justice.

In the first part of the present paper, we proceed with a systemic deconstruction of the Canadian tainted blood tragedy. We provide an alternative explanation of the events surrounding this tragedy as not ascribable to individual faults but rather to a cascade of governance failures.

This deconstruction proceeds in two stages: first, we expose four pathologies of governance *internal* to the existing organization of the blood system that contributed to governance failures; second, we identify four pathologies of governance *external* to the blood system *per se* that contributed much more significantly to amplify and exacerbate the tragedy by generating significant governance failures in the way in which the Canadian blood crisis was handled by the institutional context. In our estimation, i*n toto*, these pathologies have generated a cascade of governance failures that provides the bulk of the explanation for the Canadian blood tragedy.

In the second part of the paper, we suggest that those pathologies of governance might have been countered so as to avoid the tragedy, if a systemic perspective had been adopted. The fact that those repairs were not enacted then is regrettable, but it is hoped that our systemic perspective will help ensure that the likelihood of such repairs not being put in place will be greatly reduced, in the event of a new tragedy of this sort. Our optimism is based on the strong contention that, as Edward de Bono puts it, "once a new idea springs into existence, it cannot be unthought".

[1] Gilles Paquet and Roger A. Perrault 2015a. "A cascade of pathologies of governance: the case of the tainted blood tragedy" www.optimumonline.ca 45 (1) 1-10;.
[2] Gilles Paquet and Roger A. Perrault 2015b. "The Canadian tainted blood tragedy: four ill-founded assumptions" www.optimumonline,ca 45 (3) 41-50

Part I Deconstructing the Canadian tainted blood tragedy

A. Toxic internal pathologies

Before World War II, there was no Canadian civilian blood transfusion system. Each hospital was on its own when it came to its blood supply. Given the success of the Canadian Red Cross (CRC) in dealing with the military`s blood supply during the war, provincial governments and hospital associations asked the CRC to extend its work by operating a civilian collection service to meet the needs of both military and civilian hospitals (McDonald 2004:40)[3].

The Canadian Red Cross' Bureau of Transfusion services (CRC-BTS) provided free national blood service for a while. However, as demand grew and transfusion medicine became more sophisticated, the CRC could not continue to supply blood and blood products free of charge to all Canadian hospitals. Provincial and federal governments were pressed to provide financial support. Even though the CRC-BTS had a monopoly on the collection and distribution of blood and blood products, gradually, the provincial governments (responsible for hospitals) and the federal government (responsible for the regulation of pharmaceuticals) became more and more involved in the financing and the regulation of the blood collection and transfusion,. They also became fundamentally involved in the governance of the system. By 1974, the CRC abdicated control "entirely to government" for all practical purposes (p.44).

The sort of shared governance responsibility that ensued made intelligent governance rather difficult.

(1) CRC: imperfect organization with imperfect oversight

The Canadian Red Cross was a complex organization that dealt with a variety of activities including disaster relief, emergency services, water safety services, first aid services, and homemaker services. Despite its social importance, the blood program of the CRC was nothing more than one segment of the CRC, and had only one member out of thirty on the CRC board – a board that therefore did not necessarily have the full expertise to understand the complexity of the blood system.

As part of the constraints imposed on the CRC, as a result of the tutorship of the International Red Cross, it had to be an independent, neutral body, free from government tutelage. Yet, as it became funded and regulated by the provincial and federal governments for its blood collection and distribution, these principles were compromised.

On the one hand, whether the federal government was intimidated by the humanitarian reputation of the CRC or whether it was simply neglectful in its governance duties, the custodial regulation of the CRC by the federal government agencies was characterized by experts as "benign neglect" (McDonald *dixit*). Even though the CRC asked to be regulated, as of 1981, it is not until 1989 that its blood products were. The CRC remained until then solely responsible for the safety and quality assurance of all its operations: collection, testing, processing, storage and distribution of whole blood and its components (McDonald 2004: 54).

On the other hand, from the 1980s on, the Canadian Blood Committee (CBC) – federal and provincial representatives – purported to provide a pseudo-governing framework to ensure that the CRC would fulfil its mandate. It exercised a great deal of control of a micromanagement sort on the CRC – being ferociously stingy every time it came to new financial resources for the BTS, since the cost of the blood program had to be extracted from a fixed financial envelope for hospital funding.

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[3] Adam D. McDonald 2004. *Collaboration, Competition, and Coercion : Canadian Federalism and Blood System Governance*. A thesis for the M.A. Degree in Political Science at the University of Waterloo.

As McDonald concluded, “the Red Cross could not do the job it needed to do under the constraints of the Canadian Blood Committee`s often cumbersome processes“(McDonald 2004: 71).

It is not until 1991, that the CBC was replaced by a supposedly less cumbersome and more effective arrangement – the Canadian Blood Agency.

(2) Federal-provincial quagmire

Even under what seemed to be an improved arrangement with the creation of the Canadian Blood Agency (CBA) in 1991, and the reforms it brought forth, things did not improve.

The structural arrangement between the regulator, operator and funder remained a major source of problems for the blood system. “The Canadian Blood Agency was a creature of the provinces, designed to work on their behalf *to direct* the Red Cross`s blood system from vein to vein (i.e., the recruitment, collection, processing, and distribution of blood and blood products” (McDonald 2004: 73). Since the CBA seemed to have been created solely to act as a way to keep costs under control, safety concerns were bound to arise, and it is not surprising that the CRC would balk at the directives it got from the CBA.

The federal regulator was insistent on safety, but had no role in funding. Provincial authorities wanted lower costs, and did not differentiate between policy directions and specific management issues affecting the safety of blood. The CRC was caught in the middle, and unable to extract satisfactory working arrangements.

This may explain that analysts exploring the tainted blood tragedy found much responsibility to cast around:

> “By the time of the tainted blood scandal, there were so many different groups of people involved in the blood system that it was hard to know who was really in charge. The Red Cross bears partial responsibility for this, but the governments have a much greater culpability; they did not set in place appropriate mechanisms for the governance and funding of Canada`s blood supply, and relied too much on a private organization for managing the blood system. What mechanisms were in place – the Canadian Blood Committee and the Canadian Blood Agency – were ineffective in providing policy direction to the Red Cross, and unable to act without information and orders from their respective provincial governments.
>
> The provinces and territories did not live up to their responsibility to provide adequate health care when it came to the blood system. They and their representatives did not really understand how to manage the Red Cross`s blood program, nor did the representatives have equal power at the boardroom table. The relationships between governments, representatives and the Red Cross were completely dysfunctional; no one was in charge during the 1970s and 1980s” (MacDonald 2004: 120-121).

(3) Resistance, delays and sabotage as transaction costs

As one would expect from such flawed arrangements (and the flawed federal-provincial context in which it was forced to operate), the bureaucratic inertia found much traction. Every occasion for the Red Cross bureaucracy to rein in a line of business that was overwhelming the rest of the organization was effectively used; and every occasion for provincial government representatives to exercise their petty power to scrutinize and to impose delays on an organization that claimed independence while being substantially financed by provincial governments, was also effectively used.

Consequently, one witnessed ever more friction in the governance of what could only be regarded as a blood 'non-system'.

Disagreements were often legitimate but also often a matter of theatrics. For instance, when an effort was made in the 1970s to create a federal-provincial group responsible for governing the blood supply, Quebec pulled out of the Committee and dealt with the Red Cross on its own terms.

It could be concluded that "governments had stopped working together for a common good as they had in the war years and were engaged in direct competition over every tax dollar" (McDonald 2004:60). In fact, inter-provincial squabbles ensured that provinces took over the governance and funding of the blood system but never took responsibility for it: "there was a combination of politics and neglect at work" (p.60).

(4) The precautionary principle

At the very time when the demand for blood grew exponentially, the costs also grew, the governance ran amok, and the explicitly un-assumed overall responsibility for the blood system tended to be perceived as having to be accepted by default by an enfeebled and extraordinarily constrained CRC that was left holding the bag – and later charged by lobby groups, a commission of inquiry, as a result of a RCMP investigation, and by the Sollicitor General of Ontario – in good part as a result of the new rhetoric of the precautionary principle which emerged in the 1970s, and had become part of the culture governance – the sort of amalgam of attitudes, beliefs, conversations and propensities that distills a greater likelihood of being swayed by certain points of view (Bang 2003). [4]

The precautionary principle, as a form of prudence that suggests that one should carefully gauge the full range of possible futures before making a final decision, is laudable. However when such an attitude is not only mandated but judiciarized, and when it is open season to blame experts who may be faulted for sins of omission (i.e., for having failed to be clairvoyant), it becomes very dangerous[5].

Since the 1970s, it has become the new norm in many areas to hold experts criminally responsible for not having been clairvoyant. Indeed, through the activism of lobby groups like the Canadian Hemophilia Society, this new norm has been propagandized and widely diffused in the media. The precautionary principle has become part of the arsenal of interest groups which have argued that not only responsibility should be personalized, but that lack of clairvoyance should be criminally indictable.

In the face of flawed organizations and institutions, and in the presence of irresponsible and opportunistic behavior by many parties – over and beyond the abnormal degree of friction that one would expect in multi-stakeholder complex and uncertain circumstances – the utopian gauge suggested by a radical interpretation of the precautionary principle can only act as a catalyst for unreasonableness.

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The combination of these four pathologies has created serious challenges for those charged with the management of the blood system. Clearly nobody was fully in charge, the different groups involved were motivated by quite different objectives, many parties were using the blood system as a pawn in other games of their own, and there was much uncertainty and ignorance in circumstances that were evolving

[4] Henrik P. Bang 2003. *Governance as Social and Political Communication*. Manchester: Manchester University Press.
[5] François Ewald et al 2001. *Le principe de précaution*. Paris : Presses Universitaires de France.

dramatically in real time. Coordination failed and collaboration was at no time the order of the day. Consequently, it was not surprising that this aggregation of imperfect arrangements generated friction, resistance and delays, and that these toxic arrangements have ultimately proved lethal.

However one major player in the psychodrama that ensued as a result of the tragedy has contributed to aggravate the situation both in the immediacy of the crisis, and in the way in which the follow-up was derailed: the Canadian Hemophilia Society's (CHS) determination to ascribe responsibility for the tragedy to persons – a determination emboldened by the immense difficulty in getting the provincial governments to agree to satisfactory financial compensation for the victims of this tragedy – underpinned relentless understandable lobbying activities at first, but, later, this led to various forms of interventions of a more questionable sort that succeeded in feeding a 'swelling movement' that may be said to have generated a 'perfect storm'. This was chronicled by Michael Orsini (2001, 2002)[6].

B Venomous external pathologies

The whole apparatus of Canadian institutions charged with handling crises and governance failures might have been expected to react to the tainted blood tragedy by reasonably ascertaining the sources and causes of the tragedy, avoiding unwarranted accusations and indictments to be perpetrated, and working hard at revealing the failures in the governing apparatus that might have caused such tragedy so as to be able to put in place more satisfactory arrangements. This was not to be.

(5) The never-ending lobbying of the CHS

The aggressive and very often misguided lobbying of the CHS succeeded, with the complicity of the media, in arousing a burst of sentimentality, grief and guilt in the population. Moreover, it benefited from the complicity of provincial governments in allowing the scapegoating of the CRC and the federal regulators for the tragedy. For the provincial governments, this was not an innocent move. It served to deflect attention from the possibility of any responsibility being ascribed to them in this whole affair. Consequently, a sort of unwarranted implicit consensus emerged on the allocation of blame in the whole affair, and fueled a relentless pursuit of personal indictments of the scapegoated for the tragedy.

The determinant impact of the action of the CHS in all this has been chronicled very well in Orsini for the early period[7]. However the echo effect of this perfect storm in the latter stages of the tragedy cycle has not received full attention. More importantly, maybe, is the failure to notice that the CHS was the agent that kept the 'movement' alive all along: at each stage it ensured that relentless pressure would continue to be exercised to ensure that the pursuit of a criminal indictment of particular persons or groups, that the CHS regarded as responsible for the tragedy, would be kept alive.

The action of the CHS was crucial in feeding the social movement demanding that guilty parties be brought to court. This action received support from the media that transformed this lobby activity into *pouvoir social* in the sense Tocqueville uses the term[8].

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[6] Michael Orsini 2001. *Blood, Blame and belomging: HIV, Hepatitis C, and the Emergrnvr og Tainted Blood Activism in Canada, 1985-2000*. A thesis for the Ph.D. at Carleton University. Michael Orsini 2002. « The Politics of Naming, Blaming, and Claiming : HIV, Hepatitis C and the Emergence of Blood Activism in Canada" *Canadian Journal of Political Science* 35 (3) 475-498.

[7] Even academic studies like Orsini's doctoral thesis would appear to have been swayed by the perfect storm: nobody from the CRC-BTS was interviewed as part of his doctoral study..

[8] Raymond Boudon, a Tocqueville expert, defines *pouvoir social* as "l'ensemble des relaisqui imposent sur tel out el sujet une opinion dominante devant laquelle le pouvoir politique se sent comme paralysé ou qu'il doit du moins tenir pour un paramètre essentiel de son action; devant laquelle la critique est par

A gauge of the strength of the *pouvoir social* wave that carried public opinion in the 1990s is palpable when one reads two of the books (one in English and the other one in French) that were produced by journalists in 1995 (McDuff 1995; Picard 1995).[9]

The cumulative pressure fuelled by the CHS became such that the government felt it could not resist its demand for a commission of inquiry.

(6) The hesitation of the Krever commission

The CHS was at the forefront of the demand for a commission of inquiry when it realized that negotiations would not yield satisfactory results in terms of compensations for the victims by the provinces. And indeed, because of the social climate at the time, the CHS's demand got the support of many groups that felt that they might benefit from it – in particular, the provinces which wanted to escape any possibility of responsibility being directed to them, and were determined to wrestle the blood system they were financing away from the embrace of the CRC.

The CHS and several of its members were given official standing and sustaining funding by the Krever inquiry, and was clearly very influential in the inquiry process.

The nature of a commission of inquiry is to act as a fact finder. However, in this task, it does not operate with the strict procedures of a court of law. The consequence is that what is regarded as acceptable evidence is often evidence that would be rejected by a court of law. The inquiry received testimonies with a great variation in credibility, and suffered from all the flaws that plague such inquiries[10]. In the case of the Krever Commission, it is well known that at least one advisor to the commission resigned because of his unease about the commission's approach. Whether it was because of the influence of the CHS is not clear, but the promiscuity of the CHS (which was clearly on a lynching vendetta) with the commission has been mentioned.

Given the societal pressure on Krever (not only from the CHS but from the whole social movement it initiated), it must be said that inquiry did a creditable job on many fronts. It brought forth many important dimensions of this complex issue, and did not indict the persons and groups targeted by the lobbyists, but it did not exonerate them either.

This hesitation of Krever not to clear the name of those targeted by the lobbyists may be explained by mandate prudence, but it might also be understood as a result of the general zeitgeist of the day that would have accepted with great difficulty a report that would exonerate, on the basis of the Commission's findings, those parties that had been battered for quite a long time in the court of public opinion. This hesitation left the door open for a continuation of the fight for the CHS.

Given the fact that other commissions have gone very much further in ensuring that certain parties would be *de facto* immunized from further action if not officially exonerated, or that commissions have chosen to vindicate the complaints of certain aggrieved parties, it is not clear why certain parties that were shown

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ailleurs impuissante, voire plus ou moins discrètement censurée » (Raymond Boudon 2005. *Tocqueville Aujourd'hui. Paris : Odile Jacob,*168).

[9] Johanne McDuff 1995. *Le sang qui tue.* Montréal : Libre Expression; AndréPicard 1995. *The Gift of Death*. Toronto : HarperCollins.

[10] Ruth Hubbard and Gilles Paquet 2007. *Gomery's Blinders and Canadian Federalism*. Ottawa: The University of Ottawa Press; Daniel Livermore 2010. "The Inquiry Model: Lessons from the O'Connor and Iacabucci Commissions" www.optimumonline.ca 40 (4) 1-28.

to be unjustly targeted by the immense amount of information sifted by the commission, could not legitimately expect that the commission would feel compelled by the complement of evidence it had accumulated to act in a manner that might suppress the odium of additional harassment when the factum would appear to show that those persons were unreasonably targeted.

(7) Determining who should be brought to court

This sin of omission of the Krever Commission was consequential. As soon as the Krever commission tabled its report – in which personal accusations and indictments were not suggested, the CHS sent a letter to the RCMP demanding that police action be initiated to ensure that those persons or groups (that the CHS deemed guilty) should be indicted for the four accusations. It would take some additional 14 years (from 1993 to 2007) before a real court of law would exonerate parties that had been targeted by the CHS.

The RCMP responded by a thorough inquiry that lasted some 5 years, involved some 15 officers, some 700 interviews, two million documents seized, and visits to several countries. Four Crown counsels also worked full time with the squad.

While this investigation was thorough, it was not unfolding in a social vacuum. The relentless pressure of the CHS had elicited much sympathy for the victims in the media and in the population at large. While it is difficult to incontrovertibly establish the impact of this *zeitgeist*, and the pressure for an indictment might have played in the police inquiry, it would be surprising if it had been zero.

In the same way, the presence of members of the Crown counsel crew working full time in the squad may appear incestuous: the police inquiry is supposed to establish whether there is any matter revealing that some indictable act has been committed. Given the dramatic shadow of the victims and of the relentless lobby of the CHS over the police inquiry, and the strong sentiment expressed in the media, one should have felt it imperative to reinforce the wall between the officials of the justice system and the police inquiry.

Whatever this five-year police investigation might have generated – on this we cannot say anything since we have not had access to the full documentation accumulated, and on what has been submitted by the RCMP to the Crown Law Office Criminal (CLOC) – what we know is that there are reasons to believe that the CLOC did not feel completely at ease with the case as presented following the police inquiry. In December 2005, it requested the advice of an international expert (Dr M.N.G. Dukes) as to whether there was enough there to get an indictment. Dr Dukes requested and obtained all the additional material he requested, and provided an Advisory Report on February 12, 2006 (Dukes 2006)[11].

On page 36 of this 41-page report, Dr Dukes, after an extensive review of the files, states unambiguously "I do not believe that there is in the documentary evidence available to me a sufficient basis for the criminal charges against Blood Transfusion Service [of the CRC] and its Director [Dr Perrault]".

Despite this expert advice, the Crown decided to bring the case to Court anyway

The Sollicitor General brought one of four charges itemized by the CHS to court. The case was heard by Justice Benotto and the parties indicted were exonerated on all counts in her judgment in 2007. This led to the other three charges being dropped by the Crown.

Again, it is difficult to believe that the doggedness and obstinateness in pursuing the indictment was not influenced by the broad movement of agitation and *pouvoir social* fueled by the CHS.

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[11] M.N.G Dukes 2006. *Advisory Report* . February 12th. 41p.

(8) All this amounting to an indictment seeking process?

It is difficult to witness this determination to indict (despite the expert advice suggesting that no condemnation is likely to be obtained) without recognizing that it would appear to reveal an undue sensitivity of the *pre-justice system proper* to the pressure emerging from the CHS, the media and public opinion.

What we mean by pre-justice system proper is the whole process from the moment something untoward is noted or denounced to the moment when it is brought in front of a judge. It goes from the fact finding by the police or other means (like commissions of inquiry) through the evaluation of the case by officials of the Crown in order to determine whether or not the matter should be brought to the court.

Ordinarily, one would expect the whole segment of fact finding to be conducted in complete independence, and free from any interference by lobbies or other interested parties; in the same manner, the determination of whether the case should be brought to court or not should be made free of any direct or indirect interference or pressure from the outside – on the sole basis of the facts of the case.

Even though it may be difficult to prove direct interference in this case, it would be difficult to argue that there has not been an impact of the *pouvoir social* on the decision to pursue pugnaciously the effort to indict these individuals, and to bring to court a case that would appear to be groundless.

Much of what we have brought forward in this file may be regarded as not a full proof but only a set of circumstantial evidences. But, as Henry David Thoreau would put it: “Some circumstantial evidence is very strong as when you find a trout in the milk”.

Part II Fighting systemic governance failures

The amalgam of pathologies mentioned in the first part of this paper has revealed a fairly destructive dynamic of governance failure. It is not our intention here to tightly partition the responsibility for the tainted blood tragedy among those different factors, but it should be clear that we surmise that the bulk of the responsibility was borne by the venomous factors. However, we do not ever wish to occlude the portion of the blame ascribable to the toxic factors.

We suggest that the array of eight internal and external pathologies, explored above, has, through the unfolding of four broad perverse forces/mechanisms, generated the tragedy. Indeed, in our view, it is the compounding of these four forces/mechanisms that has produced the *cascade* that transformed the original crisis into a tragedy, the tragedy into a scandal, and the scandal into a miscarriage of justice. Consequently, if our society is to be able to be better prepared for the next crisis of the sort, it must find ways to neutralize these forces, and to find better mechanisms to handle those challenges when our society is confronted with them – which is inevitable.

Without denying the horror and human costs of the original crisis, what we are focusing on here is the *cascade* that may be regarded as the most reprehensible aspect of this tragedy from a governance point of view. For, as we explained in the first instalment of this report, in our world plagued by uncertainty and avalanches, such crises are not predictable and not totally avoidable. The only thing we can hope for is finding better and tractable ways to better limit the damages. In the rest of this sub-section, we identify these four forces/mechanisms that have failed, we show how central these failures have been in the blood tragedy, and we hint at ways to neutralize some of those pathologies.

(1) The unmet challenge of uncertainty governance[12]

The uncertainty that flows from the complexity of our modern world has blown away the simplistic analytical schemes of the past. We have mentioned, in the first instalment of this report, some of the important pathologies of governance that it generated in the form of the Forrester effect (counterintuitive effects of action based on poorly understood socio-technical system), of the Beck effect (prevailing institutions cannot adequately respond in a risk society) and of the Douglas effect (the perverse view that every accident is caused by someone's criminal negligence is no longer tenable).

Recognizing this more enigmatic nature of our world, when it is plagued by deep complexity and deep uncertainty, has triggered a reframing of our way of dealing with governance: from a science of the precise to an approach to the imprecise (Paquet 2013)[13].

More important maybe, the challenges faced by governance are complex in three ways: *dynamically* complex in the sense that problems cannot be addressed piece by piece but by tackling the system as a whole; *socially* complex in the sense that different perspectives and interests prevail and actors themselves must be engaged in resolving these issues not by ignoring them; and *generatively* complex in the sense that the future is undetermined and old best practices are of no help, growing new practices is absolutely necessary (Kahane 2010: 5)[14].

Problem definition becomes more and more murky and ill-structured. Consequently it becomes more and more difficult to *translate* such a situation into a formulation that is analytically tractable, and when such a *translation* is forcefully imposed on the issue, it most often generates a cartoon of a problem definition that has lost in the process most of the substantively interesting and important features of the situation. In such cases, the manufactured version of the situation may appear to be analytically tractable, but the results are irrelevant or even toxic from a practical point of view since the substantial aspects of the case have been lost in the effort to make the problem tractable.

One label has been used to capture the sort of problems generated in such circumstances of deep complexity and deep uncertainty – *wicked problems*. The notion has first been put forward by Rittel and Webber (1973)[15], and has been used in various ways in the public administration literature afterward (Paquet 1991)[16]. It refers to problems where goals and objectives are ill-defined, and means-ends relationships are unclear and unstable.

Wicked problems evade clear definition. Rittel and Webber have defined them by a number of characteristics synthesized by Valerie Brown and further boiled down here as follows:

- they have multiple interpretations from multiple interest groups;
- they involve trade-offs between multiple goals that are often ill-defined and unclear;
- they have no definitive solution;

[12] This sub section draws freely from Gilles Paquet and Christopher Wilson's *Intelligent Governance – A Protocol*. Ottawa : Invenire 2016, chapter 1 (in press)

[13] Gilles Paquet 2013. "La gouvernance, science de l'imprécis" *Organisations &Territoires*, 21 (3), 5-17.

[14] Adam Kahane 2010. *Power and Love – A Theory and Practice of Social Change*. San-Francisco: Berrett-Koehler.

[15] H. Rittel and M. Webber 1973. "Dilemmas in General Theory of Planning" *Policy Sciences* 4, 155-169.

[16] Gilles Paquet 1991. "Policy as Process: Tackling Wicked Problems" in T.J. Courchene et al (eds) *Essays on Canadian Economic Policy*. Kingston: Queen's University School of Policy Studies, 171-186.

- actions on this front lead to unforeseen consequences;
- the means-ends relationships in the actions taken are not stable;
- they are socially complex;
- they rarely sit conveniently within a discipline or organization;
- tackling them involves changes in personal and social behavior;
- they cannot be generalized outside their particular context;
- their formulation rests on paradoxes and call for open inquiries (Brown 2010: 62-63).

Recently, an approach better fit to deal with wicked problems, has been adopted wholeheartedly by the Australian Public Service Commission (2007)[17], and applied to the whole range of national policy decisions with great success. Indeed, it has been made the central feature of the analytical framework of Valerie Brown's research group at the Australian National University (2010)[18].

The general strategy proposed by Valerie Brown (Brown et al 2010: ch. 6) has the great merit of having served as a loose basic conceptual framework on which 15 short studies of wicked problems have been developed, but even more importantly of having been adopted by the Australian Public Service Commission (2007).

Each of the 15 studies starts with five questions:

- what is the wicked problem being addressed?
- what worldviews are involved?
- what ideals, facts and ideas are contributed from the different types of knowledge?
- how have the diverse sources of evidence been brought together?
- what are the partial, uncertain and open-ended findings from the study?

Valerie Brown's approach has proved useful in generating collective, open, imaginative, transdisciplinary inquiries. This is what will be required in the future when faced with the sort of problem that emerged with the tainted blood crisis.

An equally powerful engine of analysis for wicked policy problems has been developed by the Centre on Governance of the University of Ottawa, and has been used to probe effectively a number of wicked problems. [19]

Whether one uses the Australian approach or the Canadian approach, the *soft systems methodology* developed since the blood system tragedy offers promising avenues.[20] But one must admit that such approaches have not permeated yet the conventional ways in which such tragedies are tackled in Canada.

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[17] Australian Public Service Commission 2007. *Tackling Wicked Problems : A Public Policy Perspective*. Canberra: Australian Government.

[18] Brown, Valerie A et al (eds) 2010. *Tackling Wicked Problems –Through the Transdisciplinary Imagination*. New York: Routledge.

[19] Gilles Paquet 2013. "Wicked Problems and Social Learning" in G. Paquet *Tackling Wicked Policy Problems – Equality, Diversity, and Sustainability*. Ottawa: Invenire, 59-92.

[20] Peter Checkland and Jim Scholes 1990. *Soft Systems Methodology in Action*. New York: Wiley.

(2) *Pouvoir social* and scapegoating

Developing a more sophisticated approach embracing uncertainty will not deal with all the pathologies mentioned above. In particular, it may help but may not suffice to counter the turbulence in the social environment that carries with it all sorts of cascades. We mentioned earlier the forces unleashed by the *pouvoir social*, and the tsunami of opinions (not always sound and well grounded) that are imposed on the public on the occasion of tragedies, and that are seemingly indomitable.

This sort of movement, often fueled by the media, also often ends up in scapegoating initiatives, and, in the most chaotic circumstances, in kangaroo courts and expeditious lynching expeditions. While we have not witnessed the most horrific forms of such cascades in Canada, the tainted blood crisis has acquired this sort or momentum, and would appear to have left most actors somewhat unprepared and unable to react in a manner that would have tempered this movement.

In fact, the usual laissez-faire in the face of such cascades, when left unhindered, is likely to have some important consequences through lobbying on the political system, and have echo effects on the justice system.

There is no easy way to interfere with this dynamics of civil society without running into totalitarian tactics that are obviously unacceptable in a democracy. However it is equally unacceptable to allow rumors, malevolent gossips and systematic disinformation being disseminated by calumnious parties to contaminate the forum.

There used to be a time when one could count on a segment of the media to act as agents capable of and interested in disinfecting the debates, and clarifying the issues. One of the main lessons of the tainted blood crisis is that this countervailing power cannot be counted on any longer. In the issue of interest here, the media systematically fanned the flame, and certainly did not inject the sort of critical thinking one would have expected in the debates. And the situation is likely to worsen with the omnipresence of the social media: one may foresee yet more toxic contagion with no self-controlling mechanism in sight.

Consequently, ways will have to be found to avoid allowing organically-emerging or manufactured ill-founded information to dominate the scene and to disempower any rational discourse – obviously without extinguishing the freedom of expression and freedom of the media to disseminate what they think is appropriate.[21]

The irresponsibility and the unaccountability of the media have been denounced by Onora O'Neill and others. As O'Neill said freedom of the press does not require licence to deceive. The same can be said in their realm about lobbyists, politicians, intellectuals, and especially ideologues. For the time being, those persons and institutions, that are responsible for the dissemination of unfounded information or persiflage, and hide behind the freedom of the press and freedom of discussion to deceive and disinform, are quite self-righteous, and there is no appetite even for the very meek criterion proposed by O'Neill – *assessable reasons for trusting and for mistrusting*[22] .

It is imperative that this question be addressed as a matter of priority if the forum is to be cleansed in the sense that Augias' stables needed cleansing.

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[21] Let us not forget that the journalist who manufactured the $1 billion boondoggle at Human Resources Development Canada in Ottawa still writes his column, while many officials have been unwarrantedly excreted from their position, and it meant the end of the road for the Minister.

[22] Onora O'Neill 2003. *A Question of Trust*. Cambridge: Cambridge University Press, 98.

It so happened that in the case of the tainted blood tragedy, Justice Benotto was able to set the record straight. But it took years. Moreover, in the process, reputations were destroyed. Indeed, the choir leaders of the lynching party (who were the loudest voices calling for the punishment of the later exonerated parties in the front pages of the media) have often ensured that the content of the Benotto judgment, and the final outcome of this affair were reported on some back page of the very newspapers that had published the inflammatory accusations on the front page.

There used to be a time, thirty years ago, when we might have felt that competition among the media might suffice, and that the cacophony in the forum would suffice to ensure that the philosophy of "fairly present" would prevail.[23] Our experience since that time, in the blood tragedy file but also in a large number of other files, has transformed our views. It would appear to us now that nothing less than a professionalization of communication would make professionals conscious of what is acceptable, of what is their burden of office, and of the precautions necessary to avoid becoming agents of disinformation. [24]

Unfortunately, we are very far from this sort of responsibilization at this time; and if anything, in our world of moral relativism, truth is what is believed. So there is little in the way of blockage to the unreason of the *pouvoir social* and the *mentir-vrai* of the media. This dark power remains entirely unchecked in a world where the citizen is more and more swamped by the lack of critical thinking and the omnipresence of ideology.

(3) The plight of monopoly and bureaucracy

A central source of the internal failures of the Canadian blood system at the time of blood crisis has been the plight of monopoly and bureaucracy. We have shown earlier how the bureaucratic wrangles generated an extraordinary amount of waste and inefficiency. But another important source of difficulty has been the monopoly position of the CRC. In the United States, where a number of suppliers were competing in the blood market, there may have been, at times, reprehensible tactics, but there was also the constant pressure to offer to the customers a better product. This explains why, in many instances, delays were generated by bureaucrats and regulators in Canada, but did not materialize in the United States. Competition commands that the best quality of product is supplied if a firm is to survive. Consequently innovations were introduced as quickly as feasible, and improved products by one firm forced the other firms to adjust or face failure.

Some may say that we have now in Canada some form of competition between the blood system in Quebec and the one in place in the rest of Canada. We are sure that some emulation has emerged from it. But we are not certain that this has generated the optimal amount of competition as agent of learning and innovation.

As for the bureaucracies, a mammoth effort has been made to respond to the criticisms put forward by the Krever Commission. While the new organizational set-up is perfectible, it may be said to represent a form

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[23] Gilles Paquet 1986. « Requiem pour la normalisation » in Alain Prujiner et al (eds) *Qu'est-ce que la liberté de la presse?* Montréal: Boréal, 71-79. This was a moment when one of us (Gilles Paquet) was deeply involved with the media, and still had the conviction that critical thinking was sufficiently present to ensure that reasonable treatment even of contentious issues. He has now reconsidered his views on the matter as a result of more recent experiences.

[24] This change of mind has been commanded by a significant deterioration of the standards of reporting in good currency and the new hegemony of opinions and *doxa* over the duty of "fairly present" in the recent past. This has reached the point where even at least one editor in chief could claim proudly that he had at critical moments abandoned in good conscience *l'impartialité* in the name of *la cause* (Gilles Paquet 2015. "Failure to Confront" www.optimumonline.ca 45 (3) 16-32). This sort of new betrayal of intellectuals in the world of communication calls for a professionalization of this sort of work (Gilles Paquet 2014. *Communication politique : analyse médiologique*. Ottawa : Centre on Governance (mimeo 128p).

of organization that has been repaired *at the meccano level* to ensure better control and accountabilities without generating the sort of blockages to the management of the blood system that may be said to have been responsible for the earlier catastrophe.

A blueprint for the redesign of the blood system was etched already in the Fall of 1997 when Health Canada announced that it would manage the transition to a new system after the Krever report. A memorandum of understanding (MOU) was prepared in which the federal, provincial and territorial governments recorded their guiding principles and accountabilities, and a transition bureau was created (with representatives from provinces/regions, federal government, and consumer representative).

The MOU reconfirmed the seven principles adopted in 1989, but added four new ones:

- safety must be paramount,
- an integrated approach is essential,
- accountabilities must be clear, and
- the system must be transparent.

It also established the National Blood Authority (NBA) – an incorporated entity with a board, and empowered to borrow money. The NBA is responsible to the Canadian people, its members as provincial and territorial ministers of health play a role similar to shareholders, and their role is to do everything involved with ensuring access to a safe, secure, and affordable blood supply. The NBA was also provided with a mechanism to deal with emergencies.

The Canadian Blood Services (CBS) is a separate corporation charged with the operations of the blood system. Its board is made of contact persons with all the provinces and territories, and the CBS is dedicated only to the collection and distribution of blood and blood products. The Ministers of Health remain responsible for the use of public funds they authorize, but may not direct operational decisions, and the CBS was provided with much management discretion to deal with crises.

On the bureaucratic front, the organization redesign, following the Krever commission, has only done some work to repair the bureaucratic structure of the blood system at the meccano level, but it has not been refurbished in a way that immunizes the system completely from the sort of rigidities at the interface between the policy and the operations levels, and between the diverse Treasury Boards and the financial needs ascertained by the NBA.

(4) Commission of inquiry and the gate keepers to the justice system

The final zone of concern is the detectable promiscuity between the inquiry to establish the facts (by the police and other inquirers) and the decision, on the basis of those facts, to proceed or not with the indictment, and the case being brought to the court.

In the tainted blood tragedy, there seems to have been some *confusion des genres*. Without in any way questioning the role of the police, there seems to have been, according to some of our interviews, more than just a collection of facts. An effort to find the basis for an indictment seemed to have existed. The constant presence of a representative of the Solicitor General in the investigative squadron might explain this bent.

In the same way, the constant presence of lobbyists in the corridors of the commission of inquiry might be regarded as unhealthy.

In both cases, there seems to have been a great deal of prudence not only *not to indict* anyone (which is quite appropriate) but also *not to exonerate* on the basis of the material brought forth by the fact finding. In the case of the police results, an expert was asked to assess the proof by the Solicitor General, but in the case of the Krever inquiry, no such evaluation has been made.

This leads to questions about the role of the gate keeper who has to make a decision as to the next step. While it would appear that some prudence has been exercised by the Solicitor General Office in the aftermath of the RCMP investigation, we remain uncertain as to whether the full extent of what had been revealed by the Krever Commission was brought to bear on the final decision of the Solicitor General, and to what extent the *pouvoir social et politique* and the *zeitgeist* might have been been brought to bear on the final decision to proceed to an indictement.

These speculative notes only point to the need to establish better safeguards to ensure total and complete separation among those different stages from fact finding to indictment to assure fairness to all parties, and to eliminate any question about the possibility that public opinion and the whims of *pouvoir social* might ever have an impact on the decision to indict.

The problem is not academic. Since the Benotto judgment is only one of many cases in Ontario, where courts have thrown out indictments because it found them unwarranted. Given the immense collateral damages created by such “mistakes” (indicting when there is not strong ground to do so), it is crucial to ensure that they are minimized.

Lurking in the background is the possibility of culture governance having an undue impact: possibility that an ideology based on the principle of precaution might find its way to contaminate the all-important decisions of the Solicitor General.

As Justice Benotto says in her judgment: “… to assign blame where none exists is to compound the tragedy”.

This is over and beyond the questions one might reasonably raise about the conduct of the Hamilton trial itself – the trial in front of Justice Benotto that dealt with the fourth charge.

Brian Greenspan (the lawyer for Armour Pharmaceutical Co.) complained about the length of this 17-month trial – unnecessary prolix examinations, and the number of witnesses called by the Crown [the defence called no witness] –“a lot of them were superfluous, unnecessary and extended the trial well beyond what was reasonable”.

David Scott (who defended Dr Furesz) added: “When the public sees that criminal charges have been laid, it assumes that defendants are criminals. An when the court concludes that they are not criminals, the public says the justice system does not work. That`s exactly what happened here.”

The fact that Justice Benotto could say in her judgment that “The allegations of criminal conduct on the part of these men were not only unsupported by the evidence, they were disproved” could only lead some to conclude that “the trial was politically motivated (Earl Levy, lawyer for Rodell) and explain why some defenders have called for a public review.[25]

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[25] Jennifer McPhee 2007. « Public Review Called for in Tainted Blood Case » *Law Times News*, October 15.

This shows that the repairs to the organizational and institutional apparatus in which the tainted blood tragedy evolved are still far from complete. Some aspects of the meccano of governance have been amended, but many other zones of concern remain murky. Consequently, it would be unwise to feel entirely reassured that another crisis of the tainted blood variety would be handled satisfactorily. This remains a work in progress.

But there is little hope that these repairs will be completed, if the difficulties and pathologies raised earlier are not approached with a systemic perspective. On many of the fronts explored in Part II of the paper, this has not been the case.

Conclusion

Most certainly the Canadian blood system is better managed after the modifications that have been implemented as a result of the Krever inquiry. But it is not clear that it is governed in a way that would immunize it from being lethally wounded by another unpredictable event of some consequence. This is because we still are unable to embrace deep uncertainty, and to develop an approach to policy that builds on it.

The same may be said about our inability to deal democratically with emotional and other unreasonable cascades that throw our democratic machinery out of whack.

Finally, we are also unable to approach realistically and critically our elaborate but quite imperfect machinery to handle the problems of responsibility and punishment in a deeply complex world where there is not always one guilty party every time an unfortunate outcome materializes. From fact finding to indictment, too many things can go wrong.

In the tainted blood tragedy and in the case of other wicked problems, we seem to have a propensity to be satisfied with tweaking the management apparatus because it is the easiest thing to do. It may help, but one cannot get rid of the problem of governance failures only by tweaking the meccano. As we have said earlier, a new approach is needed to deal with current wicked problems. Until the sort of revolution in the mind allows this new approach to be in good currency, we will remain saddled with governance failures we are not well equipped to deal with.