



Notes from the Editor-in-Chief

THIS ISSUE of *HealthcarePapers* discusses an increasingly critical topic – the safety of patients in our healthcare system. The topic has been given a variety of labels – “medical error,” “human error,” “preventable clinical incident,” “adverse event.”

Unfortunately, regardless of the label, errors and mistakes do happen, and need to be dealt with in a constructive way. Error equates with pain, suffering and even death for patients and their families; while staff experience guilt and extensive anxiety about how things could have or should have been done. Many countries, particularly Australia, the United Kingdom and the United States, have studied medical error extensively and can provide lessons learned for Canadians as we begin to grapple with this problem.

In the United States, patient safety has received considerable publicity and was made a priority by President Clinton in 1999. The Institute of Medicine’s Committee on Quality of Health Care in America responded with an extensive report on the issue, *To Err Is Human*, in 2000, and this year published, *Crossing the Quality Chasm: A New Health System for the 21st Century*. I was struck by how sensible the recommendations for improving the healthcare system are, as they are outlined in *Crossing the Quality Chasm*. They encompass ideals such as safety, effectiveness, patient-centered care, timeliness, efficiency and equality in healthcare.

As the healthcare system in the United States, the United Kingdom and other developed countries undergo processes of self-examination, it is time for Canadians to do the same. We have no reason to believe that error is not a problem in this country – in fact, recent national headlines would have us believe it is very much an issue. And, we can expect it will receive increasing attention from the media and consumers who will demand action.

Our lead authors, G. Ross Baker and Peter Norton, are Canadian leaders in quality improvement strategies. They are to be commended for putting “errors” at the forefront and initiating this debate. In their paper, they point out the complexities of medical error. It is clear from their work that the topic is of international importance and several countries, including the United Kingdom and the United States, have forged ahead in bringing the subject into public debate. Canada has been slower to embrace the discussion, but the work of Baker and Norton creates an opportunity to move forward assertively.

Error evokes a variety of emotional responses – assigning blame is perhaps the most prevalent. A common second response is to punish those responsible. Although this has been a fairly typical reaction for health professionals around the world, Baker and Norton point out this is not a constructive approach. A more appropriate strategy is to focus on prevention and on finding ways to create a safer environment for patient care. Baker and Norton have outlined a number of recommendations for Canada. The first of these is the notion that health systems managers, policy-makers and academics must

What Patients Should Expect from Their Health Care

- 1. Beyond patient visits:** You will have the care you need when you need it ... *whenever* you need it. You will find help in many forms, not just in face-to-face visits. You will find help on the Internet, on the telephone, from any sources, by many routes, in the form you want it.
- 2. Individualization:** You will be known and respected as an individual. Your choices and preferences will be sought and honored. The usual system of care will meet most of your needs. When your needs are special, the care will adapt to meet you on your own terms.
- 3. Control:** The care system will take control only if and when you freely give permission.
- 4. Information:** You can know what you wish to know, when you wish to know it. Your medical record is yours to keep, to read and to understand. The rule is: "Nothing about you without you."
- 5. Science:** You will have care based on the best available scientific knowledge. The system promises you excellence as its standard. Your care will not vary illogically from doctor to doctor or from place to place. The system will promise you all the care that can help you, and will help you avoid care that cannot help you.
- 6. Safety:** Errors in care will not harm you. You will be safe in the care system.
- 7. Transparency:** Your care will be confidential, but the care system will not keep secrets from you. You can know whatever you wish to know about the care that affects you and your loved ones.
- 8. Anticipation:** Your care will anticipate your needs and will help you find the help you need. You will experience proactive help, not just reactions, to help you restore and maintain your health.
- 9. Value:** Your care will not waste your time or money. You will benefit from constant innovations, which will increase the value of care to you.
- 10. Cooperation:** Those who provide care will cooperate and coordinate their work fully with each other and with you. The walls between professions and institutions will crumble, so that your experiences will become seamless. You will never feel lost.

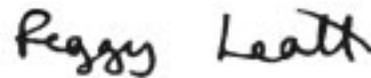
From: Committee on Quality of Health Care in America. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press.

make a strong commitment to action in this area. The authors also call for improved data collection and analysis, wider dissemination of information on medical errors and a change in the system's culture that promotes open disclosure on error rather than blame and finger pointing.

The respondents all agree about the importance of this topic and the need for clarification of the extent of the problem. Esmail suggests that Baker and Norton have not been bold enough in setting forward an action plan. He suggests that an international strategy be developed that draws on several countries' collective experiences. Turnbull, Reinertsen, and Reeder's responses provide excellent perspectives by broadening the discussion to a system level, and by pointing out the importance of creating an organizational culture that is receptive to examination of this topic. Etchells and Bernstein present some live examples and outline constructive actions that can be implemented in

hospitals immediately. Nicklin suggests we apply what we have learned from other areas of health reform, such as restructuring, to create the momentum for organizational change. McKelvey, a lawyer, helps us to keep our feet firmly planted on the ground by pointing out the legal perspective. David U, President of the Institute for Safe Medication Practices Canada, points out the importance of leadership for this area in Canada. Ohlhauser and Sherman build on this to include members of the medical profession. John Millar rounds out the debate by reminding us that patient safety is only one facet (albeit an important one) of the challenges we face in improving the quality and performance of the healthcare system. He makes a plea for better organization of data and the public distribution of information in this area.

I have learned a great deal from the authors and respondents in this issue and have been stimulated to consider the issue from a range of perspectives. This is a critical topic that will be the focus of the discussion on many levels within the system for some time to come. There are no quick solutions, but the earlier we begin to address the issue, the earlier we will experience results.



Peggy Leatt
Editor-in-Chief

Anticipation

Issues in the works: Academic Health Sciences Centres - new roles and opportunities; Human Resource Management - crisis management or new models?; The Right to Choose - consumer choices in healthcare; Drugs - accessibility, availability and appropriateness; Diversity in Healthcare - Are we meeting expectations?; Alternative Therapies/Complementary Medicine - Collaboration? Competition?; Physician Compensation - what's the big deal?

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