

building tightness, the growing use of synthetic materials, and energy conservation measures that reduce the amount of outside air supply,” notes a Health Canada technical guide on Sick Building Syndrome.

“We are developing nausea and headaches and general malaise based on air quality,” says Newton. “We have sick leaves documented, with each staff person away at about 1 day every 2 weeks, and that doesn’t include the 3 o’clock in the afternoon [moment], where your headache is bothering you to the point where you can’t work anymore.”

Worksafe B.C. is monitoring the building, but Newton said remedial measures, such as extending the length of the restaurant ventilation system, have thus far proven inadequate. — Deborah Jones, Vancouver

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Alberta to limit self-regulation

Legislation that would curb self-regulation by 28 health care professions in Alberta will go to second reading this fall — outraging the province’s doctors.

The Alberta Medical Association calls the bill “draconian” and “a threat to self-regulation” that would allow political interference in decisions that should be made only on the basis of evidence and best-practices. “Bill 41 allows the minister to direct the self-regulating body, the College of Physicians and Surgeons, to develop and amend its conduct according to a direction imposed by the minister. It gives him or her the free will to take over the college for no apparent reason,” says incoming President Darryl LaBuick.

But Alberta Health and Wellness spokesperson John Tuckwell says the amendments would merely “allow the minister to step in and make changes where necessary, working collaboratively with the health profession bodies.”

“It’s seen as a last-ditch big stick.”

The bill was drafted following outbreaks of antibiotic-resistant bacteria in medical facilities last spring in the

towns of Vegreville and Lloydminster. An ensuing review called for new standards of practice by all health professions in infection prevention and control. Tuckwell said Alberta Health Minister Dave Hancock, a lawyer, decided to amend the legislation because “public health trumps all.”

During the outbreaks, Hancock “did not have legal authority to step in and make changes where necessary,” Tuckwell said. In Alberta’s 9 health regions, some hospitals are managed by faith-based organizations that “work ostensibly for health regions ... but have a long standing tradition of independence and autonomy, not working well together. ... The minister has proposed provincial standards for infection control [to] help the health professions work together to include these standards across all professions.”

But LaBuick says the changes extend well beyond setting standards. “There’s no restriction to it, there’s no responsibility, no requirement for [regulations] to go through the legislature.” He adds that the Bill 41 would allow such political interference as censorship, for example, of a nurse who speaks out about the effect of funding cuts on patient care.

Outgoing Alberta Medical Association President Gerry Kiefer warned in a Sept. 21 letter to members that the legislation empowers the minister to direct the college of physicians and surgeons “to develop or amend its code of conduct according to direction and directives imposed by the minister, direct the college to make bylaws or regulations directed by the minister and dictate the procedures to be followed in developing said code of conduct, bylaws or regulations. Bill 41 would empower the minister to appoint administrators for a college. The minister or cabinet could impose their direction without any oversight by the Legislative Assembly, and this direction could be imposed without the benefit of a full range of knowledge of the profession impacted.”

The association’s general counsel recently passed a unanimous resolution calling on the minister “to discard the offensive amendments.” — Deborah Jones, Vancouver

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Slouching toward disclosure

The “culture of non-disclosure” about medical errors that has prevailed in Canada for years is finally beginning to change, says the physician in chief of a major Toronto hospital.

The tendency to instantly invoke “shame and blame” where harm has occurred is slowly disappearing, Dr. Wendy Levinson of Sunnybrook Health Sciences Centre told a Canadian Journalism Foundation meeting on reporting medical errors last month.

“But we’re not there yet,” Levinson said, arguing that at least part of the reason that a more open system hasn’t evolved is simply that most health care providers have not been educated about how to disclose. Levinson noted that at a recent hospital meeting, only 2 of 200 health professionals raised their hands in response to her inquiry about whether they’d received training in disclosing errors to patients. Both had been trained in Australia.

That errors happen and patients suffer harm was and is not at issue. Several panelists at the special session referred to a study indicating that between 9250 to 23 750 deaths from adverse events in



Suzanne Tucker / iStockphoto

Medical error, adverse event, harm, critical incident, accident, mishap, etc. — there isn’t even a consensus on the terminology that most aptly should be applied to medical miscues, miscalculations or mistakes.

Canadian hospitals in 2000 could have been prevented (*CMAJ* 2004;170[11]:1678-86).

Attracting an audience that included several people whose relatives had died because of medical mistakes, the panel included nurse Virginia Flintoft, who gave a blow-by-blow description of gaps in care she received for advanced (stage 3) colon cancer. Those included a session with a gastroenterologist who did not take a history or do a physical exam and who failed to schedule a timely colonoscopy, the loss of a key report, being given the wrong drug because another patient in the clinic had the same first name, not being informed about a common (and frighten-

ing) side effect of a drug and having a nurse rush her out of a clinic before her chemotherapy was complete. Flintoft found enrolment in a clinical trial a saving grace, as the research nurse became her system navigator.

Fellow panellist Dr. Terry Sullivan, president of Cancer Care Ontario, agreed that patients in cancer trials benefit from careful monitoring and to that end, his organization provides information to patients on trials for which they might be eligible. But Sullivan warned that to enshrine the idea of system navigators as a way of improving the system is “kind of a declaration of failure.”

System improvements can also come from comparisons, panellists

suggested. “There is nothing more motivating than knowing a colleague does something better,” Levinson said.

An Ontario study of 30-day mortality rates from surgery found the highest rates in the northwest part of the province, Sullivan noted, and the findings led the region’s hospitals to lay out a plan for improvement.

Replacing handwritten prescriptions with a computerized order entry system for cancer chemotherapy has also reduced errors, Sullivan added. About 60% of such prescriptions in Ontario are now ordered using the new system, but the goal is 100%. — Ann Silversides, Toronto

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National guidelines in the offing

The move towards greater openness with patients who have suffered harm from medical treatment is gaining momentum across the country.

National Guidelines for the Disclosure of Adverse Events to patients and families are promised by the Canadian Patient Safety Institute by year’s end, having been under development by a National Disclosure Working Group since the spring of 2006. It’s hoped the guidelines will help regulators implement disclosure policies, practices and training methods across the nation but already some jurisdictions are moving ahead with their own plans. Last year, Alberta finalized a provincial framework on “Disclosure of Harm to Patients and Families.” Both Manitoba and Quebec have laws about disclosure, while an Ontario regulation is to come into force next summer.

The guidelines may also help resolve the rhetorical quagmire that surrounds the development of disclosure policies.

There is a “minefield of definitions,” notes Dr. Ward Flemons, vice-president of quality, safety and health information for the Calgary Health Region. “What you mean by adverse event might be very different from what I mean. ... And medical practitioners get nervous.”

Indeed, across Canada, different jurisdictions use a variety of terms — including medical error, adverse event, harm, critical incident or accident — some of which evoke strong emotional reactions.

Such reactions, and perhaps, more importantly, fear of disciplinary action and lawsuits, are at the root of system’s historic reluctance to inform patients about medical errors, says Phil Hassen, chief executive officer of the Canadian Patient Safety Institute, a not-for-profit organization formed by provincial health ministers in 2003.

But the move towards sharing more information with patients is an important piece in developing a safer health

care system, since more openness and reporting can only lead to system improvements, Hassen said in an interview.

The Canadian Medical Protective Association, which insures doctors in Canada, is also playing a key role in developing the national guidelines. For its part, the association “and doctors in general do not like [the terms] harm, or medical error. We like the term adverse events. And we prefer to say communications rather than disclosure,” says President Dr. William Tucker, arguing that in any formulation of disclosure requirements, it’s vital that health care providers who disclose “be protected from legal and disciplinary consequences.”

Alberta has arguably gone farthest down the road of working through issues around disclosure, in part because of some highly publicized patient deaths caused by “a huge series of errors in central pharmacy,” Flemons notes, adding that greater disclosure is necessary to maintain public trust and confidence. Alberta opted to use the term harm, adopting a definition developed by the College of Physicians and Surgeons of Ontario. The term harm “drives the lawyers crazy — that is where the struggle has been — since they want to make the terms as narrow as possible,” Flemons says. “But we think that is the best patient-focused word. ... It is about if the patient suffers harm, and that may not involve medical error. Our policy is to disclose all harm.” At the same time, Alberta has a “just and trusting culture policy,” Flemons explained, to reassure health care practitioners who do disclose when harm has occurred.

The Calgary health region, considered by many the country’s most progressive, has established disclosure teams and recruited an expert in disclosure to train health care staff. As well, the region created a Patient Family Safety Council, which is an advisory body made up of individuals who have experienced “pretty bad” harm in the health care system. — Ann Silversides, Toronto