of health care and social services (if any) are they entitled? Who is qualified to ascertain the quality of their life?

If we focus solely on monetary issues in discussing this case, does this mean that all decisions about whether or not to treat patients should be based primarily on the expected costs of treatment? We need to consider whether Walker's way of thinking fits with our own attitudes and beliefs about what it means to be a physician.

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Disclosing medical errors

The commentary on disclosing errors to patients by Wendy Levinson and Thomas Gallagher[1] perpetuates the confusion created by others.[2,3] Levinson and Gallagher suggest that errors alone lead to harm; if harm is not caused, it is "by chance or because the error was corrected before harm could occur." Statements like this suggest that they have not based their writing on a model of accident causation, such as Reason's well-referenced "Swiss cheese" model,[4] which describes the complex interplay of the actions of workers, local triggering factors and latent conditions that weaken, breach or bypass defences, thereby contributing to adverse outcomes. Statements such as "some adverse events are preventable — these events can be called errors" are inaccurate; the terms error, adverse event and harm are not synonymous.

Levinson and Gallagher make reference to national guidelines for the disclosure of adverse events that the Canadian Patient Safety Institute is developing with stakeholders "including the Canadian Medical Protective Association and organizations that represent medicine, nursing, pharmacy and health care institutions."[1] We find it curious that patients and their families, the most important stakeholders, are not mentioned in this list. The guidelines use an arbitrarily chosen definition of an adverse event: "an unexpected event in health care delivery that results in harm and is not attributable to a recognized complication."[5] This definition markedly restricts the scope of disclosure and is not patient focused.

For patients, the distinctions between the terms errors, adverse events and unexpected complications are not important. Patients experience harm, and regardless of how members of the health care community and legal profession wish to classify it, patients who have suffered harm expect and deserve a timely, supportive and informative conversation about their concerns. Indeed, in 2003 the College of Physicians and Surgeons of Ontario recognized this with the publication of their policy on disclosure of harm.[6]

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