Notes from the Editor-in-Chief

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In 1999, when Lucian L. Leape, MD, heard then-President Bill Clinton affirm that bad systems – not bad people – cause hundreds of thousands of preventable medical errors every year, the Harvard professor knew he had done his job. "He got it!" Leape said (2004).

Professor Leape was the driving force behind the Institute of Medicine's report *To Err Is Human*, which when published crushed perceptions, not only in the US but also throughout the world, that healthcare systems are safe.

It seems clear that in order to begin to have an impact on the levels of healthcare safety, we must communicate not only with the providers of healthcare but also with the politicians. In this issue of *HealthcarePapers* we build upon the pioneer work of Baker and Norton, who wrote the lead paper for us in 2001 on "Making Patients Safer! Reducing Error in Canadian Healthcare." Since then, the two authors conducted the Canadian Adverse Event Study that was published this year in *CMAJ*.

The lead paper for the current issue is Dr. Matthew Morgan's "In Pursuit of a Safe Canadian Healthcare System," which reviews the state of evidence on a safe Canadian healthcare system. Part of the goal in this issue is to accelerate the action required by all levels of government to pay full attention to the problem of safety in health services in Canada. As a physician, Dr. Morgan is able to provide insights into the extent and seriousness of the problem from a provider perspective. He does an excellent job of describing the need for a Canadian patient safety board as well as the benefits that might be gained from the use of information technology to reduce errors. Specifically he makes a plea for the use of computerized order entry systems that have been shown in the US to reduce errors in hospitals, especially medical errors.

Clearly the problem of patient safety is one of profound interest to both the academic and the practitioner communities in Canada. To some extent Canada has been slow to get off the ground with a focus on errors – other countries such as Australia, the UK and the US have at least a decade of experience as a head start on seriously addressing this issue. Responding to the perspective of Morgan, we have a wide variety of opinions, but clearly all authors are of the opinion that not enough timely action is being taken in Canada.

Michael Guerriere sets the stage for Canada by describing the slow response by Canadians to the epidemic of medical errors. He rightly indicates that Canada has not been willing historically to

invest in health information management at either a provincial or a national level. Richard Alvarez indicates that Infoway is working now in seven areas to improve electronic access to health information in an attempt to reduce errors and improve accurate diagnosis and treatment. Denis Protti sees the problem as a "return on investment" issue to explain why there has been reluctance for governments to pay more attention to the need for electronic records. David Classen points out that in many ways Canada has an easier challenge to introduce an electronic health record because of the funding and structure of healthcare in Canada. Certainly with regionalization of services, albeit incomplete, there might be incredible benefits to a well-organized health information system.

Patrick Binns describes Alberta Wellnet, a provincial project to develop an electronic health record that can provide immediate access to a comprehensive database for patients no matter which region of the province they are located in. Robyn Tamblyn very aptly identifies the problems of safety associated with prescription drugs in the ambulatory setting and some possible information technology solutions to address them.

But in all, these are relatively small and slow achievements. Lucy Savitz in her commentary helps us understand the global nature of the safety problem and indicates that for progress to be made more work needs to be done to define benchmarks for safety and specific national and provincial goals to be achieved. With this in mind G. Ross Baker and Peter G. Norton make a plea for better documentation of adverse events and for decision-makers and policymakers to take the lead to gather information on errors, to publicize them and to take corrective action. In his concluding comments, Morgan aptly summarizes and draws conclusions from all the commentaries.

So as we look ahead, what advice does Lucian Leape have for us? Here are some of the strategies he indicates need to happen:

1. Efforts to computerize patient records and order entry must be implemented quickly – thousands of errors per year might be prevented.
2. Working conditions in hospitals and other health facilities must be improved so that there are a sufficient number and quality of prepared nursing and other staff to ensure a safe environment.
3. Patients should be informed immediately and compassionately when errors are made – full disclosure is essential.
4. A system of no-fault, enterprise responsibility should be put in place to compensate for medical injuries.
5. A federal agency such as the one proposed by Morgan should be established to determine and monitor safety standards.

There is a lot of work to be done for Canada to make headway in the area of patient safety, and every consumer, healthcare provider, executive and policymaker needs to feel that the politicians understand the magnitude of the issue and that they have political support.

References

Leape, Lucian L. 2004. "Learning from Mistakes: Towards Error Free Medicine." *Research in Profile* 11(1)(August). Robert Wood Johnson Foundation.