

By ROBERT RITTER
Executive Director, Newfoundland and Labrador Medical Association

Officials of the Commission of Inquiry on Hormone Receptor Testing announced on January 4 that public hearings have now been postponed to some time in February. But the controversy and accompanying drama are already in full swing. On January 23 and 24, the Newfoundland Supreme Court will hear an appeal from Eastern Health to prevent the Commission of Inquiry from making a number of its internal documents public.

This story is now also playing out in the court of public opinion. In the coming weeks, media outlets will provide a forum for animated discussion on this controversial and complex topic. It will be our collective challenge to ensure these exchanges clarify rather than confuse.

Whatever the specific tasks of the Commission, nobody would disagree that the ultimate purpose of the Inquiry is to ensure that whatever errors occurred in the past do not reoccur in the future. Commissioner Cameron alluded to this in her introductory remarks last September, underscoring the importance of restoring public confidence in the health care system.

The documents in dispute are referred to as “peer review” reports and, at the time they were prepared in 2005 and 2006, were considered “protected” under the Evidence Act, a law that has been around since 1990. The reports were based on reviews by external experts, one a laboratory medicine specialist and the other an experienced lab technician. The peer review critically analyzed the operations of the pathology labs with one sole purpose in mind – to identify and correct weaknesses in the system.

So why is Eastern Health trying to prevent the public disclosure of this information? On the surface, it certainly appears like a cover up. This perception is, of course, reinforced by statements from the Commission’s legal counsel suggesting that denial of full, unfettered access to these documents will obstruct the Commissioner from fulfilling her mandate. But is there more to this story? There certainly is.

The tragic situation in our province, which is currently being investigated by the Commission of Inquiry, is not unique. Over the last decade there has been increasing global awareness that there are many occurrences in which patients are unintentionally harmed in some way by the very system they are turning to for help.

In 2004, an extensive adverse events study was undertaken across five Canadian provinces. It reviewed 3,745 medical charts of patients admitted to acute hospitals for treatment in the year 2000. The research revealed that 7.5 % of these admissions experienced an adverse event and that almost 37% of these events were preventable. Most of these occurrences (64.4%) did not result in patient injury, but 5.2% led to permanent consequences and 1.6% were associated with patients who subsequently died. Research in other countries reveals similar findings. This may paint a bleak picture, but awareness is also the gateway to new hope.

The perils described above have prompted a proliferation of activity around the world over the last decade to develop better ways of reducing adverse events. Here in Canada, there has been

some important progress as well. In 2002, the National Steering Committee on Patient Safety published a report entitled, *Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care*. More than 100 experts in medicine, pharmacy, nursing, law and education participated in the process.

The Committee's work led to the creation of the non-profit Canadian Patient Safety Institute. It developed the *Canadian Root Cause Analysis Framework: A tool for identifying and addressing the root causes of critical incidents in health care* (March 2006). This methodology is based on best practices in use in the United States and the United Kingdom.

During this last decade, as organizations and experts have been working to improve risk management in the health sector, a number of common and widely accepted themes have emerged:

- The treatment of disease is becoming increasingly complex, involving many pieces of equipment and advanced technology, teams of people carrying out multiple tasks, and stressed working environments because of personnel shortages.
- Adverse events are typically a consequence of multiple errors, and past tendencies to focus on individual performance is not as effective as critically assessing and correcting systemic factors that may contribute to human error (root cause analysis).
- Improving risk management will require a co-operative team approach with the willing participation of all the individuals who directly involved in providing care; an atmosphere of punishment or blame will be counterproductive to improving safety.
- Prompt and complete disclosure of adverse events to patients or their authorized representatives is imperative.

In light of the preceding considerations, the National Steering Committee on Patient Safety recommended that government: *“Review and, where applicable, revise the Evidence Act and related legislation within all Canadian jurisdictions to ensure that data and opinions associated with patient-safety and quality improvement discussions, related documentation and reports are protected from disclosure in legal proceedings. The protection would extend to this information when used internally or shared with others for the sole purpose of improving safety and quality. Wording with the applicable Acts should ensure that all facts relating to an adverse event are recorded on a health record that is accessible to the patient or designated next of kin, and are not privileged.”*

The Evidence Act in our province complies fully with the preceding recommendation. It is important to note that the Act contains provisions to ensure that all the facts associated with individual adverse events are properly documented in the patient record. This enables the patient or their counsel to access all relevant information in the event that legal recourse is pursued.

When the peer review process took place in 2005 and 2006, all of the participants in the process were assured that the Evidence Act was in force and a commitment was made by Eastern Health that the reports in question would be “protected”. Since then, in December 2006, government passed the Public Inquiries Act and the Commission's lawyers are demanding the peer review documents on the basis that

this more recent law supercedes the Evidence Act. The Public Inquiries Act has provisions to appeal this demand and Eastern Health has exercised this right.

In contemplating this issue, it is important to remember that while the Commission is an independent and autonomous legal proceeding which is not intended to find fault, looming over it are pending court actions.

Armies of lawyers are already amassed – some to find fault and blame; others to redirect fault and blame; others to deny fault and blame. The process promises to be protracted and will be a source of enormous pain and distress for all concerned – the injured parties, the service providers, the administrators, and even the public bystanders.

The Newfoundland and Labrador Medical Association is one of the parties that has been granted standing for Part II of the Inquiry, the part that deals with policies, health systems and “best practices”. Over the coming weeks we will be preparing a more comprehensive brief for the consideration of the Commission on all of these matters. Our over-riding goal is the same as that of the Commission – to ensure that the errors that may have occurred in the past do not occur again. In moving forward it is of utmost importance that all parties make a consolidated effort to achieve what is in everybody’s best interest – a safer health system. To do so, we need to find a suitable way to harmonize legal imperatives with those of safety.