NATIONAL CONSULTATIVE FORUM

UALITY IN HEALTH CARE SUB-GROUP

REPORT TO THE STEERING GROUP

To: Mr. M Kelly, Chairman, Steering Group

From: Professor G McCarthy

Date: May 15th 2000

On behalf of Quality in Health Care Sub-Group

Dr Neil Brennan	Post Graduate Medical and Dental Board
Cllr Michael Cahill	Chairman, Southern Health Board
Cllr Jim Casey	Chairman, Mid Western Health Board
Mr Eddie Collins-Hughes	Carers Association
Mr John Cooney	CEO, South Eastern Health Board
Professor Denis Cusack	Faculty of Medicine, UCD
Ms Gwen Gunning	Forum of People with Disabilities
Mr Philip Larkin	Irish Association of Palliative Care
Professor Geraldine McCarthy	UCC (Chairperson)
Mr Jim Moore	UCATT
Mr Liam Murray	Irish Institute of Radiography
Ms Mary O'Callaghan	Irish Society of Chartered Physiotherapists
Dr Joan O'Riordan	Irish Blood Transfusion Services
Ms Glynnis Peel	Alliance of Nursing Homes
Ms Muriel Reeves	Barnados
Dr Dermot Walsh	Inspector of Mental Hospitals
Ms Maggie Walsh	Academy of Medical Laboratory Science
Ms Brenda Wheeler	Irish Patients' Association

Introduction

This report is the result of deliberations over three days by the Quality in Health Care Sub-Group. At the outset it is important to note that members felt the time limits imposed on the process were too short to fully consider quality in healthcare and that time did not allow for adequate participation of group members and for reading the materials which members sourced and thought necessary.

Multiple issues were initially discussed including: inequity, partnerships, vulnerable groups, social/psychological and economic barriers to service provision, need assessment and service planning; eligibility for public and private health services; people centered care; evaluation of provision; consumer involvement; professional and organisational accountability; performance measurement; decision making at appropriate levels; performance indicators for patients and health care workers; patients rights and responsibilities and legislation. However, early in the process it was also decided to focus on four specific areas in relation to quality –

- **Safety**
- **Person-focused,**
- **Efficiency and Effectiveness**
- **Equity and Timeliness**

These issues the group felt were ones where significant advances were required in the interest of improving quality for all in the health care system:

STRENGTHS AND WEAKNESSES OF PRESENT HEALTH CARE SYSTEM

STRENGTHS

Considerable strengths in the health care system were recognized. These include: more informed public; expansion/growth in services; entitlements of medical care holders; highly educated, knowledgeable, skilled, and committed health care professionals; regulating bodies such as the Medical Council, An Bord Altranais and professional bodies; national and international movement of staff enriching the service and the introduction of accreditation systems for acute hospital services.

WEAKNESSES

Weaknesses in the system were perceived as: leadership deficits particularly in higher level positions; public/private mix and financial capacity as a determinant in service provision; existence of "islands of excellence" which are neither evaluated or profiled in a systematic manner; individual practitioners fearing the "blame culture" and associated legal action; lack of human and financial resources; inability to control access to services through accident and emergency admissions; lack of medical Consultant delivered and associated personal continuity in delivery of services; information availability through varied mechanisms; inadequate and underdeveloped community services; lack of service integration at various levels and with various authorities; poorly developed management information systems; over management of the health care system moving accountability still further away from the point of care delivery; failure to create an overall equitable and quality driven national health care system. Contributions of service users have not been continually and systematically sought, i.e. patient is not in centre of Health Care system.

OVERALL KEY REQUIREMENTS

Some significant key requirements were considered necessary before quality could be assured. These include:

- A need within all organizations to develop a cultural ethos of quality which should permeate throughout the system
- Building within each organization a stock of expertise and experience with quality methods, by using quality experts, and by developing internal facilitators who can aid and develop managers and team leaders
- A requirement for continuous quality training programme promoting and sensitizing each employee to quality
- The development of skills and systems used comprehensively to collect and utilize data about quality
- A "Patients First" development programme similar to that developed for the Norwegian Health Care system
- Need to set limits and boundaries to what can be delivered as staff are at present struggling to meet demands
- Need to see increased expenditure on health as a necessity and investment

SAFETY

The two specific areas concentrated on in this section relate to: errors including medication errors and performance standards - see attachment 1.

ERRORS

Evidence suggests that significant harm comes to about 1% of those who receive health care. A Harvard study highlights the fact that 50% of errors are drug related. For a fuller treatment of issues, please see attachment 1. There appears to be a growing distrust between Doctor and Patient, which the Steering Group could possibly address. There is a perception that the medico-legal system is used generally to protect the medical practitioners rather than benefit the patient and patients are wary of stigmatization if they pursue litigation. This was perceived as a mis-use of resources. For these issues to be addressed there needs to be:

- A "no blame" culture promoted and supported
- Errors need to be identified and dealt with either through voluntary or statutory reporting systems
- Infrastructure need to be developed
- Mandatory professional education/training

Specific areas, which could be addressed to avoid errors, include

- Development of Information Technology systems which aid doctors with prescribing (drug reaction material) and nurses with drug delivery
- Secure patient I.D. system

Policy Recommendation:

- ***A National Centre for Patient Safety should be established. The Centre should be proactively focused and adequately funded to lead patient safety initiatives.***

This centre could:

- Examine current reporting systems within the context of those existing elsewhere.
- Investigate the requirements for extending Statutory-reporting systems and for the introduction of a more learning focused voluntary reporting system
- Expand systems to include any place where care is given: hospital, community, nursing home etc
- Set national goals for patient safety and track progress in meeting these goals
- Develop knowledge and understanding of errors in health care by research and by evaluating methods for identifying and preventing errors.
- Change the culture from one of "blame" to one of "prevention and learning from mistakes"

The growing distrust between doctor and patient needs to be addressed.

Policy Recommendation:

- ***A Clinical Disputes Commission should be established, consisting of all stakeholders – the judiciary, the legal and medical professions, an ombudsman and patients - to look at reform of the present system where medical errors end in the adversial system i.e. litigation.***

PERFORMANCE STANDARDS

The delivery of a safe, first class health care system is based on the premise that the service is delivered by adequate numbers of highly motivated, skilled and educated health care professionals working in a safe environment.

Most health care professionals are now educated to degree level. Despite the current shortages of health care personnel it is extremely necessary to ensure that non-national professional health care workers recruited meet explicit Irish requirements and standards. If this is not evident they should not be allowed to practice in Ireland.

The process of developing and using standards to help realize expectations for safety and quality among health care providers and consumers alike is critical. There is therefore a need to ensure the development of performance standards against which activities are judged. Setting and enforcing standards for safety through licensing, certification and accreditation can define minimum performance levels for both health care organizations and professionals.

Policy Recommendations:

- ***Professional bodies should be encouraged (and funded) to issue national professional guidelines, standards and protocols***
- ***Continuous professional development (courses, study leave) must be compulsory and resourced***
- ***Legislation should include requirements for relicensing and accreditation of competence***

PERSON - FOCUSED

Health care systems are comprised of people who provide and receive health care. Service users and service providers have different needs and may hold different values. In a quality health care system both users and providers need resourcing in different ways. In this section, the Group decided to focus on four different but interrelated issues: ownership of health, need assessment, access to services and black spots

OWNERSHIP OF HEALTH – FOCUS ON THE INDIVIDUAL

In Ireland we appear to have developed a culture of dependency in the absence of suitable policies promoting alternatives. A recent example discussed by the Working Group regarding nursing home provisions, again appeared to encourage a dependency culture rather than an individual based and community supported initiative.

We recommend a refocusing of responsibility and ownership for health with the individual concerned. To promote this philosophy service users need education and information. Information should be widely available in libraries, GP surgeries, supermarkets, Internet and public accessible "touch screens". Free phone lines need to be manned by informed individuals displaying a customer quality ethos.

Individuals need to be empowered and encouraged to become partners in the maintenance of their own health and treatment when ill. This involves

- Teaching individuals (at a young age) to seek out information and to understand health and its determinants before they get ill.
- Promoting/ensuring partnerships with recipients of health care
- Consultant delivered rather that consultant led services

Policy Recommendation:

- ***Refocusing ownership for health with individuals through a variety of initiatives including expansion of health promotion units, improving collaborative efforts to educate school children at primary and secondary levels, and interaction with non-statutory organizations as appropriate (ref. World Medical Association; Declaration of Lisbon on the Rights of the Patient).***

NEED ASSESSMENT

The Working Group felt that individual need assessment is not performed adequately or collaboratively. The elderly and individual with disabilities were seen as being particularly disadvantaged.
Requirements are for:

- Structures to collect views of patients/advocates at health board and institutional levels
- Independent advocates to assist individuals requiring services to assemble a package of care
- Assessment data (from every source-where multiple resources are required e.g. health, education, social, community and family affairs) stored on a passport of care

- Right to an independent assessment of needs and follow up evaluation to ensure that identified needs are met
- Coordinated service planning
- Key worker involvement to ensure continuity of care

There was also a perception that those who work for the health services have needs and that a quality service cannot be given without provision of a quality working environment. Poor working conditions for healthcare workers may lead to high turnover rates and consequential deleterious effects on standards of care and staff morale.

Policy Recommendations:

- ***A Healthcare Bill of Rights for users and providers , which focuses on the rights and duties of everyone, involved***
- ***A healthcare ombudsman should be appointed to deal with grievances on behalf of users and providers of the health services***
- ***Integration of needs assessment involving multi-disciplinary and multi-sectoral input to create a unique passport to services for each individual***
- ***Integrated multidisciplinary care plans and shared care records***
- ***Optimal Information and Communication Technology (ICT) systems for the provision of computerized records***
- ***The use of REACH should be considered as the mechanism to coordinate multi-sectoral services as it is mandated to integrate service delivery and capture personal information once, sharing it with all relevant agencies, subject to the agreement of the service user.***
- ***Improved integration of community care services to reduce strain on acute and limited facilities***
- ***Strengthening of interface between community and hospital services***
- ***equipment availability for the provision of quality care to passport holder***
- ***Streamlining Coroner Reporting mechanisms through just one rather then two Departments (Health and Children and Justice)***
- ***Staff retention strategies including self governance and improving professional practice environment***

ACCESS TO SERVICES

There was recognition that demand for services has continually increased and that the phenomena of entering hospital through accident and emergency departments (the only sure route available) is growing. The group felt that quality health care is impossible when the system is crisis driven, when staff work at a frenetic pace and when the service is not patient focused. There appears to be an apparent lack of forward planning and crisis management has become commonplace. The response seems to be appoint more consultants and open more acute beds. The Group were not convinced that this was the best option. Rather we suggest that policy should focus on alternatives.

Policy Recommendations:

- ***That the inequality in access to services be addressed through a truly community focused and resourced service. This may mean the establishment of community services on a statutory basis and the reallocation of resources to meet need.***
- ***Accident and Emergency Departments be staffed by Consultant Medical Staff, clinical nurse specialists and others (as required) over the 24 hour period to deliver a more appropriate service.***
- ***Expansion of out-patient and ambulatory services should be prioritised.***

Black spots

The Group discussed many perceived black spots in service provision. However as choices need to be made it was suggested that there should be a focus on:

- Adolescence services - appropriate placements and long term psychiatric provision
- People with disabilities
- rehabilitation
- Continuing care for elderly
- Young chronic sick
- Multi-ethnic groups

Policy Recommendations:

- ***Review of services for adolescents, those with disabilities, elderly, young chronic sick and ethnic minority groups - nationally and derivation of policies to deal with requirements.***
- ***Greatly increased resources for independent living supports to be made available as needed.***

EFFECTIVENESS AND EFFICIENCY

Pertinent management structures and systems are required including sufficient numbers of qualified professional managers-profession specific. Overall the group felt that there has been over the last few years a considerable increase in the number of managers and administrators in the health care system. It was felt that this had not made the system more effective or efficient and that there should be a redistribution of resources away from management/administration to the delivers of services.

The 1997 Statement of Strategy (p11) recommends "greater recognition of the key role of those who provide the service and the importance of enabling them to do so to their full potential". This tenet is also explicit in the Clinicians in Management Strategy. It suggested greater devolution of management decision-making. From the perspective of group members this has not happened in practice and more autonomy has not been given to health care professionals who should be acknowledged as experts in their own areas.

Policy Recommendation:

- ***Professional management must be promoted and decision-making must contain authority and autonomy. A consequence for professionals may be an increase in self-esteem and job satisfaction and promotion of retention of well-motivated staff.***

For the health care system to be effective and efficient individual patient needs assessed as valid should be met. However to respond from a community focused perspective it is suggested that:

Policy Recommendation:

- ***GP's should be given better and faster access to diagnostic services; technology necessary be made readily available, community based and resourced.***

Highly skilled and educated staff delivering evidence based practice is essential. Guidance on the management of individual conditions should be available.

Policy Recommendation:

- ***Case management/care planning become the norm with multiprofessional assessment as required and critical appraisal of clinical interventions based on evidence based practices.***

As a consequence of the worldwide shortages in all health care professions, an ever-increasing demand for services is impossible to meet.

Policy Recommendations:

- ***Scarce resources should not be wasted on treatments and procedures that do not alter patient management or outcomes.***
- ***Clinical pathways of care should be recommended and packages of care agreed.***
- ***All health service IT systems should be capable of running a common programme to collect statistical data which would highlight divergences etc.***

The provision of specialised services and equipment is perceived as unevenly distributed. These services and equipment should be geographically related to catchment areas.

Policy Recommendation:

- *Ideally a service should be a centre of excellence and should not be replicated in any one area before all geographic areas have the service.*

OVERALL POLICY IMPLICATIONS:

- *Establish National Institute of Clinical Excellence*
- *Review of healthcare management structures and processes*
- *Recognition of professional managers invested with decision-making and autonomy*
- *Greater allocation of resources to community facilities allowing more patients to be treated in the community*
- *Establish research based pathways of care*
- *Promote more research into effectiveness of health provision*

EQUITY AND TIMELINESS

Equity infers fair and available quality health care for all, regardless of social or economic status. The sub-group contends that the provision of appropriate health care should be available to those who need it when they need it.

By timely we mean the prevention of illness and early diagnosis and intervention. This is necessary as delayed services may ultimately result in condition deterioration and unnecessary use of vital resources both human and financial. It is proposed that anticipatory action for chronic conditions can result in more effective treatments. The potential for community services for early detection and intervention is currently under-resourced and under-developed. Attention to this could be key in enhancing quality.

The "two tier system", the phenomena of emergency admissions taking precedence over planned admissions (in the public health care system) and the fact that there is no statutory right to community services were the main issues addressed by the sub-group in this section.

TWO TIER SYSTEM

While health care policy attests to the fact that everyone is entitled to free and equitable care there was a general consensus by the group that this did not happen. It was felt that there are inadequate bed management policies for emergency services and that irrespective of increases in bed numbers that these will automatically fill. The health service is perceived as predominantly a crisis service. This has forced many of the population to buy private health insurance. A two tier health care system has evolved and those who can afford to pay insurance premiums have access to better health care that is perceived as having a higher quality leading to an inequitable situation

The Working Group felt that there should be a basic minimum health care provision for every citizen. If the state accepts this, then it has to provide the most effective care in the most appropriate setting.

The following is required:

- Clarity on the meaning of equity as it it is used relating to the principles and policy statements from the Department of Health and Children
- The Steering Group should seriously examine private and public elements separately and comparisons should be made with the Canadian model of health care and others with a view to restructuring
- Examine the possibility of consultants or private insurers paying the real costs of treating private patients in public facilities
- There should be a direct correlation between public private mix as practiced by Medical Consultants holding consultant positions in the public health services. This would ensure that all citizens be placed on a waiting list in proportion to an agreed and equitable private/public mix and clinical need.
- Inequality in provision of services based on age only should be examined.
- The Nursing Home Subvention Scheme should be transferred to a community-based scheme with payment made directly to the patient.

Policy Recommendations:

- *Amendment to present means testing system*
- *Establishment of an equitable national health system with division between public and private medicine*
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- *Emphasis placed on the development and maintenance of community services*
- *In view of the expected increase in population figures of over 65 year olds, adequate services for older persons need to be prioritised (community / domiciliary services, respite, sheltered accommodation, nursing homes and acute intervention in hospitals) and policy should drive this initiative in a proactive and rapid manner. The excellent work of the National Council on Ageing and Older Persons provides a sound basis for this policy.*

CONCLUDING REMARKS

The Working Group is pleased to submit this report to the Steering Committee and hope that it will influence in some way the principles and policies underpinning the New Health Strategy. Unfortunately time constraints imposed have impeded a fuller and more exhaustive examination by the group on aspects of its remit.

FINAL RECOMMENDATION

- **That formal arrangements be made for at least an Annual Review of the New Health Strategy by an independent authoritative body reporting publicly on implementation progress.**

ATTACHMENT 1

Additional information re: Safety

Preventing Injury from Medical Errors

Two issues that commonly arise in both medical and lay literature are the terms errors and adverse events. While they tend to be used interchangeably, they differ significantly.
An error is the failure of a planned action to be completed as intended (i.e. error of execution, 'slips of action' or 'lapses of memory') or the use of a wrong plan to achieve an aim (i.e. error of planning, 'mistakes')[1,2]. The likelihood of slips and lapses increases when people are tired, stressed, distracted, or in unfamiliar surroundings, almost a caricature of medical life [2,3].
An adverse event is an injury caused by medical management rather than the underlying condition of the patient. Not all adverse events are the result of error. An adverse event attributable to error is a 'preventable adverse event'[1].

Two studies - the Harvard Medical Practice Study about adverse events published in 1991[4] and a similar 1992 study[5] of patients in Colorado and Utah medical centers found that adverse events occurred in 3.7% and 2.9% of hospitalisations, respectively. In Colorado and Utah hospitals, 6.6% of adverse events led to death as compared with 13.6% in New York hospitals. In both of these studies, over half of these adverse events resulted from medical errors and could have been prevented. Critics of these studies state that they were not designed to describe causal relationships; that the Harvard study contained no information about the baseline mortality risks the patients presented on admission to the hospital or before suffering adverse events[6]. Furthermore the study did not compare the mortality rate in this patient group to that in a control group consisting of individuals with similar health risks who had suffered no adverse events[6]. Given the limitations of the studies there is however a consensus that error is common in the delivery of health care. This is hardly surprising given that the health care system, with its complex interactions between patients, their disease processes, medical and other staff, hospital and community environments, infrastructure, equipment, policies and procedures, is a risk laden activity. Added to this is the rapid change in medicine today. At no time in the history of medicine has the growth in knowledge and technologies been more profound. As medical science and technology have advanced at a rapid pace, however, the health care delivery system has floundered in its ability to provide consistently high-quality care to all citizens[7]. The frustrations of patients and clinicians have probably never been higher.

The majority of medical errors do not result from individual recklessness, but from basic flaws in the way the health system is organised. Safety flaws are unacceptably common, but the effective remedy is not to browbeat the health care workforce by asking them to try harder to give safe care[7] and by suing the unfortunate nurse, junior doctor or consultant who are blamed for an inadequate system. Members of the health care workforce are already trying hard to give safe care. In fact, the courage, hard work and commitment of doctors, nurses and others in health care are today the only real means we have of stemming the flood of errors that are latent in our health care systems[7]. As Lucien Leape of the Harvard School of Public Health has said, '....errors are rarely due to carelessness.....Rather, they result from defects in the design and conditions of medical work that lead careful, competent, caring physicians and nurses to make mistakes that are no different from the simple mistakes people make every

day, but that can have devastating consequences for patients. Errors result from faulty systems, not from faulty people, so it is the systems that must be fixed. Errors are excusable; ignoring them is not'[8].

Voluntary error reporting systems: learning from mistakes

A critical component of a comprehensive strategy to improve patient safety is to create an environment that encourages organisations to identify errors, evaluate causes and take appropriate actions to improve performance in the future. The goal of reporting systems and risk management is not data collection but to analyse the information they gather and identify ways to prevent future errors from occurring[1]. A continuum of cascade effects exists from apparently trivial incidents to near misses and full blown adverse events. The same patterns of causes of failure and their relations precede adverse events and near misses[9,10,11]. Only the presence or absence of recovery mechanisms determines the actual outcome. Schemes for reporting near misses, 'close calls' or 'sentinel' (warning) events have been institutionalised in aviation, nuclear power technology, petrochemical industry, military operations and air transportation[9]. In medicine, the blame culture and litigation and liability issues are powerful disincentives to reporting adverse events or near misses. The Institute of Medicine in its recent report recommends federal legislation in the US to protect the confidentiality of certain information on medical mistakes that have no serious consequences, where the information is collected and analysed solely for the purpose of improving safety and quality[1]. This would encourage the growth of voluntary, confidential reporting systems so that practitioners and health care organisations can correct problems before serious harm occurs. In Australia quality assurance initiatives can be undertaken in the long term best interests of patients[12]. The Health Insurance (Quality Assurance Confidentiality) amendment Act 1992 offers legal privilege to qualifying clinical audit and risk management documentation[12]. Notably, medicolegal safety is cited as an important ingredient in the success of the Australian incident monitoring study, in which clinicians across the Australian anaesthetic community combined to produce contemporaneous reports of 'near-miss' and actual adverse events [12,13].

By European standards Ireland experiences a very high level of medical litigation[14]. The growing distrust between doctor and patient in this country could be addressed by establishing a Clinical Disputes Commission consisting of all stakeholders - the judiciary, the legal and medical profession, an ombudsman and patients - to look at reform of the present system where medical errors end in the adversarial system i.e. litigation. Such a health care disputes forum could produce a robust complaints procedure linked with the health Ombudsman. There has to be a balance in the regulations between an appropriate level of public accountability of health care and the concerns of the medical profession for the provision of an appropriate level of confidentiality for information gathered for the purpose of safety.

Building a culture of safety; using information technology

Building a culture of safety means designing systems geared to preventing, detecting, and minimizing hazards and the likelihood of error - not attaching blame to individuals. The use of tools to organise and deliver care has lagged far behind biomedical and clinical knowledge[7]. Health care has safety and quality problems because it relies on outmoded

systems of work. Poor designs set the workforce up to fail, regardless of how hard they try. If we want safer, higher-quality care, we will need to have redesigned systems of care, including the use of information technology to support clinical and administrative processes[7].
Medication errors occur frequently in hospitals, yet many are not making use of known methods for improving safety. All hospitals and health care organisations should implement proven medication safety practices, such as using automated drug-ordering systems which can reduce errors in prescribing and dosing drugs. With a blood transfusion the greatest risk is receiving the wrong blood which can have fatal consequences. In many hospitals there is no secure patient ID. Errors of misidentification of patients could be corrected by using secure I.T. systems of identification. Computerized reminders can help both patients and clinicians identify needed services. Information technology must play a central role in the redesign of the health care system if a substantial improvement in quality is to be achieved[7].

Performance, professionals, accreditation

A further challenge is to manage the growing knowledge base and ensure that all those in the health care workforce have the skills they need[7]. The role of the learned colleges and professional bodies in certification and credentialing and re-accreditation should be supported. As part of alternate disputes forum a form of competence assurance is needed from the Medical Council, the statuary body responsible for registration, in conjunction with the professional bodies. Accreditation or certification of health care organisations should be encouraged.

All organisations can improve their performance only by incorporating care process and outcome measures into their daily work[7]. The purpose of clinical audit, through structured peer review, is to improve performance in one area. Clinical audit compares service provision against agreed clinical standards to identify whether individual standards have been met and, where they have not been, why not?
Clinical audit should apply to all who work in the Healthcare service, not just doctors and other health care professionals but also managers, ministers, civil servants.

Advance the effectiveness of teams.
The work of teams is often slowed or stymied by institutional, labour, and financial structures[7]. Clinical teams must work more effectively so that individuals are taking fewer decisions in isolation. The right infrastructure must be in place; information technology, access to evidence, and education and training as well as some protected time for individuals and teams to think about the quality of their services, review data, appraise evidence, and plan improvements[15]. Health care alone refuses to accept what other hazardous industries recognised long ago: safe performance cannot be expected from workers who are sleep deprived, who work double or triple shifts, or whose job designs involve multiple competing urgent priorities[16].

National Centre for Patient Safety

A National Centre for Patient Safety similar to that recommended by the Institute of Medicine in the United States should be established in this country. Such a body could:

- devise voluntary reporting systems
- set goals for patient safety, track progress in meeting these goals
- develop knowledge and understanding of errors in health care by research, by evaluating methods for identifying and preventing errors.
- be proactive with adequate funding to make the centre a lead to patient safety.

Conclusion

Improved performance will depend on new system designs. Such systems must facilitate the application of scientific knowledge to practice and provide clinicians with the tools and supports necessary to deliver evidence-based care consistently and safely. Carefully designed, evidence-based care processes, supported by automated clinical information and decision support systems, offer the greatest promise of achieving the best outcomes from medical care[7].

A new understanding must be struck between doctors as health care providers and the public as recipients of that care. Central to this understanding are the following which both patients and doctors know[17]:
Death, sickness, and pain are part of life
Medicine has limited powers, particularly to solve social problems and is risky
Doctors don't know everything: they need decision making and psychological support
We're in this together
Patients can't leave problems to doctors
Doctors should be open about their limitations
Politicians should refrain from extravagant promises and concentrate on reality.

Dr Joan O'Riordan
May 2001

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