



Patient safety deserves better response

In Wayne Kondro's article¹ about our report to Health Canada on governance for patient safety,² Ross Baker suggests that a national patient safety agency probably isn't feasible in Canada because jurisdiction over health care is fractured. But surely that doesn't mean it is not worth doing.

It did not take very long for either the Public Health Agency of Canada (PHAC) or the Health Council of Canada to be set up. Given that the Canadian Patient Safety Institute already exists, changing its name to the Canadian Patient Safety Agency, changing its position within the Health Canada organizational chart and clarifying its mandate should not be difficult. The main point is that Canada, like other countries, has a patient safety problem of sufficient magnitude to deserve a substantive national response. The current agenda for patient safety is itself fragmented and piecemeal precisely because there is no guiding agency to coordinate the work being done.

The PHAC was set up because of the SARS crisis in Toronto, the Walkerton problem and the threat of other infections (e.g., avian flu), none of which has had the impact that adverse events have every day in Canada. Its mandate is to provide, in collaboration with the provinces and territories, a coordinated response to these threats. To date there appears to be little concern over the

complexities of PHAC's relationships with other jurisdictional bodies.

It seems to us that if there is a will to create a more comprehensive agency to tackle the problem of adverse events, a way can be found to do so. We do our patients and their families a disservice if we fail to ensure, to the degree possible, patient safety in our hospitals and other health care facilities and programs.

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REFERENCES

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End-of-life care in Canada

In their article about end-of-life care, Daren Heyland and associates¹ conclude that trusting, communicative relationships between physicians and seriously ill patients and family members are key to quality end-of-life care, but they offer few suggestions on establishing such relationships; instead, they advocate more research.

Educational programs to promote communication between health practitioners and dying patients already exist and appear to improve attitudes toward and engagement with those who are dying.²⁻⁴ Physicians without such training, however, may avoid end-of-life discussions because of time constraints, financial disincentives, concerns about legal implications or the feeling that they are inadequately prepared.^{5,6} Families may not even realize that they have a choice about life-support measures unless they inform themselves about their loved one's condition and assertively insist upon discussions with

the responsible physician; as such, there may be inadvertent discrimination against less educated or acculturated families.

The authors' statements questioning the value of living wills and additional home care capacity¹ may also be misleading. Their findings suggest, rather, that such measures are inadequate. Trained professionals are needed, for example, to help families decide when to honour living wills — when to allow more time on life support in case meaningful recovery is possible, and when it is medically reasonable to stop; when to continue treatment in an acute care hospital as opposed to a chronic care facility or at home. Near the end of a person's life, emotions run high and discerning what is reasonable is often difficult without the help of professionals.

In addition, "quality end-of-life care" is not dictated entirely by physician-patient relationships. Hospital support is needed to implement palliative care appropriately⁵ and to ensure consistency of care. Patients staying on units where death occurs infrequently, for example, may not receive the same standard of care as those staying on oncology units, where staff are typically better trained in palliative measures. Palliative care may be interpreted as "no care" in some settings, which can result in dying patients spending their final hours unkempt, uncomfortable and alone. Tailored care may also be difficult to achieve when hospital policies are rigidly applied, as when (for example) family members are prevented from visiting, without regard for the dying patient's wishes or well-being.

Practical suggestions consistent with this study's findings might include training in end-of-life care at the undergraduate and graduate levels for all medical personnel, ensuring adequate compensation for this often time-consuming work, hospital-wide minimum standards for palliative care, guidelines for tailoring of care in end-of-life situations and hospital-wide ac-