Letters

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No-fault compensation systems

In a series of recent articles about no-fault compensation, *CMAJ* raised important questions regarding the Canadian medical liability system.[1-3] However, the length of these articles did not permit a full discussion of the issues, which are complex. In consequence, readers may have drawn incorrect conclusions concerning the merits and shortfalls of a no-fault compensation system and its relation with patient safety.

In Canada there are 3 system-level responses to an adverse event, each of which has its own role and defined processes. (An adverse event is defined as an event that results in unintended harm to the patient and is related to the care or services provided to the patient rather than to the patient's underlying medical condition.[4]) The effectiveness of the system depends, in part, on the balanced application of these responses. The patient-safety response involves learning from the event to prevent a similar result in the future, if this is possible. The professional-accountability response ensures that physicians and other health professionals meet the established standards of care. It is a vital element in ensuring public confidence in the health care system. The third response is the provision of compensation to patients injured as a result of negligent medical care; in Canada, this is generally achieved through the tort-based litigation system.

In part 2 of her series on no-fault compensation, Ann Silversides implies that removal of the fear of litigation would improve the safety of medicine through more open reporting and enhanced learning.[2] This reflects the common misunderstanding that "no fault" equals "no blame" and therefore involves less stress for patients and providers. However, the so-called no-fault medical liability systems studied by the Canadian Medical Protective Association all include a significant aspect of fault determination, most often through professional accountability frameworks.[5] In Canada, this professional accountability is the responsibility of the regulatory authorities. However, in many no-fault jurisdictions, fault finding occurs without the procedural process and fairness that characterize the current Canadian model.

There is no evidence to support the assertion that no-fault systems are more supportive of patient safety and the determination of the reasons for adverse events than other liability systems. The Canadian Medical Protective Association believes that the development of a just culture of safety in health care that supports full reporting and discussion of adverse events is an important contributor to patient safety. Health professionals should be encouraged to actively examine what occurred and to speculate on how an unexpected clinical outcome or adverse event might have been avoided in a nonthreatening learning environment. However, such discussions should be separate from professional accountability and compensation mechanisms and the information provided should be protected from use within those other domains.

All available evidence suggests the focus should be on preventing adverse events by enhancing patient safety. It is these efforts and not the type of liability system that make a difference. The Canadian Medical Protective Associa-

Letters submission process

To send a letter to the editor concerning a published article, visit www.cmaj.ca and click "Submit a response" at the top right-hand side of the article. All letters submitted through www.cmaj.ca will be considered for publication in the print journal. To submit a letter that does not pertain to an article in the journal, email your letter to pubs@cma.ca with a note indicating whether or not you would like it to be considered for publication.

Letters written in response to an article published in *CMAJ* are more likely to be accepted for print publication if they are submitted within 2 months of the article's publication date. Letters accepted for print publication are edited for length (usually 250 words) and house style.

Mécanisme de présentation des lettres

Pour écrire à la rédaction au sujet d'un article publié dans le *JAMC*, rendez-vous sur le site www.jamc.ca, ouvrez l'article en question et cliquez sur "Submit a response" parmi les choix énumérés en bleu à droite de l'article. On étudiera toutes les lettres reçues sur le site web pour éventuelle publication dans la version imprimée du Journal. Si votre lettre traite d'un autre sujet qu'un article publié dans le Journal, écrivez à pubs@cma.ca et précisez si vous souhaitez ou non que votre lettre soit étudiée en vue de sa publication.

Les lettres répondant à un article publié dans le *JAMC* sont plus susceptibles d'être acceptées pour publication imprimée si elles sont présentées dans les deux mois de la date de publication de l'article. Les lettres acceptées pour publication imprimée sont révisées en fonction du style du *JAMC* et raccourcies au besoin (elles doivent habituellement compter au maximum 250 mots).

tion believes those interested in advancing patient safety would have a greater impact if they worked to improve adverse-event quality review processes rather than diverting attention by advocating for no-fault compensation.

Much more can and should be done to improve patient safety, starting with ensuring that quality-improvement processes are in place and adhered to in all jurisdictions. The Canadian Medical Protective Association hopes that discussion of these important issues rather than of no-fault compensation will occupy the attention of physicians and other care providers.

William S. Tucker, MD
President, Canadian Medical Protective Association, Ottawa, Ont.

Competing interests: None declared.

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1. Silversides A. Fault/no fault: bearing the brunt of medical mishaps. *CMAJ* 2008:179:309-11.
2. Silversides A. Fault/no fault part 2: uneasy bedfellows. *CMAJ* 2008:179:407-9.
3. Silversides A. Fault/no fault, part 3: vested interests and the silence of suffering patients cited as obstacles to system change. *CMAJ* 2008:179:515-7.
4. Disclosure Working Group. *Canadian disclosure guidelines*. Edmonton (AB): Canadian Patient Safety Institute; 2008.
5. Canadian Medical Protective Association. *Medical liability practices in Canada: towards the right balance*. Ottawa (ON): The Association; 2005.

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Accuracy in images

I am concerned about the scary picture on the cover of the Sept. 9 issue of *CMAJ*, which highlights articles about the human papillomavirus (HPV) vaccine. Although the articles did a good job of accurately conveying the low risks associated with use of the vaccine,[1-3] the blue gloves in the picture gave the reader a sense that the vaccine was some type of biohazard. Gloving is not a routine precaution when giving intramuscular or subcutaneous injections or immunizations.

Upon further inspection of the photograph, I noted several other inaccuracies. The HPV vaccine is an intramuscular vaccine requiring a 1-inch needle, not the 5/8-inch needle pictured. The patient has a smallpox vaccination scar on her arm and thus she would be at least in her mid-thirties (in Canada we stopped vaccinating the general population against smallpox in 1972), whereas the current maximum age for vaccination against HPV is 26 years. Finally, the HPV vaccine currently available in Canada is supplied with a spring-loaded safety syringe that covers the needle with a plastic sleeve after injection, which protects the health care provider from a needle-stick injury.

It is important for us to be as accurate with our pictures in a peer-reviewed scientific journal as with our words. Stock photographs will not do, especially on the front cover.

Albert Schumacher MD
Family physician, Windsor, Ont.

Competing interests: Albert Schumacher serves on an Ontario Health Policy Advisory Committee for Merck Frosst. He is a consultant for GlaxoSmithKline in the development of continuing medical education programs about vaccines. He has received speakers fees from Merck Frosst Canada, Pfizer Canada and AstraZeneca.

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1. MacDonald N, Stanbrook MB, Hébert PC. Human papillomavirus vaccine risk and reality. *CMAJ* 2008;179:503.
2. Brotherton JML, Gold MS, Kemp AS, et al. Anaphylaxis following quadrivalent human papillomavirus vaccination. *CMAJ* 2008;179:525-33.
3. Halsey NA. The human papillomavirus vaccine and risk of anaphylaxis. *CMAJ* 2008;179:509-10.

DOI:10.1503/cmaj.1080113

The Executive Editor responds

Thank you, Dr. Schumacher, for your astute observations about the image on our cover of September 9, 2008. We agree that we need to be accurate with everything we publish in the journal. The image we used was a generic image of a person getting an injection and not a specific type of injection. We did discuss using an image of a person getting a human papillomavirus vaccine injection but in the end decided that we should not picture a branded product.

Rajendra Kale MD
Executive Editor, *CMAJ*

Competing interests: None declared.

DOI:10.1503/cmaj.081851

Corrections

A picture in the News briefs[1] section of the October 21 issue should have been identified as the Confederation Building in St. John's, Newfoundland.

REFERENCE

1. Kondro W. Briefly. *CMAJ* 2008;179:890.

DOI:10.1503/cmaj.081812

In a research article[1] in the Nov. 18 issue, Nimisha Purohit should have been acknowledged in print for her contribution as a study coordinator.

REFERENCE

1. Aaron SD, Vandemheen KL, Boulet LP, et al. Overdiagnosis of asthma in obese and nonobese adults. *CMAJ* 2008;179:1121-31.

DOI:10.1503/cmaj.081825