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Chair

Ms. Bonnie Brown

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● (1535)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): Ladies and gentlemen, it's my pleasure to welcome you to the 19th meeting of the Standing Committee on Health.

We have a few visitors with us, and on your behalf I welcome them to the committee. I also welcome our witnesses.

Our first witnesses are from the Canadian Adverse Events Study and are Dr. Baker, the co-author, and Dr. Norton, the other co-author.

I don't know which of you gentlemen prefers to begin, but I would refer my colleagues to your study, which is before you. I would invite either one of you to begin your presentation.

Dr. G. Ross Baker (Co-author of the Canadian Adverse Events Study, As Individual): Thank you very much, Madam Chair. It's a privilege and a pleasure to be here with you today.

We're going to say a little bit about this study, which was published in May of this year in the *Canadian Medical Association Journal.* We were the leaders of the study, but it's important to recognize that this study was done in five provinces across the country, and we had physicians and nurses doing reviews in each of those five provinces. It was quite a large effort to consolidate all this information in Ontario, Quebec, Nova Scotia, Alberta, and British Columbia.

This was the first national study done to provide an estimate of the number of patients who are injured as a result of their care in hospitals.

We worked with methods that had been previously used and developed in the United States, Australia, England, and elsewhere, and we used hospital records to provide this information, using reviews by trained physicians and nurses in this area.

I want to say a little bit about the language we're using here, because it's important to make a distinction about the nature of adverse events. An adverse event is a bad outcome that results from the care that a patient receives. It doesn't reflect what happens to a patient as a course of his or her illness. It is the judgment of the physicians who were reviewing the chart to say that there was an unintended injury or complication that resulted in at least a prolongation of hospital stay, and in some cases disability or death.

It's important to realize that some of these adverse events are not preventable. We know, for example, that some patients are allergic to penicillin, but until they receive penicillin, we don't know they're allergic. However, once we know they're allergic, if they're given penicillin, then that's a preventable adverse event. We were looking at all types of adverse events. Roughly 40% of them in our study were seen to be preventable.

There are many errors in health care that are caught by vigilant and well-trained physicians and nurses, so not all the errors cause adverse events. So we make a distinction here between adverse events and errors. We focused on the adverse events because that's where the harm is measured, and we want to provide information that will be useful to Canadians and to groups like the Canadian Patient Safety Institute as they work to improve safety within our health care system.

As I said, we worked in five different provinces. We looked at three types of hospitals—the large teaching hospitals in our major medical centres, the community hospitals, and the smaller hospitals—to get an estimate that covered the various types of hospital care in Canada. We looked at some 3,700 charts taken from the year 2000, and we excluded obstetrical patients and psychiatric patients to keep us comparable to previous work that had been done in this area.

The bottom line was that, as a result of our study, we determined that 7.5% of patients who were hospitalized in the year 2000 had an adverse event, and as I said, 40% of those were deemed to be preventable by our physicians. That means one in 13 patients in Canadian hospitals had an adverse event.

We did some analysis to see what the differences were between types of hospitals, and although there were more adverse events overall in teaching hospitals, it's important to say that the numbers of preventable adverse events—that is, the things we can do something about—are similar within the three types of hospitals.

Obviously there are some important impacts that we needed to study from this, and so we looked at the impact of the adverse event, first of all, on the patient. The good news is that two-thirds of patients recover within a short period of time. The bad news is that one-third of them have an ongoing disability or death. So that's an important part of our equation, and we'll come back and talk about that.

We also noted that having patients who experience adverse events leads to increased use of hospital resources. Our physicians estimated that, for the 255 patients in our study who had one or more adverse event, they used an additional 1,500 hospital days. This is an important issue, and we're doing some further analysis to see if we can come up with some cost estimates for that.

As to the implications for Canadian hospitals, we took our data and we extrapolated to all Canadian hospitals, but let me say a little bit first about what our findings were.

We said that between 140,000 and 230,000 Canadian patients would have experienced an adverse event in the year 2000 if what we found is true is generalized to the entire population. The number of patients who experience an adverse event and later die ranges between 9,000 and 24,000.

Let me point out to the committee, however, that we're not saying the adverse event was the cause of death for all these individuals, but in some cases clearly that was the case.

Because the study has been done elsewhere, it's important to know how we compare to other countries. I can tell you that our numbers were higher than numbers we've seen in the U.S.; ours are about twice as high as the U.S. numbers. We're not certain of the reason for that. It may have something to do with the methods involved, because the U.S. study was framed in the context of negligence and malpractice, whereas the Canadian study took the same approach as the English and Australian ones, which were really interested in understanding the situation and coming up with information that will lead to improved care.

Our teaching hospital rate is almost identical to the rate that was found in the English study, which only looked at two teaching hospitals. So we're roughly similar to the other non-American studies that have been done. Our rates are a little lower overall, but the number of deaths and disabilities is quite similar.

I'm going to ask Dr. Norton to comment further on the issues that we see coming out of this study.

Dr. Peter G. Norton (Co-author of the Canadian Adverse Events Study, As Individual): I'd like to thank the committee for inviting us to come as well.

We want to tell you a little bit about the next steps that this study team will be undertaking. This is not over, it was just the first result and first piece of work.

We're doing some key research studies at the moment. They include trying to understand what we can from our data and applying for grants to look at adverse events in the community. We've only looked at what's happening in the hospital. Early indications are that we have serious problems in all sectors of the health care system.

We are trying to evaluate strategies to reduce errors and adverse events. This is going on both in the study team and across multiple hospitals and regions in Canada. We believe there is a need to look at decision tools to help caregivers improve their care and reduce adverse events. From this safety agenda, the Canadian Patient Safety Institute is going to expand on it and hold a research priority meeting later this month. We're very much looking forward to that and to helping to set a research agenda in this area in Canada.

If you're looking at your handouts, you'll find there are two pictures of computer screens. One of the new features of the Canadian adverse events study was to capture the data from the charts on laptop computers. This allowed us to improve the reliability of the chart abstraction to get better results. We believe this product, which was built for the study, is a Canadian legacy product. It has been modified to work in individual hospitals without all the research components. It's in field testing in Calgary, Alberta, at the moment, and we have commitments from B.C. and New Brunswick to continue to develop it. We hope we will be able to offer it to Canadian organizations by the end of the summer so that they can carry out similar audits in a rigorous way right across the country.

It's very interesting that the new head of the World Health Organization in the area of patient safety, Sir Liam Donaldson, is very interested in this, and we've already been approached to make this product for the world. That's a huge outcome from our work.

There are key patient safety initiatives under way, and we've been part of the momentum to accelerate these. The Canadian Patient Safety Institute will be presenting to you in just a moment. Almost every national organization for health professionals now has stated safety policies and patient safety goals for those professions. CIHI has begun reporting patient safety indicators, and other folks are doing that. Ministries of health are investing in patient safety. In the four western provinces, we now have organizations at the provincial level dedicated to moving the agenda ahead. Quebec has been on board for a long time, and the maritime provinces are coming ahead. We expect Ontario to be along with us soon.

There are local initiatives going on across the country. You will know that hospitals in the areas that you come from are busy at working to try to make the system safer for Canadians.

Educational opportunities are increasing. We present at all levels, to the public, to the health professionals, and to managers.

Finally, we are mounting a campaign—and Ross and I are co-leading this with Dr. Ward Clemens, from Calgary—to join the U.S. campaign to save 100,000 lives. Dr. Don Berwick, who heads the Institute for Healthcare Improvement in the States, put a challenge out in December, saying there were six safety practices and that we would save 100,000 lives if we could get all the hospitals in the States to follow them.

We're going to mount a Canadian parallel effort. We're calling it a Canadian node, and we're being given tremendous support from the IHI. The American group is giving us faculty and tools, and we've already secured funding from B.C., Manitoba, and Alberta to mount this. We've put a request in to the Canadian Patient Safety Institute. We should hear from Saskatchewan today, because I believe their board is meeting.

So I'm seeing this as a Canada-wide, non-partisan activity to make the system better. That's why we did the study.

Thank you.

● (1540)

The Chair: We'll now move on to our other witnesses, who are from the Canadian Patient Safety Institute, Mr. Philip Hassen and Mr. Don Schurman.

Gentlemen, either one of you can start.

Mr. Philip Hassen (Chief Executive Director, Canadian Patient Safety Institute): Thank you very much. I'll make a few introductory remarks, then I'll turn it over to Don, and then back to me to finalize it.

I've been in this job all of seven days now. I'm looking forward to it. I must say I've already begun to try to climb the mountain, and I have been there doing some of the work in my previous lives.

I'm going to ask Don to introduce the subject matter, and then I'll come back to tell you a little bit about where we're going. Don has been the former acting chief executive officer for the last few months to help get this thing up and running.

● (1545)

Mr. Don Schurman (Former Chief Executive Officer, Canadian Patient Safety Institute): Thank you, Phil.

Thank you very much on behalf of the board and staff of the Canadian Patient Safety Institute for an opportunity to talk a little bit about the early work of the institute.

In the presentation overview I'm going to talk very briefly—not too much, because Peter and Ross have done a very good job—about the complexity within the health care system and a bit about the early stage development of the Canadian Patient Safety Institute. Phil is going to talk more about the future challenges that we face and some of the work of the institute.

The 2003 federal-provincial-territorial accord mandated the development of the Canadian Patient Safety Institute, and that led to the creation of the institute.

Under the "what we know" topic, health care staff have been concerned about safety forever. It is a high-risk environment. But there have been a number of studies, starting in Quebec with the Francoeur committee in 2001, that really started to lay the issue before us effectively. They looked at the current state of risk management procedures and mechanisms in hospitals and made recommendations around reducing preventable adverse events. That study was followed in Quebec by the Blais study in September 2004, which found that 5.6% of hospitalizations had an adverse event and 26% of them were preventable.

In 2001 the Royal College of Physicians and Surgeons took a bold step and brought together 50 leaders to actually talk about the issue of patient safety in Canadian hospitals. That led to the development of a national steering committee, which created a report, "Building a Safer System", that really set the agenda for safety in Canada. There were 19 recommendations. The first recommendation was the creation of a Canadian patient safety institute.

Lastly—and Ross and Peter have spoken about this, so I won't—they need to be commended for doing a very good job of bringing this issue to the forefront for all of us in Canadian society, and they've already spoken about their results.

The Canadian Institute for Health Information—Ross and Peter mentioned them as well—in their 2002 report talked about some of the issues that they saw, and this starts to bring it home a bit more. They said there were more deaths after experiencing adverse events in hospital than there were deaths from breast cancer, motor vehicle accidents, and HIV combined. They talked about the fact that one in nine adults contract infection in hospitals, and that one in nine patients receive the wrong medication or the wrong dose.

The next slide will make it even more personal. Two young children in Ontario, a 15-year-old girl and a 14-year-old boy, were mistakenly prescribed a powerful pain patch, a Duragesic patch, which is given to people to deal with severe pain, but only to adults because you need to have had experience with opiates, with something like Tylenol 3. In any event, they went into respiratory arrest and died after receiving the pain patch.

In the David Thompson Health Region in Alberta, at the Red DeerRegional Hospital a man was mistakenly given 10 milligrams of hydromorphone rather than 10 milligrams of morphine, and by the time they found out and were able to intervene he had passed away. In the Foothills Hospital in Calgary there was the example a year ago of two patients who died from getting a dialysis solution because a mistake was made and potassium chloride was used in the solution rather than sodium chloride.

So it brings it really close to home, and it can happen to all of us at any time.

The Canadian Patient Safety Institute, as I indicated before, was created to help the health care system deal with these issues. You have a business plan before you and the business plan really talks a little bit about the mission, the vision, the mandate, the governance, and some of the specific initiatives.

The mission of the institute is simply to provide national leadership in building and advancing a safer system. This will be done by people working in the system on a day-to-day basis, those people working with patients each day, every day, in all of our organizations.

● (1550)

The vision, I think, is a fairly powerful articulation by the board of the kind of system they would like to see. They see a system where patients, providers, governments, and others work together to build and advance a safer system. So all of us have a role to play—patients, providers, governments, and members of the public. They see a system where providers take pride in their ability to deliver the safest and highest quality of care possible each day, every day. They see a system where Canadians in need of health care can be confident of the health care they receive and that it is the safest in the world.

The institute was established through the good work of Health Canada, which provided $10 million a year for five years in December 2003 to support patient safety initiatives. They wanted to have a pan-Canadian approach, thereby leading to the creation of the institute. The institute is arm's-length from government, but is committed to being fully transparent and accountable. As I said before, we want to involve patients, health care providers, and the public. It's important to know what the institute doesn't do. It does not have a role in overseeing, managing, or prescribing practices. It doesn't fund, run, or regulate health care. It doesn't regulate any of the health professions. So its work will be done through building on the commitments of people in the system through developing effective relationships.

The next slide simply lists the members of the board, who have not been picked for regional representation. They were picked because they are acknowledged leaders in the field and have something to contribute to the early-stage evolution of the board. There are nine members, although the board can increase from that, and three of them are representatives of the provincial/territorial governments.

Accomplishments to date include the development of dictionaries, which seems small, but it's very important to get people talking the same language—what are the terms we're using and what is our common understanding of the terms. There's a French one and an English one. The English one came first. The French one came second and was an improvement. Now I think there's going to be a revision of the English language dictionary.

The strategic business plan, which you have before you, was developed and approved by the board. The Canadian Patient Safety Institute office was established in Edmonton, with a satellite office in Ottawa to work with national health organizations here.

The institute has developed strong collaborative mechanisms and relationships with health care organizations across the country even at this early stage of its existence, with provincial organizations as well as the national organizations.

I might also point out that the Canadian Patient Safety Institute has been quite instrumental in supporting the development of an inter-agency group, which involves Canada Health Infoway, the Canadian Institute for Health Information, the Canadian Council on Health Services Accreditation, the Public Health Agency, the National Health Council, and Statistics Canada, to come together to talk about their common objectives and commitments.

Lastly, what's not down here but I think is a significant achievement for the board is the recruitment of Phil Hassen as the CEO. Phil has been a leader in Canadian health care for a long time. He is deeply committed to quality improvement and quality management in health care, which he has demonstrated in all of his roles, as CEO of major hospitals and more recently as the deputy minister of health in Ontario. He has written a book on health care, which describes the kind of commitment he has made. I think he will do a wonderful job of leading the institute for the next number of years.

I'll turn it back to Phil.

Mr. Philip Hassen: Thanks, Don.

Again thank you, members and chair, for giving us this opportunity. I think this is a place we want to use as a basis for the leap we need to make as we are discussing these matters with all of our colleagues across the country.

What I'd like to do is take a few minutes to describe what actions are in progress, where we're going, and what the future challenges are. Those three are noted on that one slide: defining patient safety issues in a much more articulate and clear manner, identifying leading practices and how we are actually going to make change occur, and who the people are who are involved in it.

We are in the process of consultations with all the territories and provinces. Each one we're doing depends on the province as to how we're doing it, because each province has a different way of wanting to undertake this, and so also for the territories.

In two months we will have all those consultations done and will then take our business plan, which you have, and refine it further to reflect many of the issues we hear. You have to remember this was done in a manner to help us get going and to get this started, but we need to listen to the people in the field to find out what they have to say and see whether we're in fact correct in the matters we need to attend to.

Further, if you look at the business plan closely, there's lots in there, and we need to set some priorities. We have some ideas based on these early discussions with the provinces and with many of the national agencies that are committed to improving the quality of care and the safe care of patients.

We are also working with a group that's doing a national conference. It's called Halifax 3, or 4, or 5, depending on your words. It is a group of people who have initiated having a conference every year on safety. This has become the hallmark of good quality information to help people develop their safety strategies.

The first thing we'll be doing is working on defining the research that's necessary. As you can appreciate, while the work of Dr. Baker and Dr. Norton really was fundamental to getting this going and giving people a sense of the sizing of it and an understanding of the Canadian thinking of what the problems were here in Canada, there are other matters that we need to attend to that are derivatives of other issues and will require some research.

We're going to work with the other two national research groups, the Canadian Health Services Research Foundation and the Canadian Institutes of Health Research, to define precisely who's doing what so that we don't duplicate and actually have a synchronized group of research strategies that make sense to both of us and help the researchers understand how to get access to funds for those things we both agree need to be done.

We're also going to be working on what we call root cause analysis. One of the real issues in health care is understanding what underlies it—not just what happened, but what underlies it and what causes can be prevented to improve it. What are the avoidable incidents or adverse events, and how can we improve them?

A further matter is a standardized and validated patient safety curriculum. One of the matters is how we teach this, how we educate people—everything from the student in the system who is being taught professionally.... It's clear that we're going to have to use things like computerized simulation as well as look at interdisciplinary strategies.

All these things are going to become critical, because it's clear to us that many people have tried to work independently and put themselves together, and now we need to understand that teamwork is really what it's all about. There's a lot of work in that regard that we will be facilitating to help people come to grips with the issues, whether they are in the academic centres or in the universities or whether they are researchers, that will help improve the knowledge base, and then there's the resulting education that needs to be done to improve services to the patients we all serve.

Respecting the "championing change" slide, there are probably just a couple of things to say.

We really do need a clear way of understanding medication incidents. As Don mentioned to you, there are two areas that we know are really high on our list to tackle. One is infections, because of the number of infections: one in nine people who come in contact with a hospital comes out with an infection. And one in nine people has a medication error that potentially precipitates a risk to him or her. We need some way of measuring these things, and that's one of the things that's now in process through what's called the Canadian medication instant reporting and prevention system.

● (1555)

There are two groups—the Institute for Safe Medication Practices and the Canadian Institute for Health Information—that are beginning to work on it and have actually started the work to help us begin to have a fairly clear way of measuring that.

We will have up to five advisory committees, I believe, and they'll include everything from legal and professional development to evaluation research and communications to help us make sure we are gaining some assimilation of this information across the entire cast of professionals and organizations doing this work.

As to some of the future challenges, there are many, but clearly the first thing we're going to do, and I think it will be consistent with what Dr. Norton mentioned, is that we are going to look at how we can Canadianize this work they've started in the United States to save 100,000 lives. What are the relevant features for Canada? Are these the right ones to study? Given that they are, then we need to be able to gain a lot of profile for this. Clearly, when I've talked to people across the country, they already feel very strongly that this is a good start, that there are some very defined ways we can actually intervene and begin to make a difference in the safe practice of medicine.

There are other areas we're going to have to spend some time on besides education. For example, we haven't had many studies on home care, and because of the intensity of home care over time, we know there is going to be some risk profile there that we're going to want to understand and help, particularly with chronic diseases and elderly patients coming into play.

With all of that, we really believe that professionals are very concerned and want to do a better job. They want to have pride in the work they do and pride in the delivery of health services. I think the work we're going to be doing over the next little while with all of these organizations that are interested—and they are all interested.... I haven't come across anyone who doesn't have patient safety as a priority on their list of things to do.

The good news is that we've had this study done by Doctors Baker and Norton and it has really helped focus people. I think now it's time to do something about it. That's what the CPSI will be doing—facilitating that work.

Thank you very much, and I'd be happy to answer questions, as you see fit, Madam Chair.

● (1600)

The Chair: Thank you very much.

We'll now proceed to the question and answer portion. We'll begin with Her Majesty's official opposition, and I'm not sure if it's going to be Mr. Merrifield or Mr. Lunney.

Mr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Madam Chair, before you start the clock ticking on me, could I just make a comment for the record that it's disappointing to members of this committee—the permanent members who are not represented on the other side and many on our side who would have liked to be here for this presentation—that this debate on the Quarantine Act, Bill C-12, is scheduled at the same time. I think that reflects poor planning on behalf of the House leaders.

I recognize that after bringing witnesses in for this important meeting, it would have been great to have the permanent members here to hear this. Certainly our own chief critics and lead people on this file were not able to be here, and it's important on that side as well. So I'd just like to register that protest on behalf of the members who were not able to be here for this important meeting.

Having said that, I would like to thank the presenters for their very interesting presentations. I certainly would like to commend Doctors Baker and Norton for entering this arena. It certainly has been an area of concern to many people. It's a very delicate area that has been overlooked for a long time. We really appreciate your wading into this, and we know you've done this because of a heartfelt concern for advancing better health care in the country. It certainly has been a spark plug in bringing this Canadian Patient Safety Institute into being. We appreciate that.

I want to ask this, first off. On the slides in your presentation, you drew attention to a computerized program that might be a Canadian legacy product. Is that something that came out of your work, Doctors Baker and Norton, or has it come out of the CPSI work?

Dr. Peter G. Norton: It was part of what we did in the study. We built that. The funding came from the Canadian Institutes of Health Research and the Canadian Institute for Health Information. The development of it as a legacy product is being covered by some of the health regions in Canada. No one is ever going to get money back from it. I keep saying that you guys have to just put some money in so everybody can use it, because the bigger regions can afford to put in $10,000 or $12,000. It's really quite an amazing thing, in my mind.

Mr. James Lunney: I certainly compliment you on creating a tool that will help to advance the research in this area. It's a much-needed tool that gives us a platform to move ahead on.

I have to ask this because we know that many of your studies particularly focused on hospital deaths and adverse events. I note in your report that you talk about what we know about health care in Canada. You mentioned 70% is in the public side and about 30% is outside of that. You mentioned that about 11% of Canadians seek alternative treatments, and then you're looking at it for leading practices, which I see is one of the objectives of the CPSI. Maybe hospitalizations are not the best intervention if it can be avoided, obviously, because that's where we're having problems with infections and otherwise. Is anybody making any attempt to look at services that are provided by the so-called nebulous others that are produced outside of the high-risk areas that we find with hospitalization and with drug service? I mention particularly chiropractic, naturopathy, and even other medical practices that are delivered outside of the practice and are considered alternative.

● (1605)

Dr. G. Ross Baker: I think this is an important issue. Clearly, we only began this work and we focused on hospitals because that's where the previous work had been done. We wanted to provide some Canadian data that would allow us to assess the situation in Canada, compare it to other countries, and provide a stimulus to a number of organizations, including the Canadian Patient Safety Institute and the Institute for Safe Medication Practice. Some of them are new organizations and some are existing organizations, but clearly it has to go beyond the traditional professionals. It has to go beyond the hospital if we're going to get a full sense of these issues in Canadian health care. So what we see is that we've done just the first step, and clearly there needs to be an expansion of this agenda.

Mr. James Lunney: I'm a chiropractor myself, and others on the health team here come from an alternative background. Personally, I hope that a forum can be found somewhere where we can begin to discuss what works.

I'd just put on your record—and we discussed this recently, when we had the Health Council here the other day with Michael Decter—and maybe you're not aware of it, that a major study was just released in the *Archives of Internal Medicine* with a million patients, which is a big sample, with conventional treatment covered and 700,000 who had chiropractic care in addition. The overall health costs were 12% lower. That's without anybody encouraging it, but just because those services were available.

I think it's about time that somebody, in the interests of efficiency, began to look at how we can collaborate better in an interdisciplinary way to both capitalize on cost-effectiveness and also lower morbidity. Frankly, practising chiropractic for 24 years, there's been a lot of mythology about the risks associated with this. If the highest risks are with drug interventions, as clearly identified here, then maybe non-drug approaches ought to be looked at more carefully and maybe there ought to be more dialogue with naturopaths and chiropractors about alternatives that are in fact lower risk.

I've had very interesting discussions with medical doctors, and I find many of them certainly are interested in that dialogue, but most of them have very few fora or little opportunity to have inter-professional dialogue. I personally feel we could have an awful lot of fun if we actually broke some of those barriers down and began to talk about what works.

Having said that, on the natural health product file, it's something that somebody should be looking at, because there are many alternatives in the natural file that show great promise and yet are underutilized. We've been active on that file; we have a new directorate here on natural health products. I noted that a recent study showed Canadians spend about $15 billion on prescription drugs but about $1.6 billion on natural products. Yet we have efficiencies there with simple mineral supplements like chromium picolinate, which is essential for blood sugar metabolism. We have other simple strategies that would help advance health care, and yet Health Canada has removed them from the market because of health claims.

We have some real problems in actually talking about what works. I'm wondering if it's something that, if it isn't on your radar, maybe it should be. We just went through a celebrated case here with vitamin and mineral compounds having profound effects on people who are bipolar. That was in Alberta. Dr. Norton, you might be aware of that. It was published in numerous psychiatric journals. Yet Health Canada moved to take it off the market and actually shut down the study at the University of Calgary.

So we would like to see someone champion an inter-professional medium or forum where we could actually begin to talk about what works. I wonder if that could happen under the Canadian Patient Safety Institute, or under the work you're doing, or what fora, because asking the Health Council of Canada, it doesn't seem to be on its radar. Is there hope that somewhere we can begin to find a forum for inter-professional dialogue about what works?

Dr. Peter G. Norton: I believe there is a group of researchers in Canada who are very interested in some of the questions you've raised, Mr. Lunney. Hopefully, we can take this to the meeting that is scheduled for the end of the month and put it on their radar for you. Dr. Baker and I are both going to that meeting, so I will reflect that at the meeting, if I may.

● (1610)

Mr. James Lunney: Thank you.

This is on this issue of hospital infections. We have a huge issue now with MSR, methicillin-resistant Staphylococcus, getting beyond hospitals; there's a huge issue there. We have another issue with *C. difficile*. Just recently that issue came up, with about 600 deaths believed in the Montreal area and as many as 7,000 infections. When they talked about patient safety, the issues that were raised were handwashing, overcrowding, and overuse of antibiotics.

Those are all real issues, but when we know there's an issue like a class of medications, gastric acid inhibitors, that put patients at further risk, shouldn't somebody be interested in actually advising doctors first of all? This is especially when your CMA journal came out with figures of a 2.5 increased chance—250% increased chance—of having a severe infection leading possibly to death. Yet no advisory went out to doctors or to the public at large, even though the government had known about this for months.

Interestingly enough, our new Public Health Agency of Canada didn't see that as a public health mandate but as more of a practice guideline issue.

I just wonder if you'd like to comment on that.

Mr. Philip Hassen: Let me make one comment. There are two areas we both believe, I think, we need to spend some time on. One is putting together some standards of practice that are fairly clearly understood and can be implemented with respect to how infections are disseminated in a hospital and to what we need to do to intervene. Some of it is not about anyone not doing it right; there is a whole series of events we are concerned about that are root causes of that problem. The other one of course is adverse medication events.

Those two seem to be...because of the data our colleagues here have put together, but others have demonstrated....

We need to come out and have some very clear standards by which people have to perform. That's work we believe is very much upfront and is something we have to do early on in our mandate as the CPSI.

I don't know if Ross or Peter have some comments on that.

Dr. G. Ross Baker: It's just to say we agree that the issue of infection control is a critical one and needs to be at the forefront. The SARS experience in Toronto showed this isn't just a hospital issue, it's a community issue, and more resources and attention need to be paid to it. There have been some efforts made as a result of that, but I think it's pretty fair to say we still don't see sufficient resources for infection control in most of the hospitals in this country.

Dr. Peter G. Norton: If you look at the 255 patients in our study who had an adverse event, one of the things that jump out at you is *C. difficile* as a cause of those adverse events. We saw that before there were any reports from Montreal. If you're interested in that, there is a web appendix to our paper that has a couple of sentences about each of the cases. It'll tell you what was happening. We could clearly see infection before all the reports came out.

Infection control is an important issue and is becoming more important, I believe, as time goes on.

The Chair: Thank you, Mr. Lunney.

Our next questioner will be Mr. Lemay.

[*Translation*]

Mr. Marc Lemay (Abitibi—Témiscamingue, BQ): Good afternoon. I have a few questions for the witnesses.

My first question pertains to the Canadian Patient Safety Institute. It seems that many people are concerned about patient safety these days. There's also the Canadian Coalition on Medication Incident Reporting and Prevention. Can you explain to me the difference between these two organizations? What is the nature of your collaboration with this association? I'm not sure who can answer my first question.

As for my second question, I know that many people are interested in this subject. In so far as the members of the board of directors are concerned, can you tell me if nurses and pharmacists — who have direct contact with patients - are represented on the board and do you expect patients to have some representation as well? I'm speaking here about Quebec which is home to a very active association of patients, that will remain nameless. Issues such as this one are very interesting.

These are the two questions I have for the witnesses at this time. I would very much appreciate some answers.

● (1615)

[*English*]

Mr. Philip Hassen: Perhaps we can start with this. Don may want to add to it, as he was involved with putting together the board.

First of all, CMIRPS is the group that's looking at the coalition you mentioned, and we are part of that. There is a discussion with the federal government on how the transition of strategic oversight of the work they're doing moves from that group to the Canadian Patient Safety Institute. So they got started before us, and that work will be moved to us in some way. We're just working on that right now with Health Canada and with the group of stakeholders involved—if that's the coalition you're speaking of. The Canadian Medication Incident Reporting and Prevention System is the group we are working with intimately and looking at how we make sure that.... The group has an operating committee of ourselves and the Canadian Institute for Health Information and the Institute for Safe Medication Practices. We are all working together to make sure that we aren't duplicating work and that at the end we will have something that is viable and usable in that regard.

In terms of the board members, Don, as you were involved with putting it together, perhaps you could mention how that was done.

Mr. Don Schurman: Thank you, Phil.

The founding board was appointed by Health Canada upon receiving a number of recommendations. There is a mix of doctors and nurses and pharmacists. There are two nurses there, Wendy Nicklin and Patricia Petryshen; and there's a pharmacist, Bonnie Salsman; and a few doctors, John Wade, Brian Postl, Denis Roy, and David Rippey. So there's a good medical component.

However, going forward, the board recognizes that it does need to have additional people who are actively engaged in practice. Many of them are now in leadership and management positions, and as the board is redeveloped and new appointments are taken they are clearly going to look over time at adding to the board people who are practising medicine, nursing, and pharmacy.

As for the issue of the public that you raised, there is one member here who seems to represent the public. Jim Nininger, the former president of the Conference Board of Canada, now retired from that position, serves on the Ottawa Hospital Board. But he's not an employee of the health care system; he's not a health professional, and in some sense he represents the public.

Having said that, I think the engagement of the public in the work of the institute continues to be a major issue the board will want to look at—how best to engage them, how best to seek their advice, and how best to make sure that the work of the institute is grounded in their concerns. So that is a big issue you raise.

The Chair: I'm sorry, but your time is up.

Mrs. Kadis.

Mrs. Susan Kadis (Thornhill, Lib.): Thank you, Madam Chair.

It's certainly been very eye-opening to me today, and I can tell you that this Canadian is better educated now than when I walked in the door regarding this particular identification or highlighting of these concerns.

I guess that brings me to my question. I'm looking at timelines, and if ever there were information and work that needed to be implemented as quickly as possible—within reason obviously, given the complexity—I think it would be a lot of the work you're undertaking. So I guess my question is, how soon can the Canadian public benefit from a significant reduction in adverse events, mistakes, etc., in your opinion, based on what you've done to-date and what the plan is going forward?

Mr. Philip Hassen: Maybe I'll start, but I think my colleagues here who are also going to be engaged in that might have some comments.

Obviously, what we're trying to do through what Dr. Norton and Dr. Baker began is saving 100,000 lives, which IHI has started. It makes eminent sense that the work they are also going to be doing here in Canada is to translate that into a Canadian strategy enabling us to do the work here.

The goal, I think, is to have within 18 to 24 months something that begins to give some indication of what the possibilities are. I would not say we're going to get dramatic results; I think that's being overly optimistic. But the goal is to try to show that we can actually make a difference and that there are some things that we can actually deliver where there will actually be a reduction in the adverse events or the harm done by these situations. But I think it's going to take longer to really get it so that it's clearly a benefit.

Maybe either Ross or—

● (1620)

Mr. Don Schurman: Before Ross or Peter comment, I'd like to say just quickly that in some sense there already is some real value through the institute. At the early stages, the value is in sharing information. In the Calgary case of the potassium chloride and sodium chloride mix-up, they did two reviews, an internal review and then an external review. The Canadian Patient Safety Institute shared that information, the results of the review, across the country among health care organizations.

Even that sharing of information is a necessary first step, I think, to learn from the experience of others.

Dr. Peter G. Norton: With respect to the 100,000 lives campaign, we'll actually have about 16 months to produce this. For some of the initiatives that are on the table, we have the evidence. We know they work. We just have to modify the system to make them work. That's what that work will be about.

To give you one example, after people have had heart attacks they should be on a class of drugs—if they can take them—called beta blockers. They slow your heart down and don't let it work too hard. It makes pretty good sense, right? In Canada, probably every place we looked, the percentage of people on those drugs three months afterwards was 40% to 50%.

That's something we can do something about, and that's one of the targets for this work. We are going to engage the front line people as well as the senior leaders of the regions and hospitals in coming together and saying we're going to do something for Canadians.

Mrs. Susan Kadis: That's what I was getting at, that if we do have pertinent information we pass it through, as long as it's been qualified. We do have that obligation.

Again, that's a byproduct of the ongoing work that you're leading toward or involved in. We'd hate to think that there was valuable information that the public needed...and I think this goes to the reference of advising the public as you go along, where appropriate, obviously, and where responsible. That was one of my concerns.

As well, you touched on the involvement with the provinces and territories. I hope there is a great deal of cooperation. You said Quebec was onside, and Ontario was coming on imminently. Have there been issues in terms of resistance and difficulty or challenges in that area?

Mr. Philip Hassen: No, there haven't been. Just working with them, I think everyone is onside one way or the other. The key is how to do it so that we have a lot of information-sharing and cooperation among the provinces. The information is available to improve the system, and there isn't anyone who's saying, no, I don't want to do that.

Having had a previous role in that, I can say to you that there is a clarity that's universal. If I look at the provinces, if I look at the professional and regulation organizations, and if I look at even the suppliers—I've been meeting with suppliers and the commercial developers of products—there is nothing but safety on their lips. Now, whether that is executed into real return on our investment with them, or their investment with us, is another thing. We'll see how that goes. But there are some commitments we're going to expect of many of these groups to actually cause this thing to be what it really should be, which is a reduction in patient errors.

Dr. Peter G. Norton: If I may, since I brought up the Ontario issue, I wasn't meaning that Ontario wasn't doing things. I think it's a more complex situation than what we have in Alberta. It's just bigger, and they haven't progressed as rapidly. It's not that they're not trying.

The Chair: Thank you, Mrs. Kadis.

Ms. Crowder.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): Thank you.

I want to thank you for your presentation today.

A couple of these issues have been alluded to already, but I wondered if you could expand on them.

Consumer patient protection is the ultimate goal, and one of the tools that is very helpful for consumers is to have adequate access to information on both proposed best practices and what not and the actual state of affairs. I think we've been quite challenged by getting adequate information.

We heard last week, for example, that tobacco companies don't have to release certain information on their testing processes, so the public doesn't have access to that. We know from the annual report tabled by the minister that the provinces do not report out on significant amounts of information that talk about how the dollars are being spent. We also know that when the drug companies are testing drugs and releasing them on the market, there's insufficient information for many people to determine if the testing was adequate.

I know you're in early days, but I guess I'd really like to know how you see this information coming out to the general public, and in what level of detail, in a framework that's understandable.

● (1625)

Dr. Peter G. Norton: When we were getting ready to release the Canadian Adverse Events Study, we struggled a lot with this issue. I had concerns that we would hear a story of someone who needed to go to a hospital and didn't go. I mean, hospitals are wonderful; they save lives, period, the end. They can be made better.

We spent a lot of time with media folks, trying to make sure this message came to the public in an understandable way. We were partially successful. It showed me, and I think Ross would agree, how difficult it is. Our media colleagues, trying to interpret the information, occasionally made errors in it. That's my first statement.

The other thing is that we can only truly arrive at a safer system if we engage the public as true partners in their own care, with accountabilities that we've not expected, and with the ability to talk to us so that we actually listen to them. That's my feeling. It's a critical part of the journey we're on.

Dr. G. Ross Baker: I can add to that. One of the problems in the safety issue has been that it has been a hidden problem for a long time. It's time to stop that. The reason Peter and I initiated the work to start this study was that we felt patient safety was an important issue to put on the Canadian agenda. Our work is just a beginning point here, but I feel there's a responsibility to release information about injuries suffered by patients as a result of their care in every care setting across the country. We know that some of the major data-gathering organizations in this country will have the capability to do that, and we know that some of the ministries of health will want to see that data released. That information will be a tremendous spur to improving the results we currently see.

We can only hope it carries through, because at the end of the day, although we run the risk of scaring some people when they see these kinds of numbers, that kind of information will allow us to understand how big this problem is, and how we need to focus on it.

Mr. Philip Hassen: Maybe I could just add a brief comment. You've posed one of the most fundamental problems in health care—where is the clarity? What's right? Where is the best practice, and what should I do as person? We certainly, first of all, need to work with the public, but there is so much noise out there. As Don mentioned, we're working with other agencies—the Canadian Institute for Health Improvement, the National Health Council, and so on—to find a way to improve access to that information. We have a responsibility.... The board is clear, and they've certainly talked to me about how to get the public engaged and how to know what they really want.

Second, how do we ensure they get what they should? There's some real work to do there. The problem is that because so much is coming at people, we've got to give them a way of getting access to the correct information. How do we do that? We've got to find a special way of doing it, like the *Good Housekeeping* seal of approval or something, that enables them to know this has been vetted by the authorities. In medicine the Cochrane collaboratives have been a sort of distillation of the information science has at any given point about the way you should treat people. We need the same thing available to the public.

The Chair: Thank you, Ms. Crowder.

Mr. Cuzner.

Mr. Rodger Cuzner (Cape Breton—Canso, Lib.): Thank you.

I thank the witnesses for appearing today.

Being an alternate on this committee, I don't know if the questions I pose will have the depth of those asked by other members on the committee, but certainly they'd be ones posed by an average Canadian.

With respect to adverse events, the depth and the impacts when things go catastrophically wrong were enlightening to me. We read it on the front page of the papers.... Obviously there's a tremendous cost, sometimes in lives, but also in health care dollars, which are very precious taxpayer dollars.

A couple of things stand out. I understand your organization is still relatively young and just really getting its feet under it, but are we able to determine yet if these events can be attributed to certain actions—nursing workloads, inappropriate technologies, insufficient training? Is work being done in those areas? Are we getting to the point of being able to determine the cause of some of these events?

I'll ask either group.

● (1630)

Dr. Peter G. Norton: Our understanding of what happens is that when an adverse event occurs, about 70% of the time a person is involved, and about 80% of the time the system is involved. Most of the time it's both.

It's like the system has not caught up to the complexity and challenges of modern care in the hospital, and it actually almost conspires against the health professionals to deliver the best care.

Because workloads have gotten bigger and dollars have shrunk, as you point out, we sometimes don't have enough people. That's one of the things that can happen. It can even be we wouldn't have enough people even if we'd had the money because there isn't anyone there. You can't find a relief nurse who can work in the ICU one day, so instead of having two patients, the nurses have three.

Those are complex issues having to do with decisions that were made years ago. It's a complex interplay. The researchers, the institute, and the organizations who are delivering care are presently trying to ask, how can we modify this to maintain all the very good things that hospitals do, but make it better?

Mr. Philip Hassen: I would support what Dr. Norton said. I would add, though, that it's all of the things you've said, not any one of them. It is the system. Yes, there are individuals involved, of course. We have to take care that we get into a sense that there is a different way of doing this. We must reconstruct.

I think Dr. Norton said it very well. We've moved into this change, which has been added onto and moving along incrementally. All of a sudden we've said, well, we have to go back and redo that—and the system hasn't gone back and been redone. We, on the provider side, must rethink how we're delivering these things and redesign them. That will require, I believe, information technology to be used to its fullest. That's the work I think many of the agencies and organizations are now looking at, but we cannot do it without good information technology.

Mr. Rodger Cuzner: You've been in operation for four or five years.

Mr. Don Schurman: The first board meeting of the institute was held last February, less than a year ago. The first real board meeting was probably held in March of last year, so it's just started. It has a five-year mandate.

Mr. Rodger Cuzner: The statement was made that the goal south of the border is to save 100,000 lives. It's noble but probably ambitious.

When we look at measurement, how we judge our success, how do we do that in the short term? Could you expand on measurement as we go forward? Some of the measures you'll promote and some of the changes you would hope to make I guess you could compare to a lighthouse—how many ships would a lighthouse save? It would be a tough one to answer.

Could you expand on your intent on measurement?

Dr. G. Ross Baker: I think it's a very important issue. It's the critical issue. We can talk about these things at great length, but at the end of the day it's a question of how many patients are dying in association with adverse events, and how many adverse events that could be prevented are not being prevented.

Peter and I became engaged in this 100,000 lives campaign. The work has been done to identify some significant issues, where knowledge that has already been developed is incompletely implemented in hospitals. That's true in American hospitals and in Canadian hospitals. We think this is an opportunity for people to get on board and to try this in a more thorough fashion to ensure that these good practices are being implemented across the board. We're hopeful that many Canadian hospitals will use this as a springboard to identify things that they can do as well. Some significant organizations have said they want to commit to this.

● (1635)

The Chair: Thank you, Mr. Cuzner.

Mr. Merrifield.

Mr. Rob Merrifield (Yellowhead, CPC): Thank you very much for coming in. Actually, I feel bad because I missed your presentation. I've been looking forward to it since the report came out.

I have only five minutes, but I really don't know where to start, in the sense that here you are reporting to us 24,000 deaths in Canada within acute care centres because of adverse events that it has been determined could have been prevented. Twenty-four thousand is a quarter of the constituents of any one of the members around here, who we lose per year in this country, yet you're sitting there saying you had to be careful about how you brought it out because the media might have taken it and stretched it and become aggressive with it or misconstrued it to the population.

I'm telling you, I think you're too timid. I think we need to yell this from the mountaintops, that we have a serious problem in this country in this area. I don't think you've even touched the real problem, because most of those events that you saw were within acute care centres, but have you looked at seniors centres? Have you looked at what is happening to drugs outside of our facilities with regard to adverse events and the kind of problem we're having there?

Some of the numbers I've seen since I've been a member of Parliament over the last four years are astounding. They reflect what you're doing, and what you did actually went along with what we did as a committee as we went across this country last year.

I'm sorry, I just disagree with you, and I agree with the Canadian Patient Safety Institute. We have to do a lot more and we have to become much more aggressive in this whole area.

I'd like your comments on that.

Dr. G. Ross Baker: Let me say that I agree with you 100% that this is an issue that needs to be pursued with tremendous vigilance.

I think what my colleague was trying to say is that we wanted to do two things. We wanted to make sure that we were going to engage the policy-makers and politicians in this country on this issue—

Mr. Rob Merrifield: But I don't think we've done that.

Dr. G. Ross Baker: We wanted to make that message clear; and at the same time, we didn't want to scare the individual who would hear this news that it was dangerous to be in hospital and then might, as a result, make the wrong decision, which would be not to seek care. We want to improve care without at the same time unduly alarming people.

I don't know if that's the right strategy, but that's certainly the decision we made as we went forward on this, because we wanted to engage the people who had the resources and the ability to make the decisions that would help us.

Mr. Rob Merrifield: But your report came out, and it was kind of like it came out in a whisper, from our perspective. It really didn't resonate. Very little has happened since the report came out.

We knew it was going to come out and what the numbers were, and so did you, long before it came out. It reflects what's happening in the United States and other countries.

Dr. Peter G. Norton: We were unable to control when Mr. Martin called the election, I'm afraid. That was true. We had set everything up, and he called the election. I think that's part of the reason we had less.

But I do believe we have engaged our professional organizations. We're here, and I believe we've engaged you. Maybe we should be shouting it more, but—

Mr. Rob Merrifield: No, I'd like to stop you there. It isn't "maybe" you should. You should.

You've done great work, but you're the first, and really, we've been quite silent on this as a nation and as an industry. We haven't even started to see the pressure on our health care system hit yet. If all these events are happening in our acute care centres now, where are they going to be a decade from now?

Dr. G. Ross Baker: I think the other piece that you mentioned, which is that we need to understand what's happening in the rest of the system, is the other critical part here. It's important that we invest some resources into providing the tools and the information for people, the Canadian public and health care professionals, about the issues that remain in home care, community-based care, family practice, and so forth. We have this opportunity now with hopefully a research agenda on patient safety that will help provide some of that.

● (1640)

Mr. Rob Merrifield: So are you planning to do work in that area? Do you have a study started, or can we help you in that?

Mr. Philip Hassen: When we go and meet with the researchers, these gentlemen and many others—there are 60 or 70 coming together across the country who have an interest in patient safety and the issues around it—we're hopeful that we can converge our thinking on how we can best go about beginning the process of further research such as on the community.

There's so much chronic disease out there, and it's going to increase. There are elderly people who are trying to stay home. They need some help. Home care is being expanded, as I said earlier, and we need to get at some intense understanding of what the issues are and try to prospectively build a different kind of way of delivering some of those health services before it becomes a crisis of another sort.

Mr. Rob Merrifield: Okay, so where are we going from here?

Your numbers are accurate; I don't doubt those and I don't think Canadians do. We know there's a more serious problem out there. Let's just assume there is. We've identified a problem, and what are we doing right now to look at how we're going to solve it? Give us your one-two-three-four plan.

As I say, maybe you did some of that, but how can we help you in that as you move forward?

Mr. Don Schurman: May I make one comment on your earlier question? I'll let Phil think about the answer to your tougher second question.

I think you're right about engaging the public. We do have to talk about this. I think there are a number of things that will be done and are already being done. One of those things is more open disclosure about adverse events that affect people. There has been too much reluctance to tell individual members of the public and their families.

Mr. Rob Merrifield: The House made a motion last year that we have full disclosure, mandatory reporting, and we've seen nothing come of that yet, although the minister has said to this committee that he's working on it, so we're hopeful it will happen.

Mr. Don Schurman: I think once we can get the public understanding that health care is a risky environment, which they already do, but if we can be more open about it, almost by definition patients and members of their families who understand the risk will become safer patients. They will help us improve the safety.

I think you're right. The question is how it's to be done. I think Peter and Ross and the institute have always been a bit concerned about not creating such anxiety that people lose more confidence in the system, but the awareness of safety as an issue I think is increasing. Some surveys in Alberta have shown—and Peter could reaffirm this—that the public do recognize that safety in health care is an issue, and the number of people expressing concern has increased a bit, though perhaps not as much as we would like

Phil may want to answer the other question.

Mr. Philip Hassen: We've already talked briefly about the work in the six areas where we believe it's clearly scientifically proven that we can intervene. These things are tangible; we know what they look like. There are certain methodologies. If you change the way you look at ventilation, you can reduce the pneumonias related to it. If you look at central line IVs, and I'm being very specific because you've asked that question, we can actually intervene there. For the heart attack patients, it's the same thing; they shouldn't be going out of the hospital without the right drugs. Half of them are going out of the hospital without the right drugs. Therefore, we have some very specific work and standards.

Under the leadership of John Wade, the Canadian Patient Safety Institute has said one of the things it needs is an arm's-length relationship with the government, so it isn't fettered by the political process. Now you know there's a lot to debate about that, but at the end of the day Dr. Wade wants to be able to speak the truth of the matter and not have someone try to politicize it.

Mr. Rob Merrifield: Are you saying that's happening?

Mr. Philip Hassen: Yes, it is happening, and that's going to help us.

I think we are probably close to getting an agreement of how we're going to move forward the work both Dr. Baker and Dr. Norton have said they want to engage in. That's critical to our success—tangible results, so we can actually see something different happen.

Second, we have to set some very clear standards about how we review these processes that are much more.... I call it prospectively looking at them. These are around infections in the operating room, which are really high. We need to go and look at this in a way that is more methodologically sound and disciplined. We're going to do that, but we have to work with the field to do this work. We can't just impose it. We have to have the key agencies, the key infectious control doctors and nurses, the doctors in general, the nurses in general, the pharmacists all agreeing that this is the work to be doing.

You can say that some won't agree. Well, we'll set the standards because the standard-setting groups are clear that this has to be done.

● (1645)

The Chair: Thank you, Mr. Merrifield.

Next we'll have Mr. Thibault.

Hon. Robert Thibault (West Nova, Lib.): Merci, Madam Président.

I thank you all for coming.

I regret arriving late, like Mr. Merrifield and Madam Crowder. We were in the House with a health bill that was before the House, a quarantine act.

I missed your presentation, but I've seen your documentation before. When I look at it, it scares me a bit, as a Canadian and prospective client to the health care system. Then I remind myself that I'm not going to be in the health care system unless I have great needs, unless the alternative risk is a lot higher than the risk that's posed by being in the system.

You've indicated very well that it is a risky environment. We've seen the superbugs in the hospitals—I don't know if they're viruses or bacteria—but they are only found in that environment. Mostly the ill people are there. The tasks people perform there are often done under great stress, and they're very intricate. So there are a lot of things happening.

Then I started thinking about it, and I looked at some other figures. I saw what other industrialized countries were doing, and it made me a little less worried. I think I should still be worried, because it is a risky environment, but less worried about the competency of our system.

Without attempting to politicize this, because it's always dangerous, I'd like to ask a question. We fund organizations to have a look at how our system is doing, but the system is administered by another level of government, and often by people in the volunteer communities and the professions. I think we have to be a little careful that we're not passing the buck, that we look at this as a country and as a full system, and include everybody working on how to improve it.

I would ask you that question first. Should I be scared or comforted by the fact that we're as good as anybody else? Are we improving? How does our system look internationally? Are we doing well, if we compare ourselves internationally, and are we improving where we are weak?

Dr. G. Ross Baker: Dr. Norton and I, and some other colleagues, with funding from Health Canada, are doing some work now looking at the patient safety efforts in the countries that are most advanced in this area.

The country that is ahead of the rest, I would say, is the United Kingdom, where they are investing considerable resources in working at all levels of the health care system, in the community, in the hospitals, helping to train people, developing better reporting systems, developing ways to reduce infections through increased use of known hygiene techniques, and so forth. It's extremely impressive that the system has really taken this up as a major agenda item.

There are hospitals in the U.S. that I'd say are equally well advanced, but the English have the advantage of having one system that serves the entire country, and I think we could learn a lot from the efforts they're making there.

Hon. Robert Thibault: On a per capita basis, has that borne fruit in England?

Dr. Peter G. Norton: Not at this point, but they are early on, about three years into this program. We won't see the numbers change that quickly because a lot of this is delayed.

In terms of your question, as a Canadian should you be proud of your health care system, our numbers would say yes. We have as much opportunity for improvement as the other comparable countries. You may have worried about the American results of which Ross spoke very briefly, which look different from ours, but they really were based on a different framework and they were also done on patients in 1985-86. The hospitals have changed so much I don't think we should compare ourselves to the American number at all, whereas when we look at New Zealand, Australia, Denmark, and the United Kingdom, our numbers are essentially the same.

Mr. Philip Hassen: I wanted to partly respond to what Ross said about the United Kingdom and the considerable resource investment they've made. What I would say is that we have just begun. It would be unfair for us to say that we need X, Y, or Z. That's unfair. We have enough to get going and we're fine. Clearly, to me, as we see what's going on in other places and what evidence we have to demonstrate and what work we have to do, it may require further research, and how that will come about we don't know yet, but we just need to know that this is a very serious problem.

I think the good news is we have the baseline by which we can move forward and begin to construct some solutions. The difficulty will be that some of those will cost the system some dollars, but also there are real savings. When you save a person from having to stay longer in a hospital, the disability that goes with it, the death, and all those things in terms of a productive society or a productive organization, it's quite a profound statement about what we can do. And we believe we can do it.

We now have it on the table. The good news is that we have it on the table, and the second thing is that we think we have some ideas about what needs to be done.

● (1650)

The Chair: Thank you, Mr. Thibault.

Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

First, I'd like to commend you four gentlemen for being here, and I want to encourage you to keep up your work, because this is something we need to look at.

I'd like to take the approach of asking you some practical questions as a front-line health care provider for 15 years. I want to talk a little bit about reporting or potential under-reporting, and also lawsuits, because these are things that front-line professionals are really concerned about.

I remember a discussion a year ago with a colleague of mine who is a physician and I asked him about the protocol for reporting adverse effects. Number one, he told me they're not compensated for writing the reports. It appears that a physician who has a very busy day has to take a certain amount of time to fill out the reports, put it in, and it's more of a hassle for him to do that.

I was wondering, have you taken a look at the issue of reporting? Even with your statistics, you probably have a lot of under-reporting there. And even in how you defined an “adverse event”, there has to be a bias, because a physician working in a hospital is going to say this one really is not quite clear, so let's put it in the other column, because they don't want to increase statistics. Have you looked at the reporting and under-reporting issue?

Dr. Peter G. Norton: In the study, we systematically looked for any indication that incident reports had been filled out on the 255 patients. There was one out of 255.

Mr. Colin Carrie: Yes, so we have a real problem here, in other words.

Dr. Peter G. Norton: And you know, that includes nurses and not just doctors filling out these reports.

But I want to caution this. There are now three good studies about medication-adverse events just in the drug part showing that the team only recognizes, in any sense, about one-fifth. They don't see them because when you're delivering care you're focused so much on the interaction between you and the patient that things slide by you. You obviously know if you cut off the wrong leg or something, but those are very rare events. A lot of what we—

Mr. Colin Carrie: These are my concerns on how efficient and how practical the system is right now. Are you looking to put in a better system?

For example, I mentioned lawsuits. This is a big concern for hospitals, and I personally have seen where errors have occurred. It's a big concern. Is it an error, is it an adverse reaction? They're putting themselves at risk. Have you looked at this very important issue?

Dr. G. Ross Baker: The experience is different across the country. Some provinces have had legislation for a number of years to protect individual physicians, nurses, pharmacists, and other professionals who come forward to report events. That information cannot be used in court against them.

Other provinces have recently released legislation, including Ontario, but the larger reality is that there's a tremendous fear of litigation that limits the amount of reporting that goes on. We need to change the environment so that we can understand more about this and turn this into an opportunity to improve the systems through learning about what has gone wrong. A lot of that is just not discussed.

Mr. Philip Hassen: There is Saskatchewan legislation that may be worth looking at. Certainly there are some models that we believe will help appropriately protect those people who should be protected as they report these things.

You have to remember that there's a range of issues around this. We're talking about avoidable adverse events or mistakes that were made, human errors. We're not talking about conscious decisions to do something that compromised a patient, which is another whole area that happens, and we can't ignore that. There can't be no blame on that. There is blame, but it's a small part of it. We tend to focus on that because everyone is looking to blame somebody, and it's mostly not blaming individuals.

We have as part of our responsibility, and it is within our mandate and our business plan that the board has approved, to take a look at this legislation and see what we can do to help on reporting, because reporting is extremely critical to making it a more transparent system and to help do the kind of work that we know we have to do. Until we have the information, we can't do much about it; otherwise we're going to have the kind of situation that Dr. Norton just alluded to where only one in 255 of the instances is reported.

People want to report, but there is not a lot of benefit right now because of the fear that goes with it and worry they have with it, and so on. When it's a real incident, where it causes a death or disability, typically some of those major ones get reported because they're right out in your face and you can't avoid it. It's the other ones that we know are underlying, which are precipitating further debilitation of the individual, or death, which don't arise in the literature or in the reporting.

● (1655)

Mr. Colin Carrie: It is a big concern, as my colleague said, about safety and fear. I want to really encourage you to look at and discuss things with the health care professionals out there, because I think there are things that can be done. This issue is so important that we need the transparency and the ability for people to feel free to report on these issues.

The Chair: Thank you, Mr. Carrie.

Dr. Peter G. Norton: Madam Chair, I'd like to add that Dr. Baker and I did a complicated survey, which is posted at the Health Canada website, concerning the state of safety in the nation prior to the release of the report. We had hypothesized that the litigious climate was a major barrier to moving ahead, and we indeed found that in talking to key informants across the country. But we found a bigger problem, which is that we eat our children. You're afraid to tell because you're no longer in the professional camp. It's very strong in the stories that people told us. So in addition to the legality, we have to deal with the professions.

I don't know how we got to that position, but that's where we are. That's a huge agenda for a medical educator like me and my nursing educator colleagues, and so on. We can't do that, and I think it occurs in the alternate professions as well. It's something that's not very good.

Mr. Colin Carrie: It helps just acknowledging it, so keep up the good work.

The Chair: Thank you, Mr. Carrie.

I think everybody has had one turn. With your indulgence, I have a couple of questions.

First of all, could you please communicate to our researchers the six practices that you suggest will increase patient safety very quickly if they are adopted across the country?

Secondly, on the Saskatchewan legislation, which you referred to, if it's a great big long thing, perhaps you could give us some kind of synopsis that captures the essence of it.

Another concern I have is that I remember Ms. Kadis' question about how fast this will happen, but I notice that one of the steps is to change the culture. It would seem to me that anybody trying to change a culture is not going to get results very quickly.

These statistics that Drs. Norton and Baker have come up with seem to be some of the best information we've been able to get. Is that because you did it through a hospital institution and all the players were anonymous? Did you guarantee anonymity no matter how egregious the adverse event?

Dr. G. Ross Baker: We guaranteed that we wouldn't reveal the individual incidents, but we were aware of the fact that we might come across one or more incidents where there was intent to harm, so we created a safety committee that would give us sound advice on whether or not we needed to provide additional information. I am happy to say that we didn't find anything like that. The hospitals participated, but we agreed that we would not release the details on individual hospital results, nor on the individuals involved in each one of these incidents. We felt it was important to come up with a number that represented a Canadian number, that showed the state of the art in Canada, and not to get into invidious discussions about whether or not Vancouver or Toronto were different. At the end of the day, it's going to be the same initiatives that need to be taking place in both those cities, as well as the rest of the country.

The Chair: How are we going to change the culture if in fact not only physicians and nurses but also hospital boards themselves have lived in a world of non-disclosure in order to protect either their personal assets or the hospital's treasury? I don't understand how we will ever convince people, unless we move to something like no-fault insurance, as we have in the automotive field.

Dr. Peter G. Norton: I think we already see some of the cultural shift. Ten years ago, I don't think this meeting would have occurred. But I think it will be slow. It is important to look at some key indicators. For example, the Canadian Medical Protective Association has changed their position within the last five years and now tells physicians to tell their patients. Before that they'd say don't tell your patients. That's a huge change. I think it is very important for us to work with every level of the system, from the boards, through to the senior executives in hospitals or regions, through to the front-line health professionals who are doing the work every day. I don't think the culture will change in one or two years. We can do things even while we're changing it. But it has to be on our radar as we go ahead.

● (1700)

The Chair: Thank you.

Somebody said that everybody they encountered seemed to have on their lips the phrase “safety first”. I can certainly believe that about health care professionals and their intent to do good work. But I'm wondering if you also found that for pharmaceutical company executives. Certainly the news that has come out recently would suggest their phrase would be “dollars first”, not “safety first”, when one thinks of Vioxx, for example, where they had the information for a long time. Also, Propulsid was well known to have caused many deaths in the United States, but the company did not pull it off the shelves.

Did you deal with any pharmaceutical companies?

Dr. Peter G. Norton: In the Health Canada study, we dealt with health professionals only.

The Chair: Mr. Hassen.

Mr. Philip Hassen: First of all, not all pharmaceutical companies are alike. I think some of them really do believe in the diligence that's required.

The cultural change we're talking about is a series of things that will have to occur in the way we do things. That's what it's all about. It will take time. I want to come back to that, because it's a very important issue. In the long run, that's what we have to do—change the culture of how hospitals and health care providers look at the work they do and the safety required for that. What I would also say, though, is that we need to do some short-term interventions, and we've described some of those, and some intermediate things. And we have some thoughts on that. The board is going to be seized with some of this work in the next little while, as we finish off the consultations, to come back with a much tighter plan, which we'll be sharing with Health Canada, as to how we go forward with that. I just want to be clear that, ultimately, we must change the culture. If we just keep nattering at this and doing one-offs, it will not do what we need it to do. But we do need to show results. There are some ways of doing it that fit in with the evolution of the culture as well.

The Chair: Thank you.

Our next questioner will be Mr. Merrifield, followed by Mr. Cuzner and Mr. Lunney.

Mr. Rob Merrifield: When we were on a cross-country study on drugs last spring about this time, actually a little closer to spring, before we issued our report, one of the things that came to light in one of the testimonies was the line of drugs called benzodiazepines. I believe there was a follow-up to that in the *Vancouver Sun*. It was front-page news here, I believe, yesterday or the day before. This individual was saying there were 20,000 to 30,000 deaths per year just from this drug alone. They were mainly in our elderly but also in our very young. In fact, they used to call the pill mama's little helper.

I'm very concerned about this, and because of the extent I'm wondering if you're doing any work on that side of it. If these numbers are anywhere close to being accurate, we have an unbelievable situation out there. I have to believe from some of the testimony I've heard in my office that there's a lot of truth to those numbers. As a patient safety institute, are you looking at some of the recommendations coming from Health Canada? On this product they're saying seven to ten days maximum use. We now know there are individuals who are on this seven to ten years. This report in the *Vancouver Sun* said that over 10,000 people, I believe, in British Columbia alone were over 1,000 pills per year when the recommendation was no more than 100. Are you looking at that side of it?

Mr. Philip Hassen: There's some work being done on that. I mentioned the CMIRPS, which is the group that's looking at adverse event reporting. Whether it comes from the public or from professionals or hospitals, that work will all come together and help us get at that issue.

We haven't yet said here's what we're specifically going to do. Of course not. But we realize that's an issue. The question, though, really is how do we tackle this problem in a way that we can actually define each of these issues and get at it? We can't do everything or else we won't do anything well, so we're trying to define those issues. Certainly, however, we will be looking at that. The CMIRPS, this reporting system that we're now designing, will help Health Canada look at the methodologies there as well as at professionals and how they're using the drugs.

● (1705)

Mr. Rob Merrifield: To help you with that, IMS has some numbers on how prescriptions are done across this country and where drugs are being dispensed in disproportionate amounts. I would just suggest you look there.

There is another thing that crossed my mind and was given as a recommendation. When you talk to coroners, they'll tell you there's no place on the form that specifically asks for the amount of the individual's medication at the time of death. We're finding that individuals may be in an auto wreck, and as a result their cause of death may be an injury, but nobody is looking at what kind of medication these individuals were on when they were behind the wheel. If you're looking for information of disclosure, a simple change would be to make it compulsory that the coroner puts medication of the individual on the coroner's report. That's not there at the present time.

I wonder if you would comment on that.

Mr. Philip Hassen: Sure, those are the kinds of things that we're going around the country to try to find out by having these consultations, to find out what we should be looking at. I happened to have worked with Jim Young, who was a coroner. I think I'll talk to him about it and some of the coroners. I'm meeting with the Ontario government on Monday and I will ask them some of those questions to help me frame that and see how critical that is.

But I think you're right. I think that is an understated issue in our work. We don't know what that looks like and what the consequences of that are.

Mr. Rob Merrifield: I know we talked about adverse events, and I believe you're absolutely right that the numbers that are disclosed —anywhere from 1% to 10%—are exaggerated. It certainly would be the case if you're saying there's only one in 250 some. How do you get to the bottom of that? Yes, we can bring in compulsory disclosure of drug reactions, but when other countries have done that, it still hasn't solved the problem because of the potential liability. Obviously nobody wants to say he or she prescribed a medication that was inappropriate.

I'm not sure if in your testimony you addressed how you're going to get to the bottom of that. I know the minister is looking at it right now. Somehow we're going to have to break down those silos and the ideology, so that the physicians and the medical professionals across this country see this as something they can really champion rather than be afraid of. I don't think we're blaming anyone. We just want to get to the bottom of it.

I'm wondering if you have some suggestions as to how we go from understanding that we don't want to put anyone at fault to actually getting compliance with disclosure or reporting of adverse events.

Dr. Peter G. Norton: I think this is one of the problems I've been wrestling with: what would we do if we did get them all? Let me say that I believe the Canadian Adverse Events Study underestimates in hospitals. Why? The methodology systematically underestimates so that we have a low bar here in Canada and not a high bar. I think many of us would believe the true number could be two or three times as high as we saw. With charts, you're only looking at what people write down. In a busy hospital now, if they really knew about all those, and about all the near misses, you might have such a flood of data that you couldn't sort it out and use it. So we've been talking about how we might do that.

I'll share with you an interesting way of getting more data, because we did it. Our chief medical officer in the Calgary health region retired for medical reasons. Everybody was asked to give a gift, and there was $15,000 for him. He said, "I don't want this gift. What I'm going to do is put $3,000 aside each year for the next five years, and each year the three best safe catches"—it's a new term we're using, as in, catch it before it hurts a patient—"will get $1,500."

Do you know the stack of these things we got all of a sudden?

● (1710)

Mr. Rob Merrifield: Incentive.

Dr. Peter G. Norton: It's a serious question from a research perspective, or from a management perspective: can we categorize it so that we can use it to improve the system?

Mr. Rob Merrifield: Every catch might be a life; great.

Dr. Peter G. Norton: I think it's wonderful. I mean, it really works, and it's not expensive. There's an excitement in our region, and a vision from the retiring chief medical officer. But we're now sitting with all this data and asking how we categorize it and then look for opportunities where we can really help the system. So I think some fundamental work about the way we manage the system is intertwined with this.

Those are just my thoughts about it.

The Chair: Thank you, Mr. Merrifield.

Mr. Cuzner.

Mr. Rodger Cuzner: This question was touched on earlier, but I'm just wondering if we might be able to further elaborate on it. There are myriad groups trying to do good work out there—the Canadian Coalition on Medication Incident Reporting and Prevention, the Institute for Safe Medication Practises Canada, and the Canadian Adverse Drug Reaction Information System. How do the organizations relate to each other, and how do they relate to the institute? Are there formal agreements in place? How is the information shared to benefit everybody and to ensure that you're not duplicating energies and initiatives?

Mr. Philip Hassen: First of all, we're into this really early. I appreciate your question, though, because it is one of the critical things we find it's going to be important to do right.

We have had a couple of meetings already and will have meetings with all of what I call the key national bodies, like the Canadian Institute for Health Information. Canada Health Infoway is certainly a part of that, as are the Health Council of Canada, which is Michael Decter's group, and also Stats Canada. These are groups that have common interests about looking at how we're going to begin to organize this and have information to help us improve that.

The second group we have is something we didn't talk a lot about, but I'm just going to mention it; it gets into a big discussion. The members of the corporation of the Canadian Patient Safety Institute are 100 people representing 100 organizations, and we're just in the process of finalizing what that looks like.

This is about stakeholders having a commitment to safety, whether it be the Canadian Medical Association, the ICU directors, or the nurses in the ORs. These are all groups that are eligible—we are just putting together that list—because we believe that this is about getting a commitment from a whole myriad of people who have a real interest in this. There isn't one of them who will say they're not interested in it. This will help us begin to engage these people.

Many of them, researchers as well, are going to form many of our subcommittees that will help inform the board as to how we should behave. These members will also ultimately constitute our board. The board is a transition board, and ultimately they will have membership on the board. There will be 15 people from these diverse groups who will form the board to help us understand how we keep engaged with the broader community of caregivers, provider organizations, associations, agencies, and so on and so forth.

I think the model is maybe a novel model, one that hasn't been done before, but I'm hopeful and optimistic that this group will then be able to go back and interface with us on a whole series of fronts on how to begin the process of improvement. There are some practical things we're going to have to do and so on, and there are some tough standards we're going to have to take a look at. We'll hopefully see them adopted, and those things will be pretty important too, as will having the right people engaged, including the provincial governments and associations.

That's the work we're doing right now.

Mr. Rodger Cuzner: You really see it as an overarching interest to have all these other groups.

Mr. Philip Hassen: Absolutely.

The Chair: Thank you, Mr. Cuzner.

Mr. Lunney, followed by Mr. Lemay, and then I think that will be it.

● (1715)

Mr. James Lunney: Thank you, Madam Chair.

I wanted to take another approach here. One of the issues is the practice guidelines docs practise under. They are pretty tightly specified, and if the doctors practise outside those guidelines, they can find themselves in conflict with their licensing boards. Now, that's a nice safe way to practise, but it seems that once those things are established, it's a mammoth task to move or change them, even if advances come along that might improve safety or offer low-cost alternatives that might in fact improve morbidity and perhaps even mortality rates.

A study came out recently saying that 80% of those practice guidelines are of course written by people who do direct research for pharmas, and drugs are one of the high-risk venues there, certainly, as we've identified. An example I'd like to raise is heart disease, which you mentioned earlier. All the research that has been done recently on homocysteine and a simple intervention like folic acid, perhaps backed up by B-6 and B-12, if you will...but to reduce homocysteine and improve cardiac outcomes, there have been at least a thousand articles in the medical literature, as I understand it, in the last five years alone on how that could improve cardiovascular health and reduce the risk of heart attack and stroke.

I know there are cardiologists who are now recommending that their patients take folic acid, but it's not in the practice guidelines, and by and large it's below the radar of most practitioners. I'm wondering, what kind of safety watchdog should there be to help break into these practice guidelines when there are efficiencies and opportunities found that can actually help advance this?

By the way, I'm sure you saw a year or so ago that a couple of docs recommended a new poly-pill, a new super pill to help people with heart attack and stroke, that would give you the five meds you're on after you've had a heart attack plus folic acid. They expected it would reduce events by up to 80%. But what if folic acid alone would reduce the morbidity? Maybe it's something low cost and low risk that should be added to the regime.

Does anybody want to take that one on?

Mr. Philip Hassen: I just want to comment on one part of what you said when you said there are pretty tight guidelines for doctors to practise. I think you're overestimating the profession, and I think they would agree that they have lots of degrees of freedom on how do to it, and we see that all the time. We see wide variation in practice in every arena we work in. Peter, who's a physician, can maybe comment on this—but maybe he doesn't want to. There's a high degree of freedom. It isn't like you go in and say “Here's the prescription on how to treat this person”. There are many ways of doing it.

Secondly, the literature is not as clear. You may be clear, but when I go to the literature and I keep seeing changes to these best practices.... That's why we've gone to the Cochrane Collaboration and other places to try to find where the real best practices are.

There are wide guidelines. They are not as narrow as we would like them to be in some situations. Otherwise, why do we have only half the people going home with the right medications? Why are diabetics still not monitored properly, and so on? It's because the guidelines are not written in stone. They are guidelines. They give people lots of freedom.

Mr. James Lunney: There are a lot of doctors who do intravenous chelation who might beg to differ with you. They've run into some serious problems with their licensing boards, as well as others who would like to do intravenous vitamin C for viral infections and so on.

But there's a second question I'd like to ask. You mentioned the U. K. in terms of advanced patient safety. In the U.K. they have an institute called the National Institute of Clinical Excellence. I wonder if you're aware of that or if you feel that's a.... We do have an institute here that looks at new therapies for effectiveness, but there's nothing that actually examines existing treatments for effectiveness and cost-effectiveness. Is that something that's needed in Canada?

Dr. Peter G. Norton: I think it would be worth while for some of our federal agencies to look at the NICE initiative. I really like the acronym, NICE. You notice that's what it stands for. I think they do remarkable things, and in my work as a teacher I actually refer my residents to that site to look at some of the stuff. It's quite amazing. We don't do anything just like that in Canada.

The Chair: Thank you, Mr. Lunney.

Mr. Lemay.

[*Translation*]

Mr. Marc Lemay: Following up on my colleague's comments about publicity, when the bacterium *C. difficile* wreaked havoc in the Montreal area, never before had we seen such publicity. The outcry prompted the Department of Health and Social Services to take drastic, radical steps, and above all, to act very quickly. Never before has a Health Department responded so quickly, especially in Quebec.

I concur with my colleague. It's critical that your findings be made public, and quickly. We'll deal with the fallout later.

As I listened to my colleagues, some thoughts were going through my head. All hospitals are concerned about their accreditation. I was wondering — and I will put the question to you, as you're the experts and I don't need to tell you how things work — if there might not be some way of moving forward by focusing on accreditation or by cooperating on an initiative such as yours.

● (1720)

[*English*]

Dr. Peter G. Norton: If I could just speak to that, the Canadian Council on Health Services Accreditation was a stakeholder with us from the beginning in this study. Last month they put forward new standards for accreditation specifically aimed at safety. They've been in the field for a year now, and then they will become required organizational practices. I sat on the committee that drew these up, and we carefully tried to put in a high bar that many organizations could meet, but they would have to work to meet it.

I believe accreditation is one of our strong tools to produce change in this country. I think if you have a chance as this committee to encourage the educational accreditation people to say safety has to be part of the educational curriculum, I would encourage you to do that. We haven't cracked that nut. But the hospital accreditation and regional accreditation is in place, and I think it will be quite powerful.

Mr. Philip Hassen: Just to add to that, Wendy Nicklin is one of our board members. She's the CEO of the accreditation council, and that in part is to do that. In fact, I spent two hours with her and her staff today to talk about some of the ways in which the indicators resulting from these new standards will incorporate and dovetail with what we're trying to do within the Canadian Patient Safety Institute. It's obviously early yet, but I think she and I see it the same way, that this will be a great opportunity to show how we bring it together, and we aren't being inconsistent and we're not duplicating efforts.

The Chair: Thank you, Mr. Lemay.

Mr. Carrie has asked to speak. Go ahead, Mr. Carrie.

Mr. Colin Carrie: First I'd like to say how impressed I am with your work and how timely it is. Today we've seen some really great ideas come out, such as questions about there perhaps being no-fault insurance for physicians and hospitals; about things such as reimbursement for physicians for reporting; and Dr. Norton, you mentioned implementing the "best catch" in the hospital. I was wondering, though, how close Canada is to implementing an efficient reporting system for medication and adverse effects. How far away from it do you think we are?

Mr. Philip Hassen: The group that is working on this—this is the CMIRPS group that was alluded to, the Canadian medication reporting group—I think is at least three years away from having a system that would actually report what you're suggesting.

Mr. Colin Carrie: Are you going to be having interim reports, so that maybe you could get back to us to let us see how you are—

Mr. Philip Hassen: Yes, we'll have annual reports of the Canadian Patient Safety Institute to reflect some of the work that's been done. We feel very strongly that we need to get this material out, so that the public....

Our difficulty comes back to the question mentioned earlier about how we make the public knowledgeable about this, let alone the professionals, let alone the politicians. There are so many audiences for whom it's important they understand it, and in different ways, because there are different decisions for different people to make, whether it's an individual decision or a country decision or a provincial decision. All of these are important decision points.

Mr. Colin Carrie: I think that's a great goal. I personally, and I know our colleagues, would be interested to see those interim reports and to find out what the holdups are, because if there is anything we can do to raise that awareness, it would be fantastic.

Thank you very much.

The Chair: Thank you, Dr. Baker, Dr. Norton, Mr. Hassen, and Mr. Schurman.

On behalf of my colleagues, I want to thank you very much for bothering to come to see us and for sharing with us your important work. As all my colleagues have suggested, we will be interested in regular updates—anything you want to send to us. We're very interested in your work.

Thank you again for your time and your efforts and just for the work you do every day on behalf of Canadians.

This meeting is now adjourned.

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