Quality improvement and accountability responses contribute to an effective and safe health care system.
PURPOSE

This paper addresses the medical liability issues associated with the reporting of and response to adverse events, and proposes measures to strengthen the existing system. The document provides recommendations for policy makers, regulatory authorities, health institutions and physicians, which are aimed at enhancing patient safety and ensuring an equitable accountability framework by which the actions of health care professionals may be considered. The paper re-affirms that both quality improvement and accountability responses to an adverse event are important in ensuring an effective and safe health care system in which Canadians can have confidence. Such confidence can be realized through the use of appropriate system-level policies and procedures.

This paper will be of interest to physicians as well as non-physicians, including those involved in the management of the health care and justice systems. It complements a Canadian Medical Protective Association (CMPA) publication entitled Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions prepared for CMPA member physicians, including those in leadership and management positions. That publication provides advice on reporting requirements for unexpected clinical outcomes, adverse events and close calls, and on how to conduct reviews in institutions and hospitals. It may be helpful to consider these two documents in tandem.

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Reporting and responding to adverse events: A medical liability perspective.
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Health care providers always seek the best possible clinical outcomes for their patients. However, even with the best of medical care, a patient’s outcome may not be what was originally desired or anticipated. Unfortunately, despite the dedication, training and professionalism of the health care providers, some unexpected outcomes are related to health care delivery itself. An adverse event is one which results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient’s underlying medical condition.

Within the Canadian health care system, and as depicted in the diagram on page 4, there are generally three primary responses to an adverse event:

1. Once the immediate clinical needs of the patient have been addressed, the first response is to disclose the adverse event to the patient. Patients expect to be informed about harm they have experienced, whatever the reason for it. Effective communication with patients and the health care team can improve patient outcomes and satisfaction. Failure to communicate effectively may lead to patient harm, misunderstandings, complaints and lawsuits.

2. The second response focuses on learning from what has happened to support quality improvements. The development of a protected “learning environment” is vital to a just culture of safety in which health care providers are able to report adverse events and close calls, and review these events without fear of inappropriate reprimand or punishment.

3. A third response involves consideration of accountability issues and may include investigations and/or disciplinary proceedings within a hospital or regulatory authority (College). Where compensation is sought, the matter may proceed to civil litigation. Regardless of the type of proceeding, the accountability response has well-established protocols to ensure procedural fairness is accorded to all parties. Although this response may, when appropriate, lead to sanctions, remediation and education are preferred.

Recently, the CMPA has focused its educational efforts on the effective disclosure of adverse events to patients. The Association collaborated with the Canadian Patient Safety Institute on its Canadian Disclosure Guidelines and has developed a comprehensive booklet on disclosure. The Association has also supported the introduction of effective apology legislation that encourages the use of apologies by health care professionals by protecting expressions of regret from being used against the health care professional in proceedings and civil litigation.

While the roles and responsibilities related to disclosure of adverse events to patients seem to be better understood, more work is required on quality improvement processes and accountability responses. The CMPA is committed to working collaboratively with stakeholders to ensure the creation of a just culture of safety that encourages learning from adverse events. Such work will ultimately help to strengthen the system, educate physicians and others to prevent similar events in the future, and hold individuals professionally accountable in a fair and balanced way.
It is important to achieve an appropriate balance between the protected nature of the learning environment and the public’s right to understand how the safety of health care can be improved.

System improvements can be achieved by examining why adverse events happened and sharing the results of this examination with a view to preventing re-occurrence. However, this should happen in a manner that provides procedural fairness for all involved, including health care providers. This is necessary to encourage health care providers to frankly discuss what happened in a non-threatening environment – they need to know that quality improvement information collected as part of the learning process is protected from being unfairly used against them in the context of hospital or College proceedings or civil litigation.

The protection of quality improvement information is one of the cornerstones of an effective patient safety program. The CMPA encourages its physician members to fully participate in quality improvement

Diagram A — The response to adverse events

* While all adverse events need to be disclosed to patients, not all adverse events require further review and analysis.
activities, while ensuring that the information generated by such activities will be protected from use in either accountability reviews (e.g., hospital or College proceedings) or civil litigation. The maintenance of a protected “learning environment” in which those involved can freely examine the adverse event and discuss the factors that may have contributed to it is vital to the just culture of safety – a culture where health care providers are able to report adverse events and close calls without fear of inappropriate reprimand or punishment.

**Erosion of the firewall**

The CMPA is concerned that the importance of protecting quality improvement information is not well understood by decision makers. Some have taken the view that full and unfettered disclosure of quality improvement information is necessary to improve patient safety. As a result, some institutions have sought to undertake quality improvement reviews that are not constituted in a way that benefit from the legislated protection against disclosure of quality improvement information.

At the same time, the CMPA recognizes the need for a strong accountability framework that holds health care providers responsible for their actions. Accountability is reinforced through various means including regulatory authority investigations and, in certain instances, through civil litigation.

It is crucial, however, that an “information firewall” exists between quality improvement and accountability mechanisms and that they be treated as distinct processes. By separating the professional accountability process from the quality improvement process, health professionals will be more likely to provide a quality improvement committee their opinions, and in appropriate instances, hypothesize as to how certain processes could be changed to improve the system.

Each of the responses to an adverse event requires its own method of handling information. These separate flows are what make the system work – for the patient, the health care providers involved and for the system as a whole. While the specific nature of the disclosure, reporting and review will vary depending upon the situation, they will comprise one or more of the following:

- Appropriate disclosure to the patient;
- Protected discussion in support of quality improvement and enhanced patient safety; and
- Prescribed reporting procedures and information protocols for accountability responses that are in keeping with procedural fairness.

The CMPA recognizes that health care facilities and providers are under increasing pressure to improve accountability-related reporting; however, this should not happen at the expense of the quality improvement process. The challenge is to find the right balance between improving health care and helping all providers prevent similar events in the future, while fairly addressing any issues of individual provider performance and accountability.
The reporting of an adverse event is a crucial prerequisite to both quality improvement and accountability responses. Adverse events are reported through various means, including:

- Direct reporting by providers involved in the adverse event or close call;
- Concerns and complaints brought forward by patients and families, or health care providers; and
- Audits (e.g., using trigger tools).

Reporting systems should focus on capturing only factual information, recognizing that speculations or opinions may lead to misunderstandings and inaccurate conclusions. Incident/occurrence reports may not benefit from the legislation that generally protects the disclosure of quality improvement information from being used in subsequent legal, regulatory or other proceedings. While this situation is appropriate, it reflects the need to focus incident/occurrence reporting on the facts, as they are known at the time.

Currently, the legal obligation for reporting adverse events or close calls varies across Canadian jurisdictions. This represents an opportunity for considerable system improvement. A consistent approach to adverse event reporting is needed — one in which health care professionals and/or health care institutions provide factual and timely reports of adverse events to the relevant authorities. Carefully developed standardized reporting protocols will permit factual information to be gathered (and possibly prevent the inclusion of speculation), as well as support system-wide data collection and analysis, including meta-analysis of incident/occurrence trends.

Health care institutions generally have policies guiding the reporting of adverse events or close calls. These policies should specify a person or committee responsible for receiving incident reports on adverse events and such reports should be submitted only to those individuals. However, such policies do not always exist in non-institutional settings where an increasing amount of care is being delivered. This represents a growing gap through which a considerable amount of important information may be lost. Once a supporting quality improvement infrastructure is implemented, policy makers are encouraged to address how this information can be appropriately captured. This will likely require the establishment of reasonable parameters for the reporting of such events in non-institutional settings.

There should also be a mechanism to effectively collect and analyze the information provided, without identifying individuals. The resulting information will provide Canadians with a more accurate understanding of the safety of the health care delivery system, and will enable detailed analysis that supports the identification and implementation of evidence-based system improvements. While a national incident/occurrence report database would be the preferred approach, it is recognized that varying degrees of progress at the provincial level likely make such an outcome unattainable in the short term. Provincial governments should be encouraged to put in place the data collection and analysis capabilities and make the appropriate information widely available to other jurisdictions, health care institutions in their jurisdiction and to patient safety research.

A consistent approach to adverse event reporting is needed — one in which health care professionals and/or health care institutions provide factual and timely reports of adverse events to the relevant authorities.
RESPONDING TO ADVERSE EVENTS:
QUALITY IMPROVEMENT

While the reporting of adverse events is a necessary first step, it alone is not sufficient. After a serious unexpected clinical outcome or adverse event, a review should generally be considered. Building on the information provided in the incident/occurrence report, a preliminary collection of facts may be done to develop an initial understanding of an event. This “triaging” effort will assist decision makers in understanding whether more detailed reviews should follow in the form of a quality improvement review, an accountability review, or both.

Quality improvement response
The focus of the quality improvement review is to identify actions to improve the system of care for the benefit of future patients. It is not a determination of responsibility for individual providers. The quality improvement review should be conducted under the auspices of a properly constituted quality improvement committee. Quality improvement committees, depending on the province or territory, may have different titles, for example: Quality of Care, Critical Incident Review, Risk Management, etc. Legislation in each province/territory generally protects the information and documents prepared for, or generated by, a quality improvement committee from being used in subsequent legal, regulatory or other proceedings, but does not protect the fact that the review itself was conducted. The extent to which quality improvement information can currently be provided to others, including what is disclosed to patients, varies among the jurisdictions.

Generally, the relevant legislation reflects the public policy objective of encouraging health care providers to participate in quality improvement processes. Meaningful quality improvement reviews are characterized by a candid and forthright assessment by the health care providers involved of the events that occurred. In addition to reviewing the facts, it may be helpful to consider what could have happened or what the participants wished had happened. While such speculation would be highly inappropriate within an accountability review, hypothesizing about system processes during a quality improvement review may be useful to identify the root cause(s) and to develop strategies to help prevent possible re-occurrences.

For quality improvement reviews to be successful, participants must be confident that the information gained through such reviews will not be used against them. Otherwise, they are likely to be unwilling to participate (or participate fully) in the quality improvement process, thereby greatly undermining its effectiveness as a learning opportunity. The likely outcome would be that patient safety would suffer.

Efforts to eliminate or reduce the legislated protections for quality improvement information may in fact jeopardize patient safety. Indeed, patients have the most to gain from a system that allows for rigorous examination of an adverse event so that the circumstances that led to it can be avoided in the future. Such an examination is most likely to be effective only where the information gathered is appropriately protected.

While the information uncovered in the course of a quality improvement review should generally remain protected, if serious concerns regarding a health care provider’s competence or conduct are discovered, the quality improvement committee should suspend its analysis so these issues may be appropriately reviewed in a separate and independent accountability process. Importantly, the quality improvement protections are not meant to shield the accountability of health care providers. Quality improvement and accountability reviews have distinct purposes and can, if properly constituted, operate in parallel.

Given their typically speculative nature, quality improvement working documents should not be released. With a view to ensuring public confidence in the health care system and to demonstrate an ongoing commitment to improving the safety of care,

Continued...
RESPONDING TO ADVERSE EVENTS: QUALITY IMPROVEMENT
continued

consideration should be given to releasing the recommendations of quality improvement reviews, under the following conditions:

- The applicable legislation that protects quality improvement information permits the disclosure of these recommendations. As the legislation in some jurisdictions currently prohibits the disclosure of any quality improvement information to persons outside the quality improvement committee, policy makers may consider amending the legislation to permit the disclosure of quality improvement recommendations, while still extending the protection to the other information collected during the review.
- Information collected during the review, including that gathered from the health care professionals involved, should remain protected by the provisions of the relevant legislation. This information should not be available to those reviewing a provider’s performance from an accountability perspective.

RESPONDING TO ADVERSE EVENTS:
ACCOUNTABILITY RESPONSE

The sound practice of medicine, along with natural justice imperatives, requires health care professionals to be accountable for their actions. An accountability review focuses on an individual provider’s performance, although system failures may also be identified. This type of review is required whenever there are concerns about an individual provider’s performance and it is a necessary element in ensuring quality of care and the public’s ongoing confidence. This response may, when appropriate, lead to sanctions, although remediation and education are preferred. Examples of possible sanctions include the withdrawal of practice privileges in hospitals or restrictions on or revocation of licensing. The initiation of civil litigation also represents a form of accountability response, aimed at addressing appropriate compensation for the patient who suffered harm from negligent care. A strong accountability framework is a necessary component of the health care system.

While the quality improvement response may best be characterized by its focus on learning, the accountability framework requires the application of procedural fairness, prescribed protocols for information handling and the assessment of an individual’s actions. Reviews that focus on the actions of an individual (rather than on the system) should be considered part of the accountability response and guided by the legal and procedural protections that exist within that domain. Regardless of the accountability mechanism used (hospital review, regulatory authority investigation, civil litigation, etc.), in almost all cases, there are currently clearly prescribed processes in place that protect the interests of all involved: the patient, the provider and the public.

Recognizing that peer review is a term used with varied meaning, when the intent of the review is to assess the clinical competency of an individual, such a review should be considered under a properly constituted accountability framework. This type of review is
generally described as a retrospective review by peers, or subject matter experts, of an individual or groups of individuals looking at specific indicators of quality of care. The goal is to identify, within a confidential process, areas for practice improvement. In this context, peer reviews should be constituted as part of an accountability framework.

In a hospital/institutional setting, procedures should be developed that would enable those who discover issues with a provider's performance during a quality improvement review to report the performance issues to leadership/management. The report should allow for an accountability investigation to be commenced, while maintaining the protection for information gathered in the quality improvement review. Those conducting the accountability investigation should collect their own information in accordance with the established procedures and protections. As a minimum, there must be an “information firewall” that prevents quality improvement information from being used in accountability reviews. If that “firewall” is breached, it is likely health care providers will lose confidence in the quality improvement process and, fearing reprisals based on information gained without procedural safeguards, may diminish their participation in this patient safety-oriented learning effort.

While the information generated within the accountability review may not be protected by legislation, it should still be treated as confidential. Each of the various accountability responses has its own set of information procedures; for example, the information protocols guiding hospital reviews are different from those used by regulatory authorities while civil litigation also has its own procedures. Regardless of the accountability mechanism, authorities are encouraged to ensure full clarity of the procedures, and physicians and other health care professionals are advised to understand the procedures that apply to them. Health care providers should be informed as to how and to what extent the information generated may be shared with others. In many jurisdictions, if privileges are restricted, cancelled or suspended as a result of any review into competency, the hospital/institution may be required by law to report this information to the regulatory authority. Similarly, regulatory authorities are increasingly required to provide public access to findings that indicate the physician did not meet the standard of care.

In those instances in which it has been determined through fair processes that unprofessional conduct by a health care professional has occurred, the CMPA supports this information being made available. Indeed, to deny such availability would undermine the public’s confidence in the profession. However, this should occur only under carefully defined procedures and when it is viewed to be in the public’s interest. Information shared should generally be limited to the findings and recommendations and, unless it is already in the public domain (e.g., through civil litigation), the supporting information should remain protected.

**While the quality improvement response may best be characterized by its focus on learning, the accountability framework requires the application of procedural fairness, prescribed protocols for information handling and the assessment of an individual's actions.**
Governments, regulatory authorities, health authorities, institutions, physicians and other health care providers all have important roles to play in establishing the legislation, policies and procedures necessary to ensure the effective collection, analysis, distribution and, where appropriate, protection of information related to unexpected clinical outcomes, adverse events, and close calls. Achieving the appropriate balance between quality improvement and the accountability responses will require policy makers to more clearly delineate the responsibilities for each of these responses.

**RECOMMENDATIONS**

**What should policy makers do?**

Governments and other policy making bodies are key players in achieving the right balance between improving systems of care, while fairly addressing any issues of provider performance and accountability. To achieve this they should consider the following:

- Implement legislation that mandates incident/occurrence reporting and policies that clearly specify the conditions under which such reporting is to take place. It is noteworthy that to date, Québec, Manitoba and Saskatchewan have all enacted such legislation for institutions as part of their efforts to improve the quality of care.

- At the appropriate time, and once supporting quality improvement infrastructure is in place and reasonable parameters are established, consider extending reporting requirements to non-institutional settings.

- Develop a common coding system so that data can be collected, aggregated to preserve anonymity, analyzed and shared within and among jurisdictions.

- Re-affirm and, if required, strengthen the existing protections for information collected as part of the quality improvement reviews. Particular attention should be directed to ensuring an effective “information firewall” between quality improvement and accountability reviews.

- Implement policies that require the sharing of the recommendations of quality improvement reviews, and identifying those recommendations to be implemented.

- Adopt policies that more clearly specify and support a more consistent approach to the disclosure of the results from accountability reviews. Such policies must take into account and balance the interest of all parties involved, including patients, health care providers and the public, and must ensure that, except in specific circumstances, the information generated will be treated as confidential.
REGIONAL AND LOCAL HEALTH AUTHORITIES AND INSTITUTIONS SUCH AS HOSPITALS AND CLINICS SHOULD PROVIDE THE SUPPORT AND INFRASTRUCTURE NECESSARY TO ENCOURAGE THE CREATION OF A JUST CULTURE OF SAFETY THAT SUPPORTS LEARNING FROM ADVERSE EVENTS AND HOLDS INDIVIDUALS PROFESSIONALLY ACCOUNTABLE IN A FAIR AND BALANCED WAY. THIS CAN BE ACCOMPLISHED, IN PART, THROUGH THE FOLLOWING ACTIONS:

☐ Develop policies and procedures to support quality improvement, including the reporting of adverse events and close calls and ensure that these are understood by providers and followed by leadership/management. These policies should align with provincially mandated requirements for incident/occurrence reporting.

☐ Implement policies and procedures that separate the systems-oriented quality improvement reviews from examinations that focus on the performance of individual health care professionals.

☐ Accept appropriate responsibility and accountability. Individuals should not be held accountable for system failures over which they have little or no control.

☐ Ensure that the initial responses to the adverse event, as well as any subsequent analyses and proceedings, will be conducted with fairness, within the applicable legal frameworks, and in accordance with established policies.

☐ Establish procedures for the release of the system improvements recommendations of quality improvement reviews, while ensuring continued protection for the other information collected in the course of these reviews. Adhere to procedures whereby reviews of the performance of individual health care providers are completed in accordance with the provisions of the accountability framework. This would apply to hospital reviews and regulatory authority investigations, among other types of reviews.

☐ Educate health care professionals on the quality improvement process to:
  - encourage participation in properly established quality improvement reviews that protect the information collected;
  - recognize the procedural fairness and related protections available within the accountability framework.

☐ Reassure providers that quality improvement information is protected and participation in the process will not make them unduly vulnerable to reprisal in legal, regulatory or other proceedings.

☐ Develop recommendations and implement system changes based on the outcome of quality improvement processes.
In addressing adverse events, physicians and other regulated health care professionals are faced with a range of requirements related to their legal, professional and ethical responsibilities. In order to meet these requirements, they should consider undertaking the following actions:

- Regardless of their practice setting (hospital, clinic, office, etc.), fully understand and follow the legislation, policies and procedures regarding the reporting of adverse events and close calls. This understanding should extend to knowing the likely approach to analysis, and to what extent, if any, information related to this analysis will be disclosed to patients, health care and regulatory authorities or the public.

- Provide only factual information in incident/occurrence reporting and refrain from statements of blame, speculation, opinion or other commentary as to the reasons for what happened. Incident/occurrence reports are unlikely to benefit from legislative protection in legal, regulatory or other proceedings.

- Inquire as to whether the institution's quality improvement committee is properly constituted under the relevant legislation and seek assurances that quality improvement reviews will be conducted in a confidential manner.

- Promote the use of properly constituted quality improvement committees so that information collected and produced by such committees will be protected.

- Fully participate in systems-oriented quality improvement reviews. Participation by providers in quality improvement reviews may be mandated by law in some provinces/territories or by hospital bylaws.

- Understand the differences between a quality improvement review and an accountability review, in terms of their different purposes, procedures, information protections and consequences.

- Seek advice from the CMPA when necessary.
The majority of unexpected outcomes result from the progression of the underlying medical condition of a patient. Most adverse events result from the risks inherent in investigations or treatments, while others result from failures in the organization or processes of the systems of care. A minority of adverse events may be attributable to an individual provider’s performance. An appropriate analysis of adverse events holds the promise of revealing information that may prevent a similar occurrence at some time in the future. It is this promise of improvement, in either system or individual performance, which must be the imperative for policy makers, regulatory authorities, health institutions, physicians and other health care providers to substantively address the reporting of and response to adverse events.

Improving the quality of care and ensuring a robust framework that holds individuals accountable for their actions starts with an effective reporting process. While some jurisdictions have made progress in this area, there remains a great deal more to be done, such as standardizing procedures that support the analysis of incident/occurrence reports. Governments and others must move quickly to address the shortfalls in reporting requirements and to establish the mechanisms that facilitate learning from (and not merely collecting) information.

Effective quality improvement review processes are essential for improving the safety of health care. Effectiveness rests, in part, on health care professionals understanding that the information they provide will be protected from disclosure or from use in possible accountability actions. At present, these protections are being weakened, threatening the effectiveness of current and past patient safety efforts and progress.

The public’s confidence in the quality of health care depends on an understanding that quality improvement reviews do indeed generate recommendations that lead to actual system improvements. Therefore the need exists to make available the recommendations of such reviews and the actions being taken to implement those recommendations.

At the same time, these patient safety efforts must be accompanied by a robust accountability framework that investigates and deals appropriately with instances wherein the standard of care was not met or acceptable practices were not followed. A “firewall” that prevents the flow of information from the protected quality improvement domain into the accountability domain is crucial. Regardless of the accountability mechanism being employed, procedures that help ensure fairness and protect the interests of patients, providers and the public is vital.

The CMPA believes that the Canadian health care system has reached an important juncture in the area of improvements to quality of care. The path that would result in the widespread disclosure of quality improvement information threatens to undermine decades of efforts to improve care. The other path seeks to achieve an appropriate balance between the patient safety and the accountability responses, recognizes the need for both types of responses, and enables each type to contribute to a more effective and safer health care system. The Association urges decision makers to promote legislation that achieves the right balance between safety and accountability and reflects the interests of the Canadian public, including future patients whose quality of care will depend upon the decisions being made today.
For consistency, the CMPA encourages the use of the following definitions.

**Adverse event**  
An event which results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient’s underlying medical condition.  

**Close call**  
An event with the potential for harm that did not result in harm because it did not reach the patient due to timely intervention or good fortune (sometimes called a near miss).  

**Disclosure**  
The process by which an adverse event is communicated to the patient by health care providers.  

**Harm**  
An outcome that negatively affects the patient’s health and/or quality of life.  

**Incident/occurrence report**  
A report of an adverse event or close call. The information contained therein may not be protected from disclosure. (CMPA)

**Just culture of safety**  
A health care approach in which the provision of safe care is a core value of the organization. The culture encourages and develops the knowledge, skills and commitment of all leaders, management, health care providers, staff, and patients for the provision of safe patient care. Opportunities to proactively improve the safety of care are constantly identified and acted on. Providers and patients are appropriately and adequately supported in the pursuit of safe care. The culture encourages learning from adverse events and close calls to strengthen the system, and where appropriate, supports and educates health care providers and patients to help prevent similar events in the future. There is a shared commitment across the organization to implement improvements and to share the lessons learned. Justice is an important element. All are aware of what is expected, and when analyzing adverse events any professional accountability of health care providers is determined fairly. The interests of both patients and providers are protected. (CMPA)
Negligence/fault

A legal concept. In all provinces/territories of Canada except Québec, to establish negligence by a physician, a plaintiff patient must prove to the satisfaction of a court that harm to the patient was caused by the failure to exercise a reasonable standard of care by the physician. In the courts, the medical standard of care to determine negligence is not one of perfection but rather the standard of care that might reasonably have been applied by a colleague in similar circumstances.

In Québec, the concept of fault is at the heart of civil liability. Every person has a duty to abide by certain rules of conduct or standards, and if a person does not, he or she has committed a fault. The plaintiff must demonstrate the physician committed a fault, that is, did not act as a reasonably prudent physician of similar training and experience would have under the circumstances. The plaintiff must also have suffered an injury as a result of the fault committed, and the plaintiff must establish the fault caused the injury. (CMPA)

(For more on negligence/fault, see CMPA Education online at www.cmpa-acpm.ca.)

Procedural fairness

The legal concept that administrative proceedings should be conducted in a manner that is fair to the parties involved. While the extent of fairness varies with the nature of the proceedings, at minimum, affected parties should be given a fair opportunity to participate in the proceedings. This includes providing parties with notice of the proceedings and the ability to respond to any prejudicial argument or evidence.

Quality improvement review

The analysis by health care organizations (usually by a quality improvement committee) of patient outcomes, clinical practices, and systems of care in order to recommend improvements. (CMPA)

Quality improvement committees, as part of an ongoing program to improve patient care, should be structured under the relevant provincial/territorial legislation and include formal terms of reference. Quality improvement committees, depending on the province or territory, may have different titles, for example: Quality of Care, Critical Incident Review, Risk Management.

Reporting

The communication of information about an adverse event or close call by health care providers, through appropriate channels inside or outside of health care organizations, for the purpose of reducing the risk of reoccurrence of adverse events in the future.

ABOUT THE CMPA
The Canadian Medical Protective Association provides advice, legal assistance, and risk management education to 76,000 member physicians. As the principal provider of medical liability protection in the country, the Association is governed by an elected Council of physicians. A valuable contributor to the health care system since 1901, the CMPA is firmly committed to protecting the integrity of physicians and promoting safer medical care.