Ontario Council of Hospital Unions (OCHU)

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Preventing medical errors conference Monday, June 4, 2012, Isabel Bader Theatre, Toronto

TORONTO, ONTARIO--(Marketwire - June 3, 2012) - "Do no harm," is the governing philosophy of the health care industry. But according to researchers taking part in a conference on medical errors and hospital-acquired infections in Toronto on Monday, June 4, our medical system is being run with more concern for the bottom line than for individual patients.

"The result is significant medical errors and an epidemic of harm," says William Charney, the editor of *'Epidemic of Medial Errors and Hospital-Acquired Infections'* and a keynote speaker at Monday's conference. Charney an occupational health specialist for 30 years (ten as director of environmental health at the Department of Public Health in San Francisco and five at the Jewish General Hospital in Montreal) says the research findings published in the book "challenge governments to act to prevent patient deaths."

Research shows that 18 per cent of Canadian patients entering hospitals - 552,000 of them - experience harm. In Canada, estimates run from 30,000 to 60,000 deaths annually due to medical errors, likely making medical errors the second leading cause of death in the country.

Researchers who contributed chapters to 'Epidemic of Medial Errors and Hospital-Acquired Infections' attending the Conference on the Epidemic of Medical Errors & Hospital Acquired Infections in the US and Canada: The Systemic Causes, June 4, 2012 - Isabel Bader Theatre, 93 Charles St. W. Toronto Include:

8:30 am : Keynote: William Charney The systemic causes of the epidemic verses the 'low hanging fruit'. Without addressing the systemic causes of medical error only small impacts will be made and the risk to patients and staff will continue to increase over time.

9:00 am : Epidemiology of the Epidemic: Joe and Terry Graedon Data accumulated when all the categories are counted define medical error as the leading cause of death to Americans.

9:30 am : For Profit Care and Factory Medicine: Joseph Schirmer, MSF or profit medicine hospitals have 2 to 4X the rates of medical error as not-for-profit institutions.

10:00 am : The Canadian Situation: Michael Hurley Data now shows that medical errors, and all the categories it implies are the 3rd leading killer of Canadians.

11:00 am : Under Reporting: John Lange Non-reporting hovers over the healthcare industry like a dark cloud. Underreporting of adverse effect and error rates ranging from 60-90% have been reported. This creates a deep chasm of hard data on medical error and leaves the science of intervention somewhat in the dark.

11:30 am : Staffing Ratios: Beth Piknick, RN Staffing ratios, or the lack thereof, are directly linked in all the peer review science to medical error and infections. Yet only one state in the US and no provinces in Canada have any regulations dealing with staff to patient ratios.

1:00 pm : Shiftwork: Christine Pontus, RN, COHN-S/CCM Shiftwork has always been directly linked to medical error. Yet little has been done to correct the shiftwork paradigm to acceptable levels that would remove the toxicity of shiftwork in healthcare.

1:30 pm : Non Accountability: Susan Gallagher, PhD Health care workers, doctors, nurses et al in most studies, over 50% do not wash their hands between patients. Policies, though looking good in administrative manuals, are hard to enforce in healthcare and the 'great white wall' protects the guilty.

2:00 pm : Bullying: Kathleen Bartholomew, RN, MN Bullying is now one systemic cause for medical error in healthcare. Once bullied a healthcare worker's cognitive function decreases reducing their ability to make critical decisions.

2:30 pm : Cleaning of Hospitals: Tom Fuller, PhD, CIH, MSPH, MBA Hospital acquired infections lead to mortality and morbidity. The presenter will also cover personal protective equipment and their issues associated with infecting patients and workers.

3:30 pm : Ethics and Medical Error: James Brophy Ethics in healthcare, though revered as a principle, slides down slippery slopes all too often. In a macro sense, many of the systemic problems that have led to the epidemic of patient harm have been known for over a decade, but little has been done to correct or eliminate them.

4:00 pm : Legal Issues: J.P. Menard Legal issues that conflict with patient safety issues abound. The silence that surrounds errors and reporting in order to protect institutions literally put patients at greater risk.

4:30 pm : The Quebec Situation: Marc Pineault Along with the issues of C. difficile in Quebec, 171,000 medical errors were reported in one year.

Epidemic of Medical Errors and Hospital-Acquired Infections is published by Taylor & Francis, a leading international academic publisher (http://www.taylorandfrancisgroup.com/).

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