TRANSCRIPTION

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[0:00:06] My interest in patient safety started about 2002. My mother-in-law, Claire Friedman [ph], was a patient in the Jewish General Hospital. My mother-in-law was a very special person. She was special because she wasn't a mother-in-law. She didn't behave very much like a mother-in-law. She behaved much more to me like a friend than a mother-in-law. She was a very active person. She was very focused on her children. She was very much loved by her children, three daughters and a son, and by her grandchildren. She's very well remembered.

[0:00:47] We needed an apology because what had happened to my mother-in-law wasn't normal. She was recovering from cancer surgery and she was in a geriatric ward. She was a very active person, constantly walking the halls, talking to people. And as was our habit, we came Friday night after work to ensure that she ate her supper and to spend some time with her. When we arrived, we found her sitting in a chair, strapped down, pretty much comatose. What the heck is going on here? I mean, this is a woman who, quite literally – she was 80 years old, I was 50 years old – and I couldn't keep up to her. She would walk the the corridors much faster than I could. She was in good shape on Thursday. She had a caregiver who was there in the afternoon and the caregiver hadn't told us anything was wrong. So we asked the nurse and the nurse told us, “Your mother, mother-in-law is over 80 years old. She has low blood pressure. This is quite normal. This happens all the time.”

[0:01:55] We didn't really feel comfortable that that was the answer. It had never happened before. But again, we are not medical professionals and we accepted the word of the doctor and the nurse.

[0:02:05] We asked them, since we had prearranged to take her out on Sunday for Mother's Day, if that still seemed okay, and we were assured that she would be okay by Sunday. Came back on Sunday at about 11:00 and she was significantly better. And we said, “Is everything okay?” And they said, “Yeah, whatever it was, is pretty much out of her system. It's fine.” It sort of bothered us that no one explained what had happened.

[0:02:39] And a couple of weeks later, one of the nurses came over to me and said, “I'd like to tell you something in confidence.” And I said, “What?” I really didn't understand what she was getting at. And what she told me was that my mother-in-law had been given the wrong medication. And I really got upset. I'm not a very quiet person. I was angry that, first of all, we hadn't been told the truth. And second of all, I was angry that the nurse had told me but wouldn't tell me who did it.

[00:03:09] When I wrote to the ombudsman, it took many drafts of the letter because my wife kept saying, “You can't say that. You can't say that. These are people who are going to be treating my mother.” I wrote to the ombudsman. The ombudsman passed on my complaint to the director of professional services at the hospital.

[0:03:35] A couple of days later, he called me and he told me several things. First of all, he said, “Very sorry what happened to your mother-in-law? This is what we did in the short term to ensure that everything was okay. And I assure you that everything now is okay. Third of all, this is what we've done as a hospital to ensure this sort of thing doesn't happen again.” When he said, on behalf of the doctors, the nurses, the entire staff, “I'm sorry,” it was, wow. It was like a giant weight being lifted off our shoulders, my shoulders, especially, because I saw that he really meant it. Over the phone, I could tell he meant it. He wasn't just saying it.

[0:04:27] He then asked me if I would be interested in working with the hospital as a community representative on the Quality and Risk Management Committee. What happened with my mother-in-law was that they gave her the wrong medication. The long-term solution that was enacted by the hospital was that they contacted the pharmaceutical company that supplied the medication and what they found out was that there had been several incidents of that nature previously. What the pharmaceutical company did was, they changed the shape of the pill. This is a good example of, the individual wasn't wrong; the system was wrong. The system made it very difficult for the nurse to ensure that she was giving the right medication. The system had to be changed, and that's sort of the approach that this Quality and Risk Management Committee does.

[0:05:30] As a result of this incident, the Jewish General Hospital did implement a disclosure policy. And what it means to patients and their families is that they are now part of the process. It's no longer a secret. When something happens, the hospital demands of its clinicians that they allow the patient and their families to be part of the process.

[0:05:59] Another outcome of my involvement in the Jewish General Hospital is that we have implemented – and I'm the chairman of – a Speak Up campaign. Basically it has three elements. The first one is we wanted to get doctors, nurses, clinicians to speak to each other better, to listen to each other. And an important part of that better communication is the listening element so that clinicians listen to patients and speak to them in a way that they can understand. It's changing the cycle from, “I'm the doctor, I'm the nurse, you're the patient,” to, “This is a health care team and you're part of the team.”

[0:06:46] What my part of the Speak Up program is focused on is getting patients and their families, in an open and respectful manner, speaking to clinicians when they're uncomfortable or don't understand what's happening around them. In general, when you go into the hospital as a patient – and I've only been in the hospital a few times personally as a patient – you lose your power. You can be the biggest corporate magnet, but when you go in, you're just another body. By being part of the medical team that addresses your problem, you feel some power. You feel that you have something to say. And I think by doing that, the whole system is better.

[0:07:32] When Dr. Portnoy [ph] said, “I'm sorry,” and he apologized not just on his behalf, but on behalf of the doctors, the nurses, the whole medical team, it made us feel like the hospital was taking responsibility. Being told you're sorry and having explained to you what's going to be done in the long term makes you feel like you're part of the process, that it didn't happen once and that's it and that's the end of it, but that's something good, something positive has come out of this incident.

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