Dr. Roy Ilan: “We all make errors. It’s recovering from the error that’s crucial”

A Long and Winding Road: Advocating for patient safety and quality improvement

As 'quality improvement' uses both quantitative and qualitative methods to improve the efficacy, efficiency, and safety of the healthcare system, the importance of it seems almost discernible. Why not improve the system? It’s an easy question to ask, but a difficult one to answer.

Dr. Roy Ilan, an Associate Professor of Medicine and Queen's University, is an Internal Medicine and Critical Care physician at Kingston General Hospital. In addition to his clinical practice, he holds a great deal of interest in patient safety and quality improvement, in which he has a Master's degree in Clinical Epidemiology from the Department of Health Policy, Management and Evaluation from the University of Toronto.

"A few weeks ago, I did an exercise with myself. I asked myself, 'Why should I care about quality improvement?' and I came up with three answers," he explained. "The first reason was 'because we want to' - the motivation is
there. Then there's 'because we can' - as a system, we have all the strategies and resources to [move forward with this]; it can be done. The system is not complex; it is quite easy to understand."

"Lastly, 'because we have to' - it is unacceptable that seven to eight patients out of every hundred admitted to the hospital will experience some adverse event, and the fact that this is one of the main reasons that patients die in hospitals...we have to do something."

The big question then becomes, ‘how? What can we do?’ And this is where the process grinds to a halt. It’s easy to look at the system and identify the faults, but the hard part is being able to improve them to a point where the problem is solved in entirety.

A frequent question in quality improvement with regards to patient safety is whether or not specific errors occur more than others; to try to single out an error that can be addressed and used as a starting point. So you try to prioritize - what are the things that are truly demanding our attention?

"Say you look at medication errors. It’s a huge area," Dr. Ilan explained. "There are errors that have to do with the administration of medications, and whether it happened in or out with the hospital, if it happened in the pediatric or geriatric patient population, whether the medication was given intravenously or orally, or if it was pain medication or a chemotherapeutic drug. In every subquestion, a whole different process is opened up with regards to the process of correcting each error."

Dr. Ilan also serves as the Master Facilitator for the Patient Safety Education Program (PSEP) with the Canadian Patient Safety Institute (CPSI), and he has also worked with the Royal College of Physicians and Surgeons of Canada as faculty for the Advancing Safety for Patients in Residency Education (ASPIRE) program.

ASPIRE is a 4-day comprehensive workshop that works to create patient safety and quality improvement educators from current healthcare providers.
"The methodology of [ASPIRE] is that if you train people that come to the course, not just for patient safety but also in how to educate others, they will go back to their organizations and create a system within their organizations to teach this curriculum," he explained.

"However, providers come and take the course, and they get engaged and excited, saying, 'Yes! This is great; we're going to go back and do something', and they go back to their role, but reality takes over. Everyone is completely overwhelmed because when you work in this system, you're always at 110% of your capability. Of course, you can have every intention of wanting to do something, but whether you like it or not, it's going to take something of your time, at the very least."

"The most challenging thing for me can do everything that I want to do," Dr. Ilan admitted. "Between medical education, research and quality improvement, it's a lot of busy weeks and sleepless nights. But when you get things right, and you manage to get some small changes implemented, even though it's not black and white, you're able to see some color. You feel like you made a change, and it's incredibly fulfilling."

To err is human. No one person or one system is perfect, but learning from those mistakes and channeling it into improvement is the first stepping-stone on the long road to improvement.

"I have no doubt that if we can substantially improve the quality of [the healthcare system], we can make people healthier, decrease costs, decrease utilization of other resources and put this money into making the system better - it's the opposite of a vicious cycle."

"This may not be a very optimistic message, like 'oh my god we have so much to do!'", he laughs, "But I believe that mindfulness and self-awareness in the system [as well as] recognizing and appreciating that there is a problem is the first step on the way to resolution."