Password please?

"Your password will expire in 10 days; do you want to change it?" This message flashed on the computer screen at the hospital when I tried to log on. It is a little like asking "You are going to expire in 10 days, do you want to die now?" Why would I want to change my password early and why 10 days? Why not ask me if I want to change it 20 or 30 days in advance? Heck, why not prompt me to change it as soon as I choose the new one. Maybe the message should be, "You have just chosen a new password. Do you want to change it now before you forget it?"

This changing of passwords seems so arbitrary. For example, I was invited over to a friend's house for dinner but when I got there they weren't home. We knew their gate code, so we went in, and since their back door was unlocked we opened it. At this point their alarm went off shortly followed by their phone ringing. "Hello," I answered.

"This is the alarm company; could you please give me the password?"

"Um, is it 'chickens'?"

"No sir, it isn't."

"Can I change it to 'chickens'?"

At that point they called the police.

I wonder if we are really safer having all these passwords. I am reminded of Dr Richard Feynman's evaluation of security during the Second World War. Dr Feynman won the Nobel Prize for physics. As a young man, he was invited to help the war effort and worked on the Manhattan Project. He became the go-to guy for safe cracking and later admitted that all the safes at this top-secret facility came with the same preset combination that only about 5% of people had changed. He also discovered a hole in the fence, and would take great pleasure in going out through it and returning through the checkpoint over and over again, giving the guards fits.

I have so many passwords for so many sites I am in danger of not remembering any of them.

I realize we have to protect our patients' medical information, but why do I have to change my password and why can't I use any of my previous 10 passwords? If I were a computer hacker trying to make a living I'm pretty sure I wouldn't be wasting my energy on the Fraser Health site. I don't think hackers are thinking, "I know, I'll find out my neighbor's stool sample results and then blackmail him for millions. Once the word gets out that he has giardiasis his life will be ruined (insert maniacal laughter)." Personally, I haven't heard of anyone hacking into hospital computer systems to access records. I think hackers are probably focusing more on financial sites such as banks and credit card companies. Point of interest: I don't have to change my online banking password, and if I do change it I can use a previous one.

I don't know about you but I have so many passwords for so many sites I am in danger of not remembering any of them. I have put them on my phone and home computer, but what if they crash or what if I can't remember the passwords to these electronic holding sites? As I age I am a little afraid that when I expire, and if I do manage to make it to heaven, Saint Peter will say, "Welcome, good work! Now if I could please have your password."

—DRR

2012: Hurdling and hurling

It is generally accepted that physician medical error is a result of a system failure. Physician errors can be attributed to a number of factors including equipment failures or unfamiliarity, time pressures, distractions, training deficiencies, or simply not knowing what we don't know.

The recent investigation into the CT misreads by four radiologists might seem remote for most of our clinical practices. But don't be deceived. Not infrequently we perform clinical activities that result in a mistake or near mistake that under the wrong circumstance can result in patient harm. However, these clinical activities do not often leave the same permanent footprint as a diagnostic imaging misread. It therefore comes as no surprise that the recent report compiled by Dr Doug Cochrane, chair of the Patient Safety and Quality Council, made recommendations that go far beyond the world of diagnostic imaging and will impose some serious hurdles for all physicians. Reviewing the 35 recommendations contained in the report is beyond the scope of this editorial. Instead, let me define a number of terms contained in the report that are important for you to know and are frequently misunderstood.

Licensing

The granting of permission to practise medicine, which is done by each provincial College and is subject to meeting training certification requirements (MD, LMCC, and CCFP or FRCP).

Credentialing

The process of evaluating the training, experience, and competence of physicians qualified to provide certain discipline services or procedures usually extra to requirements for licensing. For example, pulmonary function testing, electrodiagnostics, and CT colonography are skills usually obtained beyond the requirements for licensing.

Privileging

The process of granting privileges as permits to undertake specified clinical activities once licensing and credentialing requirements have been met. Physicians can only be given privileges for activities for which they have necessary credentials and may be denied privileges for lack of resources or need. For example, a cardiologist may be unable to perform interventional cardiology in a rural hospital even if he or she has the appropriate credentials.

Revalidation

The process of repeat validation of medical licensure by demonstrating competence. Revalidation requirements

Continued on page 9

Continued from page 7

are evolving but, in future, will be more than providing evidence of CME.

Peer review

A proactive periodic review of clinical activities by peers for the purpose of education and improvement not in response to complaints or clinical concerns. This activity is normally highly confidential so as to promote full cooperation with the process.

Performance assessment

An ongoing evaluation of a physician's work quality, objectives, contributions, and compliance with regulations. For example, hospital departmental requirements may require attendance at M & M rounds, have requirements for minimum number of procedures, participation in research, and satisfactory resolution of complaints. Performance reviews usually occur in conjunction with hospital staff reappointments.

Multi-source feedback (a.k.a. physician achievement reviews or 360° reviews)

The process of providing feedback to physicians by patients, colleagues, and health care staff. The questionnaires can be designed to capture a range of competencies including communication, professional responsibility, professional development, and patient interaction.

Accreditation

A process for ensuring compliance of facilities, hospitals, or other organizations (not physicians) with preset and agreed-upon standards. In order for a facility to be accredited it may have to show compliance with medical staff performance management.

Given these definitions, I will leave it up to you to connect the dots as to where the health authorities, Ministry of Health, and College are heading to comply with the Cochrane recommendations.

You probably thought I was referring to your possible emetic response to these recommendations in the title of this editorial. Far from it, hurling is the national sport of Ireland and only a sporting attitude will get us through the challenges that are about to unfold.

—WRV