Standard of Practice:

Disclosure of Harm
(2021)

A **Standard of Practice** is the minimum standard of professional behavior and ethical conduct expected by the College on a specific issue.

Disclosure of Harm

Preamble

The College recognizes that despite the commitment to provide the most appropriate medical care possible, clinical outcomes may not be as desired or anticipated. When an unintended harmful or no-harm incident occurs, physicians have an obligation to disclose the event to their patients.

Definitions[1]

Harmful Incident: an incident which resulted in harm to a patient.

No-harm Incidents: an incident with the potential for harm that reached the patient, but no discernible harm resulted.

Near miss / Close call: an incident with the potential for harm that did not reach the patient.

Standard of Practice

In keeping with the fundamental commitments to the medical profession outlined in the CMA Code of Ethics and Professionalism, physicians have an ethical and professional obligation to disclose information about harmful and no-harm incidents to their patients.

[1] *Patient Safety and Incident Management Toolkit: Glossary*, Canadian Patient Safety Institute.

As clinical outcomes may not be as desired or anticipated, physicians should also prepare patients in advance for the possibility of harm by explaining common and/or possible serious complications, hazards, and risks of any procedure or treatment.

Disclosure

Physicians must disclose directly to the patient or the patient's substitute decision maker as soon as possible after a harmful or no-harm incident occurs. Physicians should carefully document the disclosure in the patient's medical record.

Disclosure is usually the responsibility of the most responsible physician; however, the involvement of multiple physicians, students or other-healthcare providers may require that a decision be made as to who is the most appropriate individual to speak to the patient.

Disclosure should provide the facts of the event, the consequences for the patient, and what has, or can be, done to remedy those consequences. Physicians should endeavor to use language which the patient can understand.

Physicians may wish to seek guidance form the Canadian Patient Safety Institute and/or the Canadian Medical Protective Association on the process of disclosure.

Physicians providing medical services within a Regional Health Authority should also review the applicable protocols within their Health Authority for disclosing harm and meeting the requirements of the *Patient Safety Act*.

Apologies

Depending on the circumstances, offering an apology to the patient may be considered appropriate.

The *Apology Act*, defines an apology as "an expression of sympathy or regret, a statement that one is sorry, or other words or actions indicating contrition or commiseration, whether or not the words or actions admit, or imply an admission of, fault in connection with the matter to which the words or actions relate". This Act states that an apology does not constitute an admission of fault or liability.

Physicians considering offering an apology may wish to seek specific legal advice on how to offer the apology.

Acknowledgements

CPSM (2020) Disclosure of Harm to a Patient

CPSBC (2019) Disclosure of Adverse or Harmful Events

CPSO (2019) Disclosure of Harm

CMPA (2017) Disclosing Harm from Healthcare Delivery

CPSS (2016) Physician Disclosure of Adverse Events and Errors that Occur in the Course of Patient Care

Related Documents

Patient Safety Act, SNL 2017, Chapter P-3.01

Apology Act, SNL 2009, Chapter A-10.1

CMA (2018) Code of Ethics and Professionalism

Canadian Patient Safety Institute *Patient Safety and Incident Management Toolkit: Glossary*

Document History

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