

Practice Standard

Disclosure of Adverse or Harmful Events

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Related topic(s):	Blood-borne Viruses in Registrants

A **practice standard** reflects the minimum standard of professional behaviour and ethical conduct on a specific topic or issue expected by the College of its registrants (all physicians and surgeons who practise medicine in British Columbia). Standards also reflect relevant legal requirements and are enforceable under the [Health Professions Act](#), RSBC 1996, c.183 (*HPA*) and College [Bylaws](#) under the *HPA*.

Registrants may seek advice on these issues by contacting the College and asking to speak with a member of the registrar staff, or by seeking medical legal advice from the CMPA or other entity.

PREAMBLE

This document is a standard of the Board of the College of Physicians and Surgeons of British Columbia. It also offers some broader guidance on the medico-legal implications of disclosure.

Within the practice of medicine, unintended adverse or harmful events will inevitably happen and do not always reflect individual or systems error. This document is focused on the necessity of appropriate communication with patients and families when such an event occurs. In such situations a sincere expression of regret and concern is almost always appropriate.

DEFINITIONS

Definitions provided by the Canadian Patient Safety Institute and the Canadian Medical Protective Association (2008) include:

- Adverse event – an event which results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient’s underlying medical condition.
- Close call – an event with the potential for harm that did not result in harm because it did not reach the patient due to timely intervention or good fortune (sometimes called a “near miss”).
- Harm – an outcome that negatively affects a patient’s health and/or quality of life.
- Error – an act (plan, decision, choice, action or inaction) that when viewed in retrospect was not correct and resulted in an adverse event or a close call.
- Disclosure – is the process by which an adverse event is communicated to the patient.
- Apology – a genuine expression of sympathy or regret; a statement that one is sorry for what has happened; an apology includes an acknowledgement of responsibility if such responsibility has been determined after the analysis of the adverse event.

Definitions provided by the Canadian Patient Safety Institute based on the terminology of the International Classification for Patient Safety developed by the World Health Organization (2011) include:

- Patient safety incident – an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient.
- Harmful incident – a patient safety incident that resulted in harm to the patient; replaces “adverse event” and “sentinel event.”
- No harm incident – a patient safety incident which reached a patient but no discernible harm resulted.
- Near miss – a patient safety incident that did not reach the patient. Replaces “close call.”

The BC *Apology Act*, SBC 2006, c.19, defines an apology as “an expression of sympathy or regret, a statement that one is sorry or any 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 legislation states that in BC an apology does not constitute an

admission of fault or liability; however, physicians should remain mindful that this document does not replace legal counsel on a specific matter.

COLLEGE'S POSITION

- In keeping with fundamental commitments of the medical profession outlined in the *CMA Code of Ethics and Professionalism* (Take all reasonable steps to prevent or minimize harm to the patient; disclose to the patient if there is a risk of harm or if harm has occurred), physicians have an ethical and professional obligation to disclose information about adverse or harmful events to their patients.
- Physicians also have an obligation under common law to disclose error to their patients, in keeping with a patient's right to information about their medical treatment, and the fiduciary nature of the patient-physician relationship.
- The first priority after an adverse event should remain the provision of appropriate clinical care.
- Disclosure does not imply blame or fault, but refers to open and timely communication with a patient or their substitute decision maker concerning an adverse or harmful event.
- The decision whether or not to disclose adverse events which have not resulted in patient harm should only be made after careful consideration of the best interests of the patient.
- Disclosure should be in understandable language and provide the facts of the event, the consequences for the patient and what has, or can be, done to remedy those consequences.
- Disclosure should be an ongoing process and should be provided with sensitivity, in the context of the patient's current clinical condition and with consideration of the patient's need for family or other emotional support.
- Disclosure is usually the responsibility of the most responsible physician (MRP); however, the involvement of multiple physicians, medical trainees or other health-care providers may require that a decision be made as to who is the most appropriate individual to speak to the patient.
- Disclosure should always be carefully documented in the medical record.
- Health authorities and public hospitals have protocols for dealing with disclosure. Physicians are generally expected to comply with such protocols at institutions where they work; however, when the situation is ethically unclear they should seek guidance from the College.
- Advice about the actual process of disclosure is provided by both the Canadian Patient Safety Institute and the Canadian Medical Protective Association.
- The Canadian Medical Protective Association (CMPA) encourages physicians to discuss adverse events with patients; however, if there is concern about a legal action, we advise the physician to consult the CMPA.

REFERENCES

Canadian Medical Protective Association (2008)

Canadian Medical Association (2019) *Code of Ethics and Professionalism*

Canadian Patient Safety Institute (2011)

Apology Act of British Columbia