POLICY

Physician Disclosure of Adverse Events and Errors that Occur in the Course of Patient Care

STATUS:	APPROVED
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Every physician must, as soon as possible, inform his/her patient, or the legal guardian of that patient, of all adverse events, errors, or complications that may have occurred in the course of that patient's medical care.

This Policy refers to disclosure to a patient. If a patient lacks capacity to make health care decisions, due to immaturity, infirmity, illness, etc. a physician has the same obligation to the person who is entitled to make health care decisions on behalf of the patient as the physician has to the patient.

The Health Care Directives and Substitute Decision Makers Act of Saskatchewan defines capacity as the ability:

(i) to understand information relevant to a health care decision respecting a proposed treatment;

(ii) to appreciate the reasonably foreseeable consequences of making or not making a health care decision respecting a proposed treatment; and

(iii) to communicate a health care decision on a proposed treatment.

The Canadian Medical Protective Association states this about informed consent[1]:

> *An individual who is able to understand the nature and anticipated effect of proposed medical treatment and alternatives, and to appreciate the consequences of refusing treatment, is considered to have the necessary capacity to give valid consent. However, there are special circumstances to which particular attention must be given.*
>
> *There is no doubt, however, that the physician does have a duty to take reasonable steps so as to be relatively satisfied that the patient does understand the information being provided, particularly where there may be language difficulties or emotional issues involved. What*

amounts to "reasonable steps" will very much depend on the individual facts and circumstances of the particular situation.

The determinant of capacity in a minor has become the extent to which the young person's physical, mental, and emotional development will allow for a full appreciation of the nature and consequences of the proposed treatment, including the refusal of such treatments.

1. The practitioner proposing and responsible for the treatment, or treatment plan, should prepare patients in advance for the possibility of adverse events (AEs) by explaining common and/or possible serious complications, hazards and risks of any procedure or treatment.

2. When an AE occurs or is identified, the practitioner responsible for that patient (including weekend or vacation coverage) is expected to explain the event to the patient, or in the case of death, to the family, or, in the case of patient incapacity, to the person having authority to make healthcare decisions on the patient's behalf. Consideration should be given to involving appropriate RHA resources, such as the Quality of Care Coordinator.

3. The physician (or his/her designate) shall meet with the patient, or in the case of death, the family, or, in the case of patient incapacity, to the person having authority to make healthcare decisions on the patient's behalf as promptly as other duties permit and as appropriate given the patient's condition. The nature, severity, and cause (if known) of the AE should be presented in a straightforward and non-judgmental fashion. (The assumption is that most patients want to know what has happened. Patients have the right to decline disclosure. If in doubt, ask. Such waivers of information should be recorded in the patient's chart.)

4. Disclosure is a process. Physicians should not feel compelled to answer all questions at the first meeting with the patient or family. Avoid speculation, and disclose only what is known at the time of the discussion.

5. Avoid attributing blame to specific individuals, but accept responsibility for actions and outcomes. Adverse events and errors are, however, rarely solely due to the action, or inaction, of a single individual.

6. An apology, or an expression of sorrow, is often appropriate and not an admission of guilt. Saskatchewan legislation[2] states that an apology does not constitute an express or implied admission of fault or liability and must not be taken into account in any determination of fault or liability in connection with that event or occurrence. Doing so at an early stage in the disclosure process can help prevent bad feelings and unnecessary legal or professional complaints.

7. Where the AE is particularly serious and/or unexpected, a family team meeting, if done in an open and prompt way, with all relevant documentation and charts on hand, can be helpful to clear the air of any worries of a "cover up". Careful documentation of what is said by all parties in such meetings is essential. RHA representatives (e.g. Chief of Staff, Quality of Care Coordinator) shall be involved in such meetings in appropriate circumstance.

8. If the AE requires further medical attention, disclose what this is and seek appropriate prompt help from others as appropriate. Describe what can be done, if anything, to correct the consequences of the AE that has occurred - offer a second opinion, the involvement of outside assistance, or the transfer of care to another practitioner.

9. Emphasizing what will be done to prevent the same thing from happening to another patient may offer solace to affected patients/families.

10. Errors committed by others, or errors that are "near misses", may require reporting and disclosure. If in doubt, an event (such as witnessing a significant error made by another person) should be discussed in a confidential way with the RHA Quality of Care Coordinator.

11. If the incident is a "critical incident" as defined in the *Saskatchewan Critical Incident Reporting Guideline, 2004, the Regional Health Authority will also have an obligation to report information about the critical incident to the Minister of Health*[3]*. A "critical incident" is defined as:*

    a serious adverse health event including, but not limited to, the actual or potential loss of life, limb or function related to a health service provided by, or a program operated by, a regional health authority (RHA) or health care organization (HCO)

Footnotes:

[1] Canadian Medical Protective Association: *Consent: A guide for Canadian Physicians* https://www.cmpa-acpm.ca/web/guest/-/consent-a-guide-for-canadian-physicians (accessed June, 2016)

[2] *The Evidence Act*, section 23.1 http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/e11-2.pdf (accessed June, 2016)

[3] *The Critical Incident Regulations, 2016* http://www.qp.gov.sk.ca/documents/english/Regulations/Regulations/r8-2r10.pdf (accessed June, 2016); *The Saskatchewan Critical Incident Reporting Guideline, 2004*, https://www.saskatchewan.ca/~/media/files/health/ministry%20overview/critical-incident-guidelines-2004.pdf (accessed June, 2016); *Critical Incidents* https://www.saskatchewan.ca/government/government-structure/ministries/health/critical-incidents (accessed June, 2016)

Other resources:

Canadian Medical Protective Association: Disclosing harm from healthcare deliver: Open and honest communication with patients https://www.cmpa-acpm.ca/-/disclosing-harm-from-healthcare-delivery-open-and-honest-communication-with-patients (accessed June, 2016)

Canadian Medical Protective Association: Disclosing adverse events to patients: strengthening the doctor-patient relationship https://www.cmpa-acpm.ca/en/duties-and-responsibilities/-/asset_publisher/bFaUiyQG069N/content/disclosing-adverse-events-to-patients-strengthening-the-doctor-patient-relationship (accessed June, 2016)