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.
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 system errors. This standard focuses on the need for appropriate communication with patients and families. When an adverse or harmful event occurs, a sincere expression of regret and concern is almost always appropriate.

Definitions
The definitions outlined by the CMPA (2015) include:

**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 analysis of a patient safety incident.

**disclosure**
The process by which a harmful patient safety incident is communicated to the patient. (Canadian Patient Safety Institute)

**harm**
An outcome that negatively affects the patient’s health and/or quality of life.

**patient**
The individual who is the subject of the patient safety incident. The term may include the patient’s family when the patient has consented to them being involved in the disclosure process; the patient’s substitute decision-maker when the patient lacks capacity to consent; or the patient’s legal representative when the patient is deceased.

**patient safety incident**
The World Health Organization (WHO) provides terminology to facilitate the sharing and learning of patient safety information globally. The Canadian Patient Safety Institute (CPSI) has adopted some of these terms. To support clarity and consistency in patient safety discussions, the College and CMPA now uses these terms:

- **Patient safety incident**: An event or circumstance which could have resulted, or did result, in unnecessary harm to the patient.
- **Harmful incident**: A patient safety incident that resulted in harm to the patient. Replaces the terms “adverse event” and “sentinel event.”
- **No harm incident**: A patient safety incident which reached the patient but no discernible harm resulted.
- **Near miss**: A patient safety incident that did not reach the patient. Replaces “close call.”
**College’s position**

**Obligation to disclose**

- In keeping with fundamental commitments of the medical profession outlined in the *CMA Code of Ethics and Professionalism* (registrants must 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), registrants have an ethical and professional obligation to disclose information about adverse or harmful events to their patients.

- Registrants 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-registrant relationship.

- 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 to disclose a no harm incident or near miss should only be made after careful consideration of the best interests of the patient.

**To whom to disclose**

- Registrants must disclose directly to the patient or, where the patient is incapable with respect to the treatment, to the patient’s substitute decision-maker.

- In the death of a patient, the registrant must disclose to the patient’s estate trustee or the person who has assumed responsibility for the patient.

**What to disclose**

- Disclosure must be in understandable language and provide the facts of the event, as they are known at the time and without speculation, the consequences for the patient and what has, or can be, done to remedy those consequences.

- The decision whether 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, including whether a potential for harm might exist in the future.

**When to disclose**

- The first priority after an adverse event must remain the provision of appropriate clinical care.

- Registrants must disclose as soon as possible and in the best interest of the patient.

- Disclosure must be an ongoing process and 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.

**Who must disclose**

- Disclosure is usually the responsibility of the most responsible registrant, supported where appropriate by others (e.g. health-care providers directly involved with the care, colleague with strong communication skills, other trusted health-care provider,
etc.). However, the involvement of multiple registrants, 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.

- The CMPA encourages registrants to discuss adverse events with patients; however, if there is concern about a legal action, the College advises registrants to first consult the CMPA.

**Documentation of disclosure**

- Disclosure must always be carefully documented in the patient’s medical record.

Health authorities and public hospitals have protocols for dealing with disclosure. Registrants are generally expected to comply with such protocols at institutions where they work. When the situation is ethically unclear, they may seek guidance from the College.

Additional advice about the actual process of disclosure is provided by both the CPSI and CMPA.

**References**


Canadian Medical Protective Association (2015) *Disclosing harm from healthcare delivery: Open and honest communication with patients* [cited March 17, 2022]. Retrieved from: [CMPA - Disclosing harm from healthcare delivery: Open and honest communication with patients (cmpa-acpm.ca)](https://www.cmpa-acpm.ca)


