DUTY TO DISCLOSE MEDICAL ERRORS

CASE COMMENT

We present below a recent case that demonstrates a physician’s liability where he or she fails to disclose a medical error.

The case involved a 28-year-old woman who underwent a laparotomy and presacral neurectomy for persistent pelvic pain and dysmenorrhea. During the procedure, a large abdominal roll was placed in the abdominal cavity, by the defendant surgeon, to pack the bowel into the upper abdomen. The roll was not included in the pre-operative count despite being hospital policy to do so. The surgeon neglected to remove the roll before closing the patient. The patient subsequently acquired a significant persistent infection requiring two lengthy hospitalizations, numerous diagnostic procedures and further surgery. During the second surgery, another laparotomy, the abdominal roll was discovered. The doctor involved did not disclose the error to the patient and made positive efforts to keep the error from being documented or reported. It was not until six weeks after the abdominal roll had been detected and almost 5 months after the initial surgery that the physician informed the clinical instructor about what had been happening:

- The roll had been recovered during the second surgery;
- No paperwork about the error had been completed;
- No one, other than those directly involved, knew of the incident;
- The patient had not been told; and
- The patient was doing well and did not need to be told.

At this point, the Vice-president of the hospital advised the physician that he must inform the patient of the error.

The patient sued for negligence, breach of fiduciary duty and deceit. One of her claims was that she had suffered additional damages as a result of the delay in being advised of the likely cause of her continued health problems. The court found that the nurses involved did not have a duty of care to the patient to disclose the recovered abdominal roll. The nurses admitted to a breach of the standard of care.
for failing to document an incident of malpractice and failing to notify the hospital. The court also found that the breach of standard of care by the nurses did not result in the damages sustained by the plaintiff.

The court held that full responsibility for the non-disclosure rested with the surgeon. The damages suffered by the plaintiff were not a reasonably foreseeable consequence of the nurses’ breach but were of the physician’s breach.

The physician owed a duty of care to the plaintiff to inform her of the recovered roll as soon as reasonably practicable. As a result of this duty, he would bear the full burden of any damages flowing from the non-disclosure. The court also awarded punitive damages against the physician, stating his “obvious attempts to conceal his part in the error which demonstrated bad faith and unprofessional behaviour deserving of punishment.”

Although an unchecked error can result in a finding of legal liability, a causal connection must still be established to demonstrate that a failure in a standard of care led to the injury. In the case considered, the court held there was insufficient evidence to demonstrate that proper documenting and reporting by the nursing staff would have resulted in the patient being informed about the retained abdominal roll earlier than she was. That finding allowed the court to hold the physician solely responsible for the damages suffered by the patient as a result of the retained abdominal roll.

POLICIES ON DISCLOSURE OF HARM

Ontario

On February 27, 2003 the College of Physicians and Surgeons of Ontario passed a policy (the “CPSO Policy”), which requires all physicians to admit medical mistakes to their patients or face a reprimand.

The CPSO Policy requires physicians to sit down with their patients and factually discuss what the error was, how it might have occurred and how a similar error could be avoided in the future.

We continue to receive numerous enquiries regarding the implications of this policy for public hospitals and other health facilities. Significantly, the CPSO policy explicitly recognizes that many health care institutions have policies on disclosure of harm. Where such policies exist, physicians are obliged to follow them, including reporting requirements.

In recent years there has been increasing focus on issues of patient safety. Patient safety is a shared obligation involving each individual health professional and the organization itself, each being responsible for ensuring that there are reasonable systems in place. The obligation is recognized either explicitly or implicitly by a number of professional Colleges. For example, the College of Nurses of Ontario (CNO) recognizes that candid discussion of errors with the patient is part of a nurse’s ethical care.

The CPSO policy is based on the principle that patients are entitled to be informed of all aspects of their health care, including disclosure of harm that may have occurred in the course of receiving treatment. The obligation to disclose harm flows from the fiduciary nature of the physician/patient relationship, that is, the physician’s obligation to maintain the patient’s best interests.

The policy applies to all physicians regardless of practice setting or type. Harm is defined broadly as an “unexpected or normally avoidable outcome that negatively affects the patient’s health or quality of life” that occurs in the course of receiving treatment and is not due directly to the patient’s illness. In such circumstances, the physician is obligated to inform the patient about this harm.
The obligation to disclose is not restricted to harm that has resulted from the actions or inactions of the individual physician. Rather, the physician has an obligation to inform the patient of harm sustained through the course of receiving health care. This may involve care received from other physicians or members of the health care team. For example, a patient may be harmed as a result of a medication error involving the hospital pharmacy and nursing staff.

**Saskatchewan**

Saskatchewan has recently passed legislation that will require mandatory reporting of all medical errors to the Department of Health. The legislation is expected to take effect this spring.

Currently, adverse event reports are submitted voluntarily.

The purpose of the legislation is to “learn from experience.” The government is hoping to develop a system that provides valuable information in order to prevent further medical errors.

The Assistant Deputy Minister of Health, Duncan Fisher, has indicated that the new system will not apply sanctions or penalties. The College of Physicians and Surgeons of Saskatchewan supports the initiative.

**Alberta**

The College of Physicians and Surgeons of Alberta has not yet published a policy similar to Ontario’s. However, we encourage all organizations to assess their polices and we recommend that policies on disclosure of errors be implemented.

**Impact on health facilities**

The CPSO Policy and the Saskatchewan legislation emphasize the importance of having clear and effective adverse event report procedures within health care facilities. Policies should be in place (particularly in those provinces) to ensure that all incidents are properly reported to try to alleviate any future incidents.

However, please note that due to discoverability laws, hospitals can be forced to disclose adverse event reports.

We strongly suggest that all health facilities develop their own disclosure of harm policy. This will allow the institution to ensure that disclosure is done effectively and that it is linked to the facility’s risk and error management programs. Importantly, it allows the institution to provide support to its physicians and staff in communicating harm by those who are most experienced with patient advocacy issues.

Since the health facility is vicariously liable for the actions of its employed staff, it is essential that health facilities have a process in place, which is supported by policy, to effectively manage error and risk. Disclosure of harm policies allow the facility to participate, as appropriate, in communications with the patient.

We would be pleased to assist in the development or review of disclosure of harm policies. If you have any questions about this Communiqué please contact Brian Curial, of our Edmonton Office, or Bryan Ede, of our Calgary Office.
This article is a compilation of articles written by Rebecca Durcan and Kathryn Frelick, lawyers practicing in our Health Industry Practice Group in Ontario who are responsible for the Legal Retainer Program in Ontario. Dawn McKeivit’s valuable contributions should also be acknowledged.

This article has been compiled and adapted to reflect Alberta’s laws by our Edmonton Office.

Our National Health Industry Practice group is dedicated to providing comprehensive and integrated legal services to health industry clients. For more information about our group, visit our website at www.millerthomson.com or contact one of our regional contacts listed below.

REGIONAL CONTACTS

Toronto/Markham
Joshua Liswood
jliswood@millerthomson.ca
Kathryn Frelick
kfrelick@millerthomson.ca

Calgary
Bryan R. Ede
bede@millerthomson.ca

Edmonton
Brian J. Curial
bcurial@millerthomson.ca

Vancouver
David Martin
dmartin@millerthomson.ca

Miltom Consulting Inc.
Dr. Isser Dubinsky
idubinsky@miltomconsulting.com

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