Mandatory Reporting Of Medical Errors

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.

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.

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For more information, please contact:

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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 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.

If you wish to discuss the status at your facility and the policies which you have in place, please feel free to contact Rebecca Durcan.

About the Author:

Rebecca Durcan is a lawyer practicing in our Health Industry Practice Group and, along with Kathryn Frelick, is primarily responsible for the Legal Retainer Program. Rebecca’s focus is on advocacy, regulatory and health policy issues.