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COMMUNIQUÉ for the Health Industry

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UPDATE ON DISCLOSURE OF HARM: ARE YOU PREPARED?

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Ontario Mandatory Disclosure of Critical Incidents

As of July 1, 2008, every public hospital in Ontario will be required to have a system in place for the mandatory disclosure of critical incidents in accordance with amendments to Ontario Regulation 965 (Hospital Management) under the *Public Hospitals Act*. The regulation sets out the obligation of a hospital's Board of Directors to ensure that the administrator establishes a system for disclosing every critical incident, as soon as is practicable after the critical incident occurs. Please see our August 30, 2007 *Communiqué* entitled *Mandatory Disclosure of Critical Incidents*, which outlines the amendments in detail.

Canadian Disclosure Guidelines

The obligation to disclose has recently been addressed on a national scale by the Canadian Patient Safety Institute (CPSI) in the release of the *Canadian Disclosure Guidelines* ("the Disclosure Guidelines"). The Disclosure Guidelines, released in March of 2008, are the result of a two year collaboration of the Disclosure Working Group which consisted of representatives from various health professions, health organizations and health professionals' associations. Mary Marshall, a partner in our Edmonton Health Industry Practice Group, acted as Special Advisor (Legal Support) to the Disclosure Working Group and is a lead author of the CPSI's *Background Paper for the Development of National Guidelines for the Disclosure of Adverse Events*.

As stated in the introduction to the Disclosure Guidelines, the guidelines "emphasize the importance of a clear and consistent approach to disclosure regardless of the variance in definitions across Canada related to harm and adverse events". The basic premise is that patients have a right to be informed about all aspects of their care, including information relating to adverse events.

The Disclosure Guidelines build on various patient safety initiatives and provide a useful framework for the disclosure process, as well as considerations that may be applicable in specific situations. Though the guidelines are intended to be used by healthcare providers and healthcare organizations in the disclosure process, they are not meant to dictate disclosure policies and procedures created by organizations, nor do they address every aspect of disclosure. It is recognized that disclosure policies should be developed with legal advice from counsel familiar with applicable provincial legislation.

Commentary

The obligation to disclose involves many considerations, which are tied to patient autonomy, ethical and professional obligations of health care professionals and systems responsibilities of hospitals and other health care facilities to establish appropriate risk management, quality and patient safety processes. Patient safety is a shared obligation, and as such, it is imperative that hospitals and other health care facilities have policies in place to manage the disclosure process and to ensure effective communication and supports are available for health professionals and patients.

As July 1, 2008 approaches, Ontario hospitals should consider whether adequate processes have been put in place to ensure that systems obligations have been met, in accordance with legislative requirements. It is important for these processes to be consistent with your existing patient safety initiatives, and from a risk and quality perspective, achieve an appropriate balance.

Health industry clients in other provinces must be aware of their own statutory obligations regarding the disclosure process. There is a great deal of confusion around the use of patient safety terminology and wide variation in how certain terms are defined. We invite you to contact Miller Thomson's health industry practice lawyers to discuss the development and review of your organization's disclosure of harm processes and related policies.

Resources

Legislation

Ontario Regulation 423/07 made under the *Public Hospitals Act*.

Disclosure Working Group. *Canadian Disclosure Guidelines*. Edmonton, AB: Canadian Patient Safety Institute, 2008.

Canadian Patient Safety Institute

Canadian Patient Safety Institute. *Background Paper for the Development of National Guidelines for the Disclosure of Adverse Events*. Edmonton, AB: Canadian Patient Safety Institute, 2006.

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Please see our previous Communiqués related to disclosure of harm at www.millerthomson.com:

Mandatory Disclosure of Critical Incidents, August 30, 2007

CPSO Policy on Disclosure of Harm: Implications for Health Care Facilities, July 4, 2003

Mandatory Reporting of Medical Errors, March 3, 2003

Case Comment: Duty to Disclose Errors, March 5, 2003

Join us...

On June 18, 2008 at 8:00 a.m. as Jesstina McFadden presents "Disclosure of Harm" as part of our Coffee Talk, A Health Industry Seminar Series. For more information, please contact us at healtheditor@millerthomson.com.

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:

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