To disclose or not to disclose: Ethical considerations

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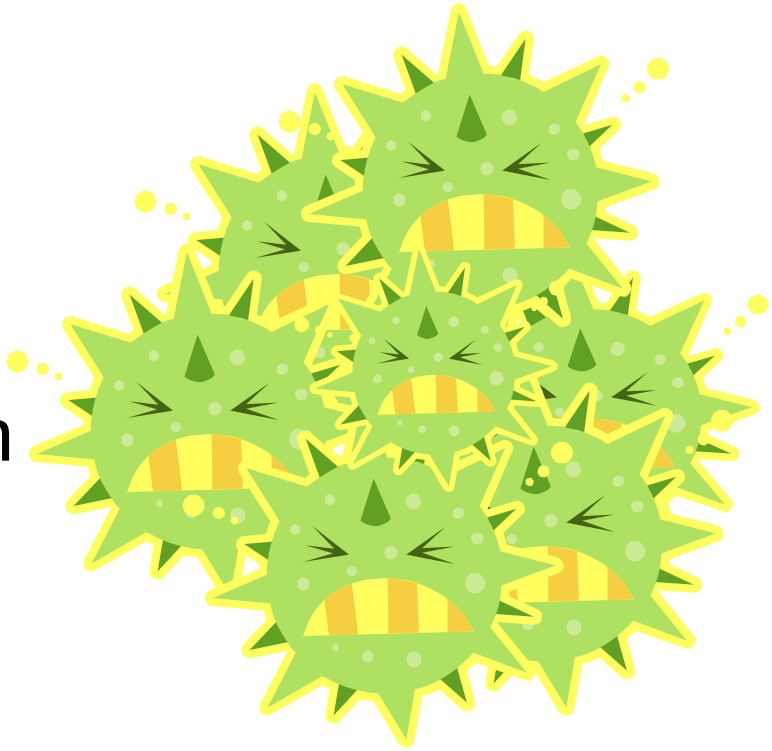
MRSA

- While in hospital a patient contracts MRSA. He is later discharged to a personal care home in the community. Who needs to know his MRSA status?



Adverse event defined

1. An unexpected and undesired incident directly associated with the care or services provided to the patient;
2. An incident that occurs during the process of providing health care and results in patient injury or death;
3. An adverse outcome for a patient, including an injury or complication.

(Patient Safety Dictionary, 2003, p. 39)

A basic approach to patient disclosure—preliminary steps

1. Provide prompt attention to the situation to eliminate or reduce immediate and potential risks.
2. Initiate an Occurrence Report
3. Notify appropriate manager(s) to seek assistance with reporting and follow-up on the error or event (e.g. Management of Program/Department or Quality and System Improvement Department).
4. A student or physician-in-training must inform his/her supervisor immediately upon becoming aware of an adverse event.

Preparation for Disclosure

5. (a) The clinical team, in consultation with the Program Leadership Team and/or Executive Management will determine the most appropriate person(s) to disclose information to the patient and/or the substitute decision-maker. This would be determined by considering if the event pertained to treatment procedure, medication, equipment, personnel, environment or other factors.

Preparation for disclosure

5 (b) When disclosing the information pertaining to the event, consideration should be given to having at least one other person from the Program or Department present at_the meeting, as well as a representative of the Quality and System Improvement Department, to disclose the information pertaining to the event.

Timing

6. Arrangements should be made as soon as possible to meet with the patient and/or substitute decision maker to disclose what is known about the event.

Making the disclosure

7. The person making the disclosure should:

(a) Concentrate on what happened and the possible consequences. Avoid too much detail and technical language.

(b) Remain factual. Refrain from providing opinions on the care and/or service of others.

(c) Take the lead in disclosure; don't wait for the patient to ask. Invite questions now and later.

(d) Outline a plan of care to rectify the harm and prevent recurrence for this patient and others.

(e) Offer to obtain second opinions where appropriate.

Making the dislosure (cont)

(f) Offer the option of a family meeting.

(g) Document the discussion in the patient's health record.

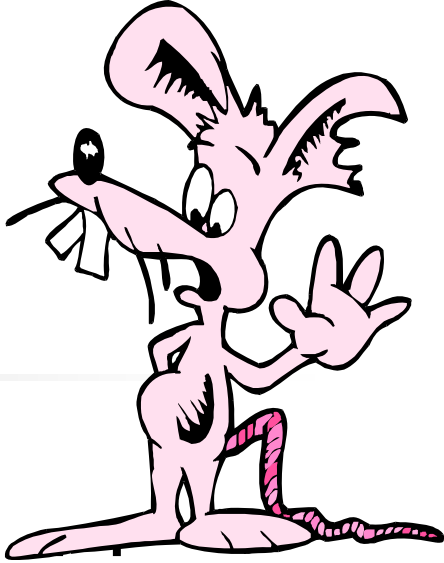
(h) Determine the need for follow-up meeting and who should attend.

(i) Be prepared for strong emotions and offer personal support and support from others.

(j) Accept responsibility for outcomes, but avoid attributions of blame.

(k) Apologies are appropriate. *(Note: and should probably be offered sooner rather than later)*

Refusal to participate

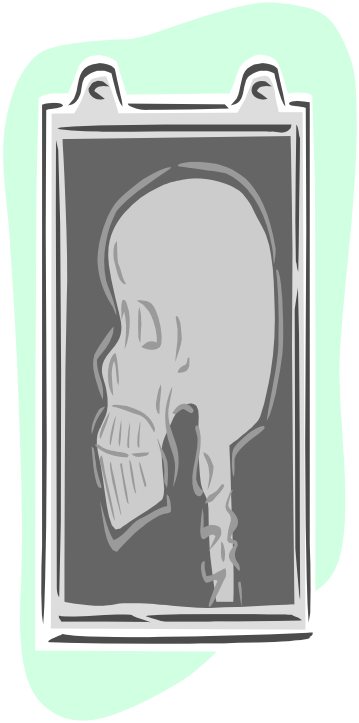


8. If the patient and/or substitute decision maker refuses to participate in a disclosure discussion, this refusal must be documented in the patient's health record. The opportunity to discuss the event at a later time should be communicated.

Ethics Consultation

- *"When uncertain about whether harm has occurred, it is recommended that disclosure take place; however, further consultation may be required before proceeding. Consider consulting with an ethics committee or another similar body of experts for advice about the clinical risk of future harm and the need to disclose" (CPSI, 2008, p. 18)*

Radiology error



- The radiology reports of a certain radiologist are reviewed when colleagues raise concerns about the radiologist's competency. A number of errors are identified. In some cases the patients in question are now deceased, but it is difficult to judge whether the radiology error was a contributing factor.

Multi-patient adverse event

An audit of a diagnostic lab reveals that certain pieces of diagnostic equipment have not been properly sterilized for several months. It is not known whether any patients were directly infected as a result.

AE with child

- A physician prescribes a dose of .5 mg of a particular drug for an infant. The pharmacist misreads the prescription and provides a dose of 5 mg which is administered to the child. The mistake is discovered the next time the child is due for more medication. There are no apparent untoward affects.