POLICY 38
(now combined with former Policy 40: Backing of Laws That Foster the Admission of Medical Errors)

The Role of Physicians in Promoting Patient Safety

Health services research has consistently demonstrated the substantial variances in achievable health outcomes due to a variety of causes: financial barriers to access, clinical decisions, procedural and system errors, problems in patient understanding, competence and compliance, and others.

Adverse health outcomes that are iatrogenic, or the result of “medical errors,” constitute a substantial impediment to the achievement of health care quality, cost, and risk management goals.

It is the responsibility of each physician to:

- Be knowledgeable about common causes for, and solutions to, medical errors;
- Communicate fully any pertinent patient information to other health care professionals;
- Participate actively in practice-specific activities that could lead to patient safety;
- Participate actively in any reporting requirement for medical errors and any analysis of the root cause of that error;
- Promptly and fully disclose to the patient and to the family any medical error affecting a patient while under the physician’s care.

The active participation in patient safety enhancement activities constitutes a medical standard of practice and a major priority for the field of medical quality management.

The passage of laws designed to require the reporting of errors by health care practitioners and entities in a confidential, legally protected, and non-punitive environment should be fully supported by health care practitioners. Such reporting of errors should occur in a timely manner so as to foster better understanding of the errors and how to prevent them in the future.

References:
Ending the Blame Game: Key to Medical Errors. Sibbald, CMAJ, Oct. 16, 2001

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