Health Professionals: Codes of Ethics

A Background Document Prepared for the Task Force on Adverse Health Events

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Introduction – Policies, Codes of Ethics and Standards of Practice of Select Health Care Professionals

The following paper is a review and update, where necessary, of codes of ethics, standards of practice, and relevant policies of select groups of health professionals as they relate to the management of adverse events in general and, more specifically, to the disclosure of such events.

Two comprehensive background papers on Canadian health care professionals' duty to disclose adverse events were published in 2006[1] and 2007[2]. In March 2008, a third review of the existing literature on the disclosure of adverse events within the Canadian health care system was completed by Dr. Sherry Espin for the Newfoundland and Labrador Commission of Inquiry on Hormone Receptor Testing.[3] A general overview of the relevant codes of ethics, standards of practice, and policies of select groups of health professionals follows. Greater detail is presented in the attached appendices.

Registered Nurses

Nurses' ethical practice is based on the Canadian Nurses Association's (CNA) *Code of Ethics for Registered Nurses*. It provides direction for ethical relationships, responsibilities, behaviours and decision making. The *Code* is intended to be used in combination with the professional standards, laws and regulations that guide practice.

Points eight and nine under the value of "Safe, Competent and Ethical Care" in the Code state:

> 8. *Nurses must admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event.*
>
> *9. Nurses must strive to prevent and minimize adverse events in collaboration with colleagues on the health care team. When adverse events occur, nurses should utilize opportunities to improve the system and prevent harm.*

These sections of the *Code* do not explicitly state to whom disclosure or admission of a mistake should be made. The terms "mistakes," "harm" and "adverse event" are not defined in the 2002 version of the *Code of Ethics*.

Most of the provincial and territorial nurses' associations, including Association of Registered Nurses of Newfoundland and Labrador, adopted the 2002 *Code of Ethics* and integrated it into their standards of practice including the (See Appendix A). In the jurisdictions where the **Code** was not adopted, other provisions relating to taking responsibility for errors or the relationship of trust between a nurse and a patient suggested a similar duty to admit mistakes.

In 2003, CNA issued a *Position Statement on Patient Safety*.[4] The CNA's position on disclosure provided that

> *Patients have a right to know when an adverse event has occurred in their care and to have appropriate treatment to address the problem as far as possible. When such an event results in injury or even death, there must be open and honest communication with the patient or the family as soon as possible. The implementation of clear agency policies on the reporting of adverse events and near misses, and on disclosure of adverse events to the patient and family, are necessary to support good clinical practice and to the overall improvement of patient safety in the system.*

Noteworthy is the fact that nurses have taken the following position:

> *Whistleblowing legislation should be enacted in all jurisdictions so that, after all avenues of addressing the problem have been tried, nurses who speak out publicly in good faith can be protected from reprisals.*

The *Code of Ethics* undergoes periodic revisions. The latest version was released in June 2008 after a three-year revision process. It provides a definition of adverse events, although the terms "harm" and "mistakes" remain undefined. Adverse events are defined as "unexpected, undesirable incidents resulting in injury or death that are directly associated with the process of providing health care or health services to a person receiving care."[5]

Point five under the value of "Providing Safe, Compassionate, Competent and Ethical Care" in the revised Canadian Nurses Association's (CNA) *Code of Ethics for Registered Nurses* states:

> *5. Nurses admit mistakes* and take all necessary actions to prevent or minimize harm arising from an adverse event. They work with others to reduce the potential for future risks and preventable harm.*

*The *Code of Ethics* encourages nurses to be aware of the provincial and territorial legislation and nursing practice standards that may include direction regarding disclosure and reporting, and that provide further clarity on whether there is a clear risk of harm.

The *Code of Ethics* provides guidance for nurses in the event a nurse encounters a situation where harm is underway or there is a clear risk of imminent harm. The *Code* suggests that immediate steps should be taken to protect the safety and dignity of the persons receiving care. Examples of appropriate immediate steps in cases of actual or imminent harm include, but are not limited to, speaking up if a potential error in drug calculation is detected, questioning an unclear order, intervening to prevent unsafe restraint practices, protecting patients when a colleague's performance appears to be impaired for any reason, or interfering with a serious breach of confidentiality involving people with sexually transmitted infections.

In the event nurses encounter situations where harm is not imminent but there is potential for harm, they are encouraged to work to resolve the problem as directly as possible in ways that are consistent with the good of all parties. Nurses are encouraged to review relevant statements in the *Code of Ethics for Registered Nurses* and other relevant standards, legislation, ethical guidelines, policies and procedures for reporting incidents or suspected incompetent or unethical care, including any legally reportable offence.

In February 2008, the Association of Registered Nurses of Newfoundland and Labrador released a *Position Statement on Registered Nurses' Professional Duty to Address Unsafe and Unethical Situations*.[6]

> The duty to identify and address unsafe and unethical situations is a professional, ethical, and legal responsibility arising out of the RN's obligation to protect clients from harm and to uphold the integrity of the nursing profession.

All registered nurses are responsible to provide leadership in the identification and resolution of unsafe and unethical situations that adversely affect or could affect the quality of client care.[7] The position statement provides examples of potential unsafe and unethical situations grouped in two categories. The first are concerns regarding the practice or behaviour of another health professional or individual in the workplace. The second are concerns regarding the workplace. A framework that reflects the process registered nurses need to follow when addressing such situations is presented and discussed. The framework consists of the following steps:

1. Verify the concern
2. Take appropriate action
3. Make a report
4. Document the concern
5. Follow-up if the concern (s) is unresolved. [8]

Canadian Nurses Protective Society (CNPS)

Health care organizations in Canada and their employed health care providers generally have liability insurance coverage provided through provincial or regional insurance reciprocals or commercial insurers. The Canadian Nurses Protective Society (CNPS) is a non-profit society owned and operated by nurses for nurses. It offers legal liability protection related to nursing practice. In 2005, CNPS issued an information sheet stating that disclosure to patients is appropriate based on the patient's right to know their own health information.[9]

The fear of professional disciplinary proceedings is a potential obstacle to disclosure of adverse events. However, as more ethics codes mandate disclosure, health care professionals may be subjected to disciplinary proceedings for the failure to disclose.

Licensed Practical Nurses

The Canadian Council for Practical Nurse Regulators does not have a code of ethics.[10] Each provincial college/association has its own code, only one of which refers specifically to admitting mistakes and taking action to prevent or minimize harm arising from an adverse event. However, in several jurisdictions acts to prevent or minimize adverse events are addressed in the Standards of Practice documents (See Appendix B).

The College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNL), in accordance with the Licensed Practical Nurses' *Act*, has the legislative responsibility for regulating the practice of Licensed Practical Nurses (LPNs) in the province. Similar to the Saskatchewan Association of Licensed Practical Nurses *Code of Ethics* and *Standards of Practice*, CLPNL's *Code of Ethics* and the *Standards of Practice* do not specifically address adverse health events, harm or mistakes. In contrast, the *Code of Ethics* of the College of Licensed Practical Nurses of British Columbia provides that Licensed Practical Nurses "Admit mistakes and take action to prevent or minimize harm arising from an adverse event." Although the *Code of Ethics* of the College of Licensed Practical Nurses of Alberta does not specifically address adverse events, *Standard 3: Patient Safety* of the *Standards of Practice* (2008) provide that

> *The Licensed Practical Nurse takes responsibility for their own safe nursing practice and patient safety. The LPN acts to prevent or minimize adverse events through identification and reporting of situations that are unsafe or potentially unsafe for clients or health providers, and reports unsafe practice, abusive behavior or unprofessional conduct to the appropriate authority.*

In Nova Scotia, the College of Licensed Practical Nurses, College of Occupational Therapists, College of Physicians and Surgeons, College of Registered Nurses, College of Pharmacists, and the College of Physiotherapists released a Joint Position Statement on Patient Safety.

> *In their quest to assist individuals to achieve an optimum level of health, health care professionals also take action to prevent or minimize harm…Health care professionals in all practice settings are responsible to identify and report actual or potential unsafe situations, including near misses, errors, and adverse events…[and are] expected to support organizational efforts to fully investigate near misses and adverse events: to identify the root causes of unsafe situations, with the goal of improving the system.*

Physicians

Section 14 of the Canadian Medical Association's *Code of Ethic*s states:

14. Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient.

This provision has been adopted in most of the provincial colleges' codes of ethics. The colleges in some provinces have instituted a specific policy addressing disclosure of harm, including the College of Physicians and Surgeons of Newfoundland and Labrador.

In all cases, some obligation is placed on physicians to inform the patient of an adverse event, although the triggering situation differs. A breach of the Code of Ethics in Newfoundland and Labrador constitutes conduct deserving of sanction, and in New Brunswick constitutes professional misconduct (See Appendix C). In 2000, Alberta enacted legislation to provide that a breach of a code of ethics or standards of practice constitutes unprofessional conduct.[11]

Canadian Medical Protective Association (CMPA)

The Canadian Medical Protective Association (CMPA)[12] is a not-for-profit mutual defense organization that provides medico-legal assistance for physicians who practice in Canada. This assistance includes legal defense and indemnification. The CMPA is independent of the liability insurers of institutions/hospitals and other health professionals.

The CMPA encourages physicians to disclose to patients the occurrence and nature of adverse outcomes, including those caused by adverse events, as soon as it is reasonable to do so after their occurrence. In 2008, the CMPA published a booklet titled *Communicating with Your Patient about Harm: Disclosure of Adverse Events.*[13] This educational tool offers suggestions to help physicians "meet their patients clinical, information and emotional needs after an adverse event."

The disclosure road map consists of the following:

1. First things first: Attend to clinical care
    a. Address clinical needs
    b. Deal with emergencies
    c. Consider the next steps in clinical care
    d. Provide emotional support
    e. Document your care
2. Planning the initial disclosure
    a. What are the facts?
    b. Think about what you will say
    c. Who will be present? Who will lead?
    d. When will the initial meeting occur?

    e. Decide where to meet
3. The initial disclosure meeting
    a. Provide facts as known
    b. Express regret as appropriate
    c. Avoid blame and speculation
    d. Confirm plan for future clinical care
    e. Outline expectations for further information
    f. Arrange follow-up, identify contact process
    g. Document the disclosure discussions in the medical record
4. Analysis
5. Post-analysis disclosure
    a. Provide further facts and information on any actions taken
    b. Express regret again, consider apology only if appropriate
    c. Document the discussions. [14]

Pharmacists

The Canadian Pharmacists Association does not have a code of ethics. Each provincial association has its own code, only two of which refer specifically to disclosure of adverse events (See Appendix D).

References

[1] Canadian Patient Safety Institute. (2006). *Background paper for the development of national guidelines for the disclosure of adverse events*. Edmonton: Author

[2] Vandergrift, E.V. (2007). Professional obligations to disclose adverse events: A changed regulatory landscape following patient safety initiatives. *Health Law in Canada,* 28 (2), 39-55.

[3] Commission of Inquiry on Hormone Receptor Testing – Newfoundland and Labrador. Espin, S. (2008). *Examining disclosure options. Procedures for disclosing adverse events: A literature review*. Retrieved June 4, 2008 from http://www.cihrt.nl.ca/pdf/BioNEWse%20_2_.pdf

[4] Canadian Nurses Association. (2003). *Position Statement Patient Safety*. Ottawa: Author

[5] Canadian Nurses Association. (2008). Code of Ethics. Ottawa: Author.

[6] Association of Registered Nurses of Newfoundland and Labrador. (2008). *Position Statement. Registered Nurses' Professional Duty to Address Unsafe and Unethical Situations.* St. John's: Author

[7] Association of Registered Nurses of Newfoundland and Labrador. (2007). *Standards for Nursing Practice*. St. John's: Author

[8] Association of Registered Nurses of Newfoundland and Labrador. (2007). *Standards for Nursing Practice*. St. John's: Author

[9] Canadian Nurses Protective Association. Retrieved July 22, 2008 from http://www.cnps.ca/index_e.html

[10] Canadian Council for Practical Nurse Regulators. Retrieved July 22, 2008 from http://www.ccpnr.ca/missionvisionvalues.html

[11] *Health Professions Act,* R.S.A. 2000, c. H-7. Retrieved August 18, 2008 from http://www.canlii.org/eliisa/highlight.do?language=en&searchTitle=Alberta&path=/ab/laws/sta/h-7/20080715/whole.html

[12] Canadian Medical Protective Association. Retrieved July 22, 2008 from http://www.cmpa-acpm.ca/cmpapd03/pub_index.cfm?LANG=E&URL=cmpa%5Fdocs%2Fenglish%2Fcontent%2Fabout%5Fcmpa%2Fpublic%2Fpub%5Fabout%5Fus%2De%2Ehtml

[13] Canadian Medical Protective Association. (2008). *Communicating with your patient about harm. Disclosure of Adverse Events.*

[14] Canadian Medical Protective Association. (2008). *Communicating with your patient about harm. Disclosure of Adverse Events.*

Appendix A: Policies, Standards and Codes of Ethics for Nurses

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
Alberta	There is a duty to admit mistakes and take the necessary action to prevent or minimize harm arising from an adverse event. The CNA's *Code of Ethics for Registered Nurses* (2002) is integrated into the College and Association of Registered Nurses of Alberta's *Nursing Practice Standards (2003)* under "Standard #3, Ethical Practice," which states that: "The registered nurse complies with the Canadian Nurses Association (CNA) *Code of Ethics for Registered Nurses (2002)*."	The terms "mistakes," "harm" and "adverse event" are not defined.	Not addressed
British Columbia	There is a duty to admit mistakes and take the necessary action to prevent or minimize harm arising from an adverse event. The CNA's *Code of Ethics for Registered Nurses* (2002) is adopted in "Standard 4: Code of Ethics" in the College of Registered Nurses of British Columbia's *Professional Standards for Registered Nurses and Nurse Practitioners* (2008).	The terms "mistakes," "harm" and "adverse event" are not defined.	Not addressed
Manitoba	There is a duty to admit mistakes and take the necessary action to prevent or minimize harm arising from an adverse event. "Standard I: Professional Responsibility and Accountability" and "Standard V: Ethical Practice" of the College of Registered Nurses of Manitoba's *Standards of Practice for Registered Nurses* (2004) provide that nurses should practice in a manner consistent with the CNA's *Code of Ethics for Registered Nurses* (2002).	The terms "mistakes," "harm" and "adverse event" are not defined.	Not addressed
National Canadian Nurses Association	The revised Canadian Nurses Association's *Code of Ethics for Registered Nurses* (2008) provides that nurses must admit mistakes * and take all necessary actions to prevent or minimize harm	The terms "mistakes" and "harm" are not defined. The term "adverse events"is defined as "unexpected, undesirable incidents resulting in injury or death that are directly	Nurses should be aware of the provincial and territorial legislation and nursing practice standards that may

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
(CNA) **2008**	arising from an adverse event. *Provincial and territorial legislation and nursing practice standards may include further direction regarding requirements for disclosure and reporting.	associated with the process of providing health care or health services to a person receiving care" (Hebert, Hoffman & Davies, 2003). If a nurse encounters a situation where harm is underway or there is a clear risk of imminent harm, he or she should take immediate steps to protect the safety and dignity of the persons receiving care. Some examples of appropriate immediate steps in cases of actual or imminent harm could include, but are not limited to, speaking up if a potential error in drug calculations is detected, questioning an unclear order, intervening to prevent unsafe restraint practices, protecting patients when a colleague's performance appears to be impaired for any reason (see CRNNS, 2006b) or interfering with a serious breach of confidentiality involving people with sexually transmitted infections. When nurses encounter situations where harm is not imminent but there is potential for harm, they work to resolve the problem as directly as possible in ways that are consistent with the good of all parties. As they work through these situations, nurses review relevant statements in the *Code of Ethics for Registered Nurses* and other relevant standards, legislation, ethical guidelines, policies and procedures for reporting incidents or suspected incompetent or unethical care, including any legally	include direction regarding disclosure and reporting and provide further clarity on whether there is a clear risk of harm.

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
		reportable offence.	
National: Canadian Nurses Association (CNA) **2002**	The Canadian Nurses Association's *Code of Ethics for Registered Nurses* (2002) provides that nurses must admit mistakes. Although it does not specify that they must admit them to the patient, this can be inferred from the context. They must also take all necessary actions to prevent or minimize harm arising from an adverse event. The Value of "Safe, Competent and Ethical Care" provides that: 8. Nurses must admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event. 9. Nurses must strive to prevent and minimize adverse events in collaboration with colleagues on the health care team. When adverse events occur, nurses should utilize opportunities to improve the system and prevent harm.	The terms "mistakes," "harm" and "adverse event" are not defined.	Not addressed
New Brunswick	There is a duty to admit mistakes and take the necessary action to prevent or minimize harm arising from an adverse event. The CNA's *Code of Ethics for Registered Nurses* (2002) has been adopted by the Nurses Association of New Brunswick. Their *Standards of Practice for Registered Nurses* (2005) provides under "Standard 4: Ethical Practice" that nurses must practice in accordance with the *Code of Ethics*.	Not addressed	Not addressed
Newfoundland/ Labrador	There is a duty to admit mistakes and take the necessary action to prevent or minimize harm arising from an adverse event. The CNA's revised *Code of Ethics for Registered Nurses* (2008) has been adopted by the Association of Registered Nurses of Newfoundland and Labrador. Their	The terms "mistakes," "harm" and "adverse event" are not defined.	Not addressed

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
	Standards for Nursing Practice in Newfoundland and Labrador (2007) provides under "Standard 1: Self-regulation and Professional Accountability" that each registered nurse understands, promotes, and complies with the values and beliefs in the *Code of Ethics for Registered Nurses.* In "Standard 4: Professional Interactions and Advocacy" each registered nurse acts as an advocate to protect clients from harm due to unsafe and/or incompetent or unethical care.		
Northwest Territories and Nunavut	There is a duty to admit mistakes and take the necessary action to prevent or minimize harm arising from an adverse event. The Registered Nurses Association of Northwest Territories and Nunavut has adopted the CNA's *Code of Ethics for Registered Nurses* (2002). *The Standards of Practice for Registered Nurses NWTRNA* (2002) provides that a nurse must practice in accordance with the CNA's *Code of Ethics*.	The terms "mistakes," "harm" and "adverse event" are not defined.	Not addressed
Nova Scotia	The CNA's *Code of Ethics for Registered Nurses* (2002) has been adopted by the College of Registered Nurses of Nova Scotia in their *Standards of Nursing Practice* (2004), which details under "Standard 1: Accountability" that nurses must practice in accordance with the CNA's *Code of Ethics for Registered Nurses* (2002). Indicator 1.3 of this standard states that each registered nurse recognizes and reports errors and takes all necessary action to prevent or minimize harm arising from an adverse event.	The terms "mistakes," "harm" and "adverse event" are not defined.	Not addressed
Ontario	The College of Nurses of Ontario published its professional standards in 2002. The *Professional Standards* (2002) provides, under the heading of "Accountability," that a nurse demonstrates the standard by taking responsibility for errors when	The term "errors," which is not defined.	Not addressed

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
	they occur and taking appropriate action to maintain client safety. Further, under the heading of "Ethics" nurses are directed to follow the College's *Ethics Practice Standard* (2002) which does not specifically deal with disclosure, although the obligation to disclose might be inferred from the section on "Maintaining Commitments to Quality Practice Settings – Truthfulness." Truthfulness means speaking or acting without intending to deceive. Truthfulness also refers to providing enough information to ensure the client is informed. Omissions are as untruthful as false information. As health care has changed, so have the restrictions on disclosure in dealing with clients. Many health professionals formerly believed that clients could be harmed by knowing the details of their illnesses. Health professionals now believe that clients have the right to, and will benefit from, full disclosure. Honesty builds trust, which is essential to the therapeutic relationship between nurses and clients. Clients from other cultures, however, may view truthfulness differently from the health care team. Situations may arise in which full disclosure is difficult, and conflicts may develop among team members. Conflicts may also occur among the team, the family and the client, as each group or person brings a particular set of values to the situation.		
Prince Edward Island	There is a duty to admit mistakes and take the necessary action to prevent or minimize harm arising from an adverse event. The CNA's *Code*	The terms "mistakes," "harm" and "adverse event" are not defined.	Not addressed

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
	of Ethics for Registered Nurses (1997) has been adopted by the Association of Nurses of Prince Edward Island. The *Standards for Nursing Practice* (1999) provide under "Standard I - Code of Ethics" that nurses must practice in accordance with the CNA's *Code of Ethics for Registered Nurses* (2002).		
Quebec	In the 2003 version of the *Code of Ethics of Nurses,* duty to disclose may be inferred from ss. 11 and 28, which emphasize the relationship of trust between a nurse and patient: 11. A nurse shall not abuse the trust of her or his client. 28. A nurse shall seek to establish and maintain a relationship of trust with her or his client. 10. A nurse shall fulfill her or his professional duties with integrity. O.C. 1513-2002, s. 10. 11. A nurse shall not abuse the trust of her or his client. O.C. 1513-2002, s. 11. 12. A nurse shall report any incident or accident that results from her or his intervention or omission. The nurse shall not attempt to conceal such an incident or accident. When such an incident or accident has, or could have ,consequences for the client's health, the nurse shall promptly take the necessary measures to remedy, minimize or offset the consequences of the incident or accident. However, there is no express duty to disclose in the latest version of the *Code of Ethics of Nurses* (2008). Section 3.02.01 of the *Code* (2008) emphasizes the integrity of the nurse:	Not addressed	Not addressed

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
	A nursing professional must discharge his professional duties with integrity and shall not abuse his client's good faith.		
Saskatchewan	There is a duty to admit mistakes and take necessary action to prevent or minimize harm arising from an adverse event. The Saskatchewan Registered Nurses' Association's *Standards and Foundation Competencies for the Practice of Registered Nurses* (2007) provides, under Assumptions #13: "All registered nurses practice in a manner consistent with the common law, provincial and federal legislation and the current Canadian Nurses Association code of ethics for registered nurses." **Standard I – Professional Responsibility and Accountability:** 17. **[**The nurse**]** Reports unsafe practice or the professional misconduct of a health care worker to appropriate authorities. 18. Recognizes, reports and takes action in a timely manner, in unsafe situations when client/staff safety and/or well-being is potentially or actually compromised. 19. Challenges and takes action as necessary, on questionable orders, decisions or actions made by other health team members, to safeguard the client. 20. In accordance with agency policy and legislation, and in a timely manner, recognizes, and reports near misses, adverse events and critical incidents, takes action to minimize harm,	The terms "mistakes," "harm" and "adverse event" are not defined.	In accordance with agency policy and legislation, and in a timely manner, recognizes, and reports near misses, adverse events and critical incidents, takes action to minimize harm, and participates in root cause analysis. Reports critical incidents through appropriate channels.

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
	and participates in root cause analysis. 21. Utilizes a systems approach to patient safety, participates with others in the prevention of errors, near misses and adverse events. 22. Integrates quality improvement principles and activities into nursing practice in an ongoing manner. **Standard III – Ethical practice** 66. [The nurse] Practices in accordance with the values of the current CNA code of ethics for registered nurses and the accompanying responsibility statements, as amended from time to time. **Standard IV – Self-regulation** 98. [The nurse]Takes the needed action to protect the client from unsafe nursing care. 99. Reports critical incidents through appropriate channels. 100. Understands and participates in the development and utilization of a framework that addresses quality improvement.		
Yukon	There is a duty to admit mistakes and take the necessary action to prevent or minimize harm arising from an adverse event. The CNA's *Code of Ethics for Registered Nurses* (2002) has been appended to the *Standards for Registered Nursing Practice in the Yukon* (2005), whose "Code of Ethics" (standard 4), provides that nurses must uphold the values contained in the CNA's *Code of Ethics* (2002).	The terms "mistakes," "harm" and "adverse event" are not defined.	Not addressed

Appendix A Reference List

Association of Nurses of Prince Edward Island. (1999). *Standards for Nursing Practice*. Retrieved June 4, 2008 from http://www.forces.gc.ca/health/hs_staff_sites/pdf/Engraph/SP_Nurses_PEI_association_standards_e.pdf.

Association of Registered Nurses of Newfoundland and Labrador. (2007). *Standards for Nursing Practice*. Retrieved June 4, 2008 from http://www.arnnl.nf.ca/pdf/standards_for_nursing_practice_april_07.pdf

Canadian Nurses Association. (2002). *Code of Ethics for Registered Nurses*. Retrieved June 4, 2008 from http://www.cna-nurses.ca/CNA/practice/ethics/code/default_e.aspx.

Canadian Nurses Association. (2008). *Code of Ethics for Registered Nurses*. Retrieved June 4, 2008 from http://www.cna-nurses.ca/CNA/documents/pdf/publications/Code_of_Ethics_2008_e.pdf

Code of ethics of nurses. (2006). R.Q. c. I-8, r.4.1. Retrieved June 4, 2008 from http://www.canlii.org/qc/laws/regu/i-8r.4.1/20060926/whole.html.

Code of ethics of nurses. (2008). R.Q. c. I-8, r.4.1. Retrieved July 21, 2008 from http://www.canlii.org/qc/laws/regu/i-8r.4/20080617/whole.html

College and Association of Registered Nurses of Alberta. (2005). *Nursing Practice Standards*. Retrieved June 4, 2008 from http://www.nurses.ab.ca/pdf/Nursing%20Practice%20Standards.pdf.

College of Nurses of Ontario. (2005). *Ethics Practice Standard.* Retrieved June 4, 2008 from http://www.cno.org/docs/prac/41034_Ethics.pdf.

College of Nurses of Ontario. (2002). *Professional Standards (Revised 2002)*. Retrieved June 4, 2008 from http://www.cno.org/docs/prac/41006_ProfStds.pdf.

College of Registered Nurses of British Columbia. (2008). *Professional Standards for Registered Nurses and Nurse Practitioners*. Retrieved June 4, 2008 from http://www.crnbc.ca/downloads/128_Prof%20Standards%202005.pdf.

College of Registered Nurses of Manitoba. (2004). *Standards of Practice for Registered Nurses*. Retrieved June 4, 2008 from http://www.crnm.mb.ca/downloads/standardsofpractice_web.pdf

College of Registered Nurses of Nova Scotia. (2004). *Standards of Nursing Practice*. Retrieved June 4, 2008 from http://www.crnns.ca/documents/standards2004.pdf

Hebert, P.C., Hoffman, C., & Davies, J.M. (2003). *The Canadian Patient Safety Dictionary*. Edmonton: Canadian Patient Safety Institute.

Nurses Association of New Brunswick. (2005). *Standards of Practice for Registered Nurses*. Retrieved June 4, 2008 from http://www.nanb.nb.ca/pdf_e/Publications/General_Publications/StandardsofRegisteredNursesE.pdf.

Registered Nurses Association of the Northwest Territories and Nunavut. (2006). *Standards of Nursing Practice for Registered Nurses*. Retrieved June 4, 2008 from http://www.rnantnu.ca/Portals/0/Documents/Standards_Nrsing_Prac_2006.pdf

Saskatchewan Registered Nurses' Association. (2006). *Standards and Foundation Competencies for the Practice of Registered Nurses.* Retrieved June 4, 2008 from http://www.srna.org/nurse_resources/standards_competencies.pdf

Yukon Registered Nurses Association. (2005). *Standards for Registered Nursing Practice in the Yukon.* Retrieved June 4, 2008from http://www.yrna.ca/pdf/Standards2005.pdf.

Appendix B: Policies, Standards and Codes of Ethics for Licensed Practical Nurses

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
Alberta	The College of Licensed Practical Nurses of Alberta's *Code of Ethics* (2008) does not address adverse events. However, "Standard 3: Patient Safety" of the *Standards of Practice* (2008) provides that "The Licensed Practical Nurse takes responsibility for own safe nursing practice and patient safety. The LPN acts to prevent or minimize adverse events through identification and reporting of situations that are unsafe or potentially unsafe for clients or health providers.	The term "adverse events" is not defined.	Not addressed
British Columbia	There is a duty to admit mistakes and take action to prevent or minimize harm arising from an adverse event. This is addressed in the Value Statement on Safe, Competent and Ethical Care in the document *Code of Ethics for LPNs: Companion Guide* (2004).	The terms "mistakes," "harm" and "adverse event" are not defined.	Not addressed
Manitoba	The College of Licensed Practical Nurses of Manitoba (2004) "Standard IV –Ethical Practice" provides that the LPN identifies, responds to and reports situations of unsafe practice or professional misconduct to appropriate authorities.	Not addressed	Not addressed
New Brunswick	The Association of New Brunswick Licensed Practical Nurses *Code of Ethics* (2002) or *Standards of Practice* (2002) do not address adverse events.	Not addressed	Not addressed
Newfoundland/ Labrador	The College of Licensed Practical Nurses of Newfoundland and Labrador's *Code of Ethics* (1995) and *Standards of Practice* (2004) do not address adverse events.	Not addressed	Not addressed
Nova Scotia	The College of Licensed Practical Nurses of Nova Scotia's *Code of Ethics* (2005) and *Standards of Practice* (2005) do not address adverse events. However, the College released a Joint Position Statement on Patient Safety with the Colleges of Occupational Therapists, Physicians and Surgeons, Registered Nurses, Pharmacists, and Physiotherapists. The position states: "*In their quest to assist individuals to achieve an optimum level of health, health care professionals also take action to prevent or minimize harm…Health care professionals in all practice settings are responsible to identify and report actual or potential unsafe situations, including near misses, errors, and adverse events…[they are] expected to support*	"Error" and "harm" are not defined. "Adverse event" is defined as an unexpected event in health care delivery that results in harm and is not attributable to a recognized complication (CPSI, 2007). "Near miss" is defined as an event that did not reach a patient because of	Not addressed

	organizational efforts to fully investigate near misses and adverse events: to identify the root causes of unsafe situations, with the goal of improving the system."	timely intervention or good fortune (CPSI, 2007).	
Saskatchewan	The Saskatchewan Association of Licensed Practical Nurses *Code of Ethics* (2004) and *Standards of Practice* (2004) do not address adverse events.	Not addressed	Not addressed

College of Licensed Practical Nurses of Alberta. (2008). *Code of Ethics*. Retrieved July 21, 2008 from http://www.clpna.com/Portals/0/Files/doc_CodeofEthics-June2008.pdf

College of Licensed Practical Nurses of Alberta. (2008). *Standards of Practice*. Retrieved July 21, 2008 from http://www.clpna.com/Portals/0/Files/doc_StandardsofPractice-June2008.pdf

College of Licensed Practical Nurses of British Columbia. (2004). *Code of Ethics for LPNs: Companion Guide*. Retrieved June 4, 2008 from http://www.clpnbc.org/content_images/documents/CodeofEthics%20Companion%20Guide.pdf

College for Licensed Practical Nurses of Newfoundland and Labrador. (1995). *Code of Ethics*. St. John's: Author

College for Licensed Practical Nurses of Newfoundland and Labrador. (2004). *Standards of Practice*. St. John's: Author.

College of Licensed Practical Nurses of Nova Scotia. (2005). *Code of Ethics and Standards of Practice*. Retrieved July 21, 2008 from http://www.clpnns.ca/regulation/regulationPDFs/CLPNNS_Ethics_Standards.pdf

College of Licensed Practical Nurses of Nova Scotia, College of Occupational Therapists of Nova Scotia, College of Physicians and Surgeons of Nova Scotia, College of Registered Nurses of Nova Scotia, Nova Scotia College of Pharmacists, and Nova Scotia College of Physiotherapists. (2007). *Joint Position Statement on Patient Safety.* Retrieved July 21, 2008 from http://www.crnns.ca/documents/Patient%20Safety%202007.pdf.

Saskatchewan Association of Licensed Practical Nurses. (2004). *Code of Ethics*. Retrieved July 21, 2008 from http://www.salpn.com/public/home.jsp

Saskatchewan Association of Licensed Practical Nurses. (2004). *Standards of Practice*. Retrieved July 21, 2008 from http://www.anblpn.ca/English/home/dynamic.cfm?id=51

The Association of New Brunswick Licensed Practical Nurses (2002). *Code of Ethics*. Retrieved July 21, 2008 from http://www.anblpn.ca/English/home/dynamic.cfm?id=51

The Association of New Brunswick Licensed Practical Nurses (2002). *Standards of Practice*. Retrieved July 21, 2008 from http://www.anblpn.ca/English/home/dynamic.cfm?id=51

Appendix C: Policies, Standards and Codes of Ethics for Physicians

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
Alberta	There is a duty to disclose harm, as provided in Section 14 of the CMA *Code of Ethics* (2004), as adopted by the College of Physicians and Surgeons of Alberta.	Harm, which is not a defined term.	Not addressed
British Columbia	There is a duty to disclose harm, as provided in Section 14 of the CMA *Code of Ethics* (2004), as adopted by the College of Physicians & Surgeons of British Columbia in its *Physician Resource Manual* (2005).	Harm, which is not a defined term.	Not addressed
Manitoba	There is a duty to inform a patient of a deficiency in care. This is addressed in Section 26.2 of the *Code of Conduct* (2005) of the College of Physicians and Surgeons of Manitoba (Schedule G of By-law #1): 26.2. When you learn that a deficiency of care has occurred, you should inform the patient and make the responsible physician aware. The College of Physicians and Surgeons of Manitoba Statement No. 169 on *Physician Disclosure of Harm in the Course of Patient Care* (2002) requires that: 1. A physician must promptly inform his or her patient of any harm that has occurred in the course of that patient's medical care. 2. A physician must provide full and frank disclosure to the patient respecting the harm.	"Deficiency of care," which is not a defined term.	In making the disclosure, the following guidelines apply: 1. When harm occurs in the course of a patient's medical care, the physician responsible for that patient (including weekend or vacation coverage) must discuss the event with the patient. The discussion should occur promptly, taking into account the patient's medical condition. 2. In the discussion with the patient, the physician should: A. Advise the patient of the facts in a straightforward and non-judgmental way. The discussion should include advice as to the nature, severity, and cause (if known) of the harm.

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
			B. Advise the patient as to what, if anything, can be done to correct the harm sustained. C. Advise of any medical care that the patient requires as a result of the harm that was sustained, and promptly seek appropriate help from other caregivers. D. Disclose only what is known at the time of the discussion. Disclosure is a process. avoid speculation. E. Accept responsibility for one's own actions, but without admitting liability to the patient. The physician must take care not to potentially prejudice the patient's right to indemnity under any insurance or protection plan. However, concern regarding legal liability that might result following truthful disclosure does not affect the physician's responsibility to be honest with the patient. F. Avoid attributing blame to specific individuals. Rarely is an adverse medical event the fault of a single individual. G. Consider whether an apology or an expression of sorrow is appropriate. An apology or an expression of sorrow offered at an early stage in the disclosure

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
			process can help prevent bad feelings and legal or professional complaints. 3. Where appropriate, the physician may offer the patient a second opinion, the involvement of outside assistance, or the transfer of care to another physician. 4. The physician must document in the patient's chart the discussion with the patient. 5. A patient has the right to decline disclosure, but must do so of the patient's own initiative. Where a patient declines disclosure, the particulars must be recorded in the patient's chart, and the physician must advise the patient that he or she is willing to discuss the matter if the patient so chooses in the future. 6. Where the harm is particularly serious and/or unexpected, provided the patient consents, a meeting between members of the care team and the patient's family may be held. An open and prompt meeting with all relevant records available can promote understanding of the event, and avoid charges of a "cover-up." As well, advice as to what will be done to prevent a similar occurrence with another patient may offer solace to affected patients/families. The discussions at any such meeting must be carefully documented. 7. Where the harm is particularly serious and/or unexpected and the patient is in a

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
			health care facility at the time the harm occurs, the physician should promptly inform the appropriate authority of the harm. 8. Where the patient is in a health care facility at the time an event with potential clinical significance occurs, the physician should consider whether it is necessary to inform the appropriate authority of the event in order to prevent possible harm in the future. 9. Errors committed by others may require reporting and disclosure. If in doubt, an event (such as witnessing a significant error made by another person) must be discussed in a confidential way with the Registrar responsible for Standards. 10. Medical learners fulfil their obligations under this Statement if the disclosure is made to the medical learner's supervisor or Program Director.
National Canadian Medical Association (CMA)	In all provinces except for Quebec, section 14 of the CMA *Code of Ethics* (2004) is embedded, under the heading of "Responsibilities to the Patient," and states as follows: Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient.	Harm, which is not a defined term.	Not addressed
New Brunswick	There is a duty to disclose harm, as provided in Section 14 of the CMA *Code of Ethics* (2004). The Council of the College of Physicians and Surgeons of New Brunswick has adopted the	Harm, which is not a defined term.	It is Council's view that early, candid, and full disclosure of adverse events to patients and their families will be of benefit to all concerned.

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
	CMA *Code of Ethics* (2004) and added commentary. Section 32 of Regulation #9 provides that a breach of the Code of Ethics constitutes professional misconduct. In a commentary, dated November 2002, and titled "Reporting of Adverse Events," the Council of the College addressed the reporting of adverse events as follows: The Colleges in several other provinces have mandated, or are considering, specific policies that mandate physicians to disclose adverse events and errors which occur in the course of patient care. Council considered whether such an initiative was necessary here. It was concluded that it was not. This is because it is Council's view that this was already an existing obligation on the part of physicians. In other words, patients remain entitled to have complete information regarding their care, including any adverse events. Council was furthermore of the view that it is improper for such an obligation to be interfered with by other parties.		
Newfoundland and Labrador	Physicians have a duty to disclose adverse outcomes. The College of Physicians and Surgeons of Newfoundland & Labrador's policy, *Disclosure of an Adverse Outcome,* provides as follows: The medical practitioner who was the	The policy provides that "...adverse outcome means a non-trivial adverse outcome or consequence of health care treatment, which adverse outcome or consequence is not solely related to the course of the illness or condition being treated, but has	The policy provides that: "The adverse outcome should be factually described, with care taken to explain medical terminology so that it is understandable by the patient. Speculation or conjecture should be avoided, and the practitioner may respectfully decline to respond to questions or comments from the patient which

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
	most responsible physician for the health care treatment during the course of which the adverse outcome occurred, should disclose the adverse outcome to the patient. In some circumstances, it may be that more than one medical practitioner was responsible for the health care treatment that resulted in the adverse outcome. In such circumstances, each responsible medical practitioner has an individual responsibility to ensure that disclosure is made to the patient of the adverse outcome. In such circumstances, the responsible medical practitioners should consult as to who among them will make the disclosure to the patient. The College has also adopted the CMA *Code of Ethics* (2004). Section 34 (c)(v) of An Act Respecting the Practice of Medicine in the Province (2005) provides that a breach of the code of ethics constitutes "conduct deserving of sanction."	resulted at least in part from the health care treatment itself or from the manner in which the health care was delivered. Adverse outcome includes a situation where the possibility of the adverse outcome may be a recognized risk of the treatment." "Adverse event" also includes an incident in the course of health care treatment which results in a recognized potential risk of a non-trivial adverse outcome or consequence at some future time.	invites speculation or conjecture. Options for treatment to address the adverse outcome should be raised. The patient should be told when such treatment or a second opinion may be able to be provided, or should be provided, by another practitioner.... Within the foregoing context, an expression of regret for the adverse outcome may be appropriate, and should not be taken as an admission of fault or liability. **Note:** The policy provides that, in circumstances where questions of fault or negligence may give rise to a claim for damages or litigation, a medical practitioner may wish to first seek the advice of the medical malpractice protection provider as to how disclosure of an adverse outcome may be made without it being taken to be an admission of fault or liability.
Nova Scotia	There is a duty to disclose harm, as provided in Section 14 of the CMA *Code of Ethics* (2004), as adopted by the College of Physicians and Surgeons of Nova Scotia by regulation on June 3, 2005.	Harm, which is not a defined term.	Not addressed
Ontario	There is a duty to disclose harm. The College of Physicians and Surgeons of Ontario's *Disclosure of Harm* (2003)	Harm is defined broadly as an unexpected or normally avoidable outcome that negatively affects the	Physicians should take the lead in disclosure rather than waiting for the patient to ask. Disclose as soon as the harm is detected or as

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
	policy, provides that: When a physician becomes aware, while treating a patient, that the patient has suffered harm in the course of receiving health care, he or she should consider whether the harm does or can be reasonably expected to negatively affect the patient's health and/or quality of life. If it does, then it is the physician's obligation to inform the patient about the harm sustained.	patient's health and/or quality of life, which occurs (or occurred) in the course of health care treatment and is not due directly to the patient's illness.	soon as reasonably possible when the patient's condition is stable and/or the patient is able to comprehend the information. When communicating with the patient, it is best to avoid speculation and to focus on what is known about the event at the time of the discussion. A short, objective, factual non-technical summary of the event is one method of disclosure. Physicians should avoid attributing blame to specific individuals or providing simple explanations as to "cause" or responsibility. A timely and empathic expression of regret and condolences may be appropriate and should not be construed or taken to be an admission of liability or fault. Discussing a plan of care that addresses the harm is of equal importance.
Prince Edward Island	There is a duty to disclose harm, as provided in Section 14 of the CMA *Code of Ethics* (2004), as adopted by the College of Physicians and Surgeons of Prince Edward Island.	Harm, which is not a defined term.	Not addressed
Quebec	Physicians have a duty to inform a patient of any incident, accident or complication which is likely to have, or which has had, a significant impact on his state of health or personal integrity. Section 56 of the *Code of Ethics of Physicians* (2006), states: A physician must, as soon as possible, inform his patient or the latter's legal representative of any incident, accident	The Act amending the Act Respecting Health Services and Social Services as regards to the Safe Provision of Health and Social Services defines "incident" and "accident" as follows: "Incident" means an action or situation that does not have consequences for the state of health or welfare of a user, a personal member, a professional involved or a third person, but the outcome of which is	Not addressed

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
	or complication which is likely to have or which has had a significant impact on his state of health or personal integrity.	unusual and could have had consequences under different circumstances. "Accident" means an action or situation where a risk event occurs which has or could have consequences for the state of health or welfare of the user, a personal member, a professional involved or a third person.	
Saskatchewan	There is a duty to disclose harm, as provided in Section 14 of the *Code of Ethics for Saskatchewan Physicians* (2005), as adapted from the CMA *Code of Ethics* (2004).	Harm, which is not a defined term.	Not addressed

Appendix C References

An Act to Amend the Act Respecting Health Services and Social Services as Regards to the Safe Provision of Health and Social Services, RSQ 2002, Bill 113, c 71. Retrieved June 4, 2008 from http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=5&file=2002C71A.PDF

Canadian Medical Association. (2004). *Code of Ethics.* Retrieved June 4, 2008 from http://policybase.cma.ca/PolicyPDF/PD04-06.pdf

College of Physicians and Surgeons of Alberta. *Canadian Medical Association. Code of Ethics.* Retrieved July 21, 2008 from http://www.cpsa.ab.ca/publicationsresources/other_resources.asp

College of Physicians and Surgeons of British Columbia. (2005). *Resource Manual for Physicians. Retrieved July 21, 2008 from https://www.cpsbc.ca/cps/physician_resources/publications/resource_manual/codeofethics*

College of Physicians and Surgeons of Manitoba. (2005). *Code of Conduct.* Retrieved July 21, 2008 from http://www.cpsm.mb.ca/bylaws/By%20Law%201%20Schedule%20G%20Code%20of%20Conduct.pdf

College of Physicians and Surgeons of Manitoba. (2007). *Physician Disclosure of Harm that Occurs in the Course of Patient Care*. Retrieved July 21, 2008 from http://www.cpsm.mb.ca/statements/169.php

College of Physician and Surgeons of New Brunswick (1983).Regulation #9. *Retrieved July 21, 2008 from* http://www.cpsnb.org/english/Regulations/regulation-9.html

College of Physician and Surgeons of New Brunswick (2002). Selected Commentaries. Reporting of Adverse Events. *Retrieved July 21, 2008 from* http://www.cpsnb.org/english/Selected%20Commentaries/Reporting%20of%20Adverse%20Events.html

College of Physicians and Surgeons of New Brunswick. Reporting of Misconduct. Retrieved July 21, 2008 from http://www.cpsnb.org/english/Regulations/by-laws-toc.html

College of Physicians and Surgeons of Newfoundland and Labrador. (2006). *Disclosure of an Adverse Outcome.* Retrieved June 4, 2008 from http://www.nmb.ca/PolicyDocument.asp?ID=21

College of Physicians and Surgeons of Nova Scotia. (2005). Retrieved July 21, 2008 from http://www.cpsns.ns.ca/publications/cmaethics.html

College of Physicians and Surgeons of Ontario. (2003). *Disclosure of Harm: Policy #1-03.* Retrieved July 21, 2008 from http://cpso.on.ca/Policies/disclosure.htm.

Collège des médecins du Québec. (2002). *Code of Ethics of Physicians*. Retrieved July 21, 2008 from *http://www.cmq.org/DocumentLibrary/UploadedContents/CmsDocuments/cmqcodedeontoan.pdf*

Code of ethics of physicians, R.Q. c. M-9, r.4.1. *Code of Ethics of Physicians*. Retrieved July 21, 2008 from http://www.canlii.org/qc/laws/regu/m-9r.4.1/20060926/whole.html.

College of Physicians and Surgeons of Saskatchewan. *Code of Ethics for Saskatchewan Physicians*. Retrieved July 21, 2008 from http://www.quadrant.net/cpss/communication/brochures/ethics.html

Appendix D: Policies, Standards and Codes of Ethics for Pharmacists

Jurisdiction	Is there a duty to disclose an adverse event?	What circumstances or conditions prompt the duty to disclose?	What must be disclosed?
Alberta	In the *Code of Ethics Bylaw* of the Alberta College of Pharmacists (1998) there is no express duty to disclose. Principle I states that a pharmacist holds the health and safety of each client to be the primary consideration. Principle VI states that a pharmacist acts with honesty and integrity.	Not addressed	Not addressed
British Columbia	The *Code of Ethics* of the College of Pharmacists of British Columbia (1998) provides the following, under Value IV: "A pharmacist provides competent care to the patient and actively supports the patient's right to receive competent and ethical health care." It is also stated that: "A pharmacist shall not participate in efforts to deceive or mislead patients about the cause of alleged harm or injury resulting from unethical or incompetent conduct."	Not addressed	Not addressed
Manitoba	The Manitoba Pharmaceutical Association's *Code of Ethics* (2001) and *Standards of Practice* (2006) do not set out an express duty to disclose. However, points one and two of the Code state: 1. Pharmacists shall hold the health and safety of the public to be of first consideration in the practice of the profession of pharmacy, rendering to each patient the full measure of their ability as an essential health care practitioner. 2. Pharmacists shall observe the law, particularly those affecting the practice, and conduct themselves in a manner that entitles them to the respect and confidence of the public.	Not addressed	Not addressed
New Brunswick	There is no express duty to disclose. However, Statements I and VI of the *Code of Ethics* of the New Brunswick Pharmaceutical Society (2003) provide that the health and safety of each patient is of primary consideration and that pharmacists must preserve high professional standards and uphold the dignity and honour of the profession.	Not addressed	Not addressed
Newfoundland/ Labrador	There is no express duty to disclose, but such a duty can be inferred from Statements I and II of the *Code of Ethics* of the Newfoundland Pharmaceutical Association (2001) which declare that the health and safety of each patient is of primary consideration, and that pharmacists must preserve high professional standards and uphold the dignity and honour of the profession.	Not addressed	Not addressed

Jurisdiction	Is there a duty to disclose?	What type of event triggers the duty to disclose?	What must be disclosed?
Nova Scotia	There is no express duty to disclose. Values I and II of the *Code of Ethics* of the Nova Scotia College of Pharmacists (2003) state that the health and safety of each patient is of primary consideration, and that pharmacists must preserve high professional standards and uphold the dignity and honour of the profession.	Not addressed	Not addressed
Ontario	There is no express duty to disclose. Principles one and five of the *Code of Ethics* of the Ontario College of Pharmacists (2006) state that the patient's well-being is at the centre of the member's professional and/or business practice, and that each member acts with honesty and integrity.	Not addressed	Not addressed
Prince Edward Island	There is no express duty to disclose. However, Statements I and II of the *Code of Ethics* of the Prince Edward Island Pharmacy Board (2001) address the primacy of the patient's health and safety, and the importance of a professional relationship with the patient and acting with honesty and integrity.	Not addressed	Not addressed
Quebec	There is an express duty to inform a patient of error in Section 3.02.04 of the *Code of Ethics of Pharmacists* (2008). A pharmacist must inform his patient as soon as possible of any error he has made in rendering a professional service to that patient.	Error. However, a definition of error is not given.	Not addressed
Saskatchewan	There is no express duty to disclose. However, sections 13.1.1 and 13.1.8 of the *Code of Ethics* (2008) of the Saskatchewan College of Pharmacists, state that a pharmacist shall hold the health and safety of the public to be of first consideration in the practice of his profession and shall be governed in advertising practices by highly professional integrity.	Not addressed	Not addressed

Appendix D Reference List

Alberta College of Pharmacists. (1998). *Code of Ethics Bylaw.* Retrieved July 21, 2008 from http://pharmacists.ab.ca/nPharmacistResources/StandardsofPractice.aspx?id=2329

College of Pharmacists of British Columbia (no date). *Code of Ethics*. Retrieved July 21, 2008 from http://www.bcpharmacists.org/standards/pdf/Code_of_Ethics_long.pdf

Manitoba Pharmaceutical Association. (2006). *Standards of Practice*. Retrieved October 26, 2006 from http://www.napra.org/provinces/Manitoba/provincial/mbstandards.pdf

Manitoba Pharmaceutical Association. (2001). *Code of Ethics*. Retrieved July 21, 2008 from http://www.napra.org/pdfs/provinces/mb/code_of_ethics.pdf

New Brunswick Pharmaceutical Society. (2003). Code of Ethics (Detailed). Retrieved July 21, 2008 from http://www.nbpharmacists.ca/page.aspx?lang=en&id=4

Newfoundland Pharmaceutical Association. (2001). *Code of Ethics*. Retrieved July 21, 2008 from *http://www.nlpb.ca/Documents/Legislation/Legislation-Bylaws-080613.pdf*

Ontario College of Pharmacists. (2006). *Code of Ethics for Members of the Ontario College of Pharmacists*. Retrieved July 21, 2008 from http://www.ocpinfo.com/client/ocp/OCPHome.nsf/object/Code+of+Ethics/$file/Code+of+Ethics.pdf

Prince Edward Island Pharmacy Board. (2001). *Code of Ethics*. Retrieved July 21, 2008 from http://www.napra.org/pdfs/provinces/pe/Code%20of%20Ethics0301.pdf.

Code of Ethics of Pharmacists, R.Q. c. P-10, r.5. Retrieved July 21, 2008 from http://www.canlii.org/qc/laws/regu/p-10r.5/20060926/whole.html.

Saskatchewan College of Pharmacists. (2008). *Code of Ethics Bylaw*. Retrieved July 21, 2008 from http://www.napra.ca/pdfs/provinces/sk/Bylaws-Drug-Schedules-I-II-III-March2008_v2.pdf

The Nova Scotia College of Pharmacists. (2003). *Code of Ethics*. Retrieved July 21, 2008 from http://www.napra.org/docs/0/203/245/480.asp.