COLLEGE OF PHYSICIANS AND SURGEONS OF NEW BRUNSWICK **COLLÈGE DES MÉDECINS ET CHIRURGIENS DU NOUVEAU-BRUNSWICK**

Bulletin

April 1999

This Bulletin is forwarded to every medical practitioner in the province. Decisions of the College on matters of standards, amendments to Regulations, guidelines, etc., are published in Bulletins. The College therefore assumes that a practitioner should be aware of these matters.

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At its meetings on 18 December 1998 and 26 March 1999, Council considered the following matters:

DR. K. A. AKUFFO-AKOTO

This physician was found guilty of professional misconduct by the Professional Conduct Committee of the General Medical Council of the United Kingdom. This finding was on the basis of four complaints of sexual abuse arising from patients in New Brunswick.

As a result of this finding, the General Medical Council revoked Dr. Akuffo-Akoto license and struck him from the Register.

Having been found guilty of professional misconduct in another jurisdiction, the Council of the College of Physicians and Surgeons of New Brunswick also found Dr. Akuffo-Akoto guilty of professional misconduct, revoked his license, and struck his name from the Registers.

DR. X

During the course of a complaint investigation, this physician entered an agreement with the College to restrict certain aspects of his practice. He confirmed this agreement in writing on three occasions.

However, he subsequently advised of his intention to continue practice without restriction, and on doing so, was charged with professional misconduct for breaching an agreement with the College with respect to his practice.

Having been subsequently found guilty of professional misconduct by a Board of Inquiry, this physician was ordered by Council to be subject to a reprimand, without publication of his name, as well as to pay the costs of the matter.

COMPLAINTS

A patient had a procedure, including a biopsy, performed by a consultant. There was an abnormal result, but the consultant left practice unexpectedly ill and the patient was not seen for a follow-up, nor advised of the results. Some months later, the patient's family physician became aware of the results and communicated them to the patient. The patient complained against the family physician for the manner in which the information was communicated. The Committee found no fault with his approach, but did note that the consultant had the prime responsibility for communicating the results of an investigation. Ideally, mechanisms should have been in place to deal with unexpected absences from practice. However, such may not always be possible.

A patient suffered a significant anaesthetic complication during a surgical procedure. A complaint was filed by the family of the patient. From a technical point of view, the Committee could find no fault with the anaesthetic care provided. The physician had responded appropriately to an extremely difficult situation. The Committee's only comment was that, under these circumstances, the anaesthesiologist would have had prime responsibility to communicate directly with the family regarding the course of events. It should not have been left exclusively to the surgeon to discuss this with the family.

A baby was stillborn and septic, twenty-six hours after the mother's

membranes ruptured. No specific treatment had been provided during this time. The complaint alleged that guidelines on prevention of Group B Streptococcus were not followed. As it turned out, the baby suffered from a different infection, which likely would not have responded to intra-partum antibiotics. Nevertheless, investigation of the matter revealed some confusion regarding the appropriate guidelines for the prevention of Group B Streptococcal infections. These have now become sufficiently established to represent a reasonable standard of care. In particular, they recommend that antibiotics be started if it is likely that labour will not proceed within eighteen hours after the membranes are ruptured. It is suggested that physicians acquaint themselves with these issues.

A physician was providing coverage, for urgent matters, for a colleague who was on vacation. The patient presented with headaches. The patient subsequently complained that the physician had not appropriately assessed her and had been rude during the course of the discussion. In response, the physician noted that the appropriate investigations were ordered and that further follow-up was recommended with the patient's regular physician. He only saw the patient at that time because he understood the matter to have been urgent. In reviewing the matter, the Committee noted that the circumstances do enhance the risk of complaints arising. The physician was particularly busy due to the absence of the colleague. The patient may have had unrealistic expectations as to the nature of the visit. In any case, the Committee noted that all appropriate investigations and follow-up were done.

While on call for the patient's regular physician, a physician saw a new mother who was having difficulty with breast feeding. The patient continued to have these difficulties subsequently. She alleged that the assessment performed by the physician was inadequate, eventually resulting in her discontinuing breast feeding. In reviewing the matter, the Committee could find no fault with the care provided. It is noted that the primary responsibility would have been the patient's regular physician for monitoring these issues.

There was a complaint that a physician had failed to provide a report to the lawyer of a patient. The lawyer had made repeated attempts to obtain the report. In response, the physician stated that as the treatment had not been concluded, it was not possible to provide a final report. In reviewing this, it was noted that the physician had failed to even acknowledge the requests. The Committee felt that the physician could have provided an interim report when requested. Finally, when the report was written, the physician had made several inappropriate comments about the entire matter. The Committee requested that these comments be removed. It is noted that guidelines on responding to these matters are being developed by the College. Until such are concluded, physicians are reminded that they have an obligation to respond within a reasonable time to such requests. At the very least, they should acknowledge receipt of the request and advise when a report might be ready. If treatment is on-going and the report would be more valuable at its conclusion. This should be discussed with the lawyer or other person who may be requesting the report.

An elderly patient had some initial investigation done by a surgeon. Before follow-up studies were done, the family arranged for another surgeon to see the patient. The original surgeon attempted to discuss this with the patient, but a difficult discussion ensued with the family and the physician. The family later complained that the surgeon had acted improperly. In reviewing the matter, there was no clear evidence as to why the family had wished to change surgeons. The Committee noted that the original surgeon may have wanted some clarification from the patient himself as to the issues, but this would have to be approached with caution. The primary responsibility is to the well-being of the patient, and certain discussions may not contribute to this.

A patient saw a family physician for a painful joint, which was treated. By chance, the patient subsequently was seen by a consultant, for a prearranged assessment for disability benefits. On learning of this, the family physician suggested to the patient that the painful joint should have been discussed with the consultant and, furthermore, that the treatment would not have been provided if the family physician had known about this appointment. On reviewing the matter, there was clearly a breakdown in communication here. In this case, the consultant was seeing the patient for a very specific purpose, a disability assessment. In these circumstances, he is considered a "third party" physician. In such a context, it would have been inappropriate for him to offer treatment, nor even recommend any particular treatment. He simply could have noted the issue and suggested the patient review the matter with the family physician.

A baby with a particular congenital deformity was being followed by a consultant. The parents subsequently took the child elsewhere where surgery was performed. The parents felt that the initial management was inadequate. On reviewing the matter, the Committee noted the wide range of approaches taken to the particular issue. This obviously occurs in many situations in medicine. On this basis, both the "conservative" and "more aggressive" approaches were well within established patterns of practice. The best that can be done under these circumstances is that whether one is using one approach or another, one must make it clear to the parents that there is a range of opinion so that any consent to treatment is as informed as possible.

A patient saw her family physician for episodes of depression. After some discussion, the physician suggested she read various religious material, alleging that the lack of God in her life was the source of her problems. On reviewing the matter, the Committee noted that,

notwithstanding the issue she had complained about, the patient was otherwise appropriately investigated and treated. The Committee also accepted that it may be open to physicians to discuss "spiritual" issues with patients. Nevertheless, the patient must agree and consent to this discussion. In this case, a vulnerable patient was not given any choice regarding such matters.

A patient had requested information from her old chart with a former physician. Unfortunately, several of his records had been destroyed in an accident. The patient alleges that the physician refused to provide her any assistance in obtaining the information she needed. The Committee notes that physicians have a responsibility to retain records for ten years after the patient is last seen. Reasonable attempts to provide this storage in a secure fashion should be made. Unfortunately, despite best efforts, accidents and disasters will occur. In these circumstances, inasmuch as it was the physician's responsibility to retain these records, the physician has some responsibility to assist the patient with alternative sources for the information, such as hospital, or perhaps other physicians the patient may have seen.

AMENDMENT OF REGULATIONS

As a result of the changes to the *Medical Act*, the General Regulation regarding the affairs of the College has been amended.. Physicians who wish a copy of such can contact the College office. In addition, in the context of a national initiative to deal with the issue of telemedicine, the following has been added as a form of professional misconduct:

> *47. practising medicine in any manner or by any means in another jurisdiction without being licensed or otherwise authorized to do so by the appropriate medical regulatory authority for that jurisdiction.*

All of these amendments will be available shortly on the College website.

TERMINATION OF CARE

In an earlier Newsletter, physicians were asked to provide comments regarding potential guidelines for terminating a physician/patient relationship. After considering the responses, Council has directed that the following comments be provided.

First of all, from the regulatory point of view, physicians should note the following item and commentary in the *Code of Ethics:*

> *10. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted, until another suitable physician has assumed responsibility for the patient, or until the patient has been given adequate notice that you intend to terminate the relationship.*
>
> *Commentary:*
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> *Termination of care cannot occur for an improper purpose such as noted elsewhere in the Code.*
>
> *"Adequate notice" will depend on the circumstances, particularly where necessary alternative care is not readily available.*

Furthermore, the regulations of the College make the following professional misconduct:

> *23. failure to continue to provide necessary professional services to a patient until the patient has had a reasonable opportunity to arrange for the services of another physician.*

Beyond noting these provisions, Council determined it unnecessary to proceed to a formal guideline on the matter. Rather, physicians are directed to the following advice, originally produced by the College of Physicians and Surgeons of Ontario.

TERMINATION OF CARE (continued) – (FROM THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO)

As far back as anyone can remember, the ethics of the profession have defined the physician/patient relationship as an ongoing one in which the doctor accepts responsibility for the patient's care and will not end the relationship with a patient without good reason, proper notice and an opportunity to obtain another doctor's services. The Canadian Medical Association *Code of Ethics* prohibits discontinuing necessary medical services unless the patient requests the discontinuance, alternative services are arranged or the patient is given a reasonable opportunity to arrange for those alternative services.

Here are some suggestions for ways to proceed when your judgement tells you that it will be in the patient's best interest to terminate your physician/patient relationship.

1. Communicate your decision to the patient as compassionately, as supportively, but as clearly as possible.
2. Give the patient a reasonable amount of time to find a new physician. This time would be that which it would take a reasonable person, using reasonable effort, to find a new doctor. This time may vary from community to community.
3. Be helpful to the patient in finding a new doctor and transferring records.
4. Document the process you choose to use. In some cases, you may wish to consider sending a registered letter with a return receipt requested. Place a copy of the letter with the postal receipt in the patient's chart along with the termination entry recording your actions.
5. Be sure your staff is aware of your decision so that further calls from the patient may be responded to appropriately.
6. Where the patient has ongoing dealings with other health care providers, (e.g., pharmacists, hospitals, physiotherapists) let those providers know that you are no longer caring for the patient.