



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 meeting on 23 November, 2001, Council considered the following matters:

COMPLAINTS

A patient alleged an intermittent, but longstanding, sexual relationship with a physician. The physician denied the allegation completely. In reviewing the matter, the Committee felt that the lack of corroborative evidence made any prosecution of the matter impossible. Hence, no action was taken. The Committee did note that, under the *Medical Act*, it is possible to reopen an investigation, should additional facts warrant.

There was a complaint of unnecessarily high narcotic prescribing to a patient. The patient had been treated with increasingly high doses following an injury. It was alleged that the duration of each prescription was often in excess of four weeks. It was alleged that the patient consequently took very large quantities at the outset of the prescription. During one such period, the patient succumbed to an overdose, evidently accidental. In response the physician felt that appropriate guidelines regarding narcotic prescribing were followed. He felt there was no indication, such as lost prescriptions, of potential abuse. Furthermore, he had no evidence that the patient was taking the medication improperly. In reviewing the matter, the Committee notes the difficulties and dilemmas faced by physicians in these matters. Perhaps the only clue of the patient's dependency may have been his refusal to accept a referral to a pain clinic. Otherwise, the Committee agreed that the patient had not shown some of the common signs suggesting abuse or misdirection. The Committee was concerned

with the amount of narcotic prescribed with each prescription. The Committee felt that, in patients receiving high dosages, physicians should only renew a prescription for as short a period as is practical. While that cannot be precisely defined, many physicians will only prescribe such medications for a period of a week or less. It would, therefore, appear to be seldom appropriate to issue prescriptions for periods of four weeks or more.

Following investigation for potential heart disease, a patient was discharged from hospital, but subsequently died, evidently of a heart attack. It was alleged by the family that the patient had not been properly assessed. In response the physician acknowledged that the patient had undergone appropriate stress tests, which showed no indication of a problem. However, one of three ECG's performed did show evidence of heart disease. This result was not noted prior to discharge. On reviewing the matter, the Committee noted the significance of the negative stress testing. Nevertheless, in this case, noting the findings on the ECG in question may have resulted in a different approach taken.

Due to a patient's underlying condition, it was recommended he be reassessed by a consultant every few years. He requested a referral for such from his family physician, but this was denied. The patient subsequently accessed another physician who made the

appropriate arrangements and it was determined that the patient had significant pathology. In response the physician stated that the patient had never mentioned symptoms which would have warranted any referral. In reviewing the matter, the Committee first noted that the *Code of Ethics* requires physicians to arrange any reasonable consultation at the patient's request. It was the Committee's view that this was reasonable based on the previous recommendation from the consultant. Furthermore, the benefits of that referral were confirmed when appropriate consultation and investigation were eventually arranged.

A patient required follow-up surgery several years after an initial procedure. She alleged that the second surgery was much more complicated than she had originally been led to believe. In response the physician stated that there were unexplained complications which could not have been foreseen. In reviewing the matter, the Committee first noted the physician's general ethical and legal obligations to obtain informed consent. The patient should be provided with reasonable information regarding the extent of the surgery, as well as any complications which are reasonably foreseeable. In this case, the Committee could not determine whether or not the physician had provided appropriate advice.

A patient alleged that he was discharged from a physician's practice for an improper reason, specifically related to a personal business arrangement between the two. The physician denied this, advising that the patient was asked to leave the practice for reasons related to his behaviour in the office. In reviewing the matter, the Committee could not determine exactly what had transpired. The Committee felt that physicians should be cautious about discharging patients from practice. If the reason is unrelated to medical care, there may be a greater obligation to make alternate arrangements for the patient.

A patient alleged that the physician failed to provide appropriate documentation regarding her return to work following an injury. In response the physician stated that there appeared to be no reason that the patient could not return to work. The documentation had stated this. In reviewing the matter, the Committee could find no fault with the care provided by the physician.

A child had had major surgery and was seen in follow-up by the consultant surgeon. It was alleged that the

surgeon had failed to respond to a deterioration in the patient's condition. Over the next several weeks, the patient was seen by five other physicians in three different hospitals. It was alleged that each had also failed to recognize the complication which the child was developing. Subsequently the child died. In each of their responses, the physicians stated that they had responded appropriately to the clinical situation with which they were presented. In reviewing the matter, the Committee considered how the child had presented to each physician and, based on that, felt that each physician had responded appropriately to the particular clinical circumstances. Nevertheless, the Committee did have some causes for concern. As noted, the child had been seen by different physicians in different centres. In this context, the Committee felt that the physicians might have made a greater effort to develop a bigger picture of the child's difficulties. For example, there was no evidence that any of the subsequent physicians had had any contact with the surgeon. Such may have put the child's difficulties in some context. Along the same lines, there was no evidence of any exchange of information between the hospitals, or even a request for such. Again, such would have provided a context demonstrating, among other things, that the child had gone several months without gaining any weight. The Committee felt that developing such a picture may have provided any of the treating physicians with important information.

It was alleged that a physician had lost a patient's medical records. The physician responded that this likely had occurred from inexperienced staff. Physicians are reminded that they are legally and ethically responsible for the conduct of their employees. Appropriate instruction and supervision should avoid such difficulties.

It was alleged that a physician had failed to provide appropriate documentation regarding a patient's return to work following an injury. On reviewing the matter, the Committee felt that the physician had responded appropriately to the patient's clinical situation. The Committee felt that the physician had correctly refused to modify the documentation to support the patient's wishes, which were not supported by the facts.

During the course of a disability assessment, it was alleged that a physician had performed a manoeuvre on a patient which resulted in a significant injury. In reviewing the matter, the Committee could find no

evidence of how such could have occurred.

A young woman developed cervical cancer. She claimed she had discussed the possibility of a Pap test with her family physician who had not recommended one, despite the fact that she had provided a history of sexual activity. In response the physician stated that the patient had only attended for an employment physical and had provided no history regarding sexual activity. If she had, he would have recommended a Pap test. Based on the information provided, the Committee could not resolve the discrepancy in the version of events. Nevertheless, the Committee does note that physicians should recommend regular Pap tests for patients who report any past sexual activity.

There had been a previous complaint regarding the care provided by a physician to an infant. In responding to that complaint the physician had made reference to certain aspects of the prenatal history. Consequently, the mother of the infant now complained that the physician had inappropriately accessed her own medical records without her permission. In reviewing the matter, the Committee noted the seriousness of such an allegation. Nevertheless, the Committee felt that this particular circumstance was among the rare exceptions where physicians could access such information. Firstly, any proper care of a young infant would require knowledge of the prenatal history. Secondly, the records themselves were held in a collective fashion. Finally, the physician was obligated, in the course of responding to a College complaint, to provide all information relevant to the matter. Hence, the Committee felt that the physician had acted appropriately under the circumstances.

Review Committee

The Review Committee met with a physician who had been the subject of a number of complaints relating to the conduct of his practice. After the meeting the Committee had some concerns with the quality of care the physician was providing and ordered an in-office assessment.

In another matter, following a complaint, the Committee had ordered a physician to submit to an assessment of competency, which he had completed successfully. The Committee did remain concerned regarding the original complaint, which involved a patient who had died of ovarian cancer, despite seeing the physician many times over several months. The Committee felt there were continued concerns regard-

ing the physician's approach to this patient. Assessments of the patient appeared, in the Committee's view, to be minimal. The patient was never properly examined. When the patient developed a deep vein thrombosis, its significance was not appreciated. When the patient developed an anemia, appropriate investigations were not done. The Committee wondered whether the physician simply had not spent enough time with this patient. However, given that the Committee felt the physician was capable of providing appropriate care, and given that further action was not possible for a variety of reasons, the Committee determined to take no further action on the matter.

Regulation Amendments

Council has approved several amendments to the Professional Misconduct Regulation. These will be published in the Medical Directory in the New Year. Physicians are expected to be familiar with them as of that point.

Most of the amendments are directed at improving wording. In brief, the significant changes preclude the following:

Encumbering or assigning any specific interest in a physician's medical records such as might occur when obtaining security for a loan. This is to avoid the possibility of the records becoming the property of a non-physician.

Failing to report to the College the commencement, settlement, or other disposition of legal action alleging malpractice. (Members previously were only obligated to report findings of negligence by a court.)

Any inappropriate compensation being provided for referring a patient, or accepting a referral. The previous rule only precluded sharing fees.

Requesting a patient to release or otherwise limit a physician's liability for negligence. Previously, only a complete release from liability was prohibited.

Influencing a patient to provide any indirect benefit to a member in a will or other testamentary instrument. Physicians should not influence a patient to benefit a family member of the physician, for example.

Other Business

Council considered several matters:

Final approval was given to proposed joint guidelines between physicians and pharmacists regarding prescribing. It is hoped such will be forwarded to members early next year.

The College has been working with the Regional Hospital Corporations to develop a process for physicians currently licensed under Section 26 of the *Medical Act* to be granted full licensure after an appropriate period and assessment of their practice.

Council reviewed a report on Dr. Allan Umar-Khitab, a psychiatrist formerly in New Brunswick. He had recently lost his license to practise in Ontario after pleading guilty to charges of sexually abusing patients.

Council reviewed initiatives from the College of Physicians and Surgeons of Nova Scotia which could have the affect of having that province not participating in Atlantic Provinces Medical Peer Review.



Handwriting of Prescriptions

The following are some examples of handwriting on prescriptions, along with their subsequent "translation".

Fluvastatin	Fluvastatin
Synthroid	Synthroid
???	???
Alprazolam	Alprazolam
???	???
Amoxil	Amoxil
Pravachol	Pravachol

While this is obviously not a new problem, there is increasing potential for difficulties, as the number of available drugs increases, along with the potential for similar names. There is a very real risk of an error and consequent harm. Furthermore, physicians are reminded that a prescription is a legal document. Its preparation should, thus, reflect the appropriate level of care and attention.

Annual Dues

By now all physicians should have received renewal notices for annual fees for themselves and for their professional corporations, if applicable.

Physicians are reminded that all such fees must be received in the College office by January 1st, 2002, to avoid suspension of license. Physicians are encouraged to take advantage of payment by pre-authorized debit, in order to avoid any such difficulties.

Feedback from Physicians

Council has recently confronted several difficult issues. While these issues are not new, they appear to be somewhat aggravated by the relative shortage of physicians and the difficulties patients may have in accessing care. Prior to developing or changing any policy in these areas, Council would appreciate comments or feedback from members.

Termination of Care

The *Code of Ethics* and commentary states the following:

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.

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.

Physicians have always had the right to discharge patients from their practice when the physician does not feel they can continue to provide appropriate care. In this context, the recommended approach has been to first attempt to resolve difficulties by discussing them with the patient. If this is unsuccessful, then the physician should advise the patient in writing that they should seek care elsewhere. Physicians are expected to continue to provide necessary care for a certain period, generally six to eight weeks. Physicians are also to advise the patient that relevant records will be forwarded to the new physician when one is obtained.

The dilemma at this time is that patients can have extraordinary difficulty accessing further care. Many of

the patients who have been discharged from a physician's practice will have medical issues which need to be addressed. As a consequence, discharging them from practice will, in essence, deny them all access to primary care, except that which may be provided in the Emergency Department. There is, thus, a real potential to "do harm".

Patients may be discharged from a physician's practice for many reasons. They may relate to a specific circumstance of the patient, or may occur when a physician is generally reducing the size of their practice. There are, however, increasing reports of patients being discharged for reasons which may be considered less acceptable. Patients may be discharged for requesting second opinions, or requesting the completion of reports, or simply asking questions.

In the ideal world, patients would be seeing physicians who they wish to see and who wish to see them. Current realities appear to make this impossible. In this context, and considering the basic tenet to "first do no harm", Council would like advice from members as to whether general guidelines on discharging patients should be altered. For example, should the allowable reasons for discharging patients be more limited? Should a physician who wishes to discharge a patient have a greater obligation to make alternative arrangements for the patient? Should the length of notice period be extended given the difficulties patients will have in finding another physician?



Objections to Treatment

The *Code of Ethics* and commentary states the following:

Inform your patient when your personal morality would influence the recommendation or practice of any medical procedure that the patient needs or wants.

If the denial or delay of treatment has the potential to cause harm, the physician is obligated to expedite access to another physician if possible. In any case, the physician cannot obstruct such access.

Council notes that no physician is obligated to participate in a treatment or process to which they morally

object. Nevertheless, it is considered improper for a physician to impose their own moral view on a patient. The patient's autonomy must be respected. In the ideal situation, patients could easily access alternative care if the physician they first approach refuses to provide treatment the patient needs or wants. The above provision precludes physicians from obstructing a patient from seeking such alternate care.

Given the real difficulties for patients accessing such care, the question arises as to whether a greater onus should be placed on a physician who has such a moral objection. The situations involved cover a range of issues, but generally involved reproductive choices. While abortion is frequently cited, the vast majority of

