



## Bulletin

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.

### Council Update

At its meetings on 24 September and 26 November, 2010, Council considered the following matters.

#### COMPLAINTS

A *Counsel* is advice as to how to improve the physician's conduct or practice.

A *Caution* is intended to express the dissatisfaction of the Committee and to forewarn the physician that if the conduct recurs, more serious disciplinary action may be considered.

A *Censure* is the expression of strong disapproval or harsh criticism.

There was a complaint regarding remarks made by a physician to a patient as both were leaving an examination room. The patient alleged that such comments could have been overheard by other patients in the waiting area. On reviewing the matter, it was unclear whether such comments could have actually been overheard. Physicians are reminded to be cautious of any unnecessary disclosure of a patient's information in such a fashion.

There was a complaint that a patient had been improperly discharged from a physician's practice. The physician had posted a notice regarding the consequences of missed appointments. The patient was advised according to this policy that, after a number of missed appointments, a further incident would result in their discharge from the practice. In this case, the patient called late regarding a missed appointment several months after such a warning. She was given another

appointment, but then later advised that she would be discharged from the practice. The Committee did acknowledge that the physician had followed appropriate guidelines regarding giving a warning to the patient of the risk of being discharged. However, the fact that such a warning had preceded the episode by many months did suggest a rather strict approach on the part of the physician. The Committee felt it would be better if the physician had considered the matter in the complete context of both the timeframe involved and this particular patient's personal difficulties.

There was a complaint that a consultant had left his practice without adequate notice. In response, the physician asserted he had made every effort to minimize difficulties for any patients. Attempts were made to refer patients with ongoing issues to other physicians, as well as to make arrangements

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for patients who had been on the waiting list to be seen. Unfortunately, the resources to accommodate all possibly affected patients were simply not locally available. In the end, the Committee noted that there was no specific allegation from a particular patient. Generally speaking, it is expected that consultants who are relocating will make reasonable efforts to minimize any difficulties for patients. In some cases, it may be sufficient to suggest to the family physician that a referral to another specialist may be necessary. In other circumstances, patients who are in ongoing care should, if at all possible, be referred directly to a qualified colleague. Ultimately, the question is whether the departing physician has made a reasonable attempt to minimize difficulties for patients affected.

There were two separate complaints regarding physicians who took adverse action against patients who had requested the assistance of the College regarding a particular matter. When a patient requests, and there appears no alternative approach available, the College may contact the physician and suggest that the matter be reviewed. This is never in the form of a formal complaint, but rather an attempt to avoid a complaint arising. In that regard, it is not acceptable for a patient to be treated adversely, such as being discharged from the practice, simply because they have sought the assistance of the College on a matter for which no other approach had proven satisfactory.

Similarly to a situation which had arisen previously, there was a complaint regarding the response of a physician to a patient who had written a letter directly to the physician regarding issues which the patient felt were not being properly addressed during the course of the patient's ongoing visits. In this particular case, the physician reacted to the letter with significant anger expressed to the patient. While a letter would not normally be the ideal way to communicate with the physician, the fact that the patient has taken that step should not, on its own, result in any adverse action.

It was alleged that a physician improperly discharged a patient from a practice, failing to give her adequate warning. In response, the physician asserted that it was the patient herself

who had stated a wish to leave the practice. In reviewing the matter, the Committee noted some ambiguity in the discussions between the patient and the physician. Under those circumstances, the physician should document as clearly as possible the patient's precise wishes and only proceed to terminate care when it is clear that that is the patient's intent, or that the proper procedures for discharging a patient have been followed.

It was alleged that a physician had improperly interfered with a patient's choice of another health professional. In this case, the evidence was less than clear, but the Committee did note that it is considered unethical to interfere with a patient's choice in such matters.

A patient complained that a rectal examination was unnecessarily painful. The Committee noted a number of factors which likely contributed to the complaint. The patient had certain personal issues which resulted in a high level of general anxiety. The patient had had previous procedures, and the physician acknowledged using a minimal amount of lubricant. The Committee felt the physician could have taken greater care to minimize the discomfort for these particularly difficulties and issued a **Counsel** in that regard.

There was a complaint that a physician had failed to respond to a request from staff in a neighbouring office regarding a patient who had become acutely

ill. The Committee noted that the *Code of Ethics* requires physicians to "provide what assistance they can for a patient in urgent need of medical care". This does not require the physician to practise outside their usual scope, but simply to attend and offer assistance to the best of the physician's abilities. The Committee also noted that specific provisions in the *Medical Act* do clarify that such assistance is immune from any liability concerns. In this case, evidence of what had occurred was not definitive and the Committee, consequently, felt no further action could be taken on the matter.

An elderly patient, with a number of medical issues, underwent a procedure. Following the procedure, there was excessive discomfort requiring ongoing observation in hospital. The patient subsequently developed a significant complication which required corrective surgery. The allegation was that the intervention was not done in a timely fashion. In response, the physician stated that he felt he was reassured by the lack of certain symptoms on assessing the patient. Furthermore, the intervention was delayed by his attendance at another emergency, as well as some delay in the interpretation of certain investigations. The Committee was concerned that the physician may not have considered all options when determining that the patient required further intervention and, consequently, issued a **Counsel**.

A patient complained that a physician had failed to provide evidence supporting a claim regarding a work injury. The physician noted that a consultant, and others involved in the patient's care, had determined that the injury was unlikely to have arisen in a work setting. The Committee could find no fault with the care provided.

A patient with a chronic issue had seen a consultant repeatedly over the course of five years. Certain procedures were repeatedly done and, on occasion, material forwarded for pathology. However, the patient developed a local carcinoma which was known to have a grave prognosis. The patient's family alleged that the initial treatment and monitoring was inadequate. On reviewing the

matter, the Committee could find no evidence of shortcomings in the care provided. The complication which occurred was very rare, but nevertheless, known to occur in patients in this situation. More specifically, there was no evidence that any earlier intervention would have altered the course of events.



### **Medical Identification Number for Canada (MINC)**

As many physicians are aware, there has been an attempt to develop an identification number which will apply to all physicians and trainees in the Canadian medical system. It is expected that various national agencies will take advantage of such an identifier when dealing with their members. Currently considering such are the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, as well as the Canadian Medical Protective Association. While many physicians in New Brunswick have already been assigned numbers, based on licensure or training in another province, others should consider taking advantage of this opportunity by signing the enclosed release form and forwarding such directly to the College office. Members may find additional information on the matter on the MINC website, which is [www.minc-nimc.ca](http://www.minc-nimc.ca). They are also welcome to contact the College office for further information.

### **Regulatory Amendment**

The Minister of Health has recently approved changes to the terminology regarding licensure of physicians. Specific information is available on the College website, or by contacting the College office. The intention is to make our terminology more compatible with that used in other provinces. It should be clear this is a change in terminology only. It has no effect on the status of a physician's license. More specifically, this has no impact at all on a physician's practice, privileges, or remuneration, in New Brunswick. There have been concerns from some physicians that it may impact their ability to seek licensure elsewhere. If any difficulties arise in this regard, members are encouraged to contact the College regarding possible remedies.

### **Facebook**

The Council has recently become aware that some physicians have posted information on Facebook, and perhaps other sites, such that specific patients have been inadvertently identified. Physicians are reminded that the disclosure of only a few basic facts, such as the location of the patient, and perhaps some fact about their clinical condition, may be sufficient to identify them to a family member or acquaintance. Even if physicians believe that the posting will only be viewed by a limited group, the certainty of such can never be guaranteed. To that end, Council wishes to remind physicians of the potential risk of a complaint, and disciplinary action, for posting or disclosure of any information which has any possibility of identifying a patient. Council does not believe there is ever a need, or a point, to posting any information regarding a physician's professional or clinical activity in such a fashion, considering the many risks and no discernable benefits.



## **Guidelines**

The College publishes various guidelines for physicians, which are intended to be helpful in their practices and to avoid complaints. Notices of such are always published in the Bulletin and are available for review on the College's website. In addition, a printed booklet of some of the most relevant guidelines is provided to each newly licensed physician. Any physician who would like their own printed copy may contact the College office.



## **From the Archives**



### **Ninety years ago**

In 1920, Council decided against allowing the Medical Council of Canada exam to be sufficient for licensure in New Brunswick. They also questioned whether it should assume jurisdiction over osteopaths. They also expressed concern regarding the prosecution of physicians for prescribing alcohol under the Prohibition Act. The annual fee was \$2.

### **Sixty years ago**

In 1950, Council first questioned whether physicians employed by the Department of Health should be allowed to attend the New Brunswick Medical Society annual meeting. They subsequently decided that such physicians should now pay annual dues. Council also reviewed licensing approaches across the country to try and determine which physicians could be licensed here on other bases.

### **Thirty years ago**

In 1980, Council referred several complaints to the Ethics Committee of the Medical Society, considered a request by Medicare to become involved in reviewing physicians' billing practices, discussed the continued availability of ether without a prescription with the Pharmaceutical Society, and increased the annual fee to \$60. There were seven hundred and sixty physicians registered.

## **ANNUAL BILLING**

By now, all physicians should have received invoices relating to their dues for 2011. Physicians are reminded that any payment for such must be received in the College office by January 1<sup>st</sup>, 2011, in order to avoid suspension of licence. This also applies to renewal of licences for professional corporations.

**Members should note that this bulletin has been forwarded to the mailing address currently on file. This is the address which will be published in the *Medical Directory*. Members should advise the College immediately of any changes.**





**CONSENT FOR RELEASE OF  
INFORMATION TO THE MEDICAL  
IDENTIFICATION NUMBER FOR  
CANADA (MINC)**

**CONSENTEMENT À LA COMMUNICATION  
DE RENSEIGNEMENTS À LA  
CORPORATION DU NUMÉRO  
D'IDENTIFICATION MÉDICALE POUR LE  
CANADA (NIMC)**



*Please complete this form and return to our  
office by mail, email or fax to the following:*

*Veillez remplir le présent formulaire et le  
retourner à notre bureau par courrier, courrie,  
ou télécopie selon les coordonnées suivantes :*

*College of Physicians and Surgeons of New Brunswick /  
Collège des médecins et chirurgiens du Nouveau-Brunswick  
1 chemin Hampton Road  
Suite / Bureau 300  
Rothesay NB E2E 1K8  
Fax: 506 849-5069  
E-mail / courriel: [info@cpsnb.org](mailto:info@cpsnb.org)*

The “Medical Identification Number for Canada” (MINC) is a federal non-profit organization that operates under the joint auspices of the Federation of Medical Regulatory Authorities of Canada (FMRAC) and the Medical Council of Canada (MCC). The MINC’s mandate is to establish and manage a database containing information (family name, first name, gender, date of birth, country of birth, medical faculty from which the medical degree was obtained, year the degree was obtained) for the purposes of issuing and managing a number unique to each physician practicing in Canada so as to be able to identify all physicians.

Le « Numéro d’identification médicale du Canada » (NIMC) est un organisme fédéral à but non lucratif. Il est sous la responsabilité conjointe de la Fédération des ordres de médecins du Canada (FOMC) et du Conseil médical du Canada (CMC). Le mandat du NIMC est d’établir et de gérer une base de données contenant des informations (nom, prénom, sexe, date de naissance, pays de naissance, faculté de médecine où le diplôme de médecin a été obtenu, année d’obtention du diplôme) dans le but d’émettre et de gérer un numéro unique pour chacun des médecins exerçant au Canada afin d’être en mesure d’identifier tous les médecins.

I authorize the College of Physicians and Surgeons of New Brunswick to provide the MINC with the information necessary to create my medical identification number. This information will be used by the MINC to authenticate my identity among licensed users.

J’autorise le Collège des médecins et chirurgiens du Nouveau-Brunswick à transmettre au NIMC les renseignements nécessaires à la création de mon NIMC. Ces renseignements seront utilisés par le NIMC aux fins d’authentifier mon identité auprès des utilisateurs licenciés.

\_\_\_\_\_  
Name / Nom et prénom

\_\_\_\_\_  
Signature

Numéro d’inscription du CPSNB Registration No: \_\_\_\_\_ Date: \_\_\_\_\_