



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 meeting on 11 June, 2004, Council considered the following matters.

### COMPLAINTS

#### Different service, different fee

A patient complained that the fee a physician quoted for an uninsured service was too high. The patient alleged that a similar procedure was done by another physician for considerably less. In reviewing the matter, the Committee determined that the procedure offered by the second physician was less complex than that offered by the first physician. As a consequence, the difference in quotation was justified. The Committee was not in a position to determine which procedure was in the patient's best interest. Nevertheless, the patient appeared to have obtained some advantage from reviewing the matter with at least two physicians.

#### First things first

A married couple attended a physician's office for the first time. Only the husband had an appointment, but the wife was introduced at the end of the visit. At this point, the wife requested a referral to a consultant and complained when the physician resisted such. In reviewing the matter, the Committee felt the

physician had acted appropriately. Only after an appropriate assessment of the patient would the physician be in a position to provide the proper advice to the patient regarding the benefits of a consultation.

#### Automatic stops

An elderly patient was admitted to hospital with multiple medical problems. At one point, a medication order was automatically discontinued. The patient deteriorated, possibly as a result. The physician explained to the family that he had inadvertently failed to reorder the medication after the automatic stop. The family subsequently complained regarding the care provided. In reviewing the matter, the Committee noted that, due to the numerous medical problems, it was difficult to determine whether the interruption in the patient's treatment was the source of the difficulties. The Committee felt the physician had acted appropriately in acknowledging the error to the family. Physicians are reminded of the difficulties which can occur due to certain hospital policies regarding medication orders. Physicians should note that they

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may not always be reminded when gaps in treatment might occur.

#### Argument or abuse

A consultant was following a patient. Against the consultant's wishes, the family physician had ordered an investigation at the specific request of the patient. The consultant confronted the patient with this and allegedly made inappropriate and angry comments. This occurred in front of the patient's young son. Following the complaint, the consultant admitted that his remarks were inappropriate and certainly should not have been made in front of a child. The Committee felt this was a satisfactory disposition of the matter.

### **When is a patient still a patient?**

A patient had lived away for a few years and sought to return to a physician's practice. An appointment was given by the receptionist. When the patient attended, the physician stated that she should not have been given an appointment. The physician initially refused to assess the patient, but eventually agreed to do so in a limited way. The Committee noted that, despite the physician's policy, the receptionist had given the patient an appointment. Once the patient attended, the physician is expected to provide care appropriate for that visit. It was noted the physician had acknowledged this and the Committee felt no further action was necessary.

### **When is a patient no longer a patient?**

A patient complained that a physician had improperly

discharged him from his practice. In response the physician noted that he had strong evidence that the patient had been improperly accessing narcotics. On this basis, he felt it appropriate to discharge the patient from his practice. Under the circumstances, the Committee could not find any fault with the care provided.

### **Some things are never funny**

A patient complained that a physician had made an improper sexual remark when she requested a referral. In response the physician stated that, having cared for the patient for many years, he had made a jocular comment which he now regretted. On this basis, the Committee considered the matter closed. Physicians are reminded of the danger of any remark being subject to an unintended interpretation, even by a

patient the physician has known for a long time.

### **Just the facts**

There was a complaint that a physician had failed to provide a report stating that a patient was permanently disabled. In response the physician felt that, while the patient may have difficulty maintaining employment, it could not be considered impossible for him to be employed. The Committee noted that the physician's responsibility is to only provide the medical facts on which decisions can be made by others. In this case, the Committee felt the physician had provided an honest opinion based on the information which was known to him. This was the appropriate approach to take.

## **EXECUTIVE COMMITTEE**



The College Executive for 2004-2005 has been chosen as follows:

<b>President</b>	Dr. Douglas Brien, Saint John
<b>Past President</b>	Dr. Rudolph Stoczek, Hartland
<b>Vice-President</b>	Dr. Marc Bourcier, Moncton
<b>Member at large</b>	Dr. Malcolm Smith, Tracadie-Sheila
<b>Public member</b>	Mr. Eugene LeBlanc, Dalhousie

## **MULTIPLE CONSULTATIONS**

In response to comments requested in the last Bulletin, Council has become aware that, in some circumstances, it has become common practice for consultants to require multiple consultation requests from the primary physician as part of the initial assessment of a patient. In other words, the patient may be initially assessed for a particular problem and appropriate investigations arranged. However, the consultant would then not provide further advice to the patient, or to the primary physician, without another consultation being requested. Council noted that this matter was addressed by the Professional Review Committee of Medicare in 1992. An excerpt from a letter to all physicians at that time stated:

*“There are certain conditions for which continuing care is inherent in the management of the patient prior to his/her being discharged from the consultant’s care. Although this may not be considered primary care, it is care, nevertheless, for a patient who has been accepted for a diagnosis and/or treatment, and neither the patient, nor the primary physician, would be well served by the patient being bounced back and forth between the consultant and the referring physician in order that follow-up visits may be billed as consultations.”*

Having said that, Council’s only concern here is that there be no unnecessary impediment to a patient’s access to timely medical care. In this light, Council believes it would only be in exceptional circumstances that more than one request for a consultation should be required in the initial assessment. A reasonable approach, evidently already followed in most circumstances, is for the consultant to provide an opinion, arrange appropriate investigations, and see the patient as required in follow-up visits. To demand, or request, that such follow-up visits be further consultations cannot be in the best interests of appropriate patient care. Council wishes to remind members that a consultation, by definition, is initiated not by the consultant, but by the primary physician. Having said that, Council does believe it is acceptable for a consultant to offer to reassess the patient, at the request of the primary physician, as part of long-term follow-up, such as on an annual, or semi-annual basis. Such a request would be a valid consultation.

## **COLLEGE OF PHYSICIANS & SURGEONS OF ONTARIO**

The College in Ontario is initiating a process to assess certain physicians who are applying for licensure there. Among other things, the process includes having an assessor visit a physician’s practice, review certain charts, and observe the physician with patients. If the physician’s assessment is acceptable, this will then be considered in their application for licensure.

In reviewing this process, Council had many concerns. While physicians will have to obtain consent from patients for the chart review, or the direct observation, there are questions as to whether this will adequately address the patient’s right to confidentiality and privacy. As a consequence, Council has requested that the College in Ontario defer any such assessments until these concerns are addressed. Council has also advised physicians considered for such assessments that it would be unacceptable for them to submit to such until such time as the Council considers the procedure ethically acceptable.

## **ACCESS TO SPECIALIST SERVICES**

Members were requested to provide comment as to whether it was appropriate for consultants to refuse to accept patients on the basis that they are from another region. Some responded that they felt their first priority was to patients in their local community. Council has also been aware that, even in relatively urgent circumstances, physicians in some communities have to put considerable time and effort into trying to transfer their patient to appropriate care. While it is understood that geography and other factors will mean that particular specialty services may not be available locally, the net result is that it may be denied outright to some patients on the basis of the location of the referring physician.

In reviewing this, Council is acutely aware of the significant resource and workload issues involved in this matter. Nevertheless, the fact that a patient can be precluded from specialty access, on this basis, should not be considered acceptable, either ethically, legally, or politically. Council bases this opinion on the following provision of the *Code of Ethics*:

- 7. In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation or socioeconomic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons.**

More specifically, the commentary in that *Code* states the following:

*The categories of discrimination are not closed. It is also improper to deny access to the other "classes" of patients. Examples might include current and former patients of a particular physician or physicians, or a class based on some other factor such as place of residence. Similarly, the right to deny access may be limited according to availability of alternate care.*

On this basis, Council feels it appropriate to challenge physicians, Regional Health Authorities, and other interested parties to develop processes, procedures, and initiatives to avoid placing physicians in possible ethical conflict.

## **ANNUAL PHYSICALS**

Some years ago, Council was advised that certain physicians were insisting their patients submit to an annual complete examination, on an uninsured basis, as a condition of continuing care. It was Council's view that this was unacceptable. Under the *Code of Ethics*, patients are entitled to accept or refuse medical care. If such a procedure is necessary, on medical grounds, then it should be provided as an appropriately insured service. If it is not medically indicated, then it cannot be a condition of continuing care as an appropriately insured service. If it is not medically indicated, then it cannot be a condition of continuing care.

## **RESPONDING TO PRESCRIPTION FRAUD**



In March, 2004, the Canadian Medical Protective Association issued an information sheet on how physicians should respond to a variety of situations, such as theft of prescription pads, theft of drugs, altering of prescriptions, or evidence of double doctoring for purposes of obtaining narcotics. The advice does note that College policies on this matter vary from province to province. To assist physicians in this regard, Council wishes to point out differences in the way New Brunswick physicians are expected to respond to these circumstances.

Council, first of all, notes the significant social problem of misuse and redirection of narcotics. There is a strong cost to society, both in terms of the effect of narcotics themselves, and the associated crime against persons and property. For this reason, Council expects physicians to acknowledge their general obligation to society and to recognize that there are situations where such may overcome their obligations to specific patients. In this regard, physicians should respond carefully when they become aware that a patient has altered a prescription, or has used other means to obtain narcotics illegally, such as double doctoring. Each case may be judged on its own facts, but Council wishes to remind physicians that if they issue further narcotic prescriptions to patients, when they are aware of such potential difficulties recurring, they place themselves at risk of being considered participants in illegal activity. As a consequence, when there is clear evidence of such, it is, in most cases, acceptable to deny all further prescriptions for narcotics and, furthermore, to discharge the patient from the physician's practice without further notice. At the same time, Council feels physicians do have an obligation to society as a whole and, consequently, should not resist assisting the police with investigating such matters. Council also accepts that providing such assistance may require the physician to disclose confidential information.

In any case, Council appreciates that these situations are difficult, both personally and ethically, for physicians. To that end, physicians are encouraged to contact the College for any assistance when such matters arise.

## **ACCESS TO PHYSICIANS**

Council has become aware that, when some physicians or clinics are considering accepting a patient who is already seeing another physician, some have required the patient to obtain permission from their current physician. Physicians are reminded of the following form of misconduct:

### **40. interfering, either directly or indirectly, with the patient's freedom of choice of a physician or a patient's right to consult another physician or other professional;**

As a consequence, it would be considered ethically unacceptable to require the permission of another physician to accept a patient. It would be similarly unacceptable for the original physician to refuse such a request. In addition, it is understood that certain physicians or clinics will contact the original physician for information prior to accepting the patient. This may also be ethically questionable until the patient has been accepted into the new practice.

## **OTHER BUSINESS**

- Council approved changes which would provide specialty recognition based on certain American credentials.
- Council also accepted that physicians could be directly assessed for specialty recognition, on the request of a Regional Health Authority, after one year of practice in New Brunswick.
- Council reviewed a national study on the prescribing of Oxycontin which showed that New Brunswick ranked third in per capita prescribing. The study also pointed out that, both in New Brunswick and nationally, 50% of the prescriptions for Oxycontin are issued by 7% of the physicians.
- Council reviewed proposed amendments to the *Optometry Act*. Based on the information available, these were felt to have no impact on the practice of physicians.
- Council also received some initial information on proposals regarding regulating midwifery in the province.

## **FROM THE ARCHIVES**



### **Ninety years ago**

*In 1914, Council began allowing physicians to make a single \$20 payment, which would grant them licensure “in perpetuity” instead of paying the \$1 annual registration fee. Council also approved increasing the Registrar’s salary to \$100 annually. There were 265 physicians registered.*

### **Sixty years ago**

*In 1944, Council reiterated its policy to refuse licensure of any “enemy alien physicians”, even if they had appropriate credentials. It noted that the annual fee for physicians would remain at \$20, with \$15 going to the New Brunswick Medical Society and \$5 to the Medical Council. The Registrar’s salary would increase to \$1,000.*

### **Thirty years ago**

*In 1974, Council reviewed a Medical Society report which suggested that there were now a sufficient number of physicians in New Brunswick. They also increased the Registrar’s annual salary to \$15,000, discussed the possible licensure of nurse practitioners, and approved a new application form which was now bilingual.*