



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 4 June 1999, Council considered the following matters:**

**COMPLAINTS:**

There was a complaint concerning a physician's billing practices. From the evidence at hand, the Committee felt that the issues had been resolved. Nevertheless, physicians are reminded of several areas, which can cause difficulty. First of all, physicians should provide receipts for any payments received from a patient. This is a clear ethical obligation. Furthermore, proper documentation is always of benefit should disputes arise later. The second difficulty can arise regarding physicians taking advantage of the opportunity to selectively opt out regarding otherwise insured services. Advice on this was previously addressed by the College in a Newsletter dated December 1997. Copies are available from the College office or on the College website.

A surgeon had performed a biopsy, but there was a significant delay before a final

histological diagnosis was reached. Initial attempts to contact the surgeon regarding the matter were unsuccessful. Furthermore, it was alleged that the pathologist involved had improperly delayed reaching a conclusion. While the Committee found that the surgeon had to await the final report being generated from the pathologist, it should be noted that the physician submitting a specimen for examination has some responsibility to make timely inquiries. Concerning the pathologists, it was noticed that the large part of the delay was due to the practice of one individual. When the matter was turned over to another, the appropriate measures were undertaken. The Committee notes that while physicians have responsibility for their own actions, there is some collective responsibility within departments. Thus, if a diagnostic report is inappropriately delayed, and this is known to other members of a

department, they retain some responsibility for ensuring procedures are in place to avoid such situations.

A procedure was recommended by a consultant. However, at the time of the appointment, the procedure was performed by another physician. No further discussion was provided to the patient. The Committee feels that it should only be in exceptional circumstances that the assessment for procedure is performed by a different physician from that performing the procedure. While there may be circumstances where such is appropriate, and an advantage, there are serious questions whether such an approach provides adequately for informed consent as required under the *Code of Ethics*. At the very least, the second physician should be available to completely discuss the matter and respond to any questions which may arise. In other words, the second physician is

responsible for obtaining fully informed consent.

A child presented to an emergency department on two occasions after an abdominal injury. She was seen by two different physicians who concluded there was no serious trauma and sent the child home. The child eventually was admitted to a regional centre. Even at that point, there was no clear evidence of a significant visceral injury. The Committee concluded that the investigation and treatment performed by the two physicians was appropriate. The eventual diagnosis was unusual and the physicians had made appropriate efforts to rule out significant pathology.

A patient with a long-standing problem was admitted under a specialist. Another specialist was consulted with a view to surgical treatment. There was an initial discussion implying that such treatment would proceed, but, in fact, it was delayed for several months. At this point, the family was dissatisfied, made repeated requests for referrals, and the patient was eventually treated out of province. It is alleged that the surgeon had failed to properly advise them of his intentions, or alternately, had failed to schedule the procedure in a timely fashion. In reviewing the matter, the Committee noted the problem came down to communication. The clear recommendations of the surgeon may not have been completely communicated to the family. Furthermore, under the circumstances, the surgeon had an obligation to interact with the patient and family on an on-going basis, rather than

intermittently, as was the case here.

A patient underwent a series of procedures, each required by a complication of an earlier one. There was an allegation of a lack of informed consent, either through the patient or through the patient's family. As a response, the surgeon felt that there had been appropriate discussions with the patient and with the patient's family when the patient was not competent to consent. Furthermore, there were discussions with other supporting individuals. In reviewing the matter, the Committee was unable to determine exactly how much discussion had taken place. Nevertheless, given the difficult circumstances involved, it was important to pay diligent attention to requirements for communication and informed consent. This includes the patient when the patient is competent to discuss matters, and the patient's immediate family when necessary. Discussion with other supporting individuals is irrelevant for this purpose.

There was a complaint that a physician had inappropriately delayed a report requested by a lawyer regarding a patient. The report was eventually provided, but there was no clear explanation on the part of the physician for the delay. It is noted that guidelines on this issue are being prepared. Until they have been adopted, it is required that physicians respond to such requests in a "reasonable time". If there is to be an inordinate delay, they should advise the requesting individual of this. Furthermore, if there is a need for any

urgency, physicians should be responsive of those issues.

A patient was admitted under a family physician. There was a consultation to a surgeon who performed a series of investigation and procedures. During this course, it was alleged by the family that requests for referral to a regional centre were refused by the family physician. The physician asserted that no direct requests were made, and in any case, appropriate care was available locally. The Committee could not determine whether, in fact, specific requests were made by the patient in this regard. If they had been, it would have been the admitting physician's responsibility to accommodate that request. While it is appropriate to discuss the matter with a patient, it is not appropriate to resist any request for referral to another physician or centre.

It was alleged that a physician had failed to appropriately respond to a hospital medication error which, the family alleged, caused significant harm to an elderly patient. In reviewing the matter, the Committee concluded that the physician had acted completely appropriately. Furthermore, there was no evidence that the error was in any way significant in the patient's clinical course. The best that can be done in these situations is to assess and document the matter from a medical point of view, noting any reasons for providing, or declining to provide, specific treatment.

A child was seen in an emergency department, was

determined to have a viral infection, and allowed to go home. A few days later, the patient was seen by her own physician who provided an antibiotic. The parents claimed that the initial physician had failed to make a proper diagnosis. On reviewing the matter, the Committee determined that the physician had reached an appropriate diagnosis. It is possible that a secondary infection may have developed which necessitated treatment later. It was uncertain as to whether the second physician had implied that earlier treatment was unequivocally necessary.

It was complained that a physician had improperly treated a patient in an emergency department. The patient had arrived with a series of complaints. The patient alleges the physician refused to communicate the results of investigation and had inappropriately discharged her. Review of the records show that the patient was assessed by two different physicians, was apprised of the investigation and in fact, had left the hospital prior to formal discharge. As such, the Committee could find no fault with the care provided.

A patient died after a serious illness and a prolonged course in hospital. It was alleged by siblings of the patient that there had been inappropriate care and communication by the attending physician. In reviewing the matter, the Committee noted the grave state of the patient and felt that the clinical care provided was appropriate. There did seem to be some communication difficulties. In part, this was due to the fact that

the physician had mainly communicated with the patient's spouse, as opposed to the biological family. From a consent point of view, this was completely appropriate. Nevertheless, it did aggravate issues which arose later. Furthermore, based on hospital policies, during the course of this admission the patient was under the care of a series of physicians. Under these circumstances, communication may also suffer.

There was a complaint from a patient that a physician had inappropriately chastised her regarding breaches of several office policies relating to making appointments, parking near the office, and other matters. On reviewing the matter, it was clear the physician had presented all patients with an appropriate information sheet, outlining specific issues. It was also noted that these matters were reinforced with signage. While these signs were not in the patient's first language, there was no evidence that they were not understood. The benefits of information sheets regarding specific issues are noted. Specific considerations regarding language should always be addressed.

A patient was off work temporarily, but denied disability coverage for a portion of the time. This appeared to be because the disability insurer would only provide coverage if the patient was specifically treated, or referred to a consultant. The family physician alleged that neither was necessary under these circumstances, and the Committee agreed. Thus, the dispute was between the patient

and the insurer. It would have been inappropriate for the physician to provide specific treatment unless such was medically indicated. The patient himself had not requested a referral, nor was one otherwise necessary. It was up to the insurer to arrange any other assessment if they wished.

### ACCESS TO PHYSICIANS

Physician resources in New Brunswick are limited. Many physicians are unable to accept any additional patients. Others have various policies which attempt to limit access to their practice. The most common of these is to deny access to any patients who have seen a local colleague. Other physicians may preclude access based on the gender or age of the patient. Finally, some physicians may require the permission of the first physician before a transfer is accepted. For several years, it has been College policy that all of these approaches are unethical and improper. This is on the basis of ethical provisions which preclude "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". Furthermore, there are other ethical provisions which preclude improper discrimination by a physician in access to their practice.

In response to concerns about this interpretation, Council has requested input from physicians. The following commentary outlines some of these issues.

It is first noted that such approaches are not available to all physicians. Neither

