



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 26 November 1999, Council considered the following matters:

DISCIPLINE

There was a complaint that a physician had improperly left his practice in New Brunswick without notifying his patients, nor making any advance arrangements for alternate care.

The *Code of Ethics* advises 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.

The Regulations of the College preclude the following:

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;

After discussions with the physician, he agreed to plead guilty to a charge of abandonment.

Council imposed the penalty of a reprimand, without publication of the physician's name.

COMPLAINTS

There was a complaint alleging inappropriate prescribing of benzodiazepines by a physician. While the physician offered some justifications, he did acknowledge there was an element of intimidation from certain patients. Several remedial measures were suggested. As a result, the physician's prescribing habits changed significantly. For this

reason, the Committee did not feel that further action was necessary on the matter, subject to on-going monitoring.

A terminal patient had a very rare diagnosis, which was not determined until just prior to death. There was a complaint from the surviving family members regarding the delay in diagnosis and delay in treatment.

The Committee agreed with the physician that the rarity of diagnosis contributed to the delay. Furthermore, until the specific diagnosis was reached, there was little treatment, which could be appropriately offered. The Committee did have concerns regarding the level of communication with patient and family, which occurred over this

relatively short period of time, particularly as relating to the aggressiveness of any treatment. The Committee notes that these can be very difficult situations. The best that physicians can do is to objectively reassess what they have told patients and family members when prognosis is poor.

There was a complaint regarding a complication following a surgical procedure. In response, the surgeon acknowledged that the complication had occurred, offered a possible explanation for such, and advised that he had undertaken some changes in his approach to avoid recurrences. As a consequence, the Committee felt that no further action was necessary.

An elderly patient was given a terminal diagnosis. The family requested a referral to another centre for a second opinion. The family physician advised that it was up to the family to make these arrangements. The family made contact with the referral centre and, on their request, the physician did provide the appropriate referral. The family complained that the physician was inappropriately obstructive to the process. In reviewing the matter, the Committee notes that it is an obligation, under the *Code of Ethics*, for physicians to arrange for referrals or consultations at the request of a patient or, when necessary, their family. Under these circumstances it was inappropriate for the physician to require the family to initiate the process. It was further inappropriate for him to appear to take offence at them attempting to expedite the transfer of information. Nevertheless, the resulting delay was minimal. The Committee felt that no further action was necessary in the matter.

There was a complaint from the family of an elderly patient who had suffered an injury. The Emergency Room physician had sought to admit the patient, but such was determined unnecessary by the family physician, notwithstanding that the latter had not seen the patient. The patient suffered a complication, although there was no evidence that this was related to the fact the patient was sent home. The Committee felt that, in most circumstances, decisions regarding management of patients should be the responsibility of the physician who has personally assessed the patient. Other than noting that, the Committee did not feel that further action is necessary in the matter.

There were separate complaints against two physicians regarding opinions they had provided in custody disputes. In both cases, the Committee felt that the physicians had offered objective comments, based on their observations and experience. In one complaint, there was an additional element in that it was alleged the physician had disclosed to one parent, information provided in confidence by another. This occurred after an interview in which the parents were first seen separately and then together. When physicians are interviewing, or providing any counselling, in such circumstances, the "ground rules" must be very clear regarding what information could be shared later. In other words, this should be clarified at the outset. Unless clearly agreed otherwise, the information disclosed by one party must remain confidential.

A physician had referred a patient to a consultant. However, the consultant's office had not received the relevant information. The patient contacted the physician's office to request that the information be faxed. However, instead of the information being sent to the

consultant, it was faxed to the patient's place of work. The physician acknowledged the error and stated that it was due to confusion by inexperienced staff. The Committee accepted that the information was forwarded inadvertently, and determined to take no further action on the matter. The critical importance of confidentiality regarding medical information must be reinforced with staff, especially ones with less experience.

The husband of a complainant was killed in a traffic accident. Immediately following this, and a few weeks subsequently, the complainant attempted to receive some information from the physician who had pronounced her husband dead. She complained that the physician was reluctant to provide any comments and stated he had no obligation to do so. In his response, the physician stated that his involvement with the deceased had been very minimal, lasting only sufficient time to determine that death had occurred. He had almost no information to provide. In reviewing the matter, the Committee accepted that the physician had very little specific information to offer the surviving wife. Nevertheless, the Committee felt it was not surprising that she would attempt to obtain what even little information she could under the circumstances. It was therefore the physician's responsibility to recognize this and offer what minimal support would be possible in a very difficult situation. The Committee felt that this obligation had been appropriately reinforced to the physician and determined to take no further action on the matter.

A patient was seen in the Emergency Department. While he

had Medicare coverage, he did not have his card. Such coverage could have been easily verified by telephone. Notwithstanding this, the physician determined that the patient would not be seen unless payment was received in advance. The Committee noted that, under College Regulations, the following could constitute professional misconduct: *“refusing to render a medically necessary service unless payment of the whole or part of the fee is received in advance of the service being rendered”*. The Committee notes that the “necessity” of a service may not be determined until it has been provided. Under the circumstances, it was improper to

refuse to see this patient. Furthermore, in this particular case, it would have been very easy for staff to verify the patient’s coverage. Beyond reinforcing these provisions, the Committee did not feel any further action was necessary in the matter.

A patient saw a physician for the first time. A minor office procedure was suggested to deal with a particular problem. The patient expressed some reluctance. It was alleged the physician took offence and suggested that the patient go elsewhere. In reviewing the matter, the Committee notes that, under the *Code of Ethics*, patients are free to

accept or reject any treatment offered. The physician should not take offence when patients raise questions. The Committee reinforced this with this physician, but took no further action.

A patient saw a physician for the first time. She complained that the physician appeared both inattentive and impatient with her. In response, the physician noted that several of his mannerisms could be so misinterpreted. Physicians are reminded that, particularly with new patients, one should consider how their conduct might be interpreted.

“CLOSED” PRACTICES

In the July Bulletin, physicians were invited to provide commentary regarding various aspects of access to a physician’s practice. A small number of responses were received and are being considered by Council. On reviewing this matter, Council noted one area which appeared to be causing some confusion. This was the question of whether it is appropriate for physicians to close their practices to any new patients and what impact that would have.

First of all, it should be clear that any physician is free to determine that their caseload is sufficient such that they generally are not accepting new patients. The determination of this is obviously a very individual matter, but this should be considered when physicians feel that their ability to serve their current patients would be significantly compromised by taking on a number of additional ones.

Thus, it is now common, and acceptable, for physicians to simply respond to any inquiries by stating that they are not accepting new patients.

Having said that, some physicians believe that, once making that determination, it would be improper for them to accept any patient at all into their practice. This is to advise that such need not be the case.

In other words, even if a physician has a “closed” practice, and is advising that new patients are not being accepted, the physician is free to make exceptions to this. If physicians wish to include a new patient into their practice, for whatever reason, they are free to do so; notwithstanding they have previously said that new patients are not being accepted. As examples, these may be patients they have encountered in another context such as the Emergency Room, may be patients who are relatives of current patients, patients who are new to the community and have particular needs, or patients seen at the request of a colleague.

It is trusted that this point is now clarified. It should be noted that this commentary does not yet address the issue of physicians who have not yet closed their practice, but who are selective regarding the patients they are willing to accept.

ANNUAL FEES

The annual dues for the College remain the same for 2000. For physicians who pay by direct deposit, the annual fee is \$490. For those who pay by cheque, it is \$510. Deadline for receipt of cheques is 4 January 2000.

Notices regarding these charges were mailed earlier in November. Physicians who do not intend to renew their license, or otherwise anticipate a change in status, should contact the College office.

INFLUENZA VACCINE

Complaints were received in several Public Health Offices that physicians were inappropriately charging patients that met the criteria for publicly funded influenza vaccine that is provided by the Department of Health and Community Services. It is Council's view that when patients clearly meet the criteria for obtaining this vaccine, there should be no charge to the patient for providing such. Doing so could contribute to a complaint of taking financial advantage of a patient, which is precluded by College regulations. If there is uncertainty regarding the eligibility criteria, the matter should be addressed with the local Public Health Office.

BILLING FOR UNINSURED SERVICES

Physicians frequently request advice regarding the appropriate measures to take when directly billing patients. The rules and principles involved had been stated in several different provisions in College rules. In an attempt to clarify these issues, Council has approved the enclosed guideline that is a consolidation of advice offered previously. The guideline represents no change in policy in these matters. Commentary from members is welcome.

FROM THE ARCHIVES

90 years ago

At meetings in 1909, the Council determined that they did not want to be considered a "College", as was the case in other provinces, and expressed concern that a new *Medical Act* would allow the practice of osteopathy.

60 years ago

In 1939, the Council determined to resist pressure from several communities which wished to recruit Jewish refugee physicians, decided that all new registrants would have to be born in Canada, and decided to take no action against a physician convicted of driving while intoxicated.

30 years ago

In 1969, Council determined that complaints of sexual impropriety should be referred to the Committee on Ethics of the Medical Society, decided to continue to deny registration to physicians from Quebec, and were advised that physicians in several communities felt there was enough competition and requested that no new licenses be granted for practices there.