



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 23 September 2011, 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.

A family complained when a patient became gravely ill following abdominal surgery. In reviewing the matter, the Committee could find no fault with the operative care provided by the surgeon, nor with the response to the complication. However, the Committee was concerned regarding the surgeon's communication with the family at certain times. The surgeon was *Counseled* to take a more active role with the family of an ill patient.

An elderly patient complained that her physician failed to provide proper follow-up for breast cancer. The physician acknowledged that the problem had not been followed closely because the patient had developed a number of intervening medical issues. The Committee could find no fault with the specific care provided to each of the patient's problems, but did *Counsel* the physician to include

a problem list or a comprehensive patient profile in his records to avoid missing outstanding issues when a patient presents.

The police were searching for a murder suspect. Because of the nature of the crime, they felt it likely the individual would have suffered certain injuries. They complained that, upon inquiring at the Emergency Department whether such a patient may be present, they were denied all access to such information. In the Committee's view, such information could be provided without any breach of confidentiality. On a second point, when the individual was eventually brought in by police for treatment, the police alleged that the physician failed to allow the police to provide appropriate security to avoid further risks to staff or patients. The Committee felt that the exact context in which the patient was treated was

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unclear. They noted that both the hospital staff and the police have specific responsibilities in these circumstances. The Committee believes that these matters are best dealt with by policies developed within the hospital or Regional Health Authority. Members should also note that a general policy on disclosing information to the police is provided in this newsletter for further comment.

A patient had been seeing a physician for some time with miscellaneous issues, including back pain. At some point, the patient saw another physician who immediately made the diagnosis of neurofibromatosis based on characteristic skin lesions which the first physician had never noted. The Committee could only conclude that the original



physician had never examined the patient appropriately considering his presenting complaints. The physician was issued a *Caution* regarding the consequences of failing to conduct a proper examination.

A family complained about the information provided by a family physician regarding a patient in the hospital. During the course of investigating the patient, a significant illness was uncovered. The family physician decided to wait until hearing opinions from specialists before discussing the matter directly with the family. However, certain members of the family became increasingly anxious about the lack of information and pressed the physician. They complained that the physician failed to communicate with the family immediately. In response, the physician felt it appropriate to wait for more information. Simply providing the family with a diagnosis would have only raised questions which he did not feel he could answer. In reviewing the matter, the Committee noted that this was a difficult issue on which there is no single best approach. It was reasonable for the physician to wish to have as much information as possible before any discussion. On the other hand, there was evidence that the family was becoming increasingly anxious regarding the situation. The Committee wondered if the physician could have been more

responsive to that and communicated with them, notwithstanding that he had not yet heard from the consultants.

There was a complaint that a physician improperly treated a child attending the emergency room with an injured foot. The physician acknowledged that she had not been as attentive as possible due to a distraction about a family matter. She apologized for any shortcomings in the care provided. The Committee accepted this as a sufficient outcome for the complaint. The Committee reminds members to do everything possible to avoid situations where they may be distracted and unable to provide complete care. Ideally, physicians should withdraw from the situation if another physician is available. However, this is often not possible.

There was a complaint that a patient was improperly dismissed from a physician's practice. The patient asked for an urgent appointment and, after a lengthy discussion with the receptionist, was given one. While the patient was in the waiting room, she expressed a profanity regarding the receptionist to the person accompanying her. This was done in a way that the receptionist could hear. The physician felt that she could only continue to provide service to the patient if the

patient was willing to apologize. In reviewing the matter, the Committee felt the physician's approach was appropriate here. The epithet was not delivered in the heat of an argument. It was a gratuitous remark for which it was reasonable for the physician to take exception. The patient was given an opportunity to correct the issue but refused to do so.

A physician was seeing a patient new to his practice. After an assessment of an unrelated matter, the patient advised the physician of a number of chronic health issues. The physician immediately went into a tirade regarding his view that the patient's problems were the result of the patient failing to take personal initiative or simply trying to avoid work. The physician had not taken any history regarding these matters nor reviewed any records. The Committee noted that a very similar complaint had arisen two years ago where the physician also expressed significant prejudgment of a patient being followed for a work injury. At that point, the Committee had issued a *Caution* to the physician regarding the inappropriateness of prejudging matters in this way. As the physician had repeated the same behavior the Committee felt it was appropriate to issue a *Censure* to express their disapproval of the approach taken.

Confidentiality and Risk of Harm

In response to a number of circumstances arising around the province, and the rather conflicting advice that physicians may receive on the issue, Council has proposed the following draft guideline on disclosing matters when necessary to avoid harm to an individual or a group of people. This policy is broadly worded and will hopefully be supplemented by specific policies developed locally to address issues such as safety within the hospital when dealing with treatment of individuals in custody. Physicians are encouraged to review the matter and provide comment by any means they wish.

Confidentiality and the Risk of Harm (Draft)

Confidentiality remains an important, and very practical, consideration in medical practice. However, physicians have always recognized that there are situations where maintaining confidentiality can potentially harm the patient or others. For example, there are specific laws which have mandated physicians to breach confidentiality in a number of circumstances, ranging from reporting child abuse, to unfit drivers. At the same time, the *Code of Ethics* has always acknowledged that physicians may breach confidentiality if such could avoid a significant risk of harm. Such a situation may arise when a patient communicates to a physician a direct threat regarding another individual. Alternatively, it may involve receiving information from law enforcement that an individual may pose a significant risk to others, including the public at large.

Nevertheless, physicians may remain concerned that they would be subject to an adverse action if they breach confidentiality in such circumstances. To avoid that concern, it has been a consistent College policy to decline to accept as a complaint when an individual is alleging that the physician's action, in breaching confidentiality, impeded the patient from an illegal or improper purpose.

Hence, the best advice to physicians has always been to weigh the risks of harm of disclosure or nondisclosure based on whatever information is available. In some cases, time may allow the physician to seek advice from the College, and other sources, in order to come to a conclusion. However, there are circumstances where decisions on these matters have to be made quickly.

Questions have been raised about the impact of recent Personal Health Information legislation, specifically the *Personal Health Information Protection and Access Act (PHIPPA)*. Fortunately for members, the legislation does articulate a similar risk assessment to that which physicians have always been expected to consider.

39 (1) A custodian, [hospital, physician, other health professional] may disclose personal health information without the consent of the individual to whom the information relates if the custodian reasonably believes that disclosure is required

(a) to prevent or reduce a risk of serious harm to the mental or physical health or safety of the individual to whom the information relates or another individual, or

(b) to prevent or reduce a risk of significant harm to the health or safety of the public or a group of people, the disclosure of which is clearly in the public interest.

At the same time, *PHIPPA* also contains provisions which limits any civil liability for a physician either disclosing, or declining to disclose, as long as such is done in good faith.

In the end, Council expects physicians to do the best they can in weighing the potential risks of harm from any particular course of action. These situations will vary. Sometimes important information may be communicated directly from law enforcement. At other times, the situation may speak for itself. For that reason, it is impossible to specify a response to all situations. In some cases, disclosing certain information will have an adverse effect on a patient but still help avoid significant harm to others. In other circumstances, the situation may be less clear. The best general advice that Council can provide is for physicians to always go back to the profession's first principles and strive to avoid causing harm wherever possible.

Importation of Prescription Drugs

From time to time, a patient may request that a physician phone prescriptions in to pharmacies in the United States. This may be for a number of reasons such as the cost. However, returning with these drugs into Canada may violate Food and Drug Regulations. As a consequence, the medication could be confiscated. Should a patient request this service, it is suggested that physicians warn them of such a risk.

Executive

The Executive of the College for 2011-2012 is as follows:

President:	Dr. François Guinard, Edmundston
Vice-president:	Dr. Mark Whalen, Campbellton
Member at large:	Dr. Lachelle Noftall, Fredericton
Member at large:	Dr. Santo Filice, Moncton
Public Member:	Dr. Teréz Rétfalvi (PhD), Moncton



From the Archives



Ninety years ago

In 1921, Council appointed a physician to assist French-speaking candidates at the Council's licensing exam, discussed prosecution of several physicians who refused to pay the annual fee of \$2.00, and agreed to publish, in the *Annual Announcement*, the licensing regulations as well as copies of examination questions.

Sixty years ago

In 1951, Council eventually succumbed to the pressure of the Minister of Health to allow licensure of certain physicians for direct employment in various provincial institutions, determined there was no need to develop a process for incorporation of physicians, and decided to waive annual dues for physicians in practice for more than fifty years.

Thirty years ago

In 1981, the Council suspended the license of a physician for reasons of alcohol and drug abuse, but reinstated it after two months based on satisfactory reports on his progress. However, he was subsequently convicted of impaired driving and his license was then revoked. He relocated to another province. Council also discussed the potential harmonization of the rules for licensure across the country. There was also the first meeting of Council elected under the new *Medical Act*.

