COLLEGE OF PHYSICIANS AND SURGEONS OF NEW BRUNSWICK
COLLÈGE DES MÉDECINS ET CHIRURGIENS DU NOUVEAU-BRUNSWICK

Bulletin April 2016

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 8 April, 2016, 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 consultant recommended to the patient's family physician that the patient be referred to a surgeon following a potentially significant finding on a CT scan. Despite several reminders from the patient, the physician failed to make the referral. In response, the physician noted that when the referral had eventually been made, the surgeon recommended immediate treatment. As a consequence, the physician asserted that any delay did not create any difficulties for the patient. The Committee felt the family physician was not in a position to anticipate the results of the referral nor could the Committee find any acceptable reason for delaying the referral for more than seven months. Such clearly created additional stress for the patient. Based on a previous issue of a similar nature, the Committee felt it appropriate to recommend a ***Censure*** to express its dissatisfaction with how the matter was handled.

A patient complained after a physician reported him to the Registrar of Motor Vehicles following a seizure. He asserted he did not have epilepsy and had a normal EEG. In response, the physician stated that the patient had an atypical seizure disorder which still presented a risk. In reviewing the matter, the Committee agreed that the physician had met his legal obligations and found no fault with the care provided.

A patient complained that a physician had prescribed Azathioprine (Imuran) without proper monitoring. The patient developed a significant bone marrow disorder. In response, the physician noted that the patient had previously been on the medication for Crohn's disease and he had only increased it to the recommended dose. The patient was monitored closely for complications. In any case, the actual complication which developed was significantly different from those usually resulting from the medication. Furthermore, this developed more than two years after the patient was last seen by the physician. He felt that there did not appear to be a causal connection between the treatment and the patient's subsequent condition. In any case, the physician had followed prevailing standards and no fault could be found with the care provided.

A patient complained that a physician took significant objection to requests from lawyers for medical information. The information actually related to an accident several years before the physician was involved in the patient's care. In response, the physician did attempt to clarify this point with the lawyers and to determine if there was anything specific they were looking for. No further information was provided. In the end, the Committee felt that the physician may have initially overreacted to the issues, but in any case, the complainant felt that his explanation was satisfactory. Consequently, no further action was taken on the matter.

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A child had a significant systemic disease. Her care was being supervised by a consultant, but another consultant was involved in monitoring her for a known complication. At one point, it was suggested that the frequency of such monitoring increase. However, the staff of the second consultant declined to provide a more timely appointment, despite repeated requests from the parents and from the physician overseeing the patient's care. In response to the matter, the physician asserted that she had no knowledge of these issues, as all matters were being handled by her staff. The Committee noted that physicians are ultimately responsible for the actions of their staff in such matters and felt the complaint was a sufficient reminder of this fact.

An elderly patient with terminal cancer was seen regarding the initiation of palliative therapy. At that point, he had no significant symptoms and the oncologist felt that the harmful effects of any treatment would outweigh any minimal benefits. The family, on the other hand, had received some information suggesting the patient's prognosis was not so dismal. The Committee noted that the matter had been discussed by a number of physicians in the same department who all agreed on the approach taken. The Committee could find no fault with the care provided.

An elderly patient was seen in follow-up of a biopsy procedure. The family alleged that the surgeon treated the patient roughly and appeared quite upset when the biopsy report was not available. In response, the physician acknowledged that he had become upset at his inability to locate the report, but assumed it had not yet been produced by the laboratory. In contrast, it was clear the report was generated quickly after the biopsy and it was the physician who had failed to have a system to properly track such results. At the least, when the patient returned for follow-up some weeks later, staff should have made some effort to locate the result prior to the patient being seen. The Committee felt it appropriate to ***Caution*** the physician regarding the expected standards for tracking such information so as to avoid gaps in care.

Two specialists from out of province complained a local consultant had practiced beyond of his expertise by providing care for a child when he was not sufficiently experienced to do so. In reviewing the matter, it appeared that the physician had initially made an honest effort to provide some assistance and had attempted to involve such other physicians as available to assist with a difficult matter. However, as matters progressed, the physician continued to be more and more involved with the patient's care. It was only when the patient was transferred to a referral centre that more appropriate intervention became instituted. In response, the physician claimed that the lack of local resources for children required him to provide care in some circumstances. He felt he relied on other assistance as much as he could, but the situation was far from ideal. In reviewing the matter, the Committee felt it appropriate to ***Caution*** the physician regarding exceeding his training and experience. There may be situations where a lack of resources require physicians to practice outside of their competence, but such should be minimized. Furthermore, in many cases, physicians may also not be in a position to realize when their abilities were exceeded.

A patient complained that a physician failed to support a claim regarding an accidental injury to his leg. In a letter, the physician had asserted that the patient's difficulties were from a longstanding problem and not related to any acute injury. In reviewing the matter, the Committee felt that the physician was entitled, as well as obligated, to provide his honest opinion regarding any particular aspect of a patient's condition.

In two unrelated cases, patients complained regarding their termination from their physicians' care. In both cases, there had been repeated difficulties over a period of time. Finally, when each patient attempted to make an appointment and was denied such within a reasonable time, they objected somewhat strongly to the staff. Both physicians responded by advising the patients that such was unacceptable and terminating their care. In one case, there was no warning prior to the action and the Committee felt it appropriate to ***Caution*** the physician regarding the expected approach. In the other case, there was only a general warning as part of the clinic's policy and not a specific warning to the patient. In that case, it was felt appropriate to ***Counsel*** the physician regarding the proper approach to take with termination of care to a patient.

As a result of a number of issues related to his employment, a patient sought the support of his physician in attempting to avoid a return to work after a lengthy absence. The need for further time off was supported by the patient's psychologist. The physician on the other hand felt that other interventions were possible and he could not support any such absence. This opinion was supported by a psychiatrist

who was consulted on the matter. In the end, the Committee felt that the physician was obligated to reach his own conclusions regarding the matter and, consequently, the Committee could find no fault with the care provided.

A patient attended the Emergency Department three times. He had no family physician. He had a number of symptoms, possibly related to toxic exposure. On the third visit the physician, without any assessment, told the patient that it was a waste of time for him to have attended. The patient, on the other hand, asserted that there had been new symptoms which should be addressed. In response, the physician acknowledged, in hindsight, he should not have been so inclined to rush to a conclusion without determining the patient's current state. While the patient's ongoing issues would need to be sorted out, likely by a number of pending referrals, the physician acknowledged that he could have still offered some assistance. The Committee felt that this response was appropriate and determined to take no further action.

A patient had a lengthy list of complaints regarding a physician. They ranged from confusion about the results of investigations to the need for certain referrals. In response, the physician provided an explanation for all the matters. In reviewing such, the Committee felt the explanations were satisfactory, but it was unclear why there was such difficulty in communication between the patient and the physician. It is true that some patients may have difficulty understanding information involved in their healthcare and physicians have to make all reasonable efforts to explain such in a satisfactory manner. The Committee could find no evidence that the physician had not apprised the patient of each development.

An elderly patient was seen in follow-up to surgery. She was accompanied by an acquaintance. The surgery had gone well and the patient, in a gesture of appreciation, touched the physician's face a number of times. The physician did not feel this was appropriate and made a comment to that effect. The patient's acquaintance took exception and an argument ensued. In response, the physician asserted that he was only enforcing appropriate boundaries. However, the tone of the argument on the part of the individual accompanying the patient had become overtly racist in his view. In reviewing the matter, the Committee felt that the entire episode was difficult to sort out but, based on the information, was regrettable. The Committee was not in a position to arbitrate exactly what was said, but did feel the matter was a result of a clash of cultures and attitudes. The Committee felt it was unfortunate that the elderly patient was in the middle of such a dispute between her acquaintance and her physician. The Committee did not feel it could offer further comment other than to suggest that physicians are obligated to do everything they can to avoid such matters escalating as this one evidently did.

A patient was seeing a new family physician. The patient had had a previous history of epilepsy, but had been seizure free for many years. She now described some symptoms of an aura which suggested to her that the seizures may recur. She requested that her medication be reinstated. Rather than responding to that issue, the physician focused on several other matters and advised the patient it was not acceptable to bring too many problems to a visit. Subsequently, the patient did actually have a seizure while driving, but managed to stop the car quickly enough. The physician did not report the fact of the possible seizure disorder for several weeks. The Committee felt that the physician's entire approach was unsatisfactory. The physician should have been prepared to deal with the matters presented by the patient according to some priority based on their significance. An arbitrary rule of one problem per visit is never acceptable. Furthermore, the physician failed to meet her legal obligation to report the patient's medical condition to the Registrar of Motor Vehicles. This created a significant risk for the patient and others. The Committee felt a ***Censure*** was the only appropriate comment to make on this matter.

A patient complained that she suffered a small burn during a procedure. She also raised a number of issues regarding the availability of the surgeon for follow-up. In response, the physician asserted that the burn was very minor and was healing satisfactorily, as confirmed by a plastic surgeon. Furthermore, the surgeon could find no evidence that there was any lack of availability to follow-up. In reviewing the matter, the Committee felt that the injury was a minor complication that can occur despite the best of care. There appeared to be other issues between the physician and the patient, but in terms of the overall picture, the Committee could not find any fault with the care provided.

Dr. Fernando Rojas Lievano

Investigation by Vitalité Health Network found that this Radiation Oncologist had improperly accessed medical records of 140 individuals, including co-workers and others. There was no clinical reason for doing so. As a result, the Regional Health Authority imposed a suspension of six months duration. With the agreement of the physician, Council of the College determined to accept this period of suspension as the appropriate penalty for this professional misconduct.

Prescriptions

In anticipation of the initiation of the Prescription Monitoring Program by the province, physicians should make note of an additional requirement for all prescriptions. At some future time, it will be expected that all prescriptions will include reference to the physician's College registration number. It is the number on each membership card. If using their own printed prescriptions, physicians can have such included on each. If using other prescription pads, the registration number could be added with the signature. Such would similarly be required of locums and resident physicians when writing prescriptions. In anticipation of this, physicians should also note that the current Prescription Drug Program will begin tracking physicians according to their registration number, rather than the previous prescriber number.

Physicians should also be aware that, likely next year, the program will place an expectation on physicians that they have access to the internet in their offices.

From the Archives

Two hundred Years Ago

In 1816 the first attempt at Medical Regulation in New Brunswick was passed, an *Act to exclude ignorant and unskillful persons from the practice of physics and surgery*. It precluded practice without a license, but provided no penalty for such. The legislation was largely ignored. At the time, most physicians in New Brunswick were American trained.

One hundred years ago

In 1916, Council complained to a hospital that it was allowing unlicensed surgeons to operate. It decided to leave the annual fee at $1.00.

Seventy-five years ago

In 1941, Council granted permission for a student to attend medical school, notwithstanding he had not been born in New Brunswick. There was also a lengthy discussion regarding excess prescribing of narcotics. The annual fee was increased to $10. This amount was shared with the New Brunswick Medical Society.

Fifty years ago

In 1966, Council decided to rescind its recognition of Quebec specialists and agreed to survey physician workloads for a professional manpower study.

Twenty-Five years ago

In 1991, Council agreed that the Prescription Drug Program be augmented to take better control of improper prescribing. It also passed a resolution stating that there appeared to be no place for narcotics in the treatment of chronic pain not arising from cancer.