**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 20 June and 19 September, 2008, Council considered the following matters.



## COMPLAINTS

A patient suffered a burn injury. The wounds were treated and the patient discharged. However, the patient subsequently developed respiratory distress, requiring readmission. Physicians are reminded of the risk of late onset respiratory symptoms in the case of certain types of burn injuries.

A patient was on a range of medications from a consultant. One of these was changed and the patient subsequently developed a number of symptoms. Her own physician was unavailable, so she attended the Emergency Department. The physician there suggested he would not make any comment on the medications, as she was already under the care of another physician. The patient complained that the physician had not adequately assessed her. In reviewing the matter, the Committee agreed that significant changes in the patient's treatment should be avoided in such situations. However, in this particular sequence of events, it was open for the physician to discuss the possibility of whether the recent change had any impact on the patient's symptoms.

A patient suffered a fracture, was casted in the local Emergency Department, and transferred to a regional centre to see a consultant. The consultant determined that no further intervention was necessary. The patient subsequently was seen at another centre and underwent more active treatment. He complained that the first consultant had failed to assess him properly. On reviewing the matter, the Committee determined that all physicians involved had provided appropriate care. Considering the acute situation, the first consultant had acted completely appropriately. The patient's condition had evolved by the time he was seen by the second consultant. It is also possible there were some communication issues, but the Committee felt no further action need be taken on the matter.

An elderly patient presented to an Emergency Department with an acute illness. She was seen by a consultant who attempted to discuss with her family the question of resuscitation orders. The family objected that this was inappropriate. The physician responded that, given the nature of the patient and her illness, it was quite important to deal with these matters. On reviewing the matter, the Committee agreed that it was appropriate for the physician to attempt to raise these issues in order to avoid unnecessary and futile treatment for the patient. It is possible such could have been approached differently in order to minimize the suspicion with which the family viewed the issue.

A Regional Health Authority complained that a consultant was failing to meet his obligations regarding attendance at a hospital. The physician responded that recent changes in the structure of the service involved had made it difficult for him to be present the expected amount of time. In reviewing the matter, the Committee noted that the College can really only deal with a matter where a specific patient had been abandoned while under the care of a physician. The general obligations of physicians to provide a particular service or support to a hospital or Regional Health Authority were best dealt with as a question of privileges with that entity.

Two surgeons were performing a procedure. One was to supervise the other, who was less experienced. A complication developed. There was an allegation that both surgeons responded inappropriately. On reviewing the matter, the Committee could find no fault with the care provided. The complication which developed is a known one which could occur in any similar circumstances. There was no evidence that it was the result of any lack of care. In any case, the supervising surgeon intervened appropriately to stabilize and transfer the patient.

Pending entering into an addiction program, a physician maintained a patient on a high dose of narcotic. The family of the patient complained that such was inappropriate. The physician responded that he felt this was the only way the patient could be maintained with some stability pending appropriate therapeutic intervention. The Committee understood that such an approach is sometimes used by physicians. Because the patient herself had not complained, there was limited access to the clinical information. For that reason, the Committee did not feel it could respond to the specific situation. Physicians are reminded that they can apply for the right to prescribe methadone, even for a single patient. In some circumstances, this could be a better approach.

A complainant found herself in significant legal difficulties as the result of various inappropriate behaviour. She complained that her longstanding family physician had contributed to this with prescriptions which had been issued over the last number of years. In response, the physician noted that the patient was difficult to manage, and frequently stopped medication inappropriately. He asserted that all treatment was provided in the patient's best interests. In reviewing the matter, the Committee could find no fault with the care provided. Nor was there any evidence that any past treatment contributed to the patient's current difficulties.

A patient attended a physician and was somewhat unsatisfied with the response to her problem. The patient said nothing to the physician, but his staff noticed the patient's dissatisfaction as she left the office. The patient returned several weeks later for a completely unrelated matter. The physician refused to address the current complaint unless the patient offered an explanation for her attitude at the previous visit. The patient complained that the physician's persistence with this matter prevented her from receiving appropriate care. In reviewing the matter, the Committee felt the physician was unnecessarily preoccupied with the circumstances surrounding the earlier visit. While it was appropriate to inquire regarding any possible issues which were unresolved, in this case, the physician failed, as ethically required, to first consider the patient's wellbeing. In this case, the first obligation would be to deal with the current acute situation. Other matters could be discussed after. The Committee approved a letter

advising the physician of these concerns.

A family member of a physician required an emergency consultation. The physician contacted the consultant directly, rather than dealing with the individual on call for that specialty. The patient came under the treatment of the consultant. Some time later, the question arose as to whether the involvement of the physician in the care of a family member was appropriate. On reviewing the matter, the Committee noted that the physician did not, in any way, participate in any specific treatment. The only role was to contact the consultant. The Committee understands that it is not uncommon for physicians to seek specific assistance when dealing with themselves or family members. In any case, the Committee did not feel there was any conflict in the behaviour of the physician involved. After the situation was resolved, the patient was always free to accept or reject care from any particular consultant.

A patient presented to an after-hours clinic with concerns regarding morning sickness. She wanted specific treatment, but the physician declined such. In response, the physician advised that, from the information taken from the patient, the situation sounded more likely to be an infection. In reviewing the matter, the Committee noted that the physician did appear to receive information in that direction. The Committee was unsure why there was such a discrepancy in versions, but did not feel it could resolve the issue. Nevertheless, the Committee felt it appropriate to warn the physician regarding the appropriateness of certain treatment and recommendations in pregnant patients.

The Complaints Committee also referred two matters to the Review Committee for further study.

## OTHER BUSINESS

In other business, Council:

- Approved a new regulation on telemedicine which will allow physicians from outside the province to provide telemedicine services into New Brunswick without formal licensure. They will be required to be listed on a telemedicine provider list. The regulation is on the College's website.
- Reviewed two cases at the request of the Chief Coroner. One involved the prescription of morphine to a patient with known alcoholism. The other concerned the now rarely used sternal approach to bone marrow aspiration.
- Conducted an initial review of various policies on blood borne infections in physicians. The College will consult with appropriate experts to determine the best approach to take in this regard.
- Approved the College budget for 2008-2009 without any increase in annual dues. It is expected that the expense of the ongoing public inquiry into pathology services will be met by current reserves.

- Welcomed newly elected member of Council:

  Dr. Lisa Jean C. Sutherland, Rothesay

- Elected the following Executive Committee for 2008-2009:

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| **President:** | Dr. Paula Keating, Miramichi |
| **Vice-President:** | Dr. Terry Brennan, Fredericton |
| **Past-President:** | Dr. Robert Rae, Saint John |
| **Member at Large:** | Dr. Jean-Marie Auffrey, Shediac |
| **Public Member:** | Mr. Gilbert Doucet, Dieppe |

## FROM THE ARCHIVES

**100 years ago**

In 1908, Council decided to pursue reciprocal registration with Great Britain, offer physicians the opportunity to add additional credentials to their listing for a fee of $1, and to increase the initial registration fee to $40, with the long range goal of eliminating the annual fee.

**75 years ago**

In 1933, Council offered "perpetual" registration for a fee of $60 and objected to Dalhousie University admitting students from New Brunswick without them first registering with the Council.

**50 years ago**

In 1958, Council agreed to increase the total fee to $65, with $8 for the Council and the remainder for the Medical Society, set up the first Specialist Register, and accepted the resignation of Dr. John M. Barry, eighty-six, after twenty-one years as Registrar.

**25 years ago**

In 1983, Council decided not to renew the license of a physician for whom allegations of sexual misconduct had been raised, but, on legal advice, decided not to advise those who had provided references on the physician's behalf. Council subsequently dismissed their solicitor, for failing to attend meetings at their request. Council also sought clarification regarding the surgical training involved in two year family practice residencies.