Managing stress when transitioning to new electronic record systems

Recognizing, managing diagnostic risks in the ED

CMPA Member Support Program: A year of positive change

Safe prescribing: Risks for older patients

The dilemma of limited healthcare resources
It seems that every day the media is reporting on another established business or organization experiencing serious difficulties; many of these organizations appear destined to fail. A common theme is that they failed to adapt to a changing environment and became prisoners of their previous success. At the CMPA, we recognize that, to avoid this fate, we must continue to evolve our services to meet the changing needs of our 100,000 physician members.

We know that successful organizations continue to innovate and look for new opportunities and partnerships to add value to their members. Our members expect the CMPA to work collaboratively with others to improve the environment in which physicians practise, protect their medical liability interests, and improve the safety of care. I am pleased to report on three examples of innovative collaboration that will advance the safety of care in Canada.

▪ The CMPA has joined HIROC (Healthcare Insurance Reciprocal of Canada) and the SOGC (Society of Obstetricians and Gynaecologists of Canada) as an equal partner in Salus Global, the provider of the MORE® program. By significantly improving teamwork and communication across all disciplines involved in obstetrical and perinatal care, the MORE® program has a long track record of improving clinical outcomes and reducing harm. This partnership among HIROC, SOGC, and the CMPA builds on many years of collaborative efforts to improve the safety of care and demonstrates a collective commitment to improving safety.

▪ In collaboration with the Resident Doctors of Canada and with the support of Canada’s 17 medical schools, we are delivering the Resident Symposia Series to residents across the country, providing early career physicians with risk reduction knowledge that will be of benefit throughout their careers.

▪ Through our subsidiary, Saegis, the CMPA is fielding the SafeOR program, aimed at enhancing safety and improving teamwork in surgical units. By partnering with Surgical Safety Technologies, the SafeOR program combines the groundbreaking technology and analysis of the Operating Room Black Box® with years of quality improvement expertise provided by the CMPA. The SafeOR program will make a measurable improvement in the safety of surgical care, benefiting physicians and their patients.

At the CMPA, we are proud of our demonstrated ability to maintain the continuity of services that members value, while adapting to change with new offerings. Our new, collaborative programs will enhance the safety of care in Canada and we look forward to introducing more initiatives in the future.

Hartley Stern
MD, FRCSC, FACS, ICD.D
Avoiding pitfalls in the emergency department: Recognizing and managing risks of diagnostic error

Diagnostic risks are an inherent part of work in the emergency department. This analysis of CMPA cases shows how they may be mitigated.

The CMPA Member Support Program: A year of positive change

Learn about the positive response to the CMPA program that assists members who have a medical-legal experience greater than their peers.

Limited healthcare resources: The difficult balancing act

Meeting the needs of patients in a healthcare system where resources are limited can be frustrating and also raise anxiety about medical-legal consequences. Hear what the CMPA advises.

Safe prescribing: Risks for older patients

Do you prescribe to older patients? This CMPA analysis of cases identifies some of the most common difficulties experienced by members when prescribing to this population.

Managing stress when transitioning to new electronic record systems

Moving from one medical records system (paper or electronic) to a new electronic system can be stressful. Read how planning for and managing the change may alleviate pressure.

Managing stress when transitioning to new electronic record systems

Moving from one medical records system (paper or electronic) to a new electronic system can be stressful. Read how planning for and managing the change may alleviate pressure.

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What is diagnostic error? Diagnostic error is a “failure to establish an accurate and timely explanation of the patient’s health problem, or to communicate that explanation to the patient.”

Physicians treating patients in the emergency department (ED) strive to make the most likely diagnosis, while frequently contending with complicating factors such as complex triaging, transitions in care, interruptions, crowding, and fatigue. An inadequate differential diagnosis, however, can mean a potentially serious condition is missed.

Among legal cases closed by the CMPA in the past five years, diagnostic error was the most common criticism of emergency physicians made by peer experts reviewing the cases. Between 2013 and 2017, the CMPA closed 486 legal cases in which patients or families alleged there was a wrong, missed, or delayed diagnosis by an ED physician. In 251 cases, peer experts were critical of a physician’s diagnostic process in the ED—and nearly all these cases resulted in patient harm, including death. The most prevalent contributing factor in the CMPA legal cases, based on peer expert opinion, was a physician’s inadequate clinical assessment of a patient.
**CASE EXAMPLE:**

**An unstable patient with atrial fibrillation is misdiagnosed as a typical, uncomplicated case**

An older woman with extensive cardiac co-morbidities—including congestive heart failure with severe left ventricular dysfunction—presents to the ED in a wheelchair following an in-hospital, pre-operative anaesthesia consultation for valve replacement surgery. She carries her ECG from that morning, showing rapid atrial fibrillation, and the anesthesiologist’s consultation note mentioning her grey skin colour. On initial assessment, an ED physician notes the ECG along with the patient’s blood pressure of 80/40 and heart rate of 160. She orders a nurse to administer 25 milligrams of intravenous diltiazem in two divided doses and then leaves to attend to other patients. The nurse administers the first dose and within minutes, the second dose. The patient soon becomes more hypotensive and nauseated. The nurse calls the ED physician, but the patient progresses to pulmonary edema and cardiogenic shock. During a three-week ICU stay—requiring intubation, vasopressors, renal dialysis, and an intra-aortic balloon pump—her ventricular function gradually improves.

**What did the experts say?**

In this case, the CMPA paid a settlement to the patient on behalf of the ED physician. Peer experts commented on the care provided. Based on the medical record, these experts opined that the ED physician did not take the time to obtain an appropriate medical history from the patient and, as a result, did not appreciate the extent of her pre-existing cardiovascular disease. Given the patient’s hypotension and extensive cardiac history, experts noted further that the ED physician should have supervised the diltiazem administration or considered a different management plan.

**Most common expert criticisms**

Peer experts retained by the parties in the CMPA legal cases most commonly criticized ED physicians for failing to ascertain an adequate medical history and physical exam, and for not ordering adequate diagnostic testing and sufficiently following up.

**Inadequate medical history and physical exam**

In approximately 60% of the CMPA cases in which there was expert criticism of the ED physician, peer experts opined that the ED physician performed an inadequate physical exam or obtained an overly limited medical history, as illustrated in the case example.

Multiple patient and system factors contributed to the outcomes. Many patient conditions were rare, atypical, difficult to detect, or prone to “search satisficing bias.” For example, among patients with fractures, about 40% presented with multiple injuries.

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Common biases: Search satisficing, premature closure

There are more than 40 types of cognitive biases that influence clinical decision-making in the ED. Common types include “search satisficing bias,” which involves calling off the search once something is found, and “premature closure,” which involves accepting a diagnosis before it has been fully verified.
Resource shortages were also contributing factors. For example, experts criticized one ED physician for discharging a trauma patient with co-morbidities from a busy ED “hallway bed” with only one vital sign measurement, at triage. Another ED physician treated a patient’s laceration, but the ED was busy at the time and no charting was made of the visit.

Experts in these cases commonly noted underestimating a patient’s risk level or not investigating key symptoms or concerns raised by a patient or family members. Consequently, ED teams failed to implement clinical protocols in a timely manner, such as a sepsis protocol. Sometimes, patients made repeat visits to the ED for the same condition as symptoms persisted or evolved. For example, a patient developing necrotizing fasciitis visited the ED three times within days, each time with worsening symptoms. Experts felt that by the second visit the ED physician should have further investigated the cause of the patient’s unexplained, intolerable pain.

In some cases, experts criticized a consultant or a nurse for not relaying important aspects of a patient’s history to the ED physician. There were also criticisms of ED physicians for not reading the medical record for a patient handed over to them. Other pitfalls included ED physicians not communicating crucial monitoring instructions to nurses, or not expressing the severity of a patient’s condition to another ED physician at handover.

**Inadequate diagnostic testing and follow-up**

Inadequate diagnostic testing was the second-most common criticism of ED physicians, occurring in nearly 50% of the cases reviewed. Peer experts noted ED physicians failing to order important diagnostic tests (including follow-up tests when appropriate), or relying on sub-optimal test results such as X-rays that were missing a clinically relevant field of view.

In some cases, experts felt the ED physician should have applied a clinical decision rule to assess the need for diagnostic imaging.

In other cases experts opined that an ED physician took too long to review, or failed to act on, a significant test finding. These cases included ED physicians who misinterpreted or misread a test result. Some physicians failed to follow up in a timely manner on discrepant reports sent by a radiologist. Experts also identified faulty hospital systems that directed test results to the wrong physician, or failed to notify a physician or patient about a test result.

**Risk management strategies**

Peer experts acknowledge that diagnosing patients in a resource-restricted ED is difficult. Yet, expert opinions in the CMPA legal cases are consistent with the following strategies for lowering your medical-legal risk:

- Gather an appropriate medical history of the patient, and conduct and document an appropriate, focused physical exam.
- Be familiar with clinical practice guidelines and clinical decision rules for investigating common conditions encountered in the ED.
- When a patient returns to the ED, re-evaluate the diagnostic assumption and consider a repeat history and physical exam with full vital signs.
Consider using a structured communication approach or tool for handovers.

Be familiar with your ED’s and hospital’s system for managing test results and promptly advise appropriate personnel of system deficiencies.

**The Bottom Line**
Diagnostic error is an inherent risk of working in the ED. It arises from cognitive and system factors that are often intertwined. Fortunately, there are ways to mitigate medical-legal risk from diagnostic error, such as recognizing your cognitive biases and documenting your clinical thinking in the medical record. Consider advocating for reliable systems and effective teamwork in your ED to better communicate diagnoses between physicians, nurses, diagnostic labs, and patients.

Additional reading at [www.cmpa-acpm.ca](http://www.cmpa-acpm.ca)
- “Improving patient handovers”
- “Stop and think—Return visits offer another chance”
- “Effectively managing hospital test results – key to timely diagnosis and patient safety”
- “Limited healthcare resources: The difficult balancing act”

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1. Includes physicians specializing in emergency medicine, residents working in the ED, and other physicians practising emergency medicine in the ED.
3. Peer experts refer to physicians retained by the parties in a legal action to interpret and provide their opinion on clinical, scientific, or technical issues surrounding the care provided. They are typically of similar training and experience as the physicians whose care they are reviewing.

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**Lawyer asking you to provide a patient’s medical records?**

You’ll need authorization.

**2 sources of authorization**
- **Patient or substitute decision-maker**
- **Legal requirement, i.e. a court order, warrant, or legislation or regulation requiring disclosure**

**3 tips on providing records**
- Notify the custodian of the record about the request if you are not the custodian.
- Have the authorization in writing, stating who the records can be released to and which records you are authorized to release.
- Check if records contain potentially sensitive information (e.g. about patient’s mental health, personal information about third parties such as the family history). If you have the patient’s consent, ask the patient whether he or she intended this information to be released. Redact any information the patient doesn’t want disclosed or that is personal information of someone else. If you are compelled for legal reasons, call the CMPA before disclosing information.

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Want more information on when you can provide records to lawyers? Contact the CMPA for advice.
THE CMPA MEMBER SUPPORT PROGRAM:

In November 2017, the CMPA launched the Member Support Program to proactively identify and assist members experiencing a high volume of medical-legal events.

We recently sat down with Dr. Todd Watkins, the CMPA's Managing Director of Physician Services, to discuss the program, learn how it’s been received, and share next steps.

Q. TELL US ABOUT THE PROGRAM. WHY WAS IT DEVELOPED?

Every one of our members aims to provide the best care possible, but there are so many pressures facing healthcare providers that sometimes members find this challenging. Often these struggles lead to difficulties with communication, collaboration, or professionalism, which in turn can trigger complaints and contribute to the possibility of legal actions.

At the CMPA, we are in a very privileged position to assist members, and we recognize that a pattern of increasing or recurring medical-legal events may be a sign that a member needs help—not punishment. We developed the Member Support Program (MSP) to help us get to know our members and identify their individual needs to reduce their medical-legal risk. The program is open to all members, but is primarily focused on assisting members whose medical-legal experience is greater than their peers. For some of our members, an increasing pattern of medical-legal issues can be a precursor to significant restrictions being placed on their practice. We want to help these members identify and address the factors contributing to their risk, and in this way prevent future issues.

Q. WHAT IS MUTUALITY AND HOW DOES IT TIE INTO THE MSP?

Mutuality is one of the defining principles of the CMPA. It means the CMPA and our members have reciprocal roles and expectations. Part of the CMPA’s role is to support our members as best we can to help reduce their medical-legal risk. Our members, in turn, are expected to practise in a safe manner in keeping with the practices of the broader membership, including working proactively to decrease their medical-legal risk.

The MSP provides all members who need assistance with a way of reducing their medical-legal risk while improving the quality of care they provide and regaining confidence in practising medicine.
Q. HOW DOES THE MSP WORK?

The first step is getting to know our members better. When we see certain patterns in a member’s medical-legal experience, we reach out to the member to see if we can help.

Next, we take a closer look at the member’s medical-legal history to try to pinpoint any underlying factors contributing to the increased rate of medical-legal events. Each situation is unique, so we seek input from the member to understand his or her practice environment and the context around events. Sometimes the pattern of medical-legal experience is truly situational or temporary—and in this case, the member likely does not need our ongoing assistance. However, most often we can identify practice-related factors that may be driving the increased risk, such as poor documentation, communication struggles, and professionalism issues.

Once we’ve identified the underlying factors, we develop an individualized education and support plan to address the member’s specific areas of need. This plan can include recommended education resources and courses, focused advice, targeted education goals, and discussions about wellness.

The final step of the program is follow-up and assistance in achieving the member’s goals. For example, we might create a schedule to check in with the member at regular intervals and provide guidance and advice.

Q. WHAT HAS THE RESPONSE BEEN TO THE PROGRAM SO FAR?

The response from our members—including MSP participants—has been overwhelmingly positive. While our focus has initially been on a small number of members, the program is available to all members. Members have told us that they support the program not only as a way of improving their own practices, but also as part of the CMPA’s broader commitment to safe medical care.

Members receiving assistance from the MSP are actively engaged and grateful for the opportunity to reduce stress levels and prevent future medical-legal events. Many have expressed relief when provided with a plan to improve their practice. In fact, participants have asked why this service was not available years ago. There is no doubt that participants want to provide quality and effective care. The Member Support Program aims to guide members back to a fulfilling and joyful practice.

Q. HAVE THERE BEEN ANY SURPRISES?

We have seen significant benefits in simply raising members’ overall understanding and awareness of their medical-legal experience as it compares to others. Physicians generally do not speak to their colleagues about medical-legal events, so it’s difficult to know what’s normal or expected. Without this baseline understanding, it is easy to dismiss an increase in medical-legal events as a consequence of a difficult practice environment or the “cost of doing business.” Many members contacted don’t realize that their medical-legal experiences are outside the norm. We have learned that simply sharing this information often motivates members to make positive practice changes.

There is research linking physician burnout to an increased rate of medical-legal events.1-2 When speaking to program participants we often ask about wellness and discuss how wellness could be contributing to medical-legal risk. Again, awareness tends to drive insight and encourage change. Interestingly, many participants have already taken steps to try to improve their well-being and address workload issues.

Q. WHAT’S NEXT?

As we begin our second year, we are focusing on evaluating and refining the support we provide. We are currently analyzing feedback from members participating in the program and evaluating the impact of each intervention. This includes assessing how the suggested courses and guidance have affected members’ practices, attitudes, and behaviours. Information from this analysis will allow us to further develop the MSP and better assist members with specific needs. The overall success of the program will be defined by our ability to reduce future medical-legal events and enhance member satisfaction and well-being.

We are also considering how to address physician wellness. At our 2018 Annual Meeting and Information Session, we discussed the need for a collective response to support a system-level approach to improve the wellness of physicians and, by extension, the safety and quality of care. Moving forward, we will examine opportunities, leveraging our position as a trusted organization, to collaborate with partner organizations to help physicians combat burnout and improve wellness. While member-specific interactions with participants in the MSP remain confidential, the overall themes learned from the program will be central to how we shape practical solutions to this important issue.

At a recent conference your colleagues were discussing their transition from an old electronic medical record (EMR) system to a new system. Despite the initial growing pains, they felt the original transition from paper records to an electronic system had improved their practice, and they were now eager to migrate again to a newer program.

Having read discouraging accounts online about some electronic record systems, you remain unsure about making such a change in your office practice. But feeling pressure to modernize and improve efficiency, you decide to take the plunge.

You select an EMR system recommended by one of your colleagues. The hurried delivery and implementation of the EMR surprise your clinic staff. It is not long before you experience regrets as you work after hours catching up on administrative work related to the new system. Your staff are also struggling with the new processes and morale drops. Overwhelmed and stressed, you contemplate scrapping the whole project.

**Benefits and Drawbacks**

Electronic records can improve both the management of individual patient care and the overall effectiveness of the healthcare system. They allow physicians to access clinical information remotely, review historical data, share information with patients, and more easily collaborate with other healthcare providers.

But as with any change, technological change concerning management of patient records can be stressful, even for the most computer savvy physician. Indeed, implementation and management of electronic records is a recognized significant source of stress for physicians and is linked to burnout. Challenges for physicians and healthcare teams include the usability and interoperability of EMR systems, technical abilities of the physician and the team, lack of time for effective implementation, and fear that the technology will negatively affect doctor-patient interactions.
The situation can be exacerbated by a difficult-to-use interface and inflexible functionality of an EMR system. For example, users may need to sort through an overload of on-screen information and may be challenged with confusing navigation. Data entry can be cumbersome when converting existing patient records into electronic files, and data integrity may be problematic when upgrading from an old EMR system to a new one. These and other factors have the potential to negatively affect workflow and ultimately patient care if not addressed. Physicians sometimes report working longer hours to complete data entry and related clerical tasks.

Among the main concerns for the optimization of EMRs stems from difficulties in the interoperability between systems, that is, how well the different technologies that comprise an EMR system interact and function. Compatibility issues may arise when, for example, there are multiple vendors offering products with different software formats.

Physicians may also be concerned about the effect that an EMR can have on the physician-patient interaction. If the transition means introducing computers for the first time in the examination room, less connection with patients and fewer discussions with colleagues may be an unintended consequence that needs to be taken into account.

**MANAGING CHANGE, REDUCING STRESS**

Many of the challenges and stressors associated with implementing a new EMR can be mitigated if physicians and their staff regard the transition as a project, devoting the time and resources—and doing thoughtful planning—to help ensure success. The transition may also be a good opportunity to assess, and where necessary, make improvements to existing work processes.

**Selecting a system and vendor**

There may be many EMR systems and vendors from which to choose, but not all will be suitable. Research and due diligence can minimize the risk of problems developing down the road.

When selecting an EMR system and vendor, consider issues such as how well the system fits the needs of your practice, the changes it will require to your existing office workflow, the transfer of existing files and data, the level of training and support the vendor can provide, security features, laboratory data management, and interoperability potential.

Once potential systems have been demonstrated and eligible vendors have been short-listed, it’s a good idea to begin using a new system on a trial or pilot basis, if possible. This may be an opportunity to request customizations to the system to fully meet the needs of the practice. Before entering into any long-term commitments, asking for references and following-up with the vendor’s past clients might reveal possible difficulties or provide reassurance.

**Creating a transition team**

A common strategy used in private offices and clinics when transitioning EMR systems is creating a transition team to oversee the implementation and liaise with the chosen vendor.

Implementation of an EMR system will impact each member of the healthcare team differently. It is important for the transition team to determine the needs of each of these individuals. Having the entire healthcare team buy in from the beginning is essential for successful implementation and transition, and generally reducing the stress level in the office.
Assessing ergonomics
Reviewing and assessing the ergonomics of the office and examination room will be important in minimizing any negative impact the new system may have on patient engagement.

One way to achieve this is by using an open configuration in which the computer does not obstruct eye contact between the physician and patient, and does not disrupt conversation. When the computer is used as an interactive educational tool during an appointment, patients are less likely to view the physician as being distracted by the computer.

Getting training
Regular and extensive training is essential to successful EMR implementation, and training should be part of the chosen vendor’s service offering.

The learning curve can be steep, and there will likely be a reduction in productivity initially after implementation of a new system. Physicians should anticipate a temporary productivity loss by carefully choosing when and how to implement a new system, such as during a quieter time of year or by temporarily assigning additional office resources. This permits more time to be spent on adapting to the new electronic record system and helps reduce stress.

Support from medical associations
Many provincial and territorial medical associations offer resources and support services for physicians who are considering implementing an EMR system, either for the first time or upgrading to a newer system, or who are experiencing challenges with their existing electronic system. These resources include information about available funding options, vendor selection, advice on data management agreements, and help in resolving issues if difficulties arise with a vendor.

Practising in other settings
While physicians working in a hospital or a larger clinic might have no ownership and feel a lack of control over decisions relating to an EMR system, taking an active role in the planning and implementation of a new system might help ensure their needs and preferences are more effectively taken into account. It may also help alleviate the stress associated with the transition. Once the implementation is underway, working collaboratively with hospital administration and the IT department can go a long way in rolling out a system that functions as intended.

The bottom line
• Planning and change management increase the likelihood of a successful transition from paper to electronic records or between electronic systems, and reduce the stress of those affected.
• Providing clinicians and support staff with proper training in new workflow processes and the use of a new EMR system can help minimize the stress associated with implementing significant change in a medical practice.

Additional reading at www.cmpa-acpm.ca
• “Using electronic record systems with care”
• “10 tips for using electronic records”
• Electronic Records Handbook

The CMPA has the largest collection of physician-related medical-legal data in the world. Using innovative quantitative and qualitative analysis techniques, we are able to gain insights and identify gaps in medical care.

In the past, we’ve shared these insights with members through risk management information and education.

Today, we’re also sharing our findings with the world by publishing in peer-reviewed journals.


We look forward to making our research available to physicians and researchers working in quality improvement, patient safety and medical education to empower safe medical care.

For more, visit the “Research and Policy” section of the website at [www.cmpa-acpm.ca](http://www.cmpa-acpm.ca)
safe prescribing: risks for older patients

Older Canadians have a higher risk of medication-related patient safety incidents than their younger counterparts. This is for a number of complex reasons, including co-morbidities, polypharmacy, metabolic changes, and evolving standards and guidelines.
The CMPA recently reviewed 469 medication-related cases closed between 2013 and 2018 involving patients over the age of 65. Seventy-one percent were complaints or investigations by medical regulatory authorities (Colleges), 22% were legal actions, and 7% were hospital complaints. Close to one-third of cases involved care provided by community-based family physicians, but a wide range of specialties—including internal medicine specialists, surgeons, ophthalmologists, and emergency medicine specialists—were also involved.

The majority of these cases concerned drugs that were given orally. The most common types of drugs were: opioids; anti-depressant and anxiolytic medications; anti-thrombotics; cardiovascular drugs; drugs given for the treatment of cancer, including chemotherapeutic agents and steroids; and non-steroidal anti-inflammatory drugs (NSAIDs).

The two most common concerns identified by peer experts were not fully appreciating the complexity of a patient's condition when prescribing a new medication, and failing to re-evaluate a patient’s existing prescriptions when clinical circumstances warranted. Communication challenges, including breakdowns in communication between patients and physicians and at handover between providers, also factored into many cases. This article explores common difficulties that may be experienced by CMPA members when managing the medications of their older patients.

**Optimize prescribing for complex medical scenarios**

An 85-year-old woman with mild cognitive impairment undergoes an uneventful endoscopy for upper gastrointestinal complaints under intravenous sedation. At admission, the gastroenterologist had ordered oxazepam to be given nightly during the patient’s hospitalization, since she had been anxious about the procedure. The next day, a hospitalist assumes the patient’s care, continuing all drugs ordered by the gastroenterologist and adding an order for lorazepam as required because the patient continued to experience anxiety. The patient breaks her hip from a fall getting out of her hospital bed the following morning, after having been given both lorazepam and oxazepam the evening before. A hospitalist peer expert consulted as part of the ensuing legal action is critical of both physicians, stating that both prescribed drugs were inappropriate for this patient, who was frail and assessed to be at high risk for a fall.

Because older patients often have a number of health conditions, they are frequently prescribed multiple medications, making them particularly vulnerable to drug interactions.

Multiple conditions also mean more contraindications and precautions with respect to dosages and monitoring. Sometimes the age or frailty of a patient can itself necessitate greater vigilance when prescribing. For example, older patients may be more susceptible to adverse effects from medications, such as dizziness or drowsiness, leading to an increased risk of falls. Therefore, some medications may need to be started at a lower dosage or require increased monitoring. Consulting with a pharmacist or geriatrician may help to identify older patients who are at higher risk.

**Re-evaluate medication regimens as patients age**

The bloodwork of a 65-year-old man taking celecoxib for arthritis shows a creatinine level and glomerular filtration rate that suggests chronic kidney disease. His family physician monitors the patient’s renal function at regular intervals. Over the next three years, the patient’s kidney function further deteriorates, and he eventually leaves the family physician’s practice when he moves to another community. There, his new family physician diagnoses stage 4 of chronic kidney disease and discontinues the celecoxib. Following an investigation by the College, the patient’s original family physician is cautioned regarding the use of NSAIDs in elderly patients with renal failure.

In addition to selecting a potentially contraindicated drug or dosage, inappropriate prescribing to older patients may include the continuation of unnecessary or potentially harmful prescriptions. Age-related changes may affect a drug’s absorption, distribution, metabolism, and elimination, making a drug no longer necessary or even harmful, which underscores the importance of regular reviews. Furthermore, in some cases an existing therapy, even if well tolerated by the patient, may
Polypharmacy is a well-recognized phenomenon in the older population. A recent CIHI report found that 1 in 4 Canadians age 65 and older were prescribed 10 or more drug classes, highlighting the scope of this problem and its challenges for clinicians.

A survey of community-dwelling Canadian seniors found that 71% would be willing to stop a medication if their physician said it was possible.

Accordingly, identifying and deprescribing potentially unnecessary medications for patients over the age of 65 is a growing area of focus for patient safety. This practice is seen as particularly important for older seniors and those living in long-term care facilities. Resources such as the STOPP/START criteria for potentially inappropriate prescribing in older people or the Beers Criteria can be used to guide prescribing to older patients in addition to clinical judgement. Deprescribing guidelines and protocols for discontinuing potentially unnecessary or inappropriate medications, including over-the-counter medications, can further help physicians manage the complex medication needs of their older patients. Physicians should review relevant updates to guidelines when re-evaluating medications and use caution when planning to discontinue medications. Pharmacists can play an important role by conducting regular medication reviews, working with older adults to reduce medication errors, and assisting with deprescribing.
Communicate clearly

A woman who is 75 years old sees her family physician for a routine visit. After reviewing the patient’s medications, the family physician decides to switch the nitrazepam that the patient is taking as a sleep aid to a non-benzodiazepine hypnotic without tapering, telling her that benzodiazepines may be harmful, and giving the patient the impression that nitrazepam was no longer available for him to prescribe. After being treated in the emergency department for withdrawal symptoms, the patient seeks out another physician who prescribes nitrazepam. In response to the patient’s complaint, the College cautions the family physician on the importance of careful tapering of benzodiazepines and is critical of the miscommunication around the availability of the drug and the lack of clarity around the rationale given for deprescribing.

Communication was a recurring theme in medication-related cases involving patients over 65. Breakdowns in communication occurred at various points in the process of care, including in the context of medication reconciliation—which is particularly important when multiple providers, and possibly family members, are involved in the patient’s care—or when there were transfers between facilities. This highlights the importance of engaging patients, their caregivers, and pharmacists in comprehensive medication reviews when appropriate.

Medication adherence can also be an issue for older patients. Poor adherence can have many causes, including cognitive decline and the “pill burden” that can come with taking multiple medications. Therefore, extra time and care may be needed to explain a medication’s indication, monitoring requirements, adverse effects, and any special precautions. These precautions may include the timing of medications and possible interactions or contraindications with over-the-counter medications and supplements. Patient education materials and support from pharmacists can reinforce adherence and support proper use of medications, including advice on the timing of medications as well as tailoring dosages to reduce pill burden. Additionally, aids such as the use of dosette boxes and blister packs can facilitate adherence.

Ensuring open and appropriate communication with family members involved in the patient’s care can be challenging, and many of the cases reviewed involved complaints from caregivers when the rationale for treatment decisions was not clearly explained or when a substitute decision-maker was not appropriately consulted about changes to the care plan.

Explaining the need and rationale for deprescribing can be particularly challenging. Therefore, using educational resources for patients and families, and partnering with a pharmacist may be helpful.

The Bottom line

Inappropriate prescribing to, and communication with, older patients are growing safety concerns given the potential for harm in this large and increasing segment of the population.

Special considerations should be considered when prescribing for this age group. For instance, the continuation of medications should be re-evaluated on a regular basis as patients age and their clinical circumstances change. Clear communication with patients, their caregivers, and other involved health professionals plays an important role in ensuring safe care while managing the medication needs of older patients.

Additional reading at www.cmпа-acpm.ca

- Consent: A guide for Canadian physicians
- “Navigating the complexities when treating patients with Alzheimer’s disease and other dementias”
- “Long-term care: Quality decisions”

Other resources

- Canadian Deprescribing Network: www.deprescribingnetwork.ca
- The Canadian Geriatrics Society: www.canadiangeriatrics.ca

1. Peer experts refer to physicians retained by the parties in a legal action to interpret and provide their opinion on clinical, scientific, or technical issues surrounding the care provided. They are typically of similar training and experience as the physicians whose care they are reviewing.
limited healthcare resources: the difficult balancing act

Managing patient access to limited healthcare resources is a reality for Canadian physicians confronted with the dilemma of balancing a patient’s needs with available resources. Physicians are understandably concerned a patient may be harmed due to a delay in diagnosis or treatment. Many physicians fear medical-legal consequences if they are unable to meet established wait time benchmarks owing to resource constraints, and are wary of complaints potentially made to their regulatory authority (College).

The CMPA hears doctors’ frustrations and anxieties. “When members reach out to us for advice relating to their practice, a recurring theme that underlies members’ concerns is the feeling of being unable to provide the level of care they would consider to be ideal or at least suitable,” says Dr. Todd Watkins, Managing Director of Physician Services at the CMPA. “Knowing the constraints the health system is under, and the difficulties physicians often encounter in trying to fix these problems, is stressful for everyone involved.”

What the courts have said
The few legal cases touching on these issues signal that the courts are willing to consider the resources available to physicians when assessing whether the standard of care was met. The courts have stated that an assessment of a physician’s clinical care is not based on a standard of perfection, but rather on the standard of care that might reasonably be applied by a colleague in similar circumstances.
A court in Ontario, for example, has stated that “…a doctor cannot reasonably be expected to provide care which is unavailable or impracticable due to the scarcity of resources.”

Nevertheless, a physician is expected, within those resource constraints, to do the best he or she can for patients, and to act reasonably in such circumstances.

**Cost Containment or Lack of Resources: An Important Difference**

The courts have been critical of conscious decisions by physicians not to offer tests or treatments simply to contain costs. This is differentiated from situations in which a physician simply cannot provide the treatment due to a lack of resources. “While physicians have an obligation to use healthcare resources prudently, the courts have confirmed that use of appropriate testing should not be limited by cost,” says Dr. Watkins. He also notes that, while physicians should place the best interests of patients first when choosing tests and treatments, they should use resources judiciously and need not overuse them as a way of avoiding possible medical-legal difficulties.

The Choosing Wisely Canada (CWC) campaign offers recommendations and resources to help spur conversations about unnecessary tests and treatments that consume valuable time and resources. The CWC recommendations may not be applicable in all cases, and so physicians may choose to refer to relevant clinical practice guidelines to assist in decision-making and appropriate care in specific circumstances.

**Ethical and Professional Duties**

A further consideration in dealing with the complexities posed by scarce resources is physicians’ ethical and professional duties to their patients. The Canadian Medical Association’s (CMA) Code of Ethics underscores the fine line physicians walk on this issue. The Code asks physicians to “consider first the well-being of the patient” but it also asks them to “use healthcare resources prudently.” The Québec Code of Ethics instructs a physician to “be judicious in his [her] use of the resources dedicated to healthcare,” while at the same time emphasizing that a “physician’s paramount duty is to protect and promote the well-being of the persons he [she] attends to…” These parallel obligations can sometimes be difficult to reconcile, and this is an ongoing and obvious source of frustration for physicians.

Hospitals, for their part, have their own duty of care toward patients. Canadian courts have confirmed a hospital has a responsibility to provide a “safe system” for patients. A hospital must, for instance, ensure systems are in place to coordinate personnel, facilities, equipment, and records so patients receive reasonable care.

Physicians have a role to play in health advocacy and are an important voice in an environment of scarce resources. They should be familiar with their institution’s and College’s policies and guidelines on their role in advocacy activities, and offer recommendations in a professional manner. Physicians in a hospital or institutional setting may face added complexities when advocating for resources that can optimally be applied equitably and fairly across their organization, including the need to navigate an organizational hierarchy or a committee process. The CMPA article, “The physician voice: When advocacy leads to change,” available on the CMPA website, offers guidance for physicians when advocating for a patient or for changes on a particular issue.

**The Bottom Line**

- When deciding whether to use an available, albeit limited, healthcare resource, you should rely upon sound medical judgment and your patient’s best interests.
- The courts will not evaluate your decisions against a standard of perfection. Rather, your decisions will be evaluated in light of what a reasonable physician of similar training and experience would have done in similar circumstances.
- Inform patients when there are difficulties in accessing limited resources, and the steps you are taking to secure these resources. If alternatives are known and available, advise patients about them.
- When appropriate and using approaches consistent with your institution’s and College’s policies and guidelines, consider advocating for patients to resolve issues that arise when limited resources pose an impediment to safe patient care. Document any steps you have taken to attempt to resolve resource issues.

**Additional reading at www.cmpa-acpm.ca**

- “Accepting new patients: The key to effective practice management”
- “Being on call when resources are limited”
- “The physician voice: When advocacy leads to change”

1. Mathura v Scarborough General Hospital [1999] OJ No 47 at para 83 (Gen Div)
5. Baynham v Robertson (1993), 18 CCLT (2d) 15 (Ont Gen Div)
You can make a difference!
Seek nomination - 2019 CMPA Council elections

10 positions are scheduled for nomination and election

British Columbia and Yukon
1 position

Quebec
2 positions

Newfoundland and Labrador
1 position

Ontario
3 positions

New Brunswick
1 position

Alberta
1 position

Saskatchewan, Northwest Territories, and Nunavut
1 position

“Different experiences and perspectives are essential for effective governance.

I encourage my colleagues from all areas of medicine to seek nomination to CMPA Council.”

Dr. Debra E. Boyce
President

PATHS TO NOMINATION

Via the Nominating Committee (Closed)
The committee is reviewing submissions from interested nominees received by the October 25, 2018 deadline. It will release the slate of proposed candidates in the Report of the Nominating Committee on January 9, 2019. Stay tuned!

Via the CMPA membership (Deadline: FEBRUARY 13, 2019)
The date to seek nomination via the Nominating Committee has past. But you can still be nominated by members in your area!

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