Creating a culture of accountability promotes safe medical care

Unanticipated complicated airways: Are you ready?

Opioid therapy and your medical-legal questions

Accepting new patients: What to consider

Report on the 2018 CMPA Annual Meeting
from the CEO

At the CMPA, I have the privilege of hearing from physicians across Canada every day, and listening to you with the intent of helping. What I’m hearing is that many of you are tired, upset, and burning out.

Stories of burnout and distress concern me. I worry about the effects of burnout on your personal lives. The work you do should not be leaving you with feelings of exhaustion, frustration, and low morale. I also worry about the system-wide impact of what’s happening. Burnout significantly affects medical-legal risk, quality of care, and financial sustainability. When physicians are unwell, the entire system suffers.

We know there are multiple causes of physician burnout. Heavy workloads, increased administrative demands, growing public criticism, and inadequate institutional support can all play a role. Because there is no single factor leading to burnout, there is no single solution.

What we need instead is a collective response. At this year’s CMPA Annual Meeting and Information Session, I called on stakeholders across the healthcare system to respond to physician burnout and support wellness. I believe that medical schools, hospitals, medical regulators, and medical associations across Canada should be creating environments that promote inclusion and caring, and allow you to thrive.

The CMPA provides considerable support to physicians facing the stress of College complaints and medical-legal issues, and I encourage you to talk to one of our physician advisors if you need assistance.

I also want you to know that we are actively working with other stakeholders to promote physician wellness. As a mutual defence organization, we have long recognized that we’re all better off when each of us is well. I look forward to hearing from more of you as we strive to create a better healthcare system that enables you to flourish.

Hartley Stern
MD, FRCSC, FACS, ICD.D
The unanticipated complicated airway: Are you ready?

Read about the three areas of risk the CMPA found in an analysis of its medical-legal cases that involved rare, serious complications in airway management.

Accepting new patients: The key to effective practice management

Accepting and refusing new patients is part of managing a primary care practice. Learn what you should keep in mind when considering whether to take on new patients.

2018 CMPA Annual Meeting summary

At its 2018 annual meeting, the CMPA affirmed its commitment to protecting Canadian physicians’ professional integrity, while using innovation to adapt to members’ changing needs.

The medical-legal risks of opioid therapy: Questions from members

Members are asking for medical-legal advice around prescribing opioids. Find out what your peers’ most pressing concerns have been and how the CMPA has responded.

Creating a culture of accountability promotes safe medical care

Are you a physician leader working to promote safe care in your healthcare organization? Learn how fostering a culture of accountability can help.

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CMPA PERSPECTIVE, September 2018, VOL. 10 NO. 3, P1803E

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SAFE CARE

the unanticipated complicated airway: are you ready?

OUT OF
9,000+ closed civil legal cases (2008–2017)

45 focused on difficulties securing an airway

Peer experts were critical of the care provided in 35 of the 45 cases

IN 25 of the 35 cases where physicians did not meet the standard of care, the patient outcome was serious brain injury or death
Airway management is an advanced technical skill that many physicians are proficient in—but when things don’t go as planned, this can be harmful for the patient and stressful for the team. The CMPA took a close look at legal cases involving rare, serious complications in airway management in all age groups and found that lost situational awareness, inadequate preparation, and poorly coordinated teams were underlying themes.

**The CMPA legal cases**

While the CMPA closed over 9,000 civil legal cases between 2008 and 2017, only 45 cases focused on difficulties securing an airway. Most of the time (35 cases) peer experts in the legal cases were critical of the care provided and in 25 of these cases in which a physician did not meet the standard of care, the patient outcome was serious brain injury or death.

Nearly all care with peer expert criticism occurred in hospital, often in the intensive care unit (ICU) (13 cases) or emergency department (6 cases). Care was in the operating room (OR) for 14 cases. The most commonly involved specialties were anaesthesia, emergency medicine, pediatrics/neonatology, and internal medicine. Esophageal intubations and post-extubation incidents were common among the 35 cases with criticism.

**What factors contributed?**

**Situational awareness**

Situational awareness is about knowing what is going on around you. It involves getting information, understanding it, and thinking ahead. In the following case an anesthesiologist had good situational awareness during an unfortunate, rare complication.

**Case example: Rapid response to a complicated extubation**

An obese, elderly man with a history of asthma undergoes bronchoscopy to investigate a lung mass. In the postanaesthesia care unit, an anesthesiologist extubates the patient, but soon afterward the patient’s oxygen saturation decreases. The physician suspects a bronchospasm and re-intubates.

Within seconds, he notes absence of air entry and queries esophageal intubation. He re-intubates a second time and confirms proper tube positioning. Still the physician notes that oxygen saturation is not improving and the patient’s abdomen is distended. He inserts a nasogastric tube, but the patient becomes bradycardic. The surgical team begins resuscitation—including emergency bilateral percutaneous needle thoracentesis and chest tube insertion—but they are unsuccessful. Following autopsy, the patient’s death is attributed to cardiovascular collapse due to tension pneumoperitoneum secondary to an acute gastric rupture, a rare event associated with emergency assisted ventilation.

Ultimately, all parties consented to dismiss the case and there was no criticism of care. Peer experts opined that the physician’s documented pre-surgical evaluation met the standard of care. They also acknowledged the quick speed at which the physician recognized and responded to the esophageal intubation and distended abdomen.

In contract, other CMPA legal cases showed evidence of “Tunneling” or focusing attention on one aspect of a procedure while other aspects were ignored (2) such as the elapsed time. Peer expert opinions in the CMPA cases suggested a common theme (as follows):

- When managing an airway, seek signs of problems early; recognize and react in a timely manner. In an airway emergency, ask a team member to alert you of key time intervals.

**Preparation**

The following case demonstrates the importance of preparing for airway complications from a provider, team, and system perspective.

**Case example: An esophageal intubation goes undetected**

A child is in the ICU with severe head trauma, awaiting transfer to another centre. An anesthesiologist plans an elective intubation, for transfer. He notes that the saturation monitor is malfunctioning, but proceeds to intubate using a video laryngoscope. Soon afterward, he realizes the end-tidal CO₂ monitor is unavailable and requests an urgent chest X-ray. The physician tries to confirm placement with auscultation and finds decreased air entry on the right side; he queries pneumothorax.

He attempts to access the X-ray images, but nobody in the room knows the computer password. Rapidly recognizing that the patient has no pulse, the team begins resuscitation.

Once gaining computer access, they confirm esophageal intubation on the X-ray. The physician immediately and easily re-intubates. The patient dies several days later from complications secondary to cerebral anoxia.

The peer experts commenting on this case in the legal action suggested that a lack of team and system readiness contributed to the outcome. Since this was an elective intubation, there was opportunity for a pre-procedure huddle to confirm that a CO₂ monitor and a functional SaO₂ monitor were available. In the end, the CMPA paid a settlement on behalf of the anesthesiologist.

Among CMPA legal cases, peer expert opinions were consistent with the following risk reduction strategy:

- When possible before airway management, verify with team members that critical equipment is available (e.g. using a checklist) and be familiar with the contents of the airway cart. Flag and report any missing or malfunctioning equipment to the stocking team and appropriate management, if possible.
Team coordination and communication

Airway management remote from the OR can be particularly challenging since it often involves ad hoc teams.3

Case example: An unexpected, difficult extubation in the ICU

A middle-aged woman, injured in a motor vehicle collision, suffers a C1-C2 subluxation injury. She undergoes surgical repair and wears a cervical spine collar post-operatively. Two days later during ICU morning rounds, the attending intensivist (a respirologist) asks a respiratory therapist to extubate the patient given her successful weaning protocol, but is unaware that her blood hemoglobin dropped significantly overnight. The respirologist leaves the hospital. When the respiratory therapist extubates the patient, she immediately notes the patient struggling to breathe and attempts manual bag-mask ventilation. Minutes later the patient is non-responsive. The respiratory therapist, with limited experience performing emergency re-intubations, pages medical staff for help. A general surgery resident and anesthesiologist arrive, repeatedly attempt to manage the airway and intubate, and eventually perform an emergency cricothyroidotomy. The patient suffers hypoxic brain injury from upper airway obstruction and dies several days later.

In this case, the CMPA (on behalf of the member respirologist) and the hospital paid a joint settlement to the patient’s family.

This case demonstrates lack of critical information sharing across the team. Peer experts criticized the physician’s decision to extubate when the patient’s hemoglobin had dropped, although she insisted the message was not relayed to her during rounds. Furthermore, a positive air leak test (suggesting readiness for extubation) was undocumented because it was hospital policy to document only failed leak tests. This policy led experts on the legal case to believe that the test was not done.

This case also highlights supervision issues. Experts felt the physician should have anticipated airway obstruction, given the patient’s neck surgery, and therefore ensured that experienced personnel were present for extubation. Notably, residents were involved in nearly one-third of CMPA airway civil legal cases with criticism, but rarely were they found to be ultimately responsible for the outcome. Peer experts noted resident deficiencies in performing intubation, delays or failures in recognizing or acting on complications, and delays in seeking help. Assessing resident competence and appropriate supervision are crucial for safe airway management. The following risk reduction strategies are consistent with peer expert opinions in the CMPA cases:

- In non-emergency airway situations, conduct and document a comprehensive airway assessment, and seek markers for a difficult airway (e.g. history of difficult airway).
- In emergency airway situations, conduct a rapid airway assessment and anticipate how to manage complications.
- When intubation is difficult, or repeated attempts are unsuccessful, promptly consult a colleague for help. Closely supervise less experienced team members.
- Prior to extubation, consider using strategies, such as a team huddle, to reach consensus that timing is appropriate for the patient and the team is ready.

The bottom line

Despite technological advancements, ultimately “hands, brains, and voices” determine patient safety. To manage your medical-legal risk during airway management:

- Engage in strategies to acquire, maintain, and recover situational awareness.
- Prepare for difficult airways from a provider, team, and system perspective.
- Practise team communication strategies and coordination methods to facilitate safe airway management.

Additional reading at www cmpa-acpm.ca

- “Thinking ahead: The value of situational awareness”
- “Why good documentation matters”
- CMPA Good Practices Guide, see the sections “Team communication” and “Situational awareness”

Other resources

- A video by the National Health Service Institute for Innovation and Improvement re-enacting the Elaine Bromiley case: “A routine operation.” Available at http://patientsafety.health.org.uk/resources/just-operation-human-factors-patient-safety

1. Events occurred between 1998 and 2013
Are you a senior hospital leader, department or division head, academic program director, or aspiring leader?

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creating a culture of accountability promotes safe medical care

A patient undergoing a carotid angiogram is injected with isopropyl alcohol instead of contrast medium. She suffers a massive stroke and dies.

Consider three different possibilities that could have led to the same event:

**Scenario 1**
The radiology technologist pours the wrong solution into the sterile steel container on the procedure tray because the isopropyl alcohol and contrast bottles look similar and are kept side by side on the storage shelf.

**Scenario 2**
Although the procedure calls for it, the radiologist and technologist do not take the time to confirm that the correct solution is being used, because this is the third case of the day and the others went well.

**Scenario 3**
Despite the technologist’s reminder to complete a pre-procedure checklist, the radiologist, who is rushed, refuses to verify with the technologist that she is using the correct solution.

As a physician leader, how would you respond to each of these situations?

Just culture and civil liability
This article supports physician leaders in creating a positive workplace culture in which patient safety incidents are reported and disclosed, and where organizations promote learning from past events to improve care. It suggests an approach to manage behaviour that enables delivery of safe medical care. The suggested approach does not, however, assume the determination of civil liability in which a defined set of legal principles is applied.
Culture rooted in values

A culture of accountability results from the consistent application of the just culture model. It is characterized by “a values-supportive system of shared accountability where organizations are accountable for the systems they have designed and for responding to the behaviours of their employees in a fair and just manner. Employees [and others in the workplace including physicians], in turn, are accountable for the quality of their behavioural choices and for reporting both errors and systems vulnerabilities.”

To create and support a culture of accountability, leaders must clearly articulate their organization’s mission and its values. Having a clear understanding of their organization’s values allows healthcare providers to embody and protect those values through their behavioural choices, and provides a foundation for any needed interventions by the organization’s leaders.

When facing undesirable behaviours among the healthcare team, leaders can take a punitive approach, often based on the severity of the outcome, or a blame-free approach where individuals are not held to account for their behaviours owing to systemic issues. When championing a culture of accountability, leaders will want to strike a balance between the two approaches.

Understanding human fallibility

Human beings have been described as an “inherently self-serving, occasionally altruistic, happiness-seeking, inescapably fallible pack animals, blessed (or cursed) with free will and a mis-tuned ability to see and avoid hazards in the world around us.” For the physician leader, reflecting on and accepting this statement creates the foundation on which a culture of accountability can be built. That culture enables lessons to be learned following patient safety incidents and near misses, and allows highly reliable clinical outcomes to be achieved.

To create a culture where everyone on the team is accountable and open to learning, healthcare leaders and providers alike must begin by acknowledging human fallibility. Building and nurturing teams that are accountable and engaged, and can identify and fix problems before harm occurs, requires leaders to accept five universal tenets:

1. To err is human.
2. To drift is human.
3. Risk is everywhere.
4. We manage in support of our values.
5. We are all accountable.

Defining organizational missions, values

A mission is the organization’s reason for being (e.g. provision of safe medical care), while its values are the guiding principles that help it achieve its mission. Values convey to healthcare providers what is important to an organization as it serves its mission.
Within a culture of accountability, three types of human behaviour are recognized as affecting the ability of providers to fulfill their duties in support of their organization’s mission: human error, at-risk behaviour, and reckless behaviour. Leaders must use appropriate interventions to promote behavioural choices that reflect the organization’s values.

■ Human error
In the context of fostering a culture of accountability, human error is an unintended action which is, by definition, inevitable and unintentional. Consequently, the appropriate response from leaders when human errors occur is to accept them and to console the healthcare provider who made the mistake. Accepting errors, however, does not preclude the organization from learning from events to identify ways of reducing the risk of recurrences.

■ At-risk behaviour
Healthcare providers typically receive training about the rules and procedures set by their organizations. But over time, as they acquire competence and learn to cope with increasing demands and pressures of clinical practice, individuals inevitably develop shortcuts, workarounds, and heuristics in their daily tasks. Thus, the provider drifts from accepted behaviours into more dangerous patterns that he or she regards as being more efficient but that are still within the spectrum of what may be considered safe. Behavioural drift (e.g. using a clean, rather than a sterile technique for a minor procedure) is a normal aspect of human behaviour. It is an unconscious choice to deviate from training, stemming from a lack of perception of risk or a mistaken belief that the risk is justifiable. As providers become more comfortable with their tasks, drift is further reinforced by the fact that any resulting harm is relatively rare, thus obscuring the link between drift and potential harm.

Drift is considered to be at-risk behaviour. Within a culture of accountability, it is generally recognized that behavioural drift is the single greatest threat to patient safety, owing to its unconscious nature and to its pervasiveness in everyday practice.

For healthcare leaders who have identified occasional at-risk behaviour, an appropriate intervention is to coach the healthcare provider back toward safe practice. Coaching is a positive discussion that may include pointing out the drift, reminding the provider of the risks, and redirecting the provider’s choices toward accepted policies and procedures. Repeated at-risk behaviour can be managed by evaluating performance-shaping factors at both the provider and system levels. Disciplinary action can be considered when coaching and modification of performance shaping factors have been exhausted.

One of the biggest challenges in managing at-risk behaviour occurs when drift is identified but no patient safety incident or near miss has resulted. Many leaders in this circumstance adopt a “no harm, no foul” approach and fail to provide the necessary coaching. This approach, however, represents a missed opportunity for learning and ultimately imperils a culture of accountability by tacitly reinforcing drift. Leaders should instead strive to coach as many episodes of drift as reasonably possible, whether or not these incidents result in adverse outcomes.

■ Reckless behaviour
Reckless behaviour represents intentional risk-taking. It is a conscious disregard to act without regard to a known, substantial, and unjustifiable risk. While often egregious, this type of behaviour is rare and thus poses a lesser threat to overall patient safety in the healthcare system.

Regardless of whether or not a patient safety incident or near miss occurred, the appropriate management response to confirmed reckless behaviour is to take action with the individual care provider. Before determining a course of action, leaders should first consider all the facts and circumstances of the case. There may be situations, for example, where the social benefit of a conscious choice to deviate from a procedure would justify an otherwise reckless behaviour. Factors such as insight, cooperation, and commitment to change are often relevant to the severity of the chosen intervention.

Addressing recurring undesirable behaviours
When an individual repeatedly makes errors or exhibits recurring at-risk or reckless behaviours, these may be symptoms of broader system or provider issues. Leaders in these circumstances may want to identify and help to address these performance-shaping factors which may be compromising the delivery of safe medical care.
**What the case scenarios can teach us**

After the radiologist promptly discloses the patient safety incident to the family, the hospital initiates an accountability review.

**Scenario 1** is most likely to be a human error. The technician is consoled and a search for contributing factors leads to changes in bottle storage and labelling.

**Scenario 2** in most cases represents at-risk behaviour. The radiologist and technologist are coached about drift and the fact that their choice to not verify the solutions represents drift from an established policy. They are reminded of the reason for, and importance of, following procedures.

**Scenario 3** is an example of reckless behaviour by the radiologist. The chief of diagnostic imaging initiates an investigation into the incident which helps inform the hospital’s accountability review. The chief meets with the radiologist to discuss potential sanctions and to set clear expectations for future performance. The chief also discusses the matter with the technologist, who is coached about the importance of speaking up and stopping the line when required. The hospital provides training for the team to promote psychological safety in the radiology suite.

**THE BOTTOM LINE**

A culture of accountability seizes opportunities for learning from otherwise undesirable behaviours. When leaders identify the causes of human error and at-risk and reckless behaviours, use appropriate behavioural interventions and modify processes when needed, the organization’s learning system is strengthened and team members become more engaged. The result is a reliable healthcare system that supports safe medical care.

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Additional reading at www.cmpa-acpm.ca

- “How physician leaders can nurture teams that provide highly reliable healthcare”

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As a CMPA Councillor, I use my knowledge and experience to **protect** and **support** the diverse needs of physicians across the country.

**Join me on Council**

Read more about the 2019 nominations and election process on the Association’s website, www.cmpa-acpm.ca, or contact the Association via email at elections@cmpa.org.

www.cmpa-acpm.ca/election
Canada’s opioid crisis is having a significant impact on the healthcare system, with serious implications for patients, their families, and healthcare providers. Managing the care of patients on high-dose or long-term opioid therapy for chronic non-cancer pain is complex. And, the Canadian Institute for Health Information estimates that 25% and 17% of patients prescribed these drugs fall into these 2 categories, respectively. This context calls for a strategic, patient-centered approach that incorporates guidelines, validated tools, provincial and territorial resources, as well as support from a multidisciplinary team. Regulatory authorities (Colleges) are also offering guidance and direction. The situation is also challenging for CMPA members, who then seek medical-legal advice from the CMPA.

The CMPA analyzed 1,989 member telephone calls received between 2012 and 2017. The purpose was to identify the most commonly discussed medical-legal themes related to opioid management for patients in the community whose chronic non-cancer pain was already being managed by these drugs.

Unsurprisingly, over 85% of calls came from family physicians. Members called most often about the medical-legal risks they may face when attempting to effectively manage pain while minimizing opioid use or when dealing with aberrant drug-related behaviours. Physicians frequently called the Association with concerns that they might receive a College complaint related to opioid management or be subject to a potential investigation or restrictions on their opioid prescribing. Other common questions concerned their duty to report in a variety of situations related to opioid use and prescribing, and their duty to accept new patients on long-term opioid therapy, including when taking over another physician’s practice.

Reflecting an improved understanding of the risks and benefits of opioid therapy, clinical practice guidelines such as the Guideline for opioid therapy and chronic noncancer pain support appropriate prescribing to reduce associated harms. Additionally, some regulatory authorities (Colleges) have issued policies to guide physicians in prescribing opioids safely.
Questions on opioid tapering and alternatives

Physicians most often called the Association with questions on their medical-legal risks in managing the care of patients taking opioids for chronic non-cancer pain conditions in light of recent guidelines. Members’ concerns included: questioning the appropriateness of continuing to prescribe opioids to patients who are not responding to non-opioid alternatives; reconciling high-dose opioid regimens or other medications (e.g. benzodiazepines) with regulatory guidelines; and working with patients reluctant to accept referrals to pain management physicians or other specialists, or having difficulty accessing these specialists.

While the CMPA cannot advise on clinical standards of care, tapering too rapidly can result in a range of withdrawal symptoms. Reflecting this, the Association received many calls from physicians who expressed concerns about patients experiencing withdrawal when patients reported running out of or losing their medication, or when the member decided to stop prescribing opioids.

Pharmacists can help physicians decide on a tapering schedule or rotation of opioids. They can also provide patients with additional resources, counselling, and follow-up. When tapering, physicians should be familiar with titration protocols and consult addiction specialists for advice when needed. As outlined in recommendation 10 of the Guideline for opioid therapy and chronic noncancer pain, some patients may require a formal multidisciplinary program.

Concerns about aberrant drug-related behaviours

Aberrant drug-related behaviours refer to behaviours that may signal misuse. Such behaviours can be particularly challenging for physicians. The most common behaviours that prompted member calls were: co-occurring alcohol abuse or use of illicit drugs or other unprescribed medications; threatening or coercive behaviour aimed at getting physicians to refill prescriptions early or increase opioid dosage; and illegal activity around obtaining or profiting from opioid prescriptions, including diversion of medication and forgery of prescriptions.

Interestingly, in some cases, members described patients’ family members or spouses displaying problematic behaviour when attending patient appointments or contacting the physicians’ offices. Many physicians observed this behaviour in the context of family members advocating for improved management of their loved one’s pain or, conversely, criticizing the physician for what they perceived as excessive prescribing; rarely members saw disruptive behaviour on the part of family members as a possible indication of diversion.

Members involved in these situations were typically concerned about how to navigate the physician-patient relationship. While these situations can be difficult to manage, physicians should consider whether it is possible to continue to provide appropriate care and not be intimidated into providing treatments they do not believe are in the patient’s best interest.
Physicians are encouraged to explore conflict resolution strategies where possible before ending the physician-patient relationship. All decisions to end the physician-patient relationship should follow applicable current College guidelines.

Physicians can also contact the CMPA for additional resources and assistance on dealing with challenging behaviour. Some Colleges also offer mentoring programs that match family physicians with consultant physicians in addiction and pain management.

**CONCERNS ABOUT RECEIVING COMPLAINTS**

Members often sought advice on how to avoid patient complaints after they decided to stop prescribing opioids, or when they planned to taper and wean patients off their medications. Another scenario in which physicians expressed concern about receiving a complaint was when family members expressed concerns about a physician over-prescribing or failing to prescribe opioids.

Clear and compassionate communication with patients and families can go a long way in minimizing the risk of a patient complaint. It is also important to document all discussions and treatment decisions in the medical record. Being familiar with College guidance on opioid discontinuance can help guide decision-making when faced with a need to revisit the care plan.

**QUESTIONS ON REPORTING VERSUS ETHICAL, PROFESSIONAL OBLIGATIONS**

Questions surrounding the duty to report in the context of opioid use was another common source of calls. These questions most often concerned reporting suspected opioid abuse or illicit drug use to motor vehicle licensing authorities, child protective services, or professional regulatory authorities. Questions also concerned reporting suspected illegal activities, such as diversion or prescription fraud, to police. Members also called when they were contemplating reporting troubling opioid prescribing practices of other physicians to their College.

Physicians should be familiar with College policies and guidelines on reporting, as well as the relevant provincial or territorial legislation. The regularly updated *CMA Driver’s Guide* is a helpful resource for evaluating the potential effects of patients’ medication use on their driving capability. Members should call the CMPA if they are uncertain about their duty to report.

**QUESTIONS FROM PHYSICIANS TAKING OVER THE CARE OF PATIENTS**

Over one-third of calls came from members in their first 10 years of practice. Many of these calls were from recently graduated or other physicians assuming new practices with patients who were receiving high-dose or long-term opioid therapy. Others sought advice on their medical-legal risks associated with accepting new patients taking these medications. Some locum physicians struggled with situations in which they disagreed or were uncomfortable with the current opioid prescriptions of the physician for whom they were covering.

Physicians should be aware that many College policies now state that physicians cannot decline to accept new patients solely due to opioid use. When meeting with prospective patients who are on opioid therapy, physicians should discuss the current chronic pain management guidelines, as well as their own approach to treating chronic pain. They should revisit the goals of opioid treatment, and also assess these patients’ pain, function, and risk for opioid misuse. Working with colleagues and relevant specialists is helpful for optimally managing the care of patients on long-term opioid therapy, including reduction strategies.

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**THE BOTTOM LINE**

Effectively managing chronic non-cancer pain and opioid therapy is complex. It requires patient-centered, compassionate care. Comprehensive guidelines, provincial programs (such as opioid monitoring systems), and guidance from Colleges support safer practice in this area. Members are encouraged to call the Association with medical-legal questions or concerns related to opioid management.

New obstetrics report from CMPA and HIROC

The recently published report, *Delivery in Focus: Strengthening obstetrical care in Canada*, is the result of a review of 10 years of CMPA and HIROC data. The key findings of the report include high-risk areas, contributing factors to obstetrical incidents, and strategies to strengthen the quality and safety of obstetrical care in Canada.

**Opioid contracts**
Opioid contracts, meant to be a useful tool in providing patients and physicians with clarity around opioid management, emerged as a distinct issue in calls to the CMPA. The most frequently asked questions related to the following:

- patients refusing to sign an opioid contract
- physicians seeking support in decision-making related to contract enforcement or offering second chances when patients breached the contract
- physicians wanting to stop prescribing opioids or terminate the doctor-patient relationship when contracts were breached

According to guidelines, these contracts or agreements often include clear descriptions of medication use and misuse, as well as the consequences for violating the contract. These provisions can aid in decision-making if the contract is breached.

Additional reading at www.cmpa-acpm.ca

- “Opioids: We can do better”
- “When physicians feel bullied: Effective coping strategies”

Other resources


Available on the CMPA website
www.cmpa-acpm.ca
Timely access to physician care is a challenge for Canadians in many parts of the country, leaving physicians to make the sometimes-difficult decision about whether or not to accept new patients. Faced with already heavy workloads, physicians face the moral dilemma of possibly turning away people seeking care in order to maintain a sustainable and well-managed practice.

Indeed, many physicians—whether they are in primary care practice such as family physicians, or consultant physicians who typically only accept patients via referrals—encounter this challenge. Differences in how these two groups accept new patients reflect the different nature of the care provided, and in this article we focus on the former group—those in primary care practice.

While there are some variations, regulatory authority (College) policies on accepting new patients share many similar elements that are grounded in physicians’ ethical responsibilities. Physicians should be mindful of these elements when they receive a request for ongoing clinical care from an individual with whom there is no existing doctor-patient relationship, including:

- urgency and need
- scope of practice and clinical competence
- discrimination
- wait lists
WAIT LISTS AND PATIENTS’ FAMILY MEMBERS

If a physician is accepting new patients, the principle of first-come, first-served should generally apply for patients in a similar situation. This also means that prospective patients on a wait list should be accepted into a practice in the same order in which they were added to the list. When using a wait list, clearly communicating the expected waiting period to new prospective patients helps manage expectations and diffuse potential misunderstandings.

It is generally justified to accept into a practice members of existing patients’ families even when a physician is not otherwise accepting new patients. Caring for patients’ family members may provide a broader view of family history, which could contribute to better health outcomes.

URGENCY AND NEED

Physicians are generally not obligated to treat any individual seeking non-urgent or non-emergent care. That said, physicians who receive a request to accept a new patient should consider whether the individual requires emergency care. While providing emergency treatment does not necessarily imply the formation of an ongoing doctor-patient relationship, providing such care when needed is consistent with the CMA Code of Ethics, which advises physicians to “provide whatever assistance you can to any person with an urgent need for medical care.”

The Colleges offer guidance that is more specific in this area. The College of Physicians and Surgeons of British Columbia, for example, states that “in medically emergent or urgent situations, physicians are expected to provide whatever medical care is appropriate, taking into account the physician’s scope of practice and available options such as access to specialist consults.”

In some circumstances, it may be appropriate for physicians to prioritize access to care for individuals with greater needs or complex conditions. The College of Physicians and Surgeons of Ontario (CPSO) advises that physicians should use their professional judgment to determine whether prioritization based on need is appropriate, taking into account social factors that may influence the person’s health outcomes such as the individual’s housing, food security, employment, and income.

SCOPE OF PRACTICE AND CLINICAL COMPETENCE

Physicians accepting new patients should not refuse individuals solely due to the presence of a complex or chronic health problem or if an individual requires more time than another patient with fewer medical needs. Nevertheless, if the individual’s care needs are not within the physician’s scope of practice or clinical competence, this would generally be considered grounds for refusing a prospective patient.

DISCRIMINATION

Physicians are bound by the human rights legislation of their province or territory. As well, the CMA Code of Ethics states that in providing a medical service, providers are not to “discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status.” Nevertheless, “this does not abrogate the physician’s right to refuse to accept a patient for legitimate reasons.”

If refusing a prospective patient’s request, physicians should consider the impact of such a refusal on the patient. Some individuals may interpret a refusal as discrimination, even when this was not the physician’s intention. For this reason, it is important to clearly and respectfully communicate the reasons for a refusal to the individual making the request, thereby dispelling possible perceptions of discrimination.
In our introductory vignette, while the patient clearly needed to be followed by a physician, her immediate needs were not urgent. By placing her ahead of others on the wait list, other patients who had been waiting longer and those with more serious problems would be adversely affected. In this example, having determined the prospective patient’s needs and current situation, the best approach might have been to add her to the wait list on a first-come, first-served basis, or if possible to offer a referral to another physician.

The bottom line
▪ The decision to either accept or refuse a new patient should always be made in good faith and in keeping with your College’s policy on accepting new patients.
▪ Your decision may depend on such factors as whether your practice is accepting new patients and whether you are qualified to provide the care requested or expected to be needed.
▪ If you decide to not provide treatment or not accept a new patient to your practice, the decision should be made in non-emergency situations only and in a way that applies to all prospective patients equally.
▪ Discuss your decision to not accept a new patient with the individual respectfully and honestly, and document this in your files.

Physicians who are unsure about what to do when requested to provide treatment to an individual where there is no existing doctor-patient relationship may contact the CMPA for individual advice.

Additional reading at cmpa-acpm.ca
▪ “New to practice? Practical tips for physicians in the first 5 years”

2018 CMPA Annual Meeting

The 2018 CMPA Annual Meeting was held in Winnipeg on August 22. In his address, CMPA President Dr. Jean-Joseph Condé took stock of the environment facing the Association and its almost 100,000 physician members.

Dr. Condé noted that new practice arrangements, new technologies, and new roles for other healthcare professionals are changing what’s needed from medical liability protection. Within this challenging environment, the CMPA remains committed to its core goal of protecting Canadian physicians. At the same time, the CMPA is offering innovative services—such as the Member Support Program and those provided by Saegis—to ensure the Association continues to evolve and adapt in response to members’ needs.

In 2017, the CMPA had more than 445,000 member interactions. Over 72,000 of these interactions were medical-legal in nature. The number of College (5,235) and hospital matters (1,675) opened in 2017 represented increases of 88% and 66% since 2008, confirming the growing pressures faced by physicians. The CMPA also provided 127 submissions and engagements aimed at influencing public policy, and held 295 continuing professional development sessions reaching over 17,000 attendees.

Dr. Hartley Stern, CMPA Executive Director and Chief Executive Officer, discussed the CMPA’s commitment to excellent member service. Dr. Stern noted that, in 2017, the CMPA had increased the number of physician advisors available to assist members, and had begun revisions to the popular Good Practices Guide. He also discussed plans to invest in technology to improve access to the Association’s online services and resources. These and other changes are being made to ensure that members’ experience with the CMPA is the best it can possibly be.

2017 Financial report
As a not-for-profit organization, the CMPA’s long-term financial objective is to hold at least one dollar of assets for each dollar of discounted liabilities. A fully funded position provides members with the confidence that their medical liability interests and those of their patients will be met.

At the end of 2017, the CMPA’s total assets were 115% of the total estimated liabilities, producing a positive financial position of $641 million. This is a marked improvement from the end 2014 position of a $360 million deficit. This improvement can be attributed, in part, to better-than-forecast investment performance and a relatively modest increase in the provision for unpaid claims. The improvement has also resulted from increases to membership fees aimed at reducing that temporary deficit. With the improvement in the financial position, these adjustments can largely be removed.

Member motion
There were no new member motions at this year’s annual meeting. The 2017 motion concerning term limits for council members is under review. An update will be provided at the 2019 CMPA Annual Meeting in Toronto.

Information session—Healthier Physicians: An Investment in Safe Medical Care
As Canada’s largest physician organization, the CMPA understands the critical importance of physician wellness, and this year’s information session was dedicated to the subject. Dr. Pamela Eisener-Parsche, Director of Physician Services, CMPA, moderated an expert panel featuring Dr. Carol-anne Moulton, Associate Professor, University of Toronto; Dr. Scott McLeod, Registrar, College of Physicians & Surgeons of Alberta; and Dr. Hartley Stern, Executive Director/CEO, CMPA.

Speakers stressed the need for a collective, coordinated response to this system-wide issue. The CMPA also released a number of recommendations outlining ways in which major Canadian healthcare stakeholders could address physician wellness. Webcasts of the annual meeting and information session, as well as supporting materials, are available at www.cmpa-acpm.ca.

Council elections
Eleven positions on CMPA Council were scheduled for election in 2018. See the back cover for results and acclamations.
### CMPA Council elections 2018

#### Results of CMPA Council elections

In 2018, 11 positions were scheduled for nomination and election to the CMPA Council. The election results are as follows:

- **British Columbia and Yukon**
  - Dr. Michael Curry  
    - Acclaimed
  - Dr. J. David R. Naysmith  
    - Re-elected

- **Saskatchewan, Northwest Territories, and Nunavut**
  - Dr. Susan L. Hayton  
    - Acclaimed

- **Manitoba**
  - Dr. Darcy E. Johnson  
    - Re-elected

- **Ontario**
  - Dr. Robert Cooper  
    - Acclaimed
  - Dr. Alexander C. Barron  
    - Re-elected
  - Dr. Gerard P. Craigen  
    - Re-elected
  - Dr. Gordon A. Crawford  
    - Re-elected

- **Québec**
  - Dr. Jean-Hugues Brossard  
    - Re-elected
  - Dr. Yvonne Molgat  
    - Elected
  - Dr. Patrick Trudeau  
    - Elected

### Meet your new members of council

- **Dr. Michael Curry** from Vancouver, British Columbia, is an emergency physician and was formerly the Electives Director and Year 4 Chair for the MD Undergraduate Program at the University of British Columbia.

- **Dr. Yvonne Molgat** from Québec City, Québec, is an ophthalmologist in full-time academic subspecialty surgical practice at CHU de Québec-Université Laval and is a professor at the Faculté de médecine at Université Laval.

- **Dr. Patrick Trudeau** from Chicoutimi, Québec, is a general surgeon at the Clinique de chirurgie du Saguenay and is a clinical professor at Université de Sherbrooke and Université de Montréal.

### Council’s leadership team

- **CMPA President**  
  Dr. Debra E. Boyce, a family physician from Peterborough, Ontario

- **1st Vice-President**  
  Dr. Michael T. Cohen, a general practitioner from Grand Falls-Windsor, Newfoundland

- **2nd Vice-President**  
  Dr. Jean-Hugues Brossard, an endocrinologist from Montreal, Quebec

A list of all members of council is available on the CMPA website [www.cmpa-acpm.ca](http://www.cmpa-acpm.ca)