Perspective

Team debriefs: Participate and minimize your medical-legal risks

Addressing pitfalls in detecting colorectal cancer

Members ask about cannabis, CMPA answers

Improving the diagnosis of acute coronary syndrome

Disclosing harm: Advice for pathologists, radiologists
From the CEO

Evolving to better meet your needs

This issue of CMPA Perspective marks a milestone. Ten years ago the first issue of the CMPA’s risk management magazine arrived in members’ mailboxes.

During that decade, we have evolved the publication, growing it into the magazine you see now—a publication that is accessible in print and online, and is filled with advice and information to help you mitigate the medical-legal risks in your professional practice and deliver safe medical care.

I am proud of the progress of our magazine. It reflects CMPA’s commitment to listen to our members, and to adapt our products and services and how we deliver them.

This proactive and adaptive approach to meeting your needs is embedded in everything we do. Using insights gained from our medical-legal cases, our calls with members, and our strong network of safe care collaborators, we develop evidence-based articles, resources, and learning sessions aimed at helping you deal with the realities of daily practice. For example, we offer advice and assistance in dealing with College complaints, we raise awareness of emerging medical-legal issues such as artificial intelligence in medical practice, we both support policy development on issues such as medical assistance in dying legislation and provide relevant information to members, and we offer targeted advice to physicians, including those practising in high-risk specialties.

Our risk management information and support is available in many formats and channels. You can connect with a physician advisor by secure web mail or by phone. You can access our advice and resources online through our website and Good Practices Guide, and via the electronic eBulletin and printed Perspective. You can attend one of our education presentations or customized face-to-face workshops, and you can read about our research findings through papers published in peer-reviewed journals.

As medical practice and technology evolve, we will continue to identify new ways to meet your changing needs, explore digital options for our products and services such as Perspective, and expand our tailored safe medical care strategies.

Thank you to all members who regularly provide ideas and feedback on our products and services. With your input we can continue to develop innovative solutions to provide you the information and assistance you need, when you need it and how you need it—ultimately benefiting your practice, your patients, and the healthcare system.

Hartley Stern
MD, FRCSC, FACS, ICD.D
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TEAM DEBRIEFS: Participate and minimize your medical-legal risks
Debriefs can improve patient care, but some physicians shy away. Learn how you can participate and keep your risks low.

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Early detection of colorectal cancer can help save a patient’s life

Managing the cycle of ordering, receiving, reviewing, and communicating diagnostic investigations is an essential part of any clinical practice, and when this process breaks down, diagnostic delays or errors can result, putting patients at risk for harm.

This concern is especially true when it comes to improving survival rates for colorectal cancer. A delay in colorectal cancer diagnosis poses a risk that the disease will be identified only at a later stage, significantly reducing a patient’s likelihood of survival. According to the Canadian Cancer Society, the “five-year relative survival for colon cancer is estimated to be 92% for cancers diagnosed at stage I compared with only 11% for stage IV; five-year survival for rectal cancer is estimated to be 87% for stage I and 12% for stage IV.”

The CMPA’s analysis of 119 cases (43 legal actions, 71 College cases, and 5 hospital complaint cases) that closed between 2014-2018 involving a delayed diagnosis of colorectal cancer reveals that 74% resulted in an unfavourable medical-legal outcome (Figure 1). This means that the case was settled on behalf of the member, or resulted in a court judgment against the member, or had a finding by the College or hospital that the physician’s care fell below expectations. Recurring allegations in these cases include cognitive biases of physicians ordering tests, lack of robust test follow-up systems, and breakdowns in communicating with patients.

Figure 1. Distribution by medical-legal outcome of closed CMPA cases involving a delayed diagnosis of colorectal cancer, 2014-2018 (n=119).
CASE EXAMPLE
Changes in primary care provider leads to a missed cancer diagnosis

A woman in her 40s sees her new family physician for the first time. She requests a prescription renewal for a hemorrhoid cream that had been prescribed by her previous family physician for persistent rectal bleeding. She shares that she had been diagnosed with hemorrhoids and had recently undergone a barium enema, which was negative for colorectal cancer. While the new family physician does not perform a digital rectal exam, he renews the prescription and requests the patient’s records from the previous family physician. The medical record confirms normal results from the barium enema, and also shows that a follow-up colonoscopy had been recommended due to incomplete bowel imaging. Nevertheless, the new physician does not review the patient’s records and does not order the colonoscopy.

Months later, during a visit to an urgent care clinic, the patient is concerned about bright red blood and mucus in her stool. The urgent care physician orders a flexible sigmoidoscopy and a barium enema that ultimately reveal the presence of stage T2 adenocarcinoma in the rectum. The patient undergoes chemotherapy and radiation treatments, and files a legal action against the family physician, alleging a delay in diagnosis.

What the experts said
Experts were not supportive of the family physician’s care in this case, stating that he should have confirmed the presence of hemorrhoids sooner through a physical exam, and then pursued further investigations. They determined that had the delay in diagnosis not occurred, the cancer would have only required surgery, and not chemotherapy and radiation. The CMPA settled the case on behalf of the family physician.

Ordering tests
There are many points during test follow-up where process breakdowns can occur, including when deciding whether to order the test itself.

When presented with symptoms of blood in stool in an otherwise healthy young woman, and having been told that hemorrhoids had already been diagnosed, the experts reviewing the physician’s care in the case example found that he anchored to the diagnosis of hemorrhoids without having confirmed their presence himself. This could have been done through a digital rectal exam and other investigative methods, such as a sigmoidoscopy. (The predictive value of barium enema has been scrutinized as a diagnostic tool for colorectal cancer, as studies have found it to have a miss rate of 17% in detecting colorectal cancer.)

Anchoring—when one focuses “on one particular symptom, sign, or piece of information, or a particular diagnosis early in the diagnostic process and fail[s] to make any adjustments for other possibilities”—is a form of cognitive bias that can hinder or delay an accurate diagnosis. A delay or failure in the performance of a diagnostic test or therapeutic intervention was identified in 34 (29%) of the CMPA cases analyzed.

Risk reduction strategies
- When treating a new patient with a previous diagnosis, consider whether it is appropriate to reassess and confirm the diagnosis prior to providing treatment.
- In addition to performing a comprehensive history, consider whether it is appropriate to perform a physical exam. Be sure to review your new patients’ prior records.
- Re-evaluate the diagnosis when symptoms persist, where appropriate.

Receiving and reviewing test results
During the multiple phases of test follow-up, requisition forms can be lost, specimens can be mislabeled, and test results may not be returned, among other possible process breakdowns.

In the above case, the need for a follow-up colonoscopy was noted in the medical record, though this went unnoticed by the new family physician and was not communicated to him during the handover of patient records.

Screening programs—Understanding expectations
Cancer organizations across the country recommend administering specific screening tests to detect colon cancer. Although not mandatory, these recommendations may influence the standard of care that regulatory authorities (Colleges) and the courts would expect physicians to follow. If a patient safety incident is found to stem from a physician’s failure to follow accepted guidelines, this may be part of the evidence used to find the physician breached the standard of care.
Several cases in the CMPA analysis highlighted system failures, including lost or mislaid reports or results, mishandled diagnostic tests, and issues with administrative policies or procedures. These failures were identified in 16 cases (13%).

**RISK REDUCTION STRATEGIES**

- Review College policies to ensure compliance with expectations to employ an appropriate system for follow-up of test requisitions and results, including suspicious, indeterminate, or discrepant findings.
- When your patient changes to a new care provider while there are still pending tests that require follow-up, discuss with the patient how best to communicate this information to the new provider.
- Review your administrative office procedures to identify possible weaknesses in your test follow-up process.

**COMMUNICATION BREAKDOWN**

Patients may not follow through with diagnostic testing for many reasons, such as not understanding the need for the investigation, forgetting, being too busy, or feeling afraid of the findings.

In the above case, a communication breakdown occurred between the family physicians and the patient. The patient did not remember having been told by her previous physician that she would need a follow-up colonoscopy, so she did not mention it during the initial consultation with her new physician. As well, when having previously received treatment for hemorrhoids, the patient may not have understood why it was important for her new physician to conduct his own assessment and was therefore reluctant about it.

In the CMPA analysis, a communication breakdown between physicians was identified as a contributing factor in 11 cases (9%), while a communication breakdown between patients and their physicians was identified as a factor in 24 cases (20%).

**RISK REDUCTION STRATEGIES**

- Confirm that the patient understands the information you provide, and answer questions honestly and openly. If further testing is required, educate the patient on the necessary timelines and risks if the test is not performed.
- Communicate to the patient the purpose of each test ordered, including the need for more testing if appropriate. Recognize that uncomfortable tests may require you to do more follow-up.
- Document discussions with patients regarding test follow-up or further necessary testing. If a patient declines further testing, explore the patient’s concerns and document the conversation.

**THE BOTTOM LINE**

Based on the expert opinions in the cases reviewed, the suggested risk reduction strategies may be suitable in your practice. Consider also the following suggestions:

- Adopt strategies to identify and mitigate your cognitive biases.
- Consider ways to assess and improve your processes for following up on diagnostic testing.
- Communicate openly with patients to assess, and if necessary improve, their understanding of the importance of diagnostic testing and cancer screening.

**ADDITIONAL READING AT WWW.CMPA-ACPMA.CA**

- “Closing the loop on effective follow-up in clinical practice”
- “When common symptoms resemble rare and serious conditions”
- “Stop and think: Return visits offer another chance”

2. While based on a real case, some facts in this case scenario have been altered to protect patient and physician confidentiality.
Reported cannabis consumption is on the rise, with nearly 18% of Canadians over 15 years old reporting having used it in the months following legalization, up from 14% before legalization. The debut of cannabis edibles and extracts to the legalized market is anticipated to add a further layer of issues for physicians to be aware of. Consider talking to your patients about their medications and any cannabis products they may be consuming. Federal regulations set limits on the psychoactive content (THC) allowed in edibles and extracts, and stipulate how they may be marketed. For example, these products cannot contain nicotine, caffeine, or alcohol; must not be visually appealing to young people; and are to be sold in plain, child-resistant packaging.

The relatively small number of enquiries suggests that legalization of recreational cannabis has generally not created significant medical-legal difficulties for physicians. Requests in the past year for the CMPA’s advice on this matter have centered around four themes: reporting requirements, prescribing medical cannabis, privacy concerns, and the CMPA’s scope of medical-legal assistance.

Cannabis legalization in Canada, one year later:
Questions from members

When cannabis for recreational purposes became legal in Canada in 2018, the CMPA advised physicians about the expected impact of the new regulatory regime on their practices. We invited you, our members, to contact us with your questions about medical-legal issues arising from patients’ use of cannabis—whether for medical or recreational purposes.
In addition to any restrictions imposed by your College, you should also consider whether the telemedicine technology employed allows you to appropriately determine the quantity and period of use, as required to complete the medical document. You will need to assess whether you can determine from a remote location the appropriateness of cannabis as treatment for a particular patient. You will also need to ensure you comply with the licensure and regulatory requirements governing telemedicine.

You may also wish to be familiar with the CMPA’s assistance with telemedicine. For information, see the articles “Providing your professional opinion concerning patients outside Canada,” and “Treating non-residents.”

If you wish to enter into a business contract with a cannabis clinic, you should obtain the services of private legal counsel as this falls outside the scope of the CMPA’s assistance.

Completing documents for medical cannabis

How should I respond to a request for...

- a medical document needed to access cannabis for medical purposes from my patient?
- a referral from a cannabis clinic or to join a cannabis clinic?
- a telemedicine consultation concerning cannabis?

As a physician, you are under no obligation to pursue a treatment or provide a referral that you do not believe is medically indicated. It is appropriate to discuss with your patient the available options to treat their condition, including answering questions they may have regarding medical cannabis, if it is within your knowledge to do so. Colleges also generally prohibit ending the doctor-patient relationship solely because a patient requests medical cannabis or opts to consume cannabis for either medical or recreational purposes. Don’t forget to document these discussions in the medical record.

If you are planning to provide telemedicine consultations to complete medical documents for medical cannabis, you should consult your College requirements before doing so. Some Colleges expressly prohibit the use of telemedicine for this purpose. The requirements imposed by other Colleges concerning telemedicine generally may create additional hurdles for authorizing medical cannabis in this way.

In addition to any restrictions imposed by your College, you should also consider whether the telemedicine technology employed allows you to appropriately determine the quantity and period of use, as required to complete the medical document. You will need to assess whether you can determine from a remote location the appropriateness of cannabis as treatment for a particular patient. You will also need to ensure you comply with the licensure and regulatory requirements governing telemedicine.

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Documentation and release of personal health information

What should I do when...

- my patient asks that I do not document his cannabis use in the medical record?
- I receive a request for patient information from an insurance company?
- I receive a request from the police for the result of a blood test?

Physicians have a professional obligation to document relevant medical information in the patient’s medical record. Further, complete and accurate documentation is a key element of good patient care and essential in defending that care if it is later questioned. Being aware of and documenting an individual’s cannabis consumption may help to identify potential problems such as Cannabis Use Disorder that can arise from frequent consumption.

As a physician, you have an ethical and legal obligation to protect confidential patient information from disclosure—any exceptions are governed by law. You may disclose information in a medical record to a third party (such as police, lawyers, and insurance companies) only with the patient’s or substitute-decision maker’s consent, or when authorized by law.

For more information see the CMPA articles “Why good documentation matters” and “When to disclose confidential information.”
The bottom line

▪ The legal framework governing medical cannabis and the role of healthcare practitioners has not substantively changed following the legalization of recreational cannabis.

▪ If you choose to complete medical documents for medical cannabis, you are expected to comply with federal and provincial legislation and your College’s policies and guidelines, and possess the necessary knowledge to authorize cannabis as a treatment option.

▪ Disclose information about a patient’s use of cannabis to third parties only with the consent of the patient or where authorized by law.

Additional reading at www.cmpa-acpm.ca

▪ “Clearing the haze: How the legalization of recreational cannabis may affect your medical practice”

▪ “Medical cannabis: Considerations for Canadian doctors”

Suggested resources


▪ Ontario Medical Association—Cannabis Resource Centre (https://www.oma.org/sections/managing-your-practice/cannabis-resource-centre/)

1. The CMPA received 134 advice requests from members concerning cannabis between June 1, 2018 and March 31, 2019. This time period takes into account enquiries received in anticipation of the new legal framework.


6. For example, the College of Physicians and Surgeons of New Brunswick, College of Physicians and Surgeons of Nova Scotia, and College of Physicians and Surgeons of Prince Edward Island


Team debriefs: Participate and minimize your medical-legal risks

Debriefs can improve patient care, but need to be properly structured and focused on learning to reduce medical-legal risks for participants.

When leading CMPA workshops for physicians and their teams, Dr. Guylaine Lefebvre asks participants to describe how debriefs have improved their workplace culture and patient care. Some physicians recount their experiences, but others tell the director of CMPA’s Practice Improvement department they are reluctant to take part in debriefs because they worry the information shared may be used in a legal proceeding.

“They collectively recognize that if you can learn from cases, that’s good,” says Dr. Lefebvre. “However, they also worry about the legal implications.” Although these concerns are understandable, she says, they shouldn’t stop physicians from participating in debriefs.

In most instances, says Dr. Lefebvre, structured debriefs that focus on learning and improvement will help teams adapt, learn from each other, and improve communication. The resulting advantages for patient care should outweigh the risk of the information being misused or disclosed in legal proceedings.

In one instance, a physician told Dr. Lefebvre she had instituted routine debriefs after every delivery in the birthing unit. “This physician noticed an improvement in communication as people gained trust and confidence with each other,” says Dr. Lefebvre. “As the communication became routine, it became easier to talk about improvements when things didn’t go as smoothly as they’d wished.”

Patient safety incidents and debriefs

If a patient safety incident occurs, you should always discuss the incident with patients to inform them of the facts. Debriefs should never interfere with or replace these discussions. As a physician, you have an ethical, professional, and legal obligation to disclose patient safety incidents to your patients. The CMPA’s handbook, Disclosing harm from healthcare delivery: Open and honest communication with patients, provides guidance and good practices about physician communications with patients regarding the disclosure of harm.
What are debriefs?
Many in healthcare, including physicians, recognize debriefs as a valuable tool in improving the quality of patient care. These discussions are conducted by the involved healthcare professionals after critical clinical events or routinely after certain treatments and allow providers to analyze and learn from what occurred during care delivery. One author describes them as “opportunities for exploring and making sense of what happened during an event or experience, discussing what went well, and identifying what could be done to change, improve and do better next time.”

Debriefs differ from morbidity and mortality (M&M) rounds. M&M rounds are structured events where members of a department review cases more generically. Debriefs generally happen immediately after care delivery and include the providers directly involved in the care of the patient.

Two ways debrief information may be protected
Depending on how debriefs are set up and conducted, it is possible that some information shared during discussions may be protected from disclosure by quality assurance legislation or common law privilege.

While the criteria to qualify for quality assurance legislation is expressly set out in legislation, it must be emphasized that common law privilege is applied on a case-by-case basis with no advance guarantee of protection. Since common law protection is uncertain, it is important to know ahead what safeguards may be available and to consider whether it is necessary to structure and conduct debriefs to potentially benefit from the protection offered by quality assurance legislation or common law privilege.

How courts may consider requests to protect debrief information
In civil litigation, the general rule is that all relevant information is admissible as evidence, but a court may rule that information shared during a debrief is protected from disclosure. The following scenario illustrates how a court may approach a request to protect such information.

An individual launches a legal action alleging he was harmed by the delivery of healthcare. During legal proceedings, the defendant healthcare providers and hospitals are asked to produce information about discussions or reviews they conducted after the care was provided. The defendants are giving evidence under oath and they acknowledge a debrief was held. The court is then asked to rule on whether the defendants have to disclose information discussed and any conclusions reached during the debrief.

In making its decision, the court may look at protection offered by quality assurance legislation. If this protection applies, the information covered by the protection does not have to be disclosed in the proceedings. If the protection does not apply, the court may look to common law privilege. This protection may be available for communications in certain relationships that are...
based on an expectation of confidentiality, among other things. The courts have ruled previously that the confidentiality of these communications should be respected when the relationship is one that society wants to foster.

When a court considers whether a debrief meets the criteria for protection under quality assurance legislation, it will likely look at factors such as how the debrief was structured and what was discussed.

When a court considers whether the debrief information is protected by common law privilege, it likely looks to a now widely-recognized test established by the Supreme Court of Canada. The test, which applies across the country including Québec, considers the following: Was the communication or document created with the understanding it would be kept confidential? Is confidentiality essential to maintaining the relationship between those communicating? Does society benefit from this relationship and want to foster the relationship? Is the injury to the relationship caused by disclosure greater than the benefit of having the information available in the litigation?

Again, it is important to realize common law privilege is applied only on a case-by-case basis. There is no advance guarantee of protection.

**Structuring Debriefs to Improve the Likelihood of Protection**

To improve the chances that information discussed during debriefs may be protected, you should consider working with your colleagues and facility to implement steps such as the following:

- Develop terms of reference and protocols for debriefing. Within these documents, clearly state that the debrief process is for quality improvement purposes and participants must keep all information discussed confidential.
- Conduct debriefs in a setting that allows all information to be kept private.
- Routine debriefs after each care episode are not usually documented. In those cases where information is collected, it should be gathered and compiled under confidential cover for purposes of quality improvement and access should be limited to those listed in the terms of reference and protocols under protection of quality assurance legislation.
- Seek advice from hospital legal counsel, the CMPA, or both before disclosing or discussing any feedback on the care provided by individual healthcare practitioners to third parties, for example patients or their families.
- Encourage hospital leadership or management to start a quality assurance review if a debrief identifies issues requiring significant changes to systems or processes. A quality assurance committee can examine the issues to identify areas for improvement and share its recommendations with leadership so appropriate changes can be made.

Although written reports are not typically generated from a debrief, any treatment recommendations made during the debrief about the patient’s ongoing care should be documented in the patient’s medical record. Such information about patient care will generally not be protected in this context.

An important part of the debrief is allowing participants to voice their emotions and reactions. A safe, respectful atmosphere is essential. In encouraging physicians and healthcare providers to speak openly and honestly, participants should also be reminded that debrief objectives do not include criticizing the care of any team member or assigning blame.

Critical, blaming comments set the wrong tone for the discussion and can potentially have significant negative consequences for the defence in a legal proceeding if the debrief does not qualify for common law privilege.

Debrief facilitator training can help encourage best practices.

**Participating in Continuous Quality Improvement activities**

The CMPA encourages physicians to participate in quality improvement activities that are created according to legislation protecting quality assurance records and information from disclosure. The Association understands that it is not always possible to have all quality assurance activities conducted by a formal and properly constituted quality assurance committee. The benefits often associated with participating in quality improvement activities focused on learning and improving systems outweigh the possible risks the information could be used or disclosed in subsequent legal proceedings.
The bottom line

▪ Participate in debriefs that keep the medical-legal risks to a minimum by being properly structured and focused on learning.

▪ If interested in establishing debriefs, talk with your colleagues, facility administration, and/or facility legal counsel about how to properly structure the process.

▪ For questions about participating in debriefs, contact the CMPA.

Additional reading available at www.cmpa-acpm.ca

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

Improving Team Communications

Saegis offers specialized, accredited communication skills programs, including **Effective Team Interactions**, a one-day accredited workshop that enables safer team communications.

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“This is an outstanding course that has significantly changed the way that I interact with my patients and my peers. I think that this makes me a safer physician.”

– Workshop participant

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SAFE MEDICAL CARE

The diagnostic challenges of chest pain:
Recognizing acute coronary syndrome

Diagnosing a patient presenting with chest discomfort or pain remains a challenge for physicians despite advances in diagnostic testing, clinical practice guidelines, and enhanced understanding of acute coronary syndrome (ACS). Appropriate triage and testing, as guided by symptoms and patient risk factors, may help improve the timely diagnosis of ACS.
A man in his 50s visits his family physician on a Monday morning. He complains of intermittent left-sided chest pain that he felt since his return from a party on Saturday night. He has a history of smoking, but no other cardiac risk factors. The physician suspects gastroesophageal reflux from excessive consumption of alcohol, and his differential diagnosis includes pancreatitis, cardiac chest pain, and influenza. The physician orders a chest X-ray, ECG, bloodwork, and an abdominal ultrasound. A few hours later, the patient has an ECG performed at a local laboratory where a computerized interpretation suggests an anterior infarction. No immediate action follows at the laboratory. The patient dies the following morning, less than 24 hours after the ECG. A cardiologist receives the ECG five days later, and interprets the findings as an acute anterior myocardial infarction.

In their complaint to the College, the patient’s family cites the physician’s lack of urgency in ordering and following up on the tests, and questions the laboratory’s procedures, which allowed the patient to leave without being informed of his condition. Though supportive of the family physician’s assessment and differential diagnosis, the College agrees that he ought to have arranged testing with an appropriate level of urgency. The College is critical that the patient was not referred to the emergency department, where troponin and ECG testing could have been more promptly carried out. After gathering evidence of the physician’s self-directed education and improvements to the system of diagnostic testing, the College dismisses the case with concern.

### CMPA CASES OF ACUTE CORONARY SYNDROME

An analysis by the CMPA of legal actions, regulatory authority (College), and hospital complaint cases closed between 2014 and 2018 identified 197 files featuring ACS. Of these, 116 involved allegations or findings of diagnostic error (missed, delayed, or inaccurate diagnoses), with the majority (72/116) occurring in the assessment and testing phases of the diagnostic process. Emergency department settings predominated (79/116), followed by primary care settings (30/116), with surgical cases, care by internists, and cardiology consultations making up the balance. In cases of diagnostic error, peer experts, Colleges, and hospitals frequently focused their criticisms on two areas: inadequate serial testing (ECG and cardiac enzymes) in emergency care settings, and delay in referral to the emergency department in primary care settings.

### CASE EXAMPLE

**Failure to recognize potential significance of chest pain symptoms results in lack of timely referral to emergency department**

Consideration of patient risk factors and diagnostic testing decisions in emergency and primary care

Two main themes arose in cases related to deficient assessment: consideration of patient risk factors (24/72) and diagnostic testing decisions (35/72), though the particulars varied by practice setting. Regarding the assessment of patient risk factors for coronary artery disease, criticism of primary care practitioners often focused on a failure to recognize pain or discomfort with possible cardiac origins, thus delaying urgent referral to the emergency department. In contrast, for emergency care, criticisms centered on the failure to consider cardiac risk factors in the diagnosis of unexplained chest discomfort or pain. With respect to diagnostic testing, care in the emergency department was subject to criticism for insufficient serial ECG and enzyme testing, while care provided in office settings was subject to criticisms around a lack of urgency in referring patients for such testing.

A woman in her early 30s presents to an emergency department in a rural hospital, complaining of severe chest pain radiating to her left arm and a burning sensation in her lungs. She is anxious, tearful, and hyperventilating.

Nursing staff perform an ECG and measure vital signs, which are normal apart from borderline high blood pressure. The patient reports a history of depression, smoking, and the use of medroxyprogesterone. Other details of her medical history missed during the assessment include a family history of cardiac disease, a previous transient ischemic attack, and high cholesterol levels. Hospital policies include a medical directive allowing nurses to expedite troponin testing for patients over 40 who present with chest pain, but they do not apply it owing to the patient’s age. The physician reviews the ECG and arranges a chest X-ray, both of which are judged to be normal. On physical examination, he notes chest wall tenderness, which the patient attributes to recent heavy lifting. The physician’s differential diagnosis includes the possibility of cardiomyopathy, but he believes that the patient’s young age and the ECG rule this out.

After analgesia, the patient’s pain decreases and she appears comfortable. The physician discharges the patient from the emergency department with a diagnosis of musculoskeletal pain and instructions to return if she experiences further symptoms. Following a cardiac arrest at home several hours later, the patient returns to the emergency department by ambulance. She dies from cardiogenic shock due to myocardial infarction.

The patient’s family complains to the College and pursues a legal action, alleging that the physician inappropriately discharged the woman from hospital without a clear diagnosis. Peer experts support the physician’s care, and the legal case is dismissed.
The College, however, is critical of the physician’s documentation and a differential diagnosis that narrowed too quickly. The College also finds it inappropriate that the physician relied on the medical directive to guide his diagnostic testing decisions, and suggests that the physician’s clinical judgment should have dictated whether to perform a troponin test. The College takes no action on the condition that the physician completes an educational course on documenting ACS risk factors and assessing patients with atypical chest pain.

RISK REDUCTION STRATEGIES
Based on the expert opinions in the cases reviewed, the following risk reduction strategies may be suitable in your practice:

▪ Consider applicable clinical guidelines, including those recommending key serial diagnostic tests when considering the differential diagnosis of ACS in an emergency setting. When guidelines are not followed, document the reasons why.

▪ Consider employing a risk stratification strategy to help guide decisions concerning diagnostic testing in the emergency department.

▪ Consider cardiac risk factors to aid with the triage of patients presenting with symptoms of non-specific chest discomfort or pain in a primary care setting.

Another theme identified among the CMPA cases reviewed was the diagnostic challenge of chest pain among female patients. Consistent with larger epidemiological studies of ACS, females comprised approximately 28% of the sample (33/116) and experienced severe clinical outcomes, with 17 of 33 cases resulting in the patient’s death. Consistent with the medical literature, risk factors for women also displayed gender-specific characteristics, such as menopause and pregnancy, and women frequently presented with atypical chest pain.

What is risk stratification?
Risk stratification is an ongoing process where a health provider uses clinical diagnostic indicators to proactively classify patients into high-, medium-, and low-risk categories. The goal of risk stratification is to effectively target healthcare services for individual patients and guide the management of patient care.

The bottom line
Recognizing ACS is a relatively common and challenging task. An awareness of patient risk factors to aid triage in primary care, or clinical risk stratification and appropriate serial testing in the emergency department, can contribute to safer patient care and reduced medical-legal risk.

FURTHER READING AT WWW.CMPA-ACPM.CA

▪ CMPA Good Practices Guide, see “Challenge to diagnosing” in the “Human factors” section

▪ “Avoiding pitfalls in the emergency department: Recognizing and managing risks of diagnostic error”

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 pertaining to the care provided. They are typically of similar training and experience as the physicians whose care they are reviewing


Healthcare providers have an ethical, professional, and legal obligation to disclose to patients harm that arises from healthcare delivery. In cases where pathological analysis or diagnostic imaging have been misinterpreted, it may be appropriate for the pathologist or radiologist to participate in the disclosure process. Participating in discussions with patients is often complicated by the fact that pathologists and radiologists typically do not have direct interaction with patients.

This article provides guidance for disclosing harm to patients involving physicians who do not usually have direct contact with patients. The CMPA handbook, Disclosing harm from healthcare delivery: Open and honest communication with patients, has more information and recommendations for physicians in general about the disclosure process, and is available on the CMPA website.

CASE EXAMPLE 1
Atypical cells are concerning, but benign
A 40-year-old male with a family history of bowel cancer has a rectal polyp biopsied at colonoscopy. The pathologist who analyzes the biopsy feels that many of the cells are atypical and considering the family history, the clinical features, the presence of atypia, and the possible consequences of missing a diagnosis of cancer, reports the biopsy as malignant. The patient goes on to have a lower anterior resection. When the pathologist reviews the resected tissue, no malignancy is identified. She rereads the initial biopsy, and in retrospect feels that she may have over-called the polyp. She asks a colleague to blindly review both samples and the colleague feels both samples were benign. Faced with these new facts, she wonders what the surgeon will tell the patient.
CASE EXAMPLE 2
Biopsy reveals previously missed carcinoma

A 47-year-old female undergoes breast cancer screening including a mammogram. No worrisome lesion is identified. Nine months later, she notices a breast lump and visits her family physician, who orders a diagnostic mammogram and ultrasound. The radiologist reviews the previous mammogram and identifies an anomaly, which he interprets as suspicious for cancer. A biopsy reveals invasive ductal carcinoma. The family physician wonders whether the previous normal mammogram result represents a diagnostic error, and is unsure how to discuss the issue with her patient.

WHO SHOULD DISCLOSE?

Once pathologic analysis or diagnostic imaging reveals a diagnostic discrepancy, it may be unclear who among the healthcare team should be involved in disclosing the issue to the patient. Treating physicians may have limited information about the discrepancy, but have a direct relationship with the patient. On the other hand, pathologists or radiologists, who generally have more context around the issues, may not feel comfortable engaging in a disclosure discussion due to their limited interaction with the patient. Indeed, one study reports that pathologists typically entrust disclosure to their clinical colleagues, despite worrying that clinicians "may find themselves with limited firsthand knowledge of the error event and may not be aware of certain pathology-specific relevant information worth sharing with the patient during the disclosure process." Consequently, in instances where patient harm is associated with potential issues involving pathology or diagnostic imaging, a team approach to disclosure may be in the best interest of patients.

While pathologists and radiologists have the same duty as their clinical colleagues to disclose to patients harm arising from the provision of healthcare, many discharge their obligation by alerting the referring physician. In some cases, active participation in the disclosure discussion by pathologists or radiologists may help support the treating physician, strengthen collegial bonds, and provide patients with a better understanding of the facts.

The prospect of a disclosure discussion with a patient with whom there is no direct interaction can be intimidating, but may ultimately be beneficial. Guidelines and policies within an organization help clarify responsibilities and processes for disclosure, promote transparency, and enable patients to receive relevant information. In one study, pathologists who were present during the disclosure discussion alongside the treating physician "expressed relief in being allowed the opportunity to provide the patient a better understanding of the circumstances surrounding the error and to have the opportunity to apologize for the error."3

THE BOTTOM LINE

- If you are a pathologist or radiologist and you suspect a diagnostic discrepancy, promptly discuss the discrepancy with the treating physician and consider reporting it to an institutional quality assurance program, if applicable.
- If you are involved in a patient safety incident, consider opportunities to participate in the disclosure process. This may include contacting the most responsible physician to review the facts, planning the disclosure to the patient, and offering to attend the disclosure meeting to provide your perspective.

ADDITIONAL READING AT WWW.CMPA-ACPM.CA

- Handbook: Disclosing harm from healthcare delivery: Open and honest communication with patients
- “Will you be sorry for saying, ‘I’m sorry’?”

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