What happened to the physical exam?

Over time, this critical part of the patient assessment can fall victim to system and practice pressures

- Reporting a patient’s fitness to drive
- Spinal surgery: 3 essential lessons
- Responding to special requests
- Texting safely about care
From the CEO

Technology in healthcare: Taking the lead in responding to change

One of the most stressful issues I hear about from members is the rapid rate of technological change in healthcare. Impacts differ within settings and specialties, but technology is affecting the way physicians practise, and members are trying to leverage its benefits while addressing the challenges it might bring.

At the CMPA, we are enthusiastic about the potential impacts of technology on both how we deliver services to our members and how physicians deliver care to patients. However, we also recognize that, if implemented poorly or without appropriate policies or regulatory frameworks, new techniques and devices can trigger unintended medical liability consequences. For this reason, we work to support the development of policies and frameworks that guide how physicians adopt and apply new technologies. In short, we want to ensure that our physician members are protected as the medical-legal environment changes.

To help shape policy and regulatory responses, we make formal and informal submissions on behalf of members to medical regulatory authorities (Colleges), governments, medical associations, and other partners. We have substantively contributed to electronic record and data sharing guidelines, addressed privacy frameworks dealing with personal health information, and are actively working to ensure medical liability considerations are resolved as new technologies reach practice. Additionally, our physician advisors provide peer-to-peer support to members each day as they work to implement new, technology-driven techniques and approaches.

Artificial intelligence (AI) is an area of technology that presents considerable potential benefit with risks that are currently not well-defined. AI-driven solutions are rapidly becoming the reality in certain types of practice and this trend should only accelerate.

To help physicians recognize the possibilities this technology offers and understand the potential medical-legal implications, the CMPA will host an information session on “Artificial intelligence in healthcare” during this year’s Annual Meeting and Conference on August 14 in Toronto.

Our keynote speaker is Dr. David Naylor, professor of medicine and President Emeritus of the University of Toronto. He will help us understand the current and potential role of AI in healthcare, and he will provide advice to physicians as AI becomes more prevalent in Canadian practices.

I encourage you to attend the session in person or via live webcast. I also invite you to visit our website and explore our resources addressing technology in practice.

The CMPA has been protecting our members’ interests since 1901—and as technology advances, we will continue to protect your practice and support your delivery of safe medical care.

Hartley Stern
MD, FRCSC, FACS, ICD.D

CMPA 2019 Annual Meeting and Conference
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- Information Session: *Artificial intelligence in healthcare* with Dr. David Naylor, University of Toronto

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Credits
Deciding whether to report a patient who may be unfit to drive can be challenging. Some patients may blame you, their physician, for the related emotional stress, loss of independence, and financial consequences and complain to the regulatory authority (College) or privacy commissioner, or commence a legal action.

While the CMPA is not aware of any Canadian cases in which physicians were found negligent for fulfilling their statutory duty to report fitness to drive, there have been cases where physicians were found negligent for failing to fulfill their reporting obligations.

**CASE EXAMPLE**

A patient with Type I diabetes reports to her family physician serious hypoglycemic episodes that she is having difficulty controlling. She is subsequently found to be at fault in a car accident. The occupant of the other vehicle suffers serious head injuries and a legal action is initiated against the patient, her family physician, and others. Experts conclude the physician fell below the standard of care to advise the patient not to drive and to report to the motor vehicle licensing authority. Without expert support, the CMPA, on behalf of the physician, contributes to a settlement paid to the occupant of the other car.

**Threshold for reporting**

It is important to know the requirements in your province or territory for reporting individuals who are unfit to drive.

**Mandatory reports**

In most jurisdictions, you must report patients with a medical condition that may make it dangerous to drive. You must make a report even if the patient says he/she will not drive or if another physician has already reported. And, a report must be made irrespective of whether the patient has a valid licence—it is sufficient in most jurisdictions that they are of driving age.

If you practise in British Columbia, however, reporting is mandatory only if the patient continues to drive after being warned not to.

**Discretionary reports**

Reporting is discretionary in Alberta, Québec, and Nova Scotia. In Ontario, the duty is discretionary for medical conditions that fall outside the list for mandatory reporting as determined by the Ministry of Transportation.

While Québec allows for discretion in reporting, the Collège des médecins states that you must report if you have reason to believe the patient represents a serious risk to public safety and continues to drive despite being warned not to.
A fatality inquiry in Alberta concluded that if you practise in that province, you have a mandatory duty to report according to the Canadian Medical Association’s Code of Ethics and Driver’s Guide. 9

Temporary conditions
The decision to report patients who suffer from temporary conditions that will not impact their long-term driving ability (e.g. post-surgical transient conditions) is not an easy one. It requires discretionary clinical judgment.

If unsure about the patient’s prognosis or recovery time, consider scheduling a follow-up appointment within a reasonable time to reassess the patient. If after the assessment, you feel the patient continues to suffer from a condition that may make him/her unfit to drive based on your review of the CMA Driver’s Guide,10 inform the patient, and make a report.

Liability for reporting
You will generally not be faulted for breaching patient confidentiality if you make a report in good faith.

Report only the information required and only in the circumstances specified in the legislation or guidelines.10, 11 Reports should be based on your assessment of the patient’s symptoms, diagnosis, and recommended treatment plan.

Patients’ use of cannabis may affect their ability to drive. You should consult the CMA Driver’s Guide10 and Canadian Public Health Association’s information package entitled Cannabasics12 for information about the health and safety risks associated with cannabis.

Permission to warn
You may be concerned about safety if your patient continues to drive despite being warned not to and even where the patient’s licence has been suspended. When you reasonably believe that a patient who continues to drive with a medical condition may pose a risk of serious harm, you may be justified in alerting a third party who can assist in preventing the harm (e.g. the police or employer).

The Supreme Court of Canada has recognized that in certain circumstances danger to public safety can justify the disclosure of confidential patient information without consent.13 The permission to warn is also recognized in applicable privacy legislation in all provinces and territories.

Reporting patients who work in safety-sensitive positions
You may also be required to report individuals with a medical condition who work in positions critical to safety in aviation, shipping, and railway services.10, 14

As well, you may need to report patients with a medical condition that may make it unsafe to operate heavy equipment (e.g. forklift, backhoe, etc.) In these circumstances, you should consider whether the patient’s medical condition creates a risk to safety that would permit you to notify the employer or other third party. Before doing so, you should make the patient aware of your concerns and encourage him/her to independently notify the employer or otherwise address the risk.
Minimizing conflict

In addition to your obligations to report patients who are unfit to drive, you should generally speak with patients before making a report. Discuss the risks of driving as a result of their medical condition and warn them not to drive. You should talk about the rationale for and the nature of the report, and your legal obligations. Emphasize that it is the licensing authority that makes the decision to restrict driving. Also, provide appropriate support and advice to patients. If you are concerned that they will respond aggressively, consider taking precautions such as asking a staff member or colleague to join in any discussions.

Your assessment of patients, as well as the advice given to them about driving, should be documented in the medical record.

The bottom line

▪ Review applicable mandatory and discretionary reporting obligations. Limit the information disclosed to what is required by the legislation.
▪ Warn patients not to drive when their medical condition makes it unsafe. When appropriate, inform patients of your obligation and intention to report. Document assessments, discussions, and advice in the medical record.
▪ Consider whether to warn third parties, such as police or employers, if concerned about the risk posed by the patient’s continued operation of a motor vehicle or equipment.
▪ Contact the CMPA for case-specific advice.

2. Manitoba and Yukon require the patient to hold a valid driver’s licence.
3. Motor Vehicle Act, RSBC 1996, c 318, s 230
4. Traffic Safety Act, RQA 2000, c T-6, s 60-60.1
5. Highway Safety Code, CQLR c C-24.2, s 603
6. Motor Vehicle Act, RNS 1989, c 293, s 279(7)
14. Aeronautics Act, s. 6.5(1); Canada Shipping Act, s. 90(1); Railway Safety Act, s. 35(2)
Medical-legal cases in spinal surgery: 3 essential lessons

Spinal surgery is increasingly challenging in Canada for a number of reasons. An estimated 5.5 million Canadian adults are now living with chronic back pain and some will seek a surgical opinion in the hope of obtaining pain relief. Advanced age and comorbidities are common, adding procedural complexity. Intra-operative injuries are rare, but often serious. These challenges frequently lead to medical-legal actions and complaints.

Cases at the CMPA

Between 2013 and 2017, the CMPA closed 103 cases (civil legal actions and regulatory authority [College] and hospital complaints) involving spinal surgery performed by a neurosurgeon or orthopaedic surgeon.

Among medical-legal cases closed by the CMPA in the past five years that involved neurosurgeons, over one-third related to spinal surgery. Among cases that involved orthopaedic surgeons, approximately 5% related to spinal surgery.

Some cases arose from poor patient outcomes that peer experts or Colleges deemed to be due to inherent risks or unrelated to the spinal surgery. In these cases, there was no criticism of the surgeon’s care. However, in other cases, there were learning opportunities.

Three essential lessons can be learned from the medical-legal cases.
1. Engage in and document a fullsome informed consent discussion

In nearly 40% of CMPA cases, patients alleged that key information was not provided during the informed consent discussion.

**CASE EXAMPLE:**

**A patient develops profound weakness after surgery**

An older woman, with severe lower back pain and a kyphoscoliotic deformity, elects to undergo surgery by an orthopaedic surgeon. She signs an informed consent form outlining the risks of surgery and later undergoes an extensive spinal fusion from T10 to the pelvis. Post-operatively, she experiences profound weakness in her distal right leg, and her recovery is incomplete. Years later, she still requires assistance walking. The patient lodges a College complaint alleging a poorly executed procedure and inadequate informed consent. She says that the surgeon did not tell her this outcome was possible.

What did the College say?

The College voices no concern about the technical performance of the orthopaedic surgeon, but does note that he should have communicated more clearly with the patient about the risks and potential complications of the surgery. Further, it cautions him to improve his record keeping. While the surgeon recalls discussing all relevant risks of surgery with the patient, he did not document this discussion clearly in the medical record.

In 12 of the CMPA cases reviewed, the peer experts, College, or hospital committee noted that the surgeon did not adequately communicate the risks of surgery or present alternative treatments to the patient. Usually, these criticisms stemmed from a lack of documentation. There were also misunderstandings about the information conveyed by the surgeon. For example, one patient sought relief from chronic lower back pain only to learn later that the intent of the surgery was to relieve the associated leg pain. Studies show that the outcomes expected from spinal surgery (e.g. recurrence) often differ between patients and their surgeons.4

The CMPA recommends the following informed consent strategies:

- Explain the material risks of the surgery and serious risks such as paralysis or death, even if rare.
- Discuss alternative treatments, including non-surgical options.
- Explain the potential benefits of surgery realistically to the patient. For chronic pain sufferers, explain your expectations for pain relief.
- Take reasonable steps to assess patient understanding of the conversation. For example, provide opportunities for questions and ask patients to state their expectations.

2. Manage the risks of an intra-operative injury

Among the CMPA cases reviewed, 32 involved an intra-operative injury. Some of these cases involved trainees to whom surgeons delegated procedures under supervision. The most common types of injury were dural tears, spinal cord injuries, and lacerated iliac arteries or veins. Patients in 13 of the 32 cases experienced severe harm, including paralysis.

One-half of the cases resulted in an unfavourable medical-legal outcome for the surgeon. In such cases, the criticism by peer experts and Colleges included:

**Before surgery**

- Surgery not indicated
- Inadequate informed consent, or inadequate documentation of the informed consent discussion

**During surgery**

- Improper use of a high-speed drill
- Misinterpretation of intra-operative imaging

**After surgery**

- Failure to investigate or treat post-operative symptoms in a timely manner
- Inadequate disclosure of injury to the patient, or inadequate documentation of disclosure

These criticisms support the following suggested risk mitigation strategies:

- Carefully consider the indications for the procedure, especially in high-risk patients and patients with chronic back pain.5,6
- Follow manufacturer safety guidelines when using surgical equipment, including taking all appropriate safety precautions when using drills. Closely supervise less experienced trainees.
- Appropriately disclose intra-operative injuries to the patient, and document disclosure in the medical record.
- After surgery, be alert to signs of injury and respond appropriately in a timely fashion. Ask team members (e.g. nurses, residents) to alert you of unexpected signs and symptoms.

3. Verify the correct level and side

Intra-operatively identifying the correct spinal level is occasionally difficult and can be stressful for surgeons. Among the CMPA cases reviewed, 14 involved surgery at the wrong level or on the wrong side (i.e. right versus left side of the spine), typically in the lumbar region.
CASE EXAMPLE: INTRA-OPERATIVE CHALLENGES LEAD TO WRONG LEVEL SURGERY

An older man with obesity and a history of lumbar surgery presents to a neurosurgeon with increasing back pain, leg numbness, and urinary retention. The surgeon orders an MRI and identifies a central disk herniation at T12-L1 with significant cord compression. The patient consents to an urgent laminectomy and diskectomy at T12-L1.

Using a posterior approach and fluoroscopy, the surgeon does not find a disk herniation. He closes the wound. He seeks consent from the patient’s substitute decision-maker to continue surgery with an anterior thoracotomy approach. With proper consent, the surgical team turns the patient and the surgeon performs a partial corpectomy and diskectomy.

Post-operatively, an MRI reveals the surgical site at the wrong level (T11-T12). The surgeon discloses this finding to the patient. The patient returns for surgery at the correct level the next day by a different surgeon. Complications ensue, leading to persistent, debilitating pain.

What did the experts say?

Experts note that the intra-operative, fluoroscopic image from the first surgery was not sufficiently clear to identify the correct spinal level. They opine that the surgeon’s decision to move immediately to an anterior approach without further and better imaging fell below the standard of care. The CMPA pays a settlement to the patient on behalf of the neurosurgeon.

Among the reviewed CMPA cases involving wrong level surgery, peer experts frequently noted that images were of lower quality, misinterpreted, not used, or not available at the right time. There were also pitfalls in team communication. In each case involving wrong side surgery, surgical team members failed to verify the surgical site intra-operatively as per hospital policy.

The literature describes multiple safeguards that may prevent wrong site spinal surgery. The following strategies are supported by the cases:

- Communicate with team members (e.g. in a pre-surgical pause) to verify the correct level and side for surgery.
- Confirm that pre-operative records and intra-operative images are available in the operating room for comparison.
- Have a plan for action if the expected pathology is not found or imaging is unclear. For example, consult a colleague or persist in obtaining a better image.

THE BOTTOM LINE

In a medical-legal case, peer experts, Colleges, and hospitals will acknowledge the technical challenges inherent to spinal surgery. However, they can be critical of your communication with the patient, your team communication skills, and your documentation. To mitigate the medical-legal risks of spinal surgery, consider the following strategies:

1. Conduct and document an appropriate informed consent discussion.
2. Consider the risks of intra-operative injuries during all phases of surgical care.
3. Use multiple safeguards to verify the correct level and side for spinal surgery.

Additional reading at www.cmpa-acpm.ca

- CMPA Good Practices Guide, see “Reducing risk in surgery” in the “Managing risk” section
- Consent: A guide for Canadian physicians
- Disclosing harm from healthcare delivery: Open and honest communication with patients

2. The proportion of spinal surgeries performed on the lumbar (i.e. lumbar, lumbosacral, thoracolumbar) region of the spine in Canada (excluding Québec) between 2012 and 2017 was 56%, according to the Canadian Institute for Health Information.
SAFE CARE

What happened to the physical exam?

Over time, this critical part of the patient assessment can fall victim to system and practice pressures

The physical examination is a powerful tool in the physician’s diagnostic toolkit. Performed effectively, it can improve the accuracy of your diagnoses and help avoid harm to patients. Yet, how you perform the physical exam can change over time and become overly limited without you realizing the impact on your patients.

In medical school, all physicians are trained in the critical skills of patient assessment. However, when you enter the world of independent practice, system and practice pressures are quickly brought to bear, pressures such as high patient volumes, rapidly advancing technology, and complex systems. These pressures can lead to concerns with performing examinations including, for some physicians, concerns with boundary issues.1

Commonly among trainees and experienced physicians, the physical examination becomes more tailored over time. This can be appropriate as clinical expertise develops and in certain settings and clinical scenarios. But sometimes, if the physical examination is too focused or omitted altogether, the opportunity to capture critical clinical data to develop a differential diagnosis is lost and the patient may be put at increased risk of harm.

One well-documented, prevailing cause of diagnostic error leading to patient harm is the absence of an appropriate history and physical to flesh out the differential diagnosis.2,3 Often due to competing demands for your time, it can be hard to pause and reflect on the implications of limiting the physical examination for an individual patient or even more systematically for groups of patients. The literature consistently supports the use and value of the physical examination, even in this day and age of sophisticated diagnostic tools.2,4 Clinical correlation remains essential since no single diagnostic test has 100% sensitivity and specificity.

CMPA medical-legal cases display a prominent theme of inadequate assessment by physicians. In the CMPA’s files that closed between 2016 and 2017, almost one-quarter of civil legal cases and regulatory authority (College) complaints contained peer expert5 criticism of issues related to patient evaluation. When examining these cases more closely, three key drivers emerge: a lack of time, a lack of physical space, and the presence of cognitive biases.

TIME CONSTRAINTS

Sometimes in busy clinical settings, the performance of an adequate focused physical examination is deferred because of the time required. This is often compounded by the need for chaperones for intimate examinations.1 Consider the following case example.
CASE EXAMPLE:

A LACK OF DIGITAL RECTAL EXAMINATION LEADS TO DIAGNOSTIC DELAY

In the middle of a compressed clinic day, a family physician assesses a new patient with a history of diverticulitis who presents with new onset of increasingly frequent stools with occasional blood. The family physician orders stool specimens for ova and parasites, and culture and sensitivity. The patient returns 3 weeks later with ongoing symptoms. The family physician notes normal culture results and refers the patient to a gastroenterologist. Two months later, the patient has yet to see the specialist and presents to the emergency department with frank blood and low hemoglobin. During admission to hospital, a colonoscopy reveals a large rectosigmoid tumour, palpable at the anal verge. The patient launches a College complaint alleging a delayed diagnosis. The College committee is critical of a lack of consideration of the differential diagnosis, documentation of the physical examination (including a digital rectal examination) at the time of presentation, and follow-up by the family physician.

LIMITED SPACE

In addition to time constraints and the need for chaperones, the extent of a physical exam can be affected by space limitations as illustrated by the following case example.

CASE EXAMPLE:

SPACE RESTRICTIONS LEAD TO A MISSED TIME-SENSITIVE DIAGNOSIS

A 12-year-old boy presents to his local emergency department by ambulance at 2000h on a long weekend, when the department is experiencing very high volumes. He describes lower abdominal pain, nausea, and vomiting. Due to crowded conditions in the emergency department, the child is placed on a hallway stretcher. The emergency physician assesses and examines the child, noting the abdomen is soft and non-tender. The physician orders bloodwork, urinalysis, analgesia, and an antiemetic, but does not perform a genital examination because the patient is not in a private area. Following normal investigations and improved symptoms,
the physician discharges the patient at 0200h. The patient returns the next day at 1600h with a painful and swollen testicle. An ultrasound confirms testicular torsion, and within 2 hours of presentation, he undergoes an emergency orchiectomy. In the ensuing legal action, peer experts opine that it was the emergency physician’s responsibility at the initial visit to find a private room to conduct the appropriate examination for this time-sensitive condition, which was an important part of the differential diagnosis.

PRESENCE OF COGNITIVE BIASES
All physicians are susceptible to cognitive biases, including when making clinical decisions to form diagnoses. At times, you will manage patients exhibiting challenging behaviours, which may increase your susceptibility to sub-optimal clinical decision-making. In the following case example, a diagnosis was missed due to attribution bias, the tendency of physicians to explain a patient’s condition on the basis of their disposition or character, rather than seeking a valid medical explanation.

■ CASE EXAMPLE:
THE DIAGNOSTIC PROCESS IS CONFOUNDED BY ATtribution bias

A 40-year-old woman with a history of chronic low back pain and alcohol use disorder presents to her family physician. She requests a refill of acetaminophen/oxycodone for her back pain. The family physician notes that this visit is early for the refill, and the patient acknowledges that she has increased the use of her prescribed analgesic due to a recent knee injury. The family physician provides the refill. Four days later, the patient returns complaining of headache, nausea, abdominal distension, and decreased voiding. She insists on an increase in the dose of her acetaminophen/oxycodone. Feeling frustrated with the patient’s confrontational behaviour, the family physician attributes the symptoms to alcohol and opioid withdrawal without further evaluation and declines to renew the prescription. The next day, the patient presents to a local emergency department with acute liver and kidney injury secondary to acetaminophen toxicity. The patient complains to the College. During the College investigation, peer experts criticize the lack of a documented physical examination at both visits to the family medicine clinic, particularly with the onset of new symptoms.

THE BOTTOM LINE
The physical examination remains a powerful tool in your diagnostic toolkit. There are many reasons why an examination may be incomplete or not adequately performed. Inadequate assessment can, however, negatively affect the accuracy of diagnosis and safety of medical care.

Consider the following when aiming to reduce your medical-legal risk:

- Engage in reflective practice. Consider what parts of the physical examination are critical for different patient groups and contexts and be mindful to preserve these as consistently as possible, even when pressed for time.
- Have a plan in place for accessing the appropriateness of chaperones and private spaces for intimate physical examinations.
- Be mindful of cognitive biases potentially influencing your clinical decision-making.
- Use the act of documenting in the medical record as an opportunity to reflect on the adequacy of the physical examination and differential diagnosis.

Additional reading at www.cmpa-acpm.ca:
- CMPA Good Practices Guide, see “Cognitive biases” in the “Human factors” section
- “Is it time to rethink your use of chaperones?”
- “Limited healthcare resources: the difficult balancing act”

5. 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.
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www.cmpa-acpm.ca/theatrearts
When patients make special requests, how should you respond?

As a physician, you may encounter patients who ask for specific care providers, treatments, or services. For example:

- A pregnant patient may ask for a female obstetrician due to her religious beliefs.
- An Indigenous patient may ask for a traditional healer to be involved in his care.
- A hearing-impaired patient may ask for a sign language interpreter.

Some requests may surprise you or put you in a challenging position. However, in every case you should consider the reasons behind the request and assess whether it can be reasonably accommodated in your setting.

In everyday practice, accommodation is an adaptation or adjustment made in response to a patient’s needs, cultural practices, or religious beliefs. It is a process of trying to find common ground between what’s being asked for and what you as a physician can reasonably provide given the setting you work in and the resources available to you.

When you receive a patient request, keep the following points in mind:

**Patients have a legal right to accommodation**

All Canadians have the legal right to equality and to receiving healthcare services without discrimination. Section 1 of the Canadian Medical Association’s Code of Ethics and Professionalism and Section 23 of Québec’s Code of Ethics of Physicians prohibit physicians from discriminating against their patients.

Refusing to make reasonable attempts to accommodate a patient’s request for a particular healthcare provider or treatment could be perceived as discrimination, which in turn could lead to a regulatory authority (College) or human rights complaint. For example, if a patient’s religion prevents her from seeing a male obstetrician, failure to make reasonable attempts to provide her with a female obstetrician may be seen as discriminatory. In cases such as these, “equal treatment” means making reasonable efforts to accommodate requests, taking into account your practice setting and resources.

**Delivering person-centred care**

Accommodating reasonable requests can help in broader efforts to be more “person-centred,” and allow the patient a greater degree of participation in their care.
Reducing the risk of a human rights complaint

To minimize the risk of a human rights complaint, the duty to accommodate means that a patient’s reasonable request should be considered unless it would cause undue hardship to the physician, the hospital, or others involved in implementing the request.

Human rights complaints must be based on one of the protected grounds set out in provincial or territorial human rights codes. The grounds vary between jurisdictions, but generally include characteristics such as race, sexual orientation, religion, language, gender identity, and disability. A patient can allege discrimination only if their request for accommodation is rooted in one of these grounds.

► Accommodation will depend on the circumstances

Reasonable accommodation does not mean having to say yes in every circumstance. Human rights legislation only requires accommodation in so far as it does not cause undue hardship. What constitutes undue hardship will depend on the circumstances. You may need to forward some requests to your hospital or clinic’s management, depending on the requirements.

A request that may be reasonably accommodated if made in advance may not necessarily be reasonable in an emergent situation. For example, it may be possible to provide sign language interpretive services for a hearing impaired patient who requests this in advance. However, it may not be possible to fulfil the same request if it is made in an emergency department.

► Accommodation does not always mean saying “yes” to the request in its original form

Sometimes it may not seem possible to accommodate a request. For example, requests involving the indoor ceremonial use of fire or smoke may have to be denied based on safety. However, it may be possible to accommodate the request in some other way. For example, you could ask the patient if he or she would consider having the ceremony outdoors. Accommodation can sometimes mean finding a compromise that satisfies the core of the patient’s request while still being reasonable based on the practice setting and resources.
Accommodation means accepting a patient’s right to make decisions about their medical care

A patient may be capable of providing consent to treatment, yet wish to delegate all medical decision-making to a third party on cultural grounds. Similarly, a patient may reject a treatment because of their religious beliefs. In both cases, you may feel that the patient is not acting in their own best interest.

Capable patients who understand the clinical implications of their decisions are free to choose treatments or approaches that may not be in their best interest. However, consent to treatment (or refusal of treatment) is valid only if given voluntarily and free from any suggestion of duress or coercion. In circumstances where there are questions or doubts about consent or duress, physicians are encouraged to consult with other physicians and contact the CMPA for advice. There may be circumstances where consulting with an institution’s ethics advisor or equivalent would also be prudent.

Accommodation is primarily about the patient, not the care providers

While physicians may have moral or religious convictions about certain medical issues, accommodation is primarily about reasonably accommodating requests from the patient—not the other way around.

The Canadian Medical Association Code of Ethics and Professionalism states that physicians must always acknowledge and respond to patients’ medical concerns and requests regardless of their own moral commitments.

Several Colleges also require physicians who are unwilling to provide certain care (such as birth control or abortions) to refer patients to another healthcare provider who will provide the services. For medical assistance in dying (MAID), Colleges have adopted guidelines stating that physicians who object to assisting patients are expected to provide information and resources that enable patients to make informed choices and access options for care, or to provide an effective referral to another physician or resource.

Saying “no” and documenting conversations and attempts to accommodate

Despite good faith efforts, there may be some patient requests that cannot be accommodated. Whether you can or cannot accommodate a request, you can help reduce your medical-legal risk by:

- Carefully considering a patient’s request for accommodation, taking into consideration the practice setting and available resources.
- Developing protocols to manage patient requests for accommodation.
- Documenting your efforts to accommodate a patient’s request, and/or your reasons for not being able to accommodate the request.
- Documenting in the patient’s record the discussions and decisions about care, including any decisions made by the patient with regard to refusing treatment or delegating decision-making to a third party.

2. Code of Ethics of Physicians, CQLR c M-9, r17
To help physicians maximize the benefits of texting and reduce the risks, the CMPA suggests the use of strategies described here to maintain patient confidentiality, support clear communication, and help prevent possible negative perceptions. When is texting appropriate (or not), what are the privacy risks, what are the communication challenges and related medical-legal concerns, and what can be done to address these matters?

Why texting in healthcare?
A recent study examined texting practices among staff surgeons at a Canadian hospital. Of the 206 surgeons surveyed, 62 responded (30%). Routine patient information was most likely to be communicated with trainees via text messaging (63%), though communication between staff surgeons trended toward traditional channels: email (55%) and phone (24%), with texting accounting for 8% of communications. Meanwhile, urgent patient information was most likely to be conveyed among other surgeons and trainees verbally by phone (90% and 65%, respectively), with texting not nearly as common (2% with staff surgeons and 29% with trainees).

When surgeons used texting, they did so because it is fast, convenient, and allows information to be transmitted to multiple recipients at once. In the study, most surgeons (72%) felt that texting enhances patient care. While most agreed that texting patient information should be regulated by hospital policy or in legislation, only one-third of respondents were familiar with their hospital’s policy regarding sharing patient information via text messaging.

To gain the benefits of texting while reducing the risks, consider how you’ll maintain patient confidentiality, support clear communication, and prevent negative perceptions.
PRIVACY AND CONFIDENTIALITY
Texting patients’ identifiable personal health information may lead to a privacy breach. Privacy legislation requires custodians of personal information, including health information, to safeguard that information from theft, loss, and unauthorized use or disclosure. Regulatory standards include federal, provincial or territorial privacy legislation, and guidelines published by medical regulatory authorities (Colleges). These requirements extend to text messaging and other electronic communication channels.

Your device is not encrypted, or the WiFi or wireless network is unsecured.
- Refrain from communicating identifiable personal health information with the device or over an unsecured network. Instead, use secure channels such as an instant messaging application that encrypts data transfer. Your hospital or health authority may advise on an approved app in your facility. For private practice, seek an app that experts recognize as suitable for your intended use.
- Alternatively, omit identifiable patient information, or use texting only for routine tasks such as setting up an appointment or requesting a phone call.

A message is sent to multiple recipients, including those outside the patient’s circle of care.
- When texting as a group (among multiple parties), consider whether all recipients need to know the information (i.e. are they part of the patient’s circle of care?). Create a new, more limited group when needed.

A message is sent to the wrong recipient. A message is received by the wrong person.
- Use your contact list to send a new message (to avoid entering recipient information each time).
- If you discover that you inadvertently sent a message to the wrong person, notify that person of the error and (if the message contains sensitive information) request that they delete the message.
- If you receive a misdirected message, reply to the sender, identifying yourself by name and informing the sender that you believe their message was misdirected. When confirmed, delete the message.
- Contact the CMPA for advice on your privacy reporting obligations.

Your office staff use their personal devices to communicate patient information with you.
- Develop policies and training on privacy requirements, including prohibiting the use of personal devices to communicate patient information.
- Have staff sign a confidentiality agreement that stipulates their responsibilities to safeguard personal health information.

Your device is lost or stolen.
- Ensure your device is password-protected.
- Use encryption on your device.

CLEAR COMMUNICATION
Texting can present unique challenges for clarity of communication. Text messages may be included as evidence in a legal proceeding or College complaint case, and as with medical records, Colleges will expect that the communication is clear and professional.

A text message contains abbreviations and unclear, cryptic language, increasing the risk of miscommunication.
- Avoid texting about complex issues that require lengthy explanations.
- Write out words in full, avoiding all but the most common acronyms and initialisms.

Auto-correct has changed words as you type without you noticing.
- Read the message carefully, and make any needed corrections before tapping Send.
- If feasible, disable the auto-correct feature.

You provide your professional opinion on a clinical case via text, possibly in the place of a consultation letter.
- Treat text messaging as you would a corridor consult, a formal written consult note, or a consult conversation via phone or email.
- Document your advice as per your usual practice.
- Continue to use consultation letters as appropriate, thereby facilitating documentation of your advice.

You haven't received a reply to a question.
- Don't assume the recipient has received or read or has the time to respond to your message.
- Consider following up on time-sensitive matters verbally.
- Upon receiving and reading a text message, practise good team communication by closing the loop: Reply to the message, acknowledging receipt and any actions requested.

You provide your professional opinion, but are not familiar with the patient or the clinical history.
- Assume that the content of the text exchange would be deemed a consult. If needed, seek clarification and more details, and suggest a discussion by phone or in-person.

You don't know where to document your advice.
- If feasible, capture all relevant text messages (e.g. using screen captures) and add these to the medical record.
• When this is not possible, summarize the text exchange and document the summary in the medical record. Some hospitals may have policies or protocols for documentation in these circumstances.

PERCEPTIONS OF PROFESSIONALISM
Texting may be convenient, but it can also lead to potentially compromising perceptions about a physician’s professionalism. Texting typically lends itself to a casual style of communication that may be seen as unprofessional. Additionally, face-to-face interactions with patients or other care providers might be disrupted when engaged in a text conversation.

You tend to fall back to a casual, unscripted style of writing.
• Do not write messages containing inappropriate language or in a tone for which you could be later criticized for lacking professionalism.

A text message contains sensitive information (e.g. mental health or sexual issues, alarming test results).
• Some subjects may be inappropriate to discuss via text messaging, even if the proper information security protocols are followed. Suggest to the other party that the matter might be better discussed verbally by phone or in-person.

You receive a text message while speaking with a patient or healthcare colleague.
• Unless the text exchange is urgent, avoid looking at your device to read the message; resume texting when time permits.

The residents and trainees in your hospital typically use texting as their default channel for case-based discussion and learning.
• Overuse of texting may compromise key teaching moments and opportunities for evaluating trainees’ decision making.2
• Support your hospital or clinic administration in developing suitable policies for mobile communications.
• Set a good example for trainees in your use of texting.

Additional reading at www.cmpa-acpm.ca
• “Using electronic communications, protecting privacy”
• “The new reality of reporting a privacy breach”
• “Can border agents search your smartphone?”

1. Text messaging, or texting, refers to composing and sending electronic messages via smartphone, tablet, or computer. It refers to messages sent using the short message service (SMS) that is associated with a mobile network, or through an application linked to the Internet.
CMPA Annual Meeting and Conference  
TORONTO  
August 14, 2019  
Hilton Toronto  

Free attendance for CMPA members

8:00-9:00 A.M. ET Welcome and breakfast

9:00 A.M.-12:00 P.M. ET Workshop
Test Results Follow-Up - Is no news good news? Build a more reliable follow-up system for test results
An interactive, hands-on workshop offered by Physician Advisors from the CMPA Practice Improvement team.

12:00-1:00 P.M. ET Networking Luncheon

1:00 – 2:15 P.M. ET Annual Meeting
• President’s report
• 2018 Report of the Audit Committee
• 2018 Financial report
• 2020 Aggregate fees by region
• 2019 Council election results
• Q&A for members
• CEO’s remarks

2:30-4:00 P.M. ET Information Session
Artificial intelligence (AI) in healthcare
Join Drs. David Naylor and Hartley Stern in discussing the medical-legal implications of artificial intelligence in healthcare.

Learning objectives:
• Increase your understanding of the current and potential role of AI in healthcare
• Identify AI’s potential role in your own practice
• Recognize the medical-legal implications of AI

Dr. David Naylor  
Professor of Medicine and President Emeritus, University of Toronto

Dr. Hartley Stern  
Chief Executive Officer and Executive Director, Canadian Medical Protective Association

4:00-4:30 P.M. ET Reception

Participate via webcast  
www.cmpa-acpm.ca  
for Annual Meeting and Information Session

Participate in person  
Registration required: www.cmpa-acpm.ca/amc19  
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For more information: CMPAmeets2019@cmpa.org