The risk management magazine of the Canadian Medical Protective Association

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Perspective

Volume 11 No. 1 March 2019

Closing the loop on effective follow-up in clinical practice

Advance care planning eases end-of-life care

Prenatal tests: Navigating changing practices

Time to rethink your use of chaperones?

Corridor consultations and duty of care

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From the CEO

Our commitment to members and the healthcare system: 2019-2022 CMPA Strategic Plan

By listening to Canadian physicians, the CMPA has been successful in meeting your medical liability protection needs since 1901. We know the shifting economic, technological, and social pressures affecting your practices require the ongoing evolution of our services and how they are delivered. We also know that you greatly value what we currently offer and trust us to find the right balance between continuity and change.

Our recently released 2019 – 2022 CMPA Strategic Plan is the roadmap for how we will build on our past success while proactively adapting to your changing needs. It is rooted in our commitments to our members and to the healthcare system.

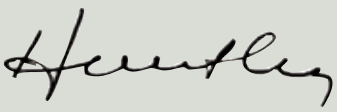
Our commitment to members is at the core of all we do, and our goal is to provide you with high-quality physician-to-physician medical-legal advice and assistance. We will continue to support you as you face the increasing pressures of delivering safe healthcare to Canadians. We are committed to providing you with an outstanding member experience, enabling you to easily access all our services and quickly find the resources available to you.

As an essential component of the Canadian healthcare system, the CMPA is also committed to advancing safe medical care and to collaborating with others to leverage our pan-Canadian experience and perspective to effect positive change. Drawing on our extensive knowledge and expertise, we work with our partners to identify risks, analyze causes, and develop safe care strategies. One example of the more active and system-wide role we are playing in improving the safety of medical care is our recent collaboration with HIROC and the SOGC to support Salus Global's MORE^{OB} program. Our collaboration enhances an already high-quality program proven to help obstetricians and family physicians deliver safer medical care.

We all know that healthy physicians are vital to the continued delivery of safe care and we are working with other organizations to both support our members in need and to advocate for meaningful investments in physician wellness. Through our subsidiary, Saegis, we are delivering programs to improve the environment in which you practise, supporting a "just culture" that is supportive of physicians.

We are committed to stewarding resources responsibly and to operating as effectively and efficiently as we can, without compromising on the assistance we provide. This includes appropriately compensating patients injured as a result of negligent medical care (fault in Québec).

I encourage you to read the Strategic Plan, which is posted on our website, and review the summary of the plan, which is included in this *CMPA Perspective* mailing. The practice of medicine and the healthcare landscape may be changing, but we remain steadfast in our support for Canadian physicians. While recognizing the challenges faced by our 100,000 members, we are excited about the future and the opportunities to better meet your safe medical care and medical liability protection needs.



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THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION

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COMMUNICATION

Advance care planning
key to person-centred end-of-life care

Don't wait until it's too late, and avoid potential disagreements and conflict

Consider this scenario experienced by many Canadians today. As a physician, what would you advise this individual to do next?

Mrs. Jones is 70 years old, recently widowed, and in generally good health. She tells you she had previously discussed her end-of-life preferences with her husband, but has not shared these wishes with anyone else, including her only son who lives in Australia. Mrs. Jones has a close relationship with a friend who lives nearby. She would like this friend to be involved in decision-making when she no longer has capacity to consent to treatment.

Conversations about end-of-life care can be difficult. Only half of Canadians discuss their end-of-life wishes with family or friends, and even fewer communicate their end-of-life care preferences to their healthcare providers.[1,2] However, a discussion between physician and patient about clinical care that is likely to be needed in the future may encourage a patient to articulate an advance care plan before it's too late.

Treatment decisions for end-of-life care can be challenging, particularly when the patient is incapable of consenting and the patient's wishes are unknown or unclear. This can increase the likelihood of disagreements and conflict between family members and within healthcare teams. Advance care planning (ACP) can reduce these challenges and risks, and help to improve the overall end-of-life experience for patients and their families.[3]

ACP is a process that includes the patient choosing a substitute decision-maker (SDM) and communicating his or her wishes, values, and beliefs to others. The goal of such planning is to ensure others understand the individual's preferences for healthcare in the event he or she is unable to provide consent when needed. ACP helps ensure the patient's wishes are respected and reduces the likelihood of conflicts between family members or with the healthcare team. It also allows healthcare providers to deliver care that more closely meets the patient's needs and wants.

ACP is not a replacement for consent. While it can help guide decision-making, consent is still required for specific treatments. That consent may come from the patient if he or she is capable, or from an incapable patient's SDM, or through an advance care directive, where permitted. It's important to note that ACP cannot include consent to medical assistance in dying, either through an SDM or an advance directive.[4]

Identifying substitute decision-makers

When a patient loses the capacity to consent, physicians need to turn to the appropriate person to obtain consent

Advance care planning ≠ advance directive

Advance care planning is not the same as an advance directive. Advance directives often include explicit instructions to consent or withhold consent to treatment in specific circumstances. They may also serve to formally assign a substitute decision-maker in the event the patient becomes incapacitated. In many provinces and territories, advance directives come into effect when the patient is incapacitated or otherwise unable to communicate his or her wishes.

for end-of-life treatment. An SDM is an individual who has the legal authority to make decisions on behalf of the patient. This authority may be granted through a legal document, such as an advance directive, by legislation, or by the courts. In the absence of an SDM, when a physician incorrectly makes an assumption about who is authorized to make decisions on the patient's behalf, this can lead to complaints to the hospital or regulatory authority (College) and potentially expose providers to civil legal actions.

Generally speaking, SDMs must comply with any wishes of the patient expressed orally or in writing when he or she was capable of making such decisions. The SDM should be guided by the patient's best interests, and ideally there will have been a prior conversation between the patient and SDM about the patient's wishes. The patient may also identify other people who can support the SDM through the decision-making process, or who should not be involved in care decisions.

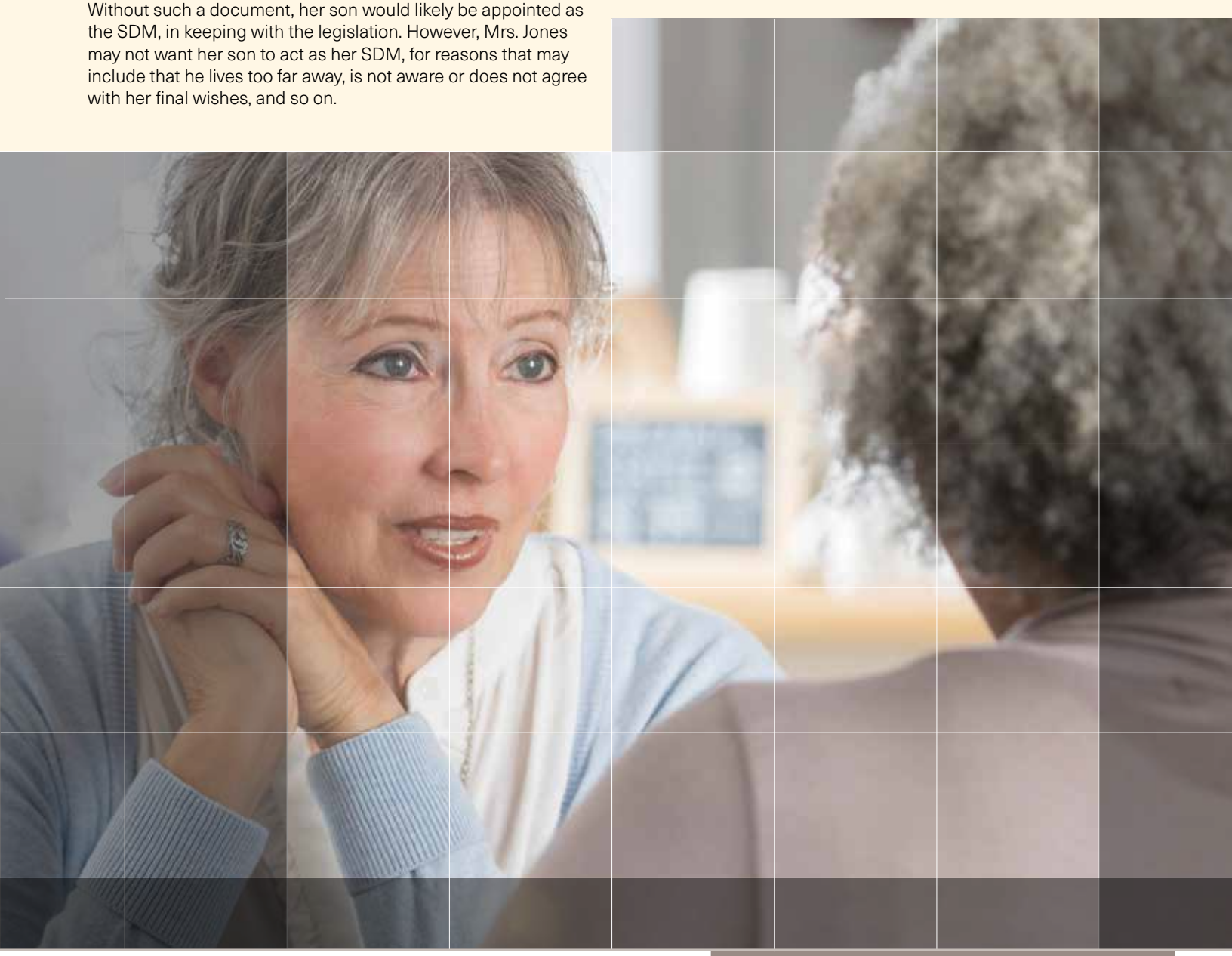
In the example scenario described earlier, Mrs. Jones did not prepare a document concerning her preferences for care. Without such a document, her son would likely be appointed as the SDM, in keeping with the legislation. However, Mrs. Jones may not want her son to act as her SDM, for reasons that may include that he lives too far away, is not aware or does not agree with her final wishes, and so on.

Mrs. Jones' doctor might choose to proactively discuss with her the importance of doing an advance care plan that specifies her care preferences at end-of-life should she become incapable of giving consent to treatment. This may include making legal arrangements to appoint someone—such as her close friend—who she feels will best represent her treatment goals, and her values and beliefs.

Discussing ACP with patients

Discussing ACP early and respectfully with patients and families can help promote person-centred care and assist in ensuring SDMs and family members support and follow through on the patient's end-of-life wishes.

Introducing ACP as part of routine care in a physician-patient relationship can help normalize these conversations. Ideally, discussions about ACP should be ongoing and revisited with the patient as his or her medical condition evolves or significant life events occur.



Here are some tips to help get started:

- Obtain available tools to guide discussions about ACP with patients. The Speak Up Campaign, an initiative of Advance Care Planning in Canada, has helpful resources for patients and healthcare professionals at www.advancecareplanning.ca.
- Initiate discussions about ACP sensitively. You may need to introduce the subject during the course of multiple visits.
- Strive to inform your patient's decisions about end-of-life care. Provide information about potential symptoms associated with end-of-life conditions. Discuss your patient's preferences or concerns about specific treatments, such as resuscitation and intubation, so that any misunderstandings by the patient are corrected and apprehensions are mitigated.[5]
- Encourage patients to document and share their care plan with loved ones, their SDMs, and other healthcare providers.

THE BOTTOM LINE

- **Advance care planning can reduce uncertainty and conflicts around difficult decisions during end-of-life care when the patient no longer has the capacity to consent.**
- **As part of routine care, consider discussing with patients the importance of having an advance care plan and appointing an SDM.**
- **Document discussions with your patients about advance care planning, and file any written documents concerning SDMs and the patient's wishes in the medical record.** ■

Additional reading at www.cmpa-acpm.ca

- "Healthcare directives: What you really need to know"
- "Is this patient capable of consenting?"
- "Providing quality end-of-life care"

Many provincial governments, regional health authorities, and medical associations or federations offer online resources to help with ACP. Read this article on the CMPA website where you will find links to some of these resources.

1. Howard M, Bernard C, Tan A, et al. Advance care planning, Let's start sooner, Commentary. Can Fam Physician. Vol 61[internet]. 2015 Aug [cited 2019 Feb 6]: 663-665
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SAFE OBSTETRICAL CARE

Prenatal tests for genetic screening and diagnosing: Changes, choices, challenges

Advances in technology have led to substantial changes in the prenatal tests physicians can use to screen and diagnose pregnant patients for genetic abnormalities. New tests are being introduced and conventional tests are being improved—and all have unique benefits and limitations. As tests grow more sophisticated, patients need guidance in navigating the complex information so they can make informed choices about the future of their pregnancy.[1]

For physicians who treat pregnant patients, being aware of the developments in tests and the current standards of practice, communicating effectively with patients and obtaining informed consent, and documenting treatments and discussions can contribute to achieving the best possible outcomes for all involved.

Advances in prenatal tests

The new prenatal tests and the upgraded existing tests come with a variety of advantages and restrictions. For example, some tests are viewed as more accurate than others. Some can be used earlier in the pregnancy than others. Some carry greater risks. Moreover, some are funded by healthcare systems, while others are not.

Non-invasive prenatal testing (NIPT), for instance, is a newer screening tool used to detect Down syndrome and other genetic abnormalities. Its benefits include being non-invasive, highly accurate, and available for use "...at a relatively early point during pregnancy."[2] However, NIPT is regarded as a screening test and not a diagnostic test.[3]

Meeting the standards of prenatal testing

Whether you are an obstetrician, a family physician with a specialty in obstetrics, or a family physician with an interest in or a need to be involved in obstetrics, the courts expect you to provide prenatal care that meets the current standards of practice. That would typically include being knowledgeable of developments in prenatal tests, both screening and diagnostic, and the nature, uses, advantages, restrictions, accuracy, risks, and availability of the tests.

Communicating with patients, obtaining informed consent

Patients need to be given sufficient and accurate information so they can make informed decisions about the future of their pregnancy.[2] The information they need will depend on their individual needs and circumstances. Some may decide to forego prenatal tests altogether, knowing that whatever the findings they would continue with the pregnancy. Others may decide to undergo a limited number of tests, while others may seek out all available tests to decide what course of treatment is appropriate for them.

Patients also need complete information about proposed tests or treatments, so when they provide or refuse consent, it is informed.[4] Among the information you should consider providing to patients is the tests that are available, their benefits, limitations, accuracy, risks, possible outcomes, time constraints, and reasonably available alternatives. You should also consider giving information on the options available should test results indicate an abnormality. In addition, patients should be made aware of the availability of genetic counselling services.

Failing to provide patients, in a timely fashion, with information and advice about prenatal tests or a referral to another provider can have a potentially life-long impact. For instance, some patients may decide that they would rather end a pregnancy than give birth to a child with a chromosomal abnormality. If a screening or diagnostic prenatal test that may have predicted such a problem is not offered or not offered within a specific time frame and the result is a baby born with an abnormality, the parents may consider legal action alleging that the physician failed to offer testing within sufficient time to consider aborting the pregnancy. In this situation, the courts will look to several legal principles to guide its examination of the physician's conduct, including whether the care followed the prenatal testing standard of care at the time of the pregnancy.

Speaking with patients about the intricacies of prenatal tests can be challenging because the language surrounding the tests can be unfamiliar and continually evolving. You should try to provide the information as clearly and simply as possible, and avoid jargon. Ensure patients understand the information and have an opportunity to ask questions. It may be helpful to investigate the material some organizations have written specifically for patients, such as that on the SOGC website, www.pregnancyinfo.ca.[5]

You may also want to consider organizing the material about the tests using structured communication and documentation tools. Some ministries of health have produced documents that may be helpful in providing structure. For instance, the Ontario Ministry of Health has produced the document *A User Guide to the Ontario Perinatal Record*.[6]

Further, when a test or treatment is beyond your competence or experience, you have a duty to refer patients to a more appropriate provider, for example to an obstetrician or genetic specialist. You may want to manage these referrals closely as time is an important factor. Some tests must be performed within set time frames to give patients the greatest number of options in deciding the future of their pregnancy.

Documenting in the medical record

The details of the informed consent discussion should be documented in the patient's medical record including the information you provided, questions asked and the answers provided, and the agreed-on plan for prenatal testing.

As well, documentation in the record may form part of your tracking system for prenatal tests. Given the importance of having some tests performed within specific time limits to allow patients more decision options, you may want to record what tests were performed and when, what results were obtained and when, further test options available, and the agreed-on next steps.

The bottom line

With advances in genetic technology, the options for prenatal tests (both for screening and diagnosing) have grown in number and sophistication. To improve testing outcomes for patients and reduce your medical-legal risk, consider the following:

- **Be aware of the current developments in testing and the current standards of practice with respect to tests that should be offered to pregnant patients.**
- **Give patients the information they need, when they need it, to make informed decisions about the future of their pregnancy.**
- **Document in the medical record all discussions with patients and the treatments agreed on.** ■

Additional reading at www.cmpa-acpm.ca

- "Genetic testing — New options, new obligations"

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6. Ontario Provincial Council for Maternal and Child Health (PCMCH) and The Better Outcomes Registry and Network (BORN) Ontario Perinatal Record Working Group [Internet]. A User Guide to the Ontario Perinatal Record. 2018 August [cited 2018 Dec. 3]. Available from: http://www.pcmch.on.ca/wp-content/uploads/2018/08/OPR_UserGuide_2018Update_Final_18-08-22.pdf

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2. **Sign in with your member number and password.**

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KEY DATES

March 20, 2019
Online voting opens

April 24, 2019
Online voting closes

August 14, 2019
Voting results announced online and at the CMPA Annual Meeting

SAFE CARE

Closing the loop on effective follow-up in clinical practice

8 suggested steps toward a robust follow-up system

CONSIDER THIS SCENARIO and how it might have turned out differently with better follow-up.

A 53-year-old man sees a general surgeon for a colonoscopy, after having received a positive fecal occult blood test and noted to have a hemoglobin of 72 g/L. The colonoscopy is difficult and is terminated without the surgeon being able to fully visualize the colon. The surgeon orders a CT colonography to rule out a tumour. Unfortunately, the requisition gets lost and the patient never undergoes the procedure. Months later, the patient returns to the emergency department with symptoms of a bowel obstruction. At surgery, a large obstructive tumour is identified. Despite treatment, the patient dies and his family initiates a legal action alleging negligent delay in diagnosis due to the surgeon's lack of follow-up on the investigation she ordered.

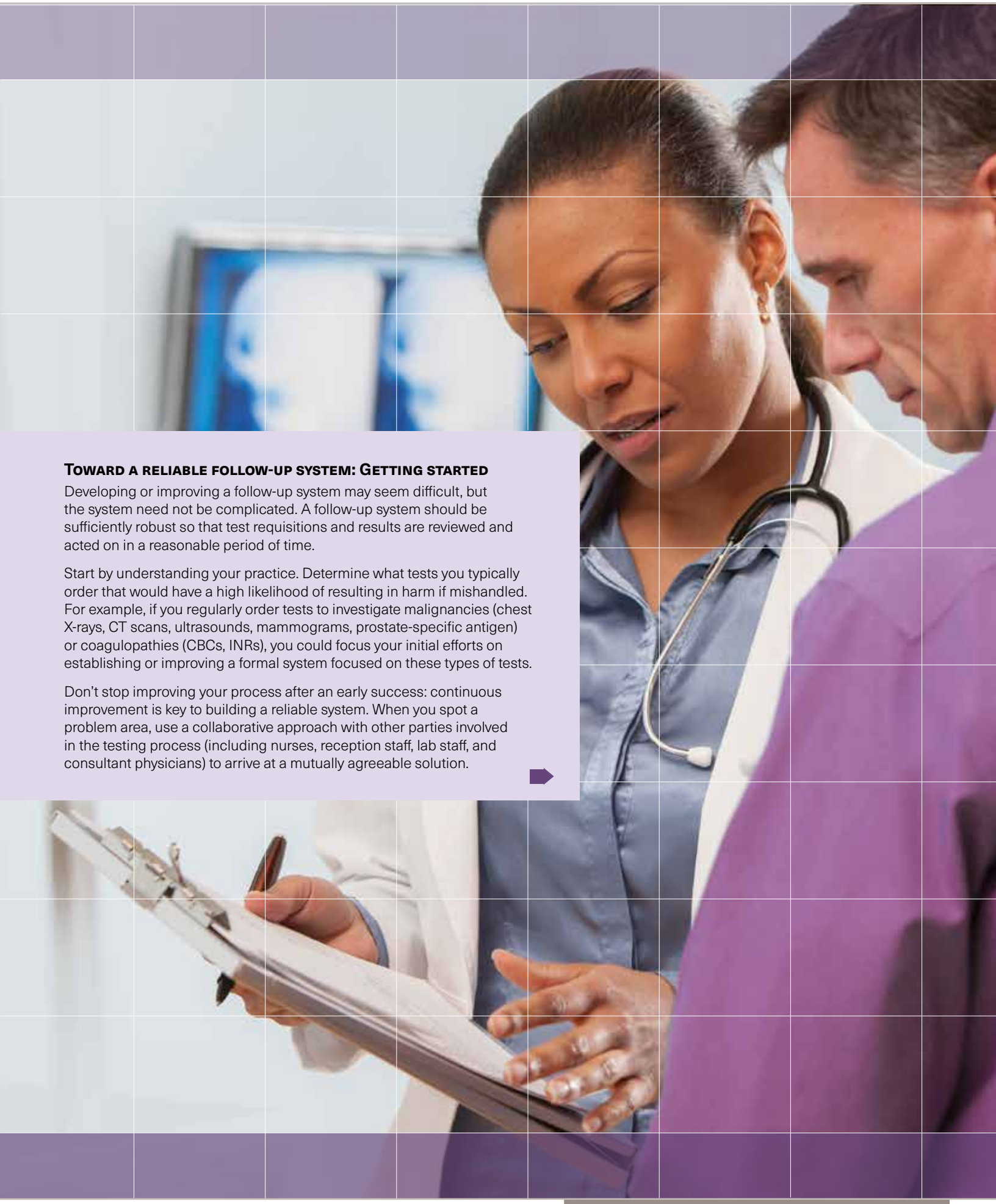
Following up is a professional obligation

Many factors may lead to a diagnostic delay, such as failing to inform a patient of a test result. Physicians can reduce the likelihood of such delays by targeting improvement efforts on their system for following up on laboratory tests, diagnostic imaging, and consultations.

Many provincial and territorial regulatory authorities (Colleges) have policies that set their expectations of physicians for following up on test, imaging, and consultation requests and results. Indeed, having a reasonable system in place to achieve this goal is a professional obligation of physicians. While some types of tests are subject to established follow-up programs (e.g. Papanicolaou smear, fecal occult blood test, mammogram screening), in most other instances the responsibility for following up rests with the ordering physician.

Getting to know your EMR's test follow-up functionality

If you have an electronic medical record (EMR) system, the EMR is possibly among your best assets for creating a reliable follow-up system. Many EMRs have effective built-in functionalities for follow-up. Do you know how to leverage yours? Your EMR vendor may be able to help. As well, your provincial or territorial medical association or federation may offer EMR support. OntarioMD (www.ontariomd.ca), for example, offers a peer support service to help physicians make the most of their EMR's features.



Toward a reliable follow-up system: Getting started

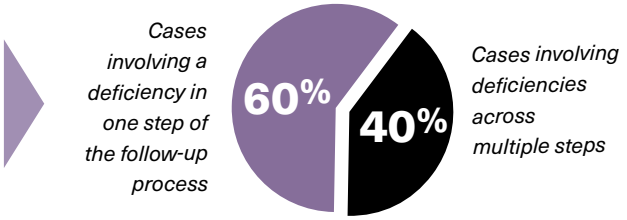
Developing or improving a follow-up system may seem difficult, but the system need not be complicated. A follow-up system should be sufficiently robust so that test requisitions and results are reviewed and acted on in a reasonable period of time.

Start by understanding your practice. Determine what tests you typically order that would have a high likelihood of resulting in harm if mishandled. For example, if you regularly order tests to investigate malignancies (chest X-rays, CT scans, ultrasounds, mammograms, prostate-specific antigen) or coagulopathies (CBCs, INRs), you could focus your initial efforts on establishing or improving a formal system focused on these types of tests.

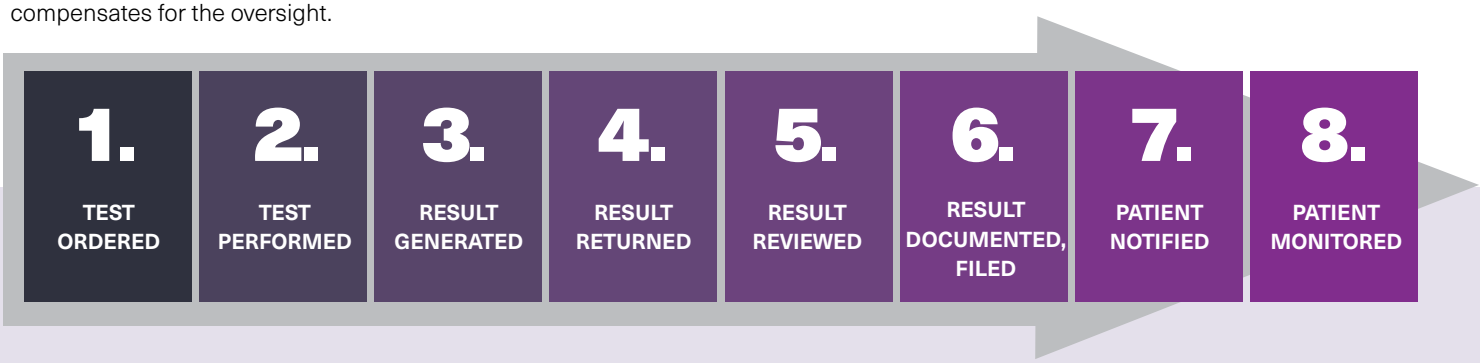
Don't stop improving your process after an early success: continuous improvement is key to building a reliable system. When you spot a problem area, use a collaborative approach with other parties involved in the testing process (including nurses, reception staff, lab staff, and consultant physicians) to arrive at a mutually agreeable solution.

Suggested steps in a follow-up system

In a review of CMPA family practice medical-legal cases in which a follow-up issue was found to contribute to a patient safety incident, more than half (60%) of the cases involved a deficiency in one step of the follow-up process while the remaining 40% involved deficiencies across multiple steps.



The diagram below, adapted from the Agency for Healthcare Research and Quality (AHRQ) in the United States, conceptualizes the process of test result follow-up as a series of steps.[1] Improvements in one or more steps may reduce the risk of failures. A reliable follow-up system includes safeguards at each step so that there is redundancy of defences. If one step fails, another step later in the process ideally compensates for the oversight.



For each step, a potential problem area is described, followed by suggested mitigation solutions.

1. TEST ORDERED

Problem: Some tests are ordered incorrectly or unnecessarily. Requisitions are mislabelled, or the physician later does not remember ordering the test or the reason for it.

Suggested solutions:

- ✔ Order only relevant and necessary testing.[2]
- ✔ Minimize variability by using the same ordering process for a given type of test.
- ✔ Train staff to confirm the patient's and next-of-kin's contact information when patients register at your office, before you order any testing.
- ✔ In clinics, employ a system that requires each ordering physician to use the correct requisition.

2. TEST PERFORMED

Problem: Some patients neglect to have the test performed or experience a long wait time between the test being ordered and performed.

Suggested solutions:

- ✔ Identify a reasonable deadline date by which you wish to receive the results, taking your practice context into account. Contact patients whose results are not back by that date to remind them to have the test performed.
- ✔ Foster patient engagement in managing their health and following through with testing. Explain the importance of the test and ask patients whether they understand.

3. RESULT GENERATED

Problem: Some critical test results do not receive the needed attention.

Suggested solutions:

- ✔ Consultants, clearly mark "ABNORMAL RESULT" or "WARNING —UNEXPECTED FINDING" at the top of all abnormal or unexpected results.
- ✔ Verbally notify the requesting physician of critical or unexpected results.
- ✔ If you receive an abnormal result you did not order, ask yourself who the most responsible physician is, who should act on the test result, and consider whether other physicians in the circle of care should be notified.

4. RESULT RETURNED

Problem: Some test results do not make it back to the ordering physician.

Suggested solutions:

- ✔ Set up an electronic reminder (in your EMR or calendar) to check that you received a pending test result by a specified date.
- ✔ Tell your patients they should expect to receive a call from your office prior to the specified date and to call your office if they have not been contacted by then. Explain that this is a safeguard against occasional loss of test results.
- ✔ Instruct locum physicians to keep a list of pending results. Upon your return, review the list and assume responsibility for following up on these results.
- ✔ If you work at many sites, consider how often you visit each location and whether you are able to perform a timely review of test results.
- ✔ If practical, link your billing to the receipt of test results—no test results, no billing.

5. RESULT REVIEWED

Problem: The test result has been returned but the physician did not see it.

Suggested solutions:

- ✔ Review test results regularly to keep your inbox manageable.
- ✔ Designate and train staff to review test results and flag abnormal ones.
- ✔ Do not click "Reviewed" or "OK" on results you have not reviewed as a means of "getting rid" of an EMR alert or reminder message.

6. RESULT DOCUMENTED AND FILED

Problem: The test result gets filed before the physician has reviewed it.

Suggested solutions:

- ✔ Train staff not to file reports that you have not reviewed and for which you have not created an action plan.
- ✔ Sign off the results and make a brief note of the action taken.

7. PATIENT NOTIFIED OF RESULT

Problem: The patient is not informed of the result or of the required action.

Suggested solutions:

- ✔ Use telephone prescription refill requests as a trigger to review whether a result is pending, prior to reordering the medication.
- ✔ Set a policy on the number of follow-up phone calls to a patient your office will make concerning a specific test requisition, and when and how to use alternative methods for follow-up (e.g. with prior consent, contacting the patient's next-of-kin).
- ✔ Create an alert for the issue, which you and your staff will see at the next contact with the patient.

8. PATIENT MONITORED THROUGH FOLLOW-UP

Problem: The physician does not take action on a test result.

Suggested solutions:

- ✔ If a follow-up investigation is warranted, order it right away where possible (do not wait).
- ✔ Include test results with consultation requests to facilitate prioritization by the consultant.
- ✔ If you are uncertain about a follow-up plan, contact other physicians in the circle of care to verify who is taking action.

1. Agency for Healthcare Research and Quality [Internet]. Rockville (MD): AHRQ; reviewed 2018 Jan. Improving Your Laboratory Testing Process [cited 2018 Dec]. Available from: https://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/ambulatory-care/labtesting-toolkit.html
2. For more information about appropriate use of clinical tests and treatments, visit Choosing Wisely Canada at www.choosingwiselycanada.org

SCENARIO REVISITED:

A POTENTIALLY BETTER WAY

The surgeon and her colleagues embark on improving their follow-up system. Because their EMR system does not support the follow-up of test results, they assign their office clerk to create and manage a spreadsheet-based parallel system to track results. The surgeons agree to harmonize their practices, including how they receive results from the clerk. They consider giving every patient automatic follow-up appointments, but because of a lack of clinic space, they opt to have the clerk close the loop with all patients, even with normal results. To help promote adherence to treatment plans, they create a simple patient handout to reinforce the importance of getting tests done, which they provide to every patient. They apply new rigour to documenting no-shows and recalls for difficult-to-reach patients. Finally, to avoid missing results due to physician absences, they assign one surgeon each week to deal with abnormal findings when the referring colleague is not in the office. ■

LEARN MORE

Visit **www.cmpa-acpm.ca/education-events/workshops** to learn more about test result follow-up systems.

- **Register for an upcoming CMPA workshop near you:** "Is no news good news? Build a more reliable follow-up system for test results."
- **Listen to the CMPA podcast** "Creating a reliable system for the follow-up of test results," and access other useful resources by the CMPA and other organizations.

YOUR PRACTICE

Is it time to rethink your **use of chaperones?**

In Canada, the past few years have seen more attention focused on reports of sexual misconduct and abuse.[1] In this environment of heightened focus, some authorities and organizations are changing their policies around the issue. For example, medical regulatory authorities (Colleges) and legislatures are enacting or reinforcing policies of zero tolerance for sexual abuse,[2] including redefining what constitutes sexual abuse, and increasing transparency and penalties for sexual abuse.[3]

This may be an appropriate time for physicians to ask: what can I do in my practice to ensure boundaries are respected and patients feel safe?

One solution is to have a chaperone present for some or all physical examinations, irrespective of your gender or the patient's, or the fact that you and the patient have a longstanding professional relationship. Even if you have previously decided you don't need a chaperone with some or all of your patient examinations, now might be an appropriate time to reassess your approach, particularly with examinations of a sensitive nature.

When deciding whether using a chaperone might be prudent, you may want to consider the following.

Deciding whether to use a chaperone

A chaperone can offer protection and reassurance to you and your patients. Patients may feel less vulnerable and more comfortable with a chaperone present during a sensitive physical examination. At the same time, you might find that a chaperone can reduce College complaints or legal actions.

When deciding whether a chaperone is appropriate, you should consider several factors. You will want to consider the expectations of your College. Some Colleges recommend that physicians have a chaperone, or at least offer to have one, for sensitive examinations such as pelvic (rectal, vaginal, testicular) or breast exams.[4] Some Colleges also encourage physicians to strongly consider a chaperone for contentious examinations, such as independent medical examinations.[5]

If you are practising in a hospital, speak with the hospital administration about policies or procedures around the use of chaperones in the hospital. Other factors you will want to consider when deciding on a chaperone include such things as the type of examination, your relationship with the patient, and the patient's disposition. For example, some patients might not want a third party present during an examination.

Patient consent is necessary for a chaperone to be present. When a member of the clinical team is both assisting with the examination and acting as a chaperone (e.g. a nurse), consent may be implied. However, a patient's express consent is required if the chaperone's only role is as an observer.

The patient's consent and the chaperone's presence should be documented in the medical record. If the patient does not consent to a chaperone, you should also document this in the medical record.

Patients who are initially reluctant to have a chaperone may change their mind if you clearly explain the chaperone's role. For example, you may tell patients the chaperone is strictly an observer who is there to protect them and ensure they feel safe. Patients should be assured that the chaperone will respect their privacy and confidentiality.

If you feel a chaperone is necessary despite the patient's contrary wishes, you might consider as a last resort deferring a non-urgent examination and referring the patient to another physician who is prepared to perform the examination without a chaperone. You should pay particular attention to ensuring the patient understands the clinical consequences of delaying care.

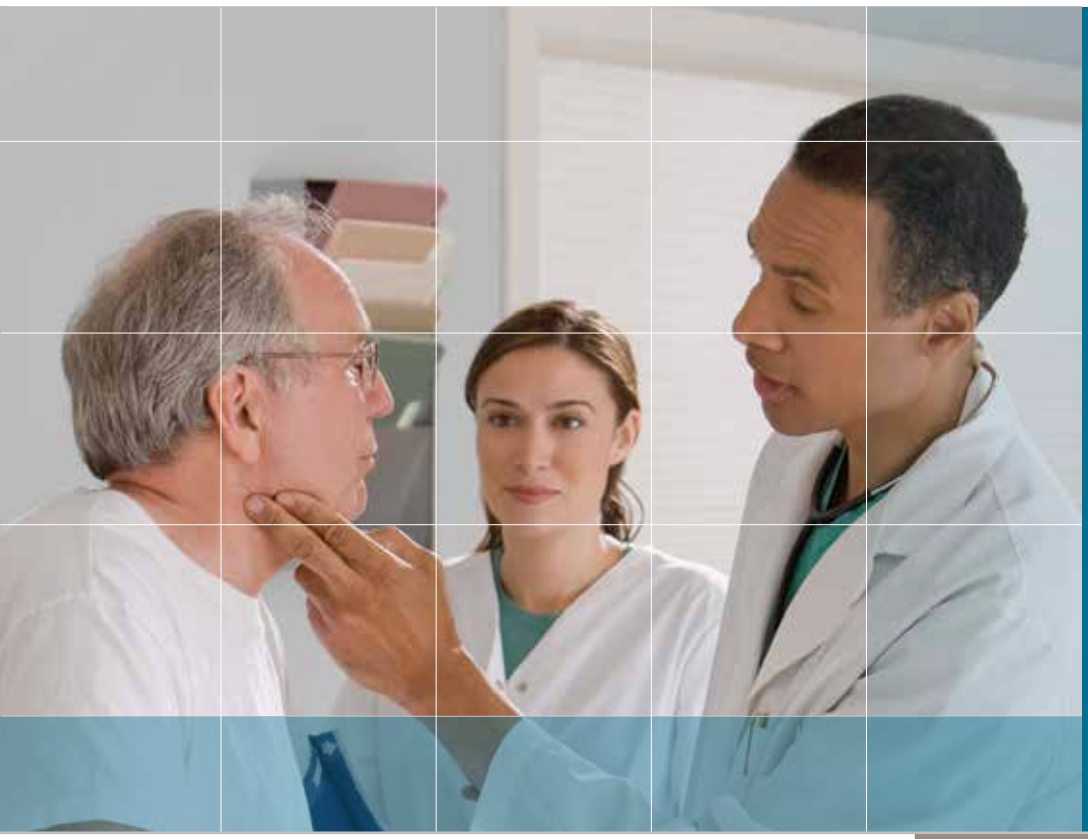
A referral should not delay required or urgent treatment. If the patient does not consent to a chaperone and you decide to delay care or not provide care, the patient might complain to the College or human rights tribunal.

If the physical examination is necessary to address an urgent or emergent condition and the patient does not consent to a chaperone being present, it is generally advisable to proceed with the urgent examination. The additional risk management steps discussed in the "Respecting boundaries" section of this article should be considered in these circumstances.

Selecting a chaperone

Preferably, the chaperone should be a trained health professional familiar with the examination so that, if necessary, they can confirm the examination was appropriately conducted. A trained chaperone may also feel more comfortable raising questions or concerns about how the examination is conducted.

When a trained health professional is not available, non-medical staff—such as an office assistant—may substitute. However, these individuals may not have the clinical knowledge necessary to comment on the appropriateness of the examination. Some Colleges offer training courses for office staff to help them understand their roles and responsibilities as



Preferably, the chaperone should be a trained health professional familiar with the examination so that, if necessary, they can confirm the examination was appropriately conducted.

chaperones.[6] If you are considering using non-medical staff as chaperones, you will want to investigate any chaperone-training resources available through your College or medical professional association. Regardless of who is chaperoning, it is your responsibility to discuss with them their role and your expectations, especially the need to respect patient dignity and privacy.

In some cases, it may be reasonable to suggest the patient bring a person of their choosing to the examination, particularly when you do not have the resources to offer a chaperone.

Alternatively, some patients may wish to have a family member or friend present during the examination, in addition to any chaperone you offer. You should generally comply with any reasonable request. Consider, however, that not all friends or family members will be impartial and might not fully understand the purpose or steps of the examination.

Respecting boundaries

If patients do not have enough information about what an examination will entail or if they misunderstand the purpose of an examination, they may feel boundaries were not respected. These individuals may be more likely to file a College complaint or start a civil action. There are other risk management strategies you can consider to maintain appropriate boundaries in addition to having a chaperone.

Respect patient privacy

Always respect patient privacy by leaving the room when patients undress and redress. This applies to you, your staff, and the chaperone. Provide a suitable cover or gown. Avoid removing or adjusting patients' clothing during the examination without express consent.

Communicate clearly and seek consent

Before you begin, ensure the patient has consented to the examination. Explain what body parts will be examined and why. Alert the patient before approaching a sensitive area. For example, patients may not know if the procedure will involve palpation. If an examination involves palpation, inform the patient in advance.

If you need to modify the examination while it is underway, tell the patient and reconfirm consent.

Encourage the patient to ask questions and to speak up immediately if they feel uncomfortable or are in distress. After the examination is complete and the patient is given an opportunity to get dressed in private, it can be helpful to ask the patient if they have any questions or concerns.

Remain professional

Some physicians try to alleviate patients' anxiety during sensitive examinations by using humour, making lighthearted comments, sharing personal stories, or minimizing the significance of the examination. While it's natural to try to put patients at ease, these types of comments should be avoided in circumstances involving sensitive examinations as they might be misinterpreted by the patient.

In the CMPA's experience, the best way to minimize patient discomfort is to be personable and compassionate, and ensure that your professional behaviour is beyond reproach.

The bottom line

- **Re-evaluate whether to use a chaperone for some or all physical examinations, regardless of the gender of the patient or the long-term nature of the doctor-patient relationship. Chaperones can offer protection and comfort for you and your patients, particularly during sensitive physical examinations.**
- **While consent may be implied when a member of the clinical team (e.g. a nurse) is both assisting with the examination and acting as a chaperone, obtain express consent when the chaperone's only role is that of an observer. Document a chaperone's presence and the patient's consent in the medical record.**
- **Irrespective of whether a chaperone is used, consider employing other general risk management strategies when performing physical examinations, including being particularly respectful of patient privacy, maintaining appropriate boundaries, and demonstrating professional behaviour at all times.** ■

1 Rotenberg C, Cotter A. Police-reported sexual assaults in Canada before and after #MeToo, 2016 and 2017. Ottawa (CA):Statistics Canada; 2018 Nov 8, Catalogue no. 85-002-X

2 College of Physicians and Surgeons of Alberta [Internet]. Edmonton: CPSA; 2018 June 11. Creating Safe Spaces for All in Alberta's Healthcare System [cited 2019 Jan 10]. Available from: http://www.cpsa.ca/creating-safe-spaces-for-all-in-albertas-healthcare-system/.

3 For example, see Ontario's *Protecting Patients Act,* SO 2017, c 11, Québec's *An Act to amend various legislation mainly with respect to admission to professions and the governance of the professional system*, SQ 2017, c 11 and Alberta's *Act to Protect Patients*, SA 2018 c 15

4 For example, see the following: College of Physicians and Surgeons of British Columbia document, FAQ on Boundary Violations in the Patient-Physician Relationship, November 2017; College of Physicians and Surgeons of Alberta document, Chaperone Requirements, June 2014; College of Physicians and Surgeons of Newfoundland and Labrador document, Practice Guideline on Chaperones & Sensitive Examinations (December 2016).

5 For example, see the College of Physicians and Surgeons of British Columbia's document, Guideline on Independent Medical Examinations, revised February 2013

6 For example, the College of Physicians and Surgeons of Alberta offers a Chaperone Training Workshop.

SAFE CARE

If a colleague relies on your professional opinion, you may have a duty of care

When you offer a clinical comment or opinion that you know others will likely rely on to make decisions about a patient's care, you might be found to owe that patient a duty of care—even if you never met the patient.

Consider the following scenario in which a duty of care was found to have been created through a "hallway or corridor" consultation. While these consultations often take place face-to-face, they can also occur using other channels of communication such as a telephone call, a text message, or an email.

Child's open fracture missed

An eleven-year-old girl arrives in the emergency department (ED) with a fractured radius and ulna with minimal displacement. She also has a small puncture wound on the forearm. The ED physician shows the X-rays to the on-call orthopaedic surgeon, who is in the department seeing another patient. The surgeon looks at the X-rays, but isn't told and doesn't ask about other pertinent details about the patient. He tells the ED physician the alignment seems acceptable, and advises dressing the wound, casting it, and arranging a clinic follow-up in one week. The surgeon's misunderstanding is that the wound is only an abrasion. He does not see or assess the patient or any other parts of the patient's record besides the X-rays.

The wound, in fact, is a significant finding. It is a result of a compound (open) fracture. The girl develops infection, compartment syndrome, and tissue necrosis. Her family launches a legal action. They also complain to the regulatory authority (College) about the ED physician and the surgeon.

The orthopaedic surgeon has difficulty accepting any responsibility for the care in this case since he had not actually seen the patient. However, the court found that he did indeed owe a duty of care to this patient as he had agreed to discuss the case with the ED physician, reviewed her X-rays, and provided an opinion on care that he knew or ought to have known would be relied on by the ED physician in treating the patient.

What the courts say about duty of care

The question of whether a duty of care is created can only be answered by the courts following consideration of the facts of each case. A duty of care is most often found to exist when there is a traditional doctor-patient relationship. However, a duty of care to provide appropriate advice in accordance with the relevant standard of care can arise in circumstances beyond this traditional relationship. At least one Canadian court has suggested that a physician may owe a duty of care where the consultant physician does not see or interact directly with the patient, such as when giving advice to a colleague during an informal hallway discussion about a patient.[1]

An important consideration in determining whether a duty of care is created is whether the consulting physician knew or ought to have known that their advice would be relied on to make clinical decisions regarding the patient's care. In the scenario involving the young girl who fell, the court found that the orthopaedic surgeon owed the patient a duty of care, in part, because he knew, or ought to have known, that the ED physician would rely on the advice and recommendations in these circumstances.

If the court finds that the consulting physician owes a duty of care to the patient, the next consideration will be whether the physician met the applicable standard of care in providing advice about the patient's care. The standard will be determined by the court based on accepted practices of the profession at the relevant time.

One of the questions the courts will consider in assessing whether a consultant physician acted in accordance with the standard of care is whether the physician had sufficient information to comment on a potential diagnosis. In the case of the young girl, the College found that despite reviewing the X-rays, the orthopaedic surgeon provided advice based on limited information. He did not review other clinically relevant information, such as the patient's history, the details of the accident or her presenting injuries. Before offering an opinion that might be relied on in treating a patient, it is important to ensure you have sufficient information to comment or provide a clinical opinion about the patient's diagnosis or treatment options.

The bottom line

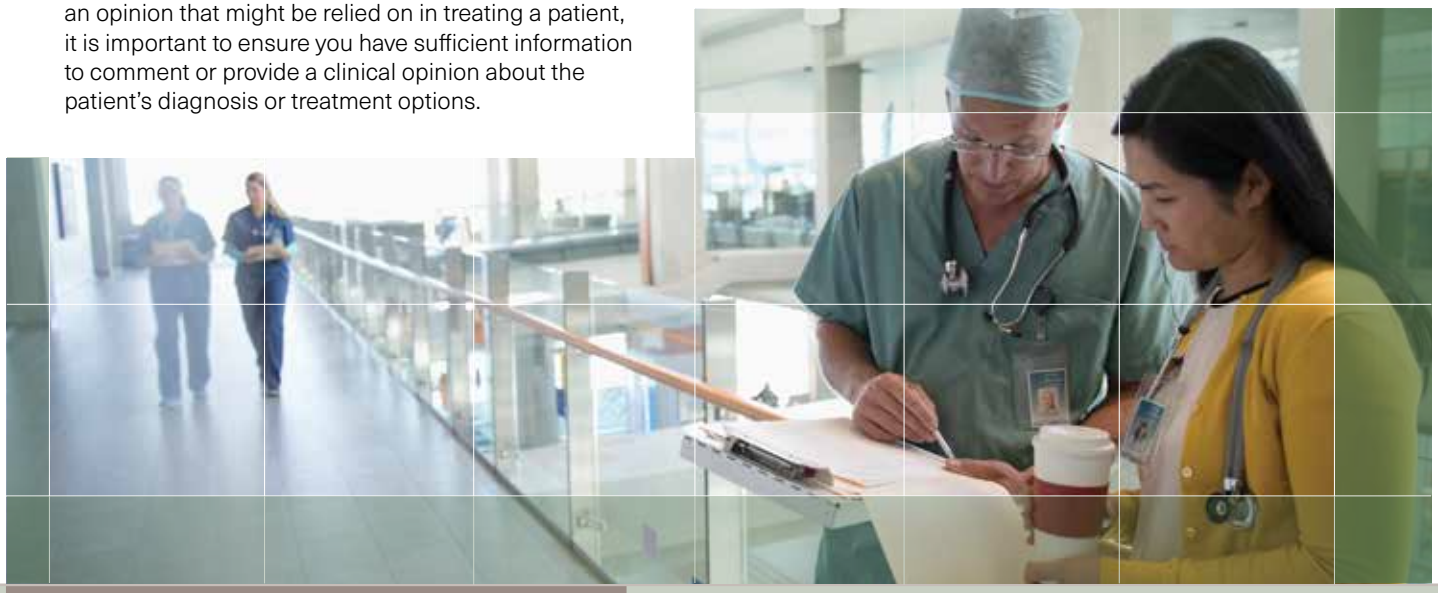
Giving advice in "hallway or corridor" consultations is an important and necessary part of clinical practice and good patient care. When providing such advice or consults, you need to consider that you may owe the patient a duty of care—even if you have not seen the patient in person. While this should not deter you from agreeing to provide such advice to colleagues, you need to consider the following:

- **Be aware that an informal discussion between colleagues in the hallway, electronically, or online can give rise to the risk of a legal action or College complaint for the consulting physician even without directly assessing the patient.**
- **Before you offer medical advice using any communication channel, assess whether you have enough relevant information about the patient and the clinical facts—ask questions, review additional documents, or offer to see the patient where appropriate and necessary to provide an opinion.**
- **Make reasonable efforts to document any information and advice you have given. While in some cases you may be constrained by factors such as whether you know the patient's name and whether you have access to the patient's medical record, your hospital or institution may have policies or protocols for documentation in these circumstances.** ■

Additional reading at www.cmpa-acpm.ca

- *Medical-legal handbook for physicians in Canada*

1. Crawford v Penney, 2003 CanLII 32636 (ON SC), aff'd 2004 CanLII 22314 (ON CA)



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