Can AI assist you with clinical decisions?
Looking at the benefits and risks of AI technologies
From the CEO

Artificial intelligence: Making healthcare better for patients

As I look back on my 40 years in medicine and think about the many technological advancements I have seen during that time, I am particularly optimistic about the potential impact of artificial intelligence (AI) on physicians’ ability to deliver quality care. At the same time, I recognize there are a number of unknowns about AI, both in healthcare and more generally, which creates uncertainty for both physicians and patients.

At the CMPA, we often talk about the importance of trust in the delivery of care. If we are to realize its potential benefits, trust in AI will also be essential. Patients will need to trust that AI helps physicians make the right decisions, and physicians will need to trust that AI produces reliable results. A high level of trust is more likely to be achieved when the same approach to AI is employed as with new medical devices and medicines, that is, through rigorous testing and evidence-based approvals—and by including the humanity and empathy physicians bring to patient care.

At this year’s CMPA Annual Meeting and Conference, our information session focused on how physicians and other health providers might use AI-enabled technologies to improve the effectiveness and efficiency of care. Our keynote speaker, Dr. David Naylor, professor of medicine and president emeritus at the University of Toronto and one of Canada’s foremost thinkers on this topic, presented his insights into the current and future use of AI in medicine. In my remarks, I noted that, despite best efforts, AI technologies may lead to medical-legal difficulties for some of our members and that the CMPA is committed to assisting physicians both proactively and in response to any difficulty that may arise.

First, we are committed to improving the safety of care, and we look forward to working with industry, governments, regulators, medical organizations, and others to ensure that the upside potential of AI is fully captured while avoiding the downside risks. With our experience in medical-legal matters, we can meaningfully contribute to the development of any required legislation, regulations, and policies.

Second, we know change can be difficult, and the CMPA’s education programs and advice help to empower physicians to explore and apply AI-enabled decision support tools with the confidence that appropriate use of these tools advances the goal of quality care.

Third, in the event there is a medical-legal difficulty arising from the use of AI, we will continue to provide physicians with trusted advice and assistance, including for College matters and civil litigation.

These are still early days for AI in healthcare, and much work remains to evolve and scale it for widespread use, including ensuring the necessary legal and regulatory frameworks are in place. As we look to the future, we should be both excited and realistic about what AI can and cannot do, and not lose sight of the key question: “Will this make care better for our patients?” If the answer is positive, we have a responsibility to adopt this technology thoughtfully, knowing the CMPA will be there to provide you, our members, with the support you need.

Hartley Stern
MD, FRCSC, FACS, ICD.D
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Walk-in clinics benefit patients. They also present unique medical-legal challenges for physicians. Learn how to mitigate some of the challenges.

Can AI assist you with clinical decisions? Looking at the benefits and risks of AI technologies

AI brings potential benefits and challenges to patient care. The CMPA looks at the possible medical-legal risks.

Artificial intelligence: Making healthcare better for patients

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Recognizing subarachnoid hemorrhage:
The role of situational awareness in preventing serious patient harm

Subarachnoid hemorrhage is a rare but potentially catastrophic cause of headache. While headaches are common, patients with subarachnoid hemorrhage typically experience a rapidly peaking and severe headache, often described as a “thunderclap.” They are frequently over 40 years of age and present with other distinct signs and symptoms, such as a brief loss of consciousness, vomiting, and neck pain or stiffness. Healthcare provider and team situational awareness are often key to the effective diagnosis and management of this emergency situation.

The CMPA reviewed 60 medical-legal cases, closed between 2009 and 2019, in which the diagnosis of non-traumatic subarachnoid hemorrhage was alleged to have been missed or delayed. Over half of these cases were legal actions (33 [55%]), followed by regulatory authority (College) complaints (22 [37%]), and hospital investigations (5 [8%]) (Figure 1). Reflecting the fact that subarachnoid hemorrhage has a mortality rate approaching 50%,1 death or severe injury was the most common category of patient outcome in these cases. However, slightly more than half of all cases (32 [53%]) had favourable medical-legal outcomes for the members involved. This was likely owing to factors such as atypical presentations, involvement of non-physician healthcare providers that contributed to the negative patient outcome, and expert opinion stating that misdiagnosis did not affect the patient’s outcome. The specialties most commonly involved were family or emergency medicine physicians (48 [59%]), neurosurgeons or neurologists (15 [18%]), and radiologists (6 [7%]). Five cases (6%) involved a resident.

Figure 1. Distribution by medical-legal type of closed CMPA cases with missed or delayed diagnosis of non-traumatic subarachnoid hemorrhage, 2009-2019 (n=60)
Case example
Return visit offers opportunity to reassess

A woman in her 60s arrives by ambulance at the ED with severe occipital pain. It is the second time she has attended this ED in the last three days. The pain first occurred while she was doing heavy yard work and returned during physical activity two days later. On her first visit, the ED physician who examined her suspected that her pain was musculoskeletal and administered an opioid analgesic before eventually discharging her.

On the second visit, the patient rates her pain at 6 out of 10 and tells the ED physician that she vomited twice the previous day and has since felt nauseated. She has a history of chronic neck pain from an old injury. During the physical examination, the physician finds no neurological deficit or photophobia. Mindful of the fact that the patient also complains of an acute increase in her chronic neck pain, the physician notes tenderness along the patient’s trapezius to the occiput, but no neck stiffness. The patient is given IV fluids, ketorolac, and metoclopramide. The patient begins to feel better, with only minor residual occipital pain. The ED physician discharges the patient with instructions to see her family physician within a few days and to try massage therapy for her neck pain. She is also advised to return immediately if her headache does not improve or if she develops new symptoms.

A few days later, the patient, still unwell, attends at another ED. Here, she receives a CT scan that shows evidence of a subarachnoid hemorrhage. The patient is immediately transferred to another facility where she undergoes coiling of a cerebral artery aneurysm. The patient recovers but is left with right-sided weakness. The patient files a College complaint alleging that, on her second visit to the ED the physician failed to diagnose the subarachnoid hemorrhage.

The College committee cautions this physician that when a patient returns to the ED with a persistent or worsening headache, the physician should focus on ruling out the possibility that it could be a serious condition such as a subarachnoid hemorrhage.
Diagnosis and coordination of care

Communication and coordination of care was an issue in 11 of the 39 diagnostic error cases (28%). These situations included return visits to different facilities or providers, resulting in a lack of coordination of care; miscommunication between providers, including issues related to the follow-up of imaging results; triage issues that led to delayed assessment of patients in the ED; and other breakdowns in communication between providers and with patients. Coordination of care can be influenced by system issues such as crowded EDs, lack of procedures for flagging or communicating urgent results, and the unavailability of diagnostic imaging. These challenges highlight the importance of coordination of care and team situational awareness when diagnosing and managing subarachnoid hemorrhage, especially in resource-constrained environments.

The bottom line

Although subarachnoid hemorrhage is an uncommon cause of severe headache, it is a medical emergency that carries a high mortality rate. A return visit for the same or worsening complaint—present in over half of CMPA diagnostic error cases—sometimes offers a second chance to avoid a potentially catastrophic outcome. Individual provider and team situational awareness, which can be enhanced with clinical decision support tools, are key to effective diagnosis and management of non-traumatic subarachnoid hemorrhage.

Additional reading at www.cmpa-acpm.ca

• “Thinking ahead: The value of situational awareness”
• “Avoiding pitfalls in the emergency department: Recognizing and managing risks of diagnostic error”

Accepting new patients: Guidance for specialists

A specialist receives a referral from a family physician. She carefully reviews the request and the accompanying documents. The patient’s condition does not seem urgent now, but some of his symptoms suggest he would benefit from being seen as soon as possible. The physician then considers her wait list, which has grown longer in the last few months. This patient’s condition falls within her scope of practice, yet she is apprehensive about accepting the referral. How soon can she see him? Is that soon enough to allow him the best possible outcomes? Is there someone else with the same scope of practice who could see him sooner?
The high demand for access to specialist care can put specialists in a difficult position when asked to accept a new patient. Those who work outside a hospital or institution may find themselves in a situation similar to the physician in the scenario above. They are using professional judgment to determine if they can provide care for a new patient while continuing to provide appropriate and timely care for current patients. Keeping in mind their obligations for accepting new patients and effectively communicating with referring physicians and patients can help these specialists make what can sometimes be a critical decision.

**OBLIGATIONS FOR ACCEPTING NEW PATIENTS**

As with all physicians, specialists’ acceptance of new patients is guided by ethical responsibilities, as outlined in the *CMA Code of Ethics and Professionalism*, and by professional responsibilities, as stated in the policies of the provincial and territorial medical regulatory authorities (Colleges).

College policies on accepting new patients vary across the country, but generally require that specialists accept new patients on a first-come, first-served basis, free from discrimination.

They also generally require that specialists take a number of factors into account, including the following:
- urgency and clinical need
- wait lists
- scope of practice and clinical competence

**Urgency and clinical need**

Although not generally obligated to agree to treat any individual seeking non-urgent or non-emergent care, specialists who receive requests to accept new patients should consider whether the patient needs emergency care.

The *CMA Code of Ethics and Professionalism* advises physicians to “provide whatever appropriate assistance you can to any person who needs emergency medical care.” College policies often advise specialists to address the urgent or emergent situation similarly.

The College of Physicians and Surgeons of Alberta, for instance, says, “A regulated member must provide care to the best of his or her ability to a patient in an urgent medical situation where no other regulated member is providing care, regardless of whether a physician-patient relationship has been established.”

**Wait lists**

With specialists’ care in high demand, many have a wait list. Although the general expectation is to accept patients on a first-come, first-served basis, Colleges advise specialists to triage patients based on the urgency or seriousness of their clinical condition. Patients may need to be moved up the list if their condition worsens.

Managing a wait list and prioritizing appointments can be a significant part of a specialist’s practice as new patients in various stages of illness are accepted and added to the list, and patients currently on the list experience changes in their condition. Some Colleges direct specialists to take relevant factors into account when prioritizing and monitoring wait lists, for instance the patient’s condition, and social factors that can influence health outcomes (e.g. housing, food security, employment, income).

Effective communication and understanding between the referring physician, the consulting physician, and the patient are valuable in managing a wait list. For instance, it should be clear to everyone who is the most responsible physician at all times, including when patients are waiting to be seen by a specialist. Patients need to know who to contact if their condition changes.

Other approaches to managing a wait list could include hiring additional resources such as an assistant or nurse, and discussing with referring physicians the possibility of discharging patients back to the care of the referring physician.

Specialists should also keep in mind the external environment, for example, government targets for wait lists. If a wait list is not close to the target, it may be necessary to decline referrals.

Even if a wait list is within the target, specialists should use their professional judgment to determine if they’ve reached their personal capacity and it’s necessary to decline new referrals.

**Scope of practice and clinical competence**

Specialists may feel they must refuse a new patient when they’ve restricted their practice and/or the patient requires care outside the individual specialist’s clinical competence or scope of practice.

If declining a referral, Colleges generally expect specialists to quickly communicate the refusal to the referring healthcare practitioner and, if appropriate, the patient. This gives referring physicians and patients time to find another healthcare provider. When possible, Colleges recommend that specialists suggest alternative providers who may be able to accept the referral.

Recognizing that some refusals can be seen as discrimination, some Colleges expect specialists to “clearly and respectfully communicate the reasons to the individual making the request, thereby dispelling possible perceptions of discrimination.” The refusal and the rationale should also be documented in specialists’ files.

While a defined scope of practice is an acceptable reason for refusing a referral, it is not acceptable to use it as a means to discriminate.
Discrimination
When asked to accept a referral, specialists should keep in mind that they are prohibited from discriminating against patients.

Many Colleges incorporate or refer to provincial or territorial human rights legislation when addressing discrimination in their policies on accepting new patients. For example, the College of Physicians and Surgeons of Nova Scotia’s policy refers to the Nova Scotia Human Rights Act. That legislation prohibits discrimination regarding provisions of or access to services or facilities on the basis of “age, race, colour, religion, creed, sex, sexual orientation, gender identity, gender expression, physical disability or mental disability, an irrational fear of contracting an illness or disease, ethnic, national or aboriginal origin, family status, marital status, source of income, political belief, affiliation or activity, or an individual’s association with another individual or class of individuals having characteristics aforementioned.”

Other Colleges’ policies also address forms of discrimination specific to healthcare. For instance, the College of Physicians and Surgeons of Ontario states physicians cannot refuse patients “with complex or chronic health needs; with a history of prescribed opioids and/or psychotropic medications; requiring more time than another patient with fewer medical needs; or with an injury, medical condition, psychiatric condition or disability that may require the physician to prepare and provide additional documentation or reports.”

The bottom line
▪ Accept new referrals on a first-come, first-served basis, free from discrimination.
▪ Triage patients based on the urgency of their clinical needs. If you have a wait list, manage it to provide patients with more urgent needs greater access to care. Ensure patients on the wait list are appropriately monitored and they know who to call if there is a change in their condition.
▪ If it is necessary to decline a referral because the patient requires care outside your clinical competence or scope of practice, assist the referring physician and patient by recommending an alternative care provider, if possible.

Additional reading at www.cmpa-acp.ca
▪ CMFP Good Practices Guide: “Consultations and referrals” in the Communication domain
▪ “New to practice? Practical tips for physicians in the first 5 years”

Other resources
▪ Guide to Enhancing Referrals and Consultations Between Physicians, a joint publication by The College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada
▪ Creating Effective Consultation Letters, a publication of Bruyère, Ottawa (https://www.bruyere.org/en/Consultationletters)
Can AI assist you with clinical decisions? 
Looking at the benefits and risks of AI technologies in medicine

This article is adapted from “A Primer on Law, Risk and AI in Health Care,” published in Healthcare and Life Sciences Law Committee Update (Vol. 3 no. 1, Sept. 2018), and is reproduced by permission of the International Bar Association, London, UK. © International Bar Association.

Technological developments currently transforming the healthcare sector, including artificial intelligence (AI), robotics, and big data, are poised to revolutionize patient care.
What is artificial intelligence?

AI can be broadly defined as the capacity of a machine or computer to mimic intelligent human thought processes and learn new information. “Machine learning” allows computers to gain experience without being programmed to do so. Common applications of machine learning include image and speech recognition. “Deep learning” involves processing information and learning patterns that can be tied to big data analytics.

Imagine your mobile phone could scan patients and immediately provide you with a diagnosis, like something out of Star Trek, or a robotic medic could perform patient procedures unassisted by humans. While these innovations might still seem like science fiction, technological developments currently transforming the healthcare sector, including artificial intelligence (AI), robotics, and big data, are poised to revolutionize patient care.

Opportunities and challenges

With time, AI technologies are expected to improve healthcare and change the way it is delivered. For example, AI is being explored with other tools as a means of increasing diagnostic accuracy, improving treatment planning, and forecasting outcomes of care. AI has shown particular promise for clinical application in image-intensive fields, including radiology, pathology, ophthalmology, dermatology, and image-guided surgery. However, evidence about the effectiveness and reliability of the practical applications of AI continues to be limited. Despite the attention AI is receiving, the reality is that many technologies have not yet developed sufficiently at this time to determine whether they can meet their potential. For example, suicide prediction models have largely been ineffective to date.

Other challenges with AI include the inability to explain its reasoning processes, otherwise known as the “black box” effect. The utility of AI in patient care can be limited in some situations when the AI-assisted diagnosis does not include information to verify its reliability. The dataset used by some AI technologies to “learn” also has the potential to introduce bias. For example, a dataset that unintentionally excludes patients with certain backgrounds, conditions, or characteristics may not be reliable for broader segments of the population.

Measured approach to AI

When considering whether to use AI in your practice generally, it is important to be familiar with when and how it should be used, and to make such decisions based on the circumstances of each patient.

While the regulation of AI remains in development, some medical regulatory authorities (Colleges) and professional associations have issued interim guidelines. For example, the College of Physicians and Surgeons of British Columbia has suggested physicians apply a grading system to assess the quality of applications (or apps) that incorporate AI. The College suggests using the App Evaluation Model developed by the American Psychiatric Association, a five-step assessment of an app’s business model: advertising conflicts of interest, privacy and security, the evidence base that informs the algorithm, ease of use, and interoperability.

The Canadian Medical Association’s Guiding Principles for Physicians Recommending Mobile Health Applications to Patients may also be a helpful resource. The objective of
using an AI-based technology should be to enhance patient care and complement the physician-patient relationship. Physicians using AI need to be mindful of their legal and medical professional obligations, and discuss the appropriateness of using AI technology and privacy risks with the patient. The CMA also suggests considering whether there is evidence of an app’s safety and effectiveness, and whether it is endorsed by a professional organization, is easy to use, and demonstrates a high standard of security.

While endorsement of an AI technology from a reputable professional or regulatory organization may be a factor to consider in evaluating whether you have complied with your professional and legal obligations, you should still review and seek advice on its suitability in clinical practice, including consideration of the following, among other things: What are the terms of use? Has the AI technology been subject to rigorous evaluation of its accuracy, consistency, and reliability? Does it use appropriate privacy and confidentiality safeguards and policies (e.g. patient consent, encryption, password protection)?

**COMPLEMENTING CLINICAL JUDGMENT**

AI offers information and recommendations based on the aggregation of a wide variety of data sources. Nevertheless, physicians must still exercise clinical judgment when making a final decision about clinical care. A CMA survey found that 6 in 10 Canadians are interested in the potential benefits of AI in healthcare, but would trust a diagnosis made only by a physician.10

Before deciding to use an AI-based technology in your medical practice, it is important to evaluate any findings, recommendations, or diagnoses suggested by the tool. While AI can provide information for you to consider, it is important to ensure that actual medical care provided to the patient reflects your own recommendations based on objective evidence and sound medical judgment.

Most AI applications are designed to be clinical aids used by clinicians as appropriate to complement other relevant and reliable clinical information and tools. In today’s environment, and for the foreseeable future, AI is not intended to replace a physician’s clinical experience and thoughtful analysis of a patient’s condition.

**THE BOTTOM LINE**

- Evaluate whether the use of the AI tool is appropriate in the circumstances of each patient.
- Critically review and assess whether AI-based technologies are suited for the intended use and the nature of your practice. Consider the quality, effectiveness, and functionality of the technology; robustness of the database; reliability of the medical evidence informing the algorithm; privacy and confidentiality requirements; and applicable policies or guidelines of your College or health institution.
- AI technologies are currently intended to complement clinical care by informing your decision-making. Continue to exercise professional judgment in making clinical decisions and treatment recommendations aided by AI technologies, in accordance with the expected standard of care.
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SAFE MEDICAL CARE

Walk-in clinics: Unique challenges to quality of care, medical-legal risk

Walk-in clinics offer convenient, same-day care for episodic patient concerns, typically without an expectation of the patient joining the physician’s roster. Such care can be valuable to patients with busy schedules, who have acute conditions, and for those who do not have a family physician. They are often valued by patients for their convenience, but may present challenges and risks to physicians. A lack of continuity of care, which may hinder quality of care, is an issue of concern.

Provincial/territorial medical regulatory authorities (Colleges) state that patients in walk-in clinics are entitled to care that is of the same “appropriate and professional standard” as in any other setting. In practice, the distinctive characteristics for physicians working in walk-in clinics, such as seeing patients episodically and in large volumes over short time periods, can heighten challenges.

Recognizing the unique medical-legal challenges faced by physicians who work in walk-in clinics, the CMPA looked at civil legal cases and College and hospital complaints that closed between 2014-2018 and involved a walk-in clinic. This analysis revealed patient safety issues such as a lack of team communication, poor management of test results, and the absence of reviewing delegated work.

COMMUNICATING WITH THE HEALTHCARE TEAM

Managing clear communication between team members can be difficult for walk-in clinic physicians, particularly when patients require ongoing care or follow-up.

CASE EXAMPLE

A physician is unreachable after prescribing a potentially contraindicated medication

An elderly woman presents to a walk-in clinic complaining of a persistent cough. The patient is afebrile but chest auscultation reveals bilateral crackles. After reviewing the patient’s list of medications, the physician prescribes azithromycin for presumed pneumonia and orders a chest X-ray to confirm the diagnosis. Upon receiving the prescription, the patient’s pharmacist has concerns this treatment would conflict with the patient’s antiarrhythmic medication, and attempts to reach the prescribing physician. However, the physician, who works part-time in the clinic, is unreachable by phone. The pharmacist does not dispense the antibiotic and advises the patient to follow up with her family physician. Days later, the walk-in clinic physician notifies the patient that she has pneumonia. The patient subsequently follows up with her own family physician who prescribes an appropriate antibiotic. The patient complains to the College that she had been prescribed a contraindicated medication by the physician at the clinic.

What did the College say?

The College committee appreciated that, subsequent to the complaint, the physician voluntarily took steps to be more accessible to other members of the healthcare team. The committee was concerned that the physician, having prescribed a contraindicated medication that could have posed a serious risk to the patient, was unavailable to correct the situation. It counseled the physician to make himself more accessible to other members of the healthcare team.
Risk mitigation strategies
- Provide clinic staff with clear instructions about who to notify of patients’ telephone calls or calls from healthcare providers. Respond in a timely manner when contacted.
- Document the patient encounter in the medical record, providing the rationale for the care plan and facilitating continuity of care.
- Advocate for policies and procedures that ensure someone can answer questions from other healthcare providers in a timely manner when the attending physician is unavailable or no longer with the clinic.

Managing diagnostic tests
The processes around ordering, reviewing, and following up on diagnostic tests can be unclear to physicians, owing to the variability of policies and procedures at different walk-in clinics. Even when working part-time or on contract in a walk-in clinic, physicians remain responsible for ensuring that diagnostic processes are followed.

CASE EXAMPLE
An incorrect diagnostic test is ordered
An elderly woman presents to a walk-in clinic after falling down the stairs and hitting her head. She complains of headache and some memory loss. The walk-in clinic physician requests a medical office assistant to complete a requisition and book an urgent CT scan of the head. When the patient arrives at the hospital, she discovers that the walk-in clinic staff had incorrectly booked her for a mammogram. The patient complains to the College about the booking error and inconvenience of attending an additional appointment. The walk-in clinic determines that the mammogram booking was intended for a different patient and that the woman’s name and information was entered in error.

What did the College say?
The physician claimed that the error was due to a mix-up by front office staff and not through any fault of her own. She claimed that staff are supplied by the owners of the clinic and that supervising them is not part of her role. However, the College disagreed, and found that the walk-in clinic physician was ultimately responsible for the conduct of the medical staff, even though she was an independent contractor at the clinic. They advised her to assure that reliable processes be implemented so that correct tests are ordered.

Risk mitigation strategies
- Advocate for and review whether adequate protocols are in place to enable appropriate ordering, management, and follow-up of investigations.
- While not a required practice, consider completing patient requisitions personally when possible, to reduce the risk of errors.
- Consider the medical-legal risks of delegating tasks to administrative staff.
The bottom line

Walk-in clinics provide episodic care to patients without expectation of a longitudinal relationship. They serve a valuable role for patients who require same-day appointments with flexible hours. However, the unique setting may raise unexpected challenges for physicians aiming to provide the safest medical care possible to their patients.

Consider the following to help reduce medical-legal risks associated with providing care at a walk-in clinic:

▪ Review the key elements of the patient’s medical record before establishing a diagnosis.

▪ Support continuity of patient care, which includes documenting each patient visit in the medical record.

▪ Be familiar with, and follow established processes at the clinic for patient follow-up and effective communication among clinic staff. If the processes are not robust, provide your feedback to the clinic’s administration.

Additional reading at www.cmpa-acpmc.ca

▪ “Limiting discussion to one medical issue per visit—know the risks”

▪ “Closing the loop on effective follow-up in clinical practice”

▪ “Who has custody of medical records and who can they be shared with”

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Reviewing delegated work

While walk-in clinics facilitate same-day visits, they may introduce challenges to quality of care in some instances, such as when a patient is new to the physician and has multiple comorbidities. Clinics may increase efficiency by assigning tasks to other staff members, such as requiring a nurse or physician assistant to obtain a medical history from the patient. However, a physician who fails to review the medical history risks proceeding with incomplete information.

Case example

A physician fails to examine a breast lump

A young woman presents to a walk-in clinic complaining of heart palpitations, which have increased in severity and frequency. During the initial intake interview, she explains to the nurse that she is also experiencing fatigue, difficulty breathing, and a fluctuating right breast lump. The woman later describes the same symptoms to the walk-in clinic physician, except for the breast lump. The physician does not review the nurse’s notes, which includes documentation of the lump. As the patient leaves the appointment, she asks about the lump. The physician does not examine the patient and declares it to likely be a cyst. He advises the patient to return to the clinic if it changes in size or becomes painful. Months later the patient is diagnosed with stage II breast cancer and undergoes a partial mastectomy, chemotherapy, and radiation.

What did the College say?

The College criticized the physician for failing to examine the patient’s breast, and noted that he was seeing too many patients per shift. The College required him to sign an agreement that limited the number of patients he would see during a shift, and that he attend a course on reviewing and maintaining documentation.

Risk mitigation strategies

▪ Review all key elements of the patient’s medical record, for example, nursing notes, vital signs, relevant past entries, test results, and consultation reports before establishing a diagnosis.

▪ Provide the patient with clear discharge instructions. The information should enable the patient to understand the diagnosis and to be aware of the signs and symptoms that may indicate the evolution of the disease or potentially point to a different diagnosis. It should also convey the importance of following up and specify whom to contact for follow-up.

▪ Encourage patients to return to the walk-in clinic or to follow up with their family physician if they have one, for concerns not adequately addressed in the visit.

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2019 CMPA Annual Meeting and Conference

Reflecting on the increasing pace of change in Canadian healthcare—including new technologies, changing service delivery models, and evolving expectations—Dr. Boyce emphasized the CMPA’s commitment to continue delivering core medical liability protection. She described how the CMPA is evolving its services to meet members’ changing needs and assist members in proactively identifying and resolving medical-legal issues before their practices are affected.

In 2018, the CMPA provided members with advice, empathetic support, and assistance on 22,600 specific medical-legal matters that resulted from the professional practice of medicine. The Association opened over 900 cases involving civil litigation, 1,900 cases related to hospital privileges and complaints, and 5,600 cases dealing with College complaints, investigations, and hearings. While the number of civil legal actions remained consistent with those of previous years, the increasing number of members seeking CMPA assistance with College and hospital matters reflects the growing pressures facing physicians.

The CMPA continued to expand the reach of its safe medical care education, delivering 300 practice improvement sessions to over 18,000 physicians and other healthcare professionals, and reaching 11 of the 17 medical schools in Canada with the Resident Symposium (with plans in place to reach all schools in 2020). Through its subsidiary, Saegis, the CMPA extended its range of tailored, safe medical care programs available to members, allied healthcare professionals, clinics, and institutions, including offering the highly regarded Just Culture certification course and working with Surgical Safety Technologies (SST) to develop the SafeORTM program. Through its support of Salus Global and the MOREO™ program, the CMPA will make a tangible contribution to the improved safety of prenatal and obstetrical care.

CMPA Executive Director and Chief Executive Officer, Dr. Hartley Stern, discussed the nature of trust and its foundational role in healthcare. He reinforced the need for all parties to work to strengthen trust—from physician-to-patient and physician-to-government—and reaffirmed the CMPA’s commitment to continue to uphold members’ trust by maintaining core CMPA values and providing compassionate assistance and support.

2018 Financial report

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

At the end of 2018, the Association’s total assets were 116% of the total estimated liabilities or a positive position of $645 million. This positive position has enabled the CMPA to reduce the fees it will collect from members in 2020.

The aggregate member fee requirements for 2020, both by region and by member, were provided and are now available on the CMPA website, www.cmpa-acpm.ca.
Governance renewal
In response to a motion from the 2017 meeting and after careful consideration, the CMPA has chosen to pursue governance renewal through means other than mandated term limits. The president outlined the action being taken to support governance renewal, including a more robust council performance evaluation process and a greater focus on candidates for council with a wide range of diversity factors and experience.

Full-day format
The full-day format provided members with access to expanded risk management and educational sessions. More than 134 attendees participated in the morning’s interactive, hands-on workshop, Test Results Follow-Up - Is no news good news? Build a more reliable follow-up system for test results, earning CPD credits and learning how to plan a safer system for managing test results.

Artificial Intelligence (AI) in healthcare
During a very well-attended information session moderated by Dr. Lisa Calder, Director, Medical Care Analytics, Dr. David Naylor, professor of medicine and president emeritus, University of Toronto delivered an insightful information session on Artificial Intelligence (AI) in healthcare. He described how AI is being used in healthcare today and outlined many of its potential applications and advantages while, at the same time, noting the current shortfalls. Dr. Hartley Stern, CEO of the CMPA, discussed some of the medical-legal implications of AI and deep learning, and encouraged policy makers to set in place the parameters to guide physicians in their use of AI in delivering care.

Both the annual meeting and information session were webcast live and accessible to members. Session recordings and supporting material are available at www.cmpa-acpm.ca.

Council elections
Ten positions on CMPA Council were scheduled for election in 2019. See the back cover for results and acclamations.

Will you join us on Council?
Diversity on CMPA Council benefits all members as we work to protect and support the needs of Canadian physicians.

- Diverse backgrounds
- Diverse lived experiences
- Diverse viewpoints

Visit www.cmpa-acpm.ca/elections for more on the 2020 CMPA Council nomination and election process, or contact us at elections@cmpa.org.
CMPA Council elections 2019

RESULTS
In 2019, 10 positions were scheduled for nomination and election to the CMPA Council. Here are the results of the election:

BRITISH COLUMBIA AND YUKON
- Dr. Paul Anthony Farnan Re-elected

ALBERTA
- Dr. Susan M.J. Chafe Re-elected

SASKATCHEWAN, NORTHWEST TERRITORIES, AND NUNAVUT
- Dr. Mansfield Mela Acclaimed

ONTARIO
- Dr. Elliot M.H. Halparin Re-elected
- Dr. M. Christopher Wallace Re-elected
- Dr. Jennifer Clara Tang Elected

QUÉBEC
- Dr. Jacques Bouchard Elected
- Dr. Fahimy Saoud Elected

NEW BRUNSWICK
- Dr. Jennifer Anne Gillis-Doyle Re-elected

NEWFOUNDLAND AND LABRADOR
- Dr. Michael T. Cohen Acclaimed

MEET YOUR NEW MEMBERS OF COUNCIL

Dr. Jacques Bouchard from Québec City, Québec, is an associate professor of clinical medicine at the University of Laval and practises family medicine in La Malbaie. He is the department head (by interim) of general medicine at the Centre intégré universitaire de santé et de services sociaux, Capital Region.

Dr. Mansfield Mela from Saskatoon, Saskatchewan, is a founder of the forensic psychiatry subspecialty in Canada, practising as a consultant psychiatrist at the Royal University Hospital and the Regional Psychiatric Center in Saskatoon. He holds a faculty appointment as a professor of psychiatry at the University of Saskatchewan.

Dr. Fahimy Saoud from St. Laurent, Québec, is a family physician with the Council of Physicians, Dentists and Pharmacists at the Lachine Hospital, affiliated with the McGill University Health Centre. She teaches at St. Mary’s Hospital supervising international medical graduates.

Dr. Jennifer Clara Tang from Hamilton, Ontario, practises emergency medicine and is an assistant clinical professor in the academic community of McMaster University. She has experience as an investigative coroner and presiding inquest coroner for the province of Ontario and the greater community of Hamilton and Brant County.

COUNCIL’S LEADERSHIP TEAM

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

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

2nd Vice-President
Dr. Jean-Hugues Brossard, an endocrinologist from Montréal, Québec

A list of all members of council is available on the CMPA website www.cmpa-acpm.ca