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Perspective

VOLUME 12 NO. 1 MARCH 2020

Writing with care Word choice and tone matter in medical records and reports

Opioid use,
rare infections,
challenging diagnoses

Having difficult
encounters with patients?

Tips on closing or
leaving family practice

Patients' medical records:
Whose are they?

COVID-19: Advice, support, and medical-legal information

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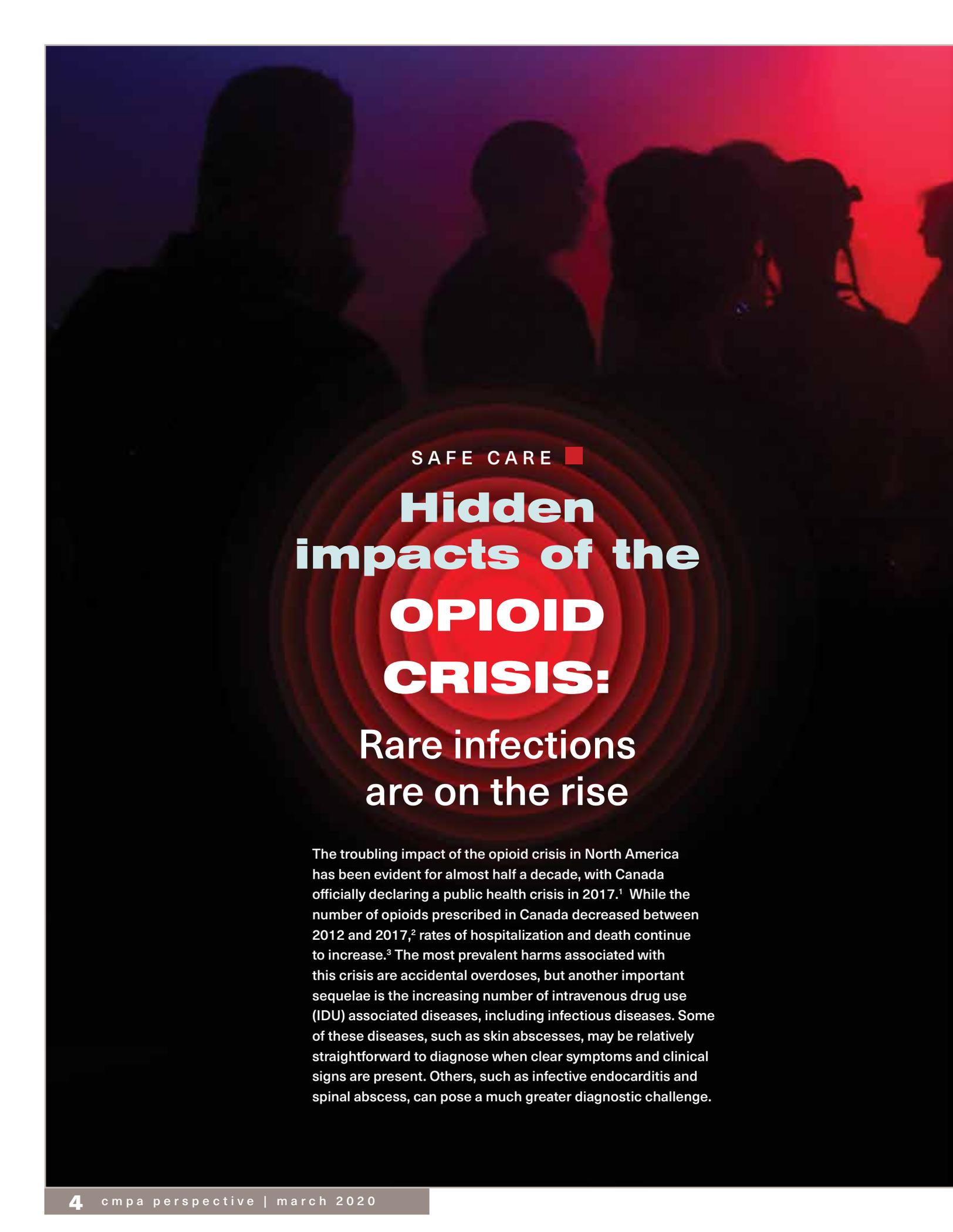
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SAFE CARE ■

Hidden impacts of the OPIOID CRISIS: Rare infections are on the rise

The troubling impact of the opioid crisis in North America has been evident for almost half a decade, with Canada officially declaring a public health crisis in 2017.¹ While the number of opioids prescribed in Canada decreased between 2012 and 2017,² rates of hospitalization and death continue to increase.³ The most prevalent harms associated with this crisis are accidental overdoses, but another important sequelae is the increasing number of intravenous drug use (IDU) associated diseases, including infectious diseases. Some of these diseases, such as skin abscesses, may be relatively straightforward to diagnose when clear symptoms and clinical signs are present. Others, such as infective endocarditis and spinal abscess, can pose a much greater diagnostic challenge.



■ CASE EXAMPLE DELAYED DIAGNOSIS OF AN EPIDURAL ABSCESS

A 47-year-old woman⁴ presents to a walk-in clinic complaining of thoracic back pain after a recent fall. Her medical history includes frequent visits to the emergency department and therapeutic use of methadone. Findings on physical examination include multiple skin abscesses on her arms and a low-grade fever. The doctor diagnoses a musculo-skeletal cause to explain her back pain, prescribes an analgesic, and orders thoraco-lumbar spine X-rays.

The following day, the patient presents to the emergency department of a community hospital with back and abdominal pain. She has a temperature of 39.2°C and her white cell count is $21 \times 10^9/l$. The physician prescribes oral ciprofloxacin, documents musculo-skeletal pain, and orders repeat blood work. At shift change, care transfers to a second physician who performs an incision and drainage of a lesion on the patient's arm, and discharges her with a diagnosis of subcutaneous abscess.

The patient returns that evening, staggering, somnolent, and complaining of numbness in both legs. The physician on duty reaches the patient's family doctor who shares that the patient currently uses intravenous fentanyl. The physician administers

naloxone, admits the patient, and orders blood cultures. Both blood cultures are positive for *Staphylococcus aureus*. The patient now complains of weakness in her legs and difficulty voiding. The physician orders an urgent MRI, which reveals an epidural abscess with cord compression at T3, and the patient is referred for an urgent laminectomy. The patient is left with paraplegia and launches a legal action.

In their review of the case, peer experts expressed concern about the absence of a documented neurological exam in the emergency department, and were critical of the first physician for a lack of clear differential diagnosis. Criticisms of the care in the first emergency visit focused on a lack of clear follow-up arrangements, inadequate discharge instructions, and poor documentation. The CMPA settled on behalf of the physicians.

DIAGNOSTIC CONSIDERATIONS

Infective endocarditis, discitis, and epidural abscesses are well known among physicians for being difficult to diagnose, and characterized by symptoms that may mimic more common conditions. If the patient is using intravenous drugs, diagnosis can be further complicated by social stigma, variability in terms of patient consent, and adherence to treatment and follow-up plans (e.g. being unable to afford medications or poor access to transportation for appointments).



From 2017 to 2018, Canadians experienced an 11.4% increase in opioid-related deaths,² and a 27% increase in opioid-related hospital admissions.⁵ A retrospective analysis of IDU associated infective endocarditis in Ontario similarly reported a rise in the average number of hospital admissions, from 13.4 per quarter in 2006 to 35.1 per quarter in 2015.⁶

A review of CMPA cases closed between 2002 and 2014 revealed 14 medical-legal matters related to diagnostically challenging, IDU-associated conditions: 11 involving spinal epidural abscess or infective discitis, and three involving infective endocarditis (Figure 1). All of the matters were civil legal cases except for one College complaint (Figure 2). Of the 13 civil legal cases, 8 ended in a settlement and 5 were dismissed by the court (Figure 3). Of the 8 cases ending in a settlement, 5 involved shared liability of the physician(s) with hospitals or telehealth services.

FIGURE 1.

Distribution of 14 closed civil legal and College cases (2002–2014) related to diagnostically challenging, IDU-associated conditions by infection type



FIGURE 2.

Distribution of 14 closed civil legal and College cases (2002–2014) related to diagnostically challenging, IDU-associated conditions by case type



FIGURE 3.

Distribution of 13 closed civil legal cases (2002–2014) related to diagnostically challenging, IDU-associated conditions by case outcome



Diagnostic difficulties resulting from lost situational awareness, complex patient social circumstances, and communication breakdowns were prominent in these cases, and have a particular relevance when treating patients who use intravenous drugs. For example, all of the primary care practitioners worked in walk-in clinics, contributing to continuity of care issues.⁷ The complexities of communication within emergency care teams presented additional challenges, and communication issues in this setting led to diminished team situational awareness. In three spinal abscess cases, this resulted in a failure to recognize neurological deterioration over time. Failure to appreciate the significance of repeat presentations to the emergency department was also prominent, as were cognitive biases.⁸ Attribution bias (i.e. assumptions about addiction influencing perceptions of patient behaviour) in particular appeared common, and could be observed in some of the language used to describe patients.

RISK MANAGEMENT STRATEGIES

When managing patients with a history of substance abuse disorder be aware of how cognitive biases can narrow diagnostic inquiry, and be on the lookout for indicators of increasingly prevalent rare infections in patients with a history of IDU. Some additional risk management strategies of relevance to the diagnostic challenges observed during this review include:

- Consider the use of structured tools at handover to communicate management plans, including monitoring and risk of deterioration, to facilitate team situational awareness.
- Be aware of repeat presentations to the emergency department⁹ and the presence of worsening symptoms that can provide an indicator of a condition that has been overlooked. Biases toward this patient population can also influence diagnostic reasoning. Recognizing these can motivate the caregivers to reconsider the differential diagnosis.
- Consider seeking a collateral history from family members or other care providers when crucial information remains unavailable.

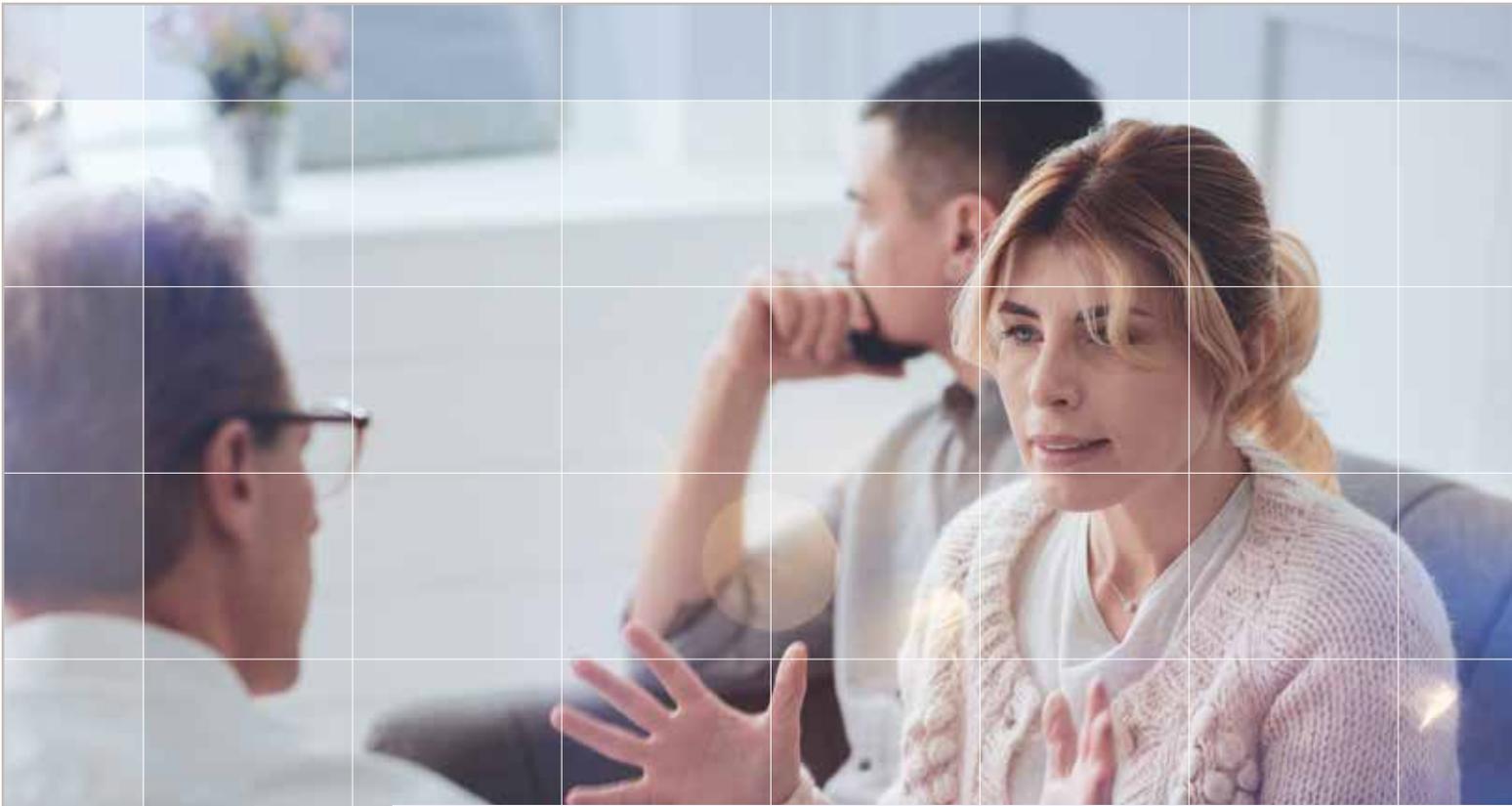


THE BOTTOM LINE

The opioid crisis has been associated with an increasing prevalence of serious infections related to intravenous drug use. These conditions can be diagnostically challenging, and many of the affected patients are vulnerable to stigma and bias. Factors contributing to diagnostic error in these cases include breakdowns in team communication, loss of situational awareness, and inadequate physical examination. ■

ADDITIONAL READING AT WWW.CMPA-ACPM.CA

- “What happened to the physical exam?”
 - “Spinal epidural abscess: A rare, insidious and potentially catastrophic infection”
 - “Walk-in clinics: Unique challenges to quality of care, medical-legal risk”
1. Health Canada [Internet]. Ottawa(CA): Health Canada; 2017. New Federal Initiatives to Address the Opioid Crisis [cited 2020 Jan]
 2. Canadian Institute for Health Information [Internet]. Ottawa(CA): CIHI; 2018. Pan-Canadian Trends in the Prescribing of Opioids and Benzodiazepines, 2012-2017 [cited 2020 Jan]
 3. Special Advisory Committee on the Epidemic of Opioid Overdoses [Internet]. National report: Opioid-related Harms in Canada Web-based Report. Ottawa(CA): Public Health Agency of Canada; December 2019 (cited 2020 Jan)
 4. This case history is a composite based on actual medical negligence claims. However, certain facts have been omitted or changed to ensure the anonymity of the parties involved
 5. Canadian Institute for Health Information [Internet]. Ottawa(CA): CIHI; 2018. Opioid-Related Harms in Canada, December 2018 [cited 2020 Jan]
 6. Weir MA, Slater J, Jandoc R, et al. The risk of infective endocarditis among people who inject drugs: a retrospective, population-based time series analysis. *CMAJ* [Internet]. 2019 [cited 2020 Jan];191(4):E93-E9
 7. Canadian Medical Protective Association [Internet]. Ottawa(CA): CMPA; 2019 Sept. Walk-in clinics: Unique challenges to quality of care, medical-legal risk [cited 2020 Jan]
 8. Edlin BR, Kresina TF, Raymond DB, et al. Overcoming barriers to prevention, care, and treatment of hepatitis C in illicit drug users. *Clin Infect Dis* [Internet]. 2005 [cited 2020 Jan];40(5): Suppl:S276-S285
 9. Canadian Medical Protective Association [Internet]. Ottawa(CA): CMPA; Sept 2013 (revised 2018 Sept). Stop and think: Return visits offer another chance [cited 2020 Jan]



YOUR PRACTICE ■

Difficult patient encounters

What you can do to prevent, manage, and de-escalate

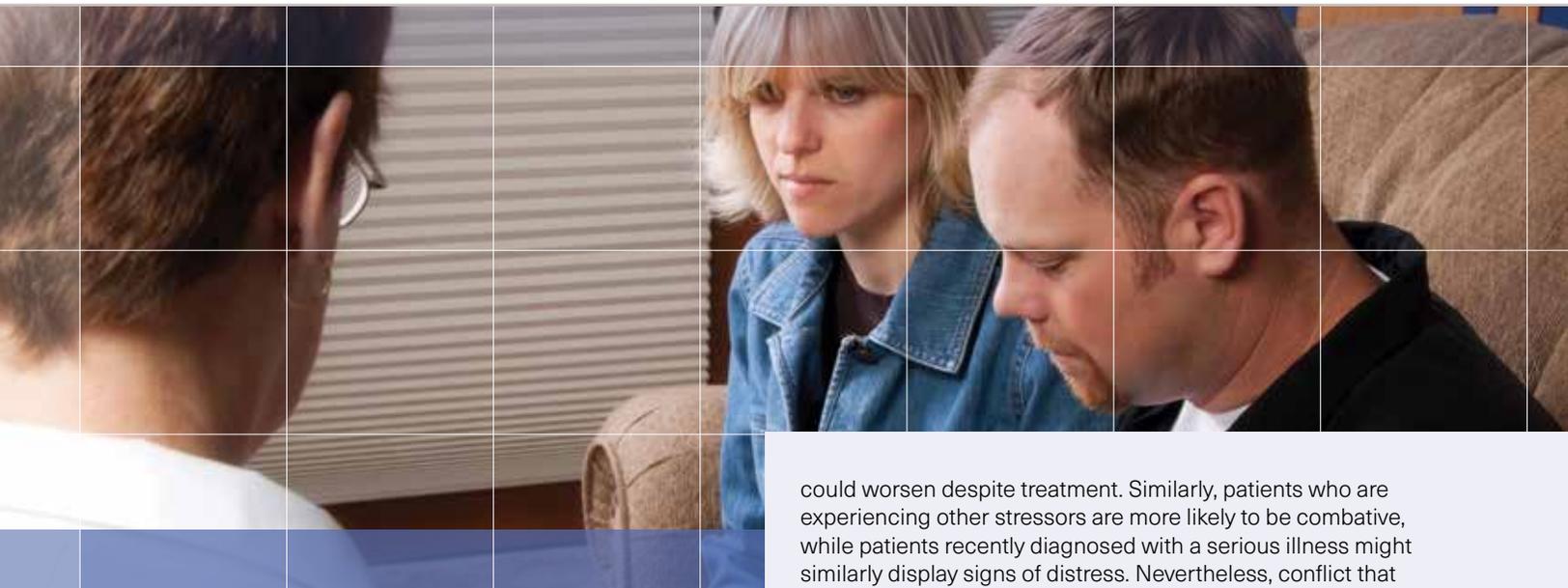
Disagreements and difficult encounters with patients are inevitable at some point in a physician's practice. Physicians who have frequent difficult patient encounters are more likely to report stress and burnout than those with fewer difficult encounters.¹ Conversely, when there is a high level of trust in the doctor-patient relationship, patients are more likely to agree with the proposed course of treatment and experience higher overall satisfaction with the care they receive.²

Conflict may also arise when dealing with patients' families, caregivers, and substitute decision-makers. "Because illness affects not only patients but also their families, physicians must be able to communicate effectively with everyone involved in the patient's care."³

Conflict in the context of clinical care may lead to complaints to regulatory authorities (Colleges) and other medical-legal difficulties for physicians. Physicians can take steps to avoid misunderstandings that may lead to conflict. When conflict does occur, it is beneficial for physicians and office staff to have the means to respond effectively and de-escalate it.

Prevention and management of conflict are important elements of a successful clinical practice. These elements can be attained through training and continuing education in conflict resolution, and by instilling conflict management principles and processes in the culture of the healthcare workplace.





LISTENING AND COMMUNICATING

Eliciting patients' concerns and listening carefully to them contributes to patient-centred care. However, when a physician does not elicit patients' concerns or interrupts too soon, the chance that the clinical encounter addresses the specific concerns that matter most to patients is reduced.⁴

The realities of medical practice necessitates efficiency in how patients' health conditions are assessed, and this includes being skilled in active listening.

- State your understanding of the issue back to patients. This helps to reassure patients and confirms that your understanding of them is accurate.
- Be aware of language barriers, cultural distinctions, and patients' overall health literacy that might affect how patients perceive your instructions and advice. Use language appropriate to patients' ability to understand, avoiding medical jargon where possible. Confirm patients' comprehension of the diagnosis and recommended care plan.
- Be clear about your intentions, such as when asking personal questions and the clinical reason for performing a physical examination.
- Consider using communication models such as ACE (Authority, Collaboration, Empathy) and FIFE (Feelings, Ideas, Functioning, Expectations) in providing patient-centred care.⁵
- In a factual and non-judgmental way, document in patients' medical records any inappropriate statements conveyed or behaviour displayed by patients toward you or your office staff. You may choose to include verbatim statements made by patients, clearly attributing these to patients and shown in quotation marks.

MANAGING EXPECTATIONS

Unmet patient expectations may result in conflict. For example, patients might not agree with your proposed care plan, they may be dissatisfied with the care provided, or their condition

could worsen despite treatment. Similarly, patients who are experiencing other stressors are more likely to be combative, while patients recently diagnosed with a serious illness might similarly display signs of distress. Nevertheless, conflict that is addressed before it becomes unmanageable can be an opportunity to better understand patients and their needs and concerns.

- Try to understand patients' behaviour in the context of their overall life situation, mental health, and medical condition. More often than not, patients' expectations can be met—such as fulfilling a request for information, expressing compassion in the face of difficult circumstances, and showing respect during treatment—thus reducing the potential for minor irritants to be magnified into major challenges.⁶

HANDLING MORE DIFFICULT SITUATIONS

Despite a physician's best efforts to resolve a conflict, there may be situations that do not improve. It is important to limit and de-escalate disagreements, thus mitigating the potential for verbal aggression or even violence.

- Obtain training for you and your staff on effective patient interactions and conflict de-escalation from a trusted learning provider.⁷
- Develop an office security policy that outlines how you and your staff will respond to offensive language and aggressive behaviour.
- Develop an office safety plan, including considerations for the physical layout of the office or clinic, and any additional security measures such as a lockdown procedure and drills with office staff.
- Communicate the security policy and safety plan with your staff, and consider renewing that communication annually.
- Post a notice in a visible location in the office, conveying that inappropriate language and behaviours will not be tolerated.
- If your efforts in changing a patient's aggressive behaviour are unsuccessful and there is a breakdown in the trust relationship that cannot be resolved, consider whether it is necessary to terminate the patient from your practice. Follow your College's guidelines when contemplating terminating a doctor-patient relationship.



THE BOTTOM LINE

- Prepare for difficult patient encounters through conflict management training, and implementing a security policy and office safety plan. Support office staff by ensuring they have adequate tools and resources to de-escalate conflict.
- When faced with rising tensions with patients, strive to keep calm, explain the situation factually, and offer possible solutions. If you perceive the situation presents a danger to patients, yourself, or your staff, prioritize safety.
- Following the event, document what had occurred in the medical record. Be objective and avoid emotional language.
- Contact the CMPA for advice on handling incidents of conflict that arise in a doctor-patient relationship. ■



ADDITIONAL READING AT WWW.CMPA-ACPM.CA

- “The office safety plan”
 - “Ending the doctor-patient relationship”
 - “How to manage conflict and aggressive behaviour in medical practice”
1. An PG, Manwell LB, Williams ES, et al. Does a higher frequency of difficult patient encounters lead to lower quality care? J Fam Prac [Internet]. 2013 Jan [cited 2019 July 2];62(1):24-9
 2. Fuertes JN, Toporovsky A, Reyes M, et al. The physician-patient working alliance: Theory, research, and future possibilities. Patient Education & Counseling. 2017;100:610-5
 3. Royal College of Physicians and Surgeons of Canada [Internet]. Ottawa(CA): RCPSC; 2019. CanMEDS Role: Communicator [cited 2019 July 9]
 4. Singh Ospina N, Phillips KA, Rodriguez-Gutierrez R, et al. Eliciting the Patient's Agenda - Secondary Analysis of Recorded Clinical Encounters. J Gen Intern Med [Internet]. 2019 Jan [cited 2019 July 9];34(1):36-40
 5. Canadian Medical Protective Association [Internet]. Ottawa(CA):CMPA; 2017 Jan. How to manage conflict and aggressive behaviour in medical practice [cited 2019 July]
 6. Royal College of Physicians and Surgeons of Canada [Internet]. Ottawa(CA): RCPSC; 2019. Conflict resolution [cited 2019 July 9]
 7. The CMPA subsidiary, Saegis, offers accredited learning programs aimed at advancing patient safety and practice management. Visit www.saegis.solutions for details

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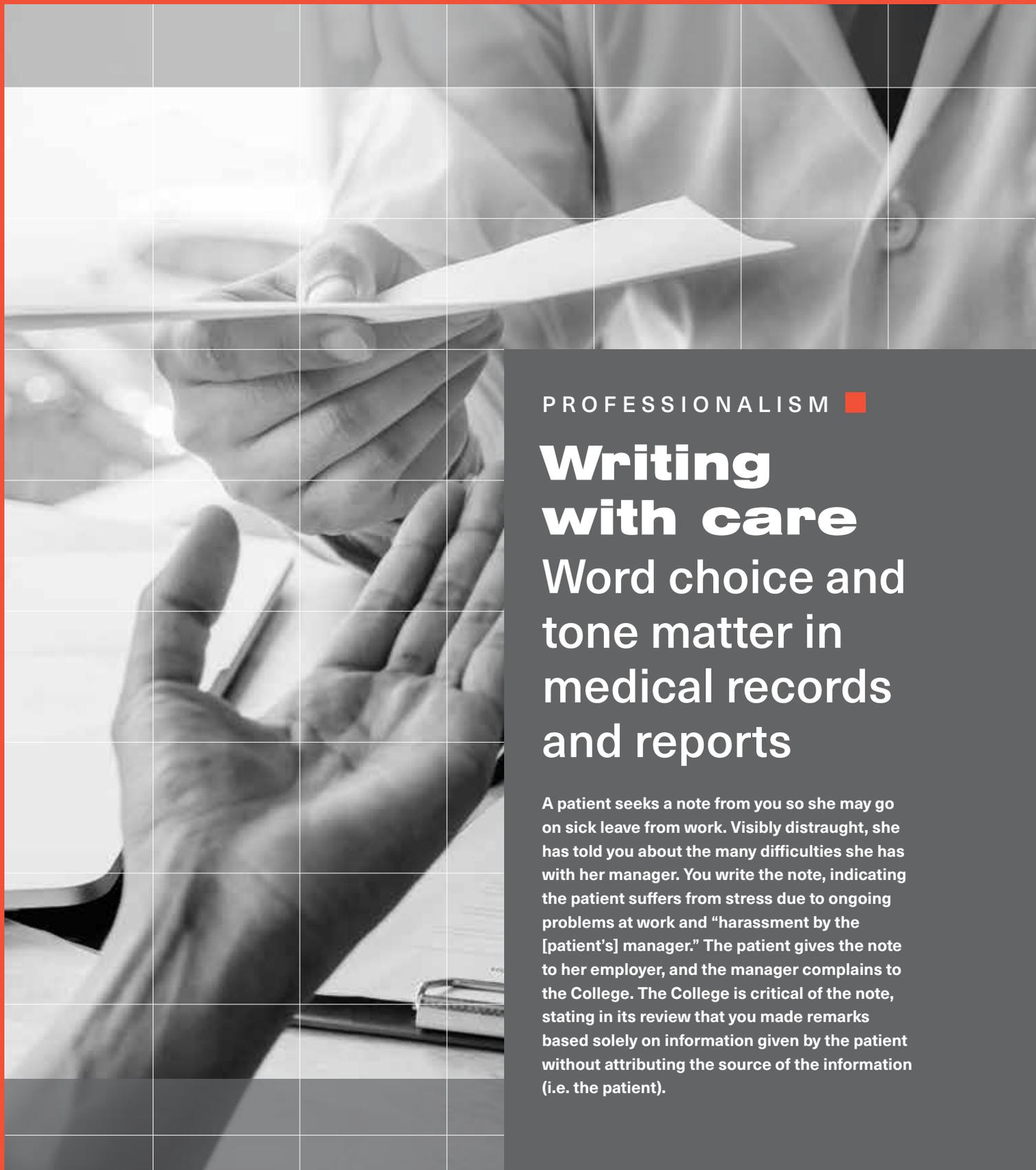


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Dr. Sharman Robertson, CMPA Physician Advisor

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PROFESSIONALISM ■

Writing with care

Word choice and tone matter in medical records and reports

A patient seeks a note from you so she may go on sick leave from work. Visibly distraught, she has told you about the many difficulties she has with her manager. You write the note, indicating the patient suffers from stress due to ongoing problems at work and “harassment by the [patient’s] manager.” The patient gives the note to her employer, and the manager complains to the College. The College is critical of the note, stating in its review that you made remarks based solely on information given by the patient without attributing the source of the information (i.e. the patient).

Another patient who has openly shared with you his history of frequent alcohol and recreational drug consumption is preparing to relocate to another province. You provide him with a copy of his medical records as he requested. He observes entries in which you refer to him as being a “pot user” and “partier.” He complains about these characterizations to the medical regulatory authority (College). The College cautions you about your choice of language, noting that the entries in question demonstrate a lapse in professionalism.

? How might you approach writing sick notes and medical record entries, and minimize the risk of misunderstandings and College complaints?

ONE DOCUMENT, MANY USES

In the event of a College complaint or legal action, medical records are often the best evidence in describing and defending the care provided.

College policies as well as legislation and regulations in each province and territory outline physicians' obligations concerning medical records. For example, the College of Physicians and Surgeons of Ontario (CPSO) specifies, among other things, that medical records be legible and that they reflect every patient encounter and patient-related information. “The record must tell the story of the patient’s healthcare condition and allow other healthcare providers to read and understand the patient’s health concerns and problems.”¹

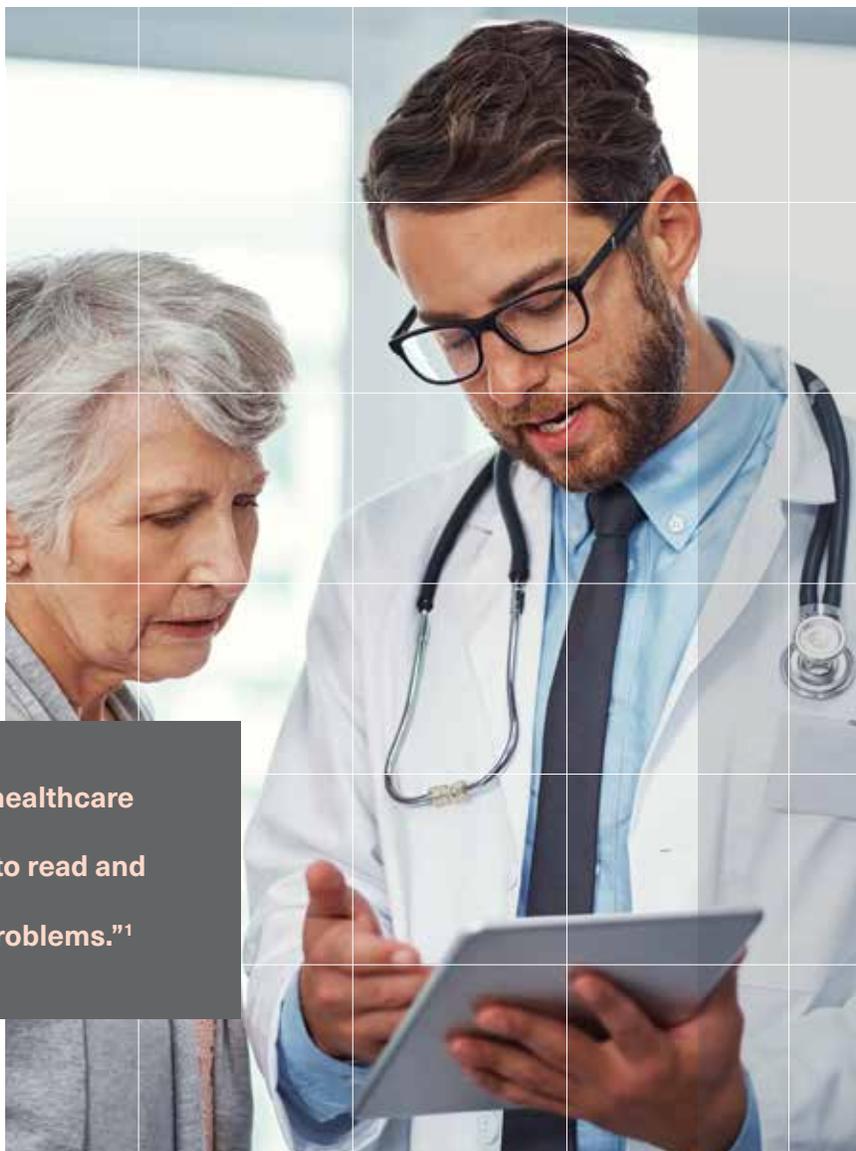
Medical records are not only for the eyes of healthcare providers. Patients are generally entitled to view and obtain a copy of their medical record, and records may also be requested by third parties such as lawyers and insurance companies. With the patient’s consent or other legal authorization, physicians may release copies of a medical record to these parties.

“The record must tell the story of the patient’s healthcare condition and allow other healthcare providers to read and understand the patient’s health concerns and problems.”¹

WORD CHOICES AND TONE

Given the varied uses of medical records, it’s important that every entry not only describe the patient encounter accurately and reflect the physician’s thought process, but that the information is presented in a way that reflects the expected level of professionalism. Physicians may choose to use various methodologies and formats, such as the Subjective Objective Assessment Plan (SOAP) format,² to help ensure entries are sufficiently detailed and presented in a standardized manner. While using SOAP or other formats may be beneficial, it’s important to use judgment in applying an appropriate tone and to choose words carefully.

What is an appropriate tone for a medical record? Generally speaking, it should reflect objectivity and contribute to patient and public trust in physicians and the medical profession—one that would be seen as “treating the patient with dignity and that respects the equal and intrinsic worth of all persons.”³ That trust, however, can erode quickly with just a single overly casual or misunderstood remark.



When describing individual patients and their reasons for seeking your professional services, ask yourself whether your chosen language could potentially offend the patient or others who might read the record, and what terms they might generally use to describe themselves and their situation.

- Be objective by stating only known facts and think carefully about language to describe a person's age, gender, race, creed, sexual orientation, lifestyle, appearance, disabilities, habits, and so on.
- Avoid subjective descriptions of a person's appearance such as "attractive," "leggy," "plump," and so on. Focus your description on neutral, quantifiable characteristics and choose clinically appropriate language.
- Put the person first if possible. For example:
 - "Female with mobility impairment" (not "disabled woman")
 - "Patient Y consumes recreational cannabis" (not "drug addict")
 - "Male with alcohol use disorder" (not "alcoholic male")
- Use quotation marks when writing verbatim statements made by patients or others.
- Respect the expressed wishes of patients to use gender-appropriate terms to describe them, such as "patient" or "they."

DISABILITY CLAIMS, DIVORCE AND CUSTODY ISSUES

Physicians provide written statements in response to many other situations, such as patient disability claims, and divorce and custody matters.

In a disability claim, patients may feel frustrated with their insurance company or their employer, and may turn to their physician for help. Patients' frustration can heighten if they perceive the physician's letter does not provide sufficient information or is not supportive of the claim.

- Claims assessors need factual information about patients' conditions, while employers may simply need to know whether patients are fit or unfit for work. Seek clarification of the third party's information needs. State the facts about patients' conditions objectively and avoid personal opinions and conjecture.

When dealing with divorce and custody issues, information is typically provided to physicians by one spouse or one of the child's parents.

- When documenting conversations in the context of a divorce or child custody issue, include the source of the information to help maintain objectivity. Limit your opinions to your area of medical expertise, especially when discussing parenting capability or choices.

CHANGING THE CONTENT

If you need to make a change to a medical record, be aware of the applicable regulations and guidelines published by your College. Corrections should be made only to your own entries to improve clarity or accuracy. Such changes should be dated and signed or authenticated electronically, while the original entry remains intact. Avoid making changes or adding new information to an entry after becoming aware you are the subject of a College complaint or legal action. Contact the CMPA if you have questions about making modifications to a medical record.

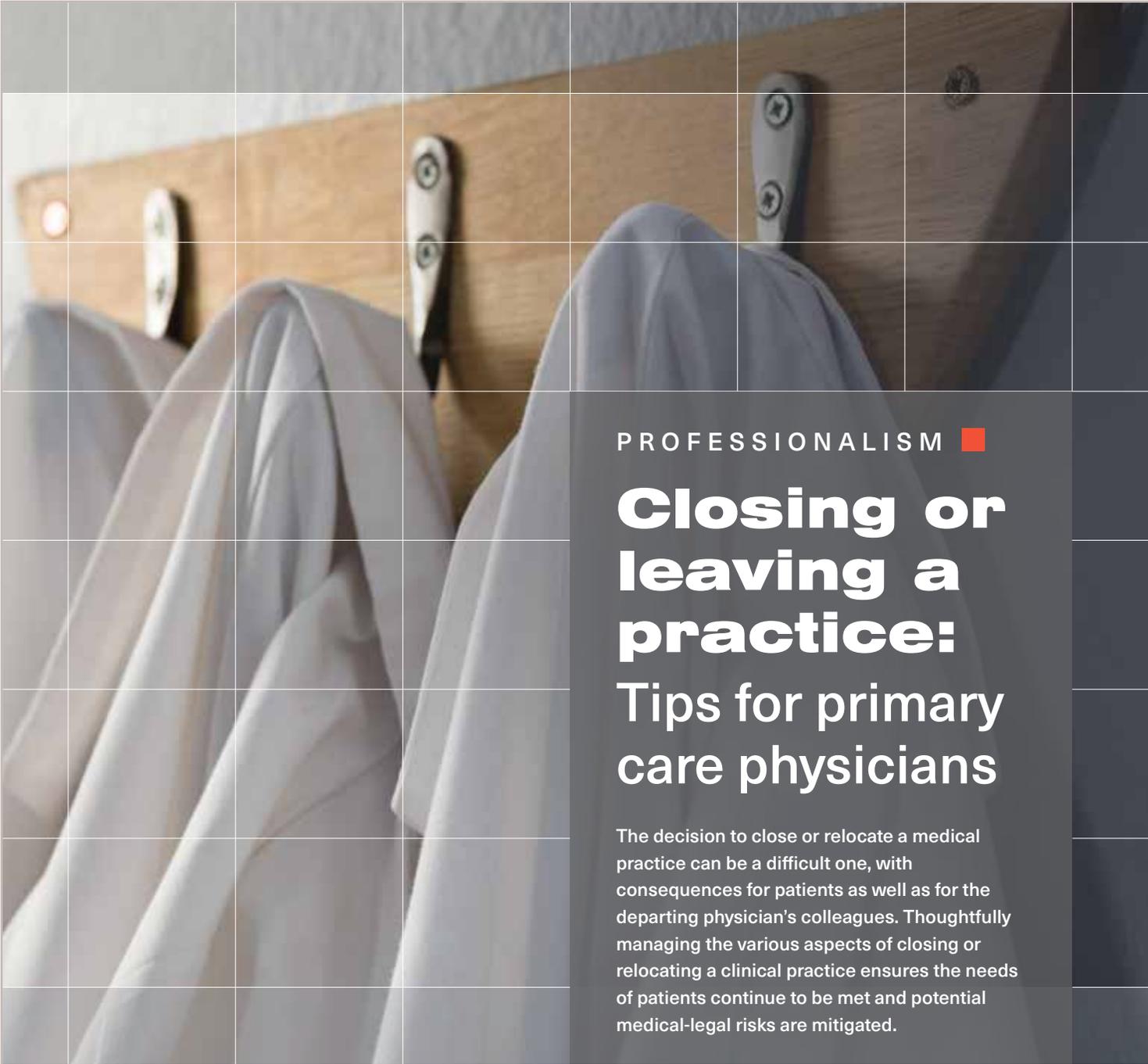


THE BOTTOM LINE

- **Include sufficient detail in each medical record entry so that another healthcare provider with no previous interaction with the patient could obtain the necessary information about the clinical encounter to continue providing care for the patient if needed.**
- **Record the information objectively and factually, being mindful of how the patient or others might interpret your word choices.**
- **Where practical, write medical record entries as soon as possible following each event (contemporaneously). ■**

ADDITIONAL READING AT WWW.CMPA-ACPM.CA

- "Treating physician reports, IME reports, and expert opinions: The way forward"
 - "Did you know? You need authorization to provide medical records to lawyers"
1. College of Physicians and Surgeons of Ontario [Internet]. Toronto(CA): CPSO; 2012 May. Policy Statement 4-12: Medical Records [cited 2019 Nov 26]
 2. For examples of SOAP notes, see the Purdue Online Writing Lab (Purdue University)
 3. Canadian Medical Association [Internet]. Ottawa(CA): CMA; 2018. CMA Code of Ethics and Professionalism [cited 2020 Jan]



PROFESSIONALISM ■

Closing or leaving a practice: Tips for primary care physicians

The decision to close or relocate a medical practice can be a difficult one, with consequences for patients as well as for the departing physician's colleagues. Thoughtfully managing the various aspects of closing or relocating a clinical practice ensures the needs of patients continue to be met and potential medical-legal risks are mitigated.

Where advance notice of a physician's departure is not possible as in the case of sudden illness, death, or other unforeseen circumstances, responsibilities related to practice closure may be undertaken by a business partner, colleague, family member, or an executor for the estate of a deceased physician. Some regulatory authorities (Colleges) require physicians to proactively plan for unexpected practice closures,¹ and so physicians may need to lay out such a plan in collaboration with partners or colleagues.

While all physicians should plan for closure of their practice in keeping with College policies, maintaining continuity of care is an especially important consideration in primary care practices. Nevertheless, consulting physicians need to consider appropriate transfer of care for those patients who are in active treatment or require follow-up. Refer to your College's policies and standards on physician responsibilities when closing or leaving your practice.

NOTIFYING PATIENTS

College policies may stipulate a minimum required duration for notification to patients of a planned closure. In Ontario and Alberta, for example, at least 90 days notice is required, unless the closure is unexpected or due to circumstances beyond the physician's control, in which case the notice must be communicated as soon as reasonably possible.^{1,2}

Physicians are generally required to notify patients directly through one or more channels: letter-mail, email, telephone, or in-person at a scheduled appointment. Consult your College's policies on specific requirements in your jurisdiction.



TRANSFERRING MEDICAL RECORDS

Patients who find a new physician may need to have their medical records transferred. You are required to facilitate this process once you have received the patient's authorization to do so. The transfer should take place as soon as reasonably possible, or as prescribed by your College. You may charge an appropriate fee for this service, which may be set by provincial or territorial medical associations or in regulations.

In a group practice such as a clinic, it should be clear who will retain the medical records when you leave the practice. This clarity can be achieved by entering into a written agreement when joining the group. Such an agreement will allow you to have continued access to the medical records that you entered even after leaving the practice. Access to these records is important to ensure you meet your professional (College) obligations and records retention requirements, and will be indispensable in the event of medical-legal issues that may later arise. Once the applicable retention period for a record has expired, you should destroy the original record in a secure manner. This task can be outsourced to a commercial service provider and the date of disposal should be documented.

Some Colleges require physicians to implement a succession plan and designate a custodian to ensure retention and access to records if they are unable to continue as custodian. In Alberta, for example, physicians are required to have in place an information sharing agreement to manage patient records in the event a physician ceases to maintain custody of existing records, and to identify another physician who will maintain them.²

Original records, whether in digital or paper form, should be retained for at least 10 years from the date of last entry or, in the case of minors, 10 years from the time they would have reached the age of majority. For more information, see the article "A matter of records: An overview of the retention, access, security, storage, disposal, and transfer of clinical records," available on the CMPA website.

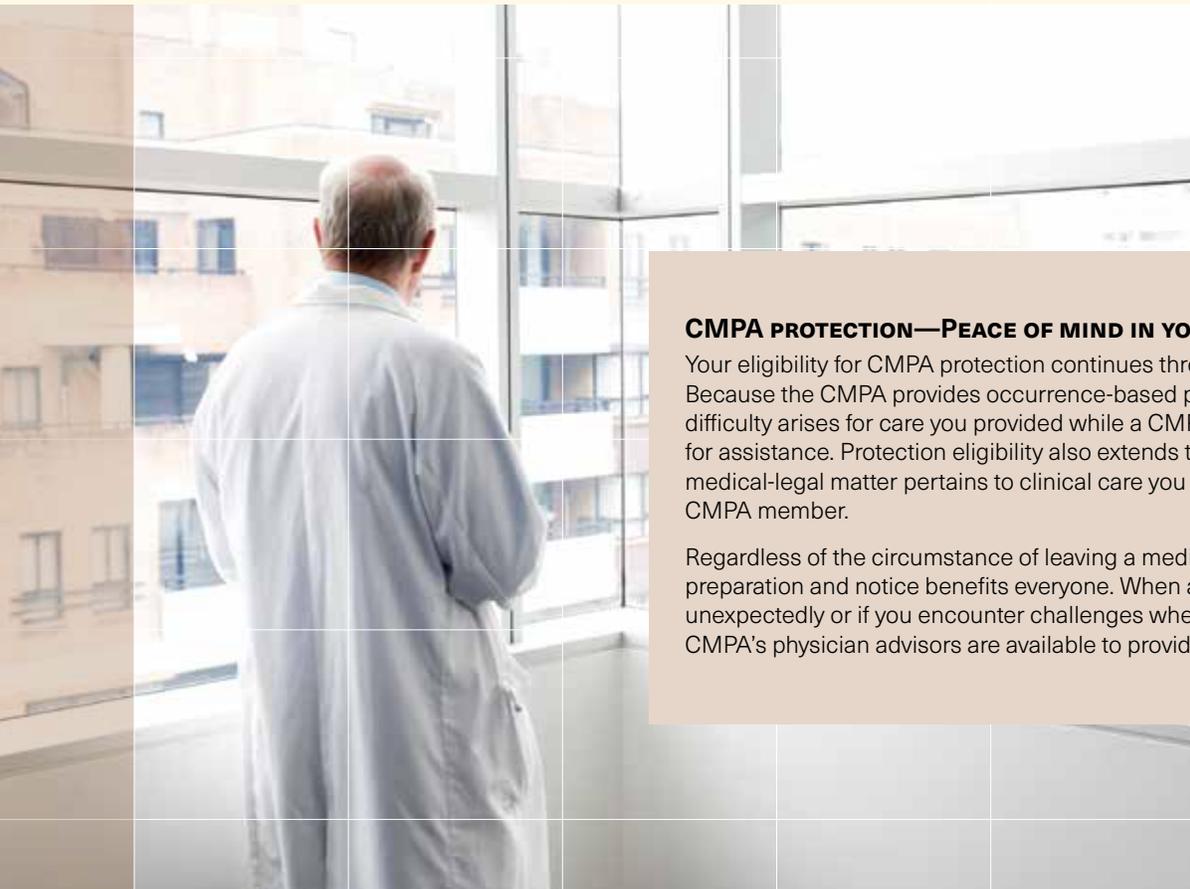
CONTINUITY OF PATIENT CARE

Physicians should make reasonable efforts to ensure all work in progress will be completed, reviewed, and appropriately acted on. Consider arrangements for alternative care for patients who have outstanding results or need follow-up after a recent test, investigation, or procedure. If patients under your care are in hospital or another health facility, complete the transfer to another physician and document this in the medical record.

INFORMING OTHERS

When planning to leave a clinical practice, you should inform colleagues, clinic owners, and employees in a timely manner. You should also inform healthcare organizations such as hospitals and specialty medical centres, other healthcare professionals such as local pharmacists, as well as the provincial or territorial paying agency, and professional associations.

Some Colleges require physicians to notify them when closing a medical practice, whether or not they continue to hold a licence.



CMPA PROTECTION—PEACE OF MIND IN YOUR RETIREMENT

Your eligibility for CMPA protection continues throughout your retirement. Because the CMPA provides occurrence-based protection, if a medical-legal difficulty arises for care you provided while a CMPA member, you remain eligible for assistance. Protection eligibility also extends to your estate, as long as the medical-legal matter pertains to clinical care you provided while you were a CMPA member.

Regardless of the circumstance of leaving a medical practice, advance preparation and notice benefits everyone. When a transition happens unexpectedly or if you encounter challenges when closing your practice, the CMPA's physician advisors are available to provide advice.

You should contact the CMPA and tell us about your plans such as if you intend to do a different type of medical work or change your province of work.

If you are closing your practice but want to continue practising medicine, even on a limited basis, you must maintain your licence as well as your CMPA membership.

If you are practising under an employment or contractual arrangement with a hospital, health authority, research organization, or government agency, review your contract or service agreement and contact your personal legal counsel to understand your responsibilities with respect to your retirement. ■

ADDITIONAL READING AT WWW.CMPA-ACPM.CA

- “Part-time practice, full-time safety: Reducing clinical workload while addressing risks”
- “A matter of records: An overview of the retention, access, security, storage, disposal, and transfer of clinical records”

1. College of Physicians and Surgeons of Ontario [Internet]. Toronto(CA): CPSO; 2007. Closing a Medical Practice [reviewed Sept. 2019; cited 2019 Nov 8]
2. College of Physicians and Surgeons of Alberta [Internet]. Edmonton(CA): CPSA; 2014. Standard of Practice: Closing or Leaving a Medical Practice [cited 2019 Nov 8]



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► SEE BACK COVER

EARLY CAREER PHYSICIANS ■

“My patients, my records?”

If you're joining a group practice, consider how to protect your ability to access patients' medical records after you leave

At some point in your career, particularly in the early stages, you may find yourself in a situation where you are leaving a practice. As well, you may be told by the medical director of the clinic that you cannot take patients' medical records with you. You may be surprised and confused because, after all, you consider these individuals to be your patients.



However, unless you are the custodian of the medical records or have an agreement with the practice owners granting you ongoing access to the records after you leave, you may have no choice but to take one of three actions—leave the records behind, negotiate ongoing access if needed, or ask patients to provide you with a copy. Negotiating for access or approaching patients for copies can take time, which can be especially concerning if you have a regulatory authority (College) complaint or legal action brought against you related to the care of that patient.

WHY TREATING A PATIENT DOES NOT NECESSARILY MEAN YOU ARE THE CUSTODIAN

Treating a patient and creating or contributing to a patient's medical record does not always mean you are the custodian of that record. Nor does it necessarily give you the right to take the record or access it after leaving the practice. While patients own the personal health information contained in the record, it is the custodian who is responsible for maintaining custody and control of the record, including who can have access to it.^{1,2}

The identity of the custodian depends on the practice setting. In a solo practice, the physician would typically be the custodian. In a hospital or other institution, the organization is usually the custodian. In a group practice or clinic, the custodian is determined according to how the practice is set up. For example, the patients may be considered the clinic's patients as opposed to the physician's patients. In those circumstances, the clinic ownership will often be the custodian. However, physicians practising in a group that shares office space and staff resources may maintain their own roster of patients and custodianship over the records of those patients.

WHY ACCESS IS IMPORTANT

As a physician, your ability to access patient records may be important for several reasons. If you face a College or hospital complaint, or a legal action, ready and direct access to those records that document the care you provided or helped deliver will make it more efficient to respond.

Depending on the arrangements made for continuity of patient care on your departure, not having ready access can also lead to questions about your ability to meet expectations set out in College policies or standards regarding follow-up patient care, and the proper retention, security, and destruction of records.

WHAT HAPPENS IF YOU LEAVE A PRACTICE AND ARE NOT THE CUSTODIAN?

If you leave a practice where you are not the custodian and you do not have a pre-existing agreement protecting your ability to access the records to which you contributed, some custodians will refuse to give you the records, copies of the records, or access to the records. You may need to make a formal request to the custodian, which can delay or impede your access.

Custodians may be unaware of your obligations or you may not wish to share with them the reasons for needing access (e.g. that you are the subject of a complaint or legal action). Similarly, obtaining access to records through patient consent or as part of the College or legal process is not always feasible, efficient, or quick.

HOW CAN YOU ENSURE ACCESS TO RECORDS?

Even though it can be a difficult conversation, the best time to address future access to patient medical records is when you first join a practice. This will minimize the risk of future access issues if you ever leave the practice.

Clarify in writing whether the patients you will see will be considered your patients or the clinic's patients. The answer will generally determine who will be the custodian of records.

If you are not the custodian, ensure you have an agreement stating that if you leave the practice or clinic, you are entitled to reasonable access to the parts of the medical records related to the care you provided.

Also, clarify if you will be able to transfer the records of patients to a future practice location. The medical record the clinic provides could be a PDF file, a paper copy, or some other electronic format. It is unlikely the clinic will transfer an electronic file that can then be incorporated into your new electronic record system or used to continue documenting patient care. With a PDF or paper copy of the record, you may have to manually enter the data into your electronic record system, a time-consuming process.

In addition, the agreement should state that patients will be notified in advance of a planned departure, and it should clarify who will take on the responsibility of ensuring continuity of patient care after you leave, including who will be responsible for follow-up and for record retention, security, and destruction.

When there is a change in practice ownership or membership, review the contract or agreement.

Consider asking your personal business lawyer or your professional federation, or provincial or territorial medical association to review any contracts before you sign. Because matters concerning the business of medicine are outside the CMPA's mandate, the Association is unable to assist with reviewing such contracts.

If you are currently working in one or more practice settings and do not have an agreement that addresses custodianship or access to records, consider asking for such agreements or clarification to ensure your access to records should you leave the practice.



Remember, after you are no longer a patient's treating physician, you should only access those parts of the record that concern the care you provided or were involved in delivering. Depending on the laws of the province or territory in which you work, looking at other parts of the record unrelated to the care you provided may be perceived as a privacy breach and/or result in a College complaint.

ADDITIONAL READING AT WWW.CMPA-ACPM.CA

- *Electronic Records Handbook*
 - "Managing access to electronic health records"
1. *McInerney v. MacDonald*, [1992] 2 SCR 138
 2. Canadian Medical Protective Association [Internet]. *Electronic Records Handbook*. Ottawa(CA); CMPA; 2014 [cited 2019 Dec 1]



THE BOTTOM LINE

- If you practise in a clinic where you are not the custodian of patient records and you leave that clinic, you will not be able to take with you the original records of the patients you treated. Further, you may face challenges when trying to access those records in the event of a medical-legal problem.
- When you join a practice, clarify that either you will be the custodian of the medical records or you will have an agreement with the custodian that gives you continued or enduring access to the parts of the patient medical records related to the care you provided or assisted in providing.
- If you have a written agreement to ensure continued access to records, it should do the following, among other things:
 - identify the custodian of medical records
 - state that if you leave or relocate you will continue to have reasonable access to relevant patient records
 - identify the person or entity that will assume responsibility for follow-up of patient care and for record retention, security, and destruction ■



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■ **Test Results Follow-Up**

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■ **Advanced Diagnostic Reasoning**

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Shift your mindset to optimize your diagnostic approach

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Afternoon program

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Advice, support, and medical-legal information

The CMPA is doing everything we can to remove barriers and provide clarity as our members respond to the COVID-19 crisis.

CMPA COVID-19 Hub

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Advice on practising during a public health emergency

FAQ

Answers to medical-legal and membership questions, such as *“Am I protected if I provide care outside my regular scope of practice?”*



Links to trusted and reliable COVID-19 information



Information on CMPA support for your wellness

Our physician advisors are available to provide support

- **Call us at 1-800-267-6522** (Monday to Friday from 8:30 a.m. to 4:30 p.m. ET), or
- **Request medical-legal assistance online**, through the online member portal (member sign-in required)