FEATURE: COMMUNICATION
HOW THE PATIENT’S VOICE ADVANCES SAFE CARE

SAFE

SURGICAL CARE hazards in the operating room: surgical fires and burns

TECHNOLOGY using electronic record systems with care

COMMUNICATION chronic care can be improved with skillful communication

LEGISLATION healthcare directives: what you really need to know
from the CEO

Last month the CMPA introduced the Member Support Program (MSP), a significant enhancement to our assistance services. The MSP recognizes that some of our physician colleagues are struggling and helps to get them back on track. As part of the continuum of CMPA services, the MSP addresses the factors that have contributed to a physician’s rate of medical-legal difficulties that exceeds that of their peers, and aims to enhance the quality of a physician’s practice and contribution to the healthcare system.

Canada consistently ranks near the bottom of surveys comparing the state of healthcare in affluent nations, placing ninth out of eleven countries in the latest Commonwealth Fund study. Health outcomes continue to be among the challenges confronting Canadian healthcare, and we at the CMPA are working steadfastly to support physicians and to enable them to provide the best care possible.

I believe that at the core of many of the challenges facing our healthcare system is a shortfall of trust. Governments, patients, and physicians all want the same thing, yet they often have different priorities and conflicting viewpoints. The focus of governments is to contain costs while meeting rising demand and expectations—doing more with less. Patients, meanwhile, expect access to safe, quality healthcare when they need it. And physicians and other care providers desire rewarding careers in their chosen profession, working congenially alongside colleagues to deliver high-quality care.

The future success of our healthcare system depends on the extent to which we can reconcile fiscal constraints, access, and the need for safe and supportive healthcare workplaces. How do we restore trust between governments, patient advocates, and physician groups? There is no easy answer, but I believe the CMPA has an important role to play.

For many years the CMPA has stood by our member physicians when they faced difficulties so that they could regain their focus on the practice of medicine. The Member Support Program takes that commitment a step further and, without making judgement, seeks to rebuild trust in physicians and their unique role. I have yet to meet a health provider who sets out to do harm, and yet we all know that things don’t always go as planned. When we see a pattern of recurring medical-legal experiences, possibly leading to restriction or revocation of a medical licence, the affected physician may benefit from the CMPA’s help.

The MSP offers tailored support to specific members and the opportunity for them to continue to have a meaningful practice. Awareness is a cornerstone of our enhanced approach, and is a necessary first step toward self-improvement. When individual members know their experiences aren’t typical, they can start the path toward positive change. Doing nothing is rarely a good option.

While the MSP will affect only a small number of members, we hope the impact for the healthcare system, and indeed for Canadians generally, will be significant. Members will be referred to our MSP team when appropriate—and will receive individualized education and support and regular follow-up. When a physician in distress returns to practising with confidence and satisfaction, everyone wins.

Hartley Stern, MD, FRCSC, FACS
Safe surgical care

CMPA cases involving surgical burns highlight the importance of effective team communications and safe systems. Learn how you can mitigate the risk of a burn.

Using electronic record systems with care

Electronic medical and health records support safe patient care when properly designed, implemented, and used. Find out how to get the most out of your system.

Chronic care can be improved with skilful communication

In chronic care, CMPA cases show that physicians who communicate effectively can make a profound difference in their patients’ quality of life. Read the key points for how to improve your communication.

Healthcare directives: What you really need to know

How do physicians give patients who have become incapacitated the care they want? Healthcare directives can help.

Many of the images in CMPA Perspective are purchased stock photographs. While we strive for these to be accurate, it is not always possible.
Surgical fires causing injury and other unintended intra-operative burns are considered "never events" by the Canadian Patient Safety Institute (CPSI). These rare events often have many contributing factors, such as the involvement of multiple healthcare professionals and non-adherence to surgical safety protocols. These factors highlight the importance of having effective team communication and systems in place to prevent unsafe situations.

A recent review of 54 closed CMPA medical-legal cases involving intra-operative burns revealed the following findings:

- 15% of patients experienced severe harm such as airway damage and full-thickness burns.
- Many patients were left with scarring, disfigurement, and psychological trauma.
- Incidents occurred mainly in hospital main operating rooms (ORs), but also in day surgery and clinic ORs.

FACTORS CONTRIBUTING TO SURGICAL BURNS AND FIRES

It is recognized that for a fire to occur, the three elements of the fire triangle must be present: ignition (heat), fuel, and oxygen. Each member of the OR team should share responsibility in managing these elements, be continuously aware of the risks, and be encouraged to identify and address them. Almost one-third (31%) of the CMPA cases reviewed involved surgical fires. The fire triangle elements were not present for all fires. Incidents in the other cases were due to burns from surgical equipment (60%) and chemicals (9%) used during the surgery.

CASE EXAMPLE: A surgical fire occurs during surgery inside the airway

An elderly woman requires intubation and general anaesthesia for a flexible bronchoscopy and debulking of an obstructing tracheal tumour. She is also receiving 100% oxygen. When the thoracic surgeon activates the laser, there is a sudden flashback followed by an intra-tracheal fire.

The patient suffers inhalation smoke injury and thermal injury to her tracheobronchial tree, and she requires three weeks of intensive care. A legal action ensues, and experts are critical of the anesthesiologist’s use of 100% oxygen. They refer to the literature that indicates the lowest possible oxygen concentration, usually between 30% to 40%, is necessary to prevent OR fires in this scenario.

Surgical specialties most often involved in intra-operative burns (closed CMPA cases 2012–2016).

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Count</th>
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<tbody>
<tr>
<td>otolaryngology</td>
<td>10</td>
</tr>
<tr>
<td>plastic surgery</td>
<td>8</td>
</tr>
<tr>
<td>orthopaedic surgery</td>
<td>8</td>
</tr>
<tr>
<td>general surgery</td>
<td>7</td>
</tr>
<tr>
<td>anesthesiology</td>
<td>5</td>
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<tr>
<td>gynecology</td>
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“Never events are patient safety incidents that result in serious patient harm or death, and that can be prevented by using organizational checks and balances.”

1
CAUSES OF SURGICAL BURNS IN REVIEWED CMPA CASES

FUEL SOURCE
Incidents involving fuel sources were usually related to incorrectly applying antiseptic agents (usually alcohol-based) during skin preparation by:

- not letting the agent dry sufficiently before placing drapes
- allowing the agent to pool under the patient
- inadequately diluting or using the wrong solution

OXYGEN SOURCE
An oxygen-enriched environment contributed to half of the surgical fires in the reviewed cases. These usually occurred when the oxygen concentration was not decreased to the lowest possible level when performing electro- or laser surgery on the head, neck, or upper chest.

IGNITION (HEAT) SOURCE
Most of the burns not caused by fires were related to equipment issues. These included:

- improper connection or using the wrong type of device (e.g. insulated or non-insulated cautery)
- not ensuring the safe positioning of the surgical device when not in use
- using the improper device setting (e.g. laser power level too high)
- not following the device manufacturer’s recommendations
- malfunction (e.g. laser cable, cautery tip)
- improper equipment maintenance

Other less frequent causes of burns were the result of not wetting the gauze or sponges that were in close proximity to electro- or laser surgical devices before igniting, as well as not allowing a flash-sterilized instrument to cool down adequately before use.

OTHER ISSUES
Peer experts in the cases reviewed identified three other noteworthy issues. The first being members of the surgical team not communicating critical information intra-operatively, such as the lack of communication between a surgeon and an anesthesiologist regarding oxygen concentration and activation of a laser during airway surgery. The second was related to a delay in diagnosing a burn or to inadequate management of burn-related complications, and the third was inadequately documenting the burn event or the post-operative care of the patient. The CMPA Good Practices Guide6 at www.cmpa-acpm.ca/gpg has more information on team communication, reducing risk in surgery, and documentation. Another CMPA resource is the article, “Shining a light on the medical-legal risks of laparoscopic surgery,”6 available on the CMPA website, www.cmpa-acpm.ca.

REDUCING THE RISKS
Based on the literature3,4,5 and expert opinions in the CMPA cases reviewed, physicians may want to consider the following risk reduction practices:

- Assess the risk of fire or burns before each procedure, and consider including in the surgical safety checklist a time out on the risk of fire.
- Encourage communication and collaboration between all members of the surgical team about identifying fire risk before and during the procedure.
- If supplemental oxygen is required, deliver the minimum concentration possible to maintain a safe blood oxygen saturation, and take extra measures to prevent oxygen from accumulating in the surgical field.
- When preparing the skin, avoid the pooling of antiseptic solutions and allow for sufficient drying before beginning the procedure.
- Follow manufacturer recommendations or institutional policies regarding the handling, use, and maintenance of surgical equipment.
- Use simulation to evaluate how the team reduces the risk of surgical fire, as well as team-response protocols in the event of a surgical fire.

THE BOTTOM LINE
Although surgical fires and burns occur infrequently, it is prudent to develop fire risk prevention strategies and to review fire risks prior to the start of a surgical procedure. The team should identify, separate, and manage the elements of the fire triangle. Ignition sources should not come into contact with fuels, and oxygen should be reduced to the minimum required concentration.
Electronic records are both a reality of modern clinical practice and a leading cause of stress for physicians. As they grow in sophistication, these systems offer new capabilities to support care and enhance safety. However, if not designed, implemented, or used appropriately, electronic medical records (EMRs) and electronic health records (EHRs) have the potential to negatively affect patient care and increase medical-legal risk, sometimes in unexpected ways.

How EMRs differ from EHRs

An electronic medical record (EMR) is an electronic version of the paper record maintained by physicians for their patients. It may be a simple office-based system or a shared record that connects healthcare professionals through a network.

An electronic health record (EHR) is maintained by a hospital, regional health authority, or provincial or territorial government and typically includes a wider cross-section of information from a number of sources and is usually accessed by several authorized parties from a number of places of care.
The CMPA reviewed its medical-legal cases that closed between 2012 and 2016, and involved an issue with the EMR or EHR. The main issues identified in this review underline the importance of taking the following actions:

- Implementing electronic record systems appropriately, with functions installed and used optimally, and with supporting procedures in place.
- Verifying the accuracy of information when using an electronic record system.
- Ensuring that the use of these technologies does not interfere with the doctor-patient relationship.

IMPLEMENTING AND OPTIMIZING ELECTRONIC RECORD SYSTEMS

The diagnosis of a severe heart defect in a fetus is delayed when an obstetrician-gynecologist fails to review the results and follow-up recommendations of her patient’s 18-week morphology ultrasound. The delay occurred because the report was not flagged or filed in the expected section of her office’s recently implemented EMR.

A hospital’s department of medical imaging discovers that close to 100 reports were not uploaded into the computer system and not sent to ordering physicians during the period in which the EHR was being upgraded.

A family physician’s practice is audited after the medical regulatory authority (College) receives multiple complaints from patients. The complaints stem from the physician’s EMR not properly transmitting immunization records to the public health system.

In CMPA cases in which results go missing in a paper-based system, peer experts will often note that using an EMR can prevent such errors. While it is true that electronic records can facilitate test result management, delays in diagnosis can occur when systems are not properly implemented or optimized.

In this CMPA review, some cases involved missed or delayed diagnoses related to electronic record systems. In these cases, the systems made it difficult for users to identify when consultant reports or test results were not received or reviewed by the ordering physician. The system failures in these cases occurred because important functions in the EMR or EHR were not available, not installed, not working, or were overridden.

Another common issue is incomplete or illegible (i.e. scanned handwritten) entries in the record. This issue may be due to challenges entering information from the patient encounter or other sources into the record due to a lack of integration with different systems.

To minimize risk, consider the following features and functions when purchasing, implementing, or familiarizing yourself with a new system:

- **The interface**—Is information easy to enter and review? Can you find the latest entries and most recent results?
- **Drop-down lists**—Are they complete? Can drop-downs be customized to minimize the risk of error?
- **System notifications**—Can users create alerts and markers?
- **Inter-operability**—Can the EMR or EHR integrate with other electronic systems to ease information receipt and follow-up? If it is necessary to use a hybrid paper-electronic system for certain functions, what procedures can be developed to minimize error in information transfer?
- **Audit trails**—Does the record’s audit trail satisfy by-laws or regulations that stipulate audit trail functionality? Can you easily reproduce a copy of some or all of the record if a patient were to request it?

It is also important to plan for the transition from paper to electronic records. Consider how to prevent the loss of patient information or delays in the follow-up of test results during the implementation, upgrade, or transfer of a records system.
VERIFYING ACCURACY WHEN USING ELECTRONIC RECORDS

A patient with rheumatoid arthritis is prescribed 7 times her weekly regular dose of methotrexate when her family physician accidentally uses his new EMR’s pre-populated dosing frequency of “q daily” rather than adjusting it to reflect the weekly dosage schedule.

A patient develops C. difficile after receiving an inappropriate course of antibiotics for sinusitis. It is discovered that the family physician’s EMR transmitted the wrong prescription to the pharmacy under the patient’s name, resulting in the patient receiving a drug regimen intended for another patient.

These situations illustrate the risk of human errors when using the automated functions in an electronic record. Automation can make it easy for these types of errors to occur. For example, it can lead to prescription errors when drop-down lists contain expired prescriptions, prepopulated dosages give adult instead of pediatric amounts for medications, and default dosage frequencies are not suitable for specific patients. EMRs may also make it easier to perpetuate an error, such as an incorrect repeat prescription sent from an EMR to a pharmacy.

Several strategies may minimize risks from automation. Consider reviewing and editing all default data, and implementing a process or mechanism to review and approve orders sent through the EMR. Take care when using templates and auto-populate features, verifying that only visit-specific data is recorded and that all other default text is removed. Where possible, limit the automatic population of information. In a number of College cases, peer experts were critical when entries contained only default text or “cut and paste” notes that did not reflect what actually occurred during the encounter.

ENSURING THAT TECHNOLOGY DOES NOT INTERFERE WITH THE DOCTOR-PATIENT RELATIONSHIP

In 12 of the reviewed cases, patients complained of physicians’ unprofessional manner or communication when they used a computer during an appointment. These patients viewed physicians as being distracted or lacking concern or empathy when they were interacting with the computer.

To make technology less intrusive to the patient encounter, physicians should consider reconfiguring their office layout so it is easier to make eye contact with patients while using a computer.

THE BOTTOM LINE

To enhance patient care and get the most out of electronic record systems consider taking the following 3 actions:

1. Learn how to optimally use your electronic records system and its functions, and evaluate how it may support or affect your clinical care.
2. Create procedures to optimize the functions and minimize risk.
3. Consider how your use of an EMR and the physical layout of technology will affect interactions with patients.

Additional reading at www.cmpa-acpm.ca
- “Protecting patient health information in electronic records”
- “Encryption just makes sense”
- CMPA Electronic Records Handbook

3. Legal, regulatory authority (College), and hospital cases.
how the patient’s voice advances safe care

Several years ago, a 15-year-old male patient with a cardiac rhythm disorder underwent an ablation procedure. During the procedure, the patient unexpectedly became acutely unstable. His physician intervened immediately to identify and correct the problem.

While the patient made a full recovery, the patient’s mother wanted to find out what had happened and why. She did research and asked questions. Changes did take place, including a decision by her son’s physician to change how he performs ablations.¹

As in the case of the young man and his mother, patients’ stories and experiences can be a powerful force leading to safer care and better patient outcomes.²,³,⁴ Their voices and involvement can contribute to planning and delivery, motivating learners in patient safety education, and improving quality and safety.
Patient engagement at multiple levels

Healthcare systems recognize that patient involvement can play a key role in planning and delivery at many levels.\textsuperscript{1,5}

At the system level, patient engagement is being sought for activities such as the development of policies and practices. For example, the Federal Advisory Panel on Healthcare Innovation recommended in 2015 that patient engagement and empowerment be one of the five key areas to inspire innovation in healthcare.\textsuperscript{1}

Organizations are also soliciting patient engagement for a number of purposes. Patients, families, and the community, for instance, have been actively involved in the development and design of a new children’s hospital in Saskatchewan.\textsuperscript{6}

Engaging patients in their direct care

At the direct patient care level, research has linked patients’ increased engagement in their own care with better health outcomes.\textsuperscript{3} There are many ways to involve patients in their own care, but deciding which are most appropriate will depend on the patients’ needs, interests, and values.

Healthcare providers should consider each individual case and determine whether it is appropriate to do one or more of the following:

- Ask patients relevant questions including about their health goals, and listen to their answers.
- Invite patients to ask questions.
- Communicate using plain language.
- Offer available information, education, and decision aids to help patients make informed decisions.
- Make it easy for patients to provide feedback. Offer them appropriate ways of communicating, such as online patient portals. These can give patients easier access to health information, facilitate interaction and communication with healthcare providers, and enhance adherence to healthcare advice and medication regimens. The benefits and risks of portals are examined in greater detail in the CMPA article, “Patient portals: A new communication tool for doctors and patients,”\textsuperscript{7} which is available on the Association’s website, www.cmpa-acpm.ca.

Motivating learners in patient safety education

Engaging patients in safety training for physicians gives learners the opportunity to view patient safety through a “patient lens,” a significant move from traditional teaching in this area.\textsuperscript{8,9} Patient stories can be used to teach a variety of topics, including the imperative to improve clinical care, patient safety science principles (e.g. human factors, decision-making, cognitive biases, situational awareness), and communication, and to increase patient involvement in treatment decisions. These first-hand accounts bring a different perspective from that of the health professional and can be impactful. Patient involvement in curriculum development and medical conference planning can also be beneficial.\textsuperscript{10}

Resources on engaging patients

Healthcare professionals looking for more guidance on engaging patients can turn to a number of resources. The Canadian Patient Safety Institute’s patient-led program, Patients for Patient Safety Canada, brings patients’ healthcare experiences to patient safety at all levels in the health system.\textsuperscript{11,12,13} The institute also has produced a guide to engaging patients in quality and safety, \textit{Engaging Patients in Patient Safety – Canadian Guide}.\textsuperscript{14} In the United States, the Institute for Healthcare Improvement is another source for information and tools on patient engagement.\textsuperscript{15}
PATIENT INVOLVEMENT IN QUALITY AND SAFETY IMPROVEMENT

Engaging patients can advance process and system improvements. Patients and families, for example, can be involved as advisors on system improvement efforts.

By involving patients, “healthcare professionals no longer need to make assumptions about what patients value or how patients and families can contribute to safer care—they have a representative on the team to ask.”16 Patient involvement also helps align quality improvement goals and activities with what is important to patients and families.

The following table provides examples of how patients and family members can be involved in quality and safety initiatives.16

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<th>QUALITY AND SAFETY INITIATIVES</th>
<th>PATIENT AND FAMILY ADVISOR ROLE</th>
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| Patient safety incident analysis (also known as root cause analysis) | • Share personal story  
• Identify pieces of process that are missing from patient’s perspective |
| Process improvement teams | • Serve on teams to reduce patient harm, such as avoidable readmissions, falls, and infections |
| Discharge planning process improvement | • Contribute to content and design of new patient education materials  
• Proactively participate in bedside rounds (discussion)  
• Assist in piloting new patient education materials |

The CMPA’s booklet Disclosing harm from healthcare delivery: Open and honest communication with patients17 notes that the patient’s and family’s perspectives on what happened are important to the success of a quality improvement (QI) or incident review. Their views on system-level improvements could benefit other patients.

Patients and families could provide their comments to the QI committee conducting the review. They could write to the committee or meet with committee members. As QI reviews are confidential in nature, patients and families are generally unable to participate in any other aspect of the QI committee’s investigation. To ensure these reviews are successful and effective, physicians and other health professionals must have satisfactory assurances that the investigation of the information will not be used or disclosed outside of the QI process in subsequent legal proceedings. The statutes governing QI information apply only if the review is conducted by a properly constituted QI committee.

THE PATIENT’S VOICE — A VITAL RESOURCE

The CMPA encourages physicians, other healthcare providers, and health system leaders to actively engage patients in healthcare, when appropriate. Whether in various levels of care planning and delivery, medical education, or direct patient care, the patient perspective is a vital and invaluable resource.

The CMPA is governed by an elected council of 30 practising physicians representing 10 geographical areas across Canada. In 2018, 11 council positions are scheduled for nomination and election in the following areas: British Columbia and Yukon, Saskatchewan, the Northwest Territories and Nunavut, Manitoba, Ontario, and Québec.

The CMPA Nominating Committee considers nominees and selects those it will recommend to the membership for election to council. Current members of council may also choose to seek nomination and re-election for an additional three-year term.

The slate of candidates recommended by the nominating committee can be found in the 2018 Report of the Nominating Committee, which will be available on the CMPA website, www.cmpa-acpm.ca, as of January 10, 2018. Terms of office commence immediately following the 2018 CMPA Annual Meeting held on August 22, 2018. Once elected, councillors serve for a three-year term.

NOMINATIONS FROM CMPA MEMBERS
In addition to those candidates proposed by the nominating committee, CMPA members have the opportunity to seek nomination and election to council on the basis of their province/territory of work (geographical area) and their type of practice. All nominees are asked to consider how their experience in the following areas may contribute to the governance of the CMPA:

- medical, clinical, and safe medical care experience
- leadership in the medical profession
- influence beyond the medical community
- medical education or research experience, or both
- business, legal, and governance experience
- financial or investment literacy, or both

Members interested in seeking nomination to council are encouraged to review the Candidate Information Guide on the CMPA website, www.cmpa-acpm.ca, or contact the Association by email at elections@cmpa.org.

KEY ACTIVITIES AND DATES

**January 10**
Release of the nominating committee’s list of proposed candidates on the CMPA website

**February 14**
Deadline for receipt of nominations from members resulting in a contested election

**March 21**
Release of election information and opening of online voting for members in geographical areas where elections are required

**April 25**
Online voting ends

**August 22**
Election results are announced at the CMPA Annual Meeting
chronic care can be improved with skillful communication

Many diseases considered fatal just decades ago are now chronic, treatable conditions. This new reality demands a shift in how care is provided to a growing number of patients. A review of the CMPA’s data shows that in chronic care, communication is an issue. Between 2010 and 2014, 1,140 CMPA medical-legal cases involved chronic conditions. In the cases where peer experts criticized the care (718), about half (343) had issues with communication—either between healthcare professionals or between the doctor and patient.

Patients with chronic diseases often have to maneuver through a complex healthcare system encompassing multiple healthcare professionals in different locations, and various medication or treatment regimens, all of which leads to many handovers of care. These care transitions are recognized as vulnerable points during which breakdowns in communication might contribute to patient safety incidents. In light of these challenges, the ability of healthcare providers to communicate effectively can make a profound difference in whether an encounter supports or discourages decisions that influence a patient’s quality of life.

**Analyzing the Communication**

To determine the role communication plays in the management of chronic disease, the CMPA reviewed five years of closed medical-legal cases involving select chronic diseases. The diseases chosen were cardiovascular disease (e.g. hypertension, stroke), respiratory conditions (e.g. chronic obstructive pulmonary disease, asthma), and diabetes.

Of the 1,140 cases examined, peer experts were critical of care in 718, and in about half of those (343) the criticism involved communication. These communication breakdowns were most often associated with diagnostic issues, treatment delays, and medication issues.

Two main areas of concern regarding communication were identified in the 343 cases. The most common was deficient interprofessional team verbal or written communication, most often involving physician-to-physician communication. The other concern was poor provider-patient communication, which was noted in almost half of the cases, as providers did not tailor the content or tone of the care-related information appropriately.

This article is based on a research abstract presented at the 2016 annual conference of the Canadian Association for Health Services and Policy Research (CAHSPR).
INTERPROFESSIONAL COMMUNICATION

Sub-optimal interprofessional team communication and documentation was identified in 83% of cases, and while it most often involved physicians, other providers such as nurses and pharmacists were also involved.

These communication deficiencies most often occurred during transitions of care. Incomplete verbal or written communication during handovers was associated with deficiencies in the diagnostic process, primarily affecting clinical decision-making. For example, in some handovers poor communication led to delaying or failing to arrange appropriate testing, or not communicating to a colleague the need to follow up on tests that were ordered. Inadequate patient follow-up also led to missed or delayed diagnoses of complications, or contributed to sub-optimal disease management including delays in adjusting the treatment plan.

Not following a formal process for medication reconciliation occasionally resulted in medications, which had been temporarily discontinued, not being re-started at transitions of care. For example, in some instances anticoagulant therapy was not restarted when the patient was discharged following a hospital stay. In a few cases, the prescribing of a contraindicated medication led to an avoidable drug-drug interaction. Other medication-related areas of concern were inadequate monitoring of the effectiveness or safety of a medication, and not documenting in the patient’s medical record the rationale for changes to a medication regimen.

COMMUNICATION BETWEEN PROVIDERS AND PATIENTS

Ineffective communication between providers and patients or their families occurred most often with primary healthcare providers or during visits to the emergency department for problems related to their chronic condition.
Common communication themes in these cases included the following: lack of informed consent for treatment, including medication; delay or failure to communicate important and timely information (e.g. treatment plans); failure to communicate information clearly in a way the patient understands; and failure to communicate difficult news about health or prognosis in an empathic way. These conversations most often concerned the seriousness of the chronic disease and the patient’s understanding thereof; the reasoning and rationale for the treatment plan, including the importance of follow-up appointments; and issues related to advance directives and end-of-life care. Not adequately listening to what the patient or their family had to say or discounting their opinions sometimes led to misunderstandings and barriers in the physician-patient relationship.

Of the cases with ineffective communication between healthcare professionals and patients, more than a third involved patients aged 70 and older. This highlights the need for open and clear communication with this growing segment of the population and the family members that may be involved in their care.

The bottom line
Communication issues play a prominent role in CMPA cases involving patients with chronic disease. Focusing educational efforts on communication has the potential to improve patient safety. In addition, better communication skills may reduce the medical-legal risks for healthcare professionals who routinely provide care to patients with complex conditions.

The following key points, based on the peer experts’ opinions in the cases reviewed and on CMPA analysis, are aimed at improving communication in the clinical management of chronic disease:

- Listen actively, show compassion, and partner with patients to achieve care goals. This allows providers and patients to make shared decisions that strike a balance between meeting clinical goals and providing optimal overall quality of life. It also strengthens the provider-patient relationship by building trust.
- Use structured communication processes and tools, such as handover mnemonics. These can help overcome the barriers to effective handovers and can help foster a culture of safety.
- Document discussions, treatment plans, and other clinical issues in patients’ medical records. This can improve continuity of care by communicating to other providers what took place during a patient encounter and the rationale for clinical decision-making.

Additional reading at www.cmpa-acpm.ca:
- “Caring for patients with chronic diseases”
- “Co-morbidities — Have you considered all health conditions?”
- “The aging patient — Responding to changing demographics”
- CMPA Good Practices Guide: Patient-centred communication; Handovers

healthcare directives: what you really need to know

One of your patients has suffered a stroke, leaving him with significant physical and cognitive impairment. The family is understandably distraught, but fortunately this patient had previously prepared a healthcare directive, a document you have on file. It means you can provide your patient with the care he needs, confident in knowing who is authorized to make key healthcare decisions when the patient can no longer do so.

When patients authorize another person to make healthcare decisions in the event they become incapacitated, it is important for their physicians to be aware of such authorizations and understand the impacts on their professional obligations. Authorization documents can be called “advance directives,” “living wills,” or “powers of attorney,” among others. Each province and territory has rules governing such documents, including requirements for their validity, what may be authorized, and when they come into effect and terminate. Physicians are encouraged to become familiar with the rules in their province or territory.

What’s in a name?

It is easy to get tripped up by the terms used to refer to healthcare directives. “Advance directive,” “advance medical directive,” and “living will” usually refer to decisions about clinical care. In Ontario, many people are familiar with the term “Power of attorney.” What they may not realize is that there are two types—“Power of attorney for personal care” for healthcare decisions, and “Power of attorney for property” for decisions about property and financial affairs.
What is a healthcare directive?

A directive is a legal document through which a capable person gives another individual the authority to advance to make decisions on his or her behalf while alive. Typically, it allows the authorized individual to make healthcare decisions when the patient becomes incapable. And, it usually includes instructions that the appointee must follow when making these decisions.

It is important for physicians to carefully review the document to determine the scope of the appointee’s legal authority and any other stipulations or limitations. For example, if two or more people are granted authority to make decisions, the applicable legislation will usually determine the manner in which they must act. Appointees in some provinces with the same authority must act together, unless the document stipulates otherwise. In other jurisdictions, the first appointee listed is entitled to act alone, followed by the next listed appointee if the first is unavailable, unless the directive stipulates otherwise.

Is the document valid?

Healthcare directives are not required to be in any particular format. They do typically have to be signed, witnessed, and dated. Each province and territory has rules around what requirements must be followed in making a healthcare directive.

The patient must have mental capacity (competence) at the time the document is prepared and signed. Legislation in each jurisdiction may set out a test for determining capacity to grant a healthcare directive. For example, in Ontario a person is capable of giving power of attorney for personal care if they have the ability to understand whether the appointee has a genuine concern for their welfare, and appreciate that they may need to have the appointee make decisions for them.

When should consent be sought from the person authorized under a healthcare directive?

Generally, a healthcare directive comes into effect when the patient loses capacity to make decisions about personal care. The person responsible for determining whether the patient lacks capacity varies depending on the rules in each province or territory and the terms of the directive itself.

For example, in Québec a protection mandate comes into effect once the patient’s incapacity is confirmed by medical and psychosocial assessments and the court has approved the mandate (called “homologation”). In other cases, a qualified capacity assessor must first determine the patient’s capacity before the healthcare directive can be acted upon.

The patient’s treating physician will often be asked to assess capacity for this purpose. If physicians find themselves in this circumstance, they should keep detailed records of their assessment and the clinical grounds for their conclusions. Physicians have sometimes been criticized for failing to have sufficient evidence on which to base their assessment of a patient’s capacity, in particular if relying exclusively on third-party opinions.

If the patient’s incapacity has been properly assessed and there is a healthcare directive in force, the person appointed under that directive is the first person the treating physician should look to for consent on behalf of the patient. In the absence of a healthcare directive, legislation in most provinces and territories sets out a hierarchy of individuals who may provide consent to treatment on a patient’s behalf.
If physicians are concerned that the appointee is not complying with the patient’s prior expressed wishes or is not acting in the patient’s best interests, they should discuss these concerns with the care team and the involved parties in an attempt to reach a solution. They should also document their efforts in the patient’s medical record. If a satisfactory solution cannot be reached, physicians may have to look for guidance from a hospital ethics committee, or ask the courts or the local public guardian or curator to intervene.

**The Bottom Line**

Greater clarity in patient care can be achieved through healthcare directives and when physicians understand their purpose and the rules governing them.

- Ask your patients whether they have a healthcare directive. Directives are especially helpful if patients are elderly or when they have a condition that will likely impact their capacity in the near future. Ask patients for a copy of the directive and add it to their medical record.

- When a patient is deemed to be incapable and the healthcare directive comes into effect, review the document carefully. Determine who has authority to consent on the patient’s behalf and whether there are any other restrictions or directions. Verify the identity of the individual(s) named in the document.

- If you are asked to confirm that a patient was capable at the time he or she signed the directive, ensure you have proper authorization to disclose this personal health information.

- If you are asked to assess the capacity of a patient, review the healthcare directive to determine whether it contains directions about how capacity is to be assessed, and then comply with those directions. Be objective in your assessment and keep detailed records. Ensure you have appropriate authorization to share your findings with the requesting party.

- Contact the CMPA if you have questions about a specific healthcare directive and what it means for you.

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3. Ontario, British Columbia, and Québec.
5. Physicians in Québec are guided by the government office of the Curateur public, which keeps a register of persons under homologated protective mandate.
6. In Ontario and Yukon, specialized tribunals have been established to address these matters.
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