FEATURE: LEGISLATION  MEDICAL ASSISTANCE IN DYING: one year later  ■ TECHNOLOGY social networks in healthcare: opportunities and challenges for a connected future  ■ SAFE MEDICAL CARE new to practice? practical tips for physicians in the first 5 years  ■ YOUR ASSOCIATION mutuality and the member support program  ■ SAFE SURGICAL CARE shining a light on the medical-legal risks of laparoscopic surgery  ■ DID YOU KNOW disarming statements can lessen conflict in the healthcare workplace
from the CEO

Physicians have a unique vantage point from which we can see issues from both the patient perspective and the healthcare system level. It’s not surprising, then, that we often act as advocates for patients while also being called upon to champion improvements in the delivery of Canadian healthcare generally.

The advocacy role of physicians is the topic of the information session that is part of this year’s CMPA Annual Meeting, being held August 23rd in Québec City. Entitled, “The physician voice: Empowering better healthcare,” the session will feature a superb panel of speakers that will examine the challenges physicians face when advocating in today’s complex healthcare environment. Attendees will have the opportunity to engage in discussions about the medical-legal issues related to advocacy and gain insight into techniques and best practices to advocate successfully. A fulsome understanding of the healthcare environment, thoughtful planning, and impactful messaging are some of the keys to success in advocacy.

The business meeting precedes the information session, to which CMPA members are also welcome. This year’s meeting promises to be especially interesting as the CMPA launches a new line of services for members, hospitals, and health authorities aimed at improving the safety of the environments within which our members practise. CMPA members may rest assured that as we introduce these new products and services, the CMPA’s trusted medical liability protection services and education offerings will not be affected. You will hear more about the new service offerings later this summer.

Through the CMPA’s membership surveys, many of you have indicated that you want access to additional programs and services that meet your evolving needs. We believe the new complementary services will address your emerging requirements and those of the institutions in which you practise—at the same high quality you trust the CMPA to deliver. As healthcare delivery undergoes more change, we are committed to ensuring you can continue to practise medicine with the knowledge and confidence that the CMPA stands ready to assist you.

I believe both segments of this year’s annual meeting will be valuable for you, and I look forward to seeing many of you in Québec City. As usual, a webcast of both segments of the annual meeting will be posted on the CMPA website, giving all of our members the opportunity to know more about the CMPA—including how your membership fees are set, how we provide cost-effective liability protection, and what we’re doing to plan for the future.

In the meantime, I hope you enjoy this issue of Perspective and that its insights will be beneficial for your medical practice.

Hartley Stern, MD, FRCSC, FACS
What do new physicians ask CMPA to assist with most often? Regulatory authority (College) complaints and investigations. Get tips for avoiding 3 primary areas of risk.

The CMPA introduces the Member Support Program to enhance its assistance to members who have a medical liability experience greater than their peers.

Performing laparoscopic surgeries? Having them performed in your organization? Learn from CMPA’s experience and reduce surgical safety incidents.

Did you know? Disarming statements can lessen conflict in the healthcare workplace

Sharpen your skills in handling conflict in the healthcare workplace: use disarming statements.

Online social networks open up a world of collaboration among physicians. Make sure you know the potential risks and how to mitigate them.

Get an overview of the current state of medical assistance in dying (MAID) in Canada and the medical-legal impacts on physicians.

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TECHNOLOGY

social networks in healthcare: opportunities and challenges for a connected future

Social media is ubiquitous in enabling personal connections online, and medical-focused professional networks are similarly influential among physicians who want to share information and experiences with colleagues around the world.
These healthcare social networks provide a means for communication and collaboration that would otherwise not be possible, and offer the promise of improved health outcomes for patients. While many physicians and patients embrace the benefits of these online networks, they should also be aware of the potential risks and understand how to mitigate them.

**Crowdsourcing diagnoses and treatment solutions**

While some may consider healthcare social networks to be part of eHealth or telemedicine, there are notable differences compared to such practices as ePrescribing and eCommunication. The primary distinction is that healthcare social networks are, by definition, social and therefore open to other Internet users.

“Crowdsourcing” is a common objective in healthcare social networks. Crowdsourcing is “the practice of obtaining information or input into a task or project by enlisting the services of a large number of people, either paid or unpaid, typically via the Internet.”

In medical crowdsourcing, responders to a clinical query may be motivated by recognition, curiosity, or simply the satisfaction of collaborating. Financial rewards may also be a motivating factor. For patients, medical crowdsourcing offers access to a large pool of medical expertise to diagnose and treat rare or difficult conditions—though patients are generally advised to not act on crowdsourcing opinions or advice, and instead seek their own doctor’s professional judgment.

There are numerous different healthcare social network platforms, though many of their features overlap. Some platforms are targeted specifically at physicians to help diagnose and treat their existing patients. SERMO and Canadian-based Figure 1, for example, allow physicians to upload images and other clinical details of their cases, and other physicians provide responses to help arrive at diagnoses and propose treatments. Other platforms are targeted at patients who seek help with troubling medical conditions from the network’s members which include physicians and other healthcare experts. CrowdMed is a leading platform in this area.

**Liability risks**

When physicians offer a clinical comment or opinion via a social network, they might be considered to owe the patient a duty of care, even if they have never met the patient. While the law continues to evolve in this area, it is possible that discussing a case over a social network would be seen in the same light as a “corridor consult.” Generally speaking, a physician owes a patient a duty of care only when a doctor-patient relationship exists. However, at least one Canadian court has suggested that a physician may owe a duty to provide advice that meets the relevant standard of care even in the absence of a doctor-patient relationship, such as when advice is given in a corridor consult.

Physicians who offer medical advice on a social network that is likely to be used by patients living outside of Canada might consider including a note that the information being provided may be applicable only in Canada. This will help mitigate the risks of non-Canadians following medical advice that might not be appropriate or relevant. The CMPA will generally not provide assistance with medical-legal matters brought outside of Canada that arise from the publication of information to a non-medical audience.

When using a social network to help diagnose and treat their existing patients, physicians should be cautious about relying on an online opinion, particularly if the identity and reputation of the other individual are unknown. Physicians may want to document in the patient’s medical record an online recommendation that is relied upon, as well as the rationale for a rejection of a particular recommendation on a course of treatment.

While platforms such as CrowdMed reassure physicians they are not legally liable if their suggested diagnoses or treatment solutions turn out to be incorrect—owing to, among other factors, the aggregate nature of experts’ suggestions where no single individual has absolute influence—such assurances are untested in Canadian courts and cannot be relied upon at the present time. The CMPA is not aware of any legal actions brought in Canada to date involving medical crowdsourcing.

**Consent and confidentiality**

Physicians who share information about their existing patients on social networks are obligated to protect patient confidentiality. This can be achieved by ensuring that the posted information is properly de-identified, that is, excludes any information or images that might identify a specific patient. While, for example, the Figure 1 platform informs users that, because their images “do not have identifying details about patients and are not attached to any patient information” and consequently are not subject to privacy regulations, physicians should nevertheless do their own due diligence to ensure their patients’ health information is not identifiable. Alternatively, physicians should obtain the patient’s express consent to share identifiable personal health information.

Some social networks provide an electronic consent form that patients can sign, and in these instances physicians should ensure the form has been tailored to the legal requirements of their jurisdiction. Canadian physicians may instead choose to use the CMPA’s photo and video consent form, available on the CMPA website, for this purpose. The consent agreement, which should include a discussion with the patient about the photos and their intended use, should be documented in the medical record. If you are working in a hospital or other institutional setting, you should also familiarize yourself with, and abide by, any relevant policies or procedures that restrict the taking of clinical photos.
Social media platforms typically provide ways to hide confidential information such as automatically detecting faces and blocking or blurring them in uploaded photos, as well as reviewing uploaded images and removing them when necessary. If a patient were to complain to a medical regulatory authority (College) or privacy commissioner, or bring a legal action in relation to a privacy breach, it is uncertain whether the physician’s reliance on the social network’s practices to identify potential confidentiality issues would be considered sufficient.

**Patient-initiated crowdsourcing**

When a patient seeks medical advice through a crowdsourcing platform such as CrowdMed, it is the patient who initially posts his or her personal health information on the site and agrees to the platform’s terms and conditions. The physicians and other practitioners who offer advice in response to such requests need not seek additional consent from the patient to discuss that patient’s health information within the social platform.

**Managing your professional reputation**

When using professional social networks, like all social media, keep in mind that you are governed by the same legal and professional standards that would apply in any other professional setting. As the Canadian Medical Association notes, “having an online profile or identifiable presence on social media can have the same degree of positive or negative impact on a physician’s social reputation as being active in any other public venue.” These standards apply whether or not you choose to be anonymous online and whether or not your identity has been “verified” (i.e. the social platform authenticates your identity by checking publicly available databases of licensed physicians and then displays your verification badge).

**FORGING A CONNECTED FUTURE**

The CMPA, together with its healthcare partners, encourages physicians to explore innovative approaches to medical care, and to consider their use of professional social networks with prudence. Similarly, the CMPA supports efforts by governments, regulatory authorities, and medical associations/federations to establish the regulatory clarity governing the use of new health technologies, and thereby help physicians to better manage the associated medical-legal risks.

When all parties work together to develop a suitable approach to the appropriate use of emerging technologies, including healthcare social networks, providers can use such tools with the confidence that they are providing the best possible care for their patients and making a positive contribution in healthcare.

**Additional reading at www.cmpa-acpm.ca**

- “Using clinical photography and video for educational purposes”
- “Top 10 tips for using social media in professional practice”

3. Crawford v Penney, 2003 CanLII 32636 (ON SC), aff’d 2004 CanLII 22314 (ON CA)
5. Figure 1. Frequently Asked Questions [Internet]. [cited 2017 Jan 16]. Available from: https://figure1.com/sections/faq/index.html
new to practice? practical tips for physicians in the first 5 years

Physicians are faced with many challenges in their first few years of practice. At a time when they are establishing themselves in the profession, they may not yet be familiar with all of the policies of their regulatory authority (College)—which can lead to medical-legal difficulties.

This was evident in a 5-year review of 227 closed CMPA medical-legal cases in which College and peer experts were critical of new physicians.1 The experts’ concerns frequently centred on practice management issues, such as office management, communication, and professionalism. The issues often impacted clinical care such as not having a reliable system to manage test results leading to a diagnostic delay.

Dr. Ellen Tsai educates many physicians new to practice in her role as a CMPA physician advisor. She says that 3 themes often come up when speaking to this group: follow-up of test results, ending the physician-patient relationship, and knowing when to ask for help. She remarks that, “It is very easy for new physicians to become isolated and feel they have to be able to ‘do it all’ because they have just finished their training.”

Approximately 20% of CMPA members are in their first 5 years of practice post-residency training.2 When compared with other types of medical-legal issues, the Association most often assisted new physicians with regulatory authority (College) matters.3

Proportion of types of CMPA medical-legal assistance provided to physicians in their first 5 years of practice (n=2,645)

<table>
<thead>
<tr>
<th>Type</th>
<th>Proportion</th>
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<tbody>
<tr>
<td>College</td>
<td>62%</td>
</tr>
<tr>
<td>Hospital</td>
<td>14%</td>
</tr>
<tr>
<td>Legal</td>
<td>21%</td>
</tr>
<tr>
<td>Other (e.g. billing, privacy)</td>
<td>3%</td>
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**CASE EXAMPLES**

The following case examples illustrate 2 areas of practice that often pose a challenge for new physicians—ending a physician-patient relationship and communicating clearly with patients.

**Case 1: Physician does not adhere to College policy in dismissing a patient from his practice**

**What happened?**
A family physician (FP) is running behind schedule when a patient arrives for her appointment to receive test results. After waiting some time, the patient becomes irritated and asks the receptionist when she will be seen. The receptionist tells her that there are still 8 people ahead of her. The patient states that the wait is unacceptable and demands an appointment for another day. Later that day, the receptionist tells the FP that the patient was rude to her. The FP instructs the receptionist to call the patient and tell her she will be discharged from the practice.

**What did the College have to say?**
The College maintained that the FP did not end the physician-patient relationship according to the College policy. He should have notified the patient of the reason for discharging her and arranged proper follow-up care. The College also noted office management issues with respect to patient scheduling and wait times. The FP, who had not been aware of the College’s policy, apologized to the patient and implemented changes to his practice to improve scheduling.

**Case 2: Miscommunication leads to dermatologist prescribing the wrong topical agent for her patient**

**What happened?**
A dermatologist prescribes topical agents for psoriasis to a new female patient. As the dermatologist gets up to leave, the woman tries to ask another question, but the dermatologist advises her to make another appointment as other patients are waiting. The woman explains that this would be difficult as she would have to make childcare arrangements and plan around her “nursing schedule.” Nonetheless, the dermatologist still refuses to allow the patient to ask her question. Feeling that her concerns were dismissed, the patient files a College complaint.

Upon receipt of the complaint, the dermatologist discovers she misunderstood the patient during the encounter. The dermatologist wrongly assumed that the patient was referring to her work schedule as a nurse, when in fact “nursing schedule” referred to breastfeeding. The dermatologist quickly realizes that she prescribed an agent not indicated for breastfeeding patients and changes the prescription to a safer topical agent.

**What did the College have to say?**
The College advised the dermatologist to take the necessary time with patients. Her haste led to an unnecessary and avoidable mistake in this case, where the patient was prescribed an inappropriate medication.

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**Strategies to improve safe medical care**

Three primary risk areas were identified:
1. Diagnostic error
2. Office management
3. Patient communication

The following strategies are based on the peer experts’ opinions in the cases reviewed.

**Conduct a thorough diagnostic assessment**
- Obtain a sufficient, relevant history and conduct an appropriate physical examination in order to formulate a clinical diagnosis and care plan with a clear rationale.
- Use an effective system to manage the timely follow-up of test results (e.g. automatic alerts in EMR) including communicating the results to patients. Avoid using the “no news is good news” approach to deal with test results.

In some cases, the experts recognized that the new physician did not have adequate knowledge, experience, or resources to address certain issues. The following tips are suggested:
- Provide assessments and treatments only within your scope of practice.
- When necessary, ask a colleague for advice or review the literature for information on unfamiliar diagnoses, medications, devices, and products.

**Focus on office management**
- Be familiar with the policies and procedures of your clinical workplace and ensure to the degree possible that they are consistent with your College’s policies.
- Be aware of your College’s policies, especially regarding accepting new patients.
- Implement an office procedure to deal with patient no-shows effectively and fairly.
- If it becomes necessary to dismiss a patient from your practice, ask yourself if the reasons are appropriate and in accordance with your College’s guidelines.
- Assess complaints and consider making improvements to your practice to address issues.

**Communicate effectively with patients**
- Communicate respectfully and professionally with patients, and address potential language, cultural, or cognitive barriers to effective communication.
Calls to the CMPA from new physicians

In 2015, the CMPA received more than 3,000 calls for advice from new-to-practice physicians. Almost one-third of these were about practice management and dealt with issues such as ending a physician-patient relationship, accepting new patients, maintaining medical records, joining or leaving a practice, and billing disputes.

CMPA assistance

The CMPA does not assist with all practice-related inquiries. For example, its assistance does not extend to contract disputes, particularly those about the custodianship of medical records. Physicians who are working in a clinic or group practice are often unclear about who has custody over patient records. In some circumstances, physicians who are planning to relocate or leave the practice can be surprised to learn that they no longer have access to their medical records as a result of the contract terms. Regulations on custodianship vary by jurisdiction. Physicians should understand the regulations before joining a practice.

New physicians are encouraged to consult their personal legal counsel and, if relevant, their professional association for assistance with contracts.

Go to www.cmpa-acpm.ca to read more on setting up a practice:

- “Medical-legal issues to consider with individual contracts”
- “The changing practice of medicine: Employment contracts and medical liability”
- “Assistance to clinics and facilities”
- “Releasing a patient’s personal health information: What are the obligations of the physician?”
- Electronic records handbook

Additional reading at www.cmpa-acpm.ca

- “Shifting practice settings makes following up investigations and monitoring medication tougher: strategies for managing risks”
- “When common symptoms resemble rare and serious conditions”
- “Stop and think—Return visits offer another chance”
- “The diagnosis: managing and following up on investigations”
- “How effective management of test results improves patient safety”
- The CMPA Good Practices Guide, at www.cmpa-acpm.ca/gpg, has more information on a number of topics, such as communication, professionalism, and diagnostic tips.

1. Based on a study of CMPA legal actions and College and hospital complaints that occurred and closed over a 5-year period, took place both in- and out-of-hospital, and involved new career physicians in their first 5 years of practice.
3. Based on a 5-year review (2010–2014) of all open and closed CMPA cases (excluding advice) involving physicians in their first 5 years of practice.
As the country gains experience with MAID, it is apparent Canadians want the service. Reports suggest that between June 17 and December 31, 2016, at least 803 Canadians received MAID. Yet, questions are being asked about a range of issues around MAID including eligibility criteria, consent, conscientious objections, and safeguards.
Medical assistance in dying and the law: One year later

Healthcare has undergone remarkable changes since June 2016 when the federal government amended the Criminal Code of Canada to allow medical assistance in dying (MAID) in certain circumstances. Canadians now have access to MAID, and healthcare providers wanting to provide the service have a legal framework in which to do so.

As the country gains experience with MAID, it is apparent Canadians want the service. Reports suggest that between June 17 and December 31, 2016, at least 803 Canadians received MAID. Yet, questions are being asked about a range of issues around MAID including eligibility criteria, consent, conscientious objections, and safeguards.

Despite the federal legislation, and Québec’s 2015 An Act Respecting End of Life Care, which governs end-of-life issues in that province, some physicians are uncertain about how to apply the rules, and their legal and professional rights and obligations. Some are also wary of potential medical-legal risks and seek to reconcile these risks with providing appropriate patient care.

The CMPA continues to receive requests from members for advice concerning MAID, and is monitoring developments by governments, regulatory authorities, and medical associations and federations as the situation evolves. With the one-year anniversary of the federal legislation this month, it is a good occasion to take stock of the current state of MAID in Canada and the medical-legal impacts on physicians.

Eligibility criteria and access

It is sometimes difficult to determine who is eligible, and patients in some parts of the country may have problems finding a healthcare professional willing to provide the service.

The Criminal Code states that patients may be eligible if they are mentally capable (competent) adults, eligible for government-funded health services, have made a voluntary request, are able to give informed consent, and suffer from a “grievous and irremediable medical condition.” Questions remain around how to apply some of the criteria, for example, how to interpret the term “grievous and irremediable medical condition,” which is not defined by the Criminal Code.

Some suggest the current federal legislation impedes particular Canadians’ access to MAID, including those under the age of majority and those suffering from some mental illnesses. The legislation is currently facing a constitutional challenge in British Columbia on the basis that the requirement for a patient’s natural death be reasonably foreseeable is too restrictive and violates constitutional rights. Another court challenge is underway in the province of Québec.

The federal government has started an independent review of the legislation to provide information. This will allow an informed dialogue to take place on the possibility of expanding the current legislation to include Canadians suffering strictly from mental illnesses, as well as mature minors, and to allow advance requests for MAID. The Québec government also indicated its intention to examine issues related to its MAID legislation.

Informed consent

Physicians have a duty to obtain informed consent for end-of-life care from patients or their substitute decision-maker. When it comes to MAID, however, only the patient can request and consent to it; substitute decision-makers do not have this authority. To the extent possible, physicians should encourage patients to consent to including their family in MAID discussions. This can help ensure everyone is on board with the decision and minimizes the risk of issues arising after the patient’s death.
The Criminal Code requires that the health practitioner providing MAID confirm the patient’s capacity and consent immediately before providing MAID, thereby precluding “advance requests” for assisted dying.\textsuperscript{11} There has been interest in providing for advance requests, which would allow individuals to prepare directives addressing their wishes to receive MAID in the future once certain criteria will have been met.\textsuperscript{12}

**Conscientious objections**

Some physicians object to medical assistance in dying on moral or religious grounds. While the law is clear that physicians have no obligation to provide MAID, there continues to be discussion on whether conscientiously objecting physicians should be required to provide referrals for patients who request MAID.

The Supreme Court of Canada recognizes a physician’s right to refuse to help a patient to die based on freedom of conscience. However, neither the Court nor federal legislation specifically address whether physicians are required to provide a referral for MAID.\textsuperscript{13} Most doctors who have indicated they would not be willing to provide MAID are similarly uncomfortable referring patients to a colleague.\textsuperscript{14} They view such a referral as morally equivalent to personally assisting patients to die.

In response to these issues, the regulatory authorities (Colleges) have developed policies and guidelines on MAID aimed at reconciling the Charter rights of patients and physicians.\textsuperscript{1} These guidelines differ from one jurisdiction to another and reaction to them has varied.

In 2016, faith-based medical groups and individual physicians launched a legal action in Ontario, arguing that the College of Physicians and Surgeons of Ontario policy violates their Charter rights.\textsuperscript{15} In another development, some Catholic hospitals are opting not to provide MAID within their facilities and are instead transferring patients who request an assisted death.\textsuperscript{16,17}

Conscientious objection to MAID will likely remain a contentious issue, as the regulations try to strike the appropriate weighting between the rights and convictions of doctors while ensuring they uphold their duty of care.

**Safeguards**

The legislation’s safeguards, which are aimed at protecting vulnerable patients from abuse of the MAID provisions, can be hard to apply in certain circumstances.

For example, to complete the MAID request form, patients must find witnesses that meet the legislation’s strict requirements for independence. This can be a struggle. Challenges have also been encountered when trying to determine the independence of the two practitioners involved in providing MAID.\textsuperscript{16} And issues have surfaced about the application and shortening of the 10-day period of reflection.
Despite concerns about applying some of the safeguards in specific situations, a number of physicians are now developing a special interest and experience in MAID. Some hospitals and health authorities have policies and resources to assist physicians and other healthcare providers with the processes around MAID, including interpreting and complying with the various safeguards. However, other hospitals and health authorities have not yet implemented any policies, which can present additional challenges for physicians caring for patients who request MAID within that facility.

**MEDICAL-LEGAL RISKS**

Unlike other healthcare services, MAID is governed by criminal law. If the safeguards and eligibility criteria for MAID are not met, it could result in criminal charges against a physician and imprisonment of up to 14 years. This is in addition to the usual risks associated with medical care, which may result in College sanctions and civil legal actions.

Because the Quebec legislation is generally more restrictive than the federal legislation, physicians providing assistance in dying in Quebec should act in accordance with both the **Criminal Code** and provincial legislation, adhering to whichever requirements are more restrictive.

**TIPS WHEN CONSIDERING A REQUEST FOR MAID**

When patients request assistance in death, physicians should consider the following:

- Become familiar with your obligations as set out in the federal legislation, provincial or territorial laws and regulations, and College and hospital policies.
- Treat each request for assisted death as unique. Assess it on its own merits based on the facts and circumstances of the case.
- Document carefully in the medical record the processes and discussions around MAID, especially assessments on eligibility and mental capacity (competence), informed consent discussions, consultations with other healthcare professionals, and, if appropriate, discussions with family members.
- Consider consulting with colleagues for support in dealing with end-of-life care and requests for MAID.
- Contact the CMPA if you have medical-legal questions or concerns about MAID.

**Additional reading at www.cmpa-acpm.ca**

- “What the legislation on medical assistance in dying means for physicians in Canada”
- “Conscientious objection to physician-assisted dying: Protecting Charter rights”
- “After the diagnosis: How to communicate with terminally ill patients”


Since its formation in 1901, the Canadian Medical Protective Association’s (CMPA) relationship with its members has been defined by the principles of mutuality. Physicians collectively share in the costs, risks, and benefits associated with membership. We also share a responsibility to practise and act in a manner that aligns with the ethics and expectations of the profession and supports the values of the Association (or mutual) as whole. This includes working proactively to reduce risk, decrease medical-legal incidents, and promote safer care.

Recognizing the benefits of mutuality, our members support these goals. Our most recent member survey indicates that the majority of members are in favour of the CMPA working more closely with members whose medical liability experience is greater than their peers. In response, we are developing the Member Support Program, or the MSP, to further enhance the assistance we provide.

The Member Support Program will help members reduce risk and decrease the likelihood of future medical-legal events. It will help us better understand our members’ needs and enable us to offer targeted support to members whose medical-legal experiences are greater than those of their peers—reducing future medical-legal risk, improving practice safety, easing stress, and returning joy and satisfaction to practice.

The program is intended to help the small number of members who have experienced higher than average medical liability difficulties. We will determine how we can provide additional assistance to these physicians. Some will be expected to access customized support or take part in educational activities to improve the safety of their practice and reduce their risk, or do both. By helping members address the root cause of the behaviours that increase their risk, the program will contribute to saving physicians’ careers and improving outcomes for patients, members, and the healthcare system.

Planning for the Member Support Program is underway and we anticipate beginning program activities in late 2017. For more information about the program, contact MemberSupportProgram@cmpa.org.
SAFE SURGICAL CARE

shining a light on
the medical-legal risks of laparoscopic surgery

Laparoscopic procedures have rapidly become the standard approach for a number of common surgical treatments. Laparoscopic surgery requires advanced surgical technique, experience with specialized equipment, and dynamic and complex clinical decision-making. As in other types of surgery, teamwork is also essential.

The minimally invasive nature of laparoscopic procedures offers the potential benefits of less pain and bleeding, and a faster recovery than open surgery. Yet, these procedures may also carry significant risks for patients as well as medical-legal risk for healthcare providers when things do not go as planned.

The CMPA reviewed 423 closed medical-legal cases involving laparoscopic procedures. Peer experts were critical of the care provided in the majority of these cases (74%). Most cases were related to an intra-operative event. Forty percent of patients experienced severe harm or died.

The laparoscopic procedures most frequently performed were cholecystectomy, hysterectomy and other gynecological procedures (e.g. salpingo-oophorectomy), appendectomy, and nephrectomy.
Patient evaluation and informed consent

Expert criticism of the pre-operative evaluation pertained to either the lack of thorough history-taking or conducting a deficient assessment, such as not ordering the appropriate tests or not reviewing available test results before surgery. This included failing to consult with a colleague with specialized expertise when dealing with a complex case. In a few cases, experts questioned the surgeon’s choice of laparoscopy over an open approach, often related to the surgeon not taking into account the patient’s co-morbid conditions such as a history of previous abdominal surgeries.

Experts were critical of surgeons for not obtaining informed consent when the documentation in the medical record could not substantiate that the surgeon had explained the treatment options and the benefits and risks of the surgery. Experts noted that consent discussions should generally include, but are not limited to, surgical injury and the need to convert to an open approach if difficulties are encountered. In at least half the cases, the consent discussion was either poorly documented or undocumented.

Adherence to surgical safety protocols

Non-adherence to surgical safety protocols and deficient clinical decision-making were leading contributors to surgical safety incidents intra-operatively. Non-adherence to surgical safety protocols was usually related to tasks commonly incorporated in a surgical safety checklist. They included failure to:

- perform a surgical pause (time out) to confirm the procedure with the team prior to initiating surgery
- verify that the correct materials or equipment was available and functional prior to use
- consider potential harm from misuse of surgical equipment

These failures were associated with wrong surgery (i.e. wrong body part, procedure, or patient), surgical injury, or burns. In 11 cases, the unintentionally retained surgical items were secondary to the failure to count items not listed on the count sheet. A few cases were related to equipment failure (e.g. endobag broke during organ retrieval).

Intra-operative decision-making and situational awareness

Experts were critical of the clinical decision-making in cases where the surgeon failed to adequately define the anatomy which later led to an injury. These injuries most often involved the common bile duct during a cholecystectomy. Experts also criticized surgeons who failed to adequately visualize and protect internal structures. In some cases, a lack of situational awareness may have contributed to deficient decision making, such as failing to recognize and react to a deteriorating situation (e.g. delay in changing a technical approach or converting to an open approach).
CASE EXAMPLE: Difficulty determining the anatomy of the bile ducts

An older woman needs major corrective surgery to repair a common bile duct transected during laparoscopic cholecystectomy. She faces a prolonged recovery as a result.

What happened?
During the original procedure, the general surgeon encountered adhesions and fibrosis in and around the gallbladder and had difficulty with the dissection. The cystic artery was identified, clipped, and divided. He isolated what he believed to be the cystic duct, and proceeded to clip and divide it. The surgeon then dissected the gallbladder off of the liver bed and noted a bile leak from what looked like a small accessory bile duct. He clipped and divided this duct. He then removed the gallbladder and placed a drain. The patient was admitted for observation. The next day, a HIDA scan confirmed a common bile duct injury, and the patient was referred to a hepatobiliary surgeon for further management.

What did peer experts say?
Experts were critical of the surgeon’s technique but acknowledged he managed the complication adequately by leaving a drain in place and appropriately referring the patient. With respect to the injury itself, experts had the following opinions:

• There was no documentation in the operative note that the surgeon achieved the “critical view” prior to any clipping. Experts maintained surgeons must visualize the triangle of Calot to adequately confirm the surrounding anatomy.

• The surgeon could have done an intra-operative cholangiogram, called a colleague for a second opinion, or converted to open surgical technique to facilitate the visualization or identification of structures.

Intra-operative injuries also included laceration or damage to the bowel, vessels, ureter, reproductive organs, or nerves.

CASE EXAMPLE: A bowel injury goes undetected

A woman requires repeated surgeries and a prolonged ICU stay for the management of intra-abdominal abscesses that resulted from the delayed diagnosis of a small bowel perforation from her first surgery.

What happened?
Due to dense adhesions encountered soon after beginning the laparoscopic removal of a pelvic mass, the gynecological surgeon converted to an open approach and proceeded with an apparently uneventful procedure.

On the second day of her hospital stay, the patient developed shortness of breath, tachycardia, and an elevated white blood cell count. The surgeon consulted an internist who diagnosed pneumonia and ordered antibiotics. On the third morning, the surgeon noted that the patient was progressing well. Later that day, the internist assessing the patient noted that the patient’s abdomen was distended and bowel sounds were reduced. The next day, the patient’s condition significantly deteriorated, with shortness of breath and discomfort. She was admitted to the ICU, and an abdominal and pelvic CT scan showed significant free air in the peritoneal cavity consistent with bowel perforation.

Bowel and vessel injuries usually occurred during laparoscopic access with a Veress needle or trocar, but also during dissection. Intra-operative injuries were often associated with patient co-morbidities such as obesity and adhesions from previous surgeries.

Importantly, in 45% of cases where a surgical injury occurred, peer experts acknowledged that, despite good technique, the injury was a recognized risk inherent to the procedure. Experts’ opinions supported the care when there was clear documentation in the medical record that the surgeon identified and appropriately managed the injury in a timely manner, including consulting other specialists.
What did peer experts say?
Peer experts were of the opinion that the small bowel perforation likely occurred from the introduction of the Veress needle or the trocar during the laparoscopic phase of the surgery. They also agreed this injury is an inherent risk of surgery.

Experts theorized there was a slight delay in diagnosing the perforation because the respiratory complications diverted the surgeon’s attention from a developing abdominal complication. They noted that small bowel injuries generally take longer to detect than injuries to the colon. Nevertheless, the surgeon failed to consider that the patient’s symptoms might indicate a bowel injury, and experts felt the surgeon should have assessed the patient more thoroughly and monitored her more closely and frequently.

Post-operative follow-up and early recognition of surgical injury
Some of the injuries that occurred during surgery (e.g. ureteric, bowel) remained undiagnosed until the patient became symptomatic in the post-operative period. Even then, surgeons sometimes failed to consider the possibility of a surgical injury. In some cases, experts felt the surgeon should have been more suspicious of injury, even when the surgery had been straightforward or uneventful.

Miscommunication between members of the healthcare team or with the patient and family was also identified as a problem in this phase of surgery. Deficiencies in team communication usually involved not sharing relevant information about the patient’s status and treatment decisions.

Communication problems were also found to exist with the patient and family, which included the physician’s failure to appreciate the patient’s or family’s voiced concerns, and inadequate disclosure and apology following a surgical incident. Unclear and insufficient discharge instructions sometimes affected continuity of care. For example, continuity of care was affected when discharge instructions failed to convey important information alerting patients to the possible symptoms of complications that would have prompted them to seek timely medical attention.

In some cases, the physician did not clearly document conversations that occurred during patient visits, as well as discharge instructions and telephone advice.

Strategies to provide safe surgical care during laparoscopic surgery
Based on expert opinions in the medical-legal cases, strategies to reduce surgical safety incidents related to laparoscopic surgery include the following:

For the surgical team
• Carefully consider and communicate to the team any relevant risk factors, including comorbidities and surgical or family history that could have an impact on the patient’s surgical management.
• Implement standardized surgical safety protocols (e.g. surgical safety checklist) to ensure inter-disciplinary team situational awareness (i.e. keeping track of what is happening and anticipating what might need to be done) and improve verification practices (e.g. patient, site, procedure, and count).
• Consider altering technique, consulting a colleague, or promptly converting to an open procedure when difficulties are encountered.
• Inform patients about any difficulties encountered or suspicion of a possible complication during surgery, possible post-operative complications, and alternate or emergency procedures performed during surgery.
• Conduct a thorough examination of the patient’s fitness for discharge with consideration given to factors such as the complexity of the surgery, any difficulties encountered during or after surgery, patient age, and overall condition. Inform the patient about symptoms and signs that should alert them to seek further medical attention, and when and whom to consult in the event of complications.

For healthcare leaders
• Facilitate and encourage maintenance of skills training (e.g. drills and simulation, peer observation, coaching) to practise dynamic decision-making, situational awareness, and effective team communication.

Additional reading at www.cmpa-acpm.ca
• Surgical Safety in Canada: A 10-year review of CMPA and HIROC medical-legal data
• Surgical safety checklists: A review of medical-legal data
• "Recognizing the risk of ureteric injury in abdominal surgery"
• CMPA Risk fact sheets—Action for safe medical care:
  - “Medical-legal risks associated with wrong site, wrong procedure, wrong patient surgery”
  - “Pre-operative period—Patient assessments”
  - “Intra-operative period—Unintentionally retained surgical items”
  - “Post-operative period—Patient discharge and follow-up”

2. Legal, medical regulatory authority (College), and hospital cases that closed between 2011–2015.
disarming statements can lessen **conflict in the healthcare workplace**

Incivility, undue aggressiveness, and other forms of disruptive behaviour in the healthcare workplace can contribute to a toxic work environment and affect patient safety. Colleagues and other healthcare professionals who are exposed to this behaviour may complain to the medical regulatory authority (College) or hospital. The risk of setting a pattern of incivility may be lessened when healthcare providers understand how to approach disagreements with co-workers.

Knowing how to turn a disagreement into an opportunity for learning and improvement can yield favourable outcomes. When someone says something you disagree with, try alternative ways to express your dissent. One way is to make a “disarming” statement before you give your own opinion, such as one of the following:

1. “Interesting—it seems we have different points of view. Do you mind if I explain where I’m coming from?”
2. “I’ve made different observations, probably because I had different experiences....”
3. “I value your ideas on this matter and I can see why you’re concerned about trying a different way. Perhaps we could look at how we can use this new approach?”

When lapses in civility occur, learning from the experience and seeking help before things escalate and a pattern of incivility develops is important. Members, including those who are physician leaders, may contact the CMPA and speak with a physician advisor—a colleague trained in dealing with the difficult situations facing today’s physicians.

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Connect with the CMPA:

1:30 p.m. Annual Meeting
- President’s report
- 2016 Report of the Audit Committee
- 2016 Financial report
- 2018 Aggregate fees by region
- 2017 Council election results
- Q&A for members
- CEO’s remarks

Members who wish to initiate a motion for consideration during the annual meeting should complete a Notice of Motion form and Support for Notice of Motion form, and submit these to the CMPA at least 60 days prior to the meeting.

More information about the 2017 annual meeting and draft minutes of the 2016 annual meeting are available on the CMPA website at www.cmpa-acpm.ca/en/annual-meeting.

4:30 – 5:30 p.m. Reception

Join us in Québec City
The Hilton Québec Hotel
August 23, 2017

3:00 p.m. Information Session
The physician’s voice: Empowering better healthcare
The CMPA has assembled a distinguished group of speakers to address this important topic.

Dr. Antonia Maioni
Associate Vice-Principal (Research and International Relations) at McGill University, Professor in the Department of Political Science and the Institute for Health and Social Policy, Dean of the Faculty of Arts, McGill University.

Dr. Andrew Smith
Executive Vice President and Chief Medical Executive of Sunnybrook Health Sciences Centre in Toronto.

Dr. Annie Léger
Director of Professional Services and University Academics, Centre intégré de santé et de services sociaux (CISSS) de l’Abitibi-Témiscamingue, board member of the Association des conseils des médecins, dentistes et pharmaciens du Québec (ACMDPO).

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