FEATURE: TECHNOLOGY IS THAT E-CONSULTATION OR E-REFERRAL SERVICE RIGHT FOR YOUR MEDICAL PRACTICE?  ■ SAFE SURGICAL CARE closing the gap with the surgical safety checklist  ■ TECHNOLOGY the ransomware threat: are you prepared?  ■ SAFE CARE IN OBSTETRICS maternal postpartum care: when things don’t go as planned after delivery  ■ YOUR ASSOCIATION 2017 CMPA Annual Meeting
from the CEO

In many ways, I believe there has never been a better time to be practising medicine. Canadians are living longer and enjoying a better quality of life than ever before, due in large part to scientific progress and technological innovations in medicine. Every day, physicians make decisions that benefit patients and their families, while new clinical breakthroughs promise further improvements to health outcomes. While providing high quality care remains a source of satisfaction, the demands placed on many physicians are on the rise—frequently resulting in excessive stress and burnout. Indeed, the need to support our colleagues as they face challenges in their professional lives has never been greater.

The CMPA has a 115-year track record of supporting Canadian physicians by providing quality medical liability protection and proven risk management advice. We have earned the trust of our members through our understanding of physicians’ liability protection needs and by providing services that enable the delivery of safe medical care. As healthcare evolves, those needs are not the same as they once were, and our approach to meeting your needs is also evolving. We want to ensure that our support continues to align with the challenges you face in practice and reflects the values of our profession.

The CMPA's member support program offers tailored support to members whose medical-legal experiences are greater than those of their peers. The program is aimed at improving safety, easing stress, and ultimately returning the satisfaction of medical practice—the opportunity for our members to continue to have a meaningful practice and to deliver quality care.

The recently launched CMPA subsidiary, Saegis, further extends the range of services available to our members. Saegis offers specialized safety programs, services, and practice management solutions that extend beyond the CMPA's current offerings. Saegis' solutions will be tailored to the needs of physicians, other healthcare professionals and institutions—all aimed at improving patient care and contributing to a safe and sustainable healthcare system.

It is exciting to look ahead to how Saegis will make a real difference for physicians and the broader healthcare community. With Saegis, we now offer a wider spectrum of services and solutions that meet today's complex needs, while we remain committed to delivering our current liability protection services and education offerings. Significantly, as we welcome Saegis to the CMPA family, we further solidify the CMPA as an essential component of Canada's healthcare system. You can learn more about Saegis programs and services by visiting www.saegis.solutions.

While I feel confident about the future of medicine in Canada, I recognize that its potential cannot simply be assumed. The CMPA stands steadfastly with Canada's doctors and we are here to help you, our members, throughout your professional careers. That commitment has not changed for over a century and it continues to guide all of our actions today.

Hartley Stern, MD, FRCSC, FACS
Closing the gap with the surgical safety checklist

In-hospital surgical safety checklists enhance patient safety, but there can be areas of risk, as shown by a review of CMPA cases.

The ransomware threat: are you prepared?

A ransomware attack puts patient care at risk and cripples a clinical practice. Taking steps ahead of time helps limit damage and speed recovery.

Maternal postpartum care: When things don’t go as planned after delivery

Peer experts identified a number of areas of risk in a review of CMPA cases related to postpartum issues after discharge from hospital. They also suggest approaches to improve care.

Is that eConsultation or eReferral service right for your medical practice?

eConsultation and eReferral services make specialist care more accessible. They should also allow physicians to meet their legal, professional, and ethical obligations.

2017 CMPA Annual Meeting

At its 2017 annual meeting the CMPA renewed its commitment to continue evolving to meet members’ changing medical-legal needs.
Since the introduction of the Surgical Safety Checklist (SSCL) by the World Health Organization (WHO) in 2008 and the Canadian Patient Safety Institute (CPSI) in 2009, there has been increased focus on the use of checklists to help improve the safety of operating rooms (ORs). In 2010, Accreditation Canada recognized the use of the surgical safety checklist as essential to patient safety and established it as a required organizational practice.

While healthcare facilities had pre-existing surgical safety protocols, these were not always consistently followed, often because of breakdowns in communication or a lack of standardized system protocols.1, 2 The SSCL established a more comprehensive surgical team approach aimed at improving communication and consistency of care in ORs.

Medical-legal issues related to the use of the SSCL3 can be grouped by the 3 surgical phases of the Canadian Patient Safety Institute (CPSI) SSCL:

1. **Briefing:** before the induction of anaesthesia
2. **Time out:** before the first incision
3. **Debriefing:** before the patient leaves the OR

The CMPA reviewed 54 closed medical-legal cases involving events that occurred between 2011 and 2015 and which included in-hospital SSCL-related issues. In many of the cases, peer experts found surgical safety processes to be inadequate, nonexistent, or not followed by the OR team. The analysis also revealed that almost two-thirds of the surgical incidents (35/54 cases) occurred during the briefing or time-out phase, and the remaining ones occurred during debriefing (i.e. before the patient left the OR). The events analyzed in the review took place within a variety of surgical specialties and involved all members of the healthcare team.

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**SAFE SURGICAL CARE**

**closing the gap with the surgical safety checklist**

**READ THE CMPA/HIROC REPORT ON SURGICAL SAFETY**

As a member of the National Patient Safety Consortium, the CMPA applies its medical-legal expertise to help improve surgical safety. In collaboration with the Healthcare Insurance Reciprocal of Canada (HIROC), in 2016 the CMPA jointly released the report *Surgical Safety in Canada: A 10-year review of CMPA and HIROC medico-legal data*, which provides recommendations on system and practice improvements to support patient safety. The report is available at www.cmpa-acpm.ca.
Effective implementation

An effective SSCL addresses team training, dynamics, and communication. It involves all members of the surgical team and requires leadership engagement. Supporting a patient safety culture, the SSCL facilitates communication across the care team and reduces the likelihood of certain surgical incidents.

“While it is recognized that optimal use of an SSCL will not prevent all surgical patient safety incidents, it is considered a fundamental step toward enhanced surgical safety.”

Briefing and time-out phases

Recurring themes in the analyzed cases were the following: inadequate verification of the identity of the patient, the failure to confirm the planned procedure and site, the lack of documentation of informed consent, the absence of appropriate marking of the surgical site (when applicable), and the failure to display relevant imaging. These lapses were associated with wrong-site surgery in 15 cases and performing the wrong procedure in 6 cases.

A further concern of the experts in these cases was the absence of a timely review of the patient’s documented clinical history or the results of pre-operative assessments. This often resulted in the physician or anesthesiologist overlooking relevant risk factors, consultant recommendations, or abnormal laboratory investigations that would have required immediate attention or follow-up.

Less commonly, checklist items that were overlooked in the briefing phase were checking patients’ allergy status and expiration dates, and failing to note that prophylactic antibiotics had not been administered.

Debriefing phase

Cases with issues involving sponge or instrument counts resulted in unintentionally retained surgical items. Either the surgical counts were not documented, were erroneously reported as correct, or imaging was not performed when there was a reported discrepancy in the surgical count. In one case where the surgical count was correct, an 18 cm forceps was overlooked and retained despite a final sweep of the cavity.

In some cases problems also arose when regularly used and additional surgical items, instruments, or instrument parts were not added to the surgical count.

Retained surgical items often took weeks or months to identify following prolonged investigation of ongoing post-operative symptoms.

In a small number of cases, specimens procured intra-operatively were not processed appropriately due to breakdowns in the specimen management process. In other cases, inadequate communication of critical intra-operative events (e.g. respiratory arrest) with the post-operative team members resulted in delay to initiate mitigating therapies (e.g. hypothermia protocol).

...almost two-thirds of the surgical incidents (35/54 cases) occurred during the briefing or time-out phase, and the remaining ones occurred during debriefing (i.e. before the patient left the OR).
The following cases illustrate SSCL-related issues.

**CASE 1:**
**Wrong procedure performed**
A patient presents for a trigger finger release but mistakenly undergoes a carpal tunnel release.

**What happened?**
At the consult visit, the surgeon diagnosed a stenosing tenosynovitis and discussed the trigger finger release with the patient. The surgeon’s dictated consult referred to the trigger finger diagnosis, and the patient consented to pulley release surgery. On the day of surgery, the patient’s name did not appear on the OR schedule and the paperwork had not arrived; consequently, the plastic surgeon did not have access to the patient’s health record including the consent or his consult notes. The hospital registration sheet, meanwhile, incorrectly stated carpal tunnel release. The patient was nervous and the surgeon did not spend time discussing the surgery, but rather focused on addressing the patient’s anxiety concerning the procedure.

**CASE 2:**
**Surgery done on wrong site**
The OR team operated on the wrong knee when “time out” was not performed properly.

**What happened?**
On the day of surgery, the orthopaedic surgeon met the patient outside the OR, confirmed the site and procedure, and marked the patient’s correct knee below the tibial tuberosity. Once in the OR theatre and prior to prepping the patient, the team initiated a “time out” while the patient was still awake; this included confirming the patient’s identity, the site, and the procedure.

The time-out protocol had recently been introduced at the hospital with no specific team training. Furthermore, the team was using a new leg holder, and while everyone was focused on applying the holder properly, the wrong leg was being set up and the surgeon’s marking on the operative leg was no longer visible. At the subsequent correct surgery, the surgeons marked the limb at the patient’s patella and two portal sites.

**CASE 3:**
**Surgical item unintentionally retained**
Five months after surgery for metastatic colorectal cancer, an elderly man requires a second surgery to remove a retained gauze.

**What happened?**
While excising an isolated metastatic lesion on the patient’s pelvic bone, the orthopaedic surgeon consulted with a general surgeon because the tumour was adherent to the patient’s bowel. The general surgeon resected and anastomosed part of the bowel, and left the OR before the end of the 12-hour surgery. In this long and complex procedure the surgical count was only carried out twice and reported as correct. As was the orthopaedic surgeon’s usual practice after a complex case, he ordered an abdominal X-ray to rule out retained surgical items. He reviewed the X-ray and noted there was a radio-opaque line over the sacrum. He consulted a radiologist who attributed the findings as likely representing anastomotic staples. No further imaging studies were done. Four months later the patient sought care for new onset abdominal pain. A CT scan identified the retained gauze.
Strategies to support appropriate use of the surgical safety checklist

Strategies to reduce surgical safety incidents are based on peer expert opinions in the reviewed cases.

For care providers

- Promote a culture of safety with open and respectful communication that encourages patients, families, and providers to speak up when they have concerns.
- Work as a team to customize the SSCL according to the facility and specialty.
- Support team members as they use the SSCL and discuss any issues involving common and necessary surgical tasks.
- Follow the hospital policy and procedure (if available) for surgical counts: count any items added to the field, document the count, and take appropriate measures in the event of a discrepancy. Document the measures taken to address the discrepancy.
- Use a structured communication tool during the transfer of care.
- Document the effective use of the SSCL and any issues.

For healthcare leaders

- Develop and implement clear surgical safety policies and procedures.
- Allocate appropriate resources for effective implementation and periodic evaluation of the SSCL to enable continuous quality improvement. Provide feedback to the healthcare providers.
- Foster a culture of safety by supporting multidisciplinary education programs to support policies related to teamwork, communication, and situational awareness.

More information

For more information on surgical safety checklists, read the CMPA’s report Surgical safety checklists: A review of medical-legal data. It is available at www.cmpa-acpm.ca.

3. SSCL-related issues are clinical care issues the SSCL is intended to address and which contributed to a surgical incident. The CMPA defines a surgical incident as a patient safety incident that occurs prior to, during, or after a surgical procedure.
A routine day at a busy community clinic suddenly turns frantic when its computer screens display an ominous message and accompanying instructions:

"Your files are encrypted. To get the key to decrypt files you have to pay USD$500."

The jumbled mess of cryptic symbols showing up in the computer files confirms it: the clinic has been hacked by ransomware.

Ransomware is computer malware that encrypts electronic files, essentially locking users out of their computers, and only the hackers have the key. The hackers hold the files for ransom and try to extort money to restore access. By the time you become aware of the attack it is usually already too late, and any files connected to the computer system may be compromised.

It’s a distressing worldwide problem, and physicians in Canada are not immune. Members have told the CMPA about ransomware incidents affecting their practices and EMR systems—events that can cripple a clinical practice and put patient care at risk.

Two principal medical-legal issues arise from ransomware. First, patient care may be impacted if health providers cannot access their electronic medical records (or any other relevant electronic files). Second, because ransomware may result in loss of information or allow hackers to access personal health information contained in the electronic files, a ransomware incident should generally be treated as a privacy breach pending further investigation. Depending on the jurisdiction, it could be necessary to provide notification of a privacy breach to the affected individuals or the privacy commissioner, or both. Contact the CMPA for further guidance.

The decision of whether or not to pay a ransom rests on your assessment of the risks and whether you have good backups and can recover quickly. The ransom can be considerable, and payment provides no guarantee that the information

There are various ways to reduce the risk of infection. Learn to recognize and avoid phishing scams. Do not open unsolicited email attachments. Seek advice from experts about implementing a layered approach to securing your computer system including employing firewalls, web scans, and up-to-date anti-virus software. And provide information security training to clinic staff to instill awareness of malware and routine precautions to take.

Perhaps the best defense, however, is to plan ahead to limit the damage and recover quickly from an attack. Segmenting systems (i.e. setting up the computer network so that one part can be quickly disconnected from other parts of the network and the Internet) may help prevent the spread of infection. Recovery is likely to be more successful when files are backed up regularly, backed-up files are kept on a separate system disconnected from the main system (physically or via cloud backup), and the back-up systems are tested regularly.

It is imperative to take steps to both protect your computer system from malware and to mitigate the damage from a possible malware incident. Owing to the myriad of ways a computer system can become compromised, prevention strategies, while essential, may not be enough.
will actually be recovered. When patient care is at risk and restoring access to medical records quickly is important, paying the ransom is one option—though not the only one. Online tools such as nomoreransom.org, a site backed by a group of recognized cybersecurity companies, offer to unlock encrypted files at no charge, though the capability of the service is limited to only some types of ransomware. Law enforcement agencies and cybersecurity experts urge victims not to pay the ransoms, as the proceeds of such extortion encourage further criminal activity and lead to other victimizations. As a CMPA member, if you choose to pay the ransom the payment remains your responsibility.

If you experience a ransomware incident, once you have promptly contacted your IT specialist and reviewed your options, it would be prudent to take reasonable steps to ensure continuity of patient care and focus on any urgent patient needs or follow-up. You may also report the incident to the Canadian Anti-Fraud Centre (www.antifraudcentre-centreantifraude.ca or 1-888-495-8601), and contact the CMPA for more information.


Members have told the CMPA about ransomware incidents affecting their practices and EMR systems—events that can cripple a clinical practice and put patient care at risk.
A busy professional tells his family physician about a rash on his back that is not getting better. After detailing his family history of skin cancer, he describes his growing anxiety. All he can think about is how would he, as a single parent, deal with a serious health problem?

After examining the rash, the family physician decides to consult with a dermatologist. However, the patient lives in a rural area that is two hours from the nearest dermatologist’s office, which has a 6–9 month wait for non-emergencies. There is another option—a remote consultation using technology to connect with a specialist, otherwise known as an eConsultation.

The physician informs the patient about the technology used for an eConsultation and, in particular, any risks to privacy and the confidentiality of personal health information. With the patient’s consent, the physician photographs the rash. She logs into the secure electronic consultation website, clicks on the drop-down list of available specialties, and selects “dermatology.” She fills in the form, gives the patient’s history, uploads the photograph, and submits the request for a consultation.

Within a few days, the family physician receives a secure email from a dermatologist. The specialist doesn’t see a need for a referral visit, but does suggest a biopsy. The family physician calls the patient and arranges for the procedure, which is performed locally. The rash, diagnosed as early skin cancer, is treated quickly and effectively. The family physician summarizes the care process in the patient’s record.
Technology enhancing patient care

Across Canada, individuals and groups are using new technology to improve consultations and referrals. These initiatives are generally referred to as eConsultation and eReferral services.

While the services can be diverse in the technology used and the features offered, they share a common goal: to streamline consultations and referrals, giving patients and primary care physicians more effective and efficient access to specialist care.

eReferral services generally allow primary care physicians to request a referral to a specialist electronically, rather than by fax or mail.1 eReferral services can involve migrating relevant patient information already contained in the physician’s electronic medical record systems into an electronic referral form that is sent to the specialist and also saved in the patient’s electronic record.

eConsultation services typically connect primary care physicians with specialists using information and communication technology. They allow physicians to have an electronic dialogue to manage patient care, without requiring a face-to-face visit with the patient.1

“eConsultations and eReferrals are exciting because of their potential benefits,” says Dr. Dennis Desai, CMPA’s Senior Physician Advisor, Quality Improvement and eHealth. “There is real potential for patient care to be enhanced because wait times for specialist care may be reduced and the barriers that prevent patients from accessing care may be removed.”

Before participating in this type of service, physicians should be satisfied that it would serve their patients’ needs, and also support them in meeting their legal, professional and ethical obligations.

Econsultation and eReferral services vary

Econsultation and eReferral services vary widely. Some use the Internet, while others use traditional technology. For example, the Champlain BASE (Bu Iding Access to Specialists through eConsultation) eConsult Service is a web-based service primarily available in parts of Ontario.2 In British Columbia, the Rapid Access To Consultative Expertise (RACE) eConsultation service uses the telephone.3 Some are developed by public organizations and are provided without charge,2 while others are created by private groups and charge users a fee.4

While the services can be diverse in the technology used and the features offered, they share a common goal: to streamline consultations and referrals, giving patients and primary care physicians more effective and efficient access to specialist care.
### What are physicians' legal, professional, and ethical obligations?

#### Duty of care

In an eConsultation and eReferral situation, primary care physicians have a doctor-patient relationship with the patient, which creates a duty of care.

That duty may also extend to consulting physicians who have been involved in the patient’s care, even if they have not seen or interacted directly with the patient. The law continues to evolve in this area, but it is probable that discussing a patient’s care through an eConsultation would establish a duty of care. And, at least one Canadian court has suggested that a physician may owe a duty to patients even in the absence of a doctor-patient relationship.\(^5\)

#### Standards of care

When evaluating an eConsultation or eReferral service, physicians should question if it supports them in meeting their obligation to treat patients according to current and applicable standards of care.

Some medical organizations and specialty societies, and all regulatory authorities (Colleges) have established standards for in-person consultations and referrals. It is likely that those would apply equally to eConsultations and eReferrals.

In general, referring physicians should be able to provide necessary information about the patient’s problem; the clinical question to be answered; patient details; and relevant investigations, treatments, and medications. Consulting physicians should have sufficient details about the patient’s condition to be able to provide answers to specific questions and give appropriate advice.\(^6\)

Specialists should generally decline to provide an eConsultation if they feel that the available information is inadequate or a physical examination is needed to provide the appropriate advice. A physician who proceeds with an eConsultation that does not meet the standard of care may be subject to disciplinary proceedings by the physician's College and may be liable in a civil action for any injury the patient suffers because of that failure.

#### Privacy

As physicians have ethical and legal obligations to keep their patients’ personal health information private and confidential, they should be satisfied that any eConsultation or eReferral service they rely on has adequate security and privacy protocols to protect patient information.

Physicians should ask the service provider to confirm that the service has the appropriate privacy safeguards. When practising within a healthcare facility that has adopted an eConsultation or eReferral service, physicians may wish to speak with their administration to ensure similar steps have been taken by the facility.

To learn about specific safeguard requirements, physicians can look to applicable federal or provincial or territorial privacy legislation, or College guidelines or standards of practice. More information about privacy considerations for eReferrals or eConsultations is available from provincial and territorial privacy commissioners, Colleges, and the CMPA.

#### Medical records

In investigating an eConsultation or eReferral service, physicians should consider if the service allows them to meet their legal and professional responsibilities to maintain proper medical records for patients.

Primary care physicians should document in the patient’s medical record the information that would normally be expected with any consult or referral request including the patient information provided to the specialist, details of exchanges with the specialist, the specialist’s recommendations, and the reasons for following the specialist’s recommendations (or not). A consulting physician providing treatment recommendations to a primary care physician through an eConsultation should document the information provided by the treating physician, the substance of any exchange with the treating physician, information considered in the course of the consultation, and their recommendations to the treating physician.

These records can provide invaluable evidence in case a question arises later about the information provided or advice given. Legal proceedings often start long after a referral is made and consultation provided, and these records may be physicians’ only source of information to refresh their memory.
Licensing

Before participating in an eConsultation or eReferral with physicians located in a different province or territory, doctors should consider whether they have met applicable licensing requirements.

Some eConsultations may be considered telemedicine, which can have specific licensing requirements. The Federation of Medical Regulatory Authorities of Canada defines telemedicine as “the provision of medical expertise for the purpose of diagnosis and patient care by means of telecommunications and information technology where the patient and the provider are separated by distance. Telemedicine may include, but is not limited to, the provision of pathology, medical imaging and patient consultative services.”

Telemedicine licensing requirements vary for each province and territory. Some physicians practising telemedicine might need to be licensed in both the jurisdiction in which they are located and in the jurisdiction where the patient is located. Some Canadian jurisdictions may also require special registration, or they may place conditions on the provision of such services, or both. So, physicians should be familiar with the requirements of each province and territory in which they practise and the patients are located.

Moving forward with care

eConsultations and eReferrals represent an exciting and promising new frontier in medical care. They offer great potential for remotely connecting referring and consulting physicians, and enhancing patient care. Before participating in such a service, clinicians should carefully examine it to satisfy themselves that it will also allow them to meet their legal, ethical, and professional responsibilities.

5. Crawford v Penney, 2003 CanLII 22314 (ON CA)

CMPA assistance

Some eConsultation or eReferral services may allow physicians to offer medical advice for patients living outside of Canada. For the purposes of determining whether the CMPA will generally assist members with an issue related to telemedicine, the CMPA deems the location where care is provided to be the patient’s location at the time of the telemedicine encounter. While CMPA members are generally eligible for assistance in the event of medical-legal difficulties if the patient is located in Canada, they are generally not eligible for CMPA assistance if the medical-legal problems arise outside of Canada or result from care provided to patients located outside of Canada.
maternal postpartum care: when things don’t go as planned after delivery

Although the focus in obstetrics is primarily on antepartum and intrapartum management, serious complications can occur in the postpartum period. These complications usually manifest after the woman has been discharged from hospital, and some, such as infections and postpartum hemorrhage, may require readmission. What are some of the contributing factors in these cases, and how can maternal postpartum care be improved?

The CMPA reviewed 87 closed medical-legal cases that occurred over a 10-year period and were associated with postpartum issues after discharge from hospital. Just over half of the cases were legal actions (54%), followed by regulatory authority (College) complaints (39%) and hospital complaints (7%).

The main issues identified in this review were related to: diagnosing and managing complications, usually infections and sepsis; secondary postpartum hemorrhage (PPH); and retained vaginal sponges. About half of the cases (45%) had unfavourable medical-legal outcomes. Peer experts identified deficiencies in both the pre- and post-discharge care.
SAFE CARE IN OBSTETRICS

maternal postpartum care: when things go wrong

In a few cases, the obstetrical team failed to recognize and respond to changes in the mother’s condition before discharge from hospital, missing the symptoms and signs of sepsis or preeclampsia. These patients were usually readmitted within 1 to 3 days. In the preeclampsia cases, the physician did not closely monitor the patient or follow up on test results (e.g. urine protein). In the sepsis cases, nurses failed to verify the patient’s vital signs before discharge or notify the physician when they were abnormal (e.g. hypotension, tachycardia), whereas the physician failed to investigate possible causes of abnormal signs.

Post-discharge issues

Many physicians, including emergency physicians, family physicians (FP), and obstetricians failed to appreciate the significance of a patient’s repeated visits for worsening symptoms. In some cases this contributed to a delay in diagnosis. Once the complication was diagnosed, patients often required readmission to hospital, surgical intervention, and at times, intensive care.

Postpartum infection and sepsis

Most postpartum infections were associated with perineal repair after vaginal delivery or with wound infection or endometritis after Caesarian section. In many cases, peer experts opined that infection was a recognized complication of the procedure and concluded that the care met the standard. In other cases, however, the patient experienced a delay in diagnosis and treatment, which resulted in increased morbidity. Identified causes of delays included the failure to consult in a timely manner, and failure to consider more worrisome causes for a presumed wound infection that had not responded to standard antibiotic treatment.

In 6 cases of sepsis following vaginal delivery, the patients presented to the emergency department (ED) within 14 days of discharge. Four patients died from related complications. In 2 of the 4 fatal cases, abnormal test results were missed, either because they were not available at the time of assessment, or because there was no system in place in the ED to follow up on abnormal results.

The following case illustrates the challenges in recognizing sepsis in the postpartum period.

CASE EXAMPLE: EIGHTEEN DAYS POSTPARTUM, A WOMAN DIES OF GROUP A STREPTOCOCCAL TOXIC SHOCK SYNDROME

What happened?

Two weeks after a forceps-assisted delivery, a woman in her early thirties presents to the ED with a 2-day history of constant abdominal pain and nausea. She is tachycardic, but afebrile. The ED physician notes lower abdominal quadrant tenderness on examination. He observes abnormal vaginal discharge and obtains vaginal and cervical cultures. The patient receives IV fluid bolus, an antiemetic and analgesic, and starts taking oral antibiotics for probable endometritis. The patient refuses overnight admission for observation, as she is breastfeeding, and hospital policies do not permit the baby to room in with her. She is discharged home at midnight and advised to return the next morning for re-evaluation and ultrasound. She is also instructed to return earlier if her condition worsens.

The patient returns 5 hours later with increased abdominal pain and hypotension. An abdominal exam reveals rebound tenderness. The ED physician orders blood cultures and other bloodwork, as well as IV antibiotics. Despite the administration of IV fluid boluses, the patient remains hypotensive. The ED physician consults gynecology. Given the patient’s rapid deterioration, she is transferred to a larger centre. The intensivist assesses the patient who is by now exhibiting signs of septic shock on the basis of positive Group A streptococcal cultures. He initiates IV fluid resuscitation, high dose broad-spectrum antibiotics, inotropes, and mechanical ventilation. The patient develops disseminated intravascular coagulation (DIC) and multi-organ failure, and despite aggressive treatment, she dies. A legal action ensues.

What did the experts have to say?

Experts were supportive of the physicians’ care and maintained that the patient’s death was unpredictable and unpreventable. They stated that earlier medical intervention would not have altered the course of the patient’s condition or prevented her death.

The main issues identified in this review were related to: diagnosing and managing complications, usually infections and sepsis; secondary postpartum hemorrhage (PPH); and retained vaginal sponges.
Retained sponges

Unintended retained surgical items, including sponges after vaginal deliveries, are considered “never events”—preventable patient safety incidents that lead to patient harm or death.4,5 Measures to minimize the occurrence of these never events include the introduction of procedures to perform a sponge count at each birth and the monitoring of provider compliance with policies.6,7 In some of the CMPA cases involving a retained sponge, the hospital did not have a policy for sponge count after a vaginal delivery; these cases occurred before 2009. Factors that contributed to retained sponges after Caesarean section were the failure to visually or manually inspect the surgical field prior to closure, and not interpreting an ordered abdominal X-ray before the patient left the operating room.

The bottom line

Based on expert opinions in the cases reviewed, suggested approaches to improve maternal postpartum care include the following:

- Before discharging a patient, review any outstanding test results and be vigilant in considering if the patient shows symptoms and signs of postpartum complications (e.g., infection, hemorrhage). Give the patient clear written or verbal instructions that include the symptoms and signs that should alert her to seek further medical attention, and the steps and precautions to take when there are concerns. Make a notation in the medical record of the instructions and information provided to the patient.

- Be alert to potential postpartum complications when a patient repeatedly returns with the same or worsening symptoms. Re-evaluate the diagnostic assumptions and repeat the physical examination. Consider whether to consult with a colleague.

- Ensure all standard and non-standard items are counted after each delivery (vaginal and abdominal) and take appropriate measures to address a discrepancy in the count (e.g., X-ray, wound exploration).
The 2017 CMPA Annual Meeting was held in Québec City on August 23. In his report to members, CMPA President Dr. Jean-Joseph Condé took stock of the environment facing the Association and its more than 95,000 physician members. He emphasized that, as members evolve their practices in response to changes in healthcare, the CMPA continues to adjust its services to meet their medical-legal protection needs.

With the healthcare system facing financial pressures in every province and territory, Dr. Condé said the CMPA is working with governments and others to contain medical liability protection costs and improve the environment in which physicians practise. In 2016, the CMPA provided over 200 submissions and engagements aimed at influencing public policy decisions affecting physicians.

The CMPA had more than 456,000 member interactions in 2016, an increase of 10% over 2015, confirming both the pressures being experienced by physicians and the value they assign to the assistance and support provided by the CMPA. Dr. Condé described the CMPA’s initiatives that are contributing to the reduction of medical liability risk. For example, through the Member Support Program the CMPA will now provide members experiencing greater-than-average medical-legal difficulties with additional, tailored support aimed at improving safety and reducing risk in their practice.

Additional reading at www.cmpa-acpm.ca:
- Obstetrics services in Canada: Advancing quality and strengthening safety
- “The intra-operative period—unintentionally retained surgical items”
- Surgical safety in Canada: A 10-year review of CMPA and HIROC medico-legal data

Additional reading at www.cmpa-acpm.ca/gpg:
- The CMPA Good Practices Guide has more information on effective communication, reducing risk in surgery, and diagnostic tips.

3. Based on a study of CMPA legal actions, and College and hospital complaints, that occurred and closed during the years 2006 to 2015.
Additional initiatives include a risk reduction program for residents to be piloted this fall and made available to all medical schools across the country starting in 2018, and the development of educational programming to improve the safety of care in specific clinical disciplines, with an initial focus on surgery.

CMPA Executive Director and Chief Executive Officer, Dr. Hartley Stern, announced the launch of Saegis, a new member of the CMPA family. Saegis offers specialized safety programs and services for healthcare professionals and institutions, as well as practice management solutions that extend beyond the CMPA's current offerings. Saegis' programs will be available this fall and can be found at: www.saegis.solutions

**2016 Financial Report**

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

At the end of 2016, the CMPA's total assets were 105% of the total estimated liabilities, producing a positive financial position of $206 million. This is a marked improvement from the end 2015 position of a $94 million deficit. This improvement can be attributed to lower-than-forecast compensation payments, a small decrease in the provision for unpaid claims, and higher fees in two of the four regions. The Association will continue to take a long-term perspective to its financial position.

**Member Motion**

In accordance with the requirements of the CMPA By-law, a member motion was received by the Association and moved by Dr. Carl Nohr of Medicine Hat, Alberta. During consideration of the motion, the president confirmed the matter of term limits for members of council was an area already identified for further consideration during the upcoming by-law review. Dr. Condé noted the CMPA remains committed to employing sound governance practices that best meet the needs of the organization and its members.

The members present and voting adopted the advisory motion as follows:

*BE IT RESOLVED THAT The Canadian Medical Protective Association will consider term limits for members of Council and will consider a strategy to amend By-law #52 accordingly by the date of the 2020 Annual Meeting.*

**Information Session—The Physician’s Voice: Empowering Better Healthcare**

During the information session, members heard from an expert panel discussing the issue of physician advocacy. CEO, Dr. Hartley Stern, moderated the panel, which comprised Prof. Antonia Maioni (McGill University); Dr. Annie Léger (Centre intégré de santé et de services sociaux (CISSS) de l’Abitibi-Témiscamingue); and Dr. Andrew Smith (Sunnybrook Health Sciences Centre). The session generated a lively discussion and several questions and comments from the attendees.

Webcasts of the annual meeting and information session are available on the CMPA website at www.cmpa-acpm.ca.

**Council Elections**

Eleven positions on CMPA Council were scheduled for election in 2017. See the back cover for election results and acclamations.

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**Interested in CMPA Council Positions Scheduled for Nomination and Election in 2018?**

Members interested in being considered for nomination to the CMPA Council are invited to learn more about the nomination and election process and the positions that are scheduled for election in 2018. The CMPA Council is made up of 30 practising physicians representing 10 geographical areas across Canada. Current members of Council may also choose to seek nomination and re-election for an additional three-year term. Read more about the 2018 nominations and election process on the Association’s website, www.cmpa-acpm.ca, or contact the Association via email at elections@cmpa.org.
Introducing Saegis

As a member of the CMPA family, Saegis offers unmatched insight for physicians, healthcare professionals, hospitals, and institutions.

Through a range of safety programs and practice management services, we contribute to a safe and sustainable healthcare system nationwide.

Saegis Safety Institute
Potential safety issues can impact your ability to deliver effective healthcare to your patients. Saegis Safety Institute offers in-depth, evidence-based programs designed specifically for the challenges facing healthcare professionals and institutions.

Our programs equip physicians and healthcare professionals with the skills and tools needed to adapt behaviours, reduce risk and, most importantly, improve safety for patients.

Saegis Practice Management Services
An efficient clinic is a safe clinic. Saegis Practice Management services assess your practice’s needs to help you reduce risk, improve quality, and ensure your practice management processes are as effective as possible.

Discover how our programs can help you.
www.saegis.solutions    |    1-833-435-9979    |    info@saegis.solutions
In 2017, 11 positions were scheduled for nomination and election to the CMPA Council. Here are the results of the election:

### British Columbia and Yukon
- **Dr. Victor F. Huckell** Elected

### Alberta
- **Dr. Steven M. Edworthy** Re-elected
- **Dr. Fredrykka Rinaldi** Re-elected

### Ontario
- **Dr. Kathryn A. Shufelt** Elected
- **Dr. Debra E. Boyce** Re-elected
- **Dr. Birinder Singh** Re-elected

### Québec
- **Dr. Michel Lafrenière** Acclaimed
- **Dr. Yolande Leduc** Acclaimed
- **Dr. Claude Mercier** Re-elected

### Nova Scotia
- **Dr. Sally Jorgensen** Re-elected

### Prince Edward Island
- **Dr. Patrick C. Bergin** Acclaimed

A list of all members of Council is available on the CMPA website.

www.cmpa.acpm.ca

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### MEET YOUR NEW MEMBERS OF COUNCIL

**Dr. Victor F. Huckell,** a cardiologist from Vancouver, British Columbia, is a clinical professor at the University of British Columbia and currently provides care to patients at the Vancouver General Hospital and University of British Columbia Hospital.

**Dr. Katy A. Shufelt,** an interventional cardiologist from Peterborough, Ontario, currently practises at the Peterborough Regional Health Centre and is an assistant professor (Adjunct 1) at Queen’s University, Department of Family Medicine.

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### COUNCIL’S LEADERSHIP TEAM

**CMPA President**

**Dr. Jean-Joseph Condé,** a family physician from Val-d’Or, Québec.

**1st Vice-President**

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

**2nd Vice-President**

**Dr. Michael T. Cohen,** a general practitioner from Grand Falls-Windsor, Newfoundland.