Medical assistance in dying: where do we stand two years later?

Nurturing teams for highly reliable care

Cholecystectomy: Making it even safer

Treating those without health cards

Providing access to IMEs

Medical scribes: An increasing reality
Many years ago, after graduating from medical school, I completed a stint in primary care and then entered a surgical training program. My fellow residents had gone directly into surgical training after medical school, so I was academically and technically behind.

I had a very rough start, and was thinking about quitting when the chair of the department, Dr. Bernie Langer, took me aside and told me I was being too hard on myself. He said I’d make a fine surgeon.

The conversation lasted five minutes and changed my life. Since that time, I’ve thought a lot about what Dr. Langer did. He showed leadership. Not in the way we normally think about it—he wasn’t a CEO making a funding decision or a researcher announcing the results of a major study.

Dr. Langer demonstrated leadership in a more fundamental way. He saw I was having trouble, and he reassured me and restored my confidence. I think this is what good leaders in healthcare do: they show people a way forward. Leaders create a vision that the people around them can share and then work to make that vision a reality. When people fail, leaders help build resilience; when people succeed, they offer praise. They show empathy, compassion, and a concern for safe, high-quality care every day.

This sort of leadership is needed more than ever now. The profession is struggling with a public misrepresentation that casts physicians as placing finances ahead of patient care. At the same time, physicians are being asked to respond to increasingly complex care situations, and they can start to wonder why they are being provided with so little support—support they truly need and deserve.

In an era of growing burnout and increasing demands, we need to cultivate the human side of leadership. The CMPA works in many tangible ways to promote effective leadership, and at this year’s Annual Meeting and Information Session we’re going to be addressing some of the system-wide changes needed to respond to burnout and enhance physician wellness.

I encourage you to attend the session. I also encourage you to start thinking about ways in which you can show leadership—through acts of empathy and observation, and by doing what you can to help your colleagues thrive. As Dr. Langer taught me years ago, a single act of leadership can change the life of a patient, a colleague, or a student—all because you took the time to notice and care, and point a way forward.

Hartley Stern, MD, FRCSC, FACS, IAS.A
How physician leaders can nurture teams that provide highly reliable healthcare

Learn how physician leaders can create an organizational environment that builds well-functioning healthcare teams and leads to safe medical care.

Laparoscopic cholecystectomy: We can still be safer

Advances in laparoscopy have made it the approach of choice for cholecystectomy. CMPA analyzes its medical-legal cases and finds areas where improvements can still be made.

Responding to a patient without a health card

It can be a difficult situation when individuals without a health card ask you to provide medical treatment. To help you decide what to do, consider these questions and answers.

Medical Assistance in Dying: Where do we stand two years later?

Since June 2016, the CMPA has received more than a thousand calls from members asking for advice on medical assistance in dying. Discover what issues are concerning members.

Providing access to independent medical examinations

Individuals have a general right to access their personal information in independent medical examination files, but there are exceptions.

Medical scribes: An increasing reality

Thinking about using a medical scribe in your practice? Learn what legal and professional obligations you should keep in mind.

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Many of the images in CMPA Perspective are purchased stock photographs. While we strive for these to be accurate, it is not always possible.
“There is no such thing as a high reliability organization.” More accurately, organizations can produce highly reliable outcomes when their leaders nurture a culture and a learning system that align with the organization’s values.

The desired outcome of healthcare organizations is the provision of safe medical care for every patient, every day. When they learn from previous events and embrace continuous quality improvement, healthcare teams are better able to provide reliable care. Nevertheless, designing and implementing systems for reliable delivery of medical care remains a daunting task. Through its various education activities that include programs for physician leaders, the CMPA supports members in providing safe medical care.

The Institute for Healthcare Improvement (IHI) and Safe & Reliable Healthcare offer a framework that can be helpful for leaders in planning and designing highly reliable healthcare delivery systems (see Figure). This framework describes two main components of a healthcare system: culture and a learning system. Culture results from the interplay of psychological safety, accountability, team communication, and negotiation that together create a positive workplace environment. The learning system is the mechanism that allows the care team to thrive and continuously improve, by deliberately promoting continuous learning, measurement of improvement efforts, implementation of reliable processes, and transparency.
Leaders are the architects of their organization’s culture and the guardians of the learning system. They can demonstrate their own engagement by doing regular executive walk rounds (EWRs). These provide valuable visibility for leaders who might otherwise be unseen in the clinical setting. With EWRs, leaders gain opportunities to converse with frontline providers and get feedback about their past decisions. Because feedback without action adversely affects the learning system and leads to low engagement, skilled leaders listen intently, act on the feedback, and make corrective actions visible.

Indeed, all of a healthcare leader’s actions should aim to support the eight elements of the Framework for Safe, Reliable, and Effective Care described here.²

CULTURE

PSYCHOLOGICAL SAFETY

Psychological safety is the foundational building block needed to support a solid learning system and a positive workplace culture. In teams that provide highly reliable care, all individuals—from housekeeping staff to the chief physician—feel safe to ask questions without fear of looking stupid, to ask for feedback without fear of being perceived as incompetent, to be respectfully critical of a plan without being labeled as disruptive, and to offer suggestions for improvement without being considered negative.

ACCOUNTABILITY

Teams that provide highly reliable care hold themselves accountable. Accountability promotes disclosure of patient safety incidents and near misses, and creates the conditions to proactively identify and correct system flaws before unwanted events occur. Leaders of these teams foster natural justice: healthcare providers know what they are accountable for and how they will be held to account. They trust that when faced with a complaint they will be made aware of its elements, have the opportunity to respond, and know that decisions will be unbiased and fair.

TEAMWORK AND COMMUNICATION

Teams that provide highly reliable care communicate clearly and anticipate problems before they occur. Individual healthcare providers put their personal preferences aside, harmonizing their approach to care and communication, while demonstrating flexibility. Skilled teams hold briefings to prepare for procedures, conduct debriefings to reflect on performance, schedule routine huddles, and use structured communication approaches to convey patient information at transitions of care. These tactics help create situational awareness, that is, they help promote an understanding of what is happening at the moment and allow for the projection of that comprehension into the future to guide safe actions.

Teams also use these activities as a way to identify issues for improvement, which serves as input to the learning system.

An important aspect of effective teamwork and communication is the use of cross-monitoring and critical language to “stop the line”—where anyone can interrupt a process of care at any time if they perceive there is a risk to patient safety. Team members understand that mistakes are
inevitable and openly invite others to respectfully challenge them in an effort to prevent harm. Even when they are wrong, team members who speak up are encouraged to speak up again.

**Negotiation**

Leaders of teams that provide highly reliable care have good negotiation skills. When resolving conflicts, they focus on interests (i.e. needs, fears, ambitions, goals) rather than positions or demands. They seek to repair and maintain relationships when making decisions on corrective actions. The best leaders “play the long game,” that is, regard decision-making and negotiation as an end in itself and a way to build engagement rather than exercise authority.

**LEARNING SYSTEM**

**Continuous Learning**

Leaders of teams that provide highly reliable care incorporate continuous learning in everyday activities. Enabled by the team communication strategies described earlier and paired with frontline empowerment, teams that self-reflect have the ability to continually heal themselves and improve.

**Improvement and Measurement**

When acted upon appropriately, effective feedback facilitates engagement. To achieve highly reliable outcomes, teams use feedback and rapid PDSA (Plan, Do, Study, Act) cycles to objectively measure the impact of their improvement efforts. Team leaders empower and enable frontline providers to take ownership of improvement and support them in learning to recognize potential problems, identify and try solutions, and measure their impact. While many institutions have developed outcome measures, effective teams supplement these with clinically meaningful process measures to gauge the impact of quality improvement efforts.

**Reliability**

While quality healthcare is about how well health services are delivered, reliability is concerned with how consistently quality services are delivered day after day, in real-world circumstances. The goal is to provide the appropriate care, to the right patient at the right moment, every time. Teams that provide highly reliable care understand that unnecessary variation is harmful on a population scale, and strive to minimize it to improve safety.

**Transparency**

In every aspect of their work, leaders of teams that deliver highly reliable care strive to be as transparent as possible within the parameters of their administrative responsibilities. By making culture and operations more visible to everyone and eliminating operational secrecy, leaders make the stakes and challenges clear and avoid the creation of an elite that purports to know more than others. They create frontline engagement for quality improvement that allows team members to see the impact of their efforts.

Teams that deliver highly reliable care create opportunities for scheduled communication about their goals, their challenges, and their contingency plans. One tool that is helpful to give providers a voice and showcase their central role in quality improvement is the huddle board. The team gathers at its huddle board during routinely held sessions to discuss progress on quality improvement initiatives and flag opportunities for improvement that were identified during debriefs. The huddle board is monitored and updated in real time using clinically pertinent metrics, which helps create a sense of urgency and makes progress clearly visible to all members of the team.

**THE BOTTOM LINE**

In well-functioning healthcare teams, the desire for learning and improvement is visible. Leaders can build such teams by empowering providers to do what is necessary to promote safe medical care without fear of unfair reprisals. As guardians of the learning system, leaders must create psychological safety in an environment characterized by appropriate accountability, and thereby set the stage for highly reliable care delivery.

Additional reading at www.cmpa-acpm.ca

- CMPA Good Practices Guide, see the domains “Teams” and “Communication”

SAFE CARE

laparoscopic cholecystectomy: we can still be safer

Since its introduction more than 25 years ago, laparoscopy has become the approach of choice for cholecystectomy. Despite ongoing advances in surgical technique and experience with specialized equipment, intra-operative injuries still occur.

Understanding the circumstances under which these injuries occur and their contributing factors may help improve surgical safety. As a result, the CMPA reviewed 53 of its medical-legal cases involving intra-operative injuries sustained during cholecystectomy. All of the cases closed between 2008 and 2012 and involved complications from laparoscopic (n=50) or open (n=3) procedures. The most frequent complications were biliary tract injuries (83%), intestinal injuries (23%), and vascular or hemorrhagic injuries (8%). Some cases involved more than one complication. Thirty-one patients died or experienced serious harm as a result of their injury.

BILIARY TRACT INJURY

What happened?
During a laparoscopic cholecystectomy for symptomatic cholelithiasis, a surgeon encounters bleeding and places multiple hemoclips, some close to the common bile duct (CBD). The patient is admitted overnight due to nausea and discharged the next day.

After discharge, the patient experiences decreased appetite, abdominal pain, and ongoing nausea; she also vomits all fluid intake. Five days after the operation, she presents at the emergency department (ED) and says her urine has been dark for 48 hours.

The ED physician reviews the dictated operative report, but sees no mention of anything unusual. He notes jaundice and elevated liver function tests. An endoscopic retrograde cholangio-pancreatography (ERCP) demonstrates narrowing of the CBD with a high-grade stricture at the level of the cystic duct. The patient is treated with a biliary stent, and her liver function returns to normal.

What did peer experts say about this case?
The surgical experts were critical of the number of hemoclips used (as identified during the ERCP study) as well as their application so close to the CBD. This indicated substandard surgical technique. Furthermore, the operative report did not reflect the difficulties encountered during the procedure.

Overview
Our review identified 44 cases involving biliary tract complications; two-thirds (68%) had unfavourable legal outcomes. Peer experts noted that the majority of cases involved an anatomical misidentification. In most cases, there was a complete ligation or transection of the CBD or hepatic duct. In other cases, the injury to the duct was less severe, leading to a bile leak, stricture, or fistula.
Experts reviewing these cases expressed concerns about:

- a lack of an informed consent discussion that addresses the risks of bile duct injury
- failures in converting to an open approach or performing intra-operative cholangiography when unsure of anatomy or experiencing difficulty
- inappropriate delays in post-operative investigation and intervention in symptomatic patients
- incomplete discharge instructions leading to delays in patients seeking care.

**In some cases, peer experts emphasized the importance of achieving a “critical view of safety”1 to identify structures within the triangle of Calot and minimize the risk of bile duct injury.**

**INTESTINAL INJURY**

**What happened?**

Following a seemingly uneventful laparoscopic cholecystectomy, a patient is kept in hospital overnight for control of nausea. The surgeon is going on vacation, so he transfers care of the patient to another surgeon.

Over the next couple of days, the patient develops an ileus and increased abdominal distension and discomfort. Investigations show no biliary tract abnormalities but do confirm distended loops of small bowel and a sub-hepatic fluid collection. The ileus persists, and the surgical team attributes it to a hematoma, noting there is significant abdominal wall ecchymosis.

One week after the operation, the original surgeon returns and realizes the patient’s condition is not improving. He reviews the previous investigations, is suspicious of peritoneal irritation on physical examination, and orders a CT scan for the next morning. The scan shows a right paracolic fluid collection that is interpreted as a potential hematoma collection. Purulent material is drained percutaneously the same day and antibiotics are started.
On the 17th day after the operation, the patient develops a fever and elevated white blood cell count. A CT scan shows a new fluid collection in the gallbladder bed and pararectal area. Percutaneous drainage is contemplated, but the patient becomes septic and is taken to the operating room for a laparotomy, which demonstrates a perforated terminal ileum and peritonitis. Following extensive bowel resection and primary anastomosis, the patient is left with partially controlled diarrhea.

**What did peer experts say about this case?**

Surgical experts noted that the laparoscopy was done according to standard and intestinal injury is an inherent risk of such surgery. They also agreed that percutaneous drainage of the abscess was appropriate. They did state, however, that the laparotomy should have been done sooner because the etiology of the abscess was not established, and the patient continued to have an ileus.

**Overview**

Our review identified 12 cases in which patients developed intestinal complications following cholecystectomy; half of these cases had unfavourable legal outcomes. All patients underwent a laparoscopic approach, and most of the complications were from direct trauma to the small bowel, as opposed to devascularization injuries.

Injury was often caused by a trocar, cautery, or other instrument. However, in some cases, the mechanism of injury was difficult to determine, since there was often significant inflammatory response by the time the site was visually examined.

Experts reviewing care in these cases were often critical of the surgical technique, as well as failure to recognize a bowel injury earlier in the post-operative period, and failure to investigate other reasons for peritonitis when a biliary tract injury was ruled out.

**Vascular and Hemorrhagic Injuries**

Four cases in the review involved vascular injuries, mainly at the liver bed. Surgical experts reviewing these cases stated that significant bleeding as a complication of laparoscopic surgery is rare, and usually presents in one of two different clinical patterns. The patient can become hemodynamically unstable immediately following the peritoneal access technique or during the dissection. A more subtle presentation with signs of ileus and decreasing hemoglobin over time can also occur in the first few hours post-operatively, demonstrating a “silent” hemorrhage. The main criticism in these cases was the delay in recognizing the vascular injury.

**THE BOTTOM LINE**

- An informed consent discussion for laparoscopic cholecystectomy should not leave the patient with the impression that it is a minor procedure without the possibility of significant complications.
- The symptoms and signs of post-operative complications of cholecystectomy (usually related to biliary tract or intestinal injuries) may be non-specific initially and develop hours to days after the surgery. Discharge instructions alerting patients to possible symptoms of complications may prompt them to seek early attention.
- Family or emergency physicians often face the challenge of assessing patients post-operatively with early and non-specific symptoms of a complication. They should communicate directly with the surgical team for further assessment of any suspicion of intra-operative injury.

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

- “Shining a light on the medical-legal risks of laparoscopic surgery”
- **CMPA Good Practices Guide**, see the section on reducing risk in surgery in the “Managing Risk” domain

LEGISLATION

medical assistance in dying:
where do we stand two years later?

The CMPA continues to monitor decisions and guidance by courts, governments, regulatory authorities (Colleges), and medical associations and federations as new issues and concerns emerge.
Despite current federal and Québec legislation that makes medical assistance in dying (MAID) legal, there continues to be uncertainty among some physicians about their rights and obligations, and the processes to be followed in this area. Indeed, in the first 18 months following the June 2016 amendments to the relevant sections of the Criminal Code of Canada, the CMPA received over one thousand enquiries from members about this developing issue.

The uncertainty felt by physicians is due, in part, to a lack of clarity surrounding the definition of certain requirements for MAID, such as “reasonably foreseeable death,” which is currently the subject of court challenges. There is also a potential for the law to evolve as it relates to conscientious objection, advanced directives, mature minors, and mental health diagnoses, among other aspects. The CMPA continues to monitor decisions and guidance by courts, governments, regulatory authorities (Colleges), and medical associations and federations as new issues and concerns emerge.

This article identifies issues physicians may encounter when asked to provide MAID. In addition to carefully considering and applying the eligibility criteria and safeguards in the Criminal Code, physicians involved in MAID must comply with provincial and territorial laws and regulations, as well as College and hospital policies. Physicians who have provided MAID on several occasions need to ensure they continue to have a thorough approach to assessing each request for MAID based on the individual circumstances of their patient. Physicians are encouraged to call the CMPA for case-specific advice, including on the issues discussed below.

**CASE EXAMPLE: PATIENT WITH ALS REQUESTS MAID**

A 45-year-old patient with ALS requests MAID. She lives in a rural community where very few physicians are comfortable being involved in MAID.

She is not yet at the “end of life”—her treating physicians believe she could live another four years. However, she is concerned she could choke on her saliva and die at any time. She is not currently experiencing intolerable physical suffering, but is suffering severe psychological and emotional distress. She has a history of mental health issues.

Although her husband supports her request, the patient’s daughter opposes her mother’s choice.

**ELIGIBILITY AND SAFEGUARDS**

The case study illustrates some of the challenges physicians may face in determining eligibility for MAID. The law currently requires that the patient make a voluntary request, and be a mentally capable (competent) adult, eligible for government-funded health services, able to give informed consent, and suffering from a “grievous and irremediable medical condition.”

There continues to be uncertainty in applying some of these criteria in specific cases. For example, does the ALS patient suffer from a “grievous and irremediable medical condition” and has her natural death become “reasonably foreseeable”? These terms are not clearly defined in the Criminal Code, nor do they reflect language used by healthcare practitioners in their clinical work. Moreover, there have been very few court decisions to date to help clarify these terms. Court challenges are underway in British Columbia and Québec in which the issue is whether the requirement that “natural death be reasonably foreseeable” is too restrictive and violates patients’ constitutional rights.

The case study also highlights challenges that can arise when family members disagree with the patient’s request. Only patients can request and consent to MAID, not substitute decision-makers. To help minimize the risk of difficulties arising after a patient’s death, physicians should—to the extent possible—encourage patients to involve their family in MAID discussions, with the understanding that a request for MAID is the patient’s decision.

Physician advisors at the CMPA stress that conversations with patients and their families about MAID are among the most important and challenging clinical conversations. As such, careful advance planning and preparation should be put into these conversations. In addition to ensuring the criteria and safeguards are met, the physician advisors suggest the preparation include considering whether the healthcare team, the patient, and those around the patient have the necessary resources and supports.

**CAPACITY TO CONSENT**

Given this patient’s mental health history, consideration must be given to her capacity to consent to MAID. The patient must be capable of consenting at the time of the request and immediately before MAID is provided. For this reason, “advance requests” for assisted dying are currently not permitted. The government continues to consider whether eligibility for MAID should be expanded to allow advance requests, as well as requests by mature minors and where mental illness is the sole underlying condition.

The CMPA has also heard from physicians about issues with the application of the required 10-day reflection period, which can only be shortened if two practitioners agree that the person’s death, or the loss of their capacity to consent, is imminent.
Access to MAID

The patient in the case study lives in a rural community and may experience challenges finding a healthcare professional willing to provide MAID. That said, some healthcare facilities have policies and resources to assist healthcare providers and identify physicians who have a special interest and experience in MAID. Other healthcare facilities have not yet implemented policies, which can present challenges for physicians practising in those facilities.

Challenges can also arise, particularly in small communities, in finding two practitioners independent from one another. To address this issue, some regions have referral services to facilitate connecting patients with providers. Groups have also organized to assist patients finding volunteers willing to act as independent witnesses.

The emotional impact of MAID among physicians

Some reports suggest that the emotional toll of providing this service is causing some physicians to reconsider offering MAID. Despite the emotional strain, many members calling the CMPA for advice on participating in MAID do so because they feel they are meeting an important need in this select patient group.

Some physicians object to MAID on moral or religious grounds. While the law is clear that physicians have no obligation to provide MAID, the CMPA continues to encounter questions about providing an effective referral for patients seeking MAID.

Most regulatory authorities (Colleges) have policies or guidelines that attempt to reconcile the Charter rights of patients and physicians. These guidelines differ from one jurisdiction to another, including with respect to what is required by way of a referral for a conscientiously objecting physician.

A court in Ontario has confirmed the constitutionality of CPSO policies requiring conscientiously objecting physicians to provide effective referrals to patients seeking MAID. This decision has been appealed. The CMPA is also aware that some faith-based hospitals have decided not to provide MAID in their facilities and are instead transferring or referring to other facilities patients who request an assisted death.

Recognizing the challenge of balancing rights, conscientiously objecting physicians should comply with their College’s requirements, while respectfully and appropriately following their personal views.

Medical-Legal Risks

Unlike most other healthcare services, MAID is governed by criminal law. Failure to ensure that the safeguards and eligibility criteria, as well as the reporting requirements for MAID, are met could result in criminal charges and imprisonment of up to 14 years, in addition to College sanctions, civil legal actions, or both.
Many physicians, especially those working in walk-in or primary care clinics, may find themselves in a situation where the person asking for treatment does not have a health card. Some institutions have policies to govern this situation, but in the absence of such a policy, you may have to make your own decision about whether to provide care.

While you can choose to provide care to someone without a health card, you are not, as a general rule, obligated to treat any new patient on an elective basis. The questions below may assist in deciding how to respond to a patient without a health card.

**Is it an emergency?**
Consider whether the patient requires emergency care. As a general principle, patients requiring emergency treatment should receive care first, with concerns about health cards being addressed later. This approach is consistent with the CMA’s *Code of Ethics*, which advises physicians to prioritize the well-being of patients,1 and to “provide whatever appropriate assistance you can to any person with an urgent need for medical care.” CMPA members will generally be eligible for assistance with medical-legal issues arising from emergency treatment provided in Canada.

**Can you verify health card status?**
If the patient has lost or forgotten their card, it may still be possible to verify their health insurance information. In Ontario, the Ministry of Health and Long-Term Care will provide health card numbers to physicians who submit a Health Number Release form signed by the patient. Physicians can consult with the ministry of health in their jurisdiction to see whether similar processes exist for verifying health card information.

**Does the patient have federal or private health insurance?**
A patient without a health card may be insured through other means. For example, individuals who are refugee claimants or resettled refugees may be covered under the Interim Federal Health Program (IFHP), while others may be covered under private insurance plans.

Individuals with federal or private coverage should be treated like any other prospective patient. Your decision to provide care will depend on whether you are accepting new patients and whether you are qualified to provide the care requested.

**Are you treating all prospective patients equally?**
While you do not have an obligation to provide non-emergency care to someone without health coverage, you cannot discriminate in providing medical services on the basis of age, gender, national or ethnic origin, or any other ground listed in provincial or territorial human rights legislation. As the BC Council on Human Rights stated in *Potter v Korn* (1996),2 a physician is not required to treat every patient who comes in the door, but the decision not to treat cannot be exercised in a discriminatory manner.
If you decide not to treat patients without a health card or alternate coverage, the decision should be made in non-emergency situations only and in a way that affects all prospective patients equally. Patients should have the decision explained to them, and understand why care is not being provided.

**Is the patient a non-resident of Canada?**

If the patient has no health card, no alternate health coverage, and cannot prove provincial or territorial residency, he or she may be a non-resident of Canada. Non-residency is significant, because it may affect the extent of CMPA protection. Members who provide non-emergency care to non-residents, or who solicit non-residents as patients, may not be eligible for CMPA protection if an action is commenced in a foreign jurisdiction. More information about non-residents and the extent of CMPA protection is available in the articles listed under Additional reading.

For more information about treating individuals without a health card, or about the extent of CMPA protection in this situation, contact the CMPA for advice.

**Additional reading at www.cmpa-acpm.ca:**
- “Treating non-residents of Canada”
- “They can’t sue me outside Canada, or can they? Considerations when treating or prescribing to non-residents”
- “Emerging trends and medical-legal risks in medical tourism”

Responding to the educational needs of Canadian postgraduate trainees

The CMPA’s data show that resident physicians experience unique medical-legal challenges during residency training. If unaddressed, these challenges can affect a resident’s future career and, more importantly, the well-being of patients. Currently, no standardized curriculum addresses this aspect of residency education in Canada, **UNTIL NOW!**

**Value for RESIDENTS**
- Gain practical tips to provide safe medical care
- Reduce medical-legal risk
- Learn how the CMPA supports its members, including residents

**Value for FACULTY**
- Help residents achieve patient safety-related CanMEDS competencies
- Access tools and resources that support faculty in teaching medical-legal topics

**Safe medical care — It’s your move!**

The CMPA Resident Symposium is a full-day, interactive, face-to-face educational event for residents in their early years of training, focusing on patient safety and medical-legal risk reduction.

**The CMPA consulted with volunteers from Resident Doctors of Canada (RDoC) to co-create the content for the workshops.**

Resident physicians from the University of Toronto attending the full-scale pilot in November 2017.

**FOR MORE INFORMATION**
visit [www.cmpa-acpm.ca/residentsymposium](http://www.cmpa-acpm.ca/residentsymposium) or email education@cmpa.org
providing access to independent medical examinations

Individuals have a general right to access their personal information in independent medical examination files, with some notable exceptions.

In 1992, the Supreme Court of Canada confirmed a patient’s right to access information in his or her medical record.1 However, the Court also limited access by stating that a patient does not have the right to information that arises outside of the doctor-patient relationship.

Independent medical examination files differ from medical records

Independent medical examinations (IMEs) represent one situation where an individual may seek access to information outside of a standard doctor-patient relationship. It’s important to note that medical records and IME files differ in many ways. Medical records are created in the course of treating a patient and are intended to summarize and record the care provided. In contrast, physicians conducting IMEs usually do not have a treating relationship with the “examinee.” Rather, the IME physician is retained to provide his or her perspective on an individual’s medical needs or condition—often in circumstances where benefits, compensation, or further treatment are being considered or where a request has been made by an insurance agency or other third party.

Physicians conducting IMEs will typically retain files that include various types of information from multiple sources, including:

- information received from the third party requesting the examination (e.g. contracts regarding the scope of instructions, timelines, and fee arrangements)
- documents relied on by the IME physician in conducting the examination (e.g. ancillary medical information, video surveillance, or transcripts of evidence given in the course of legal proceedings)
- notes taken by the physician during the examination of the individual
- the working notes of the physician
- the final IME report containing the physician’s findings and opinion
- the physician’s invoice for services rendered to the third party

Limits to accessing information about independent medical examinations

While medical records and IME files serve different purposes, they both contain an individual’s personal information. The right to access personal information contained in IME files is confirmed through privacy legislation, and the general rule is that a physician must provide an examinee with access to his or her personal information contained in the IME file upon request.

However, every Canadian privacy law includes exceptions that may limit what an examinee can access within the IME file. Exceptions include:

- information protected by solicitor-client privilege
- confidential commercial information
- information that could lead to a reasonable expectation of someone being harmed if access were granted

Courts have confirmed that an examinee has a right to access parts of the physician’s notes made in the context of an IME that include the examinee’s personal information. However, physicians may redact their own remarks, observations, notes, and deliberations. In other words, a physician can limit access to information that reflects his or her own thought processes, because this is their personal information, not the personal information of the examinee.

Based on these statutory and common law exceptions, a physician who conducts an IME may have reasonable grounds to redact certain information contained in the IME file, such as instructions received from the third party requesting the IME, financial information (including invoices), and certain portions of personal notes.
Before providing an examinee with access to information contained in the IME file, a physician should consult with the third party who requested the IME, and with the CMPA, to discuss the specific facts and circumstances of the case and to determine whether any of the exemptions apply or if there are other grounds to redact information from the records (e.g. contractual obligations).

**FEES FOR ACCESSING IME FILES**

Physicians are expected to charge only nominal fees for responding to access requests, including requests for access to IME files. Many privacy commissioners have held that modest flat fees are permissible for performing one or more tasks related to providing access (such as locating and retrieving records, preparing the record for copying, and photocopying the record). Physicians should not refuse access simply because an individual has not paid the fee. Some regulatory authorities (Colleges) and medical associations have guidelines on what constitutes a reasonable charge. Physicians should determine whether such guidelines apply in their jurisdiction.

**THE BOTTOM LINE**

- Individuals have a general right to access their personal information whether it appears in their medical record or in an independent medical examination file.
- There are exceptions, however, that may limit the information a physician is required to produce in the context of an independent medical examination.
- Physicians who receive requests for access to personal information contained in an independent medical examination file may charge a nominal fee.

Additional reading at www.cmpa-acpm.ca:
- “Independent medical evaluations: Be prepared”
- “Preparing medico-legal reports: suggestions for physicians”

1. McInerney v MacDonald, [1992] 2 SCR 138
Medical scribes offer an innovative approach to the challenge of providing patient care while simultaneously documenting the care in the medical record. These individuals sit in on patient consultations and input information into the record for physicians. The intent is to reduce the time physicians spend documenting, allowing them to focus instead on delivering patient care.

Physicians who are considering introducing a scribe into their practice should plan for how they will continue to meet their legal and professional obligations including the following:

- acting as an employer
- delegating and supervising
- documenting
- obtaining patient consent

Well-established in the U.S., medical scribes have only recently been introduced to Canadian healthcare, leading physicians to wonder about the benefits and risks of using them.

Studies have shown benefits include increasing the productivity of busy specialists, and improving clinical satisfaction and patient-clinical interactions.

From a medical-legal perspective, to date the CMPA has little experience with scribes; it is unaware of any regulatory authority (College) complaints and no civil actions have been brought.

“As we assess the role of medical scribes and the associated risks, we can use many of the lessons we’ve learned from other physician extenders, such as physician assistants,” says Dr. Todd Watkins, the CMPA’s Managing Director of Physician Services. “The most important message is that, when any new provider comes into the system, we need to continue to fulfill our role as physicians and meet the standards of care.”

**Determine who is the scribe’s employer**

When a hospital is proposing the use of medical scribes, or a physician is considering using one in their hospital practice, the first question is: who is the employer? For example, is the hiring of medical scribes a decision among a group of physicians, or are the medical scribes to be employees of the hospital where the physicians work?
The answer is important because employers have many broad obligations. They must ensure appropriate written agreements are in place to define the conditions of employment, determine minimum education and training, and determine potential business issues and liabilities. Physicians who hire a medical scribe must meet the obligations of an employer. The CMPA encourages physicians to get professional advice on such agreements and other obligations.

**DELEGATE AND SUPERVISE**

Medical scribes are neither independent nor regulated professionals. This means physicians who delegate the task of clinical documentation to scribes are responsible for ensuring it is appropriate to delegate the task to that individual. They are also responsible for supervising scribes when they are carrying out the task.

Among other things, supervising physicians should ensure scribes are qualified and properly trained, and that they follow the physician’s professional and ethical obligations for record keeping.

Scribes must also adhere to their conditions of employment, including the clinic or hospital’s professional protocols, and to privacy legislation. As with all personnel who are privy to personal health information, medical scribes should sign a confidentiality agreement as a condition of their employment.

Medical scribes generally require monitoring and evaluation of their work, like any other staff member.

**ESTABLISH CLEAR RULES FOR DOCUMENTATION**

Supervising physicians are responsible for instructing the scribe on how to document properly, in accordance with the statutory and professional obligations of physicians. In addition to the legislative requirements for keeping records, Colleges have policies and guidelines for medical records, and physicians need to ensure scribes follow these.

While there is little specific guidance on using a scribe, it is generally expected that the record will clearly identify the medical scribe who made the original entry (i.e. provide the scribe’s name) and whether the physician reviewed the note.

**GET PATIENTS’ CONSENT**

While the physician and scribe have appropriately prepared for delegating the task of documenting, physicians must also obtain patients’ consent before a medical scribe is allowed to sit in on a clinical encounter.

Physicians should introduce the scribe to patients and explain why the scribe is present. As well, physicians should make their patients aware that the scribe is bound by the same expectations of confidentiality that apply to the physician. If patients object to the scribe, physicians must honour their wishes and ask the scribe to leave.

**THE BOTTOM LINE**

The role of medical scribes in the Canadian healthcare system continues to evolve. Physicians who are thinking about using scribes in their practice should keep in mind they need to continue to fulfill their role as physicians and meet the standards of care. They should consider the following:

- Clarify who is responsible for meeting the obligations of the scribe’s employer, and for delegating tasks and supervising the scribe.
- Ensure the scribe adheres to the conditions of employment, and to the professional and legal expectations for record keeping that apply to physicians.
- Be sure to obtain patient consent for a scribe to sit in on a patient consultation.

Additional reading at www.cmpa-acpm.ca:
- “Why good documentation matters”

1. American College of Medical Scribes [Internet]. Montville (US): American College of Medical Scribes; [cited 2018 Jan 4]. Available from: https://theacmss.org/about-us/
ANNUAL MEETING 1:15 P.M.

- President’s report
- 2017 Report of the Audit Committee
- 2017 Financial report
- 2019 Aggregate fees by region
- 2018 Council election results
- Q&A for members
- CEO’s remarks

Members who wish to initiate a motion for consideration during the annual meeting shall 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.

The forms for making a motion, the draft minutes of the 2017 Annual Meeting, and more information about the 2018 Annual Meeting are available on the CMPA website at www.cmpa-acpm.ca.

RECEPTION 4:30 P.M. – 5:30 P.M.

INFORMATION SESSION 3:00 P.M.

Healthier physicians: An investment in safe medical care

Join our panel of speakers for a critical conversation about the importance of investing in physician wellness as a means of advancing safe care.

THERESA OSWALD
Moderator
CEO of Doctors Manitoba and former Manitoba Minister of Health

DR. CAROL-ANNE MOULTON
Associate Professor, University of Toronto, and Staff Surgeon, Division of General Surgery, University Health Network

DR. SCOTT MCLEOD
Registrar of the College of Physicians & Surgeons of Alberta (CPSA)

DR. HARTLEY STERN
Chief Executive Officer and Executive Director, Canadian Medical Protective Association

Join us in Winnipeg!
The Fairmont Winnipeg Hotel
August 22, 2018

#CMPA_AM18

For information: 1-800-267-6522 or executive@cmpa.org