college complaints are on the rise:

better communication can help  

Treating patients with Alzheimer’s, dementias  

Did you consider pregnancy?  

How to address a College complaint  

Unlawful activity, prescriptions, and medication
from the CEO

Technology and innovation are transforming the practice of medicine. Within my specialty of surgery, there have been dramatic, technology-driven changes that have improved both quality and safety. An open colon resection in my early practice required five days of convalescence. Today, with minimally invasive surgery techniques and early feeding protocols, patients are safely home after 18-24 hours. Similar examples can be found in every area of practice.

While there has already been marked progress, I believe we are on the cusp of even greater advances that will significantly improve our ability to deliver care. Individualized gene therapy, robotic surgery, advanced decision support tools such as Watson, and new data collection and analysis capabilities are just a few of the technologies that will transform how we practice. All of this bodes well for physicians and our patients.

At the CMPA, we are embracing new technologies and innovations that can enhance the services we deliver to our members. We also recognize that change brings uncertainty and, for all the positive potential offered by new technology, many of our members may be concerned about unintended consequences, including those in the medical-legal domain.

We are responding to the rapidly changing practice environment of our members in a number of ways:

- First, we are very active with governments, medical regulatory authorities, hospitals, and others in advocating for clear, workable policies to guide the use of new technologies. We believe that if the expectations of physicians are reasonable and clearly articulated, medical-legal issues will be greatly reduced.

- Second, we continue to adapt the advice we offer to members—through our educational programs and in one-on-one calls—so that it reflects the realities of emerging technologies. Our physician advisors answer thousands of calls each year on issues such as electronic records and other innovations, and in this way help members navigate their way through an evolving environment.

- Finally, in the event that a medical-legal difficulty does arise, we are here to provide assistance to members, including the provision of legal counsel if necessary. As a result of CMPA assistance, Canadian physicians can feel confident that their professional integrity will be protected.

Notwithstanding the challenges that many physicians face in their practices, I believe the long-term prospect for medicine and physicians is very bright. I am even somewhat envious of young residents and early career doctors who will have access to technologies and approaches to patient care that were never available to me. However, I am also realistic enough to recognize that medicine’s adoption of innovative technologies will not be without setbacks. This is why reliable, physician-oriented medical liability protection is so important.

As Canadian physicians navigate the technology-enabled future, the CMPA stands ready to provide the assistance you need.

Hartley Stern,
MD, FRCSC, FACS
Navigating the complexities when treating patients with Alzheimer’s disease and other dementias

The CMPA looks at the medical-legal risks of treating patients with Alzheimer’s disease and other dementias. Learn how an adequate assessment and the nuances of communication can help reduce risks.

FEATURE

College complaints are on the rise: Better communication can help

Most of the College complaints CMPA assists members with have an underlying issue with communication. Avoid the stress of a complaint by sharpening your communication skills.

What to do if you’re notified of a College complaint

If your College notifies you of a complaint, your first step is to contact the CMPA. Learn how you can respond with help from our physician advisors.

Suspect unlawful activity with prescriptions or medications? Here’s how to respond

Tips to help you prevent drug diversion and related unlawful prescription activity, and avoid potential medical-legal difficulties.

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SAFE CARE

navigating the complexities when treating patients with Alzheimer’s disease and other dementias

It’s easy to appreciate that the growing burden of Alzheimer’s disease and dementia poses a threat to the long-term financial sustainability of the healthcare system, with potential impacts to physicians’ practices. But less often explored are the implications for patient safety and the medical-legal risks to physicians who treat patients with dementia. To examine these risks, the CMPA reviewed 119 regulatory authority (College) cases that closed between 2012 and 2016.

Patients diagnosed with dementia may be physically frail, have multiple chronic conditions for which they receive numerous treatments, or may be receiving end-of-life care. Communication and behavioural challenges, the variability of dementia, difficult family dynamics, and the need to balance patient autonomy with personal safety increase vulnerability for patients while presenting added challenges for physicians.

While family physicians and geriatricians working in the community were involved in over half of the cases reviewed, hospital-based specialists were also involved, including internal medicine specialists, emergency department physicians, surgeons, and critical care specialists. Many cases involved transfers of care within and between healthcare facilities.

This article examines medical-legal risk by grouping cases into two categories: those in which peer experts were critical of the clinical care provided, and those for which communication was the primary issue.
The main areas of College criticism in cases relating to clinical care were the loss of physicians’ situational awareness and system breakdowns at transfers of care. Loss of situational awareness most often involved inadequate assessment, follow-up, or screening. This included failing to reassess a patient when indicated, or review the medications a patient was taking. The Colleges were critical of assessment or follow-up in nearly a quarter of cases. Deficient patient evaluation was the most common allegation overall, representing over half of complaints. Prescribing an inappropriate or contraindicated medication—a known issue in the older patient population—was the subject of criticism in a small number of cases.

Transfers of care are recognized as high-risk points in patient care, and patients with dementia experience transfers more frequently than similar-aged patients without these conditions.1 The complex care needs of patients with dementia, including their reliance on caregivers and multiple health professionals to coordinate their care, can make these transfers more problematic. Transfer of care issues in the College cases the CMPA reviewed most often involved transfers to and from acute and long-term care facilities, and included incomplete handover of information such as advance directives, details of the care plan, and inadequate medication reconciliation. A few cases involved criticism of the physician for failing to recognize their duty of care to attend to a patient. There were also examples of unclear hospital or long-term care facility policies around levels of care. Colleges were also critical of physicians who failed to document their assessments of patients in long-term care, which could have affected continuity.

To help address these and other clinical care issues, physicians should be familiar with Clinical Practice Guidelines on the Diagnosis and Treatment of Dementia, published by the Canadian Geriatrics Society.2

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**Clinical care issues**

**Three scenarios: Loss of situational awareness, breakdowns at transfers of care**

A man files a complaint against his brother’s family physician for allegedly delaying a referral to long-term care. Following an investigation, the College finds there was inadequate follow-up over a three-year period, during which the patient’s cognitive health declined, with documented weight loss and missed appointments.

A woman files a complaint against her mother’s family physician and an emergency department physician after her mother dies in hospital two days after being transferred back to her long-term care home from the same facility. The College finds that the patient’s family physician, who had assessed her in the emergency department for persistent vomiting and dehydration, did not appropriately investigate her condition and left ambiguous instructions for the on-call emergency physician who ultimately discharged her when she appeared to be improving. It is apparent to the College investigator that each physician thought the other had primary responsibility for the patient’s care.

A woman files a complaint against a geriatrician who diagnosed her father with Alzheimer’s disease, citing inadequate assessment and abrupt manner. The woman states in her complaint that another specialist subsequently disputed the diagnosis. The College is critical that the geriatrician’s assessment did not reflect current guidelines for diagnosis.
Physicians who treat patients with Alzheimer’s disease and other dementias must contend with issues that are made more complex by the nature of the patient’s conditions and their repercussions. Nevertheless, physicians can minimize their medical-legal risk by ensuring they adequately assess the patient to facilitate situational awareness, and consider the nuances of communicating with dementia patients and their families.  

Communication issues

Three scenarios: Communication with patients, families

A man files a complaint alleging that his mother’s family physician discontinued her anti-hypertensive medication, causing her to have a fatal stroke. The College supports the decision to de-prescribe in this case, but is critical of the physician’s failure to involve the patient’s family in the decision or communicate this decision to them.

A man files a complaint against his mother’s family physician when he learns that his mother, who has vascular dementia with cognitive fluctuations, was dismissed from the physician’s practice for problems related to medication non-compliance and managing relationships with the other caregivers and family members involved in her care. The College is critical of the physician for not following College policy on ending the doctor-patient relationship, including failing to make arrangements for continuing care.

A woman files a complaint against her father’s family physician after she learns that the physician’s administrative assistant had called her father to advise him to cease driving immediately because he had been reported to the Ministry of Transportation due to his worsening dementia. The College is critical of the physician for delegating such a significant conversation to office staff, which deprived the patient of the opportunity to ask questions and seek reassurance.

Inadequate communication with a patient or their family was alleged in nearly half of the cases reviewed. Peer experts were critical of the quality of the physician’s communication in nearly a quarter of all cases.

The main themes in the reviewed cases that related to communicating with patients or families were not communicating adequately or not communicating directly, where appropriate. These incidents were often based on the physician’s incorrect assumption that their patient was incapable of consenting or understanding the required information (see Understanding Capacity, page 7). However, physicians could have also been influenced by the desire to avoid a difficult discussion, particularly in the presence of behavioural issues, including aggressive behaviour or agitation, which affect some patients with dementia.

In some cases, communication problems, either with patients or their families, were a source of tension that ultimately led to the dissolution of the doctor-patient relationship.

In cases related to communicating with families, peer experts were most often critical of physicians for not seeking collateral information where appropriate, or not seeking consent for or not communicating updates to the patient’s care plan, most often pertaining to prescribing or de-prescribing medication. Misunderstandings around advance directives, goals of care, or the meaning of “palliative care” or “DNR” were also common. A lack of documentation of discussions or family meetings was also a frequent source of criticism.

The bottom line

Physicians who treat patients with Alzheimer’s disease and other dementias must contend with issues that are made more complex by the nature of the patient’s conditions and their repercussions. Nevertheless, physicians can minimize their medical-legal risk by ensuring they adequately assess the patient to facilitate situational awareness, and consider the nuances of communicating with dementia patients and their families.
Understanding capacity

Issues relating to capacity represent the largest category of advice calls received by the CMPA related to the care of patients with dementia.

An individual who is able to understand the nature and anticipated effect of a proposed medical treatment and alternatives, and to appreciate the consequences of refusing treatment, is generally considered to have the necessary capacity to give valid consent. Furthermore, a person who is incapable of making decisions regarding certain matters might still have sufficient mental capacity to give valid consent to medical treatment. Gauging capacity in patients with dementia can be challenging as capacity may fluctuate, making it necessary to re-evaluate previous assessments on a regular basis.

When a patient is determined to be incapable of consent, the responsibility for non-urgent care generally falls to a substitute decision-maker, who can be designated by the patient through an advance directive or power of attorney. Notably, a physician’s incorrect assumption of a person’s attorney for personal care, usually in the context of family disagreement, was seen in a number of College cases reviewed, as were cases involving disagreements between substitute decision-makers of equal standing.

Additional reading at www.cmpa-acpm.ca
- Consent: A guide for Canadian physicians
- “Risk management in elderly patients: Medication issues”
- “Long-term care: Quality decisions”
- “Why good documentation matters”

Other resources
- Alzheimer Society of Canada: www.alzheimer.ca
- The Canadian Geriatrics Society: www.canadiangeriatrics.ca

4. In Québec, the capacity to consent is fixed at the age of 14 years, below which the consent of the parent or guardian or of the court is necessary for the purposes of proposed treatment.
SAFE CARE

is your patient a woman of reproductive age? consider pregnancy

CASE EXAMPLE

Two months after undergoing a breast augmentation, a 38-year-old woman discovers she is 3 months pregnant.

At the pre-operative visit, the plastic surgeon had obtained the patient’s history and conducted a physical examination, but did not ask about the possibility of pregnancy. The intake form also did not ask for this information.

The patient decides to continue the pregnancy. Despite the fact that the baby does not appear to have experienced any negative effects, the patient files a complaint to the medical regulatory authority (College). She alleges that the surgeon should have ordered a pregnancy test before surgery under general anaesthesia.

In this case, the College advises the surgeon that a pregnancy test should be routine before any surgical procedure, except emergent, on a woman of reproductive age.

The case illustrates what physicians should consider before a non-emergent surgery that might potentially affect pregnancy. When contemplating investigations, procedures, or treatments for a woman of reproductive age, physicians should consider taking the following actions:

- Rule out pregnancy where and when appropriate, in accordance with professional, hospital, or other applicable protocols. Review any outstanding test results with the patient.
- If the patient is pregnant and an investigation, procedure, or treatment is proposed, evaluate the maternal and fetal impact, including that of medications, and inform the patient of the risks and benefits.
- If the patient is pregnant and surgery is proposed, discuss the surgical risks and benefits, including risks to the fetus. Consider postponing elective surgery until after delivery, when appropriate.
- If the patient has undergone an investigation or treatment with the potential to harm the pregnancy and it is later discovered that she is pregnant, speak with the patient to evaluate the risks, consequences, and available options.
- Talk with the patient about the importance of effective contraception to prevent pregnancy during a treatment that could be harmful to a fetus. Alert patients to the importance of advising the treating physician as soon as she discovers she might be pregnant.
**The bottom line**

Certain investigations, medical treatments, procedures, and surgeries are potentially harmful to a fetus, pregnant patient, or both. If a pregnancy is detected before any of these are started, then the physician and patient can have a meaningful discussion about the possible physical risks to the fetus, and the possible physical and emotional risks to the woman.

Members should call the Association for advice if they have any medical-legal concerns with asking about or determining pregnancy.
college complaints on the rise: better communication can help

Physicians who contact the CMPA about a regulatory authority (College) complaint report experiencing significant stress. At the root of many CMPA complaint cases is communication. To improve interactions with patients and potentially curb complaints and stress, physicians should consider their communication skills.

In the last 10 years, requests from members for CMPA assistance with College complaints nationally have risen substantially, up 85%. In 2007, CMPA received 1,983 requests. In 2016, that number climbed to 3,387.

Physicians have told the CMPA that working through a complaint is arduous and stressful. In many complaint cases, the Association’s data shows that communication is an underlying issue. By adopting patient-centred communication skills and behaviours, physicians can improve their interactions with patients and may reduce complaints.

The stories behind the numbers

Behind many members’ requests for help with a College complaint is the story of a relationship between a patient and a physician that did not go as expected.

Patients said they were dissatisfied with the care they’d received, and some suffered harm—sometimes severe harm—from that care. Yet, the majority of the physicians involved in complaint cases are dedicated and work hard to give their patients good medical care, often in challenging conditions.

Dr. Shena Riff, a CMPA physician advisor who speaks with members who contact the Association for assistance says,

“We hear from members every day that they are under enormous pressure. They have a waiting room full of patients needing their care, but never have enough time. They are constantly under pressure to do more.”

What is the problem?

The CMPA analyzed its College complaint cases from the last 10 years. It examined the reasons patients gave for making a complaint and it also examined what the Colleges identified as critical factors in their investigation of the complaints. A key underlying issue in most of these cases was communication.

In the complaint cases where communication was flagged, patients said things such as their physician was rude, spoke in a raised voice, used a condescending tone, or dismissed their or their families’ concerns. And the Colleges said that communication was a factor in a range of clinical situations. For example, in consent discussions where patients did not receive or understand the necessary information about a treatment.

Notably, the CMPA’s findings mirror previous studies in this area, including those from other countries.
When receiving information from patients:

► Do you focus on this patient at this moment? Do you greet the patient? Do you show respect in speech and body language? If using an electronic medical record (EMR), do you explain what you are doing and look at the person more often than at the computer or phone? Do you sit down and face your patient? When appropriate, do you introduce members of the healthcare team to the patient?

► Do you listen actively? Do you let patients tell their story uninterrupted, recognizing that research shows most patients finish what they want to say in 30 seconds to 2 minutes? Do you restate what they told you, using their words?

► Do you try to understand the patients’ perspective of their illness? Do you ask about their experience and how the illness is affecting them?

When delivering information to patients:

► Do you express empathy? Do you show compassion in what you say and in your body language? Do you communicate professionally that you understand, respect, and support them?

► Do you provide information clearly and simply? Do you assess what patients already know, and how much information they want and need to know about their condition? Do you educate them on the condition without using jargon? Do you observe how the patient is responding to what you are saying, through both their body language and in what they say?

► Do you share decision-making? Do you involve patients in making decisions about their treatment? Do you ask them to consider the pros and cons of different treatment options, including no treatment? Do you come to an agreement on a course of action? If a plan cannot be agreed on, do you consider whether it’s appropriate to consult with another physician or to refer the patient to another physician? Do you document your interactions with patients in their medical record including the agreed-upon plan and next steps?
THE NEXT STEP—TRAINING

Effective communication is essential to safe medical care and physicians may be unaware of their skill level, in some instances over-estimating it. An assessment of skills can clarify the level and any need for improvements and training. Physicians may also consider a workshop offered by the CMPA or by the CMPA’s affiliated company, Saegis.

The Bottom Line

Communication is an underlying issue in many College complaint cases in which the CMPA is involved. Physicians can improve their communication with patients by focusing on patients as individuals, listening, exchanging information, expressing empathy, and sharing decision-making.

Physicians receiving a notice from their College about a complaint should contact the CMPA for assistance as soon as possible.
what to do if you’re notified of a college complaint

At the end of a busy day, a physician sits down to read her mail. One letter is from her regulatory authority (College). Intrigued, but confident she is in good standing with the College, she opens it.

She is surprised by the first line, “This letter is to inform you that a complaint has been filed against you by....” Her heart races and her anxiety begins to rise.

Immediately she recalls a visit with the young man a few weeks before. She searches her office for his medical record and remembers that he wanted a prompt referral to a spine specialist, claiming a work-related injury. He reluctantly agreed to her examination, and was distressed when she insisted on filling out a workplace injury report. He was even more upset when she did not make the referral, but recommended non-narcotic analgesics and physiotherapy. As she reads her office notes on the visit, she realizes she did not adequately document the physical examination and did not record his anger. She picks up her pen...

STOP

This physician may be about to make a potentially serious mistake.

This scenario is similar to many real accounts told by CMPA members to our physician advisors.
In the CMPA’s experience, contacting a physician advisor, a physician with extensive clinical and medical-legal knowledge, is a good first step after being notified of a complaint. The advisor can help you with the complaint process, including managing the stress, clarifying relevant issues, and answering effectively. Most complaints do not require legal counsel, but a physician advisor can arrange legal assistance if needed.

**Dealing with the Stress**

Many physicians who face a College complaint or an investigation suffer significant anxiety. To lower that stress, the CMPA suggests keeping the following in mind:

- Call the CMPA. We can guide you through the process and provide collegial support.
- You are not alone. Most physicians face at least one College complaint during their career.
- In complaint cases where a member requests and receives assistance from the CMPA, the large majority are dismissed outright or dismissed with concern (e.g. caution or advice).
- Help on managing stress can be found in the CMPA article, “Coping with a College complaint: Suggestions for reducing anxiety.”

**Assessing the Complaint**

Colleges typically notify physicians of a complaint by email, letter, or telephone. Usually they provide a copy of the complaint letter, but they may simply enumerate the complaint issues. Most review your prior experience at the College.

To assess the complaint, begin by determining who complained about what. Anyone—patients, family members, employers, insurers, social service agencies, or colleagues—can complain if dissatisfied with your care or conduct. Although most stem from a patient interaction, occasionally complaints involve activities outside your professional practice. These can be a concern to the College if they reflect poorly on your professionalism or fitness to practice.

Review the patient’s medical record when the matter is about a clinical event. However, if the record belongs to a hospital or other institution (e.g. clinic owner), contact the CMPA before accessing it. You may not be entitled to see the record if you are not part of the patient’s circle of care. A complaint does not necessarily mean you are in the circle of care. Irrespective, there are steps that need to be considered before accessing the hospital record to respond to a College complaint.

If the College requests a copy of the patient’s record and it is under the custodianship of another organization or individual, make them aware of the request.

After reviewing the record you may find inaccuracies or omissions. If this is the case, contact a CMPA physician advisor to help you decide on the next best course of action. Do not alter the existing record and carefully consider whether to add any information. Any changes to the record can impact your credibility and may lead to an additional charge of unprofessional conduct.

Finally, confirm that you understand what the College is asking you to do. If asking you to respond, Colleges typically give directions on how and when, including deadlines. While they expect a reply within their timeframe, they will amend a deadline when informed if there is genuine need.

**Writing a Response**

Before writing your response, contact the CMPA and speak to a physician advisor for guidance.

Your initial response should reflect what factually happened; the interactions with the patient, or a third party, or both; and your rationale for providing that particular care. Include your recollections of the encounter and the appropriate information from the medical record, clearly indicating where the information is from.

Use a respectful and professional tone. Avoid expressing anger, or being defensive, condescending, or disparaging of the complainant or patient. Remain factual and avoid making subjective comments on others involved in the clinical situation.

It can be helpful if you can demonstrate to the College that you are able to assess your practice when an interaction with a patient was unsatisfactory. This means being able to consider the key issues in the complaint and determine if there are steps you could take to improve and mitigate the risk of a recurrence.

**What’s next?**

Many Colleges will send a copy of your response to the complainant, asking for further comments. Occasionally, this satisfies the complainant. Frequently, however, the complainant will send a second letter to the College, which the College may send to you for further comments.

If there are new issues to be addressed or clarification of previous statements, you should consult again with a CMPA physician advisor and send a second response to the College, if appropriate.

The College will consider the information from the complainant and the physician. If the medical issues are complex, the College might seek an expert peer opinion from an independent, uninvolved physician. On occasion, the College will seek information from witnesses such as your office staff or laypersons.
How does it get resolved?
In most cases, physicians successfully demonstrate their actions were appropriate medically and professionally, and the College takes no action on the complaint.

Sometimes physicians are criticized for being unprofessional in their interaction with the patient, even though the medical advice was appropriate. In these cases, physicians may receive a counsel or caution from the College. The College may suggest remedial actions such as targeted education or professional development, or other solutions, particularly when there are concerns about the care provided.

In more severe cases, where the physician’s actions lead the College to have serious concerns about conduct or competence, the matter may be referred to the College committee responsible for assessing professional misconduct or competency. Issues with physical or mental health may be referred to the committee responsible for assessing the physician’s fitness to practise.

How did our fictitious physician deal with her College complaint? Fortunately, she put down her pen, leaving the medical record unaltered, and contacted the CMPA. She successfully demonstrated to the College that her care was appropriate, but was required to do professional development on record keeping.

The bottom line
If you are notified of a College complaint:

• Call the CMPA. Speak with a physician advisor and visit our website to access helpful information on College complaints (see the Additional reading list, below).

• Assess the complaint. Determine what the complaint is about and what the College is asking you to do. Never alter a patient’s medical record after receiving a complaint.

• Respond professionally. In a respectful manner write to the College, addressing the concerns.

Additional reading at www.cmpa-acpm.ca

• “Coping with a College complaint: Suggestions for reducing anxiety”

• “Understanding how Colleges handle complaints or allegations of professional misconduct”

LEGISLATION

Suspect unlawful activity with prescriptions or medications?
Here’s how to respond

During a routine inventory of a clinic’s medication storage, the medical assistant notes that nearly all of the supply of oxycodone is not to be found. Distressed, he brings this news to you (his manager and clinic partner) at the end of a busy day. You ask him to reconcile the month’s prescriptions with the actual inventory, and his findings show that the vials are indeed missing.

Do you know what you might do next?

Physicians who know what to do when they become aware of potential illegal activity concerning medications they prescribe, or that are otherwise under their control, are better prepared to resolve the matter effectively—and more likely to avoid possible medical-legal difficulties. For this reason, physicians should know their obligations, which include taking reasonable steps to help prevent drug diversion—the transfer of controlled substances from lawful sources to the illicit marketplace—and related fraudulent activity.

When deciding what steps to take, physicians need to consider their professional obligation to protect the confidentiality of patient health information. Improper disclosure to the police of information about a patient may expose a physician to a complaint to a regulatory authority (College) or privacy commissioner.

The fact that obtaining controlled drugs is lawful only with a physician’s prescription sometimes places physicians at the intersection of medicine and the law. Diversion of prescription medication can occur in many ways such as drug theft, prescription forgery, or a patient obtaining multiple prescriptions from various doctors (i.e. “double-doctoring”).
What is a controlled drug?
The federal _Controlled Drugs and Substances Act_ lists the items that are defined as controlled drugs and substances in Canada. In general, these are drugs that can have a detrimental effect on a person’s health and well-being, as well as substances that are prescribed by licensed medical practitioners and sold through pharmacies and dispensaries for legitimate medical treatment. Possession of these substances is legal only with such a prescription or other lawful authorization.

**Loss or Theft of Drugs**
Controlled drugs must be stored securely to mitigate the possibility of theft. If drugs are known to be missing, this must be reported to the local police service immediately and to Health Canada’s Office of Controlled Substances within 10 days of the discovery at 613-954-1541.

**Loss or Theft of Prescription Pads**
When theft of prescription pads is suspected, physicians should contact the CMPA and consult any guidance or policies from their College. Physicians may consider notifying the police of the loss. When speaking to the police, physicians should be careful not to identify any individual patient, while providing the necessary details about the incident.

Prescription monitoring programs (PMPs) in some jurisdictions require that physicians use special paper prescription pads in which there are multiple copies: a pharmacy copy, a prescriber copy, and copy that is submitted to the PMP for tracking purposes. Physicians may be required to report any missing or stolen prescription forms to the program and potentially others, including the College. Similarly, electronic prescriptions are automatically submitted directly to the PMP and pharmacy, which ensures timely data collection and helps mitigate the possibility of fraud.

“Double-doctoring”
If a pharmacist or other practitioner notifies a physician of a patient attempting to obtain controlled drugs from various doctors (double-doctoring), the physician may consider discussing the matter with the patient if doing so does not put the physician or others at risk. Physicians may need to consult with the other

If drugs are known to be missing, this must be reported to the local police service immediately and to Health Canada’s Office of Controlled Substances within 10 days of the discovery at 613-954-1541.
treating doctors, but broader notification to pharmacies or the police could breach doctor-patient confidentiality. If physicians are suspicious about a patient’s access to drugs from other practitioners, prior to prescribing or renewing a prescription, they may ask the patient if they have sought or obtained a controlled drug from another physician in the past 30 days. Under the federal Controlled Drugs and Substances Act, it is an offence for a patient to fail to disclose this information to a physician.

Physicians may want to become acquainted with any guidelines from their College on steps to take in ending the doctor-patient relationship. Ending the relationship may be appropriate if a patient is persistently uncooperative and where there is a breakdown in trust.

**Responding to police enquiries**

The police may, on occasion, contact a physician to verify the information on a prescription in their possession. When presented with a prescription script by the police, the physician’s response should be limited to confirm the legitimacy of the prescription such as whether or not the signature on the script is authentic, that is, made by the physician in question.

CMPA members are encouraged to contact the CMPA for further guidance before volunteering information to the police.

**Prescription monitoring and safe prescribing**

Each province and territory operates some form of prescription monitoring program. These programs monitor outpatient prescription dispensing activity—collecting information about the prescriber, pharmacist, and patient involved in each prescription transaction; some systems also identify the person picking up the prescription.

PMPs typically alert the pharmacy (and in some cases the physician) in real time when unusual activity is detected. In some jurisdictions, clinicians within a patient’s circle of care may also proactively access PMP data. This can assist in clinical decision-making and assessing risk, including whether and how to prescribe and dispense a controlled drug. In other jurisdictions, however, physicians and pharmacies do not have point-of-care access to patient information (i.e. a patient’s prescription history) via the PMP, in which case physicians will want to refer to the patient’s electronic health record, if available.

**The bottom line**

- Report the theft or loss of a controlled substance to the local police immediately and to Health Canada’s Office of Controlled Substances no later than 10 days after its discovery.
- If you suspect a patient of drug diversion or other unlawful prescription-related activity, consider discussing the matter directly with that individual—but only if this is unlikely to put you or your staff in any danger.
- If a suspected prescription fraud involves a known patient, it is important to respect the confidentiality of patient health information. If it does not involve your patient, confidentiality is not an issue and you may report the incident to the police, if appropriate, if the pharmacist or others have not already done so.

Physicians who are unsure about how to proceed in responding to suspected unlawful prescription activity are encouraged to contact the CMPA for individual advice.

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

- “Preventing the misuse of opioids”
- “Ending the doctor-patient relationship”
- “Physician interactions with police”

1. Controlled Drugs and Substances Act, S.C. 1996, c. 19
CMPA reviewed data over a 5-year period (2012-2016) and found more than **500** medical-legal cases containing one or more breakdowns in the follow-up of a diagnostic test result. **87%** resulted in an unfavourable medical-legal outcome for the physician named in the action or complaint.

In over **33%** of these cases, the patients died or suffered serious permanent injuries, which may have been linked, in whole or in part, to a failure in following up on a critical test result.

Having a reliable follow-up system for test results in your practice is an integral part of providing safe medical care and avoiding harm.

**ARE YOU USING THE “NO NEWS IS GOOD NEWS” FOLLOW-UP METHOD? CONSIDER THE RISKS.**

There is no such thing as a perfect follow-up system. Even in the most optimal situation, events beyond your control can take place and adversely affect patient care. That said, physicians are responsible for ensuring that they have a reasonable and reliable follow-up system in their practice for outstanding tests or consultations. Knowing the intricacies and the vulnerabilities of your existing process is the first step in improving your system.

**SELF-ASSESSMENT: IS YOUR CURRENT FOLLOW-UP SYSTEM RELIABLE?**

- **Test ordered**
  - Have you ever used the wrong requisition?

- **Test performed, but in transit**
  - Have you or your staff ever mislabelled a specimen?

- **Test results tracked**
  - Have you ever mistakenly received a result for a patient you did not know?

- **Results returned to office or physician**
  - Have you or your staff ever misfiled a test result?

- **Results reviewed by physician**
  - Do you have a contingency plan if you can’t reach a patient?

- **Results documented and filed**

- **Patient notified**

- **Patient monitored through follow-up**

If you’ve identified weak points in your system for test follow-up, you may benefit from our new workshop: **Is no news good news? Build a more reliable follow-up system for test results.**

Learn about your professional obligations, discuss common barriers in your practice, and learn how to plan a safer follow-up system for managing test results in your practice.

Register today at www.cmpa-acpm.ca/tr
#CMPAtips for members new to practice

TOP RISK AREAS FOR NEW PHYSICIANS!
- Office management
- Patient communication
- Diagnostic error

NEW FOR RESIDENTS AND CLINICAL FELLOWS
- Type of work (TOW) code 12 is now for residents and clinical fellows who do not moonlight (includes extra resident shifts and out-of-province electives).
- TOW code 14 is now for residents and clinical fellows who moonlight occasionally (includes extra resident shifts and out-of-province electives).

KEEP YOUR CONTACT INFORMATION CURRENT
- Get information about membership, and ensure we can inform and assist you with any arising medical-legal matters.

UPDATE YOUR TYPE OF WORK AND REGION INFORMATION
- Avoid gaps in your medical-liability protection.

TAKE ADVANTAGE OF CMPA’S TRANSITION TO PRACTICE PAYMENT OPTION
- Enter practice with minimal disruptions to your cash flow.

CHECK OUT THE CMPA’S GOOD PRACTICES GUIDE
- Review CMPA case studies to identify ways in which you could improve patient care and reduce your medical-liability risk.

WE’RE HERE TO HELP!
CMPA’s professional, personalized, and confidential advice is only a click or a call away.
Contact us for strategies and tips to address areas of risk and much more.

www.cmpa-acpm.ca
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