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Medical-legal risks for physicians practising in northern Ontario

INTRODUCTION

The Northern Ontario School of Medicine (NOSM) is conducting an assessment of learners' perceived and unperceived needs with respect to continuous professional development (CPD) activities. Following a presentation by the Canadian Medical Protective Association (CMPA), NOSM's Medical Director of Continuing Medical Education requested information on medical-legal risks for physicians practising in northern Ontario. This information will be used to support NOSM's development of CPD activities and materials.

APPROACH

Cases were selected for analysis by cross-referencing their cities of occurrence with those included in the North East and North West Local Health Integration Networks (LHINs). There were 411 medical-legal cases, closed from 2010 to 2014, that involved physicians practising in northern Ontario. This analysis focused on the 260 cases (63.3%) with peer expert[1] criticism in order to identify areas of medical-legal risk. The top areas of medical-legal risk were then mapped to CanMEDS roles and competencies to further help NOSM educators.[2]

The CMPA's medical-legal data is derived from information related to CMPA cases, which include legal actions, complaints to regulatory authorities (Colleges), and hospital complaints. This information may include legal documents, medical records, peer expert opinions, and College and hospital decisions. The CMPA captures medical conditions and interventions using the Canadian enhancement to the *International Statistical Classification of Diseases and Related Health Problems*, 10th revision (ICD-10-CA) and the *Canadian Classification of Health Interventions* (CCI). An in-house coding system is used to capture contributing factors associated with patient safety incidents, defined as an event or circumstance associated with care that could have or did result in unnecessary patient harm. Not all CMPA cases are patient safety incidents; a significant proportion includes instances of unavoidable harm (risks inherent to medical care). Medical analysts, experienced registered nurses representing a wide range of clinical specialties, evaluate and code CMPA cases according to the above-mentioned taxonomies within a structured database. The CMPA conducts evidence-based analysis of aggregated data to identify areas of medical-legal risk for healthcare providers and systems.

Limitations

Physician members report medical-legal matters to the CMPA at their own discretion, and reporting may vary widely by type of medical-legal case. Civil legal actions (lawsuits) are reliably reported, however CMPA members sometimes do not always request assistance in responding to regulatory authority (College) and hospital complaints related to their provision of care[3]. Based on internal coding requirements, not all medical-legal cases are subject to review and analysis. Analysis is limited to the information available in a file.

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[1] A professional who is engaged to provide an opinion based on his/her special skill or knowledge in a particular area. For example physicians of similar training and working in similar practices are asked to interpret or provide their opinion on clinical, scientific, or technical issues and standards of care related to the clinical medical care in question.
[2] The Draft CanMEDS 2015 Milestone Guide [Internet]. Royal College of Physicians and Surgeons [cited 2016 Mar 16]. Available from http://www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds/framework/canmeds2015_draft_milestones_e.pdf
[3] The CMPA is available to assist members with many types of complaints. Early contact with the Association can often alleviate stress for physicians and contribute to a satisfactory resolution.

RESULTS

Expert criticism in these cases focused on four main risk areas: deficient decision-making; communication issues with patients and/or the rest of the inter-professional team (verbal or written); patient harm that occurred during a procedure; and other documentation issues. These areas were further analyzed to identify contributing factors, and map them to corresponding CanMEDS roles and competencies (see table).

Table: Mapping of medical-legal risk areas, contributing factors, and CanMEDS roles and competencies, CMPA members practising in northern Ontario, cases closed 2010–2014 (n=260)

Risk area	Contributing factors	CanMEDS role and competency
Deficiencies in decision-making related to either diagnosis, a surgery or other therapeutic procedure, or medication management	Inadequate history taking (e.g. not reading the patient's medical record or seeking information from patients or their families on risk factors), and performing a limited physical examination contributed to diagnostic issues, which included problems with selecting appropriate testing; failing to follow up on test results; deciding on a therapeutic treatment; and failing to refer to or consult with another physician. Some deficiencies in decision-making occurred during medication management (e.g. sub-optional medication selected to treat a condition, or dose too high or too low for the patient or condition).	**Medical Expert 2.2** • Elicit a history, perform a physical exam, select appropriate investigations, and interpret their results for the purpose of diagnosis and management, disease prevention and health promotion. **Medical Expert 3.1** • Determine the most appropriate procedure(s) for the purpose of assessment and/or management. **Medical Expert 5.3** • Adopt strategies that promote patient safety and mitigate negative human and system factors. **Communicator 2.1** • Use patient-centred interviewing skills to effectively gather relevant biomedical and psychosocial information. **Communicator 2.3** • Provide a clear structure for and management for the flow of the entire encounter.
Communication issues with patients and/or other members of the inter-professional team (includes documentation)	Problematic communication skills or style resulted in poor quality communication with patients. The key areas of concern were informed consent, the provision and documentation of the rationale for investigations or treatments, the need for follow-up, discharge instructions, and disclosure of patient safety incidents with appropriate apology. Poor inter-professional team communication was most often related to verbal and written handover processes. Information provided was incomplete, not understood and not clarified, and at times the most responsible physician was not clearly identified and communicated to all members of the healthcare team.	**Communicator 3.1** • Skillfully share information and explanations that are clear, accurate, timely, and adapted to the patient's and his or her family's level of understanding and needs **Communicator 3.2** • Disclose harmful patient safety incidents to patients and their families accurately and appropriately. **Communicator 4.1** • Facilitate discussions with patient and their families in a way that is respectful, non-judgmental, and culturally safe. **Collaborator 3.2** • Demonstrate safe transfer of care, using both verbal and written communication, during a patient transition to a different health care professional, setting, or stage of care. **Medical Expert 3.2** • Obtain and document informed consent, explaining the risks and benefits of, and the rationale for, the proposed options. **Medical Expert 4.1** • Establish the roles of physicians, other health care professionals, and the patient in the provision of patient-centred care plan that supports ongoing care including follow-up on investigations, responses to treatment and further consultation.
Patient harm that occurred during a procedure	Surgical and other therapeutic interventions (including medication administration) were sources of harm for patients. Harm occurred in two contexts: patient safety incidents (e.g. poor decision-	**Medical Expert 3.4** • Perform procedures in a skillful and safe manner, adapting to unanticipated findings or changing clinical circumstances.

	making during surgery, wrong surgery or medication, retained foreign body), or as a result of a recognized risk of a procedure. Non-physician healthcare providers and/or system issues (e.g. deficient protocols or processes) occasionally contributed to patient safety incidents.	**Medical Expert 5.3** • Adopt strategies that promote patient safety and mitigate negative human and system factors.
Other documentation issues	These issues related to notations in the medical record that were inadequate and/or non-contemporaneous	**Communicator 5.1** • Document clinical encounters in an accurate, complete, timely and accessible manner, in compliance with legal and regulatory requirements.

CONCLUSION

Medico-legal risks for physicians practising in northern Ontario were similar to those of the general CMPA membership. Based on this analysis, medico-legal CPD activities are best aligned with the roles and competencies of Medical Expert, Communicator and Collaborator as set out in CanMEDS. Information on situational awareness (i.e. keeping track of what is happening and anticipating what might need to be done) would promote better clinical decision-making during the diagnostic process, performance of therapeutic procedures and medication management. As failures in communication are considered one of the major causes of avoidable patient safety incidents, focusing CPD activities in this area is also important. This could include implementation of a patient-centred approach to communicating with patients and families, and using best practices, such as a structured tool for verbal handover that improves inter-professional team communication and collaboration. Practical activities to support and encourage better documentation practices are also encouraged.