MEDICAL MALPRACTICE

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What are a Physician's Legal and Ethical Obligations to your Injured Client?

INTRODUCTION

When your client becomes injured as a result of an accident, or is struck with a serious illness, he or she becomes dependent upon his or her family physician not only to provide medical care, but also to support him or her in the process of obtaining employment accommodations, insurance benefits and/or third party compensation related to his or her injury and/or illness.

Understanding a treating physician's legal and ethical duties to your client in these circumstances is critical to a lawyer's ability to adequately protect their clients' best interests and ensure they are treated fairly. The purpose of this article is to explore the treating physician's ethical and legal obligations to support his or her patients in this medical-legal environment.

MEDICAL RECORDS

When a client has been injured or become ill, the lawyer will need to develop a clear understanding of the nature and extent of the client's injury or illness and its prognosis, as well as the cause(s) of the injury or illness.

The starting point is to obtain a complete copy of your client's relevant medical records. While this may come as a surprise to many who routinely review and attempt to decipher physicians' handwriting and other cryptic notations contained in medical records, physicians have a legal and ethical obligation to create a *legible and comprehensive* record of the medical care they provide to their patients.[1] While the physician who created the record owns the record, the law is clear that a patient is entitled, upon request, to examine and receive a copy of the complete medical records compiled by the physician in the course of providing medical advice and treatment to the patient. This includes electronic records and copies of records prepared by other physicians that the physician may have received. There are, however, limited exceptions to this right, such as where there are compelling reasons to believe that the disclosure of these records (or certain portions of them) is likely to cause a substantial adverse effect on the physical, mental, or emotional health of the patient or harm to a third party.[2]

In terms of what records are available, physicians are required to retain records for 16 years from either the date of the last entry, or from the age of majority (19), whichever is the latest.[3] If the physician provided care in a hospital setting, the hospital must produce the medical records. Hospitals must retain primary records for 10 years from the last entry.[4]

Medical records are often relied upon in court as evidence of a claimant's injury. These records are an exception to the hearsay rule and the facts contained in the medical records can be admitted as *prima facie* evidence for the truth of those facts.[5] A diagnosis, however, may fall into the category of opinion evidence which cannot be admitted for its truth simply by entering the medical records as exhibits at trial, nor can it be admitted simply by calling the treating physician as a witness at trial without notice of the opinion evidence provided in accordance with Rule 11-6 of the Supreme Court Civil Rules. Ultimately, whether notice is required or not depends upon the purpose of entering the diagnosis into evidence. If it is entered for the truth of the diagnosis, notice is required. If the purpose is simply to confirm that the diagnosis was made, notice is not required.

MEDICAL CERTIFICATES AND OTHER THIRD PARTY REPORTS

A person injured in an accident or suffering from a medical illness may require a medical certificate or report from his or her treating physician in order to obtain workplace accommodation, insurance benefits or compensation from a tortfeasor related to his or her injury or illness. Third parties, such as the patient's employer, insurance company or defence counsel may also seek information directly from the treating physician.

The treating physician is ethically and legally obliged to provide reports on patients they have attended by providing relevant, objective medical information.[6] This obligation applies even if the physician has not seen the patient recently and cannot provide a current report.[7] The information should be provided in a reasonable timeframe, usually 30 business days.[8]

If the request is from a third party, the physician must first obtain an appropriate consent from the patient prior to providing any information. It is important to delineate the scope of what is relevant to ensure the disclosure of information does not exceed the consent provided. The patient should also be advised in advance that the physician cannot conceal or withhold relevant information which is not favourable to the patient.

DISCLOSING INFORMATION TO THIRD PARTIES

Some additional comments are warranted in relation to requests made by third parties. The cornerstone of the physician-patient relationship is trust and confidentiality. Subject to some limited statutory exceptions, a physician must obtain the patient's express consent prior to providing any information to third parties, as noted above.

In the context of personal injury litigation, however, there is legal authority that once litigation has been commenced, there is an implied waiver of physician-patient confidentiality in relation to medical information which is relevant to the lawsuit. This arises in the context of defence counsel seeking to interview treating physicians.

It is important for physicians to understand that while there may be an implied waiver of privilege where a personal injury lawsuit has been commenced, this does not obligate them to discuss their patient's medical information with defence counsel, in the absence of their patient's consent. The College of Physicians and Surgeons of BC's position is that notwithstanding this implied waiver of confidentiality, physicians have an ethical obligation to act in the best interests of their patients, and should review the third party request with their patient, and give due consideration to the patient's wishes. The reality is, however, that if the patient refuses to provide consent, and the physician accordingly refuses to answer any questions, defence counsel may obtain an order from the court to interview the physician under oath, pursuant to Rule 7-5 of the Supreme Court Civil Rules. Good practice is for the patient's lawyer in the personal injury matter to facilitate defence counsel reasonable request to interview the physician, and to be present during the interview for the purpose of ensuring defence counsel remains within the bounds of the implied waiver of confidentiality, and that no irrelevant or privileged information is disclosed.

REFERRALS AND SECOND OPINIONS

An injured client will often require one or more referral(s) to specialists in order to diagnose and treat his or her injury or illness. The process of obtaining appropriate referrals to specialists can be a time-consuming and frustrating process for a patient. It can result in delay and miscommunications between the primary care physician and the specialist. The College of Physicians and Surgeons of BC has addressed these concerns with a revised guideline for how referrals should be managed, emphasizing patient well-being as the single most important factor in ensuring an effective referral-consultation process. The relevant guideline requires clear and timely communication between the family physician and the referral physician, as well as between the physician and the patient. While there is no specific requirement in the College guideline for a consultation to occur in a timely manner, if information is communicated to the consulting physician which would indicate that a timely consult is required to maintain the health of the patient, then an obligation may arise to prioritize the referral. Once the consultation has taken place, the consulting physician should provide the referring physician with a timely (ie. 2 weeks) written report, unless the results are urgent or critical in which case more immediate verbal notification is required.

In addition to timely communication, patients should also be provided with appropriate information to assist them in making informed decisions about their health care, including whether to seek a second opinion or proceed with recommended consultation or treatments. In circumstances where a patient requests a second opinion, the College recommends the physician should "consider and respect their patient's *reasonable* requests for a second opinion" [emphasis added].

TERMINATING THE PHYSICIAN-PATIENT RELATIONSHIP

When a patient has been injured or becomes seriously ill, the patient is more vulnerable and dependent upon his or her treating physician. He or she may require multiple referrals, comprehensive reassessments and extended appointments for counselling, on top of the requirements associated with supporting the patient with the medical legal process.

There is a recognition that the physician-patient relationship is a fiduciary one in which the physician is in a position of trust. This means that the physician must act with good faith and loyalty toward the patient and never place his or her own interests ahead of the patient's.

A physician-patient relationship can be terminated by the physician for legitimate reasons. If there is an unambiguous indication that the patient blames the treating physician for failing to properly diagnose and/or treat the injury or illness and is contemplating legal action against this physician, the physician may reasonably construe this as undermining the relationship of trust and creating a conflict of interest, and may terminate the relationship.

Further, if the patient displays threatening or abusive behaviour to the physician or staff, making reasonable allowances for the role of the patient's illness (addiction or mental illness) or injury (brain injury) in his or her behaviour, this may be an appropriate basis upon which a physician may terminate the physician-patient relationship.

It is important, however, to appreciate that the increased complexity of a patient's care or the underlying legal proceedings are not legitimate reasons to terminate the relationship. Terminating the physician-patient relationship in these circumstances would be contrary to the fiduciary nature of the relationship. If a physician is actively reducing his or her patient load due to personal reasons, the College and the Canadian Medical Association Code of Ethics caution that the physician cannot simply dismiss their more complicated patients, or otherwise discriminate on the basis

of a patient's condition. Finally, terminating the physician-patient relationship must not be based on any reason that might be discriminatory under the BC Human Rights Code, including race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex, sexual orientation or age.

In conclusion, understanding the nature of a physician's legal and ethical duties to their patients, as well as the limits of those duties, will assist counsel in ensuring their injured client obtains the support needed from their treating physician(s) in pursuing their underlying legal remedies. V

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1 CPSBC, Practice Standard, Medical records, v. 2.0, revised September 1, 2017.
2 McInerney v. MacDonald, [1992] 2 SCR 138, 1992 CanLII 57 (SCC).
3 CPSBC, Practice Standard, Medial Records, v. 2.0 revised September 1, 2017.
4 Hospital Act, Hospital Act Regulation, BC Reg 121/97 s. 14(1).
5 Ares v. Venner (1970), 12 C.R.N.S. 349 (SCC); Evidence Act, RSC 1985, c. C-5 s. 30(1).
6 CPSBC, Practice Standard, Medical Certificates and Other Third-Party Reports, v. 1.0, revised November 2013.
7 supra, note vi
8 supra, note vi
9 Swirski v. Hachey, 1995 Canlii 617 (BC SC).
10 CPSBC, Professional Guideline, Referral-Consultation Process, v. 3.1 revised November 5, 2018.
11 CPSBC, Professional Guideline, Referral-Consultation Process, v. 3.1 revised November 5, 2018, Canadian Medical Association Code of Ethics, updated 2004, s. 26.
12 CPSBC, Practice Standard, Ending the Physician-Patient Relationship, v. 4.0, revised June 4, 2018; The Canadian Medical Association Code of Ethics, s. 17.
13 supra