Saskatchewan Association of Naturopathic Practitioners

Guide to Practice

(Adopted from the CNPBC "Guideline Series" by the SANP April 5, 2009)

These guidelines are intended to assist our members in their practice and in situations they may encounter. It should be noted that these guidelines are in fact a guide; each situation must be evaluated so that the best solution is obtained. They are intended to give guidance to situations our registrants may encounter.

We hope these guidelines will facilitate your practice. Should you have comments, recommendations or topics for the Guide to Practice, please forward them to the SANP.

Patient Records are to be kept on each patient. Physicians should, at minimum, keep clear and concise charts documenting patient care. The chart should record the patient history and physical findings, assessment of the patient's condition (e.g. what the doctor's hypotheses are) and a plan for further diagnostic work-up and/or therapy.

There are several important reasons for keeping charts. Most importantly the record serves as an aid to memory for on-going care. Charts are also a means of communicating with other health care professionals who have legitimate access to a patient's chart. With the emphasis being placed on in-office research, the medical record is an invaluable source of clinical data. Lastly, charts are important administrative and legal documents. Chart notes can be introduced as evidence in court. They may form the basis of a peer review process. Additionally, many third party insurers use them to verify diagnosis and to ensure services were provided.

It is recommended that the Problem Oriented Medical Record, also know as the SOAP format, be used as the standard form for keeping records. This method requires that a chart note be divided into four sections:

Subjective - The history as told by the patient, a relative or friend;

Objective - Physical signs or laboratory data;

Assessment - The physician's analysis of the problem(s);

Plan - Stating the measures to be taken (diagnostic, therapeutic, education).

Periodic review of patient office records should be conducted using the following criteria:

a) Accuracy – Analyze for inconsistencies and incompleteness in clinical facts, findings, test results, and the like. Dictated notes and reports should be dated and proofread to ensure accuracy and completeness.

b) Objectivity – Identify subjective or personal remarks or notations about the patient not clearly supported by documented facts; identify clinical findings or diagnoses not

supported in context by objective data or earlier noted observations in the record; identify subjective comments about the care of other providers.

c) Legibility – Identify obliterations or changes made in the record inconsistent with appropriate records documentation standards, such as the rendering of prior entries unreadable or failure to initial and date appropriate changes and new entries.

d) Timeliness – Review the timeliness of entries following patient office encounters. Assess the appropriateness of late entries. It is suggested that records be prepared as contemporaneously with treatments as possible and, if appropriate, dictated in the presence of the patient. Also review, for completeness and timeliness of receipt and filing, laboratory and other reports and documentation of their review by the treating/attending physician.

e) Comprehensiveness – Identify conclusions charted without documentation of rationale or intermediate clinical steps; identify critical decision points where the physician's clinical assessment or reasons for making the decision are not documented.

f) Alterations – Examine for missing pages, erasures or other inappropriate alterations, including sections of the record which may have been removed, as well as missing items like lab test reports, radiology, films, or EKG strips. Any additions or corrections to the record must be dated and signed, and the date must reflect the day of the addition or correction, know the day of the original entry being modified.

Clinical records should be kept and maintained, at minimum, for seven years from the date of the last visit. Please be aware that as many cases have recently pointed to past sexual abuse by physicians, it may be advisable to maintain your records indefinitely. The relevant limitation period may be postponed until the patient has identified the injury and the cause.

INFORMED CONSENT – For further details, refer to *Consent to Treatment Policy*.

The physician (not a delegated representative) should discuss with the patient:

a) The risks and benefits of a proposed treatment or procedure;

b) Alternatives to a proposed treatment or procedure;

c) The risks and benefits of the alternative treatments or procedures;

d) The risks and benefits of doing nothing.

The physician should provide for disclosure of informed consent information in the primary language of non-English speaking patients, if possible.

Informed consent discussions and patient decisions, including an informed refusal to undergo a recommended treatment or procedure, should be documented.

During the informed consent process, the physician should discuss with the patient:

a) The proper use and potential adverse affects of recommended substances;

b) The potential adverse affects of not using the recommended substances or not using the substance as recommended;

c) The proper use and potential adverse effects of medical devices to be used by the patient;

d) The potential adverse effects of not using the medical device or improper use of the medical device.

Discussions and decisions regarding prescribed drugs and medical devices should be documented.

Notes:

Informed consent is a legal doctrine that requires a physician to obtain consent for treatment rendered, an operation performed, or many diagnostic procedures. It is a process, not a form. The law of informed consent varies significantly from province to province and physicians should acquaint themselves with the law in their respective province.

It is essential that the patient fully understand the treatment to be rendered or the diagnostic procedure to be undertaken. The above statement applies equally to the so-called "reasonable physician" standard or "patient viewpoint" standard of disclosure for legal informed consent.

Many still use the "reasonable physician" standard. This standard of disclosure is based upon what is customary practice or what a reasonable practitioner in the naturopathic/medical community would disclose under the same or similar circumstances. In recent years, however, courts have preferred to accept the "patient viewpoint" standard.

Generally, under the "patient viewpoint" standard, disclosure of information is based upon what a reasonable person in the patient's position would want to know in similar circumstances. This standard is based upon the patient's perception rather than on professional perception of what the patient should know.

Although informed consent is a process and not a form, informed consent forms and the signature of the patient consenting to a treatment or diagnostic procedure can be critical documentary evidence that the informed consent process took place.

If the physician has any questions regarding this they should obtain independent legal advice re: patients' rights.

INFORMATION FLOW

Office systems should be established to ensure efficient processing of clinical information. Such systems should include:

a) A method for ensuring that laboratory results, consultation reports, and other pertinent documents are seen by the treating/attending physician prior to filing;

b) A reminder system which ensures that follow-up tasks are undertaken when warranted;

c) A process for making medical records available to physicians when needed, especially when talking with patients by telephone.

Notes:

Patient injury can result from system failure, even when there have been no errors in clinical judgment or treatment. Office systems should be designed to ensure consistent management of information, records and paperwork.
These systems can vary in sophistication from requiring the physician's initials on reports before they are filed to tracking information by computer.

The physician should follow up on those situations that demand immediate attention or that would yield information on conditions with potentially severe consequences. The patient also bears some responsibility for follow up care, especially when the need for such care or the patient's role in seeking follow up care are of a routine nature, or have been explained to the patient.

Physicians sometimes make a practice of requiring the patient call for results, or of only calling the patient when results are adverse. Such procedures often leave patients unaware of the meaning of tests or the need for follow up care, and also increase the risk of adverse results not being communicated to the patient.

CONSULTATIONS

Physicians should recognize that some patients' clinical problems will be beyond their expertise and should develop and follow a policy for use of consultants in these circumstances.

The referring physician should verify that the patient was seen by the consulting physician.

The consulting physician should keep the referring physician fully informed concerning the patient's course of treatment.

The referring physician and the consulting physician should:

a) Develop a plan for coordinating total patient care;

b) Agree upon who has primary responsibility for total patient care, adjusting primary responsibility as the patient's condition dictates;

c) Agree upon who has primary responsibility for providing the patient and family with information;

d) Keep the patient fully advised as to all of the above-referenced items.

e) The referring physician and the consulting physician should document their understanding with respect to the treatment of the patient.

PRACTICE COVERAGE

All physicians in practice should have practice coverage arrangements for those times when they are unavailable.

All Physicians in practice should also have secondary coverage arrangement for those times when their primary covering physician is also unavailable.

Covering physicians should be of the same naturopathic specialty as the treating/attending physician, when possible.

The treating/attending physicians should provide covering physicians with information on patients with anticipated problems and this should be documented in the patient's medical record.

All patients of the treating/attending physician should be informed of the coverage arrangements and, where possible, introduced to the covering physician(s).

The treating/attending physician should advise the answering service of the names and telephone numbers of the covering physician(s).

A covering physician(s) should advise the treating/attending physician about a patient's course of treatment during the coverage and this should be documented.

A coverage arrangement should contain an understanding as to which physician bills the patient and the patient should be informed of this by the treating/attending physician.

Note:

Although coverage agreements are especially important for solo practitioners, it is also important for physicians in group practice to understand their coverage arrangements with their associates.

PATIENT RELATIONS

Physicians should use active listening as well as thorough questioning in communicating with patients.

When treating patients, the physician should use language appropriate to the patient's level of understanding.

Where appropriate, the physician should involve the family or significant others as a support mechanism for the patient. Whenever possible, the person whom the patient request to receive information on his or her condition should be determined in advance.

The physician should provide special attention and emotional support to a patient who experiences a complication.

When a complication or iatrogenic injury occurs, the patient should be informed, preferably by his or her primary physician, in a timely manner which accurately presents the facts of the situation, but does not draw conclusions of any liability or fault.

Occasionally, continuation of the physician-patient relationship becomes impossible. When this occurs, termination should be accomplished in an appropriate manner. Advice on provincial legal requirements should be sought. In general, steps should include:

a) Notifying the patient in writing, preferably by return receipt mail;

b) Providing the patient with a reason for the termination;

c) Agreeing to continue as the patient's treating physician for a reasonable period of time, such as 30 days, while the patient makes arrangements for the services of another physician;

d) Stating clearly the date on which the termination will become effective;

e) Providing information about resources, such as the naturopathic society which will aid in identifying other physicians of like specialty; normally, the terminating physician should also offer to recommend other physicians from which the patient may choose;

f) Offering to transfer records to the new physician upon receipt of a signed authorization to do so;

g) Offering to see the patient in cases of emergency within a stated period or time after termination;

h) Including the above-referenced items in the letter notifying the patient of termination.

Notes:

Taking a good history is a basic tool of a physician. Failure to use good communication skills can result in loss of information vital to diagnosis and treatment.

Inadequate communication can also cause the physician to overlook the emotional needs of the patient. Failure to respond to these emotional needs can cause patient dissatisfaction which in turn may precipitate a lawsuit should an unexpected complication occur.

Since most patients are not medically trained, even the most routine condition or procedure may be misunderstood or cause anxiety. The patient's perception of a condition or procedure may be very different from the physician's. Therefore, the physician should be sensitive to the patient viewpoint and work actively to reduce patient fear and misunderstanding by striving to describe the situation in terms understandable to the patient.

The confidentiality of the physician-patient relationship is well established and legally protected. However, failure to recognize the emotional and informational needs of the family (or other appropriate individuals) can also be a disservice to the patient. The family often influences the actions of the patient regarding both health care and the decision to sue. Keeping them apprised of the patient's progress will often enlist their support and improve the level of patient satisfactions. It is suggested that the physician document in the medical record those individuals identified by the patient to receive information.

When a complication occurs, the patient and family have special concerns and emotional needs. The physician may be initially occupied with attending to the medical situation, or may understandably feel a reluctance to discuss the situation with the patient and the family. However, the relatively small amount of time required to attend to the patient's concerns may return untold dividends in patient satisfaction and improved outcome.

Except in special situations where potentially disturbing information may be medically contraindicated, the patient has the right to know of complication in his or her treatment. However, the manner in which this information is delivered should be carefully considered. Depending on the seriousness of the result, discussion with other potentially involved health care professionals or advice from hospital or personal legal counsel or the insurance carrier may be appropriate. Failure to completely and honestly apprise a patient of a situation could result in claims of international misrepresentation or concealment which can give rise to liability for uninsured punitive damages.

There may be times when a physician feels, for a variety of reasons, that he or she can no longer care for a patient. It may be that a patient's noncompliance prohibits proper treatment, or that the patient makes demands which the physician believes are not within the standard of care. In such case, it usually is permissible for the physician to terminate the relationship, but only after steps are taken to do so in an appropriate manner. The law or regulations pertaining to such action may differ from province to province, and legal advice should be obtained before taking such action.

APPOINTMENTS AND SCHEDULING

The number of office appointments booked should be calculated to allow the physician to maintain a realistic schedule that minimizes long waiting times for patients.

Where appropriate, the number of office appointments booked should allow sufficient time in the day for emergency appointments.

The appointment schedule should allocate extra time for a patient's initial visit.

When delays occur, patients should be promptly advised by the office staff, and the physician should acknowledge the delay when he or she sees the patient.

Missed or cancelled appointments should be documented and, when appropriate, followed up by the physician. The results of the follow-up also should be documented in the patient's record. If the patient has been referred, the referring physician should be notified of the missed appointment.

Cancellations or no-shows should not be erased from or overwritten in the daily log.

Notes:

It is extremely important that the physician and staff take an adequate medical history during a patient's initial visit. Medical liability claims have resulted from the failure to inquire about pertinent items, such as drug allergies, family history, and the like, on a patient's medical history.

Missed or cancelled appointments are often an indication of patient dissatisfaction with the physician, which may be the first sign of a potential claim. In addition, a serious medical liability claim may result if a complication or injury occurs because the patient fails to obtain treatment. Not all missed or cancelled appointments need to be followed up, however. For example, physician-patient relationship has not yet commenced, nor in the case of simple physical examinations scheduled for employment screening purposes.

TELEPHONE COMMUNICATIONS

The physician should respond to telephone calls from patients within a reasonable time. Where possible, patients should be given an indication of approximately when the call will be returned and/or directed to a suitable alternative resource for emergency services.

Office staff should be trained to know which calls should be referred to the physician immediately.

All telephone contacts should be documented. Clinically related information in particular should be documented in the patient's record.

Answering services should be evaluated periodically for courtesy, efficiency, accuracy and proper record keeping.

Office staff should have a list of emergency telephone numbers readily available.

Notes:

The physician should recognize the importance of telephone communications initiated by a patient, both as a source of important clinical information and as a method of responding to the patient's emotional needs. Lawsuits have resulted from a patient's inability to reach a physician to communicate significant information, such as symptoms of an impending myocardial infarction or a reaction to medication. Even when the patient's concerns are less dramatic or not medically significant, the lack of a courteous response within a reasonable time can lead to the kind of patient dissatisfaction that helps trigger a lawsuit.

Certainly, physicians cannot be interrupted for every call, or be available at all hours. However, proper telephone management, such as creating "telephone hours" when the physician is available for patient calls, or allocating certain times for returning calls, can reduce interruptions and ensure that patients know when they can speak with their physician.

Although a physician could not function without staff to screen calls, untrained or improperly trained personnel may perform this task inappropriately. Cases have been reported where staff renewed prescriptions without consulting the physician or turned away patients in need of immediate attention because "the physician is too busy to be disturbed."

The medical record is an essential clinical document and an important piece of evidence in court. Physicians often neglect to record information received or instructions or prescriptions given over the telephone. This can result in those actions being overlooked the next time the patient is seen in the office. It can also result in a credibility dispute should those actions become an issue in a lawsuit.

Answering services are used by some physicians to receive information in their absence or outside regular office hours. The actions of unqualified answering service personnel can result in the delay of urgent messages or cause patient discontent that transfers from the answering service to the physician. Several courts have held a physician vicariously liable for the acts of an answering service.

BILLING AND COLLECTION

A billing system should be able to identify situations requiring review and consideration by the physician for special payment arrangements.

The physician should consider special payment arrangements, when possible for patients with a true financial hardship.

When a complication results from a physician's actions, the billing system should allow for identification of that portion of the total fee relating to the repair or treatment of the complication. In these cases, legal advice or consultation with the insurance carrier should be sought before waiving or reducing the fee.

Where any service is performed to repair or treat an iatrogenic injury, special attention should be given to the billing procedure.

The physician should personally review each patient bill or file before a bill collection mechanism is initiated. Collection agency practices should be evaluated periodically.

Notes:

While a physician is entitled to fair compensation for services rendered, there are situations where consideration of waiver or adjustment of fees may be appropriate. Special payment arrangements for those truly in need generate good patient relations and achieve ultimate receipt of fees while avoiding collection difficulties and possibly lawsuits.

A patient may accept the medical explanation for a complication, but not accept having to pay for the repair or treatment of that complication. Receipt of the bill for treatment of a complication may be the act that precipitates a lawsuit. Advice should be sought from legal counsel or the insurance carrier to avoid the appearance that a fee waiver or reduction is an admission of negligence.

A physician who initiates further treatment for a patient with an iatrogenic injury often finds such efforts complicated by the bill from a consultant called in to assist in the treatment of the injury. Direct communications between providers on how the billing should be handled can result in arrangements satisfactory both to the patient and the providers.
Review of the patient's file by the physician before it is forwarded to a collection agency will avoid inadvertent referral of those cases meriting consideration for special payment arrangements. In addition, the patient's refusal to pay is occasionally an indicator of valid dissatisfaction. Medical liability claims that might otherwise be avoided are sometimes filed solely in response to a bill collection action.

FEES AND REMUNERATIONS

The fees listed here are intended to be a guide for our physicians. SANP recognizes that due to differing office overheads, locations and specialty education, fees may vary. For example, a physician that has attained a higher level of expertise in an area than the general membership may choose to be remunerated accordingly. It should be noted however, that should the SANP receive complaints regarding fees, SANP expects that the registered member will be able to demonstrate his or her fee structure to the satisfaction of all concerned.

ALLIED HEALTH PERSONNEL AND RISK IDENTIFICATIONS

The physician(s) responsible for managing the office or group practice are also responsible for ensuring that all employees and allied health personnel are properly trained and/or credentialed.

Employees and allied health personnel should be given periodic performance reviews by the physician or a designated reviewer (such as the office or group practice manager), to identify and discuss professional strengths and weaknesses.

A risk management/quality assurance program should be developed and implemented in the office or group practice setting. Such a program should include:

a) A system to identify incidents and adverse occurrences arising in the office practice setting;

b) A system to periodically assess the quality of services through retrospective and concurrent review of patients records;

c) Designation of an individual to assume this risk management/quality review function, with responsibility for assessing and prioritizing identified problems, and for coordinating the development, implementation and evaluation of corrective action.

Physicians, employees and allied health personnel should periodically receive training and education in risk management and loss prevention through in-service programs or outside seminars.

Allied health personnel and professional employees, including employed physicians, not covered under the practice or group professional liability insurance policy should show evidence, at least annually, of adequate insurance. Physicians managing an office practice setting should require such insuring entities to provide at least 30 days written notice of cancellation of any independent policies covering such persons.

Notes:

Physicians are held legally responsible for the negligent acts of their employees. Even where allied health personnel such as nurses or technicians are not employees, a physician may be responsible for their negligent practice setting. In addition to negligent actions, poor attitude or unprofessional demeanor on the part of support staff can trigger a non-meritorious lawsuit as the result of patient anger and frustration. Consequently, prospective employees and allied health personnel should be appropriately screened with respect to such factors as:

- *Verification of education and licensing;*
- *Prior employment history, including references from past employers;*

Many problems related to employee performance may go unidentified and unresolved for long periods after the initial hiring. A system of annual reviews based on the following assessment factors can identify problem areas:

- *Review of compliance with office policies and treatment protocols;*
- *Review of patient records to determine quality of test results from office laboratories, X-ray films, injection sites, and other tasks or responsibilities delegated to allied health care professionals;*
- *Review of complaints from patients and/or other staff members;*
- *Periodic on-site supervision of employee or allied health care worker activity.*

The use of a risk management/quality assurance program and the accompanying risk identification tools not only serves to identify potentially compensable events in the practice setting, but reinforces the importance of risk management among employees and allied health care workers. The effort further stresses the value of the health care team working together in a non-adversarial manner to enhance patient safety and reduce risk of loss.

Programs should cover such topics as risk identification and risk analysis, as well as patient communications, processing of patient complaints, documentation of office records. Programs should also include a review of applicable federal and provincial law, especially where it pertains to patient rights, peer review and risk management.

Although many liability policies covering office or group practices may cover affiliated allied health personnel and professional employees, some policies specifically exclude certain individuals such as nurse practitioners, nurse anesthetists, psychologists, and psychiatric social workers, for example. It is essential to incorporate the requirement of periodic proof of insurance as a routine part of the insurance/risk financing review of an office procedure.

RECEPTION AREA, GROUNDS AND FACILITIES

The reception area should be comfortable, have sufficient seating, and have reading material of general interest to patients.

The receptionist should courteously greet all patients upon their arrival.

Current patient medical education materials should be available.

Care should be taken to ensure that patients in the reception area cannot overhear discussions of confidential patient matters or other office business being conducted. The receptionist, however, should be able to visually monitor the reception area.

A physician should attempt to ensure that the building and parking lot for patients and staff are adequately lighted and free of potential hazards.

Staff should be trained in emergency exit procedures in cases of fire or other disasters.

Notes:

Having patient medical education materials readily available indicates a willingness to involve the patient in a shared effort for the patient's health care. In addition, these materials can facilitate the informed consent process by giving the patient additional information on the potential risks and benefits of a contemplated treatment.

In many physicians' offices, the receptionist is asked to conduct business in addition to greeting patients and coordinating appointments. The receptionist should be able to conduct such business in private without being overheard from the reception area. On the other hand, the receptionist should be able to visually monitor the reception area so that action can be initiated in the event of a medical emergency.

Although many physicians do not own or control the building and land used for their office practices, they nonetheless should attempt to reduce the potential for serious physical injury to patients and visitors from accidents such as slips and falls. Often, a physician is named as a co-defendant in lawsuits involving these types of general liability accidents even though the facilities are under the direct control and management of another entity, such as the landlord or building management company.