

Evaluation of End E-4

College of Physicians and Surgeons of
Saskatchewan



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College of Physicians and Surgeons of Saskatchewan

End E-4

This account reports the results of an evaluation study of one of the ends policies of the College of Physicians and Surgeons of Saskatchewan (CPSS). End E-4 reads as follows:

COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN
COUNCIL POLICY

Policy Name: Healthy Public Policy Number: E-4

Policy Type: Ends Date Approved: August 14, 1998

The End "Healthy Public Policy" is interpreted to include, but is not limited to:

1. The College is a competent, credible resource for the public.
2. Governments consult the College as a primary resource when forming health policy.
3. The College is a competent, reliable resource for other agencies.

Under the Council's governance model, the Registrar is responsible for the achievement of this end. In order to evaluate the end, Council commissioned Professor Allen Backman of the University of Saskatchewan to conduct 20 telephone interviews with key informants and to search for themes in this data. Professor Backman worked with Council to develop a question route to be used in the telephone interviews. Data were analysed using a three step iterative process consistent with standard practices of qualitative research.

Analysis yields 10 themes:

1. The Nature of the Contacts with the CPSS
2. Policy Issues
3. The Roles of Dr. Kendel and his Staff
4. Policy E-4 Itself
5. CPSS as a Primary Resource When Forming Health Policy
6. CPSS as a Resource for the Public
7. CPSS as a Competent, Reliable Resource for Agencies
8. Formal vs Informal Consultation
9. Opportunities for Further Consultation
 - 9.1. Common Code of Ethics
10. Appropriate Boundaries for CPSS Policy Activities

Most respondents reported a wide variety of circumstances in which the College has proven a valuable, competent, credible and primary resource for policy decision making. Respondents reported no hesitation to consult with the College on a broad variety of issues and consider the input of the College to be credible, timely and highly desirable.

The Registrar and his staff are highly regarded on the District, Provincial and National levels.

As expected, the study was unable to come to any firm conclusions about whether the public sees the College as a competent, credible resource as only one consumer group [Patients Rights Association of Saskatchewan] was consulted. Several respondents other than PRAS were, however, able to give some insight into this issue and reports were very positive.

Two notable exceptions to the very positive findings were the Patients Rights Association of Saskatchewan which does not see the College as a credible resource for the public and the Saskatchewan Medical Association which is suspicious of the College's intent and believes the College too often strays into its own jurisdiction.

Opportunities for further involvement as a resource for the public, governments and health agencies were; involvement in developing a common Code of Ethics for medical regulatory bodies, the development of inter-provincial standards and systems, increased media activities and common standards for credentialing of physicians.

Several respondents saw some policy boundaries which the College should not cross. These involved the working conditions and remuneration of physicians, whether programmes ought to be publicly funded or not, and disciplinary functions of other jurisdictions. There was not consensus on these issues, however, and most respondents did not see any issue as being strictly 'off limits'.

In conclusion, the College is highly regarded as a credible, competent, reliable and primary resource to governments and health care agencies in their efforts to deal with policy.

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3. The College is a competent, reliable resource for other agencies.

The policy deals with the ability of the College to influence health policy in a positive manner. It does not specify that public health policy should be influenced in a manner consistent with the other ends of the CPSS, but the policy does further define what is meant by 'healthy public policy'. Under the governance model used by the CPSS Council, if Council does not further define this end, they are indicating their readiness to accept any reasonable interpretation their Registrar formulates. Specifically, Council defines 'healthy public policy' as including the use of the CPSS by the public as a competent, credible resource, that governments consult the College as a primary resource when forming health policy and that the CPSS is a competent, reliable resource for other agencies.

Under the Council's governance model, the Registrar shoulders the burden of accomplishing the Ends, (E-4 included) and the Council shoulders the responsibility of determining whether adequate progress has been made at a cost that constitutes 'a fair swap'. While the Registrar must periodically report back to Council as to these matters, Council reserves the right to evaluate the ends through direct examination or by commissioning an external agency. In this case, Council has contracted with Professor Allen Backman of the University of Saskatchewan to evaluate End E-4.

After discussion with the President, Council and the CPSS Executive Committee, Professor Backman undertook to evaluate how successful the CPSS has been in achieving End E-4 by:

- Conducting a series of structured telephone interviews with key informants
 - who are familiar with the College and can offer insight into the College's ability to influence healthy public policy,
 - or who may have relied on the CPSS for input or advise in policy making.
 - Interviews solicited perceptions and experiences regarding the CPSS's influence in the policy arena.
 - The interview schedule (i.e., the questions asked) and the list of subjects to be interviewed were negotiated with Council and the Executive Committee.
- Searching for themes within the data collected which will serve to inform the Council of the organisation's success in achieving End E-4.
- Preparing a written report for Council.
- Making a presentation to Council (if invited) on the results.

Council and its Executive Committee determined the list of key informants to be interviewed and approving the survey question route.

Method

Telephone interviews

Purposive Sample

Purposive samples (sometimes called judgement samples) use hand-picked subjects who are expected to serve the research purpose. The subjects are usually chosen because they are representative of the population of interest.¹ After consultation with Council and its Executive Committee, the following 20 people were selected as interviewees:

1. Government
 - 1.1. Glenda Yeates, Deputy Minister
 - 1.2. Lawrence Krahn, Associate Deputy Minister
 - 1.3. Lauren Donnelly, Executive Director of Acute & Emergency Services Branch
 - 1.4. Carolyn Hoffman, Provincial Quality of Care Coordinator
2. Other Colleges
 - 2.1. Manitoba - Dr. Bill Pope
 - 2.2. Alberta - Dr. Bob Burns
 - 2.3. Nova Scotia - Dr. Cam Little
3. Health Districts
 - 3.1. Battlefords - John Yarske
 - 3.2. North Valley Health District Joe Kirwin
 - 3.3. Midwest - Doug Ball
4. Professional Organizations
 - 4.1. S.M.A. - Dr. Briane Scharfstein
 - 4.2. F.M.L.A.C. - Dr. André Jacques
 - 4.3. Medical Council of Canada - Dr. Dale Dauphinee
 - 4.4. COSAS
 - 4.4.1. Dr. Louis Poulin
 - 4.4.2. Dr. Eric Bodenstab
 - 4.5. SRNA - Donna Brunskill
 - 4.6. Saskatchewan Pharmaceutical Association - Ray Joubert
5. Consultants
 - 5.1. Steven Lewis
 - 5.2. Ken Fyke
6. Consumer Groups
 - 6.1. Patients' Rights Association of Saskatchewan - Natalie Austin

It was agreed that should any of these decline to participate in the study, they would be replaced by a similar subject.

¹ CHURCHILL, Gilbert A. Marketing Research: Methodological Foundations, 5th ed., Chicago: Dryden press, 1991, p.540

One limitation posed by the panel of respondents is that only one, the PRAS, is a consumer group and individual patients would not be interviewed in this study. It was anticipated that information regarding whether the College is a competent and credible resource to the public would be limited and that conclusions would be inexact at best.

Pre-interview Procedure

Before the interviews took place, each respondent received letters from the President of Council and the Registrar. These letters briefed the respondents about the study, provided a copy of policy E-4, asked the respondent to participate in the study and introduced Allen Backman as the person who would telephone to make an appointment.

Questionnaire structure

There are two methods of interviews that were amenable to this project. They were Structured-Undisguised and Unstructured-Undisguised² open-ended questionnaires. This study used a hybrid of the two.³

The question route was composed of Structured-Undisguised open-ended questions. The goal was to get the subject to talk freely about his or her attitudes. The idea was to begin with one open ended question and, after the presentation of this initial stimulus, all further prompts / probes were used if needed. In pure Structured-Undisguised questionnaires, questions are presented with exactly the same wording and in exactly the same order to all respondents. The reason for standardising them is to ensure that respondents are replying to the same question.⁴ For example, if one subject was asked, "Do you use the CPSS as a resource when considering major policy changes" and another was asked, "Does your organization consult with the CPSS when considering major policy changes" the replies would not be comparable. The reason why we did not necessarily ask all questions of all respondents is that we predicted that the respondents would be articulate individuals who would be able to guess the kind of information we were interested in. It was possible that a respondent would already have completely answered a question before it was asked. Asking the question would disrupt the flow of the interview. The other way in which the interviews more closely followed the unstructured model is when a respondent made a relevant observation that would not have been explored properly using the pre-determined structured questions. In these cases, the interviewer explored the new issues with the respondent in more detail.

In this protocol we did not use fixed alternative questions. These are questions in which respondents are constrained to certain choices such as "Strongly agree" or "Strongly disagree". While fixed alternative questions allow for easy tabulation and analysis, they also constrain the respondent and may force an answer that does not truly reflect the situation.⁵ Among the advantages of using this technique are that respondents are free to answer with whatever is uppermost in their minds; the types of words and phrases subjects choose to use can add useful information that cannot be captured with closed

² The term Undisguised means that the objectives and purpose of the research are made known to the Subject.

³ In the former, all questions are asked of all respondents. In the latter method only the first question is standardized. For this project, all questions were standardized, the first question was asked of all respondents and the subsequent questions were used as prompts / probes if needed.

⁴ Churchill, p. 318

⁵ Churchill, p. 319

questions. Disadvantages of open-ended question routes include the expense of analysis, as each respondent's answer is somewhat unique⁶.

Question Route

At the beginning of the interview, the respondent will be asked if s/he has a copy of policy E-4 at hand. If not, the interviewer will offer to read, e-mail or fax a copy before the interview commences. The interviewer will ask for permission to tape record the interview. The interviewer will tell the respondent that;

- The tape will be used for analysis purposes and will not be shared with the CPSS.
- The tape will be kept by the researcher for 6 months and a copy will be provided to the respondent if requested.⁷
- The respondent's words may be quoted in the final report to Council, but will be done in a manner that will not identify the respondent without the respondent's specific permission.⁸

Leading question

The first question asked of respondents was,

The Council of the College of Physicians and Surgeons of Saskatchewan has asked me to assess one of their policies. The policy relates to the College's role in influencing healthy public policy. Could you describe for me the nature of the contacts you have had with the College?

Subsequent probes / prompts

Can you describe some instances where the College has provided you with information or resources that allowed you to improve policy decision-making?

For what sort of policy-making decisions do you think it is important for your organization to consult with the College?

For what sort of policy making decisions do you think it is inappropriate to consult with the College

How important is it to your organization to consult with the College before making new policy.

Can you give me an example of a situation where, if you had not consulted with the College, you would have adopted or implemented an inferior policy?

⁶ ZIKMUND, William G. *Exploring Marketing Research*, 4th ed. Fort Worth: The Dryden Press, 1991, p.408

⁷ As of the time of completion of this report, only one subject had requested, and was supplied with, a copy of the interview tape.

⁸ Two notable exceptions were the statements of the Saskatchewan Medical Association and the Patients' Rights Association of Saskatchewan. Permission was obtained from these two groups to reproduce and attribute their comments.

Can you give me an example of a situation where consultation with the College led to worse policy?

Have you or your organization ever sought assistance in policy making from the College but did not get the support you needed?

Can you describe a situation you are familiar with where members of the public used the college as a credible resource?

Can you think of anything we have not talked about that illustrates whether the College is a good or poor resource the public, governments, and health related agencies?

Method of analysis

Upon completion of each interview, the interviewer summarized the information from notes taken during the session. Interviews were transcribed by a research assistant. These 20 summaries and transcriptions formed the basis of subsequent reporting. The researcher conducted a preliminary analysis following completion of about one-third of the interviews. The interviews were tape recorded as the researcher believed the taping was crucial as it allowed him to capture quotes in the participants' own words. He also wanted the tapes available to review any findings that were unclear and to validate his summaries as required.

Steps in the Data Analysis

1. Qualitative data analysis is an iterative process of reviewing, digesting, and summarizing data. We conducted this analysis in a series of steps beginning with the researcher reading through the summaries to become familiar with all the data. At this point we kept the information from each category of respondent (e.g. government, Health District CEO) separate. This first step allowed us the opportunity to ascertain the quantity and quality of the data from the different groups and to assess the factors influencing its variance.
2. In the second step, data organization and reduction, we created categories of data for subsequent analysis. This process was also iterative in that data that did not clearly fit into a category was used to modify the categorizing system. To retain the integrity of the data, and not impose our own biases on it (for example, by using researcher jargon), we did not paraphrase the information, and we retained reference to quotes on the tapes (we had tried to use the participants' own words in our summaries, as well).
3. The final step is data verification. To validate the data reduction process, the researcher reviewed the categorizing system. No attempt was made to triangulate the findings.

Analysis

The College has been a strong voice that other regulatory bodies can work with and speak to. Their support of other professions has been exemplary. The ability of the College to work cooperatively with other health related agencies is really remarkable. I feel very fortunate that in this province we have a College that has a strong public policy focus and a strong public interest orientation

-A high ranking policy veteran

Themes

One of the objectives of this research was to search for themes within the data collected. The themes are meant to inform the Council of the organisation's success in achieving End E-4. The themes produced by the analysis were:

11. The Nature of the Contacts with the CPSS
12. Policy Issues
13. The Roles of Dr. Kendel and his Staff
14. Policy E-4 Itself
15. CPSS as a Primary Resource When Forming Health Policy
16. CPSS as a Resource for the Public
17. CPSS as a Competent, Reliable Resource for Agencies
18. Formal vs Informal Consultation
19. Opportunities for Further Consultation
 - 19.1. Common Code of Ethics
20. Appropriate Boundaries for CPSS Policy Activities

The Nature of the Contacts with the CPSS

The contacts that subjects had with the College have ranged from recent to longstanding. Most subjects have had contact with the College in more than one capacity. A typical response came from the president of a professional association who described his contacts as, “varied, multiple and frequent”.

Health Region CEOs & Physician Managers

CEO's of health regions, for example, have had contact with the College by sitting on various committees formed or chaired by the Department of Health, through direct contact when a physician issue arises, in consultation when considering changes to district bylaws or policies, in matters of hospital credentialing and, in at least one case, where the CEO was concerned about the competency of a local physician. One CEO said that,

“I find it very necessary and very helpful to consult with the College on a number of issues. I not only consulted with... [the CPSS] but also with the SMA on how to address the challenges that we face here. This was to help me get oriented and to properly achieve some kind of working relationship with the medical staff but as time went on I had fairly regular contact with Dr. Kendel and Bryan Salte and others on staff to assist in various policy relationship issues and indeed some investigations, some of which we initiated and some, of course, which came in through the College process. Also, I found, on a collegial basis, in various meetings, conferences, and consultation forums a very valuable role contributed by the College in just about every aspect of health policy formulation. I have always felt that even going way back to the twenty years that I spent in Saskatchewan Health [before becoming a CEO], that Dr. Kendel's predecessors and others within the College are quite obviously big players, important influential players in this area and to have a major role to play and have done very well in that sense.”

One District CEO commented that his subordinate managers often contact the College about specific policy developments. He reported that these contacts have always been very helpful.

Several of the physicians interviewed had also served on College committees in their other professional capacities. They have had contacts in their capacity as members, but also in their roles as Chiefs of Staff. In this capacity, they often contact the College regarding disciplinary process issues.

Regulators & National Organisations

CEO's of other regulatory bodies described contacts as representing, “a professional collegial relationship and... a partnership role”. Regulators have contact with the CPSS on various public policy committees and the contact ranges from “working at a more micro level in a team structure relative to a specific healthy public policy goal... to the macro level in terms of visioning work”. One described the nature of the contacts as, “relating... from complaints respecting our respective members all the way to issues of a broader public policy nature.”

Heads of regulatory bodies were able to relate contacts where discipline issues bordered on or crossed over into each other's jurisdictions. Referring to one such incident, the CEO of a professional regulatory body said, “in a collaborative way we and the College managed that issue because it had to do with concerns of our respective members. Fortunately we managed it in the way to ensure that we had a consistency of messages to

the public through the media and so on, and a consistency of messages to our respective members.”

Regulators also had frequent contact with the College when consulting on policy issues. A good example of the contacts between the College and the regulators that lead to healthier public policy is the Triplicate Prescription Programme. Mr. Ray Joubert⁹, Registrar of the Saskatchewan Pharmaceutical Association said, “We’ve been willing partners in the triplicate prescription program and we’ve willingly participated with the College in broader discussions on drug use management strategies aimed at, for example, enhancing prescribing practices, educating our respective members, and things of that nature... All the way to engaging in dialogue with the College on issues such as primary health care reform and other reforms of the health care system”.

Contacts with Colleges of Physicians and Surgeons of other provinces are also frequent. One newer Registrar reported, “Well, as you know I’m sort of new on this particular watch, so for me it’s been a matter of using Dennis in particular, but [also] other members of the secretariat... Bryan Salte and Karen Shaw... I get help both in understanding what kind of review on policy matters has occurred at the Saskatchewan College, and then what sort of sources of information they have used in reaching it. A specific example is the issue of physician profiling. They [the CPSS] were gracious enough to let us pretty much do a lock, stock and barrel on all of the background work that they’ve done. So that helped us a great deal. And my Council has seen that material and has also had the benefit thereof... A second area specifically, has to do with the kind of shared problem area that’s involved both some public policy types of discussions as well the Saskatchewan policy regarding disclosure of critical incidents has also inspired other Colleges”.

The contacts that the CPSS has with other Colleges vary. The Quebec College, for example, reported that contact may be too infrequent. This does not mean that contact is only with Colleges that are geographically close. For example the Colleges of Physicians and Surgeons of Nova Scotia and Ontario have had a great deal of contact with the CPSS.

The Registrar and Deputy Registrar of the Nova Scotia College have visited the CPSS and sat in on a two day Council meeting. Their President and Deputy Registrar have attended several CPSS annual meetings and educational seminars and the Registrar, Dr. Cameron Little¹⁰, was able to recall that they were symposia on medical error and prescribing of narcotics. “We wanted to try to see what the Saskatchewan College was doing with their annual meeting and the education symposium because it was attractive to us and we thought that it might be something that we might want to emulate here. In fact, this past June for the first time we teed off our annual meeting with an education symposium and it really worked very well and we really sort of patterned it after what we saw when we were in Saskatchewan.” Dr. Little added, “I have had numerous contacts with the Registrar over the years, both at our FMLAC annual meeting and at Medical Council of Canada and on various other both sub-committees of the MCC and various other meetings in the U.S. and other places. We’re always interested in finding out what’s happening in Saskatchewan”.

One registrar reported that other Colleges, “have relied heavily on Dr. Kendel’s input on the sorts of things that the Saskatchewan College has already done, to help them develop a more appropriate, modernistic and reasonable way of protecting the public, which is their primary responsibility... I think when you’re talking public policy you can’t ignore the fact

⁹ Mr. Joubert kindly gave his permission to be quoted directly.

¹⁰ Dr. Little kindly gave his permission to be quoted directly.

that all the licensing authorities across the country have similar requirements and that by assisting other licensing authorities to see the way to do things in a different and more appropriate fashion for the safety of the public, that that is a very important influence on public policy.”

Contacts with national organisations have been through members of the College, including its Councillors and employees who have sat on their governing boards. For example, Dr. Dale Dauphinée¹¹, Executive Director of the Medical Council of Canada especially acknowledged contacts with Dr. Dennis Kendel, “who has played various roles over the years.” By virtue of having one or two members of the College sitting on their Council and their Board, the MCC have been able to benefit from the input they received on a variety of issues.” The MCC has been able to help the College too, “primarily in the area of helping them with technical or assessment issues, and one or two cases on a credentialing issue.”

Government

The College has also had contact with the Department of Health regarding all issues related to standards and the development of a hospital classification system, and standards relating to such things as critical care and obstetrics.

The Department will soon be consulting the College “around our respective roles in developing and implementing standards for issues related to physician ethics, accountability and the bylaw piece”.

A senior member of the Department of Health’s contacts with the College concentrate around the areas of specific client concerns or in areas of policy pertaining to the quality of patient care. This public servant also refers client complaints about physicians back to the College. “We’ve been working on several areas that have to do, partially or wholly, with medical care and that’s when we contact the College for specific assistance in developing the policy and we would start by getting general information and we would circulate drafts of the policy and then we would finalize it with the College’s participation”.

Another public servant contacts the College regarding policy aimed at physician aspects of the health care system such as licensing and bylaw developments under the Medical Profession Act.

The contacts with the College were described as, “Innumerable” by another senior public servant. “We would always talk to them [the CPSS] on policy matters that relate to the regulation of physicians and often on policy matters relating to other professions as there is often an interface there between scope of practice. We would also talk to the College as one of the major bodies in the province that we can count on for general health policy, for example, in the Action Plan development, or the creation of the Quality Council”.

Others

Several subjects had a great deal of contact with the College that has not been directed towards Dr. Kendel. Physicians, District CEOs and representatives of Professional Associations in particular make great use of contacts with such people as Mr. Salte and Dr. Shaw.

¹¹ Dr. Dauphinee kindly gave his permission to be quoted directly.

Two of the subjects were consultants. These have had indirect contact with the College through Dr. Kendel. For example, Dr. Kendel was on the Board of HSURC for 6 years. During this time, the board was exceptionally well informed in regards to the College's point of view.

Policy Issues

Subjects were able to provide a variety of instances where the College provided information and / or resources that allowed other organisations to improve policy decision-making. All types of respondents, both within Saskatchewan and in other provinces were able to provide examples of issues that they had dealt with using support from the CPSS. Typical of the sort of examples given are:

- A physician resource plan for a rural centre
- Triplicate Prescription Programme
- Provincial Patient Safety Policy
- Provincial Critical Incident Review Policy
- development of a hospital classification system
- standards relating to critical care
- standards relating to obstetrics
- licensing and bylaw developments under the Medical Profession Act
- Development of the Quality Council
- Establishment and ongoing support of the Chief of Staff Association of Saskatchewan
- Council's governance model
- Primary Health Care Policy
- Perinatal mortality quality assurance programmes
- Assessment and licensing of international medical graduates
- National policies regarding licensure of underserved areas of need (MCC)
- interdistrict transfer process for critical care patients
- Fyke Report
- Code of Ethics adopted by other Provincial Colleges
- Approach of Saskatchewan Pharmaceutical Association to Internet Pharmacies
- Health Facility Licensing
- Itinerant surgery
- Release of appropriate information about physicians across jurisdictions
- Prescribing of Narcotics
- Recruitment and retention of medical staff
- Credentialling
- Health Region Quality Assurance Programmes

- The governments recent Action Plan
- Inter-jurisdictional regulation and licensing
- Medical Identification Number Canada (MINC)
- The new Hospital Classification System
- Withdrawal of Services / Job Action
- Medical Staff Bylaws
- Delegation of Nursing Functions in Primary Care Settings
- Quality of Care Co-ordinator Programme
- Policy allowing pharmacists to dispense emergency contraception without a prescription
- infection control
- Quality issues with regards to laboratory licensing
- Telehealth Policy
- Delegation of Nursing Function
- Disciplinary policy and procedures at the local (District) level.

While many respondents elaborated on the nature and quality of the support that was offered them by the College, the following are characteristic:

I think the College is an excellent resource. When I think about the challenge in terms of licensing midwives or podiatrists; in both instances the College has been helpful to us [the Department of Health] and to them. When the Pharmacy association looked at the dispensing of emergency contraception without a prescription, they were able to go to the College and have those discussions. The work the College has done with the SRNA and other nursing groups on transfer of function to support the work of nurse practitioners... The support of the College on those forward looking or progressive use of health providers has been exemplary.

A district CEO said, “When we set our CME standards for the district, we did not understand the different levels of credit. We were going to implement a credit base that was too severe”.

Several government officials brought up inter-district transfers and critical incidents review policy. Typical of these comments are the following two quotations:

Definitely the inter-district transfer. We have a critical care patient transfer process and we absolutely needed the College on that. The critical incident review process as well, the CPSS are regulatory agents with a role there so they absolutely needed to be at the table. All of the ones that I mentioned, the patient safety strategy, I mean they actually initiated that one; The critical incident review process policy that we subsequently incorporated that into the new regional health authority legislation... We've incorporated a requirement for notification into our RHA legislation. That was done through having the College at the table of the critical incident review process. That's the group that we used and certainly would have had an inferior policy without having the College at the table and we also had a legal sub-table with Bryan Salte at it. We definitely couldn't have moved the pieces in legislation and the policy that followed without having that consultation.

The first example that comes to mind is the critical incident review policy. That would not have been as good, as applicable, as implementable without the College involved. That's a key one. It's not a formal policy but it's a process. It's called the District Quality of Care coordinator initiative. Each district has a quality care coordinator and we don't have specific policies around it but I've always tried to keep the College involved in that process. They get invited to all of the provincial meetings of the quality of care coordinator. And every meeting so far that I've done; and that's over a year and a half, the College has, either Dr. Kendel or someone else, Ms. Wolan in particular, has participated. So I try and keep them involved in that because quality of care issues very much involve the College, in terms of at least being aware how they're being dealt with, the mechanisms, the options, and the College needs to have a voice if they want to make any comments that way.

The Roles of Dr. Kendel and his Staff

Interviewer: How would you describe Dr. Kendel's reputation among other registrars?

Respondent: Oh, I think it's very high. In fact, I would say that Dennis is arguably the most high profile and respected registrar in the country. That's my personal opinion. He's always willing to offer an opinion, and some people may not like that, but he always thinks about issues, he's very well versed not just in his job, in all sorts of other parts of medicine. He's maintained, although he doesn't practice, he's maintained knowledge about clinical medicine. He has been active outside of his capacity with other organizations, I understand, the Saskatchewan Blue Cross, and he's developed a relationship with the government and the department of health and health districts there. That's as good as any in the country probably, outside of Quebec or something. He's always willing to act as a moderator or a chair or, you know, things like that. He's well respected by the registrar's community. He's also courageous in the sense that he's willing to say things that perhaps, in certain groups, are not appreciated, but need to be said. I'm thinking about the medical societies or the CMA or whatever, he's willing to express those opinions even though he knows that they may not be those of the particular organizations he's addressing. He's courageous in that way.

Dennis is somebody I would call for advice. As a CEO I respect his opinion on things and that's because he's got a lot of experience and he maintains an active interest in what's going on everywhere.

Many of the subjects attributed the success of Policy E-4 to Dr. Kendel and his staff. "Take Dennis out of the mix and I am not sure the College could fulfill this mandate. Another CEO would have a problem." A senior government official said, "If the registrar changed tomorrow, we might continue to do what we are doing, but it would be an 'innocent until proven guilty' type of thing. Dennis as an individual has been very thoughtful and that makes him someone we would go to quite often".

Of course, this phenomenon is consistent with the College's governance model as the Registrar is charged with the responsibility of accomplishing Council's ends. It is not surprising the Registrar's personality and skills are associated with the Council end.

In the course of the Action Plan development, the College has been very helpful: Dennis in particular, was a member of one of the sub-committees and the reference group. Dennis always gave willingly and freely of his advice. In that instance, we asked people not to come specifically as representatives of their organizations. Having said that, the SMA and the SRNA were also at that table. We were trying to get people to not just act as an advocate for their organization, but rather to give us broader policy advice. Dennis is always a very honest broker in doing that. I really find that when you ask, "what does the College think of that" he will answer, but when you raise a more general health policy question, he will always give you a very thoughtful response. In that case he was very helpful in helping us craft what a Quality Council would look like. But also in dealing with the breadth of issue like should we have hospital designations, what sort of clarity would be useful. We brought to the reference group most of the major pieces of the action plan in advance and got some very useful advice.

Part of this attribution of the success of policy E-4 to Dr. Kendel comes from the extensive contact many of the respondents have had with him. Some questioned whether another Registrar might be as effective.

Depends on how one conceives of the College. If you conceive of the College in a fairly traditional historical role, it is supposed to be the disciplinary body that is mainly concerned with registration and quality assurance and so forth for physicians, you would have a narrower range of things you should consult on and, hence, a wider range of things you should not consult upon.

To me, as an institution per se, rather than who happens to be the Registrar at any given time, I guess I would say, it's a question to me on whether you would consult the College on things like health care funding, regions configurations, or whether or not there should be a new program. I am not sure as to whether you should consult the College on those things. But then again, **if the talent happens to be in the College, I would consult it on virtually anything**¹², and if it wasn't I wouldn't consult it in anything other than, perhaps on those things where the College had an official role that was so obvious and central that you would be making a mistake not to consult it.

Certainly Dr. Kendel's personal style and skill set has distinguished him in his ability to carry out Policy E-4.

I know that Dennis is frequently consulted by the Deputy Minister and the Minister and others in the government. Has also built very good bridges to the other disciplines, i.e. he is regarded as a remarkably open minded and exterritorial representative of physicians. He doesn't elicit a territorial 'stay away' reaction from the nurses, psych nurses, social workers, therapists and others. In many ways he's been a real unifier. Again I credit that significantly to Dennis. I am not saying that the College has not endorsed these approaches, but the Council is a very changeable beast. At some times it has been very progressive and interested in a more expansive role and at other times it retreats more narrowly and becomes less of a health public policy oriented body and sticks more to the knitting and is a little bit more of an interest group than a public interest group. Council is variable. Dennis is not in his perspective. Of course Council can always curtail or expand Dennis' agenda. I think he is a constant there and I think he has been a pretty prominent source of advice and council, both provincially and nationally. If you want the College to be a player in policy in the future, you might have to consider adding this, in a more formal way, to its mandate, perhaps within its legislation. These things ebb and flow. If you don't want it to ebb, you need to obligate the College to get into these areas.

¹² Emphasis added

Dennis has a very clear view of most issues. Sometimes, when I pass on the College's advice I am asked if I talked to Dennis about this. Sometimes people think that Dennis has an uncaring attitude or that he is someone who has absolute power. I personally don't believe Dennis works that way. I think he has a clear vision of which way we should go on an issue. I think that sometimes people have misconception that he is inflexible, but I find that if we have a disagreement we can usually talk it out without a problem.

The role of the CPSS in establishing and maintaining the Federation of Medical Licensing Authorities of Canada (FMLAC) was mentioned by most of the out-of-province respondents. One fellow Registrar said, "I'm aware that in the development of the national licensing organization federation the Saskatchewan College and Dr. Kendel have been very involved over the years, and in his term as President of course. But also in the way in which he is regarded by his fellow registrars as a very important person to other licensing authorities".

Well, I think that the role is very much personality-driven, as it is for a lot of the organizations. So, it's been a strong role in the sense that Dennis has been a strong player in the FMLAC, participated actively in the annual meetings, and in workshops and in various things that the FMLAC has had and Karen Shaw was a, when she was president of the College in Saskatchewan, was very active and now she has been a member of the executive for a couple of years and is president now, so I think that Saskatchewan has had a fairly high profile for the small provinces.

Well for sure, the fact that Karen Shaw has been sitting on the executive for two years is a major contribution to FMLAC at the executive level. The participation also of Dr. Kendall at all the meetings, and some of the general assemblies. Dennis is a high profile guy, and he has a lot of experience as a registrar. He can speak freely and loudly about some of the topics because he has a huge experience. That's a major contribution. Also, I remember that Saskatchewan College sends some of the public members and some of their council members to FMLAC meetings. We have, for the first year sent someone from the board and some public members

The Registrar's role at the national level is not restricted to FMLAC. One Registrar observed, "Certainly Dr. Kendel has had major input both at the medical council level and at the board of the federation. More recently, of course, he has had major input with regard to the Patient Safety Foundation. We've been aware across the country that he and the Saskatchewan College have been fairly instrumental in making your organisation one of the key players in Saskatchewan's approach to patient safety. And so your [College is] not just a follower but you're a true leader. I worked with him [Dr. Kendel] on one of the five subcommittees of Dr. Wade's Royal College programme over the past year and we put together a matching proposal. We sat on the committee for legislation and regulation. I know that the overall task force's general plan has been put out informally and has met with fairly wide approval."

One CEO of a regulatory body said, "The College is considered by me to be a primary resource. I use the College as a primary resource and when I say the College I would say

specifically Dennis Kendel. When I've got sensitive policy issues, I would consider Dennis one of the people I would consult when I need to seek a wise opinion on a health policy issue. We have consulted with the College of Physicians and Surgeons about everything from policy governance to primary health care to regulatory issues to health issue management. If I were to think of one specific example that would be helpful, one in terms of the area of issue management, I can think about the issue of the Regina Health District and when they were restructuring and closing out the Plains Health Centre and there were all sorts of issues in terms of unsafe patient care. There was everything from their electricity and backup in certain rooms to the fact that there were heavy pieces of construction falling and missing patient heads by mere fractions of inches. Dennis was, to me, just an expert on process and I would talk with him about handling of issues of concerns that were very much public interest in terms of moving from that of the very micro issue up to the macro.

Another regulatory body respondent said, "I think of Dennis as being one of the key partners that [we] worked with in developing an initial paper on primary health care. This working group of three or four people grew to what is now still a very viable working committee on primary health care.

I find that having gone back over twenty-five years of experience with them that the responsiveness has increased remarkably in my opinion over the last ten years. I've noticed a very much-improved responsiveness from the College. I think it may be Dennis' personal style and his very aggressive approach to respond to complaints. I can only conclude that he has the support of the Council and the College and that's a culture change that has occurred in the last ten or fifteen years. I can remember way back over twenty years ago and I felt very uneasy taking things to the College. But now I pick up the phone or send an email or write a letter and they give response right away, and clearly if they feel it's something that isn't solely their area of concern that's pointed out. If they feel we should be consulting legal council they say so. I do run into others who maybe don't have that good of a working relationship with the College and I'm always surprised at that. So I don't know whether it's personal or just a cultural change that has taken place gradually but quite significantly over the past decade or so.

Finally, respondents commented on the willingness and speed with which Dr. Kendel and his staff respond to their needs. One respondent noted, "Oh, Dennis is very quick to get back. I don't know if I've ever called him when I haven't been able to get through, but next time he's in the office he'll call back. He once helped in a sort of retreat that we had and he promised that he would put something down in writing and I was surprised that within a week he had the seven or eight page summary, and I thought that might take a month or so. So, they're very responsive. Anytime I've spoken to Bryan or e-mailed Bryan, again within a matter of hours or days you get a response from him". Another said, "We have always had the support we needed. Bryan Salte has worked closely with our legal council and has developed strategies for the other Colleges and FMLAC on developing protocols for the sharing of information".

Although Dr Kendel was often referred to as an important agent of Policy E-4, several subjects remembered consulting with his predecessor as a similar important policy agent. "Dennis' predecessor (Allan Thompson) provided me with info when I was deputy minister that was credible and in the public interest."

Policy E-4 Itself

Comments on the policy were divided into two types. The first were concerned with Council's efforts to evaluate the College's performance and the second were concerned with the appropriateness of Council setting an end concerned with health policy beyond the CPSS' traditional mandate.

Several subjects found it both interesting and laudable that Council has such a policy as E-4 and that it evaluates its performance. "For a closing comment I'd say I'm very pleased that the College does that [evaluates its policies]. They go the extra step to evaluate their work and it's actually a good example of where probably the Department [of Health] could learn from what the College is doing, once again." Another noted, "The College is a very important body and I respect them for what they are doing here which is doing an evaluation in a formal way".

The head of a regulatory body wanted to know the difference between Council's notion of 'health policy' and 'healthy public policy'. "When I looked at this [policy], I saw the header as healthy public policy and then I... looked particularly at number two, that governments consult with the College as a primary resource when forming health policy... Well, it's not health policy per se, it's public policy. I'd love to see [Council's] interpretation of healthy public policy because we're not talking only health policy here, it's public policy. It's everything from speed limits to blood alcohol to whether you subsidize milk throughout the whole province. It's about highway decision making. It's about housing. When any public policy is being made from the feds on down to the most minimal level, it looks at whether this is going to have a positive impact on the health of the society. Healthy Public Policy is often in areas that may not be health, it may be schools, it may be burning crops, it may be anything."

One consultant questioned whether the E-4 policy itself was appropriate. "The notion that governments consult the College as a primary resource when forming health policy is not appropriate because of the word primary. The mandate of the College is to ensure the competence and quality of physicians practicing medicine – not health policy itself." However, this consultant was quick to state. "Given the policy as it is stated, is the College fulfilling the mandate? Yes they are! The CPSS clearly understands its duty is to represent the total public and to be a resource for overall public policy in Saskatchewan. They do a good job by setting their prejudices and biases towards the profession aside. Most professional Colleges do nothing more than protect the interests of the membership. The CPSS separates themselves from that better than any other professional body I have seen. They are competent and credible, government DOES consult with them."

The Saskatchewan Medical Association had concerns that the College should strictly adhere to its traditional "LSD" role, i.e. Licensing, Standards and Discipline. Its position was that policy E-4 should be discarded. (See Appendix A)

The Patients' Rights Association of Saskatchewan did not regard the College as being a good resource. Their criticisms were wide ranging and are detailed in Appendix B.

Some respondents recognised the tension between the role of the CPSS and the SMA and expressed the need for both to be involved in policy matters:

“People sometimes misunderstand the role of the College and SMA. There are a number of times we want to make policy decisions based on the care of the patient, and not on the perceived needs of the physician, but you must be cognizant of why the physician is going where he is going. I think it is necessary for the College to be able to take an objective view of the physician's needs and the physician's capabilities”.

CPSS as a Primary Resource When Forming Health Policy

There was a strong consensus among respondents that the CPSS is an important resource when forming health policy. These sentiments were applicable whether directed at health policy at the national, provincial or regional level.

I think certainly the College is a very valuable resource to the policy development and management of our health system in many ways. There's no doubt that they're one of the primary agencies that we [the government] would consult with.

I think the reputation seen from the outside is that the Saskatchewan College is a good one. It's a high profile one, and is well recognized in the field of medical regulation. For example, if I have a problem, I will have no problem to call somebody from your College, Dennis or any... other person that could help me and will be in my confidence.

Policy input with various parts of the Saskatchewan Department of Health have been valued and varied. Recent contacts have involved such diverse policy issues as the licensing of podiatric surgeons and other services in the province such as bone densitometry, laboratory licensing and information technology. The establishment of a patient safety strategy for the province (as is reported earlier) has caught the attention of other Colleges. One senior Department representative said that the College has furthered public policy regarding patient safety in a number of ways. “The College probably took a lead in prompting us to go broader than we were going to in terms of patient safety. We had involved the College in a group that was reviewing our critical incident review process, how it's reviewed by government, by health authorities, and by the College, and agreeing on how those pieces fit and who has what responsibility. Through medical council, where the College is a member, Dr. Kendel had brought forward that the critical incident review process was working well, but that we should be looking at something more broadly. So we also undertook a sort of a forum across the province, an invited forum where we brought a number of agencies and individuals together to agree on priority areas for patient safety and then brought that group back to the critical incident review process. Dr. Kendel is on the review process committee. We're using [the committee] as a kind of steering group until such time as our Quality Council is up and running”.

“Certainly we worked with the College on individual critical incidents. We also worked with the College on our policies around how we can respond to critical incidents and create an environment where we learn from mistakes and we can develop a broader patient safety strategy. This will identify one of the top areas that we can focus on to improve patient safety: to reduce medical error. Another contact we have had directly with the College to improve patient safety was establishing the Chief of Staff Association as a physician leadership group and a group for mentoring physicians in their leadership roles in the district. The College was instrumental in helping to sponsor getting an organization like that. I’m not aware that any other provincial governments across the country actually actively trying to develop physician leadership there. As we look at forming into bigger regions the College has flagging issues around physician leadership and how, as we restructure we can have that physician leadership at the right level in the region.”

One senior public servant indicated that the range of issues on which the government consults the College as a policy resource ranges very broadly. For example, “The area of quality in the health care system. Things like the overall public versus private involvement and management of the health sector. Health facility licensing, private MRI clinics, work done by pharmacies and the pharmaceutical sector that begin to infringe on the public health system and quality issues with regards to services provided by districts. The most direct one would have been setting up standards related to how we would manage, look at and evaluate whether we would move into private clinics and the assessment of individual submissions for private clinics in the province. The most recent example is the MRI private clinic application – setting up a process to determine the evaluation process that involves the College. They were active in setting that up for us.”

The CPSS’ involvement in the formation of provincial health policy is seen quite broadly. One government official defined appropriate areas of involvement as, “Anything that relates to how doctors relate to the health care system. So we would consult with them on issues like primary health reform, most things to do with acute care. Typically, where there is a quality of care concern or a quality issue we are dealing with in acute care facilities where physicians are, obviously, key players, we would consult with the College. So, anywhere we are dealing with a systemic or even an individual issue that deals with the practice of medicine in the province and its impact on quality.”

Districts also used the College as a primary resource in setting health policy. One CEO said, “From our past experience, on the side of quality assurance, utilization management, best practices, even advice on the medical staff bylaws, regulations and the implications or applications of those [the College] has been quite valuable to us. [Also] in regard to the interpretation and application of the Medical Profession Act as it applies to the development of local policies or the interpretation of provincial legislation and policies, I’ve found them to be very responsible. I was always impressed with the speed at which they could respond. Very prompt, very attentive to inquiries. In fact, I’ve just been literally amazed at times to send them a complex problem to them in writing or by email and to virtually get a response the next day or following day. So they’re not only well informed and responsive but they’re very prompt in what they do and often that’s very important when you’re dealing with these tough policies, interpretation issues and standard (indiscernible) some of that type of advice.”

The influence of the College also works in an indirect manner. When asked if there were circumstances where it would be inappropriate for a regulator to consult with the College on policy matters, the following dialogue resulted:

Respondent: One example I can think of is we just recently made malpractice insurance explicitly mandatory for [our members], and although that would have some impact directly on physicians and indirect impact on the public at large, we viewed it primarily as a domestic matter and didn't see the need to consult the CPSS

Interviewer: That's interesting because, of course, the College recently made insurance mandatory for their members as well. So you didn't consult with them on how the College went about doing it to see if you could learn from them a lesson?

Respondent: Come to think of it, we did. Come to think of it, we did.

Interviewer: So in fact...

Respondent: It came to us by a circuitous route, it came to us via policy planning branch of Saskatchewan Health who shared with us some information [from the CPSS] that, I think, they obtained permission from the College to release.

In summary, the College is seen as a credible, competent and reliable primary resource for policy makers. As one senior government official said:

We are blessed in this province by having a College that is strong and very public service minded which is what the College is supposed to be. I think that, if it didn't have that approach, there would be issues that we would not feel obliged to consult with the College that we now do because this College has taken such a broad approach. I think there are Colleges across the country that are fairly narrow, in terms of regulating physicians only, and even that, I might say, not always in the public interest, or not obviously in the public interest. I think that with that kind of approach we would not feel that we would include the College in such breadth of consultation. We would always include them in physician issues, but the system-mindedness of the College and their ability to think system-wide, in particular Dennis, has meant that we consult them on a broader range of issues.

CPSS as a Resource for the Public

As anticipated, this study was not particularly effective at evaluating whether the College is a competent, credible resource for the public, since only one of the respondents could be categorised as representing a patient group. (See Appendix B.) Nonetheless, a number of respondents were able to comment on this mandate. Several reported that they have referred patients to the College for information or in cases where there was dissatisfaction with a physician interaction. "To my knowledge the College have never ever failed to respond to such a complaint. And they always include us in their resources and corresponded back." One physician reported that he, himself, has provided his dissatisfied patients with the College's telephone number. Others have reported that the College provides a resource to the public through its media activities and its education sessions associated with the annual meetings and

One Registrar pointed to the, "anti-circumcision lobby [which] has used Dennis' letters on the subject. I'm actually asking my executives to look at his letter and decide whether or not they wish to have our College doing that kind of thing.

A government official noted that most correspondence s/he sees, “are critical of the College. These people are unhappy because the College is doing its job. I think the general public does not have a good understanding of the role of the College”.

Several respondents noted the transparent activities of the College from open Council meetings and administrative tribunals to its widely published 1-800 number. “Dr. Shaw, I know, and Dr. Kendel are open to talking about a concern with a person and establishing, what approach would be best dealing with that concern”.

There were a few criticisms regarding the CPSS’ activities as a public resource. One respondent commented that the College insists that the public put complaints in writing. “I think the fact that people can call in is great. Now, after they call in, though, they’re asked to put it in writing, as far as I know. I would say I would have preferred that people don’t have to put their concerns in writing. That the College could take a verbal consent and document it through the information provided over the phone, and perhaps [the College could] write a letter confirming what they see as the issue and they’ll actually take the initiative because some people won’t go as far as putting concerns into writing”.

CPSS as a Competent, Reliable Resource for Agencies

Many respondents were eager to provide examples of how the College is a competent and reliable resource for health care agencies. The support that the CPSS offers agencies ranges from policy support to advice regarding management policy. It is remarkable that the College of a relatively small province has had such an impact on the rest of Canada.

Regulators

The Registrar of a regulatory body remarked, “We have talked with the College on a number of issues, like policy governance, what we believe in terms of palliative care, what we believe in terms of things like pronouncement of death, pharmaceutical and physician collaboration, nurse functioning, pre-natal mortality. In all of that, the College has been an incredible resource.”

Another said, “the College is considered by me to be a primary resource. Specifically Dennis - if I have got sensitive policy issues. He gives me a wise opinion. We have consulted about everything from health issues to management to policy governance.”

A third related, “The most recent example, and it’s a fairly glaring one, is with respect to internet pharmacies and physicians basically autographing prescriptions for ordinary citizens which would legalize the prescription for the pharmacist to fill. The College, through Dennis Kendall and Bryan Salte have prepared quite an extensive discussion which they shared with us, and because we knew the direction the College was following, it was quite easy for us to develop a policy on how to regulate, if you want to characterize it that way, pharmacies that set up an internet mail-order type service. So, that’s a long way of saying that because of some very extensive work that the College had done, we were able to ensure that our policy was compatible with the College’s policy”.

The Registrar of another College of Physicians and Surgeons remarked, “We have reviewed your College’s policy on itinerant surgery and we incorporated a lot of it and we thought a lot about it when we are putting, trying to develop a policy about itinerant surgery

in [our province], and that is in the process. It has gone through its first iteration with our Council and we'll be coming back this fall with hopefully a final. We circulated it to various stakeholders in the province to get their feedback and this fall we'll probably come out with a policy on itinerant surgery for example. We've looked at the Saskatchewan College's council policies, looking at policy governance though our council hasn't formally gone to a policy governance model. We've been interested in the recent policy [the CPSS] have on reporting error or medical mistake or patient injury, and we'd like to look into that in the future. I guess those are the critical incidents policies”.

Another provincial Registrar remarked particularly on legal issues, “Because Mr. Salte has been quite involved with the various licensing authorities’ legal council groups. I know that my present legal council and [Mr. Salte] had talked about a number of legal issues both in developing policies and also looking at approaches that different licensing authorities take to various issues. Particularly, the really important one is how to work out a policy and a plan for the release of appropriate information about physicians across jurisdictions, because that’s a great concern to all the licensing authorities - that there be an adequate interchange of information about physicians... initially if they are licensed in more than one jurisdiction but also if they move from one to the other and somehow serious concerns are not transmitted as appropriately with that movement. The Saskatchewan College got involved in that, got interested in that and we will try to promote some sort of common approach on that.”

Other Agencies

A District CEO reported, “We had an extremely difficult physician to work with and Dr. Kendel arranged a meeting with that physician and then arranged a meeting between that physician and myself, with Dr Kendel in attendance. He acted as a resource, a mediator, so to speak, and he resolved the issue. We had [another] instance where we were doing a Physician Resource plan. That plan’s interpretation by the Board was much different from the interpretation by the [name deleted] Medical Group. It related to physician solo practices versus the group practice issue. It got into a very heated debate, and it got into a very public debate, and so the Dr. Kendel attended a meeting with us. And did an excellent job of educating the public in regards to why we had set the policy that we set.”

The President of a physician organisation said, “Dennis was responsible for establishing [our organisation] and got dollars from Sask Health to get it going. Dennis is a constant source of info on any subject at any time. He is learned, up to date, and knowledgeable. I respect his opinion. Dennis is tireless. I never have to ask Dennis to do something or get information twice.”

The President of a national physician organisation said. “We are very interested in what they [the CPSS] think of things we are doing. For example, when we were thinking of increasing the frequency of our examinations to facilitate people being able to take them more flexibly, especially for underserved areas of need; they have offered advice and opinion which has been helpful in developing these policies. Ironically, we always seem to have too many people from Saskatchewan on our board. [laughs] They have been strong contributors in the years I’ve been here. We have had two presidents from Saskatchewan in the short time I’ve been here. The College has played other major roles. For example, we had a major retreat of our board ten days ago and Dennis was the facilitator for them. So the individual contributions of those who have taken leadership positions from the College, without exception I would only give the highest compliments to them.”

The College as a Policy Broker

Some health policy matters require the cooperation of, and changes by, several players. The CPSS has been credited with providing a broker role. Several government officials mentioned the interdistrict transfer process. “We’ve been having some issues around transfer of critical care patients, primarily heart patient into the tertiary center. And some issues around where they were held in some regional hospitals while waiting for beds in the tertiary centre. And our tertiary centres not functioning as districts so there’d be a bed at one of the hospitals but not at the one that the physician preferred access to and that communications process at times held up the transfer to the disadvantage of the patient. Now, having said that there’s a whole bunch of system issues involved there as well as the communication piece. Certainly the College has been actively involved in our interdistrict transfer steering committee in developing a policy around critical care patient transfer, which we did develop and issue to all of the districts. Our latest iteration is that group has stayed together even with that policy, and to look at physician accountability and responsibility. Physicians working within the system at various sites – the referring site and the receiving site and to be quite clear about that now. The College is both active in input and developing those policies. Plus, in clarifying the physician role then communicating that to physicians broadly, even in advance of the policy. Certainly the College is very prompt in taking on their role and communicating it broadly and helping understand the issues that are contributing to the times when the system doesn’t function.”

Others mentioned, “The critical incident review policy for the province. Dr. Dennis Kendel is a member on the critical incident review process working group. That’s a provincial working group that’s looking at patient safety and the applicable public policy around that. As a representative on the committee but also in between meetings and on an ongoing basis Dr. Kendel or others in the College provide us with specific resources that might be articulated. Dr. Kendel regularly provides relevant references on the topic, but he also provides feedback in terms of the terminology used, the processes developed and how he might be best reflecting the interest of physicians in the College. He speaks from a medical perspective and so I don’t think I’ve ever heard him say that he’s changing hats. I think he’s speaking in terms of what’s best for client care through physicians. “

The College also provides support for individual Saskatchewan agencies. One physician remarked, “One of the areas we have had a lot of help from the College locally, is in dealing with Chief of Staff issues. In particular help with narcotic prescribing. There had been a lot of information passed by the College on this. The College has been a really big public policy leader in the areas of promoting good practices such as prescription of narcotics for non-malignant pain. The College has lead the whole area of the appropriate use of narcotics in the province.”

A further example of everyday support that is not necessarily policy oriented is this remark by a physician. “I can think of instances during the first month I was Chief of Staff. I had a physician who had been losing his memory. It was a very difficult thing, but with Dennis’ help we were able to have we were able to have a neuropsychiatric assessment done which showed he was definitely developing Alzheimer’s. We were able to convince him to withdraw from the practice of medicine.

Agencies indicated they had received support or advice from the College for many diverse circumstances. A few examples are:

- Interpretation of medical staff bylaws and regulations,

- Procedures regarding clinical practice,
- Prescribing practice
- Quality assurance in respect to both medical and other areas,
- Analysis of strategic environment trends
- Physician recruitment and relationship issues
- 'Critical incidents'
- Utilization management,
- Best practice approaches

Usually if we sought an opinion from the College, it was very well based, very well founded and referenced in not only historical terms but legal and best practice terms, the College obviously has access to and is privy to national and international trends and opinions and I found those to be particularly valuable in the sense that we have the ability to access that information and it's sort of like a one-stop call. If we talk to Dennis or to Bryan and they were able to cite very well found substantive information on what we needed, and indeed on occasion they came to the district personally.

It is important for our District to consult with the College before making new policy!! They have a different view of the world than the Department of Health or the SMA or our own Board. They are an expert source to us.

When it comes to making policy regarding physician services and good medical services to the patient, they have the highest benchmark and we would rather achieve the highest benchmark than a negotiated middle ground.

Our whole initiative around allowing the pharmacist to dispense prescription drugs without a prescription would have been inferior had it not been for some consultation and direct intervention by the College of physicians and surgeons. Wrapped in that is an initiative to make emergency contraception more readily accessible to the public. Had we not consulted with them, and had they not intervened, I think that we would have a far different, perhaps, I'm convinced an inferior policy or approach to our initiative.

Formal versus Informal Consultation

Many subjects reported that the relationship between their organisations and the College takes place at a formal as well as informal level. The government, other regulators, other Colleges and districts often formally request the College's information and resources that allow them to form policy but more frequently these exchanges occur at an informal level. According to a Registrar from another province, this informal interaction "may be done on a direct manager to manager basis. For example, when I was the Assistant Registrar I was responsible for prescribing practices. I frequently spoke with Dr. Kendel and with Dr. Loewen on policy issues."

One regulator stated, "There is a difference between formal and informal consultation. I wouldn't hesitate to pick up the phone and contact one of the officials at the College for an opinion on almost any matter that is related to health."

Another Registrar said, "I talk frequently to both Dennis and Bryan about [Saskatchewan's] qualifications and conditional registration and how long you'll keep people or the way in which you can do certain things with certain people and what do you do about rural specialists and all those things because geographically and numerically we are so similar".

Sometimes informal consultation can lead to inter-organisational cooperation:

[Informal consultation is] not uncommon. Not necessarily off the record but I didn't want to formalize the inquiry and just seek some collegial advice at times. What do you think if we did it this way, or what about the implications, or is there anyone else we should consult with... and because of the small 'p' political implications in our relationships here we often phone and just say, 'what do you think, does that make sense'. and they were often able to give us an opinion that I found very helpful. I expect that maybe that's not uncommon, where if you develop a good working relationship with an organization like the College or the SMA and even sometimes you get a very good, personal reaction. Say Briane Scharfstein, for example said, 'Well I could never say this to the members but between you and me this is the way I would do it' and the Dennis would do the same thing. So I find that maybe it depends on the personal working relationship one has and because by and large we've had a very positive working relationship with the College. Frankly I've felt very comfortable talking especially to Dennis and Bryan [Salte] and I know my colleagues here in the office have felt the same. Where the uneasiness comes in is I've often run into problems with the district medical society, the president of the medical staff, who would often resent having found out that we consulted with the College. There definitely is a demarcation there and a sense of why in the hell did you take this outside the district, this is our business, why do we have to air our linen out there, that other venue. But that was our call to make and we've never hesitated in doing that and indeed more recently we've taken some issues directly to the College, over and above the medical organization.

- a District CEO

Opportunities for Further Consultation

Some respondents expressed a desire to expand their use of the CPSS as a policy resource beyond their existing relationships. Typical of these comments is this one from the CEO of another regulatory body:

I think that it's important for [our organisation] to consult with the College on everything from health district or even agency consultations that we become involved in right through to macro policy on what does primary health care mean. I think it's important that we consult with the College on a regular ongoing basis and vice-versa. I think that we are both key resources and I think we have an onus to demonstrate leadership in healthy public policy.

Several respondents expressed a desire to continue dialogue on issues that cross provincial boundaries such as telemedicine, the medical identification number Canada (MINC) project, peer assessment programmes, the withdrawal of physician services, and the common treatment of International Medical Graduates. One Registrar noted as an issue, "The whole area of qualifications and assessment because none of us has the resources to handle it. So policies where we need to work together to try and get a national perspective are crucial, especially if we have any hopes of involving the federal government to provide money. But also policies on the same sorts of things where the provinces are the primary funders". This theme of inter-provincial dialogue often was directed at several provinces 're-inventing the wheel' and a need to avoid duplication of effort was stressed.

I'm constantly being told that Alberta does this or that Saskatchewan does this or vice versa and I think that they have the same things being thrown at them by their people. Prescribing practice is another one. There are a number of those kinds of things where a standard policy would be extremely helpful. And I think that is of tremendous importance. I've already mentioned the release of information, which should be national. Standards of practice is a little more interesting actually, because in terms of policy making I'm not quite sure it's the same way. Again, the interchange of what each province has in the way of a guidelines program, for example, sharing and getting that information together is important. I know that Dennis has also been very strong in promoting cooperation within the Medical Council. Something that's happening right now which is a plan that Dr. Dauphinee has funded to look at a credential verification system on one hand and a physician remediation program on the other. Both areas the Medical Council has some clinical expertise in dealing with and which the licensing authorities have a tremendous interest in. We should try to get some sort of feeling across the country for what we could use that all of us would be satisfied with and therefore could exchange information on more easily.

Within the province, respondents expressed a desire for even more College involvement in, "All issues related to physician ethics or accountability and physician leadership within health regions". One CEO recognised that the College was becoming less involved with credentialing than in the past, but hoped the College might establish, "policies and guidelines for credentialing. The College may back out of credentialing for regions, but they could help develop a standardised process for the regions that MACs or credentialing committees could use". This sentiment was echoed by several government officials.

Some respondents felt that the College should become more publicly vocal on policy issues. "I would love to see the College more visible in some of the more public arenas like the TV, the radio... doing the healthy public policy stuff... , for us to take a real leader role and jointly approach the provincial government to ban smoking in public places or to jointly approach the provincial government to [comment on] safe water."

One respondent suggested that the College should, "be looking more at quality and outcomes around practice. For example, an orthopaedic surgeon may be very qualified and may do high quality hip replacements, but do they all need to be done? The College should be more involved in that sort of quality monitoring and policy making."

Sub-theme: Common Code of Ethics

Many of the out-of-province respondents brought up the need for all provinces to have a common code of ethics. These comments were so common and similar that they represent their own sub-theme. Typical of these remarks is, "I think that ultimately we don't have a code of conduct. We have adopted the CMA's code of ethics, but I think in the future the Colleges should put together some form of unified code of conduct or something to that effect, that expands the CMA's code of ethics in areas that they don't deal with that we deal with on a more regular basis, or annotate our interpretation of the code of ethics."

Appropriate Boundaries for CPSS Policy Activities

Most respondents did not believe there were areas in which the CPSS should remain uninvolved. The Saskatchewan Medical Association and the Patient Rights Association of Saskatchewan both believe that the College exceeds its mandate when it gets involved in policy issues (See Appendices).

One respondent stated, "It is not appropriate to consult on issues as to what specific programmes and services ought to be available in the province or in specific areas of the province. Further, the CPSS does not have the mandate to comment on the quality of health services in Saskatchewan, although they sometimes do. It is not satisfactory just to consult if there is a need for a specific program in P.A. You get their opinion because you respect them to give a public interest opinion. It is their mandate to determine that a physician who comes to PA to be in the program is competent to do so. Take a diabetic program in Shaunaven... The College would not have the data to determine, from an epidemiological perspective, whether you need that program, but they could ensure that an endocrinologist moves there to treat diabetes, he is qualified. Certainly their advice is worth more than that of the SMA whose mission includes, among other things, the quality of medical care, but who do nothing about that and, instead, devote all their efforts to advocating for physicians."

Several respondents drew a line between the union functions which are the responsibility of the SMA and the quality and public interest functions which are the mandate of the College. "I think it would be inappropriate in areas pertaining to what I call the social and economic welfare of the membership, ie the union, SMA type things."

Disciplinary issues involving another regulator or another College were mentioned as areas where the College should not intervene, at least formally. "I wouldn't presume, for example, to tell the College in Saskatchewan how it should discipline physicians in Lloydminster who are registered in Saskatchewan. [But] we can seek informally to figure out how we can keep each other on the same page in the handbook as far as handling situations".

Other government officials disagreed, one government official suggested that the boundary might occur at the point where decisions are made whether or not a, "service should be incorporated within the public health system. Midwifery services or podiatric surgery services for example. [The College's role is to determine the quality. When it becomes a decision to whether the government will fund that service or how they will pay for that service, those kinds of decisions would be outside the realm of the College's responsibility".

Few other respondents wished to see the College restrict its activities. One CEO said, “I know that sometimes we have taken physician conduct to the College, and I know that that’s really an SMA thing; something that should be taken to their union. But yet, the College has such a clear picture on ethical issues that we end up going to the College just to make sure that we think we’re doing the right thing. They either support us or give us a change in direction”.

Several respondents noted that the College itself would refer them to the SMA rather than venture into grey areas.

I’ve found that when I did raise a complex question, for example with Dr. Kendel or Bryan Salte, and if it sort of spilled over into the rights and privileges of the physician, for example, that they were not reluctant to refer the matter to the SMA and to say this is probably an issue that not only you might want to talk to us about but you should consult with the SMA and we’d be happy to facilitate that. So it was a bit tougher to deal with the SMA because of their narrow interpretation of things. They were often looking at the self-serving implications as opposed to the broad policy implications that we get from the College. But I really like that Dennis in particular often said we should talk to Dr. Scharfstein about that and he’d be happy to talk to Briane and maybe we can get back to you jointly on it. Frankly I found them to be very helpful and open about that and responsive in the sense that it wasn’t, “Why don’t you talk to Briane and that’s your problem!” They were very willing to assist us and often he’d make the call and break the ice with Briane on that basis.

Conclusions

The range of circumstance for which governments and health care agencies contact the College for policy and other forms of support are impressively broad. Most respondents reported that the College has proven a valuable, competent, credible and primary resource for policy decision making. Respondents reported no hesitation to consult with the College on a broad variety of issues and consider the input of the College to be credible, timely and highly desirable.

The Registrar and his staff are highly regarded on the District, Provincial and National levels. Some respondents regarded Dr. Kendel as being key to the reputation of the College as a resource and this is consistent with Council governance. Several respondents remembered Dr. Kendel’s predecessor and saw Dr. Kendel as continuing the tradition of the College.

As expected, the study was unable to come to any firm conclusions about whether the public sees the College as a competent, credible resource as only one consumer group was consulted. Several respondents other than PRAS were, however, able to give some insight into this issue and reports were very positive.

Two notable exceptions to the very positive findings were the PRAS which does not see the College as a credible resource for the public and the Saskatchewan Medical Association which is suspicious of the College’s intent and believes the College too often strays into its own jurisdiction. More information is available in the appendices to this report.

Opportunities for further involvement at a resource for the public, governments and health agencies were; involvement in developing a common Code of Ethics for medical regulatory bodies, the development of inter-provincial standards and systems, increased media activities and common standards for credentialing of physicians.

Several respondents saw some policy boundaries which the College should not cross. These dealt with the working conditions and remuneration of physicians, whether programmes ought to be publicly funded or not, and disciplinary functions of other jurisdictions. There was not consensus on these issues, however, and most respondents did not see any issue as being strictly 'off limits'.

Conclusion: The College is highly regarded as a credible, competent, reliable and primary resource to governments and health care agencies in their efforts to deal with policy.

Appendix A

The Position of the SMA

Before agreeing to the interview, Dr. Briane Scharfstein consulted with his board of directors and they agreed, as a group, what sort of message to communicate to the CPSS Council. This appendix has been shared with Dr. Scharfstein in advance of publication, so as to be sure it is an accurate reflection of the SMA's opinion.

Dr. Scharfstein acknowledged that there exists a fair degree of direct phone contact between the staffs of both organizations and between him, personally, and Dr. Kendel. The two organizations also exchange communications between various committees. While the College provides the SMA with information letters, the SMA does not send info or minutes to the College. Dr. Scharfstein admitted that there is a feeling that the sharing of information will lead to it being used against them by the College.

Dr. Scharfstein reported that much of the information the SMA gets from the College allows for useful policy discussions at the Board level, if not for policy making. When asked for an example of a situation where, if the SMA had not consulted with the College, it would have adopted or implemented an inferior policy, Dr. Scharfstein pointed at the Transfer of Records policy and the policy on after-hours coverage. "We don't always agree of course, but I think the dialogue and interaction has always been helpful. I actually can't think of an example where the College was unwilling or unable to provide the appropriate resources to respond to an inquiry. Our only concern is that sometimes we are not asked to provide observation input to issues or items that would be of interest or concern to us. For example, when the College is doing the drafting of new bylaws or regulations we would like to have earlier and more frequent dialogue to be able to influence the decisions more than we perhaps have in the past." Another example is the adoption by Council of a policy on professionalism from the American College of Physicians. The CMA is currently developing its own policy and the SMA would have preferred that Council wait for a Canadian policy. Dr. Scharfstein said that there is the opportunity to make better decisions with the input of the College in areas such as governance, bylaws and licensure.

The SMA believes it is important for it to consult with the College on anything that overlaps with the College's "natural jurisdiction of licensing and regulation." Dr. Scharfstein indicated that physician billings and payment issues and working conditions were not areas where it is important to consult. Dr. Scharfstein emphasized the difference between advocacy roles, in which there is some overlap, and bargaining of payments and working conditions which is, and should be, the domain of the SMA. It is the SMA's place to make those policies but some degree of consultation may still be appropriate.

Dr. Scharfstein described the working relationship between the two organizations as "less than ideal". He believes that the SMA and the College both desire similar policy outcomes but that the relationship between the two organisations needs a lot of work if improvement is to be seen. Dr. Scharfstein reports that it is his Board's perception that Dr. Kendel has

significant influence over what the College does and says and that many of the differences between the SMA and CPSS are related to actions or opinions expressed by Dr. Kendel and not by the Council.

When asked how important it is for the SMA to consult with the College before making new policy, Dr. Scharfstein stated that it is very important in areas where the jurisdiction of the two organisations overlaps and that, "We don't do that enough. We don't share enough information as to the SMA's activities." Dr Scharfstein reported that one reason why the SMA does not share information with the CPSS is, "Because we don't have confidence that it won't be misused or mistreated, i.e. used against the SMA or physicians in general, or circulated beyond the College to others and / or the media."

In counterpoint, Dr. Scharfstein said that inadequate consultation has led to the SMA and the College adopting policies which are sometimes diametrically opposed to each other. As an example, he mentioned the policies on podiatric surgery. He felt that it would have been useful for the SMA and the College to have had a greater exchange of information. With adequate discussion, he believes that the Council and Board would have reached a consensus decision that the SMA, "could have lived with". Dr. Scharfstein stated that Dr. Kendel had recently provided the SMA with information that, if it had received earlier, would have tempered the Board's reaction against licensing podiatrists. He added that the SMA has information which, had it been shared with Council might have reduced Council's enthusiasm.

When asked to describe a situation he was familiar with where members of the public used the college as a credible resource, Dr. Scharfstein said he often referred calls from the public on standards of practice and licensure to the College.

Dr. Scharfstein noted that, as a generic question on whether the College is a good resource to the public, the answer would be yes. However, the degree to which the College is a good resource to the government on health policy is excessive. The issue is not whether the College does enough, but whether it does too much. The SMA Board believes that the College has gone beyond its mandate by adopting policy E-4. The mandate of the College is better restricted to areas ensuring good quality physicians and medical care. This applies in particular to the Government and health regions, and especially as to issues pertaining to scarce resource management. The perception of the SMA is that Council is spending an inordinate amount of time assisting and attempting to influence the Government in great detail as it develops and implements health policy. These activities that are beyond the mandate of the College constitute one of the predominant reasons why the SMA is reluctant to share information with the College. The SMA assumes that providing information to Council is the same as giving it to the Government of health regions. Dr. Scharfstein noted the close alignment between the College and districts outside of the area of the quality of care provided by physicians. Notably, the College strays into the area of physicians' working conditions. In fact, the close alignment between the College and the Government's agenda regarding health system reform and resource management is the main area of conflict between the SMA and the College.

During the College's 1991 strategic planning exercise, the SMA told college it was moving into inappropriate areas. The SMA still holds the same concerns.

Appendix B

Natie Austin, President of the Patients' Rights Association of Saskatchewan (PRAS)

Summary of Interview

Mrs. Austin was interviewed on August 14th, 2002, by telephone. A tape recording was made of the interview and her permission was given to share her identity and interview with Council. A copy of the tape recording was sent to Mrs. Austin.

Mrs. Austin based her information on her experience of attending Council meetings and from her extensive correspondence with the College.

A number of themes emerged from the interview.

The Power of the Registrar

- The Registrar has too much power. This power shows itself in several ways
 - Power over Council.
 - The Registrar's 'corral' is too large.
 - He deflects concerns that Council members have.
 - He does not answer uncomfortable questions asked by Councillors.
 - He has legal counsel prepare charges for Council to vote on rather than having Council draft the charges
 - Power over the public
 - He (and the College generally) blames the public for their own misfortunes and does not act with honesty, trustworthiness, and integrity.

The Power of the Council and the College

- The College and Council have too much power. This power shows itself in several ways
 - The College sweeps the concerns of patients 'under the rug.'
 - The College hinders the services the public needs and wants. It is inefficient and not user-friendly.
 - In spite of open Council meetings, Council and the College do not make the public welcome. Information and documentation to her group

(example: Council agendas and documents) have become less and less available.

- Power over physicians.
 - Physicians are intimidated by the College and want to remain uninvolved in it. Appointing a Lawyer as Associate Registrar sends the message that the College is out to get doctors.
 - Certain physicians have been unjustly persecuted by the College. This has affected their reputations, their incomes and the well-being of their patients. The College's attitude is to continue to persecute this select number of physicians until a charge is successful.
 - Other physicians who have been wrong-doers were treated leniently because of their association with the College.
 - Witnesses in discipline cases are often ill-informed or prejudiced against the defendants.
- Council fails to hold the organization accountable by not asking probing questions
- Council fails to deliberate adequately over important issues before making decisions. In spite of this (or because of it), Council's decisions are often unanimous.
- Council allows staff to do Council's work. For example, a lawyer draws up charges and Council rubber stamps them.
- Council does not ask questions or fully inform themselves. They rubber stamp what the Registrar and the Executive Committee put before them.

Other Issues

- Public representatives are political appointees. They are not available to members of the public.
- The Medical Profession act needs to be reviewed and the power of the College greatly curtailed.
- The Registrar and Council members should have limited terms after which they must step down.
- Representatives of the College make statements that are racist or ageist.
- Letters from PRAS to Council have not been distributed.
- The Registrar is reluctant to meet with PRAS