



# College Newsletter

*A publication of the College of Physicians and Surgeons of Saskatchewan*

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## Message from the President

*Best wishes for the festive season. I wish all of you a very prosperous and Happy New Year.*

As an experiment in the year 2003, the number of meetings that the governing Council of the College of Physicians and Surgeons held was reduced from six to five times a year. This was done largely to reduce costs, and I believe it has been a success, although it has meant lengthier and more onerous meetings.

I would like to thank my fellow Councillors and the College staff for their co-operation in this regard.

The Health Quality Council (HQC), which most of you know is an independent Saskatchewan agency created through legislation and funded through tax dollars, has a mandate to report on and recommend innovative ways in which to improve quality within Saskatchewan's health care system. In July of 2003, the HQC launched the Quality Improvement Network (QIN) and the Medical Council were asked to nominate two representatives to participate on the QIN Advisory Group. I am pleased to announce that I nominated Dr. Karen Shaw, Deputy Registrar of the College, for one of those positions and the nomination was accepted. Dr. Shaw also serves as the Medical Manager for three major College committees including the Complaints Resolution Advisory Committee. I know that she will do an excellent job in this new position.



*Dr. David Ahmed, President*

What is looming on the horizon? Well, probably most interesting is the relatively new issue concerning revalidation/recertification of physician licensure. This has been implemented, or is under review by regulatory bodies in other provinces and countries.

The Council formed a Revalidation Committee to further research this matter and to provide recommendations to the Council. This 'Newsletter' contains a request on behalf of the Committee for feedback from College members to the possibility that Saskatchewan physicians be required to

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meet MAINPRO or MAINCOMP.

The Revalidation Committee will continue to keep abreast of what revalidation efforts are occurring in other provinces and countries. At present, the Committee is not prepared to recommend a

more robust revalidation process to the Council.

My sincere thanks to all my fellow Councillors and to the College staff for their kind help and support during 2003. A special thanks to Jo-Anne Wolan, our Director of Communications and

Education, for the hard work she puts into producing this College 'Newsletter' and her other College duties, and to Jeannette Heinen for helping me prepare the agendas and always being available when I need her assistance.



## Council - Public Members Report

The past year has been an active year for the College. We have enjoyed being involved in Board activities and Board decisions, and we would like to report to the general public the following activities.

The College commissioned early in the year a report on End Four of the College's Ends and Policies. A survey was conducted and a report was made to the College indicating that the College is perceived as a very strong organization with good relationships with the majority of the individuals that it deals with.

From the report arose issues with respect to the relationship between the Saskatchewan Medical Association and the College, leading up to a number of meetings between the SMA's Executive and the College's Executive. These meetings have led to fruitful discussions, hopefully ironing out any difficulties

between the two groups so that they can carry on in a constructive manner representing the parties that they act for in a proper and respectful manner.

The College has also entered into the area of review of issues of licensure for International Medical Graduates. We have found this to be an interesting and enlightening experience. While the College seeks input from various stakeholders on these issues, it continues to put together the necessary information that it requires to come up with a recommendation, which will be continued and pursued in the following year.

The College has actively pursued inter-reaction with various public groups and has made an effort to ensure that its public meetings are visited by many different groups. One of the most prominent groups that attended and entered into a fairly lengthy

discussion with it was the FSIN. The issue of consent forms required by Aboriginal people to access medical care is a concern for all parties and is an issue that is being reviewed by the College with the FSIN.

In addition, the FSIN has approached the College about the possibility of assisting in the hiring of someone to advocate on health issues for Aboriginal people who might otherwise feel disenfranchised from the health care system.

I have enjoyed being the public representative on the College's Executive Board for the past two years. I believe that I have learned a great deal in that time and have made every effort I can to contribute in a positive and useful manner to the operations of the Executive.

The College continues to use its best efforts to ensure that the interests of the public are well protected and that it stays current with

trends that are relevant to the medical profession and industry so that it can be a leader in each of these fields. All public and non-medical members of the Council have worked very

diligently at being a good representative, and the result has been that the College's interests have been well looked after by the current Council.

*Respectfully submitted by  
Mr. M. Fisher on behalf of the  
other public members of  
Council. They are Mrs. G.  
Chartier, Mrs. J. MacKay,  
Mrs. B. McKenna and Mr. E.  
Van Olst.*



## The Good, the Bad and the Ugly of 2003

*D.A. Kendel MD, Registrar*

As 2003 draws to a close, it's natural to reflect on both the positive and negative experiences of the year.

Over the past year we've had much positive experience at the College. We've very much appreciated the selfless contribution of valuable time and energy that many members of the College have made through service on the Council and many College committees. Your collective effort does much to assure the citizens of this province optimally safe and high quality medical care.

We recognize that physicians generally are striving to achieve the very best possible outcomes for patients who rely upon their expertise and judgment. More and more of the work we undertake at the College has the goal of continuous quality improvement.

Modern health care is an increasingly complex enterprise. Optimal provision of high quality care requires well-coordinated action on

the part of a wide range of health professionals and health agencies.

When all the members of the health care team work collaboratively to meet the health care needs of people, the outcomes and benefit of such collaboration is truly impressive.

There are many communities in this province in which we see physicians collaborating with one another and with other health professionals in a truly exemplary manner. Their sense of respect for colleagues and co-workers creates a positive work environment in which all of the energy of the team is focused on the needs and well-being of patients. These colleagues deserve our commendation and support.

However, we must honestly acknowledge that there are some communities in which the situation is not nearly so positive. There are communities in this province where interdisciplinary collaboration is sadly lacking.

There are many reasons why interdisciplinary collaboration may not flourish and not all of these are attributable to physician action or inaction. However, because the College is publicly accountable for the conduct and performance of physicians, it's natural that we should focus on both the positive and negative contributions that physicians make to interdisciplinary collaboration.

One of the most prominent barriers to interdisciplinary collaboration is professional territorialism.

While different health care professions may have some distinct competencies, there is significant competency overlap between the professions. Mature self-assured professionals tend to recognize this and to work with other professionals in a way that harnesses their full capacity. In contrast, those who are "territorial" in their mindset tend to actively discourage other professionals from undertaking any part of the

work that they regard as their "territory".

The Council of the College has an explicit policy that directs the Registrar and the staff of the College to reduce inter-professional territorialism and to foster inter-professional collaboration. Over the past year, we have found ourselves interacting in many circumstances where we have been able to facilitate better collaboration between physicians and other health professionals. That work has been rewarding.

That covers some of the good and the bad memories of 2003. But in the title of this piece, I made reference to some "ugly" moments.

Ugly is a strong word that should not be used casually. But, I believe it is an appropriate word to describe a troublesome phenomenon that has confronted us in 2003.

While we accept it might take some effort to achieve and sustain optimal respect and collaboration between physicians and other professionals, we often take for granted that physicians will respect one another and work collaboratively in the interests of their mutual patients.

Recognizing that physicians are human, we understand that they will disagree with one another from time to time. On

occasion such differences may erupt into injudicious verbal communication with each other. When that happens, most often the parties quickly come to their senses, apologize for their indiscretion and restore a mutually respectful working relationship.

Over this past year, we have been confronted with situations in which inter-collegial strife and conflict between physicians has reached a disappointing zenith. Some of this conflict has erupted within discipline-specific medical communities while some has erupted within geographically-defined medical communities. In both circumstances, it has been ugly.

The norms of civility have given way to vicious accusations and counter-accusations between warring physicians. Rather than focusing their attention and energy on the needs of their patients, it would seem that these physicians are focused more on crushing the colleagues whom they have identified as their foes.

In at least one community, this inter-collegial warfare has spilled into the public media creating palpable anxiety within the public about patient safety in such a context.

This is a situation that does have grave potential to increase risk of patient harm. It is also a situation that has

enormous potential to damage public trust in and respect for the medical profession. It is a situation that cannot be permitted to continue.

The professional conduct of physicians is regulated concurrently at the local level by RHA Boards and at the provincial level by the College. The regulatory tools embedded in Regional Health Authority Medical Staff Bylaws and in *The Medical Profession Act* are not well designed to deal effectively with the inappropriate and disruptive physician behavior that I've described earlier.

There is a growing body of published literature in respect to the phenomenon of disruptive physician behavior. That literature clearly demonstrates that when disruptive physician behavior is allowed to persist unchecked, it can significantly poison the work environment. The literature therefore suggests that such behavior must be addressed promptly and firmly.

The College of Physicians and Surgeons has taken a number of steps to deal with this worrisome problem. First, it played a significant role on a SAHO committee that has assembled resources that should help RHAs deal more effectively with disruptive physician behavior when it occurs. A summary report from this committee is available on the College's website.

The College is also serving on a multi-agency committee striving to define appropriate and effective medical staff bylaws that will be applicable in each of the Regional Health Authorities. We are committed to the development of bylaws that will empower RHAs to deal more effectively with disruptive physician behavior.

Finally, the Council of the College has also confirmed its willingness to use the

College's full disciplinary power to deal with physicians whose behavior is so disruptive as to constitute unprofessional conduct.

The College continues to work collaboratively with RHAs that are experiencing disruptive behavior within their medical communities. We are committed to using all of our resources and influence to assure members of the College and members of other professions that they

will not be at risk of harm from manipulative and abusive behavior perpetrated by a small minority of our members.

As we approach a new year, I would extend an earnest plea to all members of the College to demonstrate the level of respect and courtesy to colleagues and other health professionals that they would want for themselves.



## LEGAL REPORT - 2003

*B. Salte, L.L.B., Associate Registrar*

There have been a number of matters with legal implications for the College that have occurred over the past year. These have included the College's disciplinary and competence activities and court proceedings affecting the College. Certain changes to *The Medical Profession Act, 1981* took effect and some of the College's bylaws were changed. In addition, *The Health Information Protection Act* came into effect. This legislation imposes obligations on physicians to protect the privacy of patient information.

### DISCIPLINE AND COMPETENCE MATTERS INVOLVING THE COLLEGE

- 1) *Dr. Naushad Hoosen*  
Dr. Hoosen was charged with having

performed an ungloved internal examination on a female patient. The patient testified that this had occurred. Dr. N. Hoosen testified that he had been wearing a glove during the examination.

The Discipline Hearing Committee concluded that it did not find the evidence sufficiently clear and convincing to find Dr. Hoosen guilty of the charge.

- 2) *Dr. Carlos Huerto*  
Dr. Huerto was charged with a number of charges of unprofessional conduct. The Discipline Hearing Committee found him not guilty of 5 charges, including altering a patient's chart, mislead-

ing a preliminary inquiry committee and the College with respect to his possession of a patient's chart, failing to provide a patient with sufficient information to make an informed choice about her care, and kissing a patient.

Dr. Huerto was found guilty of three charges. These were maintaining a sexual relationship with a patient, prescribing drugs in a patient's name not intended for the patient, and making a false statement in an affidavit to the College.

Dr. Huerto's licence was revoked. He was required to pay \$52,500 towards the costs incurred by the College in connection with his discipline. The Council made certain recom-

mendations that should be met before he would be granted a licence to practice. Dr. Huerto has appealed against the decision and the penalty.

3) *Dr. Ronald Young*

Dr. Young was charged with two charges of unprofessional conduct. The first of these was that he had telephoned a Prince Albert physician and, in that telephone call, had made statements that were threatening, or could be perceived as threatening, to another physician, Dr. M. The second charge was that, during this telephone conversation, he had asked for patient-specific information respecting former patients of Dr. M.

The discipline hearing committee concluded that the telephone call had occurred, that the statements made by Dr. Young during that telephone conversation were, or could reasonably have been interpreted to be threatening, and that this conduct was unprofessional.

The committee concluded that the second of the charges, requesting confidential information, was not proven.

The Council directed that Dr. Young be reprimanded and that he

pay \$7,895.77 towards the costs incurred by the College.

The decision of the discipline hearing committee and the council are the subject of an appeal to the Court of Queen's Bench, discussed below.

4) *Dr. H. Wrobel*

Dr. Wrobel was previously the subject of an inquiry by a Competency Committee. The Competency Hearing Committee concluded that he did not have the necessary skills and knowledge to practice medicine in Saskatchewan. The Council required him to take specific courses and specified forms of retraining. The order of the Council included a direction that his skills and knowledge be assessed after completing those courses and retraining.

His skills and knowledge were found to be satisfactory, and he was permitted to remain in practice.

5) *Dr. Tony Ogundipe*

Dr. Ogundipe applied for licensure with the College of Physicians and Surgeons. In his application he did not disclose that he was the subject of criminal charges in Nova Scotia and did not disclose that he had been licensed in Nova Scotia.

The College became aware shortly after granting him a licence that the information provided was incomplete and misleading. Dr. Ogundipe's licence to practice was revoked.

Dr. Ogundipe was found not guilty at the criminal trial. He then sought restoration of his licence. He entered a guilty plea to a charge that he provided information to the College in connection with his licensure that was incomplete or misleading.

Dr. Ogundipe was suspended for three months, retroactive to the time that his licence was terminated by the College, and was fined \$5,000. Dr. Ogundipe's licence to practice medicine was restored.

6) *Dr. Oluwatoyin Oluwasanmi Yusuf*

Dr. Yusuf was assessed by a Competency Committee. The report of the Committee concluded that his skills and knowledge were deficient.

Dr. Yusuf has continued to practice, with his practice limited to surgical assisting. No date has yet been set for a hearing to determine whether he does, or does not, have the skills and knowledge to practice medicine in this province.

7) *Dr. Esther Louise Stenberg*

Dr. Stenberg was found to lack the necessary skills and knowledge in the practice of psychotherapy as a family physician.

The Council directed that she practice psychotherapy only under the supervision of a physician knowledgeable in psychotherapy approved by the College. She was required to complete a course in counseling skills. She was required to undergo a further assessment after the counseling skills course and the period of supervision.

8) *Dr. Eugene Gibney*

Dr. Gibney was charged with having engaged in behaviour that was disruptive, threatening, harassing and/or abusive to two nurses. An agreement was reached with Dr. Gibney that if he provided a letter of apology to the two nurses, and successfully completed the R.E.S.P.E.C.T. program in Edmonton, the charges against him would be withdrawn.

Dr. Gibney did both of these things, and the charges against him were then withdrawn.

9) *Dr. Mahesh Chand Khurana*

Dr. Khurana was

charged with having engaged in a pattern of behaviour that was disruptive, and/or abusive to other health care professionals and that he did not collaborate with other health professionals in the care of patients and the functioning and improvement of health services.

A mediated solution was reached, involving an external mediator, and counseling. Dr. Khurana has completed the mediation process and the charges against him will not proceed.

10) *Dr. John George Rye*

Dr. Rye was charged with unprofessional conduct in connection with his prescribing of opiates to patients.

Dr. Rye is participating in a program of remediation designed by the Registrar to modify his prescribing habits. If the program is successful, the charges against Dr. Rye will be stayed.

11) *Other outstanding charges*

Dr. Elarien Daniel Korchinski is charged with having engaged in a pattern of behaviour that was disruptive, and/or abusive and/or intrusive and/or failed to respect the privacy and personal boundaries of residents and/or co-workers and/or patients

and/or other persons.

At the date of this report, no hearing date has been set.

Dr. Lawrence Hibram is charged that he prescribed diazepam to an employee known to have been addicted to opiates, and known to have been enrolled in the methadone program.

He is also charged that he asked her to locate a supply of cocaine for him.

No date has yet been set for the hearing.

Dr. George Pantazopoulos is charged that he failed to maintain proper boundaries with a patient and that he provided her with personal health information about another of his patients.

No date has yet been set for the hearing.

12) *Other outstanding investigations*

A physician is currently under investigation for allegedly having left his position without making appropriate arrangements for the continuing care of his patients.

Another physician is currently under investigation by a preliminary inquiry committee for allegedly billing for medical services he did not provide.

## COURT ACTIONS INVOLVING THE COLLEGE

### 1) *Dr. Keith Anstead - Judicial Review*

Following an office assessment, the Practice Enhancement Program reported to the College that Dr. Anstead was a "category 3" physician. The Executive Committee of the College reviewed the information provided by the PEP Committee and concluded that it would appoint a Competency Committee to assess whether Dr. Anstead had the appropriate skills and knowledge to practice medicine in Saskatchewan.

Dr. Anstead challenged the appointment of the Competency Committee on a number of grounds. He claimed that the PEP committee did not have a proper basis to report the matter to the College. He claimed that the report did not provide a proper basis for the Executive Committee to appoint a Competency Committee. He claimed that the PEP Committee, and the College, had not treated him fairly.

The court dismissed all of the claims made by Dr. Anstead. The court provided some direction to the PEP committee respecting the information that the PEP committee should provide to the College in

future if it should determine that a physician should be reported to the College.

When Dr. Anstead agreed that he would limit his practice to surgical assisting, the competency proceedings were discontinued.

### 2) *Dr. Ronald Young - Appeal from Discipline Committee*

Dr. Young's discipline hearing and penalty are discussed above.

Dr. Young appealed the finding of unprofessional conduct and the imposition of costs to the Court of Queen's Bench.

Dr. Young argued that the evidence before the Discipline Hearing Committee did not justify the finding of unprofessional conduct and that the costs awarded were excessive.

The court heard the appeal and reserved judgment. No decision has been made at the date of this report.

### 3) *Dr. Marc Puts -defamation action*

Dr. Marc Puts was formerly a physician practicing in Broadview, Saskatchewan. He filed a letter of complaint with the College of Physicians and Surgeons in which he alleged wrongdoing by Dr. Jones, who was then a physician practicing in Broadview and Mr. Harvey Duke, a

pharmacist who operated a pharmacy in Broadview.

Mr. Duke successfully sued Dr. Puts for defamation. Dr. Puts was found to have made a number of defamatory statements about Mr. Duke. The only statement that was of concern to the College was the statement made in the letter of complaint to the College.

When Dr. Puts appealed the court decision, the College sought and was granted intervenor status to argue that the statements made to the College of Physicians and Surgeons could not be the subject of an action in defamation. The College's position is that statements made to the College in connection with a complaint are absolutely privileged and cannot be the subject of litigation. The argument of Mr. Duke was that the comments made about him in the complaint to the College were not relevant to the complaint against Dr. Jones. The argument of Mr. Duke was that, by including irrelevant information about a person who was not a physician in the letter of complaint, Dr. Puts was not protected from an action in defamation.

The College regards this as a very important issue. The Court of

Appeal heard arguments early in 2003. There has been no decision at the time of this report.

4) *Dr. Carlos Huerto - Appeal*

The appeal by Dr. Huerto against a previous finding of unprofessional conduct has not yet been resolved. He was found guilty of unprofessional conduct with respect to his treatment of two patients, and with respect to the information that he provided to family members of a third patient.

A hearing date has been sent for March, 2004.

5) *Dr. Carlos Huerto - Appeal*

Dr. Huerto has appealed against the decision of the discipline hearing committee referred to above, that he maintained a sexual relationship with a patient, that he prescribed drugs to that patient not intended for her use, and that he made a false statement in an affidavit provided to the College.

He has appealed against both the finding of unprofessional conduct and the penalty imposed or revocation of his licence.

At the date of this report, no hearing date has been set for this appeal.

6) *Dr. Carlos Huerto - Application for a stay of revocation*

As described in the preceding paragraph, Dr. Huerto appealed against the decision of the discipline hearing committee that he maintained a sexual relationship with a patient, that he prescribed drugs to that patient not intended for her use, and that he made a false statement in an affidavit provided to the College.

When Dr. Huerto appealed, he also applied to the court for an order that he be permitted to practice until the appeal is heard.

At the date of this report, no decision has yet been made by the court.

*CHANGES TO THE MEDICAL PROFESSION ACT, 1981*

In my report for the year 2002, I identified amendments to *The Medical Profession Act, 1981* that had been passed by the Saskatchewan Legislature. Some of those changes did not immediately take effect. In 2003 the following amendments became law:

- a) On January 1, 2003 the amendment to clarify that physicians who are no longer registered with the College of Physicians and Surgeons can have disciplinary action taken for a period of up to two

years after they cease being registered with the College came into effect.

On September 1, 2003 the amendment to allow for podiatric surgeons to be registered by the College of Physicians and Surgeons of Saskatchewan came into effect.

**CHANGES TO COLLEGE BYLAWS**

A number of changes to the College bylaws were made during the past year. These were:

- a) A physician who is no longer registered with the College of Physicians and Surgeons, and who is the subject of disciplinary proceedings, is to be notified within 30 days that disciplinary action is being taken against that physician;
- b) Offering an inducement for medical treatment is now defined as unprofessional conduct. Physicians are prohibited from offering any inducement for a patient to receive a benefit or service. Some jurisdictions have identified that physicians involved in providing uninsured procedures (laser eye correction and cosmetic surgery for example) have offered inducements to patients or to individuals or organizations who refer patients

for these procedures. That is now prohibited in Saskatchewan;

- c) Bylaws relating to registration of podiatric surgeons are now in effect. There is a detailed list of requirements to achieve registration, including certification in foot surgery by the American Board of Podiatric Surgery, two years of surgical residency in an accredited program and passing The National Board of Podiatric Medical Examination Parts I, II and III;
- d) Detailed requirements were introduced for facilities to provide bone densitometry and interventional radiology as part of the Diagnostic Imaging Facilities bylaw;
- e) Following extensive consultation with RHAs, government, the SMA, etc., bylaws were introduced that will allow physicians who wish to practice on a provisional or a special licence to seek an exemption from all or part of the examinations of the Medical Council of Canada. This bylaw has been submitted to the Minister of Health, and we are awaiting approval of the bylaw;
- f) Following extensive consultation with RHAs, government, the SMA,

etc., bylaws were introduced to change the nature of locum tenens permits in Saskatchewan. Among the requirements is the ability to set conditions for physicians to obtain or maintain locum tenens permits. Physicians working on locum tenens permits may be required to undergo an assessment. This bylaw has been submitted to the Minister of Health, and we are awaiting approval of the bylaw.

#### THE HEALTH INFORMATION PROTECTION ACT

The primary purpose of The Health Information Protection Act (HIPA) is to protect the privacy of patient information. The September, 2003 College 'Newsletter' contains an article describing some of the more important aspects of this legislation.

Physicians should be aware of this legislation as there are a number of things physicians must do to comply with the legislation. Among the more important provisions for physicians are the following:

- a) Physicians should not disclose patient information to others unless with patient consent or unless authorized by the legislation;

- b) Physicians must provide patients access to their medical record unless there is a compelling reason to deny access. There is also a requirement that if the patient requests a copy of their file, the physician must generally provide a copy within 30 days;
- c) Physicians must advise patients of the expected use of their information and the circumstances in which they may disclose that information;
- d) Physicians must establish policies and procedures to advise patients of their rights under HIPA and to advise patients of their right to access their information;
- e) Physicians must establish policies and procedures to protect against loss of patient information and unauthorized access to patient information;
- f) Physicians must limit which employees can access patient records or other personal health information. Only employees who need to know patient information for patient care, or who need to know such information for some other purpose authorized by the Act, (such as billing) can have access to that information;

g) Physicians cannot use a file storage facility, nor can physicians use an organization to destroy files, unless there is a written agreement in place that protects the information and governs access to and use,

disclosure and destruction of the information;

h) Physicians who use another person or organization to provide information technology services respecting

records that contain patient information (this includes MSP information) must have a written agreement in place governing the use, disclosure and destruction of that information.



# PLANS TO MODIFY THE COLLEGE'S ELECTORAL DISTRICT BOUNDARIES

The governing Council of the College is comprised of:

- 1) Eleven physicians elected from nine Electoral Districts
- 2) Five public members appointed by the Lieutenant-Governor-in-Council
- 3) The Dean of Medicine
- 4) The immediate Past President of the Council (if not at the table by election).

The current boundaries for the nine Electoral Districts are defined in *Bylaw 3*. The cities of Saskatoon and Regina constitute two of the Electoral Districts. The boundaries for the remaining seven Districts follow specific meridians of latitude and longitude.

One of the unfortunate consequences of defining Electoral Districts along meridians of latitude and longitude is that these boundaries correlate very poorly with the organization

and delivery of health services.

Recognizing the benefits of correlating collective physician activity within RHAs, the Saskatchewan Medical Association has reorganized its local Medical Associations along Regional Health Authority boundaries. At its December meeting, the Council of the College made a decision to similarly modify the Electoral Districts of the College to coincide with RHA boundaries. The tentative plan is to have ten Electoral Districts, with the RHAs of Keewatin Yatthé and Mamawetan Churchill River being merged respectively with Prairie North and Kelsey Trail because of the very small number of physicians resident in the two most northern RHAs.

The Council perceives a number of benefits accruing from such a restructuring of the College's electoral boundaries. The two most

significant benefits include:

- 1) Improved communication between Councillors and members through the vehicle of Regional Medical Association meetings.
- 2) Enhanced potential for coordination of quality improvement initiatives between the College of Physicians and Surgeons and RHAs with elected Councillors playing a liaison role.

If Saskatoon and Regina continue to each elect two Councillors, the proposed change would result in increasing the Council size by one. If each Electoral District elects only one member, the Council membership will be decreased by one.

The trend among professional regulatory bodies is to reduce the size of governing councils as a means of cost control and increased efficiency. Since

physicians are not elected to the Council table to advance the interests of their colleagues, representation by population has less relevance in professional regulatory bodies than it does in professional advocacy bodies. Some Colleges elect their governing Councils through province-wide elections. The concept of electing

Councillors from geographic districts serves to foster diversity in physician perspectives at the Council table.

This proposed change in electoral boundaries will require a modification of *The Medical Profession Act* since Section 11 of that Act specifies a requirement for nine rather than ten Electoral Districts. It is our

hope that such a legislative amendment can be achieved in 2004.

Since Councillors are elected to three-year terms, 2004 is a year in which we do not anticipate holding elections. The first year in which revised electoral boundaries would become applicable would be the elections conducted in the fall of 2005.



## Continuing Medical Education Requirement

*Bryan Salte, Associate Registrar*

The Council of the College has established a Revalidation Committee. The task of this committee is to make recommendations to the Council respecting requirements for physicians to demonstrate ongoing education and/or competence as a condition of practice in Saskatchewan. The Committee consists of Dr. David Ahmed of Regina, Dr. Suresh Kasset of Herbert, Dr. Prakesh Patel of Regina, Dr. Karen Shaw, Deputy Registrar, and Mr. Bryan Salte, Associate Registrar.

The Committee is considering whether it should recommend to the Council that physicians be required to meet the requirements of MOCOMP (for physicians with

specialist credentials) or MAINPRO (for physicians with family physician credentials). It appears that both the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada are prepared to enroll physicians who are not members of their Colleges in these programs. There would be some cost to physicians who are not members of either College to enroll in the MAINPRO or MOCOMP programs.

Most health professions in Saskatchewan have ongoing maintenance of competence requirements in order to remain in good standing with their regulatory body. It seems likely that in the near future there will be ongoing maintenance of competence

requirements for physicians in other provinces of Canada.

If you wish to discuss this issue, you can contact any one of the members of the Committee. We would ideally appreciate responses in writing. This will allow the responses to be distributed to members of the Committee and to the Council. Please direct written comments to: Bryan Salte, Associate Registrar, College of Physicians and Surgeons of Saskatchewan, 211 Fourth Avenue South SASKATOON SK S7K 1N1 FAX: (306) 244-0090

*Please ensure that your comments arrive at the College by January 31, 2004 in order to be considered by the Committee and the Council.*

# Methadone Educational Day

The College of Physicians and Surgeons of Saskatchewan will be conducting a Methadone Educational Day January 31<sup>st</sup>, 2004 at the Radisson Hotel in Saskatoon, 9:00 a.m. to 5:00 p.m.

Physicians, Addictions Counsellors, Pharmacists, Correction and Justice Workers, the Police and others will find the presentations and speakers of great interest and value.

Speakers will include Dr.

D. Gourlay, an addiction specialist from Toronto, Dr. K. Kok, a psychiatrist from Saskatoon, Dr. B. Fern, a methadone prescriber from Saskatoon, and Ms. L. Postnikoff from the Saskatchewan College of Pharmacists.

Subjects to be covered include: Managing pain in the addicted patient; Urine testing - Why? - How and what to do with the results; Methadone and pregnancy; Concurrent care in methadone patients; and

Proper prescription writing for Triplicate Prescription Program medications.

The fee to attend is \$15.00 and will include a continental breakfast and lunch. Those wishing to attend are asked to register by January 16<sup>th</sup>, 2004

*For further program information and to request a registration form, please contact Ms. Amanda Lee at (306) 244-8778, or Dr. L. Loewen at (306) 653-0586.*



## Medical Marijuana – A Concern

Recently, the College of Physicians and Surgeons of Saskatchewan received a letter from the Schizophrenia Society of Saskatchewan raising some concerns with respect to exemptions for medical marijuana. In the letter, it was stated that, "The Schizophrenia Society of Canada with its provincial counterparts had put forward a very emphatic protest against...legalization. This strong opposition was based on both supportive research findings and first-hand experience of care-giving families that marijuana (and other street drug usage) has been found to trigger symptoms of schizophrenia if one is genetically or otherwise predisposed to it. Stressful life events, including marijuana usage,

have been known to both bring on the symptoms initially as well as predispose one to experience repeated episodes of the onset of acute symptoms of schizophrenia. Those patients who have been known to try to cover-up these symptoms by using marijuana and/or alcohol have usually suffered serious consequences, including relapsing to the point that they require hospitalisation.

Very recently members of our society reported that their ill relatives have been hinting at their interest to seek out medical specialists...in an effort to have marijuana prescribed for their chronic pain. Since many of these consumers

can be very persuasive and manipulative, we felt that we should make you and your members aware in the event that some of these persons whose medical history is unknown to your members, come shopping around for such prescriptions."

Any physicians assisting applicants in their bid for exemption for medical marijuana should be aware that there are a number of conditions in which the use of this product is contraindicated, one of which is a history of serious mental disorders such as schizophrenia and/or depression. Physicians assisting applicants should take a full history, including a psychiatric history, to rule out any such disorders.

# QA Commentary

## *Anaesthetic and Operative Deaths Study Committee*

The Anaesthetic and Operative Deaths Committee has reviewed several cases of potentially preventable deaths related to early (< 1 week) tracheostomy tube change. Tracheostomy tube change before a well-defined tract is formed can make reinsertion technically challenging. Unfortunately, events such as tube occlusion, cuff disruption or tube dislodgement may necessitate the need for urgent or emergency intervention and early tube change.

In some cases, patient factors such as morbid obesity, trauma or anatomic abnormality have made these urgent/emergency tracheostomy tube changes complicated, resulting in acute deterioration. In other cases, the physicians or other health care professionals doing the tracheostomy change may not have had the complete skill set needed to secure the airway.

Ideally, when an early (< 1 week) tracheostomy tube

change is needed, the surgeon (or an equally skilled designate) should participate in the decision to change *and* the procedure of tracheostomy tube change.

Basic and advanced airway management alternatives should be immediately available in the event that the tracheostomy tube cannot be successfully replaced.

## *Complaints Resolution Advisory Committee*

The Complaints Resolution Advisory Committee of the College of Physicians and Surgeons of Saskatchewan reviews formal written complaints about physicians' care and conduct. Many of the educational points raised are of value to the wider physician population. The Committee wishes to share a concern identified in its process to hopefully assist other physicians in avoiding similar problems.

Analgesics/antipyretics, like acetaminophen and ibuprofen, come in different strengths and formulations such as suspension and infant drops. The Complaints Resolution

Advisory Committee would like to alert physicians to the concern that patients may not be aware that the dosage dispensed of these drugs differs with the type of formulation, for example, the concentration of available products such as acetaminophen:

- 1) Tylenol
  - Infant Suspension is 80 mg. per ml.
  - Children's Suspension and liquid and elixir is 160 mg. per 5 ml.
- 2) Temptra
  - drops 80 mg. per 1 ml.
  - syrup 80 mg. per 5 ml.
  - syrup 160 mg. per 5 ml.

The same problem can exist with ibuprofen:

- 1) Advil
  - Pediatric Drops at 200 mg. per 5 ml.
  - Children's Suspension 100 mg. per 5 ml.
- 2) Motrin (Children's)
  - Suspension drops at 40 mg. per ml.
  - Suspension liquid at 100 mg. per 5 ml.

It is important for physicians to provide patients and/or parents with the appropriate dose in milligrams. Patients (parents) should also be alerted to the different concentrations of that drug that are available. If a parent is unaware that there is a difference in the concentration of drugs in the different formulas of Tylenol

Infant Suspension 80 mg./ml., Children Suspension 160 mg./5 ml., they may substitute infant suspension for children's

suspension. Mistakes in dosing due to failure in recognition of the availability of different strengths or concentrations of the

product can lead to complications that are life-threatening.



## Committee Annual Reports:

### Anaesthetic and Operative Deaths Study Committee

The Anaesthetic and Operative Deaths Committee reviews all deaths occurring within ten days of surgery and/or anaesthesia in the province of Saskatchewan for purposes of assuring quality care. The Committee's aim is to be educational and to provide feedback to physicians on the quality of care provided. The Committee reviews and discusses all aspects of patient care, but communicates specifically with anaesthetists and surgeons. The Committee, however, makes observations on the care provided by other physicians and members of the health care team when appropriate.

Between December 2002 and September 2003, the Committee met four times to review 368 cases – 11 from 1999, 34 from 2000, 61 from 2001, 250 from 2002, and 12 from 2003. The Committee reviewed 352 new cases and 16 that were carried over for completion from the previous one-year period.

There are 12 cases still under review awaiting further information. Of the cases completed, 350 were classified non-preventable and 2 were classified as potentially preventable. These cases were further classified for contributing factors, i.e. physician error in judgement, physician error in technique, inadequate equipment/facilities, and concerns regarding care provided by non-physician medical staff, including nursing and pharmacy.

The review process identifies areas of concern to be addressed by the providers of care. This past year several issues were worthy of emphasis. The major issue has been consistent use of beta blockade in the perioperative period. There is a considerable body of literature that supports the use in the elderly, hypertensive, diabetic or patients with known coronary artery disease. Problems persist in identifying suitable patients and identifying who is

responsible to start the treatment and when the treatment should be started. In addition, it is important to confirm how these patients will be followed and who will be responsible for follow-up management. The Committee will attempt to facilitate a process involving the pre-assessment clinics, surgeons, internists and anaesthesiologists to ensure the optimal management of patients requiring beta blockage.

Other issues currently being addressed by the Committee:

1. Continuing to encourage optimising prophylactic Heparin anticoagulation therapy for patients who are at high risk for developing pulmonary embolism.
2. Encourage improvement in documentation of history, physical examination and progress notes in the clinical record.
3. Suggest improvements to the health regions to ensure adequate post-operative monitoring of

- high-risk patients.
4. Remind physicians that cardiovascular disease must be part of the differential diagnosis when the patient presents with abdominal pain.
  5. Encourage standardization of appropriate management of fresh tracheostomy complications.
  6. Encourage open communication between

physicians and families to consider non-operative options for high-risk patients when risk outweighs the benefit of the procedure.

On behalf of the College, I would like to thank the members of the Committee, Dr. G.B. Gilliland (Chair), Dr. A. Akhtar, Dr. J. Carter, Dr. W.M. Ezzat, Dr. J. Javier, Dr. M.T. Jurgens, Dr. F.R. Lee, Dr. D.R. Loback,

Dr. G.B. Miller, Dr. L.A. Taranger, Dr. D.J. Thomson and Dr. S. Vuksic for their dedication, hard work and valued contribution to quality assurance.

*Respectfully submitted by  
Dr. K. Shaw, Medical  
Manager and Ms. K.  
Bergstrom, Coordinator*

## Complaints Committee

The Complaints Resolution Advisory Committee receives and reviews complaints regarding physicians' care and conduct. In the calendar year of January 1 to December 31, 2002, the Committee received 128 formal written complaints. The 128 complaints comprised 283 allegations, ranging from concerns of care such as delayed diagnosis, surgical or medical mismanagement, delayed referral, to communication concerns such as lack of informed consent, lack or error in communication, rudeness. 123 allegations were unfounded, 95 allegations were founded, 36 allegations were partially founded, 6 were categorized as patient responsibility, and 21 were categorized as "no determination".

In the cases where the

Committee could not find evidence to substantiate either party's contention, the Committee coded the case as no determination. The Committee, however, took the opportunity to alert physicians to the expected behavior. For example, if the allegation was one of rudeness but no determination was made, the Committee indicated that although the physician had not intended to be rude, the patient's perception was that the physician was rude. The Committee further indicated that it does not condone rudeness on the part of the physician and/or the patient.

The Committee continues to provide educational suggestions to physicians in cases where the care or conduct could be improved.

Patient/physician satisfaction surveys regarding the College's

complaints process have been sent over the past year. Suggestions made by the complainants and physicians have been considered by the Committee in order to continue to improve the process.

On behalf of the College, I would like to thank the three public members, Mrs. A. Brayshaw, Ms. V. LaCroix, and Mrs. S. Loughheed and the three physician members, Dr. J. Kriegler (Chair), Dr. L. Baker and Dr. M. Harington for their dedicated hard work. Also, thanks to Ms. J. Wolan, Patient Advocate and Intake Worker, and Mrs. C. Dunlop, Coordinator, for their hard work and continued support

*Respectfully submitted by  
Dr. K. Shaw, Medical  
Manager*

# Complaints - Allegations and Determinations

*Breach of Confidentiality* - 1 founded  
*Communication Error/Lack of* - 14 alleged, 10 founded, 1 unfounded, 1 no determination and 2 partially founded  
*Complication of Treatment* - 1 founded  
*Delayed Diagnosis* - 7 with 4 founded and 3 partially founded  
*Delayed Reporting* - 1 partially founded  
*Delayed Treatment* - 2 with 1 founded and 1 unfounded  
*Failed Procedure* - 3 with 1 founded and 2 unfounded  
*Failed to Investigate* - 2 unfounded  
*Failed to Refer* - 7 with 2 founded, 4 unfounded and 1 patient responsibility  
*Failure to Attend* - 3 unfounded  
*Failure to Treat* - 5 with 4 unfounded and 1 with no determination  
*Fragmented Care* - 2 with 1 founded and 1 unfounded  
*Inaccurate Reporting* - 12 with 2 founded, 8 unfounded, 1 partially founded and 1 failed to return the authorization, unable to proceed  
*Inadequate Communication* - 16 with 6 founded, 2 unfounded and 8 partially founded  
*Inadequate Examination* - 13, with 7 founded and 6 unfounded  
*Inadequate Follow Up* - 6 with 3 founded, 1 unfounded and 2 partially founded  
*Inadequate History* - 2 founded  
*Inadequate Investigation* - 21 with 6 founded, 10 unfounded, 3 partially founded and 2 patient responsibility  
*Inadequate Records* - 2 with 1 founded and 1 unfounded  
*Inadequate Treatment* - 13 with 3 founded, 6 unfounded and 4 partially founded  
*Inappropriate Comments* - 4 with 1 founded, 1 unfounded and 2 no determination  
*Inappropriate Communications* - 4 with 1 founded, 1 unfounded and 2 partially founded  
*Inappropriate Medication* - 15 with 2 founded and 13 unfounded  
*Inappropriate Referral* - 1 unfounded  
*Inappropriate Treatment* - 3 unfounded  
*Incorrect/Missed Diagnosis* - 33 with 14 founded, 15 unfounded, 2 partially founded and 2 patient responsibility  
*Insensitive Care* - 17 with 6 founded, 4 unfounded, 2 with no determination and 5 partially founded  
*Lack of Informed Consent* - 7 with 2 founded, 4 unfounded, 1 no determination  
*Medical Mismanagement* - 7 with 2 founded and 5 unfounded  
*Overmedicating* - 2 with 1 founded and 1 unfounded  
*Refused Treatment* - 3 with 2 unfounded and 1 patient responsibility  
*Roughness* - 3 with 1 founded, 1 unfounded and 1 with no determination  
*Rudeness* - 22 with 7 founded, 2 unfounded and 12 with no determination  
*Surgical Misadventure* - 8 with 5 founded, 2 unfounded and 1 partially founded  
*Surgical Mismanagement* - 10 with 2 founded and 8 unfounded  
*Undermedicating* - 1 unfounded  
*Unethical Conduct* - 9 with 1 founded, 7 unfounded and 1 no determination

## Diagnostic Imaging Quality Assurance Program (DIQA)

The Diagnostic Imaging Quality Assurance Program has been busy preparing for a peer review process of all imaging done in the province of Saskatchewan. Initially, this will include radiologists, obstetricians and internists.

Some of these audits will be on-site visits and some will be distance audits whereby the images will be mailed to the Committee for

review. An ambitious schedule will result in 35 audits per year.

The Committee looks forward to the education and networking that will result, and is confident that the quality of imaging services in Saskatchewan will demonstrate a very high standard.

I would like to take the

opportunity to thank the members of the Committee. They are: Dr. B. Biem, Ms. C. Craig, Dr. E. Dudzik, Mr. D. Hickey, Dr. J.P. Hillis, Ms. D. Hladum, Dr. G.W. Stoneham, Mr. W. Tiefenbach, Dr. I.C. Waddell and Ms. G. Yaroshko. I would also like to thank Dr. L. Loewen and Mrs. G. Hearn.

*Respectfully submitted, Dr. I. Suchet (Chair)*

## ECG Committee

The members of the Committee are Dr. R. Chernoff (Chair), Dr. R. Balakrishna, Dr. A. Unger and Dr. P. Schwann.

Continuing Medical Education offered the ECG training course in September of 2003. It has been their practice to offer this course every other year. In follow-up, the ECG exam was held October 20<sup>th</sup>, 2003.

The ECG Committee met on October 29<sup>th</sup>, 2003 to discuss the results of the examinations held throughout the year. Of the 28 candidates who wrote the ECG exam, 20 were

successful. The Committee was pleased with the overall results as the exam is a difficult one with a 75% passing mark. Exams are offered twice a year, usually in April and October. The next examination is scheduled for April 5<sup>th</sup>, 2004.

At this time, there are approximately 330 physicians who are eligible to bill for ECGs. It was determined by the Committee in October of 1997 that a physician must interpret a minimum of 40 ECGs in a 3-year period, or 60 in a 5-year period. A letter would be generated by the College to the physician

if a physician did not meet the minimum standard for competency requesting that the physician take the ECG course, if available, or provide proof of additional supervised training by an internist or cardiologist. This is also the recommendation given to those physicians who are unsuccessful in the examination. It is noted that the only province the Saskatchewan College reciprocates with for the ECG privilege is Manitoba.

The Committee wishes to thank Mrs. C. Bowkoy for her assistance throughout the year with the examination process.

## Health Care Facilities Credentialling Committee

The Health Care Facilities Credentialling Committee has reviewed requests for privileges from a total of 23 physicians in the past year.

Recommendations regarding these privileges have been forwarded to their respective Regional Health Boards. Additionally, the Committee

has considered requests for advanced privileges from 3 physicians and made recommendations to their respective Regional Health

Boards as well as reviewed, at length, a request from a physician for reconsideration of the Obstetric and Gynaecological recommended privileges by the Committee.

In addition, the Committee reviewed privileges in the following areas:

- 1) Gynaecological:  
Hysterosalpingogram – requests for this procedure have been removed from the application for privileges because it is rarely done. The Committee also discussed the appropriateness of local anesthesia for dilatation and curettage for incomplete abortion. When a physician makes a request for this procedure, the Committee will request an outline of the protocol for patient monitoring, sedation and for a list of the equipment used for the procedure in the facility.
- 2) Obstetrical Privileges:  
The Committee discussed the joint policy statement of The Society of Obstetricians and Gynaecologists and The College of Family Physicians of Canada regarding the number of births to maintain competence. They state, "Requiring attendance at a minimum number of births should not be an element of any credentialing program." The SOGC goes on to

state, "Maintaining competence in all elements of practice is the professional responsibility of every practitioner. Maintaining competence depends on an appropriate, ongoing and self-directed program of continuing professional development, which should be structured to the needs and responsibilities of the individual and practice group. This program may include, but is not limited to, consultation with colleagues, attendance at meetings and courses, and participation in special workshops, such as Advances in Labour and Risk Management (ALARM) and Advanced Life Support in Obstetrics (ALSO) provider courses." This may be difficult for some physicians in rural Saskatchewan.

- 3) Anaesthesia Changes:  
Dr. Morris, the anaesthesia specialist on the Committee, has arranged for physicians with a diploma in anaesthesia and sufficient experience to be eligible for Level I (A) anaesthesia to have an assessment at the Department of Anaesthesia, Royal University Hospital, Saskatoon. This program would be one or two weeks long and would enable physicians to upgrade their

anaesthesia skills. It would give the physician an opportunity to learn the system and make contact with people who could advise them if they have questions. Dr. Penny Davis of the Continuing Medical Education Department has approved the program. Dr. Tom Johnson, Director of G.P. Anaesthesia, is the contact person.

In the last year, the Committee reviewed the guidelines for:

- 1) Infection Control and Waste Management in Physicians' Offices
- 2) Standards for Carrying out Exercise Ecg/trocardiograph Stress Testing
- 3) Thrombolytic Therapy

Copies of these guidelines may be obtained by contacting the College.

I would like to thank and acknowledge the contribution of Dr. L. Loewen and Ms. K. Bergstrom of the College staff for their support to the Committee in the day-to-day handling of requests for credentials. Additionally, I would also like to thank the following members of the committee for their contribution, Dr. R. Cardoso, Ms. I. Denis, Dr. G.O. Hansen, Dr. G. Morris, Dr. F. Oleniuk, Dr. A. Nel, Dr. I. Pillary and Dr. M. Thomasse.

*Respectfully submitted by  
Dr. P.T.R. Saunders (Chair).*

## LABORATORY QUALITY ASSURANCE PROGRAM

The Laboratory Quality Assurance Program has adopted the Quality Systems Essentials (QSEs) model and applies those principles to their processes.

Accreditation of medical labs is a major focus and the Program is currently busy with accreditation audits, having just completed the Saskatoon and Prairie North Health Regions.

Nationally, our Program is collaborating with other provinces to develop accreditation processes that will ultimately become the foundation for common accreditation practice.

This involves a major

educational and communication initiative, and the Program has embraced this challenge.

The Program would like to acknowledge the contributions of the following members:

*Program Management Committee:* Dr. B. Murray (Chair), Dr. E.C. Alport (SMA/Transfusion Medicine), Ms. S. Clarke (SSMLT), Dr. D. Devaraj, Dr. G. Horsman, Dr. E. Jones, Dr. L. Massey, Ms. B. Neumeier (SACLXT) and Mr. B. Havervold (Lab Licensing).

*Biochemistry Committee:* Dr. L. Massey (Chair), Mr. E. Serediak, Ms. E. Trask and Ms. M. Currie.

*Hematology Committee:* Dr. R. Devaraj (Chair), Ms. B. Flowers, Dr. A. Saxena, Ms. C. Bear and Ms. N. McPeek. *Anatomy/Pathology*

*Committee:* Dr. E. Jones (Chair), Dr. K. Pauw, Ms. S. Frombach, Ms. S. Pierce and Ms. S. Nardin.

*Microbiology Committee:* Dr. G. Horsman (Chair), Dr. E. Thomas, Ms. B. Borgford, Dr. M. Kanchana, Ms. P. Southgate, Ms. I. Knight and Dr. P. Levett.

*Transfusion Medicine Committee:* Dr. E.C. Alport (Chair), Ms. L. Purcell, Ms. J. Hoff, Ms. S. Shimla, Mr. I. Peterson and Ms. L. Baryluk.

*Clinical Input Committee:* Dr. B. Huber (Chair) and Dr. M. Davidson.

## PRACTICE ENHANCEMENT PROGRAM

### ASSESSMENT STATISTICS:

PEP assessments completed Jan-Oct 2003:

Family physicians:	62	Category 1:	65
Specialists:	9	Category 2:	12
F.P. reassessments:	7	Incomplete (illegibility):	1
<b>TOTAL</b>	<b>78</b>	<b>TOTAL</b>	<b>78</b>

Total assessments completed to date: 637

### UPDATE ON SPECIALIST ASSESSMENTS:

<i>Section of Dermatology:</i>	Section complete
<i>Section of Nephrology:</i>	3 assessments left to complete section
<i>Section of Psychiatry:</i>	8 assessments completed, recruiting/training assessors
<i>Section of Ophthalmology:</i>	2 assessments completed, recruiting/training assessors
<i>Section of General Surgery:</i>	Started in 2003, initial section mail-out complete

All statistics are available in more detail on the PEP website: [www.lights.com/pep](http://www.lights.com/pep)

## WHAT PEP HAS BEEN DOING IN 2003:

### *Inter-assessor Variability*

This research project is designed to study the consistency of PEP's assessment tools and how outcomes may vary between assessors. Ethics approval has just been received and so the project will now go ahead. Charts will be chosen from several upcoming assessments and photocopied with all patient information removed to create sample charts. PEP assessors will then be asked to assess these sample charts according to designated scoring criteria. Outcomes will be recorded to determine variability of assessors and assessment tools.

### *Correlations of Good Practice*

The purpose of this research project is to determine common threads of good practice and the tools used to assign outcomes. A report from a similar project was recently released by the Alberta PAR program. The PEP project will be based on greater numbers of outcomes and actual observation of quality of care. The committee has established goals and parameters for the project. A research consultant will conduct data collection and analysis on information in the assessment Final Reports. The PEP Committee will apply for ethics approval to enable

future publication of results.

### *Medical Record-Keeping Course*

This educational resource is being developed jointly by PEP and CME to offer local instruction for maintaining good medical records. In May 2003 Dr. Davis, Dr. Kukha-Mohamad and Ms. Peat attended the MRK Course offered by the CPSO. Currently a planning committee is being assembled and a Saskatchewan curriculum being developed which will also include Information regarding the new HIPA (Health Information Protection Act). PEP/CME are planning to offer the course in early 2004.

### *Reclassification Questionnaire*

This questionnaire was developed by PEP as a quality control process to monitor reassessments that resulted in an upgrade from Category 2 to Category 1. Very positive responses have been received. Most assessees agreed that the assessment/reassessment process was fair and informative. Most responders also agreed that the PEP recommendations were appropriate and beneficial and they concurred with the conclusions of PEP Committee. The Committee will continue to gather responses to the Reclassification Questionnaire as reassessments are completed.

### *Review of PEP Chart Review Guidelines*

In 2003 the PEP Committee reviewed and updated all of the Chart Review Guidelines used by PEP assessors in conducting family medicine chart reviews. The disease entities include: asthma, depression, diabetes, cardiovascular risk management, and hypertension. A new format was created with checklists that will enable assessors to complete more efficient and consistent chart reviews. The new guidelines will be distributed to each new physician assessed and will also be available very soon on the PEP website at: [www.lights.com/pep](http://www.lights.com/pep).

We sincerely thank our assessors for their continuing contributions to the improvement of the quality of medical practice in Saskatchewan. Thank you to the Saskatchewan Medical Association, the College of Physicians and Surgeons, and Saskatchewan Health for their continued advice and financial support.

There are no new Committee membership changes to report.

*Respectfully submitted by the PEP Committee, Dr. B. Laursen (Chair), Dr. G. Carson (Deputy Chair), Dr. P. Davis, Dr. A. Endsin, Dr. D. Greve, Dr. S. Kukha-Mohamad and Ms. J. Peat (Coordinator)*

## Perinatal and Maternal Mortality Study Committee

The Perinatal and Maternal Mortality Study Committee studies matters that pertain to the quality of obstetrical practice and neonatal care identified by the Committee through the review of medical records.

The Committee reviews perinatal deaths including stillbirths and early neonatal deaths (up to seven days) in addition to maternal deaths (during pregnancy or within 42 days of termination of pregnancy).

The Committee's aim is to be educational and provide feedback to physicians on the quality of care provided. When generally applicable issues are identified from cumulative records, the Committee will undertake education for all physicians providing obstetrical care. When appropriate, the Committee corresponds with other professional regulatory bodies or health regions to provide suggestions and/or raise concerns that the Committee was unable to resolve itself.

The total number of births in Saskatchewan for 1 April 2002 to 31 March 2003 was 11,685. The number of stillbirths and perinatal deaths (up to seven days) is approximately 80 per year. Since the last annual report, the Perinatal and Maternal Mortality Study Committee has met on four

occasions: November 2002, March 2003, May 2003, and October 2003. We are reporting over this fourteen-month period due to a change in the timing of reporting the committee's statistics in the "annual report". The Committee reviewed a total of 162 new cases. These cases spanned the period from 2000 to 2003, with the majority of the cases reviewed being from 2002 to 2003.

From all of the perinatal deaths, only 9 were classified as preventable and 3 as ideally preventable. Areas of concern identified in the cases categorized as preventable and ideally preventable were:

- 1) Difficulty in recognition of intrauterine growth restriction, particularly in obese women,
- 2) Inadequate fetal surveillance when intrauterine growth restriction is suspected,
- 3) Inadequate fetal surveillance during labour,
- 4) Delay in reporting abnormal ultrasound findings and/or abnormal biophysical parameters to the attending physician, and
- 5) Inadequate fetal surveillance in the management of post term pregnancy.

The Committee further sought patterns of care that appear to be associated with increased risk of adverse outcome. Identified areas for potentially beneficial change include:

- 1) Promote the use of Betamethasone as the appropriate antenatal steroid for use in preterm labour at the gestational age between 25 and 34 weeks. (CPSS Newsletter, July 2002, Vol. 18, No. 50).
- 2) Encourage the appropriate use of serial ultrasound in the obese patient for surveillance of fetal growth. Recognition of intrauterine growth restriction is difficult; it is particularly difficult in the obese patient (CPSS Newsletter, March 2002, Vol. 18, No. 49).
- 3) High risk pregnancy must be monitored. Appropriate fetal surveillance must be continued without interruption until the delivery is completed.

The Committee considered whether there is a need to review pediatric deaths in Saskatchewan. Saskatchewan's rate of infant mortality is unacceptably high. The Committee discussed the possibility of expanding the work of the Perinatal

Committee to include all pediatric deaths up to one year, but it did not believe it had the manpower, expertise, or finances to review those deaths. The Committee, however, believed it could complete the review of all perinatal deaths, thereby increasing the review of cases from seven days to the end of the perinatal period (28 days). The Committee believed this was a reasonable expansion, as it would require the same expertise that currently exists. It would increase the number of cases reviewed by approximately ten per year.

The Committee recommends the establishment of a congenital anomalies registry, to include all pregnancies including those with a gestational age too young to be in the birth registry.

A survey of pediatricians in the province regarding the need for a pediatric death review process in Saskatchewan returned overwhelming support. The Province needs the services of (a) specialized pediatric pathologist(s). The Committee continues to support discussions between other agencies and Sask Health in these initiatives.

The Committee continues to publish Newsletter articles on areas identified

for improvement. Dr. Carson, chairperson, wrote an article on best practice regarding artificial rupture of membranes (CPSS Newsletter June 2003, Vol. 19, No. 53).

The lack of adequate documentation has hampered the Committee's quality assessment process. Completion of the existing forms is too often deficient. This has been brought to the attention of those responsible for the obstetrical services where this deficiency most commonly occurs. A simplified indication for induction of labour sheet was adopted by the Committee and circulated to the obstetrical departments in the Regions. It is hoped that the simplified form would be easier for the physician to complete, and would result in complete documentation of the pertinent information necessary for the Committee's work. This undertaking is in process.

The Perinatal and Maternal Mortality Study Committee has joined with the Anaesthetic & Operative Deaths Study Committee to prepare a joint statement recommending prelabour/pre caesarean section anaesthesia assessment for morbidly obese patients and other patients who pose a challenge for emergency venous and/or airway access.

The Perinatal and Maternal Mortality Study Committee has assisted the Advisory Committee on Medical Imaging with suggestions regarding the information and format of the ultrasound reporting form. The Committee plans to work on a joint statement recommending a list of obstetrical fetal emergencies that must result in immediate reporting by the radiologist to the attending physician. The Committee refers cases for consideration by the Advisory Committee on Medical Imaging, when the quality of the ultrasound is questioned.

Physicians are encouraged to visit the SOGC website at [www.SOGC.org](http://www.SOGC.org) for review of obstetrical guidelines and policies, which the Perinatal and Maternal Mortality Study Committee endorses.

On behalf of the College we would like to take the opportunity to thank the Committee members for their hard work and valued contribution to quality assurance. They are: Dr. G.D. Carson (Chair), Dr. C.E. Clark, Dr. K.C. Fong, Dr. M.A. Halyk, Dr. J. Hey, Dr. M.J. Martel and Dr. N. Wonko.

*Respectfully submitted by  
Dr. K. Shaw, Medical  
Manager and Ms. K.  
Bergstrom, Coordinator.*



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# Newsletter

## Mark your calendars...

**Second Annual  
 Partners in Health  
 Conference and Exhibition**

**March 21 - 24, 2004**

**Saskatchewan Centre of the Arts  
 Regina, Saskatchewan**

**Conference: March 21-24, 2004**

**Exhibition: March 22 & 23, 2004**

**Watch for more information coming soon  
 or check out our web site**

**[www.saho.org](http://www.saho.org)**

*Partners in Health 2004*

## Building *the* Health Care Mosaic



**SAHO**

Saskatchewan Association of  
 Health Organizations

*in partnership with*



*Supporting partners:*

- College of Physicians and Surgeons of Saskatchewan*
- Saskatchewan Association of Licensed Practical Nurses*
- Saskatchewan College of Pharmacists*
- Saskatchewan Emergency Medical Services Association*
- Saskatchewan Medical Association*
- Saskatchewan Registered Nurses Association*