



# College Newsletter

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

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## Message from the President

### Seasons Greetings!

Since the last 'Newsletter', some excellent educational events have taken place. The Annual General Meeting was held in October with a very interesting educational component. Coming from a mental health perspective, I felt it was positive that pertinent issues such as depression, physician support, communication and balancing work and family needs, were addressed so effectively in that forum.

Sometimes it is hard to, "keep all the balls in the air", as we juggle everything that matters in our life, and still

have time and energy to focus on our own needs, and on the needs of those closest to us.

One of the educational sessions that piqued my interest, possible because it is the "buzz word" of the day, and I found myself thinking why it is such a talked about issue, is the concept of "balancing work and family."

Dr. Michael Myers spoke to this issue in his presentation on 'Health Professionals in Relationships: Toward Balancing Work and Family'. As we look at our work world and the many challenges and changes that we face every day, it is a wonder that we have any energy or time left for our life outside of the hospital or the clinic. I think that if we are honest with ourselves, there are some days when we feel that we really don't have a lot left over, and we need to go into a "mental shut down" for a moment to regroup and to let go of the day's stress. Most often, there is little time for that moment of peace, as at the end of the day, we move on to yet another meeting or family activity.



*Dr. M.G. Mirchandani*

The challenge of how to stay balanced and happy with all the important things in our life, aside from our work, is tempered with the reality that our work consumes the bulk of our day, and for most of us, the time spent on the job is often long and the hours unpredictable.

The thought of taking an inventory of our needs, the time required to meet those needs, and how it is balanced in the division of the "time pie", is one approach. How much time do we need to spend to keep our relationships alive with our partners/spouses/

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children and friends? How much time do we need for recreation, exercise and relaxation? What time commitment do we want to make to meet our spiritual, community or volunteer activities?

It is possible that one of those areas of our lives is not getting the full attention that it needs. If that area is neglected, what is the cost of our limited investment of time and energy? Is it the loss of a relationship, or having relationships that are

not supportive or really intimate? Will our health suffer in the long term, or will we be chronically stressed and overwhelmed?

When we imagine looking back at the end of our career, will we be happy with the choices that we made, the people and the lifestyle we have around us?

Taking care of others means firstly, taking care of ourselves. Setting limits, defining our priorities and making the time is the first

step to creating the balance that we need.

As we approach the busy holiday season, it may be a good time to reflect on where we have been, and where we want to go.

Despite what the media and our society may want to tell us, "living well" may really mean living with no regrets.

*Have a safe and peaceful holiday.*



## Medical Practice Call Coverage – An Inherent Professional Responsibility Or Elective Option?

*D.A. Kendel MD, Registrar*

Some of our professional responsibilities as physicians are defined in statute and bylaws. Others are informed by codes of ethics. Still others are more implicit, having been part of a very long professional tradition.

The medical profession has long prided itself on the importance it places on the patient-physician relationship. We've regarded that relationship as a very special one that embodies much more than the usual business relationship that might exist between a customer and service vendors.

The nature of the patient-physician relationship varies somewhat between physicians who offer continuing care to patients, as opposed to those who serve as consultants to primary care colleagues.

For those physicians who accept responsibility for the continuing care of patients, the patient-physician bond is particularly strong. Most patients prefer to access care from a physician, or group of physicians, with whom they have established an enduring relationship.

For generations primary care physicians have

sustained this special relationship with patients by making arrangements for those patients to access care from them, or from designated on-call colleagues, outside daytime weekday hours.

These arrangements for continuous patient access to primary medical care have historically been maintained distinct from the emergency care option made available to the public through hospital emergency departments. Initial contact between on-call physicians and patients in need of care is generally made by phone. Quite often the patient needs can be

met by advice from a physician over the phone. Where it seems evident that more direct and/or intensive medical assessment is required, patients are directed to a hospital emergency department where they may be attended by the physician who so directed them, an on-call colleague at the hospital, or a full-time emergency room physician.

In smaller rural communities that do have hospitals, the physician who is on call for medical colleagues in the community is often the same physician who is on call for the hospital emergency department. With explicit approval from the RHA, hospital emergency departments in smaller communities often become the focus for delivering all primary medical services outside conventional daytime weekday hours.

There has never been a statutory requirement that physicians arrange on-call medical services for the patients for whom they accept responsibility for continuing care. The impetus for these arrangements has largely been the *CMA Code of Ethics*, fundamental precepts of professionalism and professional tradition. One could say that medical practice after-hours coverage is an implicit standard of care within the medical profession.

Almost a decade ago, the College of Physicians and Surgeons, the Saskatchewan Medical Association, and Sask Health partnered in the creation of the Practice Enhancement Program (PEP). This program has a single purpose of fostering continuous quality improvement in medical care, provided through medical offices and clinics.

The PEP Program has assembled a group of physician volunteers who conduct medical office assessments, evaluate the standard of care being provided by individual physicians, and make recommendations for enhancement of care where opportunity for enhancement is identified.

Several years ago, the PEP Program found itself in an ethical dilemma when it assessed a number of primary care practices in major urban centres that make no arrangements for on-call coverage of their practices. When these clinics close at the end of the day, they simply leave a message on an answering machine directing patients in need of care to the local hospital emergency departments. The physicians in these clinics make no prior arrangements with hospital emergency departments and/or their colleagues working in these departments to accept continuing care responsibility for their patients.

The PEP Committee deemed this to be a deficient standard of medical care, and so advised the physicians in question. This drew protest from the SMA, which claimed that the PEP Program has no statutory authority to define acceptable standards of medical care. It can only apply standards that have been defined in statute, bylaws, codes, and/or policies of the College.

The PEP Committee then invited and encouraged the College and the SMA to articulate a consensus position on physician responsibility to maintain after hours practice call services.

The PEP Committee had interpreted Section 10 of the *CMA Code of Ethics* to mean that all physicians do have a professional responsibility to provide or make alternative arrangements for continuing medical care for their patients.

On its initial review of this issue, the College Council concurred with PEP's interpretation of the *CMA Code of Ethics*. While the Council did not explicitly define the range of on-call arrangements that might be acceptable, it did note that the *CMA Code of Ethics* speaks about "another suitable physician assuming responsibility for the patient". That has historically been interpreted to mean that continuity of care

arrangements ought to be made between specific colleagues, with comparable knowledge and skills.

Over the past three years, the SMA has been reluctant to accept the position of the College on this issue but has not, until very recently, articulated an alternative policy option.

Two months ago, the SMA Board did articulate a draft policy position that subsequently received discussion at the SMA's Representative Assembly. The SMA's draft policy position begins with an affirmation that all physicians involved in direct patient care have an obligation to arrange for twenty-four hour coverage of patients currently under their care. It goes on to say that physicians who transfer coverage of patients in their practice to another physician should have the agreement of that physician before doing so.

However, the next statement in this position paper conflicts with these fundamental principles when it sanctions the practice of physicians "signing out" to a hospital emergency department without any requirement for prior

approval from the emergency room physicians and/or the RHA.

It became clear from the discussion at the SMA's Representative Assembly that many physicians are troubled by such a policy option. The College also has difficulty accepting such a policy as an option that might be exercised by all physicians.

Unless a policy is framed in language that makes it explicitly applicable to a select group of physicians, it must be considered applicable to all physicians.

Maintaining on-call practice coverage is undeniably a burden for physicians, but one that is currently shouldered by the overwhelming majority of physicians as an inherent professional responsibility. The phenomenon of unilateral physician sign-out to hospital emergency departments appears to be a phenomenon that is limited to Saskatoon and Regina.

Unless someone is able to raise compelling arguments as to why a select cohort of physicians should be exempt from this traditional professional responsibility, the College is inclined to

regard this as a universal responsibility to be shouldered by all physicians who are involved in direct patient care.

The College has sought, and is currently receiving, feedback from RHA Chiefs of Staff, Medical Heads of RHA Family Medicine Departments, Medical Heads of hospital emergency departments, RHA CEOs, and Saskatchewan Health on this issue. At its most recent meeting, the Council also identified a desire for feedback from all College members who may wish to share their perspective on this issue.

To that end, this issue of the 'Newsletter' includes a brief survey that we would encourage members to complete, and fax back to the College by January 20, 2003.

If the survey questions do not afford you an adequate opportunity to convey your perspective, please feel welcome to send a letter which will be forwarded to the Council, and reviewed by the Council at its next meeting on January 31, 2003.



# MEMBER SURVEY RE: PROFESSIONAL PRACTICE CALL RESPONSIBILITIES

1. Do you believe that all physicians involved in direct patient care have an obligation to arrange for 24-hour coverage of patients currently under their care?

Yes

No

2. Do you believe that practice coverage arrangements should be made directly between medical colleagues?

Yes

No

3. Do you believe it is acceptable for physicians to sign out all after hours practice coverage responsibilities to a hospital emergency department?

Yes

No

4. If sign out to a hospital emergency department is acceptable practice, should sign out be conditional upon prior agreement with:

a) medical colleagues in the emergency department?

Yes

No

b) RHA administrative personnel responsible for emergency room management?

Yes

No

5. Are there circumstances in which selected physicians who have responsibility for direct patient care should be exempted from any requirement to make explicit practice coverage arrangements?

Yes

No

6. If your answer to 5 above was yes, please identify the circumstances in which you believe such an exemption may be appropriate.

**Please fax your response to: (306) 244-2600. Thank you.**

# College Bylaw Prohibiting Inducements

Bryan Salte, Associate Registrar and Legal Council

In early 2002, the Alberta College passed a bylaw to prohibit physicians offering inducements to their patients, or to others who might refer patients to them.

Apparently, some Alberta ophthalmologists were paying a referral fee to optometrists who referred patients for laser surgery. While the Alberta bylaw was primarily motivated to prohibit this practice, the Alberta College recognized that such inducements could, however, occur in other ways as well.

Council for the Saskatchewan College decided that this practice should be prohibited in Saskatchewan as well.

At the October meeting of Council, the Council passed a bylaw which defines offering an inducement for medical treatment as unprofessional conduct, which could result in discipline proceedings against a physician who made such an offer. The Council's definition is:

- (i) "offering an inducement for medical treatment" includes any situation in which:*
- (i) a physician, or any person or organization with the knowledge of a physician, offers or provides any inducement to a patient, a prospective patient, or any other person, for the referral of a person to the physician for the provision of any service or product, whether that service or product is, or is not, medically necessary;*
- (ii) a physician, or any person or organization with the knowledge of a physician, offers any inducement, or causes any inducement to be received directly or indirectly by a patient of the physician, or any other person for the benefit of the patient of the physician, in return for the provision of any service or product to that patient, whether that product or service is, or*

*is not, medically necessary; but does not include a reduction of a fee or charge that is made by a physician to a patient where that reduction is not related to products or services that may be provided to persons other than the patient.*

Such offers are most likely to occur where physicians provide non-insured services such as laser eye surgery, plastic surgery, or chelation treatments. However, they could arise in any situation where a benefit is provided to anyone as a result of treatment provided to a patient.

Anyone wishing to discuss this can contact Dr. Dennis Kendel, Dr. Karen Shaw, Mr. Bryan Salte, or Ms. Jo-Anne Wolan, at the College offices at (306) 244-7355.



**VISIT OUR WEBSITE AT:**  
**[www.quadrant.net/cpss](http://www.quadrant.net/cpss)**

# Recent Legislative Change

Bryan Salte, Associate Registrar and Legal Council

There has been a recent legislative change which significantly expands the responsibility for individuals, including physicians, to report sexual abuse of young persons.

Currently, a report must be made to the Department of Social Services, or the police, where the person has reasonable grounds to believe that, as a result of action or omission by a child's parent:

- (i) the child has suffered or is likely to suffer physical harm;
- (ii) the child has suffered or is likely to suffer a serious impairment of mental or emotional functioning;
- (iii) the child has been, or is likely to be, exposed to harmful interaction for a sexual purpose, including involvement in prostitution, and including conduct that may amount to an offence within the meaning of the *Criminal Code*;
- (iv) medical, surgical or other recognized remedial care, or treatment that is considered essential by a duly qualified medical practitioner has not been, or is not likely to be, provided to the child;

(v) the child's development is likely to be seriously impaired by failure to remedy a mental, emotional or developmental condition; or,

(vi) the child has been exposed to domestic violence, or severe domestic disharmony, that is likely to result in physical or emotional harm to the child.

There is also a responsibility to report where no adult person is able and willing to provide for a child's needs, and physical or emotional harm has occurred, or is likely to occur.

For the purposes of the existing legislation, a report need only be made if the individual is under the age of sixteen years.

New legislation, *The Emergency Protection for Victims of Child Sexual Abuse and Exploitation Act* now requires a report, where an individual is under the age of eighteen years, if the individual has been, or is likely to be, exposed to harmful interaction for a sexual purpose, including involvement in prostitution, and involvement in conduct that may be an offence pursuant to the *Criminal Code*.

Physicians should be aware that the age for mandatory reporting of sexual abuse has been increased to include sixteen and seventeen year old persons.

Physicians should also be aware of the change to consent requirements for procedures performed in hospitals.

Until January 2002, no surgical operation could be performed on an unmarried patient under the age of eighteen, unless the written consent of that individual's parent or guardian was obtained.

That requirement has now been abolished.

The effect of this is to place consent for surgical procedures on the same basis as consent to any other form of medical intervention. A physician has an obligation to obtain informed consent from all patients, including patients under the age of eighteen. However, if a patient is under the age of eighteen, and is capable of providing informed consent, there is no obligation to obtain the consent of that person's parent or guardian.

# The Art of Communication

Jo-Anne Wolan, Director of Communication/Education

At the College's Annual Educational Session held in October, part of the program was directed at improving physician- patient communications. Evidence has suggested that problems with physician-patient communication are common.

From Health Canada's *Talking Tools* program entitled, "Putting Communication Skills to Work":

Studies show that:

- 45% of patient's concerns about their problems are not elicited
- 50% of psychosocial and psychiatric problems are missed
- In 50% of visits, the patient and physician do not agree on the nature of the main presenting problem
- Physicians interrupt patients, on average, 18 seconds into the patient's description of the presenting problem
- The majority of complaints arise from communication errors, not competency errors
- The most common complaint is the lack of information provided by physicians in order for the patient to take an active role in their medical care

The good news is:

- Good physician-patient communication contributes to positive health outcomes in addition to helping the physician do his/her job better in a time-limited environment
- Physicians can expand and improve their communication skills in order to meet a wide range of patient needs and circumstances.
- Communication skills can be adapted, personalized and adjusted to meet individual patient needs and personalities
- Practice and self-assessment are excellent means of acquiring and honing communication skills

Studies have also identified some of the key elements of effective communication to be:

- The physician asks many questions
- The physician shows support and empathy
- The patient has the opportunity to express themselves fully
- The patient feels that his/her problem as been fully discussed

The evidence has also indicated that physicians are most dissatisfied when dealing with patient's emotions, when they have difficulty understanding what

the patient wants, and when there is any medical uncertainty.

Offsetting these dissatisfactions, the literature describes physician satisfactions as including; dealing with patients and relatives together; providing continuity of care; performing a health education role; and establishing collegial relationships with patients.

Rigorous analytical studies have shown that physician satisfaction is related to medical labelling, social chatting, a visit where a prescription was warranted, and conducting a physical examination. The less need there was for the physician to provide emotional support, the higher the physician satisfaction.

Dr. Paul Caulford, who instructs the Ontario College's course on *Communicating with Patients* states, "The problem is there are no guidelines for dealing with a difficult patient encounter in the same way that there are guidelines for a C-section or managing an MI. So, it's okay if you don't feel that you are an expert. In the contest of patient-centered interviewing, the patient more often than not will be most satisfied when the doctor combines being a skilled clinician with an

empathetic, respectful and sensitive approach. Often what the patient wants most is a partner in conversation, and a partner willing to explore their problems.”

Remember, good communication is a two-way, interactive process.

*The following is reprinted from the College of Physicians and Surgeons of Ontario’s “Members’ Dialogue, Sept/Oct, 2001.*



## **DO YOUR COMMUNICATION AND INTERVIEWING SKILLS INCORPORATE THESE ELEMENTS**

### **RESPECT**

- *Uses a non-judgmental approach with patients*
- *Places patient needs ahead of own*
- *Able to apologize for running late*
- *Acknowledges limitations: able to say “I don’t know, but I will find out.”*
- *Obtains fully informed consent for patient decisions*
- *Maintains confidentiality*
- *Avoids assertive, dominating or sarcastic language*
- *Educates, shares decisions and plans with patients*
- *Understands that a license to practise medicine is not a license to legislate the values of others*

### **COMMUNICATION SKILLS**

- *Facilitates information flow without “controlling” it*
- *Avoids medical jargon*
- *Encourages discussion of patient concerns*
- *Puts patient at ease*
- *Uses constructive skills of negotiation and refusal*
- *Fosters empathy and support*
- *Listens well, avoids interrupting*

### **RESPONSIBILITY**

- *Keeps commitments (i.e., follow-up), continuity*
- *Maintains knowledge and skills and works on strengthening weak areas*
- *Controls temper in negative/difficult situation*
- *Proves to be trustworthy*
- *Respects and interacts positively with peers*

### **REFLECTION, SELF-EVALUATION AND SELF-AWARENESS**

- *Learns from experience and errors, and changes behaviours accordingly*
- *Uses constructive feedback to enhance competence*
- *Avoids burnout, knows own limitations*
- *Reflects on difficult cases and improves as a result*
- *Willing to make changes*
- *Avoid impugning the reputation of colleagues*

# Shortage of Medical Laboratory Technologists

*Saskatchewan Society of Medical Laboratory Technologists*

A nation-wide shortage of medical laboratory technologists (MLTs) is predicted as early as 2005, resulting in a serious health risk to all Canadians. This shortage is particularly evident in Saskatchewan. Updated membership numbers indicate that the number of practicing MLTs in Saskatchewan is shrinking at a more rapid rate than expected. *As of December 201, the number of practicing MLTs reached 967, a level not expected to be reached until 2010.*

The Saskatchewan Society of Medical Laboratory Technologists (SSMLT) has urged the provincial government to take immediate action to avert this health care crisis.

The SSMLT is the licensing and professional society for medical laboratory technologists in Saskatchewan. It represents 967 highly trained medical laboratory technologists who conduct sophisticated tests on blood, body fluids, and tissue specimens in medical, research, and other laboratories. Medical laboratory technologists represent the third largest group of health care professionals, after physicians and nurses.

At current training rates (16 students annually), there simply won't be enough new technologists entering the workforce to replace those who retire. Nor will Saskatchewan be able to recruit MLTs from other Canadian jurisdictions because many training programs in Canada have been cut back, and some have been eliminated altogether. Compounding this crisis is the fact that it will hit at a time when the demand for health care services is expected to grow due to the aging of the population.

A recent (December 1999) survey of approximately 1200 SSMLT members indicated the following:

The majority of MLTs currently practicing in Saskatchewan:

Are between the ages of 35 and 45

Intend to retire between the ages of 50 and 60

Actually do retire within the age range of 50 to 60

By the year 2015:  
~ 480 or 40% of the current SSMLT members will be retired

~ the total SSMLT membership will fall to less than 700 if current training levels are not increased

The replacement of 480 MLTs between the years 2000 and 2015 will require an average training rate of 30 graduates per year.

The Advisory Committee on Health Human Resources (ACHHR), an inter-provincial committee comprised of deputy ministers of health, or their designates, conducted an environmental scan on the human resource issues affecting medical laboratory technology. The results were published in a May 1999 report. The report concluded that, "the anticipated rate of retirement in the 'baby boom' technologist workforce in the next 5 to 10 years is expected to create a significant shortage, which is already being felt." It was recommended that a national strategy be developed to address this impending human resource crisis.

Our entire level and quality of health care is at risk. When steps are taken, it will take a minimum of two years before any additional medical laboratory technologists will be available to enter the workforce.

Although this crisis is no longer avoidable, quick,

decisive action needs to be taken to reduce its duration.

We must take action to ensure that there will be a sufficient number of medical

laboratory technologists to meet the needs of Saskatchewan residents.

*As the current trend continues, laboratory testing*

*capabilities may be downsized; resulting in referral of testing out of province, and the possible delay of diagnosis and treatment.*



## Notes

### 2003 COUNCIL MEETINGS

January 31<sup>st</sup>/February 1<sup>st</sup>  
March 23<sup>rd</sup> and 24<sup>th</sup>  
Annual General Meeting – March 25<sup>th</sup>  
June 20<sup>th</sup> and 21<sup>st</sup>  
September 19<sup>th</sup> and 20<sup>th</sup>  
November 14<sup>th</sup> and 15<sup>th</sup>

A portion of each Council meeting is open to the public.  
For further information contact J. Wolan, Director of Communications/Education  
at (306) 244-7355

### Next ECG Exam

Monday, April 7th, 2003 – 1:00 – 4:00 p.m.  
College of Physicians and Surgeons, Saskatoon

For further information, contact Carol Bowkoy at (306) 667-4635



***Best Wishes for the Holiday Season  
and for a Happy New Year From all the  
staff at the College***



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Newsletter

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