



College Newsletter

A publication of the College of Physicians and Surgeons of Saskatchewan

211-4th Ave. S., Saskatoon, SK S7K 1N1 • Tel: (306) 244-7355 • Fax: (306) 244-0090 • Email: cpss@quadrant.net

Message from the President

Autumn is often a time of reflection between the busy, somewhat carefree summer season, and the hectic schedules of winter we often seem to keep. Therefore, it is appropriate that the Council has decided to devote a part of its November meeting to pause and reflect on how it is doing business.

There can be no doubt that our governance model is extremely efficient. It has allowed our administrative staff to organize and accomplish more work in a more timely and thorough manner than ever before. This is unquestionably a benefit to all College members and the public at large. At the same time, this has placed the Council

members in a somewhat new position – that of policy makers. This position requires new skills and even new and different thought processes. It is no longer enough to receive and analyze reports. Rather, Council must focus on somewhat theoretical and, at times, philosophical matters and through thought, research, and vigorous debate, distil these concepts into practical policies that will and do guide the profession now and into the future. Topics on our agenda range from all-encompassing subjects such as patient safety, preparing physicians for practice in the 21st century, to such practical and mundane matters as licensing of international medical graduates and overseeing of the College's financial matters.

In order to develop meaningful, practical policies in those matters that will serve to guide the profession and so protect the public, the Council has decided to conduct a review of the practical aspects of doing business. Items such as frequency of meetings and content, format of agendas, and the use or not



Dr. Garry Hansen, MD

of committees and sub-committees, will be under discussion.

Hopefully, these discussions will lay the framework that will enable Council to effectively and efficiently develop into a policy making board that will serve the profession and public well in this new century.

I, and the Council, would welcome any suggestions the members may have in these matters. Many of the membership have substantial expertise in these areas and your input would be most welcome. An informed and enthusiastic membership is, and will be, the cornerstone of a self-governing profession.

IN THIS ISSUE

President's Message	1
Patient Safety	2
Post-it Note Proves Deadly	3
Antepartum Planning for IV Access	4
Adverse Reaction Reporting	5
Physician Resp. & Deceased Patients	6
Amending Health Information	8
Temporary Licensure Changes	8
HIPA	9
Revalidation	10
To All SK Physicians	10
Recommended Resources	11
Feedback	11

Patient Safety – Challenges and Opportunities for the College

D.A. Kendel, MD, Registrar

In May of this year, research with respect to adverse events in Canadian hospitals, which was led by Drs. Ross Baker and Peter Norton, was published in the CMAJ.

In some respects, the outcome of this research was highly predictable as there was no reason to believe that hospital care in Canada is inherently safer than that in the U.S., the U.K. or Australia where adverse events have been previously studied. However in other respects, the Baker-Norton research served as a sobering reminder to us that complex health care is a high-risk undertaking. On the basis of a 7.5% adverse event (AE) rate, we are confronted with compelling evidence that about 180,000 of the 2.5 million hospital admissions in Canada each year are associated with adverse events. Of these, about 70,000 are likely preventable.

These data pose a challenge to every agency involved in the health sector. Every agency that has any potential to reduce the risk of harm to patients in the course of health care ought to be asking itself whether it could be more effective in advancing the safety agenda.

Professional regulatory bodies such as the College of Physicians and Surgeons have a large stake in this issue. Of the various organizational goals that the College's governing Council has identified, public protection is ranked as our highest goal. So, what College policies and programs are most likely to advance the goal of patient safety? Are there any policies or practices that might actually hinder our effectiveness as a patient safety agent?

The historical view of professional regulatory bodies is that they are publicly accountable for the competence, effective performance, and ethical conduct of the individual professionals whom they license to practice. Most of the time, the energy and resources of these agencies have traditionally been deployed in response to evidence to suboptimal performance, or inappropriate conduct by individual professionals.

In patient safety parlance, this focus on the suboptimal performance of individual professionals is often labelled as "name and blame activity". Name and blame activity is seen by many in the patient safety movement as being

counterproductive to systemic approaches to patient safety. And, there is little doubt that the greatest potential gains in patient safety are associated with systemic approaches to safety enhancement.

I would like to draw an analogy with another domain of human activity that involves risk of harm, that being the operation of a motor vehicle. Operating a motor vehicle will never be totally risk free, but much can be done to increase safety on roads and highways.

Traffic safety is a multi-faceted issue. There are public policy issues at stake with respect to driver training, driver licensure, traffic flow control, traffic law, etc. There are system design issues at stake such as roadway design, the strategic placement of road signs, the placement and timing of traffic lights, etc. There are issues with respect to law enforcement such as the endorsement of speeding laws and laws pertaining to impaired driving. There are educational issues such as public awareness and sensitivity to the dangers associated with impaired driving.

There are a host of agencies that share an interest in traffic safety. It is

not difficult to appreciate the fact that traffic safety is likely to be optimized when these agencies work collaboratively to achieve maximum integration of their effort.

The same principles are applicable to safety in the health care system. We are likely to achieve optimal patient safety if all organizations with a stake in the issue work collaboratively with a focus on systemic factors influencing safety.

I believe the College, and all other professional regulatory bodies, need to become more systemically focused in their approach to patient safety. However, professional regulatory bodies will never be able to totally abandon their public responsibility for dealing with public concerns about the competence and performance of individual physicians. We cannot and should not shy away from our responsibility to deal with professional incompetence any more than law enforcement agencies ought to turn a blind eye to evidence of impaired driving. However, in our approach to physician performance

deficiencies I believe we need to become much more sensitive to the systemic factors that may impact upon a physician's capacity to perform optimally.

I am sensitive to the fact that some people with considerable expertise in the field of patient safety hold a view that traditional regulation of health professionals in organizational silos is part of the problem rather than part of the solution. While some professional regulatory bodies might be inclined to be defensive in response to that perspective, I do not think that perspective can be ignored.

Sometimes the most impressive improvements in organizational effectiveness come from the insight of people who look at an organization from an external vantage point and who are not bound by tradition and internal allegiance. They may see things that we who work within the organizations have difficulty seeing because we're simply too close to the action on a day-to-day basis.

With that reality in mind, I have invited experts from the newly created Canadian Patient Safety Institute to critically evaluate the current policies and practices of the College of Physicians and Surgeons in Saskatchewan, and offer recommendations as to how we might significantly enhance our effectiveness as a promoter of patient safety.

There is obvious risk in inviting such external scrutiny because the recommendations emerging from such a process may challenge us to think and act in radically different ways. However, if we are truly committed to making health care safer, I believe we have to be willing to change where the evidence suggests that such change might enhance patient safety.

I do hope the Canadian Patient Safety Institute will accept our invitation to regard the Saskatchewan College as a learning laboratory. For our part, we will be pleased to share with other regulatory bodies in Saskatchewan, and across the country, whatever lessons we learn from this experience.



Results on Post-it Note Prove Deadly

Reprinted from Medical Post August 17, 2004, Vol. 40, Issue 31

CORK, IRELAND – The family of a young man who died after vital blood results were missed by doctors because the results had been stuck in his file on a

Post-it note....The court was told the young man should have died.

The test results showed severe hypercalcemia but were stuck on the back of a

referral letter. The missing note set off a chain of medical errors.

The patient was admitted to hospital but the hospital's standard blood

tests didn't measure calcium. He was misdiagnosed with nephritis

and went into cardiac arrest. The autopsy showed the highest levels of blood

calcium ever recorded at the hospital.



Antepartum Planning for IV Access

*Dr. G. D. Carson and Dr. J. Martel, Perinatal and Maternal Mortality Study Committee
Dr. S. Vuksic, Anaesthetic & Operative Deaths Study Committee*

PREAMBLE

The following is a hypothetical case regarding the need for antepartum planning in advance of the need for intravenous access.

CASE

A 26-year-old gravida 1 para 0 presented for delivery at a level II hospital in spontaneous labour at 39 weeks gestation (confirmed by ultrasound).

She was 160 cm tall. Her weight at first visit was 120 kilograms (BMI 46.9) and at her last visit 138 kilograms (BMI 53.9). Glucose tolerance testing in the pregnancy was normal and the pregnancy progress seemed satisfactory. Due to her morbid obesity (BMI > 35), serial ultrasound scans were obtained for evaluation of fetal growth, and this was consistently about the 85th percentile.

She had initially slow progress in labour with arrest at 6 centimeters dilatation. Intravenous access was established (20G cannula dorsum left hand) in order to allow Oxytocin augmentation of labour. Oxytocin was given and she advanced to full dilatation. Labour analgesia

was provided with systemic opioids.

After 1½ hours in the second stage of labour, she had persistent fetal bradycardia. The head was LOA at station +3. A vacuum extractor was applied and delivery was effected.

Postpartum, there was excessive vaginal bleeding. Uterine massage and additional intravenous Oxytocin were given but bleeding continued. Exploration of the genital tract was difficult given the patient's size. It was found that there was some extension of the median episiotomy. The uterus was also intermittently atonic.

The patient became tachycardic and blood pressure fell to 60/40. Three attempts to start an intravenous drip were unsuccessful. An attempt at jugular puncture was unsuccessful. Eventually, the GP surgeon in the community achieved a cut down to the left saphenous vein and fluids could be administered rapidly.

PRIOR PLANNING FOR INTRAVENOUS ACCESS

In several of the cases reviewed by our Committees

difficult venous access was predictable. Anesthetists are frequently called upon to establish "difficult IV's" but often do not see obstetric patients prior to what can be an urgent need for an IV. Although fortunately rare, it is usually a preventable problem if the need is anticipated and action is taken before there is a crisis. Adverse patient outcomes can often be prevented.

OBJECTIVE

To help physicians caring for obstetrical patients to identify those in whom venous access might prove difficult, with a view towards securing such access early in labour.

PREDICTORS OF DIFFICULT IV ACCESS

1. Previous difficult IV access
2. Previous frequent use of subcutaneous veins for access
 - a. History of chemotherapy or parenteral nutrition given peripherally
 - b. IV drug abuse
 - c. Frequent hospital admissions with IV therapy
3. Constitutional factors
 - a. Morbid obesity (BMI > 35)

- b. Extensive involvement of the skin with medical conditions e.g. burns, dermatitis, psoriasis, frostbite
- c. One or more limbs unavailable for use (e.g. multiple amputations, use of (a) limb(s) for hemodialysis or plasmapheresis or previous axillary lymph node dissection.)
- d. Para or quadriplegia

PREDICTORS OF POST-PARTUM HEMORRHAGE

1. Previous PPH
2. Prolonged use of Oxytocin
3. Macrosomia
4. Polyhydramnios
5. Multiple Gestation
6. Coagulopathy

MANAGEMENT OF CASES

Although most obstetrical patients have uneventful courses, unfortunately some will experience significant postpartum hemorrhage leading to hemodynamic

instability. Consequently, establishment of larger bore (16G or 14G) intravenous access is necessary to allow the emergent administration of medications and large volumes of fluids. Although these events can occur with little warning, in many cases they can be anticipated. It makes sense that, if IV access is expected to be difficult, it be established in a semi-elective, unhurried manner early in labour.

The particular manner in which cases are handled will vary regionally, depending on available expertise; what is most important is that these patients be identified. A large bore (16G or 14G) IV should be in place soon after admission of these women to the labour ward, and should be evaluated periodically as to certainty of intravenous placement, and attainable flow rates. As multiple attempts make

eventually obtaining IV access more difficult, the most experienced person available should attempt the IV; this person should also feel comfortable calling upon another for help. The physician providing anesthetic coverage for the Obstetric Unit should be notified earlier rather than later in these cases.

Consultation prior to admission (e.g. in the Pre-Admission Clinic by an anesthesiologist, or in the office of a family practitioner-anesthetist) is highly recommended, especially so in patients with multiple risk factors. Although local practice may vary, planning the management of these cases prior to the onset of labour (typically at between 26 and 34 weeks gestation) is routine in many Canadian centres, and highly advantageous for all concerned.



Adverse Reaction Reporting by Health Professionals and Consumers

Reprinted from Health Canada – Therapeutic Products Directorate: TPD-Web

WHY REPORT?

All marketed health products have benefits and risks. Although health products are carefully tested for safety and efficacy before they are licensed, some adverse reactions (side effects) may not become evident until the

general population uses a health product under “real life” circumstances. By submitting a suspected adverse reaction report, you are contributing to the ongoing collection of safety and effectiveness information that occurs once health products are marketed.

Reported adverse reaction information *may contribute* to:

- the identification of previously unrecognized rare, or serious adverse reactions;
- changes in product safety information, or other regulatory actions such as withdrawal of a

- product from the Canadian market;
- international data regarding benefits, risks, or effectiveness of health products;
- health product safety knowledge that benefits all Canadians.

WHAT TO REPORT?

Health Canada, through the Canadian Adverse Drug Reaction Monitoring Program, is responsible for collecting and assessing adverse reaction reports for the following health products marketed in Canada: pharmaceuticals, biologics (including fractionated blood products as well as therapeutic and diagnostic vaccines), natural health products and radiopharmaceuticals.

Physicians do not have to be certain that a health

product caused the reaction in order to report it. Adverse reaction reports are, for the most part, only suspected associations.

Health Canada wants to know about all suspected adverse reactions, but *especially if they are:*

- unexpected* adverse reactions, regardless of their severity (not consistent with product information or labelling);
- serious* adverse reactions (requiring hospitalization or continued hospitalization), whether expected or not;
- adverse reactions *related to recently* marketed health products (on the market for less than 5 years).

WHEN TO REPORT?

As soon as possible!

HOW TO REPORT?

Complete the adverse reaction reporting form which can be obtained:

- at: www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/adverse_e.html;
- by contacting your Regional Adverse Reaction Centre: Toll-free phone: 1-866-234-2345 or Toll-free fax: 1-866-678-6789
- in the CPS publication.

KEEP INFORMED:

By subscribing to Health Canada's Health_Prod_Info mailing list. You will automatically receive the most recent Canadian Adverse Reaction Newsletter and health product advisories free by e-mail. Go to: www.hc-sc.gc.ca/hpfb-dgpsa/tdp-dpt/subscribe_e.html.



Physician Responsibilities in Respect to Deceased Patients

D.A. Kendel, MD, Registrar

Physicians play a critically important role when people are born and when they die. The timing of both of these events is largely beyond human control. This creates challenges for physicians in terms of assuring physician availability for functions that are reserved for physicians.

In respect to physician services at the time of birth, the medical profession has

adopted effective call coverage arrangements that assure pregnant women that a physician will be in attendance when they give birth. No responsible physician would go on vacation without making explicit arrangements for medical attendance of births that may occur during his/her absence.

As a profession we don't do nearly as well in respect

to assuring essential physician services at the time of death. When a person dies, either a physician or a registered nurse may certify that the death has occurred. However, by law, only a physician is permitted to sign the death registration form, which must be signed before the deceased can be embalmed, cremated, or buried.

The death of any person, whether anticipated or not, is always traumatic to a family. Funeral arrangements must be made. By tradition, most funerals in Canada occur within three days of death, and arrangements are often made for a viewing of the deceased the day prior to the funeral. This creates a significant time pressure for funeral homes, particularly when the body of the deceased may have to be transported from the community where the death occurred to a community where the funeral will be held.

Because of the sequence of events that rely upon physician signature of a death registration form, there is considerable time pressure for physicians to complete and sign this essential document in a timely manner. Although they are not obligated to do so, most funeral homes will assist physicians by bringing the death registration form to a location that is most convenient for the physician responsible for signing that form.

When the circumstances surrounding a person's death are well known to the physician, there is usually little difficulty in obtaining expeditious physician signature of the death registration form. However, problems often occur when the usual attending physician of the deceased is away and the practice is being covered by a colleague.

Physicians are understandably reluctant to sign a death registration form in respect to a person whom they've not professionally attended. However, the refusal of physicians to provide this essential service does create a real crisis for grieving families and for the funeral home personnel who are under time pressure to prepare for a planned funeral. There is a growing and worrisome trend among physicians who are covering the practice of a colleague to decline a request to sign a death registration and to automatically refer the matter to a coroner. While coroners do have legal authority to sign death registrations, the engagement of a coroner in a death review is appropriate only where there is a genuine basis for concern regarding the circumstances of a person's death. Many of the deaths being referred to coroners by physicians are deaths that are fully anticipated. There is often ample information available which provides a basis for identifying the probable cause of death.

When a death is referred to a coroner, the coroner is in precisely the same situation as a physician who has not previously attended the deceased. The coroner must gather sufficient information to reach an understanding of the probable cause of death, document this information, and sign the death registration form.

Physicians are equally well positioned to gather the same information about the circumstances surrounding a patient's death. Because many coroners are non-physicians, physicians are often better positioned to quickly evaluate information about a patient's pre-moribund condition and form an opinion about that person's probable cause of death.

When it is not possible for a physician to immediately access all relevant information about a deceased person, but there's no reason to suspect the person may have died of unnatural causes, the physician may enter the date of death on the medical certificate, write the words "this body is hereby released for burial" and sign the certificate. This allows funeral arrangements, including burial of the deceased, to proceed without delay. This also allows the physician in question more time to access sufficient information that allows the physician to identify the probable cause of death.

It is important to remember that a physician who releases a body for burial by this expedited process does have a professional responsibility to ultimately complete all of the information required on the death registration form.

The College receives numerous calls from funeral

homes and from grieving families who are distraught by the reluctance or refusal of a physician to sign a document that is a prerequisite for preparation and burial of a deceased person.

Since death is inevitable for everyone, every one of us has or will face circumstances in which we rely upon a physician to perform this essential service for a deceased member of our family. As we would be

most displeased to have our grief exacerbated by a disruption of funeral plans, we ought to be equally sensitive to the needs of other grieving families.

The bottom line is that, when making arrangements to have a colleague cover your practice in your absence, you should have an explicit understanding with that colleague that he/she will accept responsibility for essential physician services in the

event that one of your patients may die during your absence.

Where it appears that the death of one of your patients may be impending or imminent at the time you turn over responsibility for practice coverage to your colleague, it is prudent to brief your colleague on that patient's circumstances so your colleague will be better positioned to fulfil his/her responsibilities if the patient dies while you are away.



Amending Personal Health Information

Reprinted from FOIP FOLIO, July 2004

A Saskatchewan patient has the right to ask a trustee to correct errors in that patient's health record.

The Alberta Commissioner considered this issue in Order H2004-004 (available at www.oipc.ab.ca). The patient alleged that she had been described as "paranoid" and exhibiting "personality

disorder" and wanted her record corrected. The Commissioner found that the information at issue was an accurate description of a professional opinion and observation. He noted that, "*A correction or amendment in this case would be tantamount to substituting the Applicant's opinion for the Custodian's opinion.*" (A "custodian" is equivalent to

"trustee" in Saskatchewan). Our office (i.e. Saskatchewan Information and Privacy Commissioner) also takes the view that in matters under HIPA there is a difference between matter of fact (that can be amended if in error) and matters of professional opinion or observation (that cannot normally be amended).



Temporary Licensure Changes

B. Salte, LLB, Associate Registrar

Council has adopted significant changes to its licensing bylaws for physicians on temporary licences (also referred to as *locum tenens* permits)

These changes will only affect physicians registered

in future. Physicians who currently hold temporary licences will not be affected by these changes.

Among the significant changes are:

- Family physicians will generally be required to

challenge the CAPE evaluation through the University of Manitoba in order to maintain a temporary licence, or obtain a provisional licence;

- The College will establish a registration committee

- to assist the Registrar's staff to deal with difficult licensing situations;
- Interview committees will be established to interview physicians who have specialty credentials but who do not have RCPSC certification eligibility. The interviews may be conducted in person or by telephone. The results of the interviews will be reported to the Registrar's officer to assist the Registrar's office to decide whether physicians should be granted temporary licences;
- Physicians who are fully registered in another province, and who will practice in Saskatchewan on a short term basis, will not be required to have a sponsor in order to obtain

- a temporary licence;
- The bylaws give the College the authority to require physicians to demonstrate English language proficiency before being granted licences to practice medicine;
- The bylaws give the College the authority to establish methods of assessment for physicians holding temporary licences. Licences may be granted subject to proof of proficiency in such assessments;
- The bylaws give the College greater flexibility to place restrictions or conditions on temporary licences. These may include such conditions as practicing only in a specified location,

- practicing under the supervision of another physician, etc.;
- The bylaws give the College the authority to revoke temporary licences if physicians do not meet conditions of their licences.

These changes are intended to provide a significant degree of flexibility in licensing physicians on temporary licences. They are also intended to allow the College to measure physicians' practice abilities at an early stage for public protection.

When the changes are approved by the Minister of Health, the bylaws on the College's website at: www.quadrant.net/cpss will be updated to include the changes.



Health Information Privacy Act

B. Salte, LLB, Associate Registrar

The College and the SMA have jointly developed a Privacy Toolkit to assist physicians to comply with privacy legislation. The Toolkit will be available in the near future on the SMA website at www.sma.sk.ca, and in printed form.

The Toolkit contains a summary of physicians' rights and responsibilities under the legislation. It also

contains sample agreements and documents that physicians should find useful in complying with the legislation.

The Privacy Commissioner of Saskatchewan sponsored a two-day seminar in Regina on October 27th and 28th, 2004. The seminar dealt with a number of practical issues relating to privacy require-

ments, included case studies on privacy issues, and information on when physicians can, and cannot, disclose health information.

Information relating to this seminar, and other HIPA issues, is available at the website of the Privacy Commissioner at: www.opipc.sk.ca/whats_new.htm.

*Visit the College website at:
www.quadrant.net/cpss*

Revalidation

B. Salte, LLB, Associate Registrar

Participation in either CCFP MAINPRO or RCPSC Maintenance of Certification is likely to soon be a requirement for Saskatchewan physicians.

The College has twice published 'Newsletter' articles providing physicians the opportunity to provide input with respect to this requirement. The few

responses received have generally been positive.

The College will soon begin discussions with the SMA and other interested parties regarding implementation of the requirement.

The College encourages all physicians, whether they are, or are not currently a

member of either certifying body to enrol in either the MAINPRO or the Maintenance of Certification program.

For further information, contact either Dr. Dennis Kendel or Bryan Salte at the College office.



To All Saskatchewan Physicians

W. Albritton, MD, Dean, College of Medicine, University of Saskatchewan

The College of Medicine at the University of Saskatchewan is very reliant on the support from physicians in the province. Physicians who provide teaching, supervisory and/or other roles have historically come from two groups – those that are full time faculty members and those who are practising clinicians with part time appointments. We now refer to these two groups as University Based and Community Based Faculty.

Through the efforts of the Saskatchewan Academic Health Sciences Network (SAHSN), a Community Based Faculty Task Group was established in 2003 and its report was completed earlier this year. This Group consisted of many physicians from the community, not only in Saskatoon, but also from Regina and Prince Albert.

The Community Based Task Group Report identified several priorities for attention. The Action Plan arising from this report consists of three major areas:

1. Faculty Appointment Categories
2. Educational Support Systems; and
3. Clinical – Academic Enhancements

FACULTY APPOINTMENT CATEGORIES

The Task Group recommended that the University consider new categories for Faculty Appointments to recognize the range and the variety of contributions made by physicians in supporting the College of Medicine. Some other universities already have such systems in place and we are now moving forward with developing such

a system here. A Clinical Appointment Categories Working Group is being established in the College under the leadership of Dr. Bob Card, Vice Dean. This will consist of both University and Community Based Faculty. Also, I have asked the SAHSN to convene and facilitate a Workshop on October 12th with representation from both University and Community Based Faculty. The purpose of this Workshop is to allow the Working Group an opportunity to hear suggestions from a broader group as it begins its work.

EDUCATIONAL SUPPORTS

Through the office of the Associate Dean, Education, we are examining a number of ways to provide better support to both University and Community Based

Faculty to undertake teaching or other academic roles in the College. Funding for this will be made available as part of the new funding provided by Government to support the Accreditation of the College. Anyone having a particular interest in this matter should contact Dr. Sheila Rutledge Harding.

CLINICAL - ACADEMIC
ENHANCEMENTS

As part of the Accreditation funding package some new resources will be available to support clinical departments where there are particular issues around the provision of the required teaching and supervisory roles for medical students and residents. I will be working closely with the Physician Vice President, SHR, and with medical

leaders in Regina to identify priority needs.

I look forward to your support and input on the above initiatives as we strive to achieve better approaches to engage both University and Community Based Faculty in the programs of the College of Medicine.

Recommended Resources:

The Resilient Physician Newsletter
www.TheResilientPhysician.com

The Resilient Physician Newsletter offers advice on effective emotional management for physicians, their families, and their organizations. Published 6 times yearly, each issue features columns on:

- Effective Emotional Management: Managing Yourself and Others
- The Resilient Medical Organization: Keys to Medical Leadership
- Work/Life Balance: Medicine, Marriage, and Family Life
- Surviving Medical Training: For Students and Residents
- Women Physicians: Reshaping Medicine
- Extraordinary Physicians: Improving Adherence in Medical Care

Institute for Safe Medication Practices (ISMP)
www.ismp-canada.ca

The Cochrane Library: Health Information Resource
www.thecochranelibrary.com

This resource is available in all 13 health regions and all public libraries. The Health Quality Council is offering training sessions to health care providers, to assist them in learning how to use The Cochrane Library. If interested, please contact Christing Marshall, HQG Librarian, at (306) 668-8810 ext 131 or by email at: cmarshall@hqc.sk.ca.

Feedback

The College of Physicians and Surgeons of Saskatchewan welcomes your feedback on any of the articles that appear in the 'Newsletter'.

Our apologies for the following printing error that occurred in the article entitled, "*Abbreviations Can Cause Medication Errors*".

"U" and "IU" – The "U" can easily be mistaken as the number "0", particularly when the "U" is written too closely after the number. This can lead to tenfold overdoses. And "IU" can be mistaken for "IV" or the number "10". So instead of using "U" and "IU", use the terms "unity" and "international unity". (Should read "**unit**" not "**unity**").



College of Physicians & Surgeons
211 - 4th Ave. South
Saskatoon, SK
S7K 1N1

Newsletter

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