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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

The wheat fields have turned golden and the moon is hanging low. After a generally good growing season, farmers are harvesting an above average crop. Some of us are already preparing for Thanksgiving, while children are happily contemplating the arrival of Halloween. Traditionally, we think of family gatherings and reunions to celebrate the conclusion of a year's hard work and to share the joy of harvest. Not all of us are so lucky. Some members of our profession may be stricken with sickness and other family members of our physician colleagues may be in bereavement. For those of us who are fortunate to be in good health and with our beloved family members, the thought of sick colleagues and their unfortunate family members is saddening.

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The Medical Benevolent Society was originally established to assist the families of two physicians in 1962. Dr. John Knox of Maple Creek and Dr. Robert Nixon of Estevan died in an air crash after they attended a meeting to assist the settlement of a Medicare Crisis. The physicians in the province were saddened by the news and responded to the overwhelming appeal for a donation to assist their families. Today the Medical Benevolent Society has evolved into a charitable organization with the mandate to help physicians and their families in need. The Society is jointly directed by the College of Physicians and Surgeons and the Saskatchewan Medical Association. It continues to rely on donations from physicians in the province for operational and resource funding. Appeals for donations to the Society are sent out twice a year. As the president of the Medical Benevolent Society, I would like to urge our physician colleagues to consider supporting the work of the Medical Benevolent Society generously and appropriate part of your charitable

Dr. Edward Tsoi

donation budget to the Medical Benevolent Society every year. What better way is there to extend the love of your family to your physician colleagues' families?

The College's Annual General Meeting was held at the Sheraton Centre, Saskatoon on September 17th this year. The meeting was well attended. It combined an educational event with presentations from a very distinguished faculty with speakers from the Department of Professional Learning, University of Saskatchewan, the Clinician Assessment Program of the University of Manitoba, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the

Pharmacy Information Program of Saskatchewan, the Pharmacy Information Network of Alberta, speakers with expertise on Privacy Acts and addiction medicine, and our in-house legal Counsel. The theme was "Measuring, Maintaining & Revalidating Professional Competence". We learnt that traditional methods for measuring a physician's competence has been modified to suit today's need. We also learned about new evolving tools and innovative ways to integrate CME and professional revalidation through the availability of technology such as the electronic health record, making internet point-of-care and validation of learning closer to reality. The quality of presentation was top notch and information presented was current and detailed. I would like to take this opportunity to whole heartedly thank the speakers and staff of the College for their hard work in the long preparation and meticulous attention to detail to make this event successful.

In a related topic of electronic health records, the Pharmacy Information Program as presented at the educational day promises to revolutionize the way clinicians prescribe and manage pharmacological therapies. When successfully implemented, it will ensure effective and safe prescribing. Some electronic medical record software providers have already started to develop programs to interface with this valuable source of information.

Another piece of news related to the application of new technology in medicine is related to telemedicine. In anticipation of a new era of remote health care delivery, the Council in its last meeting reviewed bylaw options pertaining to regulation of telemedicine and gave direction to legal counsel on drafting of new bylaws. While the role of physicians may not change substantially in the next decade or two, one can contemplate that there will be some changes in the way clinicians practice. All these should be to the benefit of patients, thanks to technology.

The primary functions of the College of Physicians and Surgeons are licensing and regulatory. The mandate of the College is protection of the public. The mission of the College is commitment to quality care. Quality care forms the foundation of public trust, and public trust is the basis of professional self-regulation. This privilege of self-regulation is treasured and guarded by members of the medical profession.

Quality of health care is reflected in timeliness of delivery, outcome of service and patient satisfaction. While timeliness of delivery and outcome may both be affected by many variables including availability of material and human resources, outcome is affected by the experience and diligence of the service providers. Service providers are the physicians, nurses, paramedical personnel and all administrative staff who may or may not come into direct contact with patients. When there was an adverse outcome in the past, the question frequently asked was: "Whose fault is it?" This was then followed by a series of inquiries and hearings that frequently resulted in blame on individuals. It is no wonder that so many errors that occur during the provision of patient care are intentionally forgotten, lest it result in a sense of personal failure, blame, punishment and anger of the individuals involved. Experience has shown repeatedly that when there is an adverse outcome, individual error is seldom the only reason. "People don't come to work to hurt someone or make a mistake", to quote Dr. Bagian, director of The National Center for Patient Safety, U.S. Department of Veterans Affairs. There is frequently a failure of the system in more than one area or one level. A robust system would likely detect and correct the error before it impacts on the safety of patients or causes an adverse outcome. Responding to an adverse event by blaming and penalizing an individual is to miss the opportunity for system improvement.

The development of a robust system however will require a shift of our current culture. Instead of asking "Whose fault is it?", we must

ask "What and why things went wrong?" Instead of punitive measures, we should encourage sharing of information and timely reporting of errors which will prevent repetition of those same errors. To effect a culture change, strong leadership is required.

Clinic Signs Precipitate Very Negative Public Reaction

D.A. Kendel, MD, Registrar

Over recent months the College of Physicians and Surgeons has received a great deal of negative public feedback in respect to medical clinics that post signs in their waiting rooms advising that the family physicians in the clinic will only deal with one patient problem or concern per visit. Some of these signs further recommend that patients who have multiple problems need to book multiple appointments. Some of the signs also advise that physician visits will be limited to a specific time duration.

Some patients interpret these signs to mean that they can only identify one symptom to their physician at each visit, which would make it impossible for a physician to accurately diagnose any condition with a constellation of symptoms.

Some patients who are being followed medically for multiple chronic illnesses feel

they can only deal with one of their illnesses at each visit. For example, if they're having a blood pressure check, they cannot even ask their physician a question about their diabetes.

Most of the patients who have written to us, or called to speak with us, about this subject appreciate the fact that their personal physicians are busy. They also appreciate that they cannot expect to have open-ended consultation time with their physician. They do feel they have been responsible in their expectations of their physician, and they find these signs very disturbing.

Some of the citizens who have spoken with us express a view that these signs convey a message that patients are being treated as "widgets" on an assembly line that is moving at a rigidly fixed speed. They feel that doctors whom they have trusted and respected for many years are losing their capacity and willingness to tailor patient interactions to the differential needs of patients.

At the College of Physicians and Surgeons we are not insensitive to the time pressures that confront many physicians, particularly those in communities where there is a shortage in physician supply. We are also aware that publicly insured payment rates for physicians do not afford physicians the luxury of very extended consultation with every patient. However, we would encourage all physicians who have posted such signs to reflect on some very fundamental principles of professionalism.

With the exception of some mental health consultation services, some anesthesia services, and some intensive care services, fee-for-service physician compensation is not based upon explicit time definitions for each service.

The medical profession has historically been resistant to professional compensation strategies that assume all patients will have precisely the same needs that can be satisfied by precisely the same allocation of physician time. In respect to both consultation services and procedural services, physicians have long recognized that some consultations and procedures will be briefer, and some will be more time consuming. The negotiated level of patient care for these services is based upon an averaging of service complexity over time.

Most physicians who prefer to be compensated on a fee-for-service basis recognize that a fixed fee for each patient service coupled with patient problems of varying complexity will necessarily mean that some patient encounters are more generously compensated than others. Most physicians strive to avoid fixation on this variation in compensation but rather focus on whether their overall compensation is fair and reasonable.

Every physician will from time to time encounter a patient who has unreasonable expectations of that physician. Experienced compassionate physicians generally deal with such circumstances by discussing the matter privately and confidentially with the patient who has unreasonable expectations. They avoid penalizing all of their patients for the unreasonable expectations of a few.

The posting of signs that signal all patients will be treated the same, notwithstanding their differential needs, projects an image of a profession that has become uncaring and mechanistic.

There are some aspects of professionalism that are not amenable to regulation by statute or bylaw. This is one of these situations.

It is most unlikely that the Council of the College of Physicians and Surgeons will ever adopt a bylaw prohibiting physicians from posting such signs in their clinics. Physicians need not live in fear that the College is going to establish a "sign patrol" to ferret out all physicians who post these signs.

However, I would sincerely hope that every physician who has posted such a sign or may be anticipating doing so would seriously reflect on the wisdom and appropriateness of this strategy. Whatever might be gained in terms of

better control over patient scheduling, I would suggest is more than offset by a diminution of public respect for you as an individual physician and our profession collectively.

As a profession we very much resent it when the public or the public media paints us all with the same brush based upon the unprofessional attitudes and/or actions of a minority of our peers. Patients also resent being painted with the same brush and such signs do precisely that.

Beers, Benzos and Seniors

D.A. Kendel, MD, Registrar

In the last Newsletter, I conveyed some information about an initiative being led by the Health Quality Council (HQC) to foster optimal prescription drug utilization among senior citizens who live independently in the community.

Included with the last Newsletter was a list of drugs that have been identified as carrying special risks for seniors. These risks were first studied and described by Dr. Mark Beers, so this drug listing is known as "The Beers List".

Ideally the drugs on the Beers List should be avoided in the medical treatment of seniors. Where there are indications for the use of one of these drugs, suggestions are offered in respect to drugs that might offer equal benefit with lower risk.

On or about October 19th, the HQC will be publicly releasing data from its study of prescription drug utilization by community dwelling seniors. The HQC report will identify significant room for improvement in physician prescribing practices related to senior citizens.

The College of Physicians and Surgeons has agreed to work collaboratively with the HQC, other professional regulatory bodies in the health system, and the Seniors Mechanism to better align prescribing for seniors with the evidence of best practices.

We will strive to improve drug utilization in respect to all of the drugs on the Beers List. However, we've elected to focus our initial quality improvement activities on the use of benzodiazepines by seniors.

The risk of confusion and preventable falls is increased among seniors who utilize benzodiazepines. These risks are increased with longer acting benzodiazepines, long-term use, high dosage, and concurrent use of more than one benzodiazepine.

The College of Physicians and Surgeons is inviting and challenging all physicians in Saskatchewan to carefully review each situation in which you are currently prescribing one or more benzodiazepines to a senior citizen. Where possible we would encourage physicians to discontinue these medications in favour of lower risk options, use short acting products, try lower dosages, and avoid concurrent use of more than one benzodiazepine.

We're confident that significant quality improvement can and will be achieved by all physicians making a concerted effort to align their prescribing practices in accordance with the Beers criteria.

The College of Physicians and Surgeons will monitor the prescribing of benzodiazepines in the same manner as the other drugs on the Triplicate Prescription Program.

Where the College does identify individual prescribing practices that remain persistently worrisome, we will communicate directly with these physicians with two goals:

1) To gain an understanding of the physician's rationale for prescribing

that is not aligned with the Beers criteria; and

2) To provide more focused professional development recommendations that may help the physician to achieve and sustain more evidence based prescribing practices.

If some individual physicians prove to be refractory to all educational interventions and their prescribing practices remain persistently high risk, the College may need to invoke more formal regulatory interventions. It will not be our intention to do so unless other measures fail.

When this issue was discussed at the College's Annual Meeting on September 17th, a question was raised about seniors who have developed either physical and/or psychological dependence on benzodiazepines that were initiated by another physician. The College was asked if we will just "accept" the reluctance of some seniors to discontinue medication they have used for a very long time.

We do recognize that there may be valid reasons why the treatment of a particular patient should vary from that which is described in evidence based clinical practice guidelines. However, it is rarely appropriate for a physician to continue an intervention that carries more risk of harm than hope of benefit for a patient.

While the risk of falls and associated factors may be moderate among younger benzodiazepine using seniors, such risks do increase as seniors become more frail. So if seniors are allowed to remain on benzodiazepines as they develop progressive frailty, the risk of falls and fractures will rise significantly.

There are protocols that can be helpful in weaning patients who have developed dependency on benzodiazepines. One such protocol entitled "Benzodiazepines: How They Work and How to Withdraw" (aka The Ashton Manual) can be accessed at: www.benzo.org.uk. Accessible at the same site is a document entitled "Benzodiazepine Abuse" also authored by Prof. H. Ashton.

If any physician would like to communicate with either the Registrar or Deputy Registrar about their efforts to align prescribing with the Beers criteria, you are always welcome to call, write or e-mail us. Dr. Shaw's e-mail address is shawk@shin.sk.ca, and my e-mail address is kendeld@shin.sk.ca.

Independent Medical Examinations

B. Salte, LLB, Associate Registrar

Can a person who is the subject of an independent medical examination obtain information from the physician who performed that examination?

Some insurers insist that the report must be delivered only to the insurer, and that the physician cannot provide information about the assessment to the person examined. Patients frequently want to access information from the physician who performed the examination. This conflict puts physicians who provide independent medical examination in a difficult position.

In 2001 the Council of the College adopted a guideline (available from the College) for medical examinations by non-treating physicians. Among the recommendations was that physicians:

> *Provide the claimant access to the medical records, reports prepared or records relating to the examination subject to the same conditions that apply to a patient who seeks access to his/her own medical records. This does not apply to situations where the physician has no patient contact and offers an*

opinion based on preexisting records.

That advice has been reinforced by a recent ruling from the Canadian Privacy Commissioner. The Commissioner ruled that PIPEDA (The Personal Information Protection and Electronic Documents Act) requires a physician to disclose his/her notes to the person who they examine.

Physicians should assume that their entire record of an examination, including the report, will be available to the patient and to the insurer or other third party that requested the report.

A summary of the Commissioner's decision is available at: http://www.privcom.gc.ca/cf-dc/2005/306_ 20050317_ e.asp.

Efficacy and Safety of Enoxaparin in Non-ST Elevation Acute Coronary Syndromes

Lane Rathgeber, MD, CCFP(EM)

Patients with non-ST elevation acute coronary syndromes (NSTEACS), including unstable angina (UA) and non-ST elevation myocardial infarction (NSTEMI), are commonly treated with heparin. Low molecular weight heparin (LMWH) is more convenient than unfractionated heparin (UFH) and arguably more effective. However, new therapeutic agents and approaches have created doubt regarding the place of LMWH in the prevention of death and myocardial infarction (MI) in these patients.

According to the most recent update of the American College of Cardiology / American Heart Association guidelines,[i] "anticoagulation with subcutaneous LMWH or intravenous UFH should be added to antiplatelet therapy with ASA and/or clopidogrel" and "enoxaparin is preferable to UFH as an anticoagulant in patients with UA/NSTEMI, in the absence of renal failure and unless CABG is planned within 24 hours". A number of different low molecular weight heparins have been studied in NSTEACS. Some have been shown to be superior to placebo. However, enoxaparin has become the preferred LMWH because of the ESSENCE[ii] and TIMI-11B[iii] trials. They are the only double-blind randomized studies to show superiority of LMWH over UFH.

It is interesting to compare the evidence for heparin with the evidence for aspirin. The earliest study[iv] enrolled 1266 men with unstable angina; 324mg of aspirin daily for 12 weeks reduced the rate of death and MI from 10.1% to 5.0% (p=0.0005), with an equal relative reduction in each. Not all the patients were high-risk; ischemic ST segment depression (a known marker of high risk) was not necessarily required, and patients with elevated cardiac enzymes (another marker of high risk) were excluded. The evidence supporting the use of aspirin is of such strength that the question is not whether heparin is effective, but whether there is any additional efficacy in patients who receive aspirin.

The best evidence for the incremental efficacy of UFH over aspirin alone is a meta-analysis[v] of six randomized trials including a total of 1353 patients. Patients receiving UFH enjoyed a 33% relative risk reduction in MI and death; there is a 6% chance that

this difference is due to chance alone. Conventionally, this is not statistically significant.

Together, the ESSENCE and TIMI 11B trials enrolled 7081 patients. ESSENCE included recurrent angina and TIMI 11B included urgent revascularization in their primary composite endpoints along with death and MI. While these are important outcomes, they are not as important as death or MI; thus, the endpoints were relatively "soft". Higher risk patients were included, such as patients with non-Q wave MI. After 1800 patients were enrolled in TIMI 11B the inclusion criteria were modified to include only patients with ECG ST segment deviation or positive cardiac markers. The size of the studies, the use of a soft composite endpoint, and enrolling only high risk patients optimized the likelihood of finding enoxaparin to be superior to UFH.

Nonetheless, the results were modest. In ESSENCE, the primary endpoint was met by 19.8% of the UFH group and 16.6% of the LMWH group at 14 days (p=0.019). Most of this difference was due to less recurrent angina in the LMWH group (12.9% vs. 15.5%), with a trend toward less MI at 14 days (3.2% vs. 4.5%) and 30 days (3.9% vs. 5.2%). There was no significant difference in the incidence of major bleeding within 30 days (UFH 7.0%, LMWH 6.5%). In TIMI 11B, the primary endpoint was met by 14.5% of the UFH group and 12.4% of the enoxaparin group at 8 days (p=0.048); the enoxaparin group also had fewer MIs (3.4% vs. 4.8%, p=0.028). There was no statistically significant difference in the incidence of major hemorrhage (UFH 1.0%, LMWH 1.5%; p=0.143).

Meanwhile, glycoprotein IIb/IIIa (GP IIb/IIIa) inhibitors arrived. They became standard treatment for patients at the highest risk of MI and death, particularly in the context of early percutaneous coronary intervention (PCI). The first studies proving their efficacy combined them with UFH, not LMWH. Most recently, four studies have been published comparing enoxaparin with UFH, combined with GP IIb/IIIa inhibitors. In the ACUTE II study,[vi] patients treated with tirofiban and enoxaparin group had less refractory ischemia requiring urgent revascularization and less rehospitalization because of UA. However, there was no difference in the rate of death or MI. An open-label study with 746 patients combining enoxaparin with eptifibatide did find a reduction in death or MI at 30 days (5% vs. 9%, p=0.031), as well as less major hemorrhage at 96 hours (2.1% vs. 5.5%).[vii] However, the A-to-Z trial,[viii] with 3987 patients, was only able to demonstrate that enoxaparin was not inferior to UFH in patients treated with tirofiban. The SYNERGY trial[ix] showed no difference in the rate of death and MI at 30 days and an increase in the rate of TIMI major bleeding (enoxaparin 9.1%, UFH 7.6%, p=0.008). Investigators combined ESSENCE and TIMI 11B with the four new studies, totalling 21946 patients. They found a slight but statistically significant reduction in death or MI at 30 days (10.1% vs 11.0%) with no significant difference in transfusion or major bleeding.[x]

An Ovid Medline search (enoxaparin, adverse effects) uncovered many case reports of bleeding in patients receiving enoxaparin, but only a few studies to determine who is at increased risk of bleeding. A chart review found that 30% of patients with a serum creatinine of 2.0 mg/dL (180 µmol/L) or greater had major bleeding while on enoxaparin compared to 2% of patients with a lower creatinine (p<0.05).[xi] 6.6% of 143 patients with severe renal impairment (creatinine clearance 30 mL/min or less) enrolled in ESSENCE and TIMI 11B had major hemorrhage compared with 1.1% of patients without severe renal impairment (p<0.0001), regardless of whether they received UFH or enoxaparin.[xii] In a prospective observational study of 334 patients

receiving therapeutic-dose LMWH (61% received enoxaparin) there were 15 bleeding events. Increasing age, increasing debility, decreased creatinine clearance and SSRI (selective serotonin reuptake inhibitor) antidepressant co-medication were independently associated with an increased risk of bleeding.[xiii] Finally, a chart review of 208 patients with acute coronary syndromes who received enoxaparin found increasing age, renal insufficiency, previous peptic ulcer disease, and clopidogrel use were associated with increased risk for major bleeding.[xiv] Patients using angiotensin-converting enzyme (ACE) inhibitors had less major bleeding.

LMWH instead of UFH is attractive because of the simplicity of twice daily subcutaneous dosing without the need for monitoring the PTT. There is a lower risk of thrombocytopenia. The evidence suggests that enoxaparin is modestly more effective than UFH. However, an UFH infusion can be stopped in the event of an adverse event, and more easily reversed with protamine. Invasive cardiologists and surgeons may believe that LMWH increases the risk of intervention-related bleeding. Patients at highest risk also enjoy the most benefit, but they benefit most from GP IIb/IIIa inhibitors and early PCI. Enoxaparin is not (yet?) commonly combined with GP IIb/IIIa inhibitors. Anticoagulation is not recommended in patients at low (<4%) risk of death and MI.[xv] The choice of anticoagulation therapy rests on an estimate of the benefit, the risk of bleeding, whether an invasive (early PCI) or conservative approach is planned, and the preference of the consultant who will assume ongoing care of the patient.

References available on request by contacting the College.

Methadone 101 Education Day

The College of Physicians and Surgeons is hosting a Methadone 101 Education day on November 5th, 2005 – East Room, Sheraton Cavalier Hotel, Saskatoon. If you are interested in addiction and in becoming a Methadone prescriber, please contact Amanda Lee at (306) 244-7355, or by e-mail at: leea@shin.sk.ca for more information. For room reservations, please contact the Sheraton Cavalier Hotel at: (306) 652-6770.

The College has implemented a **Second Level Prescriber Program for Methadone.** A Second Level Prescriber is a physician who will not initiate new patients on Methadone, but who will have patients from their area who are already stabilized on Methadone returned to their care for maintenance only. The maintenance treatment program will continue to liaise with the primary care physician as needed, and will reassess and resume management of the patient for a period of restabilization, if required. This referral process with primary care physicians will free resources in the formal clinics to increase availability of initial assessment and treatment.

Pharmaceutical Information Program

Prescription drugs have the power to make us well but also the potential, when used improperly, to make us ill.

That's why Saskatchewan Health is launching a new program to make using prescription drugs safer. The initiative, called the Pharmaceutical Information Program (PIP), lets doctors, nurses, pharmacists and other authorized health care

professionals view patients' medication records electronically.

Beginning in mid-October, the PIP Medication Profile Viewer will be rolled out to emergency rooms in Regina and Saskatoon and a limited number of pharmacies, physicians' offices, home-care sites and long-term care facilities throughout the province. The Viewer will allow health care professionals involved in this initial phase of the project to see the prescription profiles of their patients.

By viewing full prescription profiles, health care professionals can see what medications a patient may already be taking. This will help prescribers choose the best possible drugs to treat patients to avoid harmful drug interactions. It will also prevent the duplication of therapy and prescription drug abuse. The PIP Viewer will prove especially useful for health care providers treating people who have been prescribed a number of medications, or those who have several doctors or pharmacists involved in their care.

Amendments to *The Prescription Drugs Act,* made in 2002, authorized Saskatchewan Health to develop the prescription data-base available through PIP. Prior to the introduction of the program, doctors and pharmacists did not have a complete source of prescription information to refer to when making decisions about drug therapy.

The PIP Viewer will be extended in future phases to include information entered directly by physicians and other health care providers. This could include things like allergy information and prescriptions entered electronically by prescribers.

While most people would agree there are many benefits associated with participating in this program, some patients may prefer to not share their prescription information. These people can request a "masking" option, which will hide their prescription information from view. Individuals who would like to investigate this option should be advised to phone Saskatchewan Health's privacy call centre, at 1-800-667-1672, or go to: www.health.gov.sk.ca.

Patients should also be aware that masking may be removed in critical health situations, such as in emergencies or to prevent harm to patients. As well, patients will be able to request a printout of the names of people who have viewed their prescription information.

PIP is driven by challenges contained in *The Action Plan for Saskatchewan Health Care,* the province's blueprint on health service provision. The program has also evolved in response to recommendations made by the coroner's inquest in to the death of Darcy Dean Ironchild. Mr. Ironchild was the Saskatoon man who died from an overdose of prescription medications in 2000. He received more than 300 prescriptions in the year before his death.

Canada Health Infoway has been an important partner in PIP, contributing approximately $5 million of the $7 million invested in the project.

People who have general questions about the Pharmaceutical Information Program can contact the department at:

Saskatchewan Health Drug Plan & Extended Benefits Branch
3475 Albert Street
S4S 6X6
In Regina: 787-8963
In Saskatchewan:
1-800-667-1672
www.health.gov.sk.ca.

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

Assistance in Accessing Health Canada's Special Access Programme

The *Special Services Pharmacy,* Saskatoon Health Region, located at Royal University Hospital, was developed to provide support to clinical trials operating within the health region and to provide access to the Special Access Programme (SAP) of Health Canada. The Pharmacy is open Monday to Friday from 0900 to 1500 hours and provides walk-up service for patients in clinical trials and those receiving SAP medication as well as local and provincial delivery.

The Special Access Programme of Health Canada provides access to non-marketed drugs for practitioners treating patients with serious or life-threatening conditions where conventional therapies have failed, are unsuitable or unavailable. It is the mandate of the program that all medications must be delivered and dispensed from either a hospital pharmacy or the practitioner's office.

The Special Services Pharmacy provides support to practitioners wishing to obtain medications through the SAP. Assistance is provided to complete and maintain the required forms, liaise with Health Canada and manufacturers, order medication and maintain stock for ongoing patients, as well as to oversee any financial aspects involved with the medications. Any practitioner or other hospital pharmacy may access the program independently through Health Canada. In such instances the Special Services Pharmacy is not responsible for any charges incurred by those individuals.

Not all medications provided through the Special Access Program are free of charge. Costs not covered by the Saskatchewan Prescription Drug Plan, NIHB or other third party payers will be the responsibility of the patient. This can include the cost of the medication, shipping charges, all monetary exchanges and the cost of delivery to the patient if they reside outside of Saskatoon. A professional fee will be charged for all SAP medications dispensed through the Special Services Pharmacy regardless of the cost of the medication.

INITIATING A SAP REQUEST

Any practitioner wishing to obtain a medication through the Special Access Programme and wanting support through the Special Services Pharmacy should contact the pharmacy directly. The appropriate forms will be sent to the practitioner for completion. Once completed, the forms can be returned to the Special Services Pharmacy for submission to Health Canada. If necessary, assistance can be provided in completing the forms. Once approval is received and the manner in which the drug will be paid for is verified, the drug will be ordered. A written prescription for SAP medications is required by the Special Services Pharmacy prior to any dispensing. All practitioners will be alerted when their approvals require renewal. Practitioners are responsible for informing patients that a potential cost may be associated with receiving medications through this program. They are also responsible for providing all documentation requested by Health Canada.

Further information on Health Canada's Special Access Programme can be obtained from the website: http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/index_sap_e.html.

Feedback

The College of Physicians and Surgeons of Saskatchewan welcomes your feedback on any information that appears in this *'Newsletter'*.

Upcoming Conferences

ECG Exam - College of Physicians and Surgeons

Monday, November 7th, 2005 – 1:15 p.m. - 4:15 p.m.
Monday, January 9th, 2006 – 1:15 p.m. - 4:15 p.m.
To register contact: Camille Dunlop, Tel: (306) 667-4622

Refresher Course for General Practitioner Anesthetists

Hyatt Regency, Vancouver BC
November 12th, 2005
Contact: Winnie Wong, Tel: (604) 875-4745 or winniewo@interchange.ubc.ca

2005 Home Care Summit, A Pan-Canadian Consultation

15th Annual National Conference, November 3rd - 5th, 2005
Fairmont Banff Springs Hotel, Banff AB
For further information contact: www.cdnhomecare.ca/conference.php

Institute for Healthcare Improvement (IHI) National Forum on Quality Improvement

Health Quality Council Broadcast – December 13th & 14th
For more details: http://www.ihi.org/ihi
or contact Sheila Ragush at: sragush@hqc.sk.ca

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

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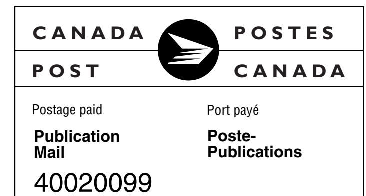

POLICY: PHYSICIANS ACCESSING PATIENT-SPECIFIC INFORMATION FROM THE PHARMACY INFORMATION PROGRAM (PIP)

Preamble

The Pharmacy Information Program (PIP) has been developed with the primary purpose of improving patient care in Saskatchewan. The PIP program provides Saskatchewan physicians access through a secure computer network to information about drugs dispensed to Saskatchewan patients in Saskatchewan pharmacies. Access to information within the PIP program is provided to physicians to assist them to provide the best possible quality of medical care to their patients. Access, using or disseminating information from the PIP program, other than as permitted in this policy, is improper conduct.

General Principles

Physicians must be able to justify the reason for accessing information through the PIP program.

Physicians should only access information through the PIP program when the information that the physician expects to obtain may reasonably affect the medical care provided to the patient.

Physicians should only access the minimum amount of information through the PIP program that is reasonably required for the purpose for which the information was accessed.

Only those persons who have a need to know the information should be permitted to access the information.

Physicians should only use the information from the PIP program for the purpose of providing medical care to their patient, or as is otherwise permitted by *The Health Information Protection Act.*

Physicians should only disclose the information from the PIP program for the purpose of providing medical care to their patient, with the consent of the patient, or as is otherwise permitted by *The Health Information Protection Act*.

Physicians should have appropriate policies and procedures in place to protect the information accessed through the PIP program from being seen by persons who are not authorized to see that information.

Physicians must comply with *The Health Information Protection Act* in connection with the information accessed through the PIP program.

Physicians should ensure that persons who the physician authorizes to access the information within the PIP program are aware of and understand their responsibilities.

Specific Requirements

Physicians will not permit any other person under their authority or control to access the information within the PIP database unless the following conditions are met:

- That person has been specifically authorized by the physician to access the PIP data base for a purpose for which the physician may access the information;
- That person has signed a confidentiality agreement in which that person has agreed, among other things, to access the information only on a need-to-know basis, and not to disclose the information to any other person except as permitted by *The Health Information Protection Act.*

Physicians must report to the PIP program, or such other person or organization as may be specified by the PIP program, all activities by any individual or entity that the physician reasonably suspects may compromise the confidentiality of confidential information or be a breach of this policy.

Council, June 2005

POLICY: MEDICAL MARIJUANA

The College of Physicians and Surgeons of Saskatchewan recognizes the necessity of the Federal Government to respond to the direction of the Ontario Court of Appeal in *Parker v Regina* in providing regulations governing the possession and production of marijuana for medical purposes.

The College supports evidence-based medicine. In the absence of scientific information that provides the grounds to support the medical use of marijuana for the conditions set out in the regulations is evidence-based, the College of Physicians and Surgeons of Saskatchewan is uncertain of the safety and efficacy of the medical use of marijuana.

The College would advise that physicians should not prescribe any drug for their patients without knowing the risks, benefits, potential complications, and drug interactions associated with this agent.

Physicians who decide to assist with the application process and prescribe marijuana should be aware that the College would expect adequate documentation to acknowledge that the patient has been informed that the study on this agent is incomplete, and that the long-term complications associated with chronic use are unknown. The College would also expect documentation clearly stating the reasons(s) for the decision to use this agent, and an inventory of drugs and procedures previously tried, and the reason(s) for their failure or inadequacy. Documentation should also include the risks, benefits, potential complications, drug interactions, and the plan for treatment and follow-up.

Under the Medical Marijuana Act, Regulations A, "a 'medical practitioner' is a person who is authorized under the laws of the province to practice medicine in that province **and** who is not named in a notice given under sections 8 or 59 of the Narcotic Control Regulations". A medical practitioner may support the application for a *Category* 1 condition. A "medical practitioner" for the purposes of completing this application is either a general practitioner or a specialist who specializes in the area of the medical condition, for example, an oncologist in the area of cancer treatment, a rheumatologist for severe arthritis, neurologist for spinal cord disease or epilepsy. A "specialist" means a medical practitioner who is recognized as a specialist by the medical licensing authority of the province in which the practitioner is authorized to practice medicine.

A medical practitioner may support the application for a *Category* 2 condition. An assessment of the case by a specialist is required if the medical practitioner is not already a specialist. The medical practitioner, if not a specialist, must declare that (1) the applicant's case has been assessed by a specialist; (2) the specialist's area of specialization is relevant to the treatment of the applicant's medical condition; (3) that the specialist concurs that the conventional treatments for the symptom are ineffective or medically inappropriate for the treatment of the applicant; and, (4) the specialist is aware that marijuana is being considered as an alternative treatment for the applicant.

The College would encourage physicians to access the Medical Use of Marijuana site at Health Canada to obtain a description of the medical conditions and symptoms for *Categories 1 and* 2, copies of the application forms, and for further information as necessary. Alternately, physicians may wish to contact the Marijuana Medical Access Division, Drug Strategy and Controlled Substances Program, AL: 3503B, Ottawa ON K1A 1B9.

Council, September 2005