



## Message from the President

*Dr. Grant Stoneham, Saskatoon*

At our September meeting, Council met with the Deputy Minister of Health, Mr. Dan

Florizone. Most of the discussion centered on the Saskatchewan-based IMG Assessment Process. When the Saskatchewan Government announced the decision to implement a “made in Saskatchewan” IMG Assessment Process, the College of Physicians and Surgeons was asked to serve on the Advisory Committee in collaboration with the Government, the College of Medicine, the SMA and Regional Health Authorities. This process has been in active development over the last year, culminating in a formal announcement of the Program by the Minister of Health, the Honourable Don McMorris, on September 20<sup>th</sup>, 2010.

The goal of this assessment program is to ensure that physicians have the appropriate mix of academic knowledge, technical skills and clinical judgment to provide safe patient care. The program will assess IMG’s prior to starting their practices in Saskatchewan, thereby avoiding the current situation where physicians have to leave their practices to be assessed, and avoiding disruptions associated with physicians subsequently requiring remediation, or having their licenses terminated if the outcome of the assessment merits that. This will also avoid the potential for patient harm that might occur under the current system if physicians in practice are later found to be lacking significant skills and knowledge, which may place the patients served by these physicians at risk of inadequate care.

The College Council reviewed and endorsed the proposed IMG assessment process at the recent Council meeting. Council is confident that the process will be credible, reliable and fair.

With respect to the development of National Standards of licensure that will be necessary to allow appropriate recognition of licensure by the various Medical Regulatory Authorities across Canada, the College has been in on-going discussions with the Ministry of Health regarding the necessary legislative and regulatory amendments that will be required to ensure National alignment of standards. In keeping with this, the College has adopted a bylaw requiring CFPC certification as a prerequisite for first time, or initial, “full” licensure of Family Physicians. In addition, Council has adopted a bylaw requiring the Medical Council of Canada Evaluating Examination (MCCEE) as a prerequisite for eligibility for licensure of all IMG’s. This will align the standards in Saskatchewan with the requirements in other jurisdictions across the country.

In the future, Council is planning on developing a comprehensive communication strategy for the College. It is hoped that the College may be able to develop improved communication and messaging for the members of the College, as well as other stakeholders, particularly given the transitions occurring and the complicated period we find ourselves in with respect to the evolution of licensure and regulatory standards in Saskatchewan and across Canada.

“This will align the standards in Saskatchewan with the requirements in other jurisdictions across the country.”

**2010 Council Members**  
**College of Physicians and Surgeons of Saskatchewan**

Ms. Joanna Alexander, Regina	Public Member
Dr. James Carter, Regina	General Surgery
Dr. Mark Chapelski, Lloydminster	Family Medicine
Dr. Alanna Danilkewich, Saskatoon	Family Medicine
Dr. Gerry Fernandes, North Battleford	Otolaryngology
Dr. James Fritz, Regina	Otolaryngology
Rev. John Fryters, Prince Albert	Public Member
Dr. Pierre Hanekom, Melfort	General Practice
Mr. Ron Harder, Moose Jaw	Public Member
Dr. Sheila Harding, Saskatoon	Internal Medicine
Dr. Dan Johnson, Kindersley	Family Medicine
Dr. Suresh Kassett, Herbert	General Practice
Ms. Margaret Kuzyk, Saskatoon	Public Member
Dr. Tilak Malhotra, Prince Albert	Pediatrics
Mr. Graeme Mitchell, Regina	Public Member
Dr. Mukesh Mirchandani, Yorkton	Psychiatry
Dr. Grant Stoneham, Saskatoon	Diagnostic Radiology
Dr. Edward Tsoi, Estevan	Family Medicine
Dr. Gerrit Van Wyk, Moose Jaw	Urology

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**Council Member change**

Thank you to Karen Prisciak for your dedication to Council over these past years.  
 Welcome to our new member, Ron Harder. Ron was born and raised in Herbert, Saskatchewan. He is married with two children and recently retired from the Moose Jaw Police Service. He now provides technical support to area farmers and to oil and gas services.

**Letter from the Registrar**

*Dr. Dennis Kendel*



**A New Saskatchewan Based IMG Assessment Process**

In the fall of 2008 the Government of Saskatchewan announced its intention to implement a Saskatchewan based IMG Assessment Process for IMG Family Physicians seeking medical licensure in Saskatchewan. This new process will commence in January of 2011. I want to extend my gratitude to the many people who have worked extremely hard to bring these plans to fruition.

Since this is a Ministry of Health led initiative, senior Ministry staff are playing key leadership roles in the roll-out of the program. Both Ms. Shaylene Salazar and Ms. Ingrid Kirby of the Medical Services Branch at the Ministry of Health have devoted an enormous amount of time and energy to the project. They also engaged Ms. Karen Gibbons as a Project Manager.

Dr. Gil White, the Associate Dean of the College of Medicine based in Regina, obtained a \$500,000 federal grant to develop and pilot the new process. Dr. White engaged Dr. Penny Davis, the Director of Continuing Professional Development at the College of Medicine to do much of the pragmatic planning activity. She is assisted by Ms. Gail Greenberg, an employee of the Academic Department of Family Medicine at the University of Saskatchewan.

The Ministry of Health established an Advisory Committee to guide the process. The committee is Chaired by Shaylene Salazar and includes the following representatives:

1. Dr. Martin Vogel – SMA
2. Dr. Louisa Roets – IMG Representative
3. Dr. Sheriff Rahaman – Five Hills Health Region
4. Mr. David Fan – Prairie North Health Region
5. Ms. Carolyn Hubble – Ministry of Advanced Education and Employment
6. Ms. Barb Porter – CPSS
7. Dr. Dennis Kendel – CPSS

The project is obtaining psychometric expertise from Dr. Claudio Violato, a respected psychometrician at the University of Calgary. Personnel from mature IMG Assessment Programs in other provinces have also provided valuable guidance and support.

The Assessment Process will include a centralized assessment of several days duration as well as assessment in community based practices for an interval from three to twelve weeks.

Dr. Penny Davis has recruited over 25 family physicians to do the community based assessment and is providing training to them. We are particularly grateful to all of these family physicians who are making such a valuable commitment to the province through this service.

The transition from the old assessment process which relied upon the CAPE Assessment at the University of Manitoba to the new process will not be without challenges and some pain. The Assessment Process will be offered in three or four cycles per year. This will mean that IMG applicants will arrive in Saskatchewan just before each assessment cycle begins. They will receive a very comprehensive orientation process that will help to ensure their success in the assessment.

Those IMGs who successfully pass the centralized process will proceed to a community based assessment

in a community other than their eventual practice location. They may spend as little as three weeks or as long as twelve weeks in the community based assessment at the discretion of the assessor who must ultimately make a decision if each candidate has the requisite knowledge, skills, and capacity to practice safely.

While going through this assessment process the IMGs will be enrolled on the educational register of the College. They will receive compensation directly from the Ministry of Health at a level to be determined by the Ministry of Health. The family physicians doing the community based assessment will also receive compensation for their time based upon a negotiations currently being conducted between the Ministry of Health and the SMA.

The entire assessment process will yield a pass/fail outcome for each candidate. Those who pass the assessment will be granted provisional registration. They may then work toward full registration status with the College either by acquiring the LMCC and CFPC Certification or through a summative assessment process being defined as part of the new national licensure standards.

There is much work yet to be done to make this new IMG Assessment Process successful. The College of Physicians and Surgeons is committed to working collaboratively with the Ministry of Health, the College of Medicine, the Saskatchewan Medical Association, the RHAs, and other stakeholders to ensure its success.

Yours truly,



Dr. D. Kendel  
Registrar

... [IMG'S] will receive a very comprehensive orientation process that will help to ensure their success in the assessment."

## ...from the Deputy Registrar

*Dr. Karen Shaw*

### Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

In the last edition of the College's newsletter, the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain was introduced.

Physicians can access and download complete copies of the Canadian Guideline from the Michael G. DeGroot National Pain Centre, McMaster University.

The Canadian Guideline is presented in two separate documents:

Part A is the Executive Summary and background and Part B is the recommendations for practice.

Recommendations from this Guideline are presented in five clusters:

Deciding to initiate opioid therapy

Conducting an opioid trial

Monitoring long-term opioid therapy (LTOT)

Treating specific populations with LTOT

Managing opioid misuse and addiction in CNCP Patients

Physicians can also access a one page, double-sided tool called an Opioid Manager, which is designed to be a point-of-care tool which distills onto one double-sided page; Essential information and advice from the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. The Opioid Manager is designed to be a practical tool to guide and track the initiation and monitoring of opioid therapy for chronic non-cancer pain patients. Although the Opioid Manager has been tested during its development, interested practitioners are encouraged to try the tool and provide feedback and suggestions for improvement. The tool can

be downloaded. However, registration is required in order to encourage feedback for improvement.

Over the next several newsletters, the College will provide a summary of recommendations. In this newsletter, you will find recommendations regarding Cluster 1 and Cluster 2:

### Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

#### List of Recommendations

#### Cluster 1: Deciding to Initiate Opioid Therapy

##### **R01 Comprehensive assessment**

Before initiating opioid therapy, ensure comprehensive documentation of the patient's pain condition, general medical condition and psychosocial history (Grade C), psychiatric status, and substance use history. (Grade B).

##### **R02 Addiction-risk screening**

Before initiating opioid therapy, consider using a screening tool to determine the patient's risk for opioid addiction. (Grade B).

##### **R03 Urine drug screening**

When using urine drug screening (UDS) to establish a baseline measure of risk or to monitor compliance, be aware of benefits and limitations, appropriate test ordering and interpretation, and have a plan to use results. (Grade C).

##### **R04 Opioid efficacy**

Before initiating opioid therapy, consider the evidence related to effectiveness in patients with chronic non-cancer pain. (Grade A)

##### **R05 Risks, adverse effects, complications**

Before initiating opioid therapy, ensure informed consent by explaining potential benefits, adverse effects,

complications and risks (Grade B). A treatment agreement may be helpful, particularly for patients not well known to the physician or at higher risk for opioid misuse. (Grade C).

#### **R06 Benzodiazepine tapering**

For patients taking benzodiazepines, particularly for elderly patients, consider a trial of tapering (Grade B). If a trial of tapering is not indicated or is unsuccessful, opioids should be titrated more slowly and at lower doses. (Grade C).

### Cluster 2: Conducting an Opioid Trial

#### **R07 Titration and driving**

During dosage titration in a trial of opioid therapy, advise the patient to avoid driving a motor vehicle until a stable dosage is established and it is certain the opioid does not cause sedation (Grade C); and when taking opioids with alcohol, benzodiazepines, or other sedating drugs. (Grade B).

#### **R08 Stepped opioid selection**

During an opioid trial, select the most appropriate opioid for trial therapy using a stepped approach, and consider safety. (Grade C).

#### **R09 Optimal dose**

When conducting a trial of opioid therapy, start with a low dosage, increase dosage gradually and monitor opioid effectiveness until optimal dose is attained. (Grade C).

#### **R10 Watchful dose**

Chronic non-cancer pain can be managed effectively in most patients with dosages at or below 200 mg/day of morphine or equivalent (Grade A). Consideration of a higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes. (Grade C).

#### **R11 Risk: opioid misuse**

When initiating a trial of opioid therapy for patients at higher risk for misuse, prescribe only for well-defined somatic or neuropathic pain conditions (Grade A), start with lower doses and titrate in small-dose increments (Grade B), and monitor closely for signs of aberrant drug-related behaviours. (Grade C).

from Canadian Guideline –

<http://nationalpaincentre.mcmaster.ca/opioid/>

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### **Prescribing Concerns**

Physicians are reminded that there are two bylaws which speak to the manner in which prescriptions issued by physicians must be written. The minimum standards for written and verbal medication prescriptions issued by physicians are set out in **Bylaw 17.1 – Minimum Standards for Written and Verbal Medication Prescriptions Issued by Physicians**, and **18.1 – The Prescription Review Program**, which outlines the requirements to prescribe those medications under the Prescription Review Program. There is an additional Bylaw, **Bylaw 19.1**, which speaks to the current requirements for the prescription of Buprenorphine. College Bylaws can be accessed on the College website at <http://www.quadrant.net/cps>.

Concerns commonly raised are as follows:

Some physicians are not abiding by the requirements as listed in the Bylaw. In particular, physicians are reminded that they must provide the date of birth of the patient, name **and** address of the patient, total quantity of medication, both **numerically and in written form**, the patient's health services number, the prescriber's name **and** address. Direction for part fills must include **total quantity, amount** to be dispensed each time and the **time intervals**.

Another concern is with electronic transmission of prescriptions. The Saskatchewan College of Pharmacists will allow prescribers who computer generate prescriptions with an electronic signature **and** have a unique **identifier code** to send directly from the prescriber's computer to the pharmacy. Those physicians who computer generate prescriptions and electronic signatures **without** the unique identifier code and arrangements with the pharmacy, most **cosign in ink** for the prescription to be legal. A rubber stamp signature is **not** a legal or valid signature for the purposes of prescribing. Simply put, if a physician generates a computer generated electronic prescription which goes directly to the pharmacist and allows the pharmacist to identify the physician by electronic signature and a unique identifier code, then there is no requirement to cosign. Those physicians who generate prescriptions electronically and then print a copy to hand to the patient must cosign the printed copy of the prescription for it to be legal.

The Saskatchewan College of Pharmacists has a website that has additional detail regarding "Electronic Transmission of Prescriptions". It can be accessed at [www.NAPRA.org/pages/Saskatchewan/default.aspx](http://www.NAPRA.org/pages/Saskatchewan/default.aspx).

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### Complaints - Communication

Many of the complaints reviewed by the Complaints Resolution Advisory Committee are related to communication issues. The importance of good communication between patients and health providers cannot be disputed. However, reports from patients of their experiences of the care they receive appear to fall short of the ideal. This was echoed in the summary of findings from patient consultations in the Patient First Report.

Although the Patient First Report identified examples of positive experiences with good two-way patient-

physician communication, there were reports of negative experiences.

There is considerable evidence to show that physicians who communicate well with their patients are more likely to make an accurate diagnosis, as good communication skills enable one to collect information about a patient's problem that is comprehensive, relevant and accurate. Physicians who communicate well are also more likely to detect emotional distress in patients and respond appropriately, and have patients who are satisfied with the care they have received and are less anxious about their problems. Physicians with good communication skills also tend to have better outcomes with their patients, as their patients agree with and follow the advice given.

Unfortunately, many of the cases reviewed by the Complaints Resolution Advisory Committee are examples of where there was poor patient-physician communication. Patients are most likely to complain about aspects of patient-physician communication rather than the technical aspects of care. Frequent complaints about physician's communication and behavior include:

- Would not listen
- Would not give information; and
- Showed a lack of concern or a lack of respect for the patient

Good communication skills can be learned. Often, what patients are looking for, in terms of communication with their physician, is fairly basic. They want someone who is warm and sympathetic, easy to talk to, introduces himself or herself, appears self-confident, listens to the patient and responds to their verbal cues, asks questions that are easily understood and precise, and does not repeat himself or herself.

There are many factors which influence patient-physician communication. Patient related factors include: physical symptoms, psychological factors related to the illness or the medical care, for example, anxiety, depression, anger,

etc, previous experience of medical care, and current experience with medical care. Physician related factors include self-confidence and ability to communicate, personality, physical factors, such as fatigue or burn out, and psychological factors, such as anxiety, along with experience and training in communication skills.

It is important that the interview setting be appropriate, provide privacy, and comfortable surroundings with an appropriate seating arrangement. Ensuring the patient is put at ease prior to starting the interaction, is important. A number of patients raise the concern they are not greeted by name, and report the physician fails introduce himself or herself.

Patients also appreciate and respond positively to physicians who listen carefully. Listening is one of the most obvious components of the communication process, yet active or effective listening is one of the most difficult skills to acquire. The first step is to receive the information from the person. Tools that help us listen in such a way that information is registered and passed on accurately include taking notes, asking the speaker to repeat or clarify the parts that are not clear, and check that the information received is accurate by summarizing it. It is often helpful when interviewing a patient to demonstrate that you are paying attention and try to understand what the person is saying and feeling. Key features of active listening are:

- Gathering and retaining information accurately
- Understand the implications for patient of what is being said
- Respond to verbal and non-verbal signals or cues; and
- Demonstrate that you are paying attention in trying to understand

Non-verbal cues can reveal a lot of information about ourselves and our feelings. It is important to be sensitive to the patient's body language during the interview and

to pay particular attention to eye contact, posture, gestures, facial expressions and the way the voice is used.

It is important to allow sufficient time to end an interview properly in order to summarize what the patient has told you, check the accuracy of what has been said, and ask the patient if any information has been left out that the patient feels important, inquire if the patient would like to add anything and explain the next steps.

It is important to have appropriate communication during physical examinations. Occasionally, there are misunderstandings between physicians and patients during the physical examination. It is important for physicians to be aware that patients are likely to be very conscious of their vulnerability as they await to be examined. They may also feel embarrassed or anxious about what might be found. Guidelines that assist putting the patient at ease are:

- Always respect the patient's sensitivity and modesty;
- Physicians must leave the room and offer appropriate gown for the patient to change into. A blanket should also be available to cover the patient before and during the examination;
- Explain what you are going to do and ask the patient whether they have any concerns about this; and
- Be careful not to instill anxiety during the physical examination.

Often, speaking about what you are doing and what you are looking for during the physical examination assists the patient in understanding what is occurring. Avoid causing discomfort, be aware of the patient's expressions and ask the patient to advise you if anything in the examination technique is causing discomfort.

It is easy for physicians to skip over some of the steps in order to provide service to the many waiting patients.

However, it is important to be focused on the individual patient at the time. Physicians who have mastered the ability to give their full attention to the patient at hand, allow the patient to tell their story without interruption, provide a summary of the history and an explanation of the purpose of the physical examination, and a final description of what next steps, tend not to receive complaints.

As previously mentioned, communication skills can be learned. Each and every physician can improve their communication skills which can result in better outcomes for both patients and physicians.

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### MS Funding and Clinical Trials

On October 19, 2010, the Government of Saskatchewan made five million dollars available to the Saskatchewan Health Research Foundation (SHRF) to fund clinical trials for MS Liberation Treatment. Information will be posted on the SHRF website about this call for clinical trials and physicians should direct patient inquiries regarding these clinical trials to the website at [www.SHRF.ca](http://www.SHRF.ca)

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### Providing Test Results

Physicians are reminded they have an ethical and legal obligation to provide test results in a timely fashion, and to arrange the follow-up care. In addition, physicians leaving practice for any reason must provide arrangements for continuity of care for their patients, including identifying who will be responsible for reviewing and acting upon investigation results.

CMPA had provided guidance in their information letter, June, 2008 – Volume 23, 2-IL0820E (previous guidance information letter, June, 2004). An excerpt from the June, 2008 information letter indicates:

### “The Bottom Line

Physicians ordering investigations have a duty to communicate the results to the patient and to make reasonable efforts to ensure appropriate follow up is arranged.

When physicians order an X-ray or any other test – whether in their own office practice or in a hospital – they need to be satisfied there is a system in place to follow up on the results.

Any physician who becomes aware, even incidentally, of an abnormal test result may be seen by the courts to have a duty to make reasonable efforts to inform the patient or the patient’s physician of the result.

Physicians are reminded of their professional responsibility to make reasonable efforts to ensure that patients receive the appropriate care whether they order tests or become aware of abnormal test results. The more serious abnormality and possible consequence on the patient’s health, the more urgent it is for the physician who is aware of the result to act appropriately.”

Another area of concern with timely follow-up occurs in multi-physician offices when results are either not reviewed by any physician, in the absence of the ordering physician, or are reviewed by another physician and filed without the original ordering physician reviewing them. The following tool is useful in a multi-physician practice when it is necessary to ensure that laboratory results are reviewed in a timely fashion and appropriate contact with the patient made if the matter is urgent. The tool outlined below can be used to document who reviewed the test result in the absence of the ordering physician, and to indicate whether the chart or patient were recalled. The stamp does not allow for filing of the result, until the ordering physician’s initials are in the top box of the stamp. This allows for timely review by a second physician in the absence of the ordering physician, but

will not allow for the result to be filed until the ordering physician has had an opportunity to review.

Often, what happens when a result is reported as normal, the result is filed without the ordering physician seeing it. The absence of an abnormal result does not necessarily mean the ordering physician will have no further action plan and therefore, it is more reasonable to allow authorization of filing to be done by the ordering physician once they are aware of the results.

The following is an example:

<b>File</b>	<input type="text"/>
<b>Chart</b>	<input type="text"/>
Sept 09 2005	
<b>Recall</b>	<input type="text"/>
	<input type="text"/>

The box to the right of 'File' should be signed off by the ordering physician and without the ordering physician's initials, the result cannot be filed.

The 'Chart' and 'Recall' boxes can be used to tick off whether the covering physician wishes to review the entire chart with the result and/or recall the patient.

The box at the bottom of the stamp is for the interim signature of the on-call physician, and a box for the date when the physician reviewed the matter.

The middle box is the date stamp for the receipt of the document.

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### ... From Associate Registrar/Legal Counsel

*Bryan Salte*

#### College Disciplinary Actions

The College reports discipline matters in the next issue of the Newsletter after the disciplinary action is complete. There have been two such matters since the last Newsletter report.

#### Dr. Samir Saha

Dr. Saha was charged with unbecoming, improper, unprofessional or discreditable conduct after having been convicted of the criminal offence of attempting to obtain a bottle of Cotridin from a patient by a false pretence and with intent to defraud.

The evidence at the criminal sentencing hearing was that Dr. Saha told a patient who had attended his office to obtain a sick note that he would not complete the sick note until she filled the prescription for Cotridin which he wrote in her name and returned the drug to him.

The court commented that the conduct was not for the patient's benefit but was only intended to serve Dr. Saha's desire to obtain the medication for his own use. The court also commented:

*Every doctor has a duty to the patient.... It is to act in the best interest of the patient/client and to put that person's interests ahead of one's own.*

*Dr. Saha breached that duty in this instance. He endeavoured to use this young woman, who was his patient. He put her in a terrible spot. He basically put her in the position where if she did*

*what he wanted, she would be trafficking in a narcotic, or at least a schedule 1 substance.*

*But the result of Dr. Saha's breach of his obligation to the patient is that the patient now suffers from a lack of trust in the medical profession.*

*In my view, what Dr. Saha did to his patient is most egregious. ...*

*With respect, public wants to have access to doctors in whom the public can have confidence. That confidence involves knowing that the doctor will act like a doctor. And in that reason (sic), will not act contrary to the patient's interests.*

By the time of the penalty hearing, Dr. Saha was no longer licensed in Saskatchewan and therefore he had no licence to suspend or revoke. The Council imposed the following penalty:

- a) The maximum fine permissible under the legislation of \$15,000;
- b) Reimbursement of the College's costs in the amount of \$3,018.04.

#### **Dr. Russell Knaus**

Dr. Knaus was charged with unbecoming, improper, unprofessional or discreditable conduct. He entered a guilty plea to charges of:

- a) Prescribing desiccated thyroid to patients in a manner that did not meet the standards of the medical profession; and,
- b) treating members of his immediate family when such treatment did not meet the conditions of paragraph 20 of the *Code of Ethics*.

Legal counsel for the College and legal counsel for Dr. Knaus entered into a joint penalty recommendation, which was accepted by the Council.

The Council ordered that:

- 1) Dr. Knaus was prohibited from prescribing thyroid replacement therapy or Lugol's Iodine;
- 2) Other than practising as a surgical assistant, Dr. Knaus was limited to practising under the

supervision of a physician approved by the Registrar of the College of Physicians and Surgeons;

- 3) Dr. Knaus was required to complete the course in pharmacology that was developed by the College of Medicine, Department of Continuing Professional Learning for physicians who require remediation in pharmacology and successfully complete that course within a period of 12 months;
- 4) Dr. Knaus was directed to pay the costs of an incidental to the investigation and hearing in the amount of \$3,515.38

The College would like to remind physicians that the *Code of Ethics* requires physicians to limit treatment to immediate family members. The Canadian Medical Association *Code of Ethics* is adopted as part of the College bylaws, and a breach of the *Code of Ethics* is defined as professional misconduct in the College bylaws.

Paragraph 20 of the Code of Ethics states the following:

*20. Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available; there should be no fee for such treatment.*

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## **... from the Director of Physician Registration**

*Barb Porter*

### **Change of Annual Registration Cycle**

Physicians are advised that the date of the annual registration cycle is changing. At the April meeting of the Council, a motion was passed that changes the annual licensure cycle "from January 1 to December 31 to December 1 to November 30."



2010 is the final year that the annual registration cycle ends on December 31. In the fall of 2010 when physicians renew their annual registration, the next registration cycle ends November 30, 2011. Locum tenens or temporary licenses are not subject to annual renewal and are not impacted by this change.

In the fall of 2011, physicians will be advised that the completed registration renewal package and accompanying fees are due by no later than November 1, 2011 and that the physician's annual licence will end November 30, 2012.

There are a number of reasons that Council considered and approved the change to the registration renewal cycle. In spite of the fact that fees and completed registration renewal forms are due annually by December 1, each year a significant portion of registration renewals are processed in the month of December. Many physicians are away during the December holiday season and are unavailable to provide complete information to the College. Administrative offices responsible to pay fees on behalf of the physicians are often closed during the holiday season and fees are not submitted in a timely manner. The Royal College and the College of Family Physicians of Canada close prior to Christmas and open after the New Year. Physicians who require information regarding their Continuing Professional Learning programs or who need to enroll in one of the programs are unable to obtain the assistance they require.

If you have questions or concerns as to how the changes may affect your registration please contact Barb Porter, Director, Physician Registration at 1-306-244-7355.

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#### **If you moved to a Provisional Licence in 2010....**

This is your reminder that you will need to enroll in a continuing professional learning program with the Royal College of Physicians and Surgeons of Canada or the Canadian College of Family Physicians of Canada **before**

you will be permitted to renew your registration for 2011. This process is known as revalidation.

Once enrolled in a learning program, you will not be required to submit your CME information to the College during the course of your five year learning cycle. Instead, you will record the information with your learning program and at the end of the five year learning cycle you will provide the College of Physicians and Surgeons of Saskatchewan with a statement from your learning program that you have satisfied the requirements of the program in which you are enrolled.

At the time of registration renewal you will be asked to confirm that you are enrolled in a program and you need to provide the date of your learning cycle (set by the program in which you have enrolled).

You are encouraged to attend to this matter promptly as both the Royal College and the College of Family Physicians close prior to Christmas and open after the New Year; they are not available to assist you during the holiday season.

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#### **Enrolling in an approved Continuing Professional Learning Program**

The contact information for the two Colleges is:

##### **The College of Family Physicians of Canada**

2630 Skymark Avenue  
Mississauga, ON L4W 5A4

You may call the CFPC dedicated hotline at 1-866-224-8104 or  
call toll free 1-800-387-6197 ext 204  
Website: <http://www.cfpc.ca>

##### **The Royal College of Physicians and Surgeons of Canada**

774 Echo Drive  
Ottawa ON Canada  
K1S 5N8

You may call the RCPSC Department of Professional Affairs at 1-613-730-6243 or call toll free 1-800-461-9598  
Website: <http://rcpsc.medical.org>

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### Mandatory On-Line Registration Renewal

At the April, 2010 meeting of the Council of the College of Physicians and Surgeons of Saskatchewan, a motion was passed that approved mandatory on-line (or electronic) registration renewal “effective in the fall of 2011 for the 2012 registration cycle”

Physicians will recall that in the fall of 2009 the College introduced on-line registration renewal as an option for its members. The online renewal system was available through the College website; it opened for use on November 1, 2009 and closed on December 1, 2009 which is the date when registration fees and packages were due to be submitted to the College. Approximately 450 physicians took advantage of this opportunity to complete registration renewal electronically and the response to the on-line option was very positive.

2010 will be the final year that all annual registrations are provided to physicians in a paper package. As in 2009, physicians will have the option of submitting paper or an electronic renewal form to the College. Locum tenens or temporary licenses are not subject to annual renewal and will not be impacted by this change.

In the fall of 2011, physicians will be advised that they need to renew their registration and will be required to submit their registration renewal to the College electronically. The College anticipates that in 2011 physicians will be advised by email and letter that the registration renewal system is open and will provide the necessary information to permit physicians to log onto the system and renew their registration.

There are a number of reasons that Council considered and approved the change to the format of registration

renewal. In spite of the fact that the fees and the completed registration renewal forms are due December 1 each year a significant portion of registration renewals are processed in the month of December. Many of the paper based renewal packages are incomplete or contain errors when they are submitted. The cost to hire additional staff to follow up with physicians to obtain complete or correct information is significant. Physicians who misplace their paper packages or who moved to a new address and did not receive their paper package by mail are unable to complete registration renewal without contacting the College and requesting a new registration renewal package.

The College encourages physicians to try on-line registration in the fall of 2010 and provide feedback or suggestions for improvement.

If you have questions or concerns as to how the changes may affect your registration, please contact Barb Porter Director, Physician Registration at 1-306-244-7355.

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### Revalidation Questions and Answers



Since 2007, Saskatchewan physicians who are licensed on a full, provisional or special licence are required to fulfill revalidation requirements in order to renew their professional registration for the upcoming year.

**Q - Do I need to submit my CME information (attendance records, certificates etc) to the College of Physicians and Surgeons of Saskatchewan?**

**A - No**, in fact we do not retain any of the information that is submitted to us. For our purposes, we require and only accept a statement from your continuing professional learning program that you have successfully completed program requirements at the end of your learning cycle.

**Q – I am at the end of my current learning cycle. What do I do now?**

**A-** You will need to obtain a statement from the relevant program that confirms you have met all of the requirements of your program. This is the information that you need to provide to the College of Physicians and Surgeons of Saskatchewan. A statement of accrued credits is not sufficient for revalidation purposes.

**Q – I need a new learning cycle, what do I need to do?**

**A -** Contact your continuing professional learning program at your respective College (CFPC or RCPSC) to request the dates of your new learning cycle. Retain this information as you will need to provide it to the College of Physicians and Surgeons of Saskatchewan when you complete your next annual registration renewal.

**Q - Am I eligible for an exemption from revalidation?**

**A -** Physicians who meet the following criteria may be eligible to apply to the College for exemption from revalidation requirements:

- Physicians practicing outside of Saskatchewan who wish to maintain an active Saskatchewan license;
- Physicians whose practice is restricted to surgical assisting;
- Physicians whose practice is restricted to administrative medicine.

Physicians who meet the above criteria will need to contact the College office to apply for an exemption. Applications for exemption must be submitted on an annual basis prior to professional registration renewal. Only the College of Physicians and Surgeons of Saskatchewan can approve an exemption from revalidation.

**Q – What do I need to do if I think the exemption criteria may apply to my circumstance?**

**A –** Contact Barb Porter, Director of Physician registration at 10306-244-7355 to discuss your situation. She will provide the advice you require.

**Still confused about revalidation?**

Contact Barb Porter, Director of Physician Registration at 1-306-244-4643 for further information about what you need to do.

**Don't delay;  
make your revalidation arrangements today!**



**“Prescribing Corner – Myth vs science & experience in using meperidine (Demerol) for chronic pain”**

*Reprinted with permission from Dr. Susan Ulan, Senior Medical Advisor, College of Physicians and Surgeons of Alberta*

**“Scenario:**

*A 43 year-old female visits your office as a new patient. Her current physician is retiring and she is hoping you will refill her medications, including oral meperidine (Demerol) 100 mg QID, which she takes on a daily basis for chronic headaches. What are your thoughts regarding prescribing this medication for chronic pain?*

*This is a common scenario for many physicians so we asked chronic pain expert Dr. Chris Spanswick, of the Chronic Pain Centre in Calgary, what his response would be.*

Meperidine was first synthesized in 1939 as an atropine analogue. Noting its analgesic properties, its use for moderate-to-severe pain began. Meperidine was also considered to have less spasmogenic effect on smooth muscle, and produced less risk of addiction, respiratory depression, constipation and urinary retention. Studies

since then show the spasmogenic properties are similar to other opioids at equianalgesic doses.

However, these same studies demonstrate meperidine is a poor analgesic, performing lower for post-operative pain than other opioids, and with greater variability in outcome. 75 mg parentally produces analgesia that may last as little as 30 minutes. 50 mg orally has demonstrated in several randomized, double-blind trials to be no more effective than a placebo.

Traditionally, use of meperidine was specific to treating pain from cholecystitis and pancreatitis. However, this type of clinical use is not supported by scientific findings. In fact, the use of meperidine lacks evidence to support superiority over other currently available opioids, and offers a greater risk of serious side effects. Much of meperidine's historical clinical use is based on anecdotal versus scientific evidence. A recent review of the literature confirms that meperidine has no advantages over other currently available opioids, and more potential for serious side effects. Some countries, such as Australia, restrict meperidine use because the risks and side effects outweigh any potential benefits.

Meperidine has no advantages over other available opioids, and more potential for serious side effects.

Meperidine has unique properties that can increase the risk of addiction in susceptible individuals, much more than observed with other opioids. Use of the medication also produces:

- More pronounced euphoric effects
- Very intense central effects that are short-lived (approximately five minutes\_ and produce a rapid and fleeting "reward".

When used for treatment, meperidine metabolizes into normeperidine, a non-opioid but active metabolite. Normeperidine is neurotoxic and can precipitate anxiety, hyperreflexia, myoclonus, seizures and mood changes within 24 hours. Low levels of normeperidine can also be

associated with serious side effects, even in healthy subjects with normal renal function.

Overall, long-acting drugs that produce consistent blood levels are more effective in treating long-term pain. Opioids with short-lived effects such as meperidine are not recommended for chronic non-cancer pain. You should consider other analgesics instead. "

If you have feedback or comments on this article, contact Doug Spitzig B.S.P., Manager of the Prescription Review Program at the College of Physicians and Surgeons of Saskatchewan.

(306)667-4640 or email [doug.spitzig@cps.sk.ca](mailto:doug.spitzig@cps.sk.ca)

### Delisting of Chiropractic Services is not Deregulation

*Submitted by M. Jim Stewart, Executive Director, Chiropractors' Association of Saskatchewan*

In the last provincial budget chiropractic services were delisted. There may be some confusion about what this term means and an assumption that it equates with deregulation. Delisting is not deregulation; far from it.

Delisting a service simply means that it will no longer be paid for, in whole or part, from the public purse. This, in essence, is all that has occurred with the chiropractic profession. Chiropractic, as it has since 1943, remains a self-regulating profession with a legislative responsibility to protect the public. All privileges that chiropractors had before delisting, including those regarding defined radiology privileges and the ability to directly refer to medical specialists, remain in place and in full effect.

If you have any questions in this regard please contact Mr. Jim Stewart, Executive Director, at the office of the Chiropractors' Association of Saskatchewan in Regina at: 585-1411 or e-mail: [jstewart@saskchiropractic.ca](mailto:jstewart@saskchiropractic.ca)

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## “Application for Medical Registration in Canada”

*Prepared by the Medical Council of Canada (MCC)*

The Federation of Medical Regulatory Authorities of Canada (FMRAC) and the Medical Council of Canada (MCC) are collaborating to create a single, streamlined online application for international medical graduate (IMG) physicians applying for medical licensure in Canada.

Human Resources and Skills Developments Canada (HRSDC) has granted \$2.8 million in funding for the Application for Medical Registration in Canada project through its Foreign Credential Recognition Program. FMRAC and its members and the MCC will contribute the remaining funds for the project, which is expected to cost a total of \$4.9 million.

The project will provide an effective web-based physician application process for the registration of IMGs, and eventually for all physicians, which will be valid for all 13 provincial and territorial medical regulatory authorities. This will benefit all physicians and especially IMGs, who tend to apply to many regulatory authorities and medical organizations when they begin the process of applying for integration into the Canadian health-care system.

The MCC’s 2009-10 President, Dr. Oscar Casiro, completed his medical education in Argentina, where he graduated from medical school in 1974. He immigrated to Canada to begin a career in pediatrics. As an IMG in Manitoba, he wrote the MCC examinations, applied for residency programs and took the certification examination in pediatrics. Each step required him to submit his credentials to a different organization.

Years later, when he moved to a new province in 2004, he virtually had to start over. “When I moved to B.C., I had to present everything again. I remember because I had all my diplomas and everything framed. I had to take

everything out of the frames and bring them to the College of Physicians and Surgeons, including all the original documents and translations.”

Each province and territory reserves the right to set its own licensing standards, and there are discrepancies between what each jurisdiction requires. “In B.C. they wanted a criminal record check, and originals of everything. Every province or territory requires something a bit different,” Dr. Casiro explained.

The new online system will build on the current repository that allows IMG candidates to permanently store verified electronic copies of all of their credentials in one place and give access to those stored credentials to medical organizations. “That will be the beauty of having one application for registration process: being able to register through the central site, which shows what each province needs. And with the repository, if you produce the documents once, then they are filed there for life,” Dr. Casiro said.

“This system will not only allow IMGs to have a central account to control all of their data but will also allow them to attach their stored documents to their electronic applications,” said Pierre Lemay, MCC Director of the Repository and Registration Centre. “That’s really the key.”

Dr. Casiro said the new application process will especially benefit IMGs, who are new to Canada. “If you come from another country, it can be difficult to understand the process if you are not familiar with the rules. Having everything in one place is much easier than having to seek information from various medical organizations. If you are looking to apply to various provinces, it can be a very daunting task to figure out the requirements independently.”

The Application for Medical Registration in Canada project will benefit from the medical regulatory authorities’ current efforts to harmonize their licensure requirements. This will better facilitate physician labour

mobility between provinces and territories as required by the Federal/Provincial/Territorial Agreement on Internal Trade, said FMRAC 2010-11 President Dr. William Lowe. This agreement requires that workers in regulated professions licensed in a province or territory to also be recognized for licensure by another Canadian jurisdiction upon application.

“We’ve already achieved a consensus on the Canadian standard for full licensure for new applicants,” said Dr. Lowe. “We have also agreed that new physician applicants who do not meet this standard may only be eligible for a provisional licence, and we are in the process of developing standards for provisional licensure.”

The new registration process will also support the principles outlined in the Forum of Labour Market Ministers’ Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications: transparency, fairness, impartiality and timeliness. Registration practice fairness has already been given particular attention in many provinces. “Since fair registration practices are already in place in several provinces, it will be advantageous to have a pan-Canadian registration process that complies,” said Dr. Lowe.

The application project is building on the existing repository, which is currently being used by the Canadian Resident Matching Service (CaRMS), the College of Family Physicians of Canada and ten medical regulatory authorities. The MCC is working with regional health authorities and other stakeholders to start using the repository by the end of 2010, Mr. Lemay said. The repository is at present only available to international medical graduates.

When the relevant software is complete, medical regulatory authorities can enable the new, common application process, which Dr. Lowe said will be very beneficial to them. “Any process that is common to all 13 medical regulatory authorities can benefit from best practices and benefit from common processes, saving

staff time and expense,” Dr Lowe said. “After all, we are really asking the same questions by and large.”

FMRAC and the MCC are aiming to launch the Application for Medical Registration in Canada in 2012.



### **Maternal Mental Health Strategy: Building Capacity in Saskatchewan**

The MotherFirst Working Group was created following a Regina conference “Unmasking Postpartum Depression” in the fall of 2009. The goal was to address the issue of inconsistent identification and treatment of women with maternal mental health problems. It brought together interdisciplinary stakeholders, including major professional health associations, community organizations, First Nations groups, and women with lived experience. The group is geographically, culturally, and professionally representative.

#### **The Ministry of Health endorsed the following recommendations in August 2010 :**

##### **Recommendation #1: Education**

Increase awareness of the frequency, impact, and treatment of maternal mental health problems, and promote positive mental health through ongoing access to evidence-based materials.

Materials were sent out to all physicians who are known to be involved in pre and postnatal care. They are available through the Saskatchewan Prevention Institute.

##### **Recommendation #2: Screening**

Universal screening for depression and anxiety using the Edinburgh Postnatal Depression Scale (EPDS) in pregnant and postpartum women.

The EPDS will be used consistently at regular intervals during routine health care visits during pregnancy and postpartum. Positive mental health will be promoted with all women. A score of 12 or will be used for a referral to a health professional, while those who score 10 or 11 will have the opportunity for follow-up. Partners of women who score positive for depression (>12) will also be offered depression screening. Screening will occur at the first or second prenatal visit and again at 28-34 weeks gestation and at 2-3 weeks and 2 and 4 months postpartum.

### **Recommendation #3: Treatment**

Prioritize maternal mental health within Mental Health Services, improve accessibility, and increase treatment options.

Timely treatment is essential to restore the well-being of mothers suffering from mental health problems and to minimize the adverse effects they can have on their infants and families. Each region will develop a flow chart to show access to care.

### **Recommendation #4: Sustainability and Accountability**

Implement the MotherFirst policy recommendations and ensure maternal mental health remains a priority within Saskatchewan.

Groups will be developed at the provincial and regional levels and will include multiple stakeholders, including First Nations.

For more information please contact Alanna Danilkewich, College of Physicians and Surgeons representative [alanna.danilkewich@usask.ca](mailto:alanna.danilkewich@usask.ca) or Angela Bowen, College of Nursing, University of Saskatchewan [angela.bowen@usask.ca](mailto:angela.bowen@usask.ca)

### **“Medical Genetics”**

*Submitted by Krista Homstol, MPH, Epidemiologist and Coordinator of the Congenital Anomalies Surveillance System, Royal University Hospital, Saskatoon Health Region*

“At this time, there is no formal system in place for reporting of congenital anomalies (CAs) in Saskatchewan. This is a major shortcoming as CAs are the second leading cause of infant mortality in the province.<sup>1</sup> CAs pose a significant burden on medical and non-medical resources and create a considerable emotional and economic burden for families and communities. Despite Saskatchewan being one of the provinces with the highest rates of infant mortality<sup>1</sup>, it is one of few provinces without a surveillance system to monitor CAs.

In January 2008, a proposal to establish a CA Surveillance System was put forward by the CA Steering Group in the Saskatoon Health Region (SHR). In the fall of 2009, a memorandum of agreement was established between SHR and the Public Health Agency of Canada (PHAC). The goal is to enhance the Canadian Congenital Anomalies Surveillance System (CCASS) by piloting the development of a surveillance system in SHR with the intention of expansion across the province. In April 2010, PHAC funded the hiring of a coordinator in SHR to develop the surveillance system.

The purpose of a CAs surveillance system is to produce high quality population-based data. The information will help to understand the causes of CAs and inform government agencies about the efficacy of programs and services. As new technologies and programs are introduced to help further prevent, detect and manage children with CAs, it is vital that timely surveillance be conducted to measure the impact of these strategies. Along with understanding the impact of prevention strategies, surveillance systems can be used to monitor trends over time and space. There is increased concern over adverse exposures that affect fetal development,

and surveillance systems can be used to measure the impact of these exposures, as well as identify opportunities to prevent or modify these exposures.

The SHRCASS Steering Committee is in the initial stages of identifying all locations that have information on infants up to 1 year of age with CAs. For more information, please contact coordinator Krista Homstol (Tel: 306-655-1699; Email: [krista.homstol@saskatoonhealthregion.ca](mailto:krista.homstol@saskatoonhealthregion.ca)).

<sup>1</sup> Saskatchewan prevention Institute. Infant mortality in Saskatchewan. Evidence to inform public health practice. February 2009."

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1-800-667-9945 (243) or 359-4243 in Regina

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Dr. Dennis Kendel, Registrar  
Dr. Karen Shaw, Deputy Registrar  
Mr. Bryan Salte, Associate Registrar/Legal Counsel  
Ms. Barb Porter, Director of Physician Registration

#### **Along With:**

Amanda Lee, Registration Officer  
Amy McDonald, Manager of Accounting/Finance  
Ashley Tomiak, Complaints Co-ordinator  
Carol Bowkowsky, Senior Registration Officer  
Doug Spitzig, Contract Pharmacist  
Ferne Hand, Admin. Assistant – Registration  
Jillian Halayka, Database/Website Administrator  
Karen Mazurkewich, Registration: Information and Certificate Officer  
Karen Mierau, Reception/Assistant to B. Salte/Newsletter  
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**Take Note . . .**

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ECG exams are scheduled for the third Wednesday of each month, from 1:30 p.m. to 4:30 p.m. in the CPSS Boardroom at 500 - 321A 21st Street East, Saskatoon, SK, S7K 0C1. For information or to book a sitting contact Tracy Hastings by phone (306) 244-7355 or by email [tracy.hastings@cps.sk.ca](mailto:tracy.hastings@cps.sk.ca).