February 2003 Volume 19 Number 52

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

Greetings!

I hope all of you are having a nice winter so far.

At our last Council meeting held recently, my fellow Councillors did me the honour of electing me as President of the College of Physicians and Surgeons of Saskatchewan for 2003. As some of you may know, I have held this particular position before and, although somewhat unusual, this has happened in previous years on a couple of occasions.

What's new with the College? Well, to begin with, I am very pleased to announce that we have two new councillors, one from Saskatoon, and the other from Regina. Dr. Prakash Patel (who represents Regina) is a respirologist, and a well-respected member of the medical community. The Saskatoon member is Dr. Tomas Sylwestrowicz, a gastroenterologist who is also a well-respected member of the medical community in his jurisdiction. These new members are replacing Dr. Borden Bachynski and Dr. Roy Chernoff to whom I extend my personal thanks for the excellent service they provided to Council during their term of office.

From now on, instead of meeting six times a year, Council is only going to meet five times a year. Even though this will mean more arduous and lengthy sessions for the Councillors, the end result will be of some cost-saving benefit to the membership.

The Annual General Meeting of the College is scheduled to be held in March of this year instead of in October. This is going to be in conjunction with SAHO's Partners in Health conference and, if everything works out O.K., we may continue to do this on an annual basis. If you have time, try and make it out to Saskatoon to participate.

A special thanks to our outgoing President, Dr. Mukesh Mirchandani, for the fantastic job he did during his term of office. I will try and follow in his footsteps.

Finally, I urge you to try and take as good care of yourselves as you do of your patients.

Dr. David Ahmed, President

IN THIS ISSUE

President's Message 1
2003 Council 2
2003 Council AGM 3
Call Coverage - Policy Dev. 4
Conflict of Interest Bylaw 6
Attending Physician Statements . . 7
Documentation for QA 8
New Childhood Vaccines 9
First SK Internet Pharmacy 10
CME/PD New Website 13
CFPC Patient Information 14
Information/Programs 14

2003 Council

Dr. David Ahmed, President, Executive Committee . . . . Regina

Dr. Mukesh Mirchandani, Past President, Executive Committee. . . . Yorkton

Dr. Garry Hansen, Vice President, Executive Committee . . . . . . Saskatoon

Dr. William Albritton (Dean, College of Medicine) . . . . Saskatoon

Dr. George Gilmour. . . . . Prince Albert

Dr. Warren Huber . . . . Humboldt

Dr. Suresh Kassett . . . . Herbert

Dr. Fred Morris . . . . Moose Jaw

Dr. Prakash Patel . . . . Regina

Dr. Tomas Sylwestrowicz . . . . Saskatoon

Dr. Edward Tsoi . . . . Estevan

Dr. Malcolm Warburton, Executive Committee . . . . Paradise Hill

Public Members Appointed by the Minister of Health

Mrs. Georgiana Chartier . . . . Saskatoon

Mr. Michael Fisher, Executive Committee. Melville

Mrs. Jean MacKay . . . . Regina

Mrs. Betty McKenna . . . . Moose Jaw

Mr. Evert Van Olst. . . . . Saskatoon

COUNCIL MEMBERS RELINQUISHING APPOINTMENTS

On behalf of the Council, the President would like to thank

Dr. Borden Bachynski, Regina
Dr. Roy Chernoff, Saskatoon

For their valuable and generous service to the College,
the profession, and the people of Saskatchewan

2003 College Annual General Meeting

In 2002 the Saskatchewan Association of Health Organizations (SAHO) invited the College of Physicians and Surgeons, the Saskatchewan Medical Association, and other professional organizations in the health sector to join as partners in hosting a major health conference in the spring of 2003. The conference agenda includes the SAHO Annual General Meeting, and other partner organizations were invited to also schedule their annual meetings during the conference.

The Council for the College accepted the invitation. Accordingly, the 2003 Annual General Meeting of the College of Physicians and Surgeons will be convened at 10:00 a.m. on Tuesday, March 25th, 2003 in the Saskatchewan Room (2nd floor) of the Centennial Auditorium in Saskatoon. *The meeting will be open to all physicians and members of the general public without charge.* Attendees are required to register at the conference registration table located directly inside the main entrance.

The integration of the College Annual Meeting with this conference will result in cost savings for the College as well as offering the governing Council of the College unprecedented opportunity for interaction with RHA Board members and RHA senior managers. The Council will also be participating selectively in some of the excellent educational sessions associated with the conference.

The conference educational sessions are open to all physicians, but there is a registration fee. A copy of the conference program describing the educational opportunities and the registration options is included with this newsletter. We would encourage all physicians to access these educational opportunities.

MAINPRO-MI Study Credits are pending approval by the College of Family Physicians of Canada.

Partners in Health

Saskatchewan's premier multi-disciplinary health care conference and commercial exhibition

March 23 - 26, 2003

Saskatoon, Saskatchewan
Centennial Auditorium & Convention Centre

Sunday, March 23

- **Gary Gregor** on creating winning organizations, teams and individuals
- Green Ribbon Awards presentations & reception

Monday & Tuesday, March 24 & 25

Monday's opening session: **Maude Barlow**, Council of Canadians, on the future of health care in Canada and the impact of the Kirby and Romanow reports
Tuesday's opening session: **John Marriott & Ann Mable** on primary health care around the world

- 18 other leading-edge presentations
- 14 Gilbert Wright/Smith-Walshaw presentations
- Saskatchewan's largest commercial health care exhibition
- book fair, SAHO member education tables and Cyber Station
- College of Physicians & Surgeons of Saskatchewan Annual General Meeting – Tuesday, 10:00 a.m. Saskatchewan Room – No registration fee

Wednesday, March 26

- SAHO's Annual General Meeting

Early bird registration deadline: February 28, 2003

College Policy Development on Medical Practice Call Coverage

D.A. Kendel MD, Registrar

The College extends its appreciation and gratitude to the members who responded to the member survey in the December 2002 College *Newsletter* on medical practice call coverage. We want to especially thank the members who took the time to write detailed letters to the College in respect to this issue.

When it met on January 31st and February 1st, 2003 the College Council considered all of the feedback it received on this issue from members, RHA Chiefs of Staff, RHA Emergency Department Heads, RHA Family Medicine Department Heads, RHA CEOs, the SMA, and Saskatchewan Health.

The feedback from members who responded to the member survey can be summarized as follows:

1) 76% believe that all physicians involved in direct patient care have an obligation to arrange for 24-hour coverage of patients currently under their care.

2) 85% believe that practice coverage arrangements should be made directly between medical colleagues.

3) 62% believe that it is not appropriate for physicians to sign out all after hours practice coverage responsibilities to a hospital emergency department, while 38% believe that such arrangements are acceptable.

4) If medical practices sign out to hospital emergency departments, 57% believe that such arrangements should be made between the medical practice and colleagues in the emergency department. Thirty-eight percent (38%) believe that such arrangements should be made with RHA personnel responsible for emergency room management.

5) 36% feel that selected physicians should be exempted from any requirement to make explicit practice coverage arrangements, while 64% believe that no exemption should apply.

6) Of those who favoured selective exemption of physicians from practice call coverage responsibility, a wide range of reasons for such exemption were identified.

There was significant variation in the responses that the College received from RHA Chiefs of Staff, Emergency Department Heads, Family Medicine Heads, and CEOs. However, the RHA responses followed two dominant themes.

In most RHAs outside Regina and Saskatoon, there is quite strong support for hospital emergency departments being the primary mechanism for serving the needs of all patients who require urgent health care outside weekday daytime hours.

One gets a sense that this approach to after hours health service delivery has been significantly influenced by the policy that provides on-call compensation to physicians who cover hospital emergency departments in those communities that do not have fulltime emergency room physicians.

In communities without fulltime emergency room physicians, the physician on call for the ER is generally the same physician designated to provide on-call coverage for the medical practices in the community. In such communities there is no longer a distinction between ER coverage and medical practice coverage

as the two have essentially become integrated.

The situation in Regina and Saskatoon is quite different. In these communities the distinction between medical practice coverage and services delivered through hospital emergency departments remains quite clear. The emergency departments in Regina and Saskatoon are not staffed to address the total burden of patient demand for medical services outside weekday daytime hours. The expanded hour walk-in clinics in those communities absorb a great deal of this burden between 5:00 p.m. and 11:00 p.m. It is also still the norm in these two major urban centres that medical practices maintain on-call coverage distinct from the parallel options of patient access to emergency departments.

The Council considered this information as well as the policy position that had been articulated by the Saskatchewan Medical Association Board, and presented for discussion at the SMA's Fall Representative Assembly. The SMA policy position was discussed at a joint meeting between the Executive Committees of the College and the SMA.

After considering information from all these sources, the Council approved in principle a policy statement that contains four points:

1) *All physicians involved in direct patient care have an obligation to arrange for 24-hour coverage of patients currently under their care.*

2) *Recognizing the impossibility for a physician to be available continuously; where physician numbers permit (four or more), they are encouraged to form call groups with physicians of similar interest and training to share responsibility for after hours and weekend coverage.*

3) *Physicians who transfer coverage of patients in their practice to another physician should have the agreement of the physician before doing so.*

4) *Physicians may make arrangements with a Regional Health Authority (RHA) for transfer of practice call coverage to a hospital emergency department or other facility/program governed by the RHA so long as these arrangements are acceptable to the RHA Board.*

However, the Council felt it important that this policy statement be accompanied by a companion paper that emphasizes:

1) *The pressing need for a health information system that ensures health professionals real time access to reliable information about patients whom they may attend outside weekday daytime hours.*

2) *The trend towards greater integration between community-based medical practices and the health services governed and managed by RHAs.*

3) *The need for citizens to have accurate information about the arrangements that different medical practices have in place to assure access to urgent health advice/care outside weekday daytime hours.*

VISIT OUR WEBSITE AT:

www.quadrant.net/cpss

College Bylaw – Conflict of Interest

B. Salte, Legal Council, Associate Registrar

The College bylaws relating to conflicts of interest have been in effect for a number of years. This article is written to remind physicians that conflict of interest is defined as unprofessional conduct, and to remind physicians that they should ensure that their financial arrangements do not infringe the bylaw.

The College bylaw follows the form that was adopted by the Ontario College of Physicians and Surgeons prior to Saskatchewan's adoption of a conflict of interest bylaw.

College bylaws state that having a conflict of interest is unbecoming, improper, unprofessional or discreditable conduct. The bylaw defines what is a conflict of interest:

(f) "conflict of interest" includes a situation whereby a physician, or a member of the physician's family, or a corporation, wholly, substantially or actually owned or controlled by the physician or a member of the physician's family,

(i) receives any benefit, directly or indirectly from,

1. a supplier to whom the physician refers his patients or their specimens, or
2. a supplier who sells or otherwise supplies any medical goods or services to the patients of the physician;

(ii) rents premises to:

1. a supplier to whom the physician refers his patients or their specimens, or
2. a supplier who sells or otherwise supplies any medical goods or services to the patients of the physician, except where,
3. the rent is normal for the area in which the premises are located and,
4. the amount of the rent is not related to the volume of business carried out in the premises by the tenant;

(iii) rents premises from,

1. a supplier to whom the physician refers his patients or their specimens, or
2. a supplier who sells or otherwise supplies any medical goods or services to the patients of the physician. except where,
3. the rent is normal for the area in which the premises are located, and
4. the amount of the rent is not related to the referral of patients to the landlord, or

(iv) Sells or otherwise supplies any drug, medical appliance, medical product or biological preparation to a patient at a profit, unless the physician can demonstrate that the product sold or supplied was reasonably necessary for the medical care of the patient.

(v) It is a conflict of interest for a physician to order diagnostic tests other than medically necessary tests to be performed by a diagnostic facility in which the physician or a member of the physician's family has any proprietary interest.

A conflict of interest can arise if a physician sells any product to a patient, or refers a patient to a facility in which the physician has a financial interest unless the physician can demonstrate that the product or diagnostic test was necessary for the patient's medical care.

Some other examples where a conflict of interest may arise are:

1. A physician or group of physicians rents premises to a laboratory or pharmacy at greater than market rent;
2. A physician or group of physicians rents premises from a laboratory or pharmacy at less than market rent;
3. A pharmacy provides service to a physician or group of physicians at no cost;
4. A pharmacist gives an interest-free loan to a physician or a loan at less than prevailing rates.

The first two examples above can arise because a diagnostic imaging facility, laboratory or pharmacy will often want to be located in close proximity to a medical practice, and may be prepared to pay a premium in order to be so located. Diagnostic imaging facilities or laboratories will locate in close proximity to physicians' practices expecting that most of the patients of the medical practice will have their lab work or diagnostic imaging done at their facility. Pharmacies will locate in close proximity to physicians' practices expecting that most of the patients will have their prescriptions filled at their pharmacy.

The bylaw does not require that the medical practice actively directs patients to utilize the services of the diagnostic imaging facility or laboratory, or that the medical practice encourages their patients to have their prescriptions filled at the pharmacy for a conflict of interest to exist.

The bylaw does not prohibit diagnostic imaging facilities, laboratories or pharmacies from being located in close proximity to medical practices. However, if a medical practice either receives rent that is greater than fair market value, or pays rent that is less than fair market value, the physicians may be the subject of an investigation to determine whether they have practiced in a conflict of interest, and hence acted unprofessionally.

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

Attending Physician Statements

K. Shaw MD, Deputy Registrar

In October 1997, the College of Physicians and Surgeons of Saskatchewan alerted physicians to concerns raised by insurance companies with respect to the tardiness of completion of Attending Physician Statements (APS) and other insurance forms. This tardiness resulted in delays in processing disability claims and/or insurability of the applicant. To not disadvantage their patients, physicians were encouraged "to complete these forms as promptly as possible, preferably within two weeks of receipt of the form".

Recently, one insurance company alerted the College to a problem where an increasing number of physicians are refusing to complete APS requests unless their patients first undergo a physical examination. However, the insurance company has indicated that APS form requests most frequently used by life insurers do <u>not</u> require a current physical

examination. Instead, most request only a summary of the physician's records.

The insurance company goes on to explain that the effect of a physician requiring an examination, not requested by the insurer, is two-fold: (1) the insurance company is unable to issue the insurance applied for until this is done; and (2) if the examination should uncover any abnormality of which the patient is unaware, the patient's insurability status may be adversely affected. Each of these situations may cause an individual's coverage to be delayed or denied by the insurance company.

Physicians should not require the attendance of a patient for an "update visit", and/or a physical examination prior to completing APS forms, except in those circumstances where it has been specifically requested by the insurance company.

Complete Documentation Critical to Quality Assurance

K. Shaw MD, Med. Mgr. Anaesthetic & Operative Deaths and Perinatal and Maternal Mortality Study Committees

Members are reminded that the Anaesthetic & Operative Deaths Study Committee and the Perinatal and Maternal Mortality Study Committee are quality assurance committees of the College that review, in the case of the Anaesthetic & Operative Deaths Study Committee, all deaths occurring within 10 days of surgery and or anaesthesia in the province of Saskatchewan for the purposes of assuring quality care. The Perinatal and Maternal Mortality Study Committee studies the matters that pertain to quality of obstetrical practice and neonatal care identified by the Committee through the review of medical records including the review of medical records of perinatal deaths (stillborn and early neonatal deaths) and maternal deaths.

Both of these quality assurance committees rely heavily on the written records for their reviews. It is essential therefore, that enough information be documented by the physician in order that a complete and thorough review can be made.

The Perinatal and Maternal Mortality Study Committee has noted some deficiencies in the records that they have reviewed. Deficiencies include absent or incomplete documentation regarding the prenatal and delivery records, progress notes including management of labour and delivery, and the clinical indication for induction. The Anaesthetic & Operative Deaths Study Committee has noted incomplete or absent history and physical examination documentation, and incomplete progress notes, especially in situations where the patient's condition changed and necessitated a transfer to a different care area. As well, documentation of the circumstances of death and whether compassionate terminal care was discussed with the patient or family is often absent.

Detailed, legible notes should be made contemporaneously; however, if that is not possible, a notation regarding the situation should be made with documentation that it is a late entry. Both committees will request additional information from physicians when they find the records incomplete, or if they do not have enough information to make an assessment of the case.

In summary, the Committees would encourage physicians to pay attention to their documentation with respect to patient interaction. Complete, contemporaneous documentation will be more accurate and provide enough detail for quality assurance committees to review the work. This would avoid the necessity of requesting additional information at a later date, which might be more difficult for the physician to supply and more time consuming. Physicians should also be reminded that the written documentation in the record is what is used should they be faced with a legal challenge.

New Childhood Vaccines

Dr. Angela Sirnick, Medical Officer and Margaret Ross, General Counsel CMPA

The following article is reprinted from the CMPA Information Letter, December 2002, Vol. 17, No. 4

Both the National Advisory Committee on Immunization and the Canadian Paediatric Society have recommended routine immunization of young children with pneumococcal, meningococcal and varicella vaccines. However, most provinces and territories have not yet included these vaccines in the list of vaccines covered by their health plans.

The approval of these new vaccines has some physicians wondering whether they should be routinely recommending them to parents as part of the standard of care. They are also concerned that some parents, despite this recommendation, may refuse to have their children vaccinated because of the cost.

WHEN PHYSICIANS ARE OBLIGED TO RECOMMEND VACCINES

Whether physicians should notify parents of new vaccines depends on whether administration of the vaccine is considered the standard of care by other physicians in the community. There are a number of factors that determine whether such a standard of care has developed. Courts might look to standards expressed in accepted medical publications, the common practice of other physicians, and recommendations adopted by professional bodies or health organizations. Specific circumstances, such as an outbreak of a particular infection, may also influence the standard of care.

It seems likely that a court would hold that recommending pneumococcal, meningococcal and varicella vaccines has become part of the standard of care for physicians.

If physicians do recommend these vaccines, the informed consent discussion with parents should disclose:

- the material risks and benefits of the vaccine;
- the possible consequences of refusing the vaccine;
- the fact that the cost of the vaccines is not covered by provincial health plans; and
- information about their actual cost.

Physicians should take the time to answer parents' questions, and provide written material describing the nature of the vaccine, its benefits and risks, and the recommendations for its use. They should also clearly document this discussion.

It is then up to the parent to decide whether to accept or refuse the recommendation for vaccination. A parent's refusal of the vaccination should also be thoroughly documented by the

physician. A detailed note should be made in the child's medical record of the consent discussion and the refusal. The physician could also ask the parent to sign a standard form stating that he or she has been informed of the benefits and risks of the vaccine, but has refused the vaccination although fully aware of the risks of doing so.

WHEN PARENTS CAN'T PAY

The difficulty is when a parent refuses a vaccination solely for cost reasons. This raises a troubling issue for physicians and is not one that lends itself to an easy solution. It is clearly frustrating and discouraging for physicians to recommend a course of preventive treatment, which the patient accepts as a valid recommendation but cannot be followed because it is unaffordable.

In such a situation, all that physicians could reasonably be expected to do is reiterate the benefits of the vaccines and document the refusal in the medical record. Physicians might also suggest alternate sources of funding that might be available in the community or at the workplace. These suggestions should also be documented in the medical record.

First Internet Pharmacy Licensed in Saskatchewan

A number of internet pharmacies have been operating in other Canadian provinces for some time.

The Saskatchewan Pharmaceutical Association recently licensed the first such pharmacy to commence operations in Saskatchewan. The Association issued a conditional license to this internet pharmacy with a number of conditions attached.

The Council demonstrated foresight in its earlier adoption of a bylaw that defines the criteria under which Saskatchewan licensed physicians might prescribe for patients outside the context of a traditional doctor-patient relationship.

Bylaw 51 – Bylaws Defining Unbecoming, Improper, Unprofessional or Discreditable Conduct – Sub-Section (h) reads as follows:

(h) "Prescribing to a patient without establishing an appropriate physician-patient relationship" includes any situation in which a physician issues a prescription, via electronic or other means, unless the physician has obtained a history and has performed an appropriate physical evaluation of the patient adequate to establish diagnoses and identify underlying conditions and/or contraindications to the treatment recommended/provided.

"Prescribing to a patient without establishing an appropriate physician-patient relationship" does not include a situation where the prescription is issued:

(i) In an emergency situation to protect the health or well-being of the patient;

(ii) In consultation with another Saskatchewan physician who has an ongoing relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications;

(iii) In an on-call or cross-coverage situation in which the physician has access to the record of the patient for whom the

prescription is issued.

(iv) In an on-call or cross-coverage situation, or in a situation of dealing with a physician's own patient where a doctor-patient relationship has been established, in which the physician is able, on the basis of a telephone discussion with the patient or a representative of the patient, to reach an appropriate diagnosis that is consistent with good medical practice.

Medical Statistics 101 for Clinicians

Seth L. Haber MD – Innovations in Pathology, College of American Pathologists (CAP), September 2002

Clinicians who order tests should remember that each test has certain characteristics related to how the result should be interpreted. Two of these characteristics are "sensitivity" (that is, screening – how well a test picks up every case of disease) and "specificity" (how well the test excludes those who don't have disease).

After you have the results of a test, how sure can you be the patient does or does not have disease? How much can you rely on the test results? For the answer we look to Bayes' theorem, the basis for what follows:

The results of a test must always be interpreted in the context of the population you are testing. This means that your suspicion of disease actually influences the interpretation of the test. Suspicion of disease is called "pretest probability," as opposed to "posttest probability," which is the suspicion of disease after you have the test results. This is statistically measured as the "predictive value" of a positive or negative test, which is a measure of the test's reliability.

Basically, the predictive value of a test takes the specificity, sensitivity, and pretest probability into account and comes up with a value. Here are the formulas from which you can derive these values.

$$\text{Predictive value of a positive test} = \frac{TP}{TP + FP}$$

True positive (TP) tests mean the test is positive and the person actually has disease.

False positives (FP) mean the test is positive but the person does not have disease.

True negatives (TN) mean the test is negative and there is no disease.

(Predictive value of a positive is the percent of all positive tests that are true positives.)

$$\text{Predictive value of a negative test} = \frac{TN}{TN + FN}$$

(Predictive value of a negative is the percent of all negative tests that are truly negative.)

The following illustrate some examples – first using a test to screen a population.

The ANA is a test for systemic lupus. Our current assay has a 94 percent sensitivity and a 92 percent specificity.

- Approximately one of every 1,000 young women has lupus, so if we decide to screen 1,000 young women for lupus, we would expect one to have disease.
- The test is 94 percent sensitive, so we would expect 94 percent x 1 = 0.94 true positive tests.
- The test is 92 percent specific, so we would expect eight percent of all tests (8% x 1,000) = 80 false-positive tests.

The predictive value of a positive test is 0.94/0.94 + 80) = 0.01 (1%). This means that if we were to use this test for screening, we would expect that 99 percent of positive tests would be false-positive. The predictive value is extremely low, and we cannot rely on the result of the test. Therefore, the ANA makes a poor screening test.

Now, let's say we use the test to confirm our suspicion of lupus. A 45-year-old woman is in our office with a malar rash, pleuritis, and arthralgias. We think she has a 65 percent chance of having an autoimmune disease, so we do the ANA. The test is positive.

- In 1,000 similar women, 65 percent (650) would have disease. Ninety-four percent of these (611) would be picked up by the test (TP).
- Eight percent would still be false-positive (0.08 x 1,000 = 80).

Predictive value of the test = 611/(611 + 80) = 88%.

Therefore, when the test is used to confirm a suspected case, you can rely on a positive test.

Good clinicians use the predictive value of test results intuitively every day when they order tests on their patients. As you can see from the example, you can be misled easily by a test result if you forget the nature of tests when ordering. Remember to order the test when you suspect disease. Few tests have the specificity they would need to be good screening tests. In addition to specificity, the test cost must be justified by the test's benefit in the population tested.

DISTINQUISHING THE MICROCYTIC ANEMIAS

This guideline to help distinguish the microcytic anemias has been endorsed by the regional haematology/oncology chiefs of The Permanente Medical Group.

The two most common causes of microcytic anemia (MCV < 80) are iron deficiency or one of the thalassemia syndromes. The distinguishing characteristics are as follows:

- Onset. Thalassemias are congenital. A previous normal CBC is strong evidence against this. Hemoglobin electrophoresis should not be sent if iron deficiency is suspected.
- Ratio of MCV/RBC. The decrease in MCV is proportionately greater with iron deficiency than with thalassemia. The Mentzer Index (MCV/RBC) suggests that thalassemia has an MCV/RBC < 13. This is not completely reliable.
- Platelet count. Iron deficiency and inflammation often stimulate high platelet counts.
- RDW. Red cell distribution width is a measure of anisocytosis (uniformity of size of red cells.) RDW is usually elevated in acquired anemias and normal or low in thalassemias. Peripheral blood smears may also show target cells in thalassemia, or elliptocytes in iron deficiency, in addition to other findings.
- Ferritin, TIBC. While ferritin is an acute-phase reactant, it is pathognomonic of iron deficiency if < 15, even in the setting of anemia of chronic disease (low TIBC), and suggestive if near that. A ferritin can be ordered first and the TIBC added if needed. The % iron saturation calculation is useless if TIBC is low and should be ignored in that case.

Thalassemia patients can also have iron deficiency and should be treated accordingly.

A therapeutic trial of iron (in patients with low suspicion for malignancy and not severly symptomatic) can produce a remarkable improvement in iron deficiency. This should be of limited duration so as not to obscure a significant reason for blood loss, such as colon cancer. If the trial is successful, be sure you know the etiology of the iron deficiency.

If iron deficiency is demonstrated outside of the setting of known surgical or menstrual losses, or frequent blood donation, a gastroenterologist should be consulted.

News Release from the Department of Continuing Medical Education and Professional Development – College of Medicine

P. Davis MD, Director Continuing Medical Education

The Department of Continuing Medical Education and Professional Development is delighted to announce the launch of its expanded website at: www.usask.ca/cme/.

The site will list general information on staffing, programs, and the mission of the Department which is on the current website. In addition, the site will have the capacity for on-line registration for major conferences.

We are looking forward to introducing MAINPRO-M1 and MAINPRO-C eligible courses, an up-to-date Core Library list, Grand Round extracts and Review articles, a Video Lending Library, and Specialist consultations via the Internet.

In the future, we hope to combine this internet programming with teleconferencing, videoconferencing, individual assessment tools, and the capability for individual tutoring by faculty into a Virtual Teaching Unit which will enable Saskatchewan physicians to develop and access personalized continuing education and professional development in their home or workplace.

A trial project for this will soon be underway and CME/PD hopes to make these additional services available to all Saskatchewan physicians in 2004.

Check out the new website at:

www.usask.ca/cme/

College of Physicians and Surgeons Annual General Meeting
March 25th – 10:00 a.m. – Saskatchewan Room,
Centennial Auditorium, Saskatoon

CFPC Patient Information

P. MacKean MD, CCFP, FCFP, President, College of Family Physicians of Canada

Colleagues, don't be surprised if some of your patients arrive in your office with the latest edition of Canadian Living (or Coup de ponce) magazine tucked under their arms with the page highlighting the CFPC's new *"Ask your family doctor"* column clearly earmarked for some further discussion with you.

We're very excited about the CFPC's new relationship with the magazines. With the generous support of Scotiabank, the CFPC has arranged for this feature to appear quarterly - and on their websites - for at least the next 18 months. As part of its message, each article will encourage patients to speak with their family doctors and direct them to the CFPC website for more extensive information on each topic highlighted in the magazine.

Sixty topics are now available on the CFPC website in both English and French.

The program will continue to be updated regularly as new information is received within each subject area. Online information is set up in a way that is easy to access and print, for both physicians and patients. The website address is www.cfpc.ca - choose your language preference, then look to the right of the screen for the words *"for patients".*

The Canadian Living website has additional patient education information gleaned from CFPC patient educational materials. Their website address is www.canadianliving.com/health/features/cfpc.

For physicians receiving printed brochures, quantities are limited. To order, please contact Cheryl Selig, Patient Education Coordinator at: 1-800-387-6197 or by e-mail at cselig@cfpc.ca.

Information/Upcoming Programs

Next ECG Exam

Monday, April 7th, 2003, 1:00 p.m. – 4:00 p.m. College of Physicians and Surgeons, 211 Fourth Avenue South, Saskatoon SK S7K 1N1
For further information, contact Carol Bowkowy at (306) 667-4635

Essentials of Electrocardiography

September 12th & 13th, 2003
Sheraton Cavalier, Saskatoon SK

Registration Fee: Physicians/Allied Health $450.00
Medical Residents/Students $225.00

For further information, contact:
Continuing Medical Education at: (306) 966-7787

Natural Health Products Directorate

The Natural Health Products Directorate has recently restructured its website. The objective of the updated site is to describe regulatory processes and to promote the Directorate's programs and activities. Readers are invited to access the site via the following link: http://www.hc-sc.gc.ca/hpfb-dgpsa/nhpd-dpsn.

Canadian Cochrane Network & Centre

The Cochrane Collaboration is an international non-profit organization that aims to help healthcare practitioners and the public make well-informed decisions about health care by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions. The Canadian Cochrane Network and Centre is a partnership of representatives from all 16 Canadian academic health sciences centers, 19 professional healthcare provider organizations, government, and consumer organizations, and eight other Canadian based Cochrane entities.

A systematic review is a quality-controlled summary of primary research studies that provides more precise results because it is based on a synthesis of several studies. These reviews are contained in the Cochrane Database. Currently, the Library contains 1,596 completed reviews.

The main focus of the Collaboration is the preparation and updating of the systematic reviews. There are approximately 300 reviewers in Canada with protocols or completed reviews.

Providing Cochrane reviewers with the skills and tools necessary to successfully complete a review is the focus of a two-day reviewer training workshop being offered March 7 and 8 at the University of Saskatchewan. Details are as follows:

Canadian Cochrane Network & Centre

Reviewer Training Workshops for Reviewers & Potential Reviewers
Room 12, Main Library, University of Saskatchewan Campus

Friday, March 7, 2003 - 0830h-1600h – This workshop will highlight the rationale for developing a protocol, including understanding the components of a research question, the approaches to searching for randomized controlled studies, and the tools required to evaluate those studies.

Saturday, March 8, 2003 - 0800h-1600h – Participants will gain an understanding of the bias inherent in some trials and reviews, determine the indicators of a "quality" review, and delve into the statistics of summarizing the findings of multiple studies.

Fee: $125 per day. Registration deadline – February 28, 2003
For information, please contact: Pat Tremaine, Course Coordinator
(306) 966-2043, tremaine@sask.usask.ca

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

Newsletter