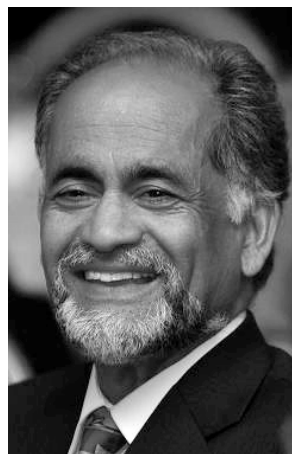


President's Message

By Gerry Fernandes, MD

Our April meeting began with a long over due "Retreat" for the Council and the College staff. I felt the retreat was invigorating and for me it "opened my eyes" to what is important to the Governing Council. A whole day was divided into two sessions. The first session, involving two hours, was spent in discussing the relationship of Government and the College Council. This was covered by Mr. Roger Francis who is the President of Gryphon Reputation Management Company. Mr. Francis explored a number of ideas, one of which he advanced is that he could help the Council to develop a strategy for individual Councilors to attain a positive liaison with their respective MLA's. Mr. Francis has had previous experience in initiating such a strategy with other organizations. The second session of this retreat involved Dr. Allen Backman, acting as a Resource Person and a Facilitator. In that session we discussed the Council's Governance issues and policies. Dr. Backman was a Public Member in the late 1990's when the current Governance policies were initially developed and implemented. He helped us to review and revise these policies, something I intend to carry on with revision of the monitoring process during my term of Presidency.

Even though we are only at the beginning of the second half of this year, it is fair to say that already we are encountering significant changes that may have an impact on the College. How we deal with these changes may allow the College opportunities to enhance its future effectiveness. We live in interesting times. Our CEO, Dr. Dennis Kendel once pointed out to me that we "may encounter a number of very significant changes in the external environment that may have an impact on the College". Whether organizations suffer or decline in times of external exchange or whether they thrive and excel depends a great deal on their capacity for positive adaptation. He went on to tell me that "it is the adaptive capacity of people in an organization, at both the Governance and staff level that ultimately determines the future vitality of an organization". It is also very important that the College's Governing Council is fully engaged and working cohesively as a team if the College is to respond effectively to imminent changes in our Health



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System. I also feel the College staff is a group of people who are very talented, skilful and dedicated people who are well prepared to deal effectively with environmental change.

Though it is only about six months into the 2009, the number of complaints and allegations seem to have lessened this year compared with 2008. This, as we all know, tends to consume a lot of organizational time and resources.

Agreement of Internal Trade "AIT" continues to pose a lot of concerns about the possible unintended and adverse impact on the physician supply and distribution particularly in Saskatchewan. The Federation of Medical Regulatory Authorities of Canada "FMRAC" and its thirteen Members have adopted four broad principals namely:

- Affirm that the protection of the public is the prime responsibility of the Medical Regulatory Authorities;

- Support that mobility of physicians across Canadian jurisdictions is an important objective;
- Will, in the spirit of the Federal/Provincial/Territorial Agreement on Internal Trade, ensure the greatest possible degree of mobility for qualified physicians across Canadian jurisdiction, and;
- We'll work together to ensure consistent and sufficiently rigorous registration and licensing processes for physicians across all Canadian jurisdictions. FMRAC and its thirteen members have also suggested the assessment of certain criteria prior to issuing a license to practice medicine.

Quality as a Business Strategy "QBS" coordinated by the Health Quality Council "HQC" has been quite active in Saskatchewan and with the help of local, national and international resources is achieving transformational improvement in the quality of the services.

Putting Patients First

Dr. Dennis Kendel, Registrar

When prospective medical students apply for admission to medical school, they universally declare a commitment to "helping people". Most practicing physicians similarly declare a commitment to the interests and welfare of their patients.

However, declaring a commitment to patients does not necessarily mean that we consistently meet the needs and expectations of the patients we serve. In fact, we rarely seek explicit feedback from patients about how well we are serving them and how we might improve the care we provide to them.

In January of this year the Government of Saskatchewan launched an initiative designed specifically to solicit feedback from patients in respect to their experience with health services in Saskatchewan.



The frustrations of patients with the system, and particularly with the services they receive from doctors are forcefully articulated . . .

From January through March the Patient First Review actively solicited feedback from patients through focus groups, interviews, and an online blog. In March Mr. Tony Dagnone, the Patient First Commissioner, released a report that summarizes the feedback that patients provided.

Much of the feedback from the patients about their experience with health services in Saskatchewan is positive. In fact when Saskatchewan citizens find themselves in a true health crisis, for the most part they report that the health system responded very effectively to

Patients First from page 2

their urgent or emergent healthcare needs.

Many patients also reported very positive experiences with family physicians that provide comprehensive care, take the time to listen to them, and fully engage them in shared decision making about their healthcare. Some of the positive patient quotes about their experiences with family doctors included the following:

- “I have had nothing but very positive experiences with my family doctor. I have always been able to get in right away. He is really good and he is always willing to admit that he doesn’t know everything. He admits when he cannot diagnose something and acknowledges that we need to see someone who can.”
- “I would credit my cancer care to my family doctor. She had a good chain of communication and contacts. After finding the lump we moved very quickly through the healthcare system. I felt everything was under control.”
- “I am diabetic so I get to see the doctor pretty often and my experiences have all been positive. I have gotten to see a specialist when I have needed to, they always make sure that everything is going okay, they make sure everything is under control and always put me in touch with people who can help me.”

However, this patient consultation process has also yielded a good deal of negative feedback about health services including the services provided by physicians. Many people report:

- Feeling “lost” in the healthcare system and having difficulty navigating their way through poorly integrated services;
- Experiencing uncaring and dismissive attitudes from healthcare workers, including physicians;
- Frustration with long waiting wait times in emergency departments and for access to certain diagnostic tests and surgery;
- Difficulty in changing family doctors when they are dissatisfied with their current family doctor;
- Poor communication with physicians who don’t

take adequate time to truly listen to patients;

- Physicians who do not encourage and support patient participation in healthcare decision making;
- Poor case management;
- Cultural incompetence among health workers, including physicians.

The frustrations of patients with the system, and particularly with the services they receive from doctors are forcefully articulated in the following direct quotes:

- “I always feel rushed through when I go to see my family doctor. I am allowed only one problem per appointment that makes me so frustrated because some things might be related. Doctors are too over booked, they see too many patients”
- “You have to go through an interview in order for a family doctor to agree to see you”
- “Doctors do not speak in basic language when discussing the diagnosis with the elderly and non-educated people”
- “The only way to get a psychiatrist here is to threaten to commit suicide. That is the only way to get access to a psychiatrist”
- “I had to wait for 18 months to see a neurologist who later ordered some tests and those tests took a year and a half for each one. Afterward I never heard back from the neurologist to see if we were going to undergo a course of drug treatments. That was frustrating”

The critical feedback which patients provided to the Patient First Review about their experiences with physicians was not entirely surprising to us at the College of Physicians and Surgeons. It aligns quite well with the patient complaints we receive through our complaints investigation and resolution service.

For the most part, we do not regard formal

“The truth is that we all fail from time-to-time to meet the expectations of people whom we are committed to serve.”

Patients First from page 3

professional discipline as an appropriate or effective way to enhance physician performance. We most commonly strive to enhance future physician performance through focused educational feedback to physicians who are the subject of complaints.

Some physicians do make changes in their approach to practice based upon the guidance and feedback they receive from us. There are to be commended for using critical patient feedback as an opportunity for quality improvement.

However, some physicians unfortunately reject the feedback and guidance to them. They tend to regard most patient complaints as being driven by “unreasonable patient expectations”. They make no adjustments to their practice based upon patient feedback and they tend to be the subject of repetitive patient complaints.

It would be however be unduly simplistic to assume that 90% of physicians provide flawless patient care consistently day-in-day out while 10% of physicians are the “bad apples” who tarnish the public’s respect and regard for our profession.

The truth is that we all fail from time-to-time to meet the expectations of people whom we are committed to serve. We are, after all, human. Humans do not perform flawlessly even when they strive to do so.

When physicians do discover that they have failed to meet the needs and expectations of a patient, it is often helpful to acknowledge that fact to the patient and to engage in respectful dialogue with the patient about options for enhancing future service.

It is also more likely that physicians will consistently meet the needs and expectations of patients if they follow the following simple suggestions:

1. Show respect to all patients and sensitivity to their culturally driven beliefs and preferences;
2. Take time to listen to the patients you serve;
3. Seek to understand your patients’ perceptions of health and disease as well as their sources of anxiety about their health status;
4. Adjust your communication with patients to

match their capacity to understand those communications;

5. When giving patients critically important information about their health and instructions for self care, ask them to briefly “play back” what they heard you say to ensure that your communications have been understood;
6. Help patients to understand the full range of options for dealing with their health issues and encourage their active participation in shared decision making about investigational and therapeutic options;
7. Help patients with complex and/or chronic disease to “navigate” the complex array of services they may require from the health system;
8. Set up mechanisms in your practice to regularly solicit feedback from patients in respect to the services you provide;
9. Act upon the feedback you receive from patients with the goal of making your future services not just acceptable, but exceptional.

DocTalk Chuckles

Mr. Lee was terribly overweight, so his doctor put him on a diet. “I want you to eat regularly for two days, then skip a day, and repeat this procedure for two weeks. The next time I see you, you’ll have lost at least five pounds.”

When Mr. Lee returned; he shocked the doctor by losing 20 pounds. “Why, that’s amazing!”, the doctor said, “Did you follow my instructions?” Mr. Lee nodded.

“I’ll tell you though, I thought I was going to drop dead that third day.” “From hunger, you mean?”



“No, from skipping.”

Fetal Ultrasound: Business Entertainment?

Dr. Ian Waddell , Chair, ACMI

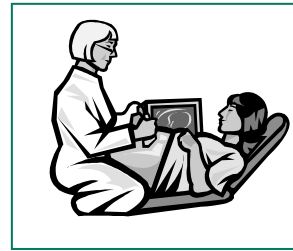
The College of Physicians & Surgeons of Saskatchewan Advisory Committee on Medical Imaging (ACMI) is made up of physicians with backgrounds in Radiology, Ob/Gyn and Nuclear Medicine, also with Radiography Technologists, and other members from Radiation Safety, and Government. We are very concerned with the

emerging ‘business’ of fetal ultrasound for entertainment, primarily for the following reasons:

2. Although ultrasound has a good safety track record to date, ultrasonic energy delivered to the fetus cannot be assumed to be completely innocuous, and the possibility exists that harmful biological effects may be identified in the future. This is especially so with higher energy levels more recently employed with certain machine settings and especially the 3-D ones used for the ‘entertainment’ baby pictures. The latter also tend to be focused on the developing fetal head/brain for longer periods of time.

3. Despite claims from those running the entertainment ultrasound business, that clients are informed that it is not a ‘diagnostic’ ultrasound, there is considerable concern that patients will assume this *is* the case, at least to some degree. They may then end up not having medically indicated scans, ‘because they already had one.’

4. What will happen if the ‘entertainment’ ultrasound happens to reveal an anomaly? Bear in mind that around 3% of births have some anomaly (1% Brain/Nervous system, 1% Cardiovascular, 1% Other), so such a business could potentially come across an anomaly every week or two, if running only one machine. Either the operator of the business would have to ‘look the other way’ (potentially citing the defense in retrospect that everyone *knows* it is not a diagnostic examination), or they would have to declare the finding – that is, admit medical practice without a licence. What if they *think* they see an abnormality, leading to additional investigations, but turn out to be wrong?



“Baby Business”

5. Baby sexing outside of a clinical ‘context’ may result in such information being used very inappropriately, especially by individuals who place a higher value on babies of either sex.

This isn’t a self-serving turf issue; radiologists don’t get paid by the patient, and only perform medical scans on patients referred from other, independent physicians. Position statements opposing this practice already exist from the Canadian Association of Radiologists, the Society of Obstetricians and Gynecologists of Canada, Health Canada, the Saskatchewan Medical Association, the American College of Obstetricians and Gynecologists, the Saskatchewan Association of Diagnostic Medical Sonographers and even the US Food & Drug Administration opposes the use of ultrasound machines in this way for non-medical purposes.

We would urge all physicians with pregnant patients to try and dissuade them from using this business. We would also wish all such physicians to be aware of this practice so that they may better advise and guide patients who go ahead with ‘entertainment’ scans (e.g. making them aware of the need for medical ultrasound scans, when indicated).

“. . .we are very concerned with the emerging ‘business’ of fetal ultrasound for entertainment, . . .”

Refresher Course – GP Anesthetists

Hyatt Regency, Vancouver, BC
October 31, 2009

REFRESHER COURSE FOR GENERAL PRACTITIONER ANESTHETISTS

Before Sep 18: \$325
permitting)

After Sep 18: \$375

After Oct 16: \$425 (if space

This course covers a wide spectrum of problems relevant to the provision of anesthesia in community hospitals. Didactic presentations will review case selection in GP anesthesia, regional anesthesia, airway problems, stabilization of major trauma and recent useful advances in the practice of anesthesia. In addition there will be case presentations with panel discussions and audience participation covering obstetrics, pediatrics and adult anesthesia.

Contact: Winnie Yung, 604-875-4575
wyung@interchange.ubc.ca, UBC Department of Anesthesiology, Pharmacology & Therapeutics

Membership Statistics

College of Physicians and Surgeons of Saskatchewan College Membership Statistics for the Annual Report

	Active Licensure	Inactive Licensure
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Total Registered as at December 31, 2007	1766	212
Newly registered from Saskatchewan	39	0
Newly registered from other provinces	14	0
Newly registered from other countries	65	0
Reactivated to Full from Inactive	2	-2
Reactivated to Full or Inactive from absence	7	2
Moved to Inactive In-Prov Licensure	-13	13
Moved to Inactive Out-of-Prov Licensure	-17	17
Licenses Expired/Invalid	-2	0
License lapsed at Request or Non-payment	-47	-29
Deceased	-2	-2
Retired	-1	0
Total Registered as at December 31, 2008	1810	211

Registration Renewal and Revalidation

Barb Porter, Manager Registration

The Bylaws of the College of Physicians and Surgeons of Saskatchewan require that all physicians except those who are registered on an educational or temporary licence, are required to be enrolled in a Continuing Professional Development program in order to renew their registration for the upcoming year.

The approved programs for the purpose of revalidation in Saskatchewan are:

- the Mainpro program with the College of Family Physicians of Canada; or
- the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada (fellows); or
- the Continuing Professional Development Program of the Royal College of Physicians and Surgeons of Canada (non-fellows).

The programs list above will assign each physician enrolled in a program a five-year learning cycle at the time of enrollment in the program. You need to know the dates of your learning cycle in order to complete your registration renewal.

You do not need to provide the College of Physicians and Surgeons of Saskatchewan with information respecting your learning activity on an annual basis. However, at the end of your assigned learning cycle you will be required to demonstrate that you have complied with the programs in which you are registered.

Family Physicians:

The College of Family Physicians of Canada has agreed that non-members can enroll in Mainpro and have their Continuing Professional Development activities tracked in the same way as members currently have their CPD activities tracked.

Specialists:

Fellows of the Royal College of Physicians and Surgeons of Canada must be enrolled in the

Maintenance of Certification program.

The Royal College of Physicians and Surgeons of Canada has agreed that physicians who don't hold fellowship can enroll in the Continuing Professional Development program to have their activities tracked in the same way as physicians holding FRCP or FRCS currently have their CPD activities tracked.

Provisionally Registered Specialists and Family Physicians:

The revalidation requirement means that all physicians who *became registered on a provisional licence* during 2009 will be required to enroll in a Continuing Professional Development Program prior to renewing their registration for 2010. If you transferred to a provisional licence in 2009 you should take the necessary steps to enroll in a program as quickly as possible. The offices of the Royal College and the College of Family Physicians routinely close between Christmas and New Years day and physicians are unable to enroll in programs during this time. *Don't delay -enroll today!*

Exemptions to Revalidation:

In a limited number of situations, you can apply to the Registrar of the College of Physicians and Surgeons for an exemption from the Revalidation requirement.

Physicians who previously were granted an exemption will need to make arrangements with the College of physicians and Surgeons of Saskatchewan to renew their revalidation exemption. *Unless an exemption is granted or renewed, you will not be able to renew your licence for 2010 without enrolling in either Mainpro or Maintenance of Certification.*

For further information respecting revalidation requirements contact Barb Porter, Manager of Physician Registration at 1-306-244-7355 at the College of Physicians and Surgeons of Saskatchewan.

College Disciplinary Actions

Bryan Salte, Associate Registrar/Legal Counsel

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

Dr. Thomas Chambers

Dr. Thomas Chambers was found guilty of unprofessional conduct following a hearing before the discipline hearing committee. The discipline hearing committee concluded that he billed Medical Services Branch for patients who he had not seen and falsified patient charts to indicate that he had seen those patients.

At the time of the penalty hearing Dr. Chambers had left Canada.

The penalty imposed by the Council was:

- 1) a six-month period of suspension from practice;
- 2) a fine of \$10,000;
- 3) a requirement that he undertake psychiatric treatment for a period of two years in a form acceptable to the Registrar;
- 4) a requirement that he take an Ethics program in a form acceptable to the Registrar;
- 5) a requirement that he pay the cost of the investigation and hearing totaling \$16,058.34

Dr. Bruce Zimmermann

Dr. Bruce Zimmermann admitted that he had engaged in unprofessional conduct on five occasions. He acknowledged that his conduct in failing to attend at Indian Head Hospital on three occasions when he was called by the hospital was unprofessional. He admitted that his conduct in ordering medications for himself at the hospital

and treating patients at the hospital thereafter on two occasions was unprofessional.

The penalty imposed by the Council was:

- 1) a reprimand;
- 2) a fine of \$10,000;
- 3) a requirement that he take treatment under the direction of the Physician Support Program of the Saskatchewan Medical Association for a period of two years, with that program to provide reports to the College of Physicians and Surgeons each 6 months;
- 4) a requirement that he pay the cost of the investigation and hearing totaling \$16,351.66

Dr. Laurens Steenberg

Dr. Laurens Steenberg admitted that he had engaged in unprofessional conduct by failing to maintain appropriate records for approximately 5,000 patient encounters over a period of approximately 4 years and by failing to provide reports requested by several patients within a reasonable time.

Prior to the penalty hearing, Dr. Steenberg signed an undertaking with the College that he would maintain appropriate patient records for his current patients and that he would send a letter to those patients for whom he had not maintained appropriate patient records.

The penalty imposed by the Council was:

- 1) a one-month period of suspension from practice;
- a requirement that he pay the cost of the investigation and hearing totaling \$3,389.84.

The Cochrane Library

The Canadian Cochrane Centre, registered in August 1993, is one of 13 independent, not-for-profit Centres of The Cochrane Collaboration worldwide, and we are located at the Institute for Population Health at the University of Ottawa. We support the activities of over 1,600 members of the Collaboration in Canada in order to promote The Cochrane Collaboration, *The Cochrane Library* and evidence-based health care in Canada. To do this, we collaborate with health professional organizations, health researchers, health technology assessment groups, national consumer associations, governments and other interested groups.

The Canadian Cochrane Network and Centre is pleased to announce, that in partnership with the Canadian Health Libraries Association, a pilot for a national license to *The Cochrane Library* has been successfully secured. This means that all healthcare practitioners now have access to the full content of the *Library* and will save valuable time to research the best patient treatment options through easy access to this wealth of information. Please visit www.thecochranelibrary.com for the best evidence available!

Occupational Therapy ~

Your Secret Weapon to Improving Your Patients' Health and Function

Occupational therapy is a health profession concerned with promoting health and well-being through occupation. Occupation refers to everything that people do during the course of everyday life (CAOT Position Statement on Occupations and Health, 2003). The primary goal of occupational therapy is to enable people to participate in the occupations which give meaning and purpose to their lives. Occupational therapists have a broad education that provides and equips them with the skills and knowledge to work collaboratively with people of all ages and abilities that experience obstacles to participation. These obstacles may result from a change in function (physical, cognitive, affect) because of illness or disability, and/or barriers in the social, institutional and/or physical environment (Adapted from the World Federation of Occupational Therapists, 2004).

Occupational Therapy is unfortunately healthcare's best kept secret weapon in preventing hospital admissions, reducing length of stay in hospital, assisting clients achieve greater independence, improving children's developmental success, reducing suffering during end of life, improving reintegration into the community post institutionalization, reducing the need for surgery,

or improving surgical outcomes for upper extremity conditions, increasing community access, preventing workplace injuries and more.

Your patients can access these high powered health care professionals in many settings. Homecare, Acute Care, Long Term Care, Outpatient Clinics, Correctional Institutions, Mental Health settings, School and Preschool settings, palliative care, private clinics specializing in universal design, return to work, pediatrics or medical-legal cases are some of the places your patients can access occupational therapy.

The preemptive strike is the most effective use of this therapeutic weapon. Early referral to occupational therapy by a physician can reduce complications due to illness, disability or injury. Together physicians and occupational therapists can fight loss of independence and function and improve the quality of life of patients.

To find an occupational therapist practicing in your area contact your local health region. To find out more about occupational therapy visit the Saskatchewan Society of Occupational Therapists at www.ssot.sk.ca and the Canadian Association of Occupational Therapists at www.caot.ca. If your patients are interested in learning more direct them to www.otworks.ca

H1N1 Influenza Update for Physicians

Monday, June 1, 2009

Epidemiologic Update

Increasing evidence points to the low-level continuing community transmission of the A H1N1 influenza virus in the Saskatoon Health Region (SHR) at this time. Region-wide emergency room influenza-like-illness (ILI) surveillance has shown a slightly higher than expected rates of ILI, as compared to typical rates at this time of the year. In our health

region, as of May 28, 2009, we have not had reported any cases of severe respiratory illness (SRI), and no death attributed to H1N1 influenza. SHR has been conducting enhanced surveillance for influenza-like-illness (ILI) and severe respiratory illness (SRI) as of April 27, 2009.

As of June 1, 2009, SHR had received 105 lab-

H1N1 from page 9

confirmed cases of influenza A H1N1. The average age is 21.8 years. The majority of cases are under 20 years, which is consistent with the demographic found in much of North America, that few cases are over 55. To date, lab-confirmed cases in SHR have been described as mild to moderate, as has been the presentation in most of the named community contacts. Reported symptoms have included fever, cough, sore throat, myalgia, and fatigue. The majority of cases meet the case definition of ILI. Diarrhoea and vomiting have also been reported in some cases as well, and do not appear to be dependent on age. No outbreaks in long-term care facilities for the elderly have been reported to date.

Recommendations for Testing

Testing continues to be recommended for ONLY those with moderate to severe symptoms, or those with underlying medical conditions who are symptomatic. Respiratory testing in SHR has more than doubled since the end of April, 2009.

Updated Guidance on Antiviral Treatment

- Providers should prioritize EARLY ANTIVIRAL treatment for patients who:
 - Are being hospitalized with acute febrile respiratory illness (fever and influenza-like illness (ILI), pneumonia, ARDS, or respiratory distress), or
 - Have underlying health conditions (see Table) and present with ILI
- All efforts should be made to initiate antiviral therapy within 48 hours of symptom onset.

Recommendations for Infection Control Remain Unchanged

It is recommended that physicians and physician offices continue with infection control measures as outlined in the original "Guidance for Medical Practitioners in Ambulatory Care Settings re: Diagnosis, Treatment and Infection Control of Influenza A H1N1

(swine flu)" sent out in early May. These measures include the following:

- careful screening of patients presenting (in person or on phone) with respiratory symptoms
- separate waiting areas for patients with ILI, or alternately arrange an area in waiting room, at least 2 meters separate from other patients
- surgical/procedural masks available and used as warranted by patient and health care worker (HCW)/physician
- hand-hygiene facility and/or alcohol-based hand sanitizers available in each office area, and consistently used by patient and HCW/physician
- tissues and hands-free garbage available
- remove magazines, toys, and all unnecessary items from waiting areas designated for ILI patients
signage posted re: swine flu advisory, cough etiquette, and hand washing for physicians and other HCW's
 - change lab coats/uniforms daily and launder
 - wear gloves, goggles, surgical/procedural masks when providing care for
- patients with ILI
clean patient contact areas, equipment used on symptomatic patients after each
- patient use
clean separate ILI patient waiting areas and bathrooms daily
a patient or HCW/physician who is diagnosed with suspect ILI/swine flu, is to be advised to self-isolate at home until 24 hours post-recovery

Report to local public health at 655-4512:

Any hospitalized patients with acute febrile respiratory illness (fever and ILI, pneumonia, ARDS, or respiratory distress) who ALSO have a positive test for influenza A (by DFA, PCR or viral culture)

Any critically ill person with acute respiratory illness for whom there is a strong suspicion of influenza, including when rapid testing for influenza is negative or not available

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Please note that these recommendations are subject to change as more information on the clinical and epidemiologic features of influenza A H1N1 becomes available. Providers should continue to check the Saskatchewan Ministry of Health webpage at <http://www.health.gov.sk.ca> for updated information and recommendations.

If you have any questions, please call Disease Control, Public Health Services at 655-4512. Additional information can also be accessed at the following website: www.fightflu.ca

Prescription Review Program – Reminder

Doug Spitzig, CPSS Contract Pharmacist

An increasing number of concerns have been received by the College of Physicians and Surgeons recently from pharmacies in respect to missing required information on Prescriptions written for Prescription Review Drugs. Physicians are reminded that Bylaw 40(3) under the Medical Profession Act, 1981, requires physicians to complete a written prescription for all PRP drugs which meets federal and provincial legal requirements and includes the following:

- The patient's date of birth;
- The patient's address
- The total quantity of medication prescribed, both numerically and in written form;
- The patient's health service number; and,
- The prescriber's name and address.

Not only is it difficult for the pharmacy to fill prescriptions that are missing required information, the possibility of diversion of these drugs is substantially diminished when all required data is included. There has been a rash of forged prescriptions recently and the inclusion of this required information will help pharmacists to identify such easier.

The College of Physicians and Surgeons is also fielding a number of complaints with regards to physicians putting refills on their PRP drug prescriptions. As per the Prescription Review Program bylaws repeats are **not** allowed for prescription review drugs. However, in Saskatchewan, in order to maintain continuity of care for patients, where it is appropriate for long term use of PRP drugs, Bylaw 40(5) under the Medical Profession Act, 1981, allows physicians to prescribe **part-fills** of PRP medications if the following

information is specified in the prescription:

- The total quantity
- The amount to be dispensed each time; and,
- The time intervals between fills.

Prescriptions failing to meet the requirements for part-fills can NOT be filled by pharmacies resulting in undue inconvenience and hardship by patients.

Accurately written prescriptions, for prescription review drugs with part-fills, also reduce the possibility of diversion for these drugs.

Please ensure completeness in future prescriptions written for prescription review drugs including those with part-fills.

Example of Prescription meeting Requirement for Part Fills

TYLENOL # 3

Sig. 1 TID PRN

M: 300 tabs (total amount)

In lots of 100 tabs every 30 days

The original prescription is for 300 tablets and the partial dispense every 30 days minimizes the potential for misuse and overuse of the drug.

For more Information contact Doug Spitzig at the College office.

We're on the Web!

Visit us at:

www.quadrant.net/cps

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“Competent caring physicians providing quality health care.”

Medical Students Need You

Are you a practicing physician? A retired physician? Our medical students need **you** to teach!

Teaching is a wonderful way to share your clinical knowledge and experience. It can help refresh you, update your own knowledge, and diversify your professional practice. The medical students and residents rely on you to help train them as our future physicians. The need for teachers is greater than ever, as we increase our medical student class size to help meet the health care needs of the province.

Teaching opportunities abound, to meet your different interests and availability. We provide orientation and training to help you be confident about your teaching skills. Clinical teaching space and patient volunteers are available if you need them. Please contact Cathy Yourk (966-6946, cathy.yourk@usask.ca) if you are interested in learning more about clinical teaching opportunities. We would love to hear from you!

Take Note . . .

Dr. Susan Shaw

A caring and compassionate physician with special training in adult critical care medicine, Susan Shaw's commitment to providing quality health care is evident in every interaction she has with a patient and their family. Her current clinical roles – Director of Adult Critical Care, for which she is the first department head, and Anesthesiologist– combined with her affiliation with the Saskatoon Health Region at senior administrative levels are testaments to her strong leadership skills. Through her strength and tenacity in what has historically been a male-dominated field, she provides young women in the community with an ideal role model and is someone for those entering health care professions to emulate.

–from the YWCA Women of Distinction Awards Dinner Program, June 3, 2009

1st Annual Canadian Perinatal & Pediatric Nutrition Conference

September 25–26th, 2009

Edmonton, AB

For more information email:

RNFSeduc@cha.ab.ca or call: (780) 735-1359

Our Staff:

Dr. Dennis Kendel, Registrar

Dr. Karen Shaw, Deputy Registrar

Mr. Bryan Salte, Associate Registrar/Legal Counsel

Ms. Barb Porter, Manager of Physician Registration

Along With:

Amanda Lee, Registration Officer

Amy McDonald, Manager of Accounting/Finance

Ashley Tomiak, Administration Assistant [Complaints]

Carol Bowkowsky, Registration Officer

Doug Spitzig, Contract Pharmacist

Ellen Wadden, Office Assistant/Reception

Ferne Hand, Administrative Assistant [Registration/PRP]

Karen Mazurkewich, Office Assistant/Reception

Lowell Loewen, MD, Contract Physician

Melanie Lafonde, Office Assistant/Reception

Melissa Hoffman, Office Assistant/Reception

Rebecca Constant, Executive Assistant to the Registrar

Tracy Hastings, Regulatory Services Coordinator

And In Regina:

Diagnostic Imaging & Lab Quality Assurance

Georgia Hearn, Director Diagnostic Quality Assurance

Tracy Brown, Lab Proficiency Testing Consultant

Angela Wiebe, Executive Assistant

Marg Zahorski, Executive Assistant