



College Newsletter

A publication of the College of Physicians and Surgeons of Saskatchewan

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Message from the President

I hope everyone is having a good summer so far, and will continue to do so.

I would like to bring you up to date on the important issue of "Licensure of International Medical Graduates". This important topic is currently being debated not only by the College of Physicians and Surgeons of Saskatchewan, but by all the other Colleges across the country.

There is now a National IMG Task Force who met recently in Ottawa. Dr. Dennis Kendel, our CEO & Registrar, is one of the members who serve on this committee which discussed a large number of draft

recommendations that should be available in the near future.

The Council of the College met to discuss IMG assessment and licensure. The most relevant stakeholder agencies were invited to attend (Saskatchewan Health, the College of Medicine, the SMA, the RHAs, etc.) Hopefully, this proved fruitful and solutions will be agreed upon that will address this current problem. It is important that any registration policies and regulations that are contemplated must:

1. Protect the public from unreasonable risk of harm.
2. Effectively, and fairly, evaluate the professional competence of all licensure applicants coming from both domestic and international streams.
3. Be compliant with human rights codes and policies.
4. Be responsive to shifting Canadian immigration policies and patterns.



Dr. David Ahmed, President

I must admit that the current mosaic of Provincial and National policies for evaluation, integration, and licensure of IMGs is an extremely confusing one.

For example, requirements for licensure in Newfoundland is somewhat different from that in Saskatchewan, and a lot different than in jurisdictions such as the Yukon. This is just one of the issues that the Council will be addressing.

A special thanks to Dr. Kendel and Bryan Salte for the huge amount of work they have done in preparing for the special session.

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Without their input, it would have been impossible to arrange.

Please write to me, c/o the College, if you have any concerns, criticisms, or gripes!



The Roadmap to Quality

D.A. Kendel MD, Registrar

If you're planning a trip to a distant city, there may be many ways to get there. You might elect to travel by air, rail, bus, or car. You might elect to take the most direct route or take a more scenic route with planned stops along the way.

When you're traveling to a specific geographic location, there is little uncertainty as to when you've arrived at your planned destination. Your plane touches down on the runway. Your train pulls into the station. Or, as you approach the destination in your car, you note a prominent roadside sign welcoming you to the community.

Organizations and individuals do a lot of planning that is considerably more complex and less certain than planning a trip from Point A to Point B.

Organizations and individuals sometimes set goals for themselves that are considerably more complex than being in a certain location at a fixed time. It may be difficult to know when you've actually arrived at the goal because endpoints are elusive.

It can be even more difficult for organizations and individuals to select the most appropriate method for getting from where they are to where they want to be. The options may be legion and the implications of each option less than certain.

Organizations and individuals who articulate goals of "quality" related to products and services they deliver face a particularly difficult challenge. Quality may mean different things to different people. Quality never has a finite endpoint. The roadways of history are littered with organizations and individuals who thought they had achieved the zenith of quality, became complacent, and were bypassed by more innovative organizations and people.

The College of Physicians and Surgeons of Saskatchewan expresses its organizational mission as "Competent caring physicians providing quality health care". There are three words in this Mission Statement that are goal-focused.

How do we know, at any given point, whether every physician whom we authorize to practice is competent and is performing at an acceptable level? Is it acceptable in this era to make assumptions of professional competence until we see irrefutable evidence of patient harm? Or, is there a public expectation of more proactive strategies to assure continuing physician competence without incurring avoidable risk of patient harm?

Who determines if a physician is or is not "caring"? Should that judgment rest exclusively with patients who are reliant upon physician services? Do we have any capacity to increase the empathic response of physicians to patients where patients judge that response to be inadequate?

What does quality health care really mean? Is quality measurable? Can and should we be setting tangible quality goals? If we do set such goals, what are the most effective strategies for achieving those goals?

These are very big and difficult questions.

We could elect to struggle with these questions from a narrow local perspective. Alternately, we can explore the response of other agencies to these questions and learn from their experience.

I see great merit in learning from others whenever possible and obtaining the benefit of their experience. I therefore continually strive to identify innovative quality improvement activity in other jurisdictions and consider how those innovations might be applied in Saskatchewan.

There are some very innovative responses to the big question of health quality evident in other nations, provinces, and local agencies. I'd like to share with you a bit of information about some of these.

At the international level the United Kingdom is currently showing strong leadership in respect to innovative strategies for assuring continuing physician competence and for continuous health care quality improvement.

Perhaps because they came dangerously close to losing the privilege of professional self-regulation in recent years, physicians in the U.K. are taking some bold new steps to affirm

their willingness and capacity to act in the public interest. The GMC is now recognized as a world leader in its strategies to implement mechanisms for revalidation of all medical licenses at five-year intervals. The revalidation process will not involve artificial examinations but it will involve a good deal more than simple logging of CME or CPD credits. The GMC is working in collaboration with the National Health Service (NHS) to develop some credible measures of physician performance that can be applied in a continuous way at low cost and with little intrusion into professional practice.

Closer to home, the governing Council of the College of Physicians and Surgeons of Ontario (CPSO) has made a policy decision to implement periodic medical licensure revalidation in that province. Planning toward that goal is still at the very early stages but the CPSO has a very competent Quality Assurance Division that has developed credible tools for evaluating physician performance.

Even closer to home, I've asked the governing Council of the Saskatchewan College to establish a committee that will explore options for us to establish a credible licensure revalidation process.

In respect to continuous quality improvement in health care, there are some very exciting new developments in the U.K. Most of the innovation is occurring in primary care, which has previously been considered a domain of health care particularly resistant to effective systemic evaluation and quality improvement.

Just a little more than three years ago a four-member team of family physicians was appointed in Manchester to establish a National Primary Care Collaborative (NPCC). The NPCC was created to achieve rapid improvement in primary care through the use of proven quality improvement tools.

What has been achieved by the NPCC over the past three years is nothing short of miraculous. Working through the Primary Care Trusts in England and Scotland, the NPCC has now engaged thirty-five hundred family medicine practices in a quality improvement strategy that is making a positive difference for twenty million patients in the U.K., roughly half of the national population.

To its credit the government in the U.K. has provided funding that allows family physicians and other primary health care practitioners to spend a half day each week critically evaluating their own

practices and seeking ways to improve those practices. Frontline practitioners are achieving remarkable improvements in service quality by using the rapid cycle QI tool called PDSA, which was first pioneered by the Institute for Health Care Quality Improvement in the U.S.

The acronym PDSA stands for Plan, Do, Study, Act. It is a proven methodology for implementing very small changes in care processes and evaluating the impact of those changes over a short period of time. Changes that don't generate improvement are abandoned while those that do are retained and refined.

Part of the philosophy that has led to the impressive success of this initiative in the U.K. is that each practice that identifies a process improvement is encouraged to share that learning experience with all other practices involved in the collaboration. Over the past thirty-four months this has yielded very impressive measurable quality improvements. For example, patient access to G.P. services has been improved by 72%. The same tool has achieved a fourfold reduction in mortality for patients with coronary heart disease.

A team of health professionals led by Dr. Stewart McMillan recently

visited the U.K. to learn more about these quality improvement initiatives in the U.K. Primary Trusts. A number of Saskatchewan health care professionals also attended a recent Quality Improvement Conference in British Columbia where representatives from the National Primary Care Collaborative provided useful insights in respect to their work.

The most impressive presentation at the Quality Improvement Conference in British Columbia was made by Dr. Hugh Sturgiss, a G.P. practicing in Oldham, U.K. Dr. Sturgiss explained that just two years ago he was highly skeptical of the potential for the NPCC to bring about meaningful change in primary care in the U.K. However he decided to become involved and is now a very articulate ambassador for this collaborative initiative.

It's incredibly refreshing to encounter frontline health care workers who are so excited about their capacity to achieve measurable positive change in the quality of health care services they're delivering. It naturally prompts one to ask what might foster equally enthusiastic engagement by frontline health care professionals in Saskatchewan.

I've reflected on the insights I've gained to date

from the U.K. experience and tried to identify any prerequisites for equally positive quality improvement initiatives in Saskatchewan. I think I've identified the following three prerequisites:

1. The capacity to reliably measure health system performance and to measure performance changes over relatively small intervals of time.
2. Appropriate systemic infrastructure to support change processes.
3. A public investment in professional education to achieve widespread understanding of the PDSA tool.

If one hopes to achieve positive systemic change it is axiomatic that there must be a system in place. It is futile to pursue systemic improvement goals in the absence of an identifiable system.

The U.K. has a distinct advantage in the fact that it has been progressively developing a logical primary care system over the past three decades. In contrast I don't think we can actually claim to have a primary care system. We have many of the elements that are essential features of a system, but the linkages between these elements vary enormously across the province.

But there is light at the end of the tunnel in Saskatchewan. Each of the twelve RHAs is currently developing plans for a more systemic approach to the delivery of primary care services within their boundaries.

There is also new hope on the performance measurement front as the Health Quality Council is building its capacity to reliably measure system performance and to report those measures.

The greatest residual gap between our situation and that in the U.K. is our relatively poor application of information technology in family practice. In the Primary Care Trusts within the U.K., fully 90% of the family physician offices have computerized patient records. This enables them to very effectively monitor correlation between health care processes and the health status of the population they serve.

Regrettably we will remain significantly handicapped in our capacity to match the QI improvements being achieved in the U.K. until we have more comprehensive information management capacity at the coal face where health services are delivered.

So, what are the response options for the College of Physicians and Surgeons in respect to some of these big

quality questions? These are some of my thoughts.

We will always be held publicly accountable for assuring the continuing competence of every physician whom we authorize to practice medicine. We need to hone our capacity to meet the public expectation that we will achieve this goal without putting the public at risk of preventable harm.

However, we would be very short-sighted indeed if we did nothing more than assure the continuing competence of each physician whom we license. Physicians practice in a systemic context and it is the systemic context that significantly influences the quality of health outcomes for patients. The College must positively influence the system in which physicians practice.

The College has established and sustains very positive collaborative working relationships with many other agencies that shape the health care system. There will likely emerge some exciting new possibilities for us to work collaboratively with the Health Quality Council.

The reality of working in collaboration with other agencies is that one doesn't get to unilaterally pick your destinations or your roadmap to those destinations. Working

collaboratively with other agencies requires new team based attitudes and skills. We consider it important to help physician leaders develop those attitudes and skills.

One of the collaborative initiatives in which we are currently involved is the development and launch of a Leadership Institute at the University of Regina. With start-up slated for October, this Institute will offer a wide range of health professionals an opportunity to build their leadership skills in partnership with leaders from other professions. We'll be in a position to disseminate more information about the Institute in the near future.

The College will also need to objectively evaluate the quality improvement gains we are achieving through our current quality assurance programs. Where there is evidence to suggest that we could achieve larger quality gains through alternative strategies, we should be willing to act upon that evidence.

The roadway to quality is not a single route. There are many potential routes to quality and quality is not a fixed destination. Organizations and individuals who are committed to a pursuit of quality will need to be innovative and adaptive.

If there is evidence favoring a road to quality that we have never traveled before,

we must have the courage to try new roads.

It promises to be a very interesting journey!

The College of Physicians and Surgeons would like to take this opportunity to congratulate Dr. Brian Colquhoun, FRCS (Ed), FRCSC, FACS on being awarded the RAC2 Mentor of the Year Award from the Royal College of Physicians and Surgeons of Canada

FMRAC - Public Member Report

Evert Van Olst, Councillor, Public Member - Saskatoon

On June 7th to 10th, 2003 I was privileged to attend the 23rd Annual Meeting of The Federation of Medical Regulatory Authorities of Canada in Quebec City as a Public Member delegate from the College of Physicians and Surgeons of Saskatchewan. This was my first opportunity to attend such a meeting, and I gained many insights into the issues and challenges facing the provincial/territorial and international medical licensing authorities.

Firstly, as legal counsel for the Saskatoon Health Region, in addition to being a public member of Council, I was invited to an all-day session with legal counsel from across the country involved in medical self-regulation. New federal privacy legislation was discussed and debated. The potential impacts on physician practice, and the College's work, were canvassed. Our Associate Registrar, Bryan Salte, took the lead in outlining the

possible interpretations and effects of this new law. It is clear that both the public and physicians may find the new privacy law impacting the way private medical information is collected, used, and disclosed. As in many things, a balance will need to be found between the important principle of privacy and the ability of physicians and their regulatory bodies to effectively carry out their duties and responsibilities.

The group of legal counsel also discussed new cases from across the country dealing with professional self-regulation. Of particular interest was a recent decision from the Supreme Court of Canada reinforcing the concept of deference that the courts should show to the decisions of discipline committees holding hearings under provincial medical self-regulating legislation. Other topics included human rights commission investigations into licensing processes,

other provinces' move towards omnibus health professional legislation, and the consideration of alternative models to deal with the adjudication of competency of particular physicians.

Secondly, the traditional "Roundabout" was held on June 7th where each of the provincial and territorial Colleges discussed issues and concerns particular to them. As a public member, I was struck by the commonality of many of the issues raised. For example, the assessment and registration of international medical graduates is clearly a concern for all Colleges. Subsequently, an entire morning was spent reviewing the issue in one of the educational sessions held in conjunction with the annual meeting. Again, it appears that a balance needs to be found between lower standards, which may raise concerns of competency, and higher standards that may result in

a lack of access to medical care in some regions of the country.

Thirdly, the education sessions, in addition to the one referred to above, provided the opportunity to hear from distinguished speakers on a variety of topics. New models in the delivery of health care were outlined, including examples of the use of nurse practitioners both in the community and in acute

tertiary health care. Physician profiling was also discussed in detail. The pros and cons of publishing, or making available demographic and other information about licensed physicians produced a lively debate on the usefulness and appropriate profiling. The information received will be useful to me as I participate in our College's consideration of the establishment of a physician profiling service.

In conclusion, it was both encouraging and a bit disappointing to observe that the challenges faced by our College are, for the most part, shared by all similar bodies in Canada. Though a search for a united or common solution to these challenges is attractive, for the interests of the public in Saskatchewan, there remains a likely need for flexibility provincially to ensure access to medical care.



Artificial Rupture of Membranes: Helpful or Harmful

G. Carson, MD, FRCSC, FSOGC, Chair – Perinatal and Maternal Mortality Study Committee

Artificial rupture of the fetal membranes is a very commonly done and simple – perhaps deceptively simple – procedure. Despite its widespread use, there is regrettably little good evidence about the procedure to allow a conclusion to be reached about whether and to what extent it may confer benefit in obstetrical management. Anecdotes exist about complications including ascending infection or prolapse of the umbilical cord associated with artificial rupture of the membranes (AROM).

Information available about AROM will be reviewed according to the various indications for its use.

INDUCTION OF LABOUR

Amniotomy has been used alone or in combination with oxytocin to attempt to induce labour. In all these trials the entry criteria require that rupture of the membranes is at least feasible and thus exclude the most difficult patients to induce, who are those with a long and closed cervix. Since to be able to have membranes ruptured at all requires at least a somewhat favorable cervix, then a good response to the AROM should be anticipated.

a) Amniotomy Alone for Induction of Labour

Labour will occur after amniotomy alone in up to 88% of women, but

the interval before labour may be long with associated risk of ascending infection. Depending upon the urgency of the indication for the induction of labour, a long interval after amniotomy before labour may be unacceptable.

In the only randomized trials, outcomes were poorly reported. There was no difference in the quite high cesarean section rates in the study groups of amniotomy alone versus no intervention or versus oxytocin. With amniotomy alone, oxytocin augmentation was required in 44% of

women compared to 15% with vaginal prostaglandin. (relative risk, 2.85; 95% confidence interval, 1.82-4.46) The Cochrane Review on this matter concluded that data on the effectiveness and safety of amniotomy alone for induction of labour are lacking and thus no recommendations for practice can be made.

b) Amniotomy Plus Intravenous Oxytocin for Induction of Labour

This package of induction interventions includes use of intravenous oxytocin commencing shortly before or shortly after an amniotomy. Fewer women remained undelivered at 24 hours with amniotomy and oxytocin than amniotomy alone. (relative risk, 0.3; 95% confidence interval, 0.001 to 0.76) Many more women were dissatisfied with amniotomy and intravenous oxytocin compared to vaginal prostaglandins. (relative risk, 53; 95% CI 3.32-846.5).

AMNIOTOMY FOR SHORTENING SPONTANEOUS LABOUR

Active management of spontaneous labour is advocated by some to improve maternal satisfaction with labour and

reduce the cesarean section rate; amniotomy is a component of this package of care. Active management, if used in a particular institution, would be offered to all women in labour. Amniotomy has also been used selectively as part of the management for labour which is thought not to be progressing satisfactorily.

In the Canadian Early Amniotomy Trial, Dr. Fraser and colleagues randomly assigned women at less than 3cm and \geq 3cm dilatation to have early rupture of the membranes or conservation of the membranes. Labour progressed faster with amniotomy. The median length of time from randomization to full dilatation was 277 minutes in the amniotomy group and 413 minutes in the conservative-management group. For those women randomized at less than 3 cm, the median length of time from randomization to full dilatation was 442 minutes for those with early amniotomy versus 512 minutes with conservation of the membranes. For women with cervical dilatation \geq 3 at randomization, the difference was greater with a time until full dilatation of 260 minutes for those with amniotomy compared to 385 minutes with conservative management. Slow labour progress of $<$ 0.5cm per hour occurred less frequently with amniotomy

(relative risk, 0.8; 95% CI 0.6-0.9) but this happened only among women at \geq 3cm at randomization. (Dystocia occurred in 33% with early amniotomy vs. 48%, (relative risk, 0.7; 95% CI 0.6 to 0.8)) Cesarean section delivery was not reduced, however, being done in 12% of the amniotomy group and 11% in the group with conservation of membranes. Fetal/neonatal condition was the same in both groups.

In the Cochrane Review of this intervention, women with early amniotomy had an average reduction of the duration of labour between 60-120 minutes. The duration of the first stage was shortened with no difference in the length of the second stage. The likelihood of an Apgar score of less than 7 at 5 minutes was reduced, while arterial cord pH and NICU admissions were similar. Analysis of fetal heart rate tracing data from one trial which considered the different durations of labour found that more fetal heart rate abnormalities in the first stage occurred in the AROM group. There was a trend towards an increase in the cesarean section rate (Odds Ratio, 1.26; 95% CI 0.96 to 1.66).

It was concluded that the trend towards an increase in the cesarean section rate and an increase in the hourly rate of fetal heart rate monitoring abnormalities suggest that amniotomy

should not be done routinely, but should be done in pregnancies in which labour is progressing slowly.

AMNIOTOMY FOR ACCESS TO THE FETAL SCALP OR THE AMNIOTIC CAVITY

During labour there may be uncertainty about fetal well-being for which electronic fetal monitoring with a scalp electrode could assist resolution. If the membranes are not already ruptured, and the fetal scalp is well applied to the cervix, this would constitute an indication to do so.

Certain fetal heart rate abnormalities with decelerations (typically severe variable decelerations) may be improved by amnio infusion. If membranes are not already ruptured, then it would be necessary to do so in order to place an intrauterine catheter for such an infusion. Warmed saline is then infused rapidly into the amniotic space to attempt to relieve umbilical cord compression. Fetal heart rate decelerations (RR 0.54, 95% CI 0.43 – 0.68) and cesarean sections for suspected fetal distress (RR 0.35, 95% CI 0.24 to 0.52) are significantly reduced. Also, in the presence of thick meconium staining of the amniotic fluid, amnio-infusion will reduce the risk of meconium aspiration syndrome in the newborn.

AMNIOTOMY FOR MECHANICAL INDICATIONS

Here there is an absence of published evidence from any trials. Only opinions can be provided, accompanied by the caution that opinions are the weakest basis for recommendations about practice.

Circumstances may exist with instability of the presenting part or poor application of the presenting part to the cervix. These are more likely to be found with polyhydramnios. Intervention may be undertaken with hands on stabilization of the presenting part and fundal pressure to try and secure application to the cervix, followed by a planned and controlled artificial rupture of membranes. (A pudendal block needle and needle guide is one useful way to do this.) Gradual release of the amniotic fluid in this circumstance may result in achievement and maintenance of a favorable lie and presentation and a reduction in amniotic fluid volume. The concern is that spontaneous rupture of membranes with a poorly applied presenting part may be associated with cord prolapse. When performing artificial rupture of membranes, cord prolapse may still occur, but with prompt recognition and implementation of planned management, the adverse consequences can be

reduced. These are uncommon indications. If done, amniotomy in these circumstances should be done by experienced practitioners and there should be prior planning with prompt access to cesarean section required during this intervention.

With poor application of the presenting part of the cervix, consideration could be given to initiation of oxytocin with the establishment of contractions and achieving a better application of the presenting part before performance of amniotomy.

RISKS OF THE PROCEDURE

Although there is anecdotal concern about increase in cord prolapse or ascending infection with prolonged rupture of membranes, randomized trials of amniotomy show no increase in adverse fetal/neonatal events. Specific studies of complications allegedly attributed to ruptured membranes have in fact been reassuring about the intervention showing no increase of occurrence of complications.

CONCLUSIONS AND RECOMMENDATIONS

For the induction of labour, amniotomy may play a useful role in patients with a favorable cervix. A combination of amniotomy with early initiation of oxytocin infusion is more

likely to achieve prompt entry into labour. Before undertaking this intervention, the attending physician should be really sure about the indication for induction and the favourability of the cervix, which predicts success with the induction. If a woman is not in labour it is better for her to be not in labour with intact membranes than with ruptured membranes, particularly artificially ruptured membranes. If there is doubt about whether the woman will promptly enter labour, then use of vaginal prostaglandins has been demonstrated to be superior to the use of oxytocin to achieve entry to labour. Furthermore, maternal preference is strongly in favor of the use of prostaglandins rather than oxytocin.

When artificial rupture of membranes is to be done, it is preferable that the fetal head be well applied to the cervix. If it is not, consideration should be

given to the administration of oxytocin first to achieve contractions and resultant descent of the presenting part and better application to the cervix prior to amniotomy. Alternatively, membranes can be ruptured on a planned basis including the prior organization of the ability to do a cesarean section very quickly in the event there is a complication. This may avoid the delayed recognition of cord prolapse or the occurrence of such a complication without the prompt capacity for intervention.

Used selectively, amniotomy can contribute to the induction of labour and may shorten the duration of established labour, although it does not secure a reduction in the cesarean section rate.

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Managing an Inappropriately Angry Colleague

Wayne M. Sotile, PhD and Mary O. Sotile, MA

The following article is reprinted from, The Resilient Physician, Vol. 2, Number 2, 2003. WM Sotile, PhD and MO Sotile, MA, Co-Editors-In-Chief

Conflict with colleagues has emerged as one of the most toxic stressors reported by physicians today. Primary culprits are physician colleagues who inappropriately express

anger. Some are masters of passive aggression. They habitually fail to follow organizational policies and procedures, arrive late (or not at all) to important group meetings, and/or delay or

fail to respond to pages and calls. Others spread their sullenness and irritability throughout the workplace, creating a less-than-optimal work environment. Perhaps worst of all, some put their organization and their own careers at risk with their periodic angry outbursts.

WHAT CAUSES SUCH BEHAVIORS?

Our clinical experience suggests that a relatively small percentage of physicians fall into the "chronically disruptive" category, and many of these suffer from character disorders and/or substance abuse. More often, inappropriate workplace behaviors are due to a transient problem such as stress overload or failure to adjust to some personal transition. When this is the case, confrontation of the inappropriate behavior can begin an important dialogue in which the distressed physician is helped to access needed sources of support.

Organizational problems contributing to the stress overload may also be uncovered. In turn, this may lead to important clarification of what the disruptive physician needs by way of support. Finally, many of the disruptive physicians we have evaluated could best be described as psychosexually immature individuals who had never had their behavior shaped

by appropriate limit setting. No matter what "flavor," a colleague who refuses to appropriately manage anger is a liability – to your organization, to him- or herself and to your own resilience.

TAKING CHARGE

Here we offer guidelines for confronting and managing a colleague who shows inappropriate anger:

- ◆ Advocate policies that prohibit inappropriate displays of anger in the workplace and behaviors that sabotage effective collaboration and collegiality. Don't limit your policy to simply prohibiting outrageous behaviors, like temper tantrums. A good behavioural policy also prohibits passive-aggressive behaviors like gossiping about a colleague or failure to act in ways that support your organization.
 - ◆ Do it. Avoid waiting too long before confronting your colleague in an appropriate way.
 - ◆ Do it in person. Avoid gossip by going directly to the person of concern and never give negative feedback through a memo or email.
 - ◆ At first, do it in private. Criticism delivered in front of staff or peers damages collaboration.
 - ◆ Be definitive, but never blame or shame. Be clear that inappropriate displays of anger are unacceptable and damaging to you and to your organization, but also let colleagues know that you value and respect their thoughts and opinions.
- ◆ Be specific. Avoid using vague terms or innuendos. Colleagues need to know exactly which behaviors they need to change and may also need help with developing acceptable alternative behavior.
 - ◆ If one-on-one discussion yields little results, try group intervention. Include colleagues or staff who are willing to speak up about how the transgressor's behaviors are damaging and what needs to change. Coaching the participants regarding their role in the discussion may prove beneficial.
 - ◆ Do not debate. Your colleague will probably feel that his or her anger is justified. That's not the point. The point is that, regardless of the legitimacy of any underlying issues, expressing anger inappropriately is unacceptable.
 - ◆ Do not get defensive. Receiving unwanted feedback is embarrassing and striking back is a natural reaction. If this happens, make it clear that your own behavior is,

indeed, a legitimate topic, but one that deserves its own conversation. Offer to schedule a follow-up meeting to discuss anyone's concerns with your own behavior.

- ♦ If need be, insist that your colleague seek

professional help. Most state medical boards have alliances with either individual practitioners or organizations that monitor this type of problem and facilitate physicians receiving the help they need for behavioural problems.

With the proper policies and procedures in place, medical groups are empowered to mandate that a disruptive colleague seek and participate in treatment.



Online CME for Physicians

MDcme.ca is a website dedicated to providing accredited CME to physicians nationwide.

With eight (8) Canadian medical schools supporting the content of this portal, physicians can be assured that the education provided is credible, and because it is accessible via the Internet, physicians can finally complete CME programs at their own convenience.

The online courses at MDcme.ca are MAINPRO-M1 or C accredited (3-5 credits per course) and run 3-4 weeks in length.

Each course is case-based and participants can interact via an asynchronous discussion board.

An expert facilitator is available through the duration of the course for consultation, and a help desk is available seven (7) days a week.

Physicians can register at www.MDcme.ca.

Current course offerings are: Emergency Medicine: Case Studies (MAINPRO-M1); Introduction to Assessment and Management of Dementia

(MAINPRO-C); Introduction to Telehealth (MAINPRO-M1); L'ostéoporose au fil des ans (MAINPRO-C); Years of Our Lives: The Osteoporosis Continuum (MAINPRO-C); and Management of Whiplash and Back Injuries (MAINPRO-M1).

*Please check website for available dates.

Courses available in September 2003 are: Management of Arrhythmias; Parkinson's Disease; Follow-up Cancer Care; Cervical Disc Disease; and Lipid Management.



Drug Alert: ZOLOFT

Pfizer Canada Inc. has issued information with regard to a change to the Product Monograph for Zoloft (sertraline hydrochloride) capsules.

The concomitant use of ZOLOFT (sertraline hydrochloride) and pimozide is contraindicated as ZOLOFT has been shown to increase plasma pimozide levels. Elevation of pimozide blood concentration may result in QT interval prolongation and severe arrhythmias including Torsade de Pointes.

Response to “Medical Statistics 101”

Lorne Massey, MD, Professor & Head, Dept. of Pathology, College of Medicine, Univ. of Sask.

"Medical Statistics 101 for Clinicians" was an article published in the February 2003 edition of the College 'Newsletter'.

Your publication of the article by Seth Haber from the September 2002 edition of CAP Today adds useful information for clinicians when ordering and interpreting laboratory tests. This is a matter of such importance to the laboratory that we teach it in our introductory course in Pathology at the Medical School.

Those of your readers who are interested in this topic (everyone should be) can find a worksheet (written in JavaScript) on my web page at:
<http://skyway.usask.ca/~masseyk> which will do all

these calculations for the clinician.

Those who wish further instruction on Bayes Theorem generally should visit the Freiburg University website (Freiburg, Germany) who have developed a complete instructional course on the subject called "Visual Bayes", to be found at: http://www.imbi.uni-freiburg.de/medinf/projekte/v_bayes_e.htm.

This program may be downloaded from this site onto your own computer and completely explains Bayes Theorem, the basis of Predictive Values, and the use of Receiver-Operator Characteristic (ROC) Curves in the assessment of the value of laboratory tests. I encourage your readers to visit this site and work their way through this program.

If you do this, you will find Dr. Haber's figures for the 45 year-old woman in your office who has an *a priori* probability of 65% are incorrect. The True Positives (TP) will indeed be 94% of 650 patients (out of 1000) or 611. The False Positives (FP) will be 8% of the remainder of 350 disease-free patients, of 28. Therefore the PV(+) will be $611/(611 + 28) = 96\%$.

I suppose the lesson in this is to double-check the accuracy of everything you borrow from others, even when they are written by established authorities like Dr. Haber.

The College of Physicians and Surgeons would like to thank Dr. Massey for his response.

MCCQE Part II Course

A course for physicians preparing to take the Medical Council of Canada Qualifying Exam – Part II (Clinical Exam) will be held on Saturday, September 6th, 2003 at Royal University Hospital, Saskatoon. Registration fee - \$600.00. **Early registration is advised as the course is limited to 24 physicians. Registration deadline is August 8th, 2003.**

Sydney Smee, Manager, MCC, QE Part II, Evaluation Bureau, Medical Council of Canada, will speak on *MCC Qualifying Examination Part II: A Response to Myths and Misconceptions* on September 5th at 1930 in the Theatre in the Mall, Royal University Hospital, Saskatoon. This presentation is open to anyone who wishes to attend. For further information contact: Continuing Medical Education & Professional Development at (306) 966-7795

Are you a physician leader?

Increasingly physicians are seen as instrumental participants in the management of Canada's health care system. The Canadian Society of Physician Executives (CSPE) can offer physicians the opportunity to develop the necessary skills and gain knowledge to excel as leaders in these management positions.

Who should join

All physician managers, physician executives and any other physician interested in enhancing their effectiveness and involvement in system, institutional, organization or group management.

Benefits of joining

- ◆ quarterly *CSPE Newsletter* – a highly valued information source for Canadian physician executives
- ◆ *CSPE annual meeting* – your opportunity to meet face-to-face with colleagues and learn from one another
- ◆ *physician management education* – developed in collaboration with the CMA's Physician Manager Institute (PMI) to provide you with the latest management skills and information
- ◆ *online Q & A program* – colleagues from around the country can provide answers to your most challenging management questions.

For more information contact: Canadian Society of Physician Executives, 1559 Alta Vista Drive, PO Box 59005, Ottawa ON K1G 5T7 Tel: (613) 731-8610 x2254 Fax: (613) 731-1779 or carol.rochefort@cma.ca. Visit their web site at www.cspexecs.com.

Refresher Course for General Practitioner Anesthetists

November 1, 2003
Westin Bayshore Hotel
Vancouver BC

Registration Fee: \$250. Deadline for registration: October 3rd, 2003

This course, sponsored by UBC Department of Anesthesia, 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.

For further information contact: Winnie Wong at (604) 875-4575, winniewo@interchange.ubc.ca or Nicola Dorken at (604) 875-4464 or ndorken@vanhosp.bc.ca

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

Next ECG Exam

Monday, October 20th, 2003, 1:00 p.m. – 4:00 p.m.
College of Physicians and Surgeons,
211 - 4th Avenue South,
Saskatoon SK S7K 1N1

For further information, contact Carol Bowkow at (306) 667-4635



Membership Statistics

	Active Licensure	Inactive Licensure
Total Registered as at December 31, 2001	1646	227
Newly registered from Saskatchewan	33	0
Newly registered from other provinces	22	0
Newly registered from other countries	76	0
Reactivated to Full from Inactive	4	-4
Reactivated to Full or Inactive from absence	7	1
Moved to Inactive In-Province Licensure	-7	7
Moved to Inactive Out-of-Province Licensure	-29	29
Licenses Expired/Invalid	-7	0
License lapsed at Request or Non-payment	-72	-33
Deceased	-4	-1
Retired	0	0
Moved from Active/Inactive to Temporary Locum	-1	0
Total Registered as at December 31, 2002	1668	226



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Newsletter

