



College Newsletter

A publication of the College of Physicians and Surgeons of Saskatchewan

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Message from the President

I would like to begin by briefly introducing myself. Born in a small town in Africa (Kenya), I moved to Great Britain at the age of eleven. I obtained my medical degree from Southampton University and spent some time working in Britain before moving to Saskatchewan, 22 years ago, to a solo practice in Herbert. How time flies when you're having fun! As some of you may know, to say I have a passion for cars would be an understatement! On a more serious note however, it is an honour to be elected President of the College of Physicians and Surgeons of Saskatchewan for the year 2007. I have served as a College Councillor for five years and Vice President for the last two.



Dr. S. Kasset, Herbert

On behalf of the College, I would like to take this opportunity to thank Dr. Tsoi for his dedication and Presidential leadership over the past two years. I am finding out quickly that this job can take up a substantial amount of time and Dr. Tsoi has left large shoes for me to fill.

I would also like to thank outgoing Counsellors, Dr. M. Mirchandani, Dr. G. Hansen, Dr. B. Bachynski, Mr. E. Van Olst, and Ms. J. MacKay for their many years of dedicated work and admirable services.

Physician manpower shortage remains a global problem and a substantial amount of Council time during the past few meetings has been dedicated to licensure of International Medical Graduates (IMG). At the February meeting, the Council held a joint session with the SMA on the subject of IMG registration. This meeting was productive and not surprisingly, in the majority of areas we shared common ground. Most importantly, we agreed that the registration process be made as simple as possible, without compromising quality of care by lowering standards.

I would like to encourage everyone to attend the Annual General Meeting of the College, which will be held in September in Saskatoon.

This year's education portion will involve a joint presentation from the SRNA, the Saskatchewan College of Pharmacists, and the Saskatchewan College of Physicians and Surgeons. More information will be forthcoming.

Until next time... enjoy your Spring!

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Organizational Renewal Opportunities

D. Kendel, MD, Registrar

In the lifecycle of any organization, opportunities arise for an organization to reflect on its history and renew its sense of mission and purpose.

As Dr. Edward Tsoi convened the first Council meeting for 2007, he concluded two years of very committed leadership in the vital role as Council President. Before turning over the Presidency to Dr. Suresh Kasset, Dr. Tsoi challenged his fellow Councillors to establish a Strategic Planning Committee comprised of seven Councillors and senior management staff of the College.

Dr. Tsoi expressed a hope and expectation that the Strategic Planning Committee will critically review the College's historical strategies for fulfillment of its mission and boldly explore new strategies that may enhance its future effectiveness and impact.

The mission of the College, as defined by the Council, is *"Competent caring physicians providing quality health care."*

Like most organizational mission statements, the College's mission statement articulates an ideal goal. There are some key words in the statement that invite reflection on their implications.

If every physician we licensed to practice medicine was perfectly competent every day of his/her career, what might that mean? It could mean that every physician would have perfect knowledge of the most current medical science and every decision he/she makes would be aligned with current scientific evidence.

If every physician constantly demonstrated a genuine caring attitude and demeanor in his/her interface with patients, colleagues, and co-workers, the College would never receive another complaint regarding physician insensitivity or rudeness.

If every physician were consistently competent and caring, I believe there is little doubt that the quality of health care in Saskatchewan would be enhanced. But, would the quality of health care be perfect? I do not believe it would be. Indeed, I believe it would be far from perfect and I want to explain why.

Because physicians are fallible human beings, like everyone else, we're prone to errors. Physicians often carry excessive workloads and work long hours that results in fatigue. There's good research evidence suggesting that error rates increase with fatigue. Physicians also work in complex systems that are poorly designed to detect errors and intercept them before they cause harm to patients.

So, the inescapable reality is that very competent and caring physicians still commit errors of commission and omission virtually every day that they practice medicine. And, sadly, some of these errors cause grievous patient harm, including patient death.

Over the past decade we've learned a great deal about the incidence of harm that occurs to patients in the course of health care. The seminal research undertaken by Dr. Ross Baker and Dr. Peter Norton in Canada proves that the incidence of serious patient harm to hospitalized patients in Canada closely parallels that in the U.S., the U.K. and Australia. Baker and Norton's work was published in the Canadian Medical Association Journal.

Across the world some exciting new strategies are being identified and implemented to make health care safer and of higher quality. This research is based upon an awareness that physicians and all other health care professionals will commit errors during the course of their

work, but the research strives to identify ways of mitigating the risk that those errors will cause patients harm.

Agencies such as the Institute for Healthcare Improvement in the U.S. have shown real leadership in terms of health care quality improvement and patient safety. In Canada, similar leadership is being demonstrated by the Canadian Patient Safety Institute and by our own Health Quality Council (HQC) in Saskatchewan.

Since the inception of the HQC I've had the great privilege of serving on the HQC Board of Directors along with a remarkable group of people from Saskatchewan, elsewhere in Canada, and the U.S. Service on the HQC Board has enabled me to gain some valuable insights into factors that impact health care quality and patient safety. I believe these insights will have significant implications for the College of Physicians and Surgeons as we contemplate future organizational strategies.

Historically professional regulatory bodies have sought to improve the quality and safety of services provided by their members by ensuring member competence at the time of initial registration, by providing guidance to their members, and by disciplining those who violate significant norms and boundaries.

Ensuring the competence of initial registrants and sanctioning physicians who violate professional norms are statutory responsibilities that the College must continue to perform. The task of "guiding the profession" is not statutorily defined, but probably has the greatest potential to positively impact on the quality and safety of health care.

I believe the College needs to critically revisit its historical approaches to professional guidance and strive to align future approaches with evidence of strategies that are optimally effective.

Because we're obligated to investigate and respond to all complaints about physicians, it is inevitable that the College will always need to provide some focused guidance to individual physicians about their future professional performance or conduct. However, we also need to become more active in identification and mitigation of systemic factors that increase the risk of physician error. And, we need to work more effectively with other agencies to achieve systemic changes that better shield patients from harm when errors do inevitably occur.

I look forward to exploring all of these issues and options with the Council's Strategic Planning Committee as it begins its work.



Providing Care To Incompetent Patients

B. Salte, LLB, Legal Counsel

What should you do if your patient needs medical care but cannot provide informed consent for the required medical care? The patient may be prevented by illness or injury from providing the necessary consent. That incapacity may be temporary or permanent.

The College has received several inquiries, asking for advice in specific circumstances. We hope that this article will assist physicians to understand the principles that apply.

Saskatchewan legislation, **The Health Care Directives and Substitute Health Care Decision Makers Act** provides most of the answers.

The Act applies when a person “does not have the capacity to make a health care decision respecting a proposed treatment.”

If the patient has signed an Advance Health Care Directive (sometimes called a “Living Will”), the terms of that document will usually provide the necessary direction to the physician:

- 1) If the Advance Health Care Directive specifically addresses the treatment for the specific circumstances that exist, the physician should follow the directions in the document;
- 2) If the Advance Health Care Directive does not specifically address the treatment for the specific circumstances that exist, but provides guidance in the approach to be taken, the physician can consider that guidance in determining the patient’s treatment;
- 3) If the patient’s wishes as expressed in the Advance Health Care Directive are not clear, then the proxy or proxies appointed in the Advance Health Care Directive can make the decision on behalf of the patient.

If the patient has not signed an Advance Health Care Directive, the legislation states who can make a health care decision on the patient’s behalf:

- 1) firstly, a spouse (including a person with whom the patient has cohabited in a spousal relationship);
- 2) secondly, an adult son or daughter;
- 3) thirdly, a parent or legal custodian;
- 4) fourthly, an adult brother or sister;
- 5) fifthly, a grandparent;
- 6) sixthly, an adult grandchild;
- 7) seventhly, an adult uncle or aunt;
- 8) eighthly, an adult nephew or niece.

If none of the persons described in the previous paragraph are available, the physician can provide treatment to the patient without consent if another physician agrees in writing that the treatment is required.

If a proxy will be making a decision on the patient’s behalf, the physician should provide all necessary information to the proxy to allow the proxy to make an informed decision respecting the treatment to be provided.

The legislation protects physicians who provide or decide not to provide treatment if the physician:

- 1) follows the direction in the directive; or
- 2) provides treatment without being aware that the patient had signed an advance care directive.

Most of the situations where physicians are required to deal with patients not capable of making their own health care decisions can be dealt with as described above. However, there are some circumstances that a physician may wish to obtain advice, if there is sufficient time to do so:

- 1) If the physician is concerned that the proxy is making a decision that is not consistent with what the patient wanted.
- 2) If the physician is concerned that the proxy is making a decision that is not in the patient’s best interests;
- 3) If there is significant disagreement among relatives respecting treatment, and there is no Advance Health Care Directive that specifically addresses the treatment that the patient wanted.

The *Code of Ethics* also provides guidance to physicians dealing with incompetent patients. Paragraphs 21 through 23 state the following:

- 21 Respect the intentions of an incompetent patient as they were expressed (e.g., through a valid advance directive or proxy designation) before the patient became incompetent.
- 22 When the intentions of an incompetent patient are unknown and when no formal mechanism for making treatment decisions is in place, render such treatment as you believe to be in accordance with the patient's values or, if these are unknown, the patient's best interests.
- 23 Be considerate of the patient's family and significant others and cooperate with them in the patient's interest.

The text of **The Health Care Directives and Substitute Health Care Decision Makers Act** is available at the website of the Saskatchewan Queen's Printer, <http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/H0-001.pdf>

A pamphlet from the Public Legal Education Association is available at their website, <http://www.plea.org/freepubs/hcd/hcd.pdf>

The End of Life Project of Dalhousie University has useful information for physicians and patients at their website, http://as01.ucis.dal.ca/dhli/cmp_advdirectives_faq/default.cfm

Saskatchewan Justice has basic information intended for patients at their website http://www.saskjustice.gov.sk.ca/learning_centre/healthdirectives.shtml

There is a very useful general discussion relating to the types of things patients can consider in preparing an Advance Health Care Directive at the website of the Queensland, Australia government. However, as the law relating to Advance Health Care Directives appears to be somewhat different in Australia than in Saskatchewan, it should not be considered as specifically applying in Saskatchewan. That website is <http://www.justice.qld.gov.au/guardian/poa/ahd.htm> and a form that is appropriate in Australia, and provides guidance as to some of the matters that patients may wish to consider in completing an Advance Health Care Directive, is available at <http://www.justice.qld.gov.au/guardian/poa/ahd.htm>



Diagnostic Imaging Referral Guidelines

K. Shaw, MD, Deputy Registrar

The Canadian Association of Radiologists has published a diagnostic imaging referral guideline book, which was prepared by an expert advisory committee of the Canadian Association of Radiologists in collaboration with the Canadian Association of Nuclear Medicine. This book was based on the Royal College of Physicians document "Making the best use of the Department of Clinical Radiology: Guidelines for doctors, 5th edition", and "designed to assimilate, evaluate, and implement the ever increasing amount of evidence and opinion on current best practice". This is a useful resource for any physician involved in the referral of patients for diagnostic imaging procedures.

The Canadian Association of Radiologists invites physicians to consult the guidelines on the CMA website (for CMA members only) at www.cma.ca or on the website of the College of Family Physicians of Canada (for CFPC members only) at www.cfpc.ca. Physicians wishing to order a copy may download the application form from the website of the Canadian Association of



Correction Notice

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An error was noticed in the 2006 Legal Report, section III, changes to College Bylaws regarding b) Revalidation – Page 8. There was an incorrect reference to the Royal College of Physicians & Surgeons of Canada, Maintenance of Competence Program rather than the current terminology MAINTENANCE OF CERTIFICATION PROGRAM. We apologise for this oversight.



Role of Physicians in Certifying Illness and/or Assessing Capacity for Work

K. Shaw, MD, Deputy Registrar

Physicians must respond to requests from patients and employers to certify illness and/or assess capacity for work. The College of Physicians and Surgeons and the Saskatchewan Medical Association (SMA) developed a joint policy with respect to the role of physicians in certifying illness and/or assessing capacity for work. This policy was circulated in 2006 to assist physicians with this practice issue.

The policy indicates that the purpose of a medical certificate is to verify an employee's illness/injury to an employer or insuring agency and to provide relevant information to enable the patient/employee to return to work as soon as medically possible.

Employers and their insurers rely on the information provided to them and in doing so, they may incur financial liability for sick leave or disability pay. The employer also relies on the physician's opinion that the employee is fit to return to work. Misinformation or erroneous opinions can result in harm to those who rely on this information. Physicians should note that any release of information to an employer regarding their employee should be strictly on a "need-to-know" basis, and should be limited to the worker's injury/illness and only after the patient has provided a signed consent for the release of such information.

With respect to brief periods of limiting injury or illness, physicians are advised to use the "medical certificate" prototype developed by the SMA or a similar reporting format. The SMA has recently revised its "sick slip" and a copy of the new "medical certificate" is enclosed within this Newsletter. This form is also available electronically on the SMA website.

If the physician has not attended the patient professionally during the period of illness, no document should be signed that may infer they had.

With respect to a more extensive illness or injury that may involve an early return to work with modified strategies, the joint policy of the College and the SMA recommends the following sequence of assessment and reporting:

- a) At the time the injured/ill patient attends a physician, an initial form is completed and returned to the employer indicating the nature and extent of the condition and functional limitations;

- b) The employer discusses a modified work option that might allow the employee to return to work;
- c) The employer sends a summary of the modified work plan to the employee and the physician to review;
- d) The physician certifies the ability of the patient to undertake the proposed modified work plan and establishes an appropriate date for review; and
- e) Following review, the patient/employee may increase the scope of work as the limitations of the medical condition allows.

Physicians are encouraged to review the entire policy, which has been reprinted in this Newsletter and follow it when requested to certify illness and/or assess for capacity for work.

It may be of some assistance to share this policy with patients to assist them to understand that the physician's role in certifying illness or assessing capacity of work is to provide an objective evaluation and report the limitations that the patient/worker's injury/illness places on their ability to perform certain functions. It is the responsibility of the employer to manage the worker's return to modified or usual work duties with the benefit of the objective professional input from physicians and/or other health professionals.

**MEDICAL
CERTIFICATE**



I attended _____ on _____
(date)

Due to illness/injury the following restrictions apply from _____:
(date)

• Next clinical review _____ **or,**
(date)

• Fit for full duties _____ **or,**
(date)

• He/she informed me that he/she was not able to be at work

from _____ to _____ due to illness/injury.
(date) (date)

Signed _____

Print _____

Note: Medicare does not insure completion of this certificate.
You can expect to be billed directly for this service.

Policy: Role of Physicians In Certifying Illness And/ Or Assessing Capacity For Work

The purpose of a medical slip is to verify an illness/injury to an employer or insuring agency and to provide relevant information to enable the patient/employee to return to work as soon as medically possible.

Employers and their insurers will be relying on the information provided to them and in so doing, they may incur financial liability for sick leave, or disability pay. The employer is also relying on the physician's opinion that the employee is fit to return to work. Misinformation, or erroneous opinions, could result in harm to those relying on this information.

- 1) Some illnesses/injuries may impair a person's capacity to do their regular work or alternative work. However, planning for return to work should begin at the first visit. A patient's limitations should be evaluated and emphasized to him/her. Work and other activities should be encouraged within the patient's evolving limitations.
- 2) With respect to worker injury/illness incurred in the workplace, the procedures defined by the Workers' Compensation Board (WCB) apply.
- 3) With respect to brief (i.e. several days) worker absence from the workplace due to injury/illness not incurred in the workplace, an employer may require written documentation from the physician of the worker's injury/illness.
- 4) With respect to more severe worker injury/illness, an employer may require an objective physician evaluation of the worker's functional limitations to guide return to work (RTW) decisions.
- 5) In each of these situations, the responsibility of the physician is to do an objective evaluation and to report the impact of an injury/illness and the limitations that the patient/worker's injury/illness places on their ability to perform certain functions.
- 6) It is the responsibility of the employer to manage the worker's return to modified or usual work duties with the benefit of objective professional input from physicians and/or other health care professionals.
- 7) To the extent that it is possible, functional capacity and limitations should be assessed objectively. It is, however, recognized that in formulating any professional opinion regarding a patient's/worker's functional capacity or limitations, a physician may be substantially reliant upon information from the patient/worker regarding subjective elements related to their injury such as pain, anxiety or dizziness.
- 8) Some forms of restriction may delay healing and could lead to prolonged symptomatology and can also leave the impression that any activity beyond the limit is harmful or dangerous and may lead to permanent disability.
- 9) It is prudent to avoid long-term prognostic opinions but rather to re-evaluate an injured worker's functional capacity at regular intervals. Many employers can align a modified job if they know an employee's capabilities and/or restrictions and will be counting on a physician's report to enable this process. An employer needs to know approximately when they can reasonably expect an employee to be able to return to their regular duties. This way they can properly manage and plan for the changes in their workplaces. They will generally be looking to the physician for an anticipated return to an employee's regular work date.

- 10) With respect to brief self-limiting injury/illness, physicians are advised to use the “sick slip” prototype developed by the Saskatchewan Medical Association (SMA) or a similar reporting format. If a physician has not attended a patient professionally during the period of illness, no document should be signed that may infer they had.
- 11) With respect to more extensive illness/injury that may involve early return to work with modified strategies, the following sequence of assessment and reporting is recommended:
 - (a) At the time the injured/ill patient attends a physician an initial form is completed and returned to the employer indicating the nature and extent of the condition and functional limitations.
 - (b) The employer discusses a modified work option that might allow the employee to return to work.
 - (c) The employer sends a summary of the modified work plan with the employee to the physician for review.
 - (d) The physician certifies the ability of the patient to undertake the proposed modified work plan and establishes an appropriate date for review.
 - (e) Following review, the patient/employee may increase the scope of work as the limitation of the medical condition allows.
- 12) Any release of information to an employer should be strictly on a “need to know” basis, limited to the worker’s injury/illness and only after the patient has provided a signed consent for the release of such information.


Council/SMA April 2006



Health Canada Site – MedEffect

Physicians are reminded of a very useful reference from Health Canada to get up-to-date information about consumer product safety, diseases and conditions, drugs and health products; and in particular adverse reaction information and advisories, warnings and recalls, along with many other sources of information. An easy way to access all this information is through the MedEffect site at www.hc-sc.gc.ca/dhp-mps/medeff/index_e.html.

Physicians can sign up for a MedEffect e-notice on this website and check advisories, warnings and recalls, and review the Canadian Adverse Reaction Newsletter (CARN). The site also has quick links to sites of consumer product safety, diseases and conditions, and other drugs and health product topics. This site will keep you up to date, enable you to alert your patients to possible problems, and to respond to your patients’ questions in a timely fashion.



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

Physician Tardiness in Completion of Insurance Forms

K. Shaw, MD, Deputy Registrar

Completion of forms, whether they be Attending Physician Statements (APS) or other insurance forms, is an ongoing issue for the physician, the patient and the College.

In October 1997 and then again in 2000 the College of Physicians and Surgeons alerted physicians to concerns raised by insurance companies with respect to the tardiness of completion of Attending Physician Statements and other insurance forms. At that time physicians were advised **to complete these forms as promptly as possible, preferably within two weeks of receipt of the form.**

The College continues to receive many calls regarding tardiness in completion of forms. It is important to realize that while many of us do not enjoy filling out forms, it is a necessary and important part of medical practice. When physicians fail to complete insurance forms in a timely fashion, the insurance companies do not have the information required to assess the needs of that particular client. Often at that point the insurance company makes contact with the physician's office to remind them of the outstanding form. If physicians do not respond to the reminders, the insurance companies often resort to denying benefits to the patients or denying insurability. Both of these outcomes have a profound negative affect on the individual patient.

Patients will call the College usually as a last resort when all their previous efforts have failed to result in the completion of the form by the physician. Generally patients do not wish to lay a formal complaint at this stage, and they are only asking for assistance from the College in raising the issue with the individual physician. At this stage, the Regulatory Services Coordinator, Ms. V. Marsh, (or other members of the Executive Staff), will place a call to the physician's office clarifying to the physician that it is the expectation of the College that such an insurance form be completed at the earliest opportunity and within two weeks of receipt of the form. If there are reasons that the form cannot be attended to within the required time period, the physician is advised that it is appropriate to alert the insurance company or whomever requested the information and acknowledge receipt of the form, and request an extension. Alerting the insurance company in this manner usually results in extra time being granted, but more importantly, will avoid the company terminating benefits and/or affecting the insurability to the individual patient in this situation. However, when a physician seeks extra time, it is expected that they will complete the form within this time period. Repeated reminders or "empty promises" that do not result in completion of the forms usually lead to a formal complaint being lodged by either the insurance company or the patient.

Occasionally insurance companies will advise the College that physicians are refusing to complete the APS request unless their patient first undergoes a physical examination. Insurance companies have indicated that most frequently the APS form request is for a summary of the physician's record only, not a current physical examination.

Insurance companies go on to explain that the affect 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 an insurance company. Physicians should not require the attendance of a patient for an "update visit" and/or a physical examination prior to completing the APS form except in those circumstances where it has been specifically requested by the insurance company.

When College staff interact with a physician regarding completion of these forms, most physicians are reasonable in their response and complete the form without any further delays. However, some physicians report they are “too busy with important things like seeing patients” to complete these forms. Physicians are reminded that completion of such forms is a service that is as important and valuable to the individual patient as an “office visit”. These patients rely on the completion of these forms for ongoing insurability and/or disability benefits. An interruption of these due to the physician’s tardiness is not merely an inconvenience, but may result in discontinuation of the “only source of income they have”.

Recently College staff have been advised of another situation with physicians who are contacted regarding tardiness in completion of forms. Some physicians have indicated that they will be terminating the patient-physician relationship. Patients who call the College on this issue are not registering a complaint. They have usually run into a “brick wall” with the physician or the physician’s office. Most express regret at having to call the College office and are eager to advise us that they “are not unhappy with the care they have received”, they just can’t get their forms completed. Although there are legitimate reasons to terminate a patient-physician relationship, a call to the College by a patient to seek advice on such an issue should not be seen by physicians as a reason to terminate the patient-physician relationship.

How can such tardiness be avoided in your office?

- 1) Have your office diarize receipt of such time-sensitive requests.
- 2) Have your office “book” time within your schedule to complete such forms.
- 3) If you are unable to complete a form within the required timeframe, immediately notify the insurance company or the appropriate individual who requested the form and request an extension.

Management in this manner should reduce the aggravation for all.



Notice of Amendment to the Bylaws Governing The Prescription Review Program

The Council of the College of Physicians & Surgeons has amended the bylaw governing the Prescription Review Program (PRP) to eliminate the need for prescriptions for PRP products to include a statement that the prescription is only valid for three days.

Physicians may still elect to place such a condition on prescriptions but there is no longer a regulatory requirement to do so.



Youth Drug Detoxification and Stabilization Act – Help for Saskatchewan Youth

J. McCallum, Addiction Medicine Advisory Committee

The Youth Drug Detoxification and Stabilization Act (YDDSA) was proclaimed April 1, 2006 to help engage the most vulnerable and at risk of our youth who are harmfully involved in substance use. Providing involuntary secure care is one of a number of initiatives along a

continuum of services under the Premier's *Project Hope*, a three-year \$18.7 million strategy to reduce substance abuse in the province. Through *Project Hope*, the Premier has committed the government to a better future for all citizens of the province. It is a future where every child has the best possible chance of growing up free of addiction, in Saskatchewan's communities, families and homes.

The legislation is limited to 12 – 17 year olds who:

- are severe substance abusers or chemically dependent
- at risk of harm to themselves or others
- resistance to interventions
- challenging for professionals to engage in services
- typically not served on a voluntary basis

The YDDSA is intended as a measure of last resort for parents, legal guardians, and others significant in the youth's life when the youth's substance use has damaged their decision-making ability to the point they present a risk to their own safety or the safety of others. The rights of youth are protected through the inclusion of due process provisions. Involvement of the youth in voluntary services is encouraged.

The YDDSA provides for involuntary detoxification and stabilization of youth through an order by two physicians for up to five days and allows for extensions for a maximum of two additional five-day periods at the Secure Youth Detox Centre, a 6-bed facility currently located in Regina. The Act also provides for the issuing of community orders for up to 30 days as an alternative to residential detoxification.

Roles under the Act include:

- Applicants: initiate process
- Judges: adjudicate, issue warrants
- Police: apprehend and transport youth
- Physicians: conduct assessments, issue Detox and Community Orders
- Secure Youth Detox Centre: detoxify, stabilize youth
- Addiction Counsellors: assist physicians with assessments, case management, follow-up, outreach
- Official Representatives: protect youth's rights
- Review Panels: hear appeals

Issuance of a Community Order or Detoxification Order requires an examination by and the opinion of two physicians. Assessments can be carried out concurrently, however in most cases, the first physician will conduct an initial examination, then request an examination and opinion from a second physician. The Act does not limit this role to any particular physician group or specialty. The College of Physicians and Surgeons maintains a roster of physicians with particular experience in the relevant medical areas, and who are likely to be accessible to complete assessments under the Act.

Every Regional Health Authority has been funded for dedicated staff to provide support to youth, families and professionals working under the Act in the areas of assessment, community orders, case management, follow up and outreach, including providing assistance to physicians. Physicians interested in providing this important service to Saskatchewan's youth and families by joining the roster should contact the College of Physicians and Surgeons.

For more information on the Youth Drug Detoxification and Stabilization Act:

http://www.health.gov.sk.ca/ps_ads_ythdrugdetox.html



Sources Of Supply For Illicit Opioid Use

D. Spitzig, Consultant Pharmacist, Prescription Review Program

Heroin has traditionally been a primary opioid of abuse in Canada. However, a report in the November 21, 2006 edition of the CANADIAN MEDICAL ASSOCIATION JOURNAL (CMAJ) indicates that prescription opioids have become the country's predominate form of illegal opioid abuse. This is not a revelation for us in Saskatchewan as illegal opioid abuse has resulted entirely from those that have been prescribed.

The report stated that a substantial proportion of prescription opioids were obtained directly or indirectly (i.e. through family and friends) from sources within the medical system. Law enforcement officers in Saskatchewan have identified that this is the case here as well.

As there are many appropriate and necessary indications for the prescribing of opioids, any program or activity directed towards reducing inappropriate use of these drugs must also ensure access of legitimate patients who benefit from them.

It is believed that it would be unusual for a Saskatchewan physician to write a prescription for a patient to support illicit use. This indicates that illegal opioids for abuse are unknowingly being prescribed by physicians.

Only through education and awareness will the access of prescription opioids for abuse be reduced. Fortunately in Saskatchewan there are TWO programs that if used to their full potential would dramatically reverse this trend, of not only illicit prescription opioid abuse but also of other drugs of abuse such as benzodiazepines. These two programs are the PRESCRIPTION REVIEW PROGRAM and THE PRESCRIPTION INFORMATION PROGRAM (PIP).

The Prescription Review Program, which replaced the Triplicate Prescription Program, with its expanded list of targeted drugs is a valuable tool not only to centrally monitor apparent inappropriate use of prescription review drugs by patients, but also if a physician is concerned with regards to a patient's past usage of these drugs. The profile of prescription review drugs pertaining to an individual can be obtained through the College by contacting Ms. A. Lee.

The (PIP) Medication Profile Viewer has been available since March 2006. It is a secure web-based application that allows clinicians to view medication profiles for patients based on submissions to the Saskatchewan Drug Plan from community pharmacies. These submissions are uploaded to the PIP Medication Profile Viewer hourly. This phase has the ability for clinic staff to print out profiles for use before patients arrive for appointments. As of February 27, 2007 a total of 126 physicians from 39 clinics have signed up and are using the PIP Viewer.

The second phase of PIP, Electronic Prescribing is scheduled to pilot on April 1, 2007 and the third phase, Integration into Electronic Medical Records (EMR) and Pharmacy Software in 2008. This may be a good time to obtain a PIP viewer. With the increase in usage of the PIP viewer by physicians, the amount of double doctoring by patients for prescription reviewed drugs will dramatically decrease, therefore its use is strongly recommended. To receive web-based access to PIP or if you have any questions contact the PIP information line at (306) 787-9833 or (306) 791-4065, FAX (306) 781-8480 or E-mail: pipinformation@shin.sk.ca

It is inevitable more patients will be identified to have developed dependency or addiction to opioids and other prescription review drugs with the use of these programs. Physicians should refer to the document, Concurrent Disorders And Withdrawal Management compiled by the Addictions Medical Advisory Committee, December 2004. If you cannot locate your copy, they are available from the College via the website at www.quadrant.net/cpss or email us at cpss@quadrant.net

We have the tools now at our disposal to dramatically limit illegal opioid abuse in Saskatchewan, however it will take a collaborative effort to make it a reality.



2007 Interdisciplinary Conference Collaborative Care Models to Advance Patient Safety

The Saskatchewan Registered Nurses Association, Saskatchewan College of Pharmacists, and the College of Physicians & Surgeons of Saskatchewan will be hosting an Interdisciplinary Conference at TCU Place in Saskatoon September 14-15, 2007.

The theme, 'Collaborative Care Models to Advance Patient Safety', is meant to challenge us to focus on patient centered care and reflect on our differential roles in the circle of care.



Notes

ECG Exam – College of Physicians & Surgeons

Monday, May 7, 2007 – 1:15 p.m. – 4:15 p.m.

Monday, September 10, 2007 – 1:15 p.m. – 4:15 p.m.

To register contact: Camille Dunlop, Tel: (306) 667-4622

4th Annual Peter & Anna Zbeetnoff Memorial Drug Therapy Decision Making Conference

Friday March 23 & Saturday 24, 2007

Travelodge Hotel – Regina, Saskatchewan

Assessment and Stabilization Care of Sick Infants (The Stable Program)

Friday March 30 & Saturday March 31, 2007

Regina General Hospital – Regina, Saskatchewan

Regional Psychiatric Centre - Employment Opportunity

The Regional Psychiatric Centre is a secure designated mental health facility under the Mental Health Services Act of Sask. and a penitentiary under the Corrections and Conditional Release Act of Canada. The Centre provides mental health services for about 200 federal offender/patients from the federal penitentiaries in the Prairie Region.

Historically we have utilized physicians from the Saskatoon medical community. Our population generally has approximately 20 patients who have significant physical health problems. We are currently looking for a Group of Physicians to become our New Contractor and provide Medical Services for our patients. Please contact Dr. Olajide Adelugba, the Clinical Director for more information.

Health Care in Saskatchewan An Analytical Profile by Gregory Marchildon and Kevin O'Fee

Canadian Plains Research Institute Centre and the Saskatchewan Institute of Public Policy

The purpose of this document is to provide health providers, managers and policy – makers, as well as students taking courses in health studies, with an analytically based description of the Saskatchewan health system. Contact (306) 585-4758 for a copy.

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Newsletter

