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College Newsletter

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Message from the President

A new year is upon us. At this time it is traditional to reflect on the past and to look forward in anticipation to the coming year.

I began last year's *Newsletter* with a somewhat personal introduction, and therefore it seems only fitting to write my last *Newsletter* in a similar vein.

It has been somewhat of a tumultuous year for me personally. A "cardiac event", loss of a dear family member, return to full activities including the presidency of the College – all have had their blessings and challenges. Through this process, I have become a close associate of that vaulted instrument of cardiac rehabilitation, the treadmill. Time on the treadmill is in some ways akin to time spent on College matters. It is long, it can be hard work, and at the end of the day one has not gone anywhere!

But, lest we despair, there is good news in this seemingly dreary outlook. In legislative process, "the mills grind slowly" and usually for good reason. Legislative matters need to be thoroughly researched, vetted, and debated. Change, if necessary, should come somewhat slowly and deliberately to insure that all affected are given a consultative voice and that the change, if and when it occurs, is for the betterment of those involved both directly and indirectly.

In the past year, the College has made, or is in the process of making changes, such as changes to our IMG licensing methods, to the reporting of disciplinary matters, to our relationship with the PEP program, and to our internal methods of executive function and formation.

Dr. Garry Hansen, MD

These are but some examples of thoughtful, progressive changes that will hopefully make positive impacts upon our profession and benefit the public we serve. All these items have come about through seemingly slow and ponderous, but I feel necessary, processes of legislative management.

The coming year will undoubtedly hold many new and varying challenges for the College and its Council. If I may digress for a moment of self-reflection, it would be to say that we have attempted as a Council, during my term as President, to take the time while on the legislative treadmill to ponder how we

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will handle these new challenges. The Council, through the development of a strategic planning committee, and thereafter a strategic plan, is attempting to lay the foundations for how it will deal with new issues and the future of legislative medicine. We cannot even foresee all the issues that may need to be addressed, but we can set in play a strategic plan as to our present and future priorities and how we will attempt to deal with them. As with our treadmill journey, the work may be slow and somewhat tedious, but hopefully our end goal will be that of a Council more fit to deal with the challenges presented to it.

It has been both an honour and a pleasure to serve as Council President for the past year. I wish to thank my fellow councillors and the executive and support staff of the College for their efforts and support in the past year.

A Time for New Beginnings

Dennis Kendel, MD, Registrar

The beginning of a new year is often seen as an opportune time to make some changes in our personal lives. We make resolutions to eat more healthy, to exercise more regularly, or to strike a new balance between our work and personal lives.

A new year can also be an opportunity for organizations like the College of Physicians and Surgeons to consider some new beginnings. At its January meeting the Council will elect new leaders. It will establish some new priorities for the College as it reflects on the outcome from a facilitated Council Retreat convened at the end of 2004.

There are a host of variables that may precipitate, facilitate, or impede change in our personal lives and in organizations. In respect to organizational change, sometimes change is precipitated by cataclysmic events in the external environment. Sometimes change occurs through transition in leadership and the new ideas that different people bring to an organization. Sometimes change occurs through exposure to new information, reflection on that information, and acceptance of its validity.

Regardless of the external forces that may either precipitate or impede organizational change, the possibility of organizational renewal depends heavily on organizational leadership at both the governance and management levels.

Over the past year Dr. Hansen has provided strong leadership at the governance level by challenging the Council to refocus its priorities.

At the management level I perceive the responsibilities of leadership as embracing more than simply effective stable management of long established organizational programs. Effective leadership involves a commitment to continual learning and transfer of new knowledge into practice.

The Institute for Healthcare Improvement (IHI) in the US and the British Medical Journal (BMJ) collaborate in the publication of a very high quality journal entitled “Quality and Safety in Health Care”. A supplement to the December 2004 issue of this journal contains a very interesting article by Rushmer and colleagues at the University of St. Andrews in Scotland entitled “Unlearning in Health Care”.

It is axiomatic that before we can adopt new ways of thinking and doing things we often need to “unlearn” things that have been the basis for current policies and practices. Even

basic assumptions on which we have crafted policies and programs must be critically re-examined in the light of new evidence. When new evidence suggests a need for change, we need to have the courage to apply the evidence.

The growing literature on patient safety and health care quality improvement suggests that we need to pay a great deal more attention to the processes of health care rather than focusing so narrowly on the performance of individual health professionals.

Sometimes lessons we glean from the literature can seem very abstract until we link them with real life experiences. Let me share with you a story from our efforts to work collaboratively with other agencies to reduce childhood deaths.

A thirteen-month-old child with a severe respiratory tract infection was transferred from a rural community to a tertiary care hospital. A chest x-ray taken in the rural community was sent with the child. The attending physician in the rural community and the receiving physician in the tertiary hospital both reviewed the chest x-ray with a focus on the bilateral lung infiltrates related to the child's immediate clinical problem.

X-rays that are transferred to a tertiary hospital with a patient get stored in a special location and eventually get returned to the community of origin. Sometimes, as in this case, return of the x-ray is delayed.

There are currently no processes in place to ensure that these x-rays receive timely interpretation by a radiologist. This x-ray wasn't seen by a radiologist until thirty-six days after it was taken. The radiologist identified healing rib fractures, which are pathognomonic for child abuse. The information came to light too late to help this baby. The child had died nineteen days earlier from chronic non-accidental trauma (child abuse).

Earlier detection of these healing rib fractures might have caused this child to be taken into protective custody and might have spared the child's life.

Clinicians may gain useful information from x-rays that guide them in their clinical management of patients. However, they don't have the same interpretive expertise as radiologists. Also, clinicians often focus on the pathology they're currently managing and do not do a systematic review of an x-ray.

What might be the most effective response strategies of the College in such a situation? Should we simply advise the clinicians that they missed important information on an x-ray and exhort them to do better in the future? Should we recommend that the clinicians take some remedial education in x-ray interpretation? Or, should we work collaboratively with other agencies to ensure that all x-rays transferred with patients in the future receive prompt radiologist interpretation with prompt feedback to the clinicians involved in the care of the patient?

If isolated intervention with the clinicians involved in this case offered an ironclad guarantee that they would never again miss important information on an x-ray, we may have slightly mitigated future risk for a small number of patients. However, nothing would have been done to address continuing risk for hundreds of other patients because of a flawed process of care.

Consider these facts. In the tertiary level hospital identified in this case, there are at any time two hundred to five hundred packages of x-rays that had been transferred with patients to the hospital. No one knows whether these x-rays have or have not been reviewed by a radiologist. There is no system in place to ensure that they will be. There are five tertiary hospitals in this province that receive referrals from smaller centres. At any given time, there may be several hundred patients in this province who had x-rays transferred with them, and the definitive interpretation of those x-rays may be very significantly delayed.

Effective strategies to remedy this systemic flaw may involve a host of variables such as the availability and use of technology, payment methodologies for radiologists, "hand off" communication strategies between referring and receiving physicians, and physician sensitivity to processes of care as a potential safety risk. The College may have some potential to directly modify some of these risk factors, but many of them require action by other agencies.

Our historical focus at the College has largely been on the performance of individual physician members, believing that systemic issues are the responsibility of RHAs and/or Sask. Health. The evolving evidence related to patient safety teaches us that all stakeholders can and must play a role in reducing systemic risk if we are to achieve optimally safe health care.

What are the pragmatic implications of this emerging reality for the College? I suspect we may need to "unlearn" some of the assumptions that have informed our work to date, and learn to use our resources and influence in new ways. We need to pay more attention to processes of health care rather than focusing so narrowly on the performance of individual physicians.

Would such a refocusing of our work mean that we would never bring to the attention of individual physicians situations where they might improve their future performance? Of course not. We do have a statutory duty to ensure that each of our members are practicing safely and striving to continually improve the quality of their performance. However, we need to expand our focus to make a larger impact on systemic risk factors.

For decades we have devoted thousands of hours to meticulous review of the medical care provided to patients who die within ten days of surgery or anesthesia. The endpoint of all of this effort is that we provide written educational feedback to a few physicians each year, and that feedback often comes more than a year after the patient's death.

I think we can and must do better than this. I believe there is much that can be learned from retroactive review of adverse patient outcomes. However, I also believe that optimal safety gains from such reviews will only be derived when the review process is multi-disciplinary and engages all of the players in the system.

I've made at least one important New Year's resolution for 2005. I'm going to challenge and press the College's governing Council this year to critically review some of the work we've historically done to enhance patient safety and quality of patient care. I'm going to challenge the College to "unlearn" some strategies that may be sub-optimally effective and to learn new strategies. It's a time for new beginnings.

The "What & Why" of Public Members on Professional Regulatory Bodies

J. MacKay, Public Council Member

The Council for the College of Physicians and Surgeons of Saskatchewan consists of both medical members elected by fellow doctors, and non-medical members appointed and reimbursed by the Minister of Health. We are, in Saskatchewan, keeping abreast of the trend nationally and internationally as our public members number approximately 40% of the total membership of Council.

All Council members have as their main purpose (we call it our first “End”), the provision of good medical care for the people of Saskatchewan. It is believed that ordinary citizens who do not provide medical care can offer a unique and critical perspective that serves this “End”. From my personal Council experience (this is the beginning of my fifth year on Council), I have seen that we, as public members, add a valuable viewpoint. We read, consider, dialogue at Council meetings, vote, and attend conferences and working groups just like the medical members. We spend many hours on attentive reading and serious consideration, and travel time to attend meetings. Each June, one of the public members attends the Federation of Medical Regulatory Authorities of Canada meeting.

Sometimes, discussions get lively, but I don’t believe there is a sharp difference in voting patterns between the public members and the physician members of Council. After all, we are *all* members of the public, and we *all* need, and will continue to need, medical care throughout our lives. We have agreed upon norms of behavior, and we do act with respect, energy and transparency. The staff assists the Council members, but do not interfere with the Council’s business. Only Council members are voting members. Indeed, the Registrar and Executive Staff are often not even present at the table as a discussion proceeds, and before voting takes place on important decisions. The College staff are available, then and always, to clarify and inform Council members of information to enable us to do the work of the Council.

Among the five public members, we have two lawyers, an administrator, a parole judge, a respected Elder, a parish nurse, Commissioners, and an educator. Some of us are parents, and even grandparents. All of us have been patients. We serve the public in this role. The role as a public member on Council has been both a stimulating and rewarding experience.

On behalf of the all the public members, Mr. E. Van Olst, Mr. M. Fisher, Mrs. B. McKenna, Mrs. I. Fraser, and myself, Mrs. J. MacKay, we would like to encourage you to attend the open portion of the Council meetings. A schedule of meeting dates can be obtained by contacting the College office, or by accessing the College website at: www.quadrant.net/cpss.

Discipline Report

The Council of the College has directed that matters of discipline and competence will now be reported in the College newsletter immediately following the completion of the hearing. This should make reporting more timely than in the past, when such reports were made only on an annual basis.

DR. S. S. GANDHAM

Dr. Gandham held a licence to practice medicine in both British Columbia and Saskatchewan.

In discipline proceedings before the British Columbia College, Dr. Gandham admitted that he had engaged in internet prescribing. He received a fine of $25,000.

Section 54.01 of *The Medical Profession Act, 1981* states that:

“*the council may impose one or more of the penalties set out in Section 54 on a person registered under this Act where, before or after registration under this Act the person is found by an external regulatory body to have done or failed to have done any act or thing and, in the opinion of the council, that act or failure is unbecoming,*

improper, unprofessional or discreditable"

Prescribing to a patient without establishing an appropriate physician-patient relationship is defined as unprofessional conduct in the College's bylaws. Subject to some exceptions, such prescribing is defined as including:

"*any situation in which a physician issues a prescription, via electronic or other means, unless the physician has obtained a history and has performed an appropriate physical evaluation of the patient adequate to establish diagnoses and identify underlying conditions and/or contraindications to the treatment recommended/ provided*."

The Council directed that Dr. Gandham appear before the Council. Following his appearance, the Council directed that he pay a fine of $15,000.

2004 Legal Report

There have been a number of matters with legal implications for the College that have occurred over the past year.

During the past year the College changed its practice in reporting matters of discipline and competence. Disciplinary and competency proceedings will now be reported in the College *Newsletter* immediately following the completion of the hearing. This should make reporting more timely than in the past, when such reports were made only on an annual basis.

This report will deal with court actions involving the College, with changes to *The Medical Profession Act, 1981*, and the College's bylaws.

I. COURT ACTIONS INVOLVING THE COLLEGE

DR. CARLOS HUERTO - *Appeal From The Finding Of Unprofessional Conduct In His Treatment Of Two Patients And In Providing Information To A Third*

In the year 2000, Dr. Huerto was found guilty of unprofessional conduct following a lengthy hearing before the discipline hearing committee. The Court of Queen's Bench heard the appeal from that decision in June, 2004.

The discipline hearing committee concluded that Dr. Huerto had:

a) Failed to strongly advise his 16 year-old patient to discontinue her use of oral contraceptives after she had a transient ischemic attack, submitted an invoice for medications that he had not provided, falsified his clinical notes by adding to them at a time after the notes were created, falsified information in the typed transcript of his handwritten clinical notes, and falsified his patient chart by removing from it a medication record that had been provided to him by the patient's mother;
b) Advised an elderly male patient's family who had died in hospital after being transferred for treatment following treatment by Dr. Huerto that the patient was in stable condition upon admission to Royal University Hospital when he was not;
c) Treated an elderly male patient with milrinone in circumstances that were not within the standards of the medical profession; treated the patient with thrombolytic therapy in circumstances that were not within the standards of the medical profession; failed to provide the patient with the information necessary to make an informed choice whether to incur the costs for his treatment; wrote a prescription for two narcotics for the patient

when it was not intended that the patient receive those drugs and failed to advise the administrator under *The Vehicles Administration Act* of the patient's medical conditions that made it dangerous for him to drive a motor vehicle;

d) Failed to maintain proper medical records with respect to his care of these three patients.

The Council had suspended Dr. Huerto while these charges were pending. Following the findings of the discipline hearing committee, the Council ordered that Dr. Huerto be suspended for 14 months, retroactive to the date that the interim suspension was imposed upon him. He was prohibited from providing inotropic or thrombolytic therapy and was required to pay the costs of the investigation and hearing in the amount of $172,600.

Dr. Huerto appealed from the findings of misconduct, the suspension imposed, the conditions imposed, and the amount of costs that he was required to pay.

The court concluded that the discipline hearing committee had adopted the correct onus of proof to decide if a charge had been proved.

The court reviewed the standard to be used by the court in such appeals. The court concluded that a decision of a discipline hearing committee should be reviewed to determine if it was reasonable. That test determines if the discipline committee's decision is supported by reasons that will stand up to a probing examination.

When a discipline hearing committee hears charges such as those under review in this appeal, the discipline hearing committee must do two things:

a) decide whether the conduct alleged in the charge has been proved to the required standard of proof;
b) decide whether the conduct which was proved was unprofessional.

The court concluded that it would review the discipline hearing committee's decision that certain conduct had occurred to determine if that decision was reasonable. The court concluded that it would also review the discipline hearing committee's conclusion that the proved conduct was unprofessional to determine if that conclusion was reasonable.

The court concluded that the discipline hearing committee had "engaged in a careful and extensive analysis of the evidence, pro and con, presented in relation to each of the allegations".

With respect to all of the discipline hearing committee's findings but one, the court concluded that the evidence supported the committee's findings. The court dismissed the appeal with respect to all of the findings, with one exception.

The court allowed the appeal with respect to the charge that Dr. Huerto had advised the elderly male patient's family that the patient was in stable condition upon admission to Royal University Hospital when he was not. The court concluded that the discipline hearing committee had failed to turn its mind to the question whether this conduct was sufficiently serious to amount to unprofessional conduct.

The court concluded that, as the charge involving this patient had been set aside on appeal, the Council should review the costs imposed on Dr. Huerto. The court directed the Council to reconsider the cost award.

DR. CARLOS HUERTO - *Appeal From The Cost Order*

Following the court decision referred to above, the Council reconsidered the costs that Dr. Huerto was ordered to pay.

Following a hearing, the Council directed that Dr. Huerto pay the sum of $120,000 towards the costs incurred by the College in connection with the investigation and hearing.

Dr. Huerto has appealed to the Court of Queen's Bench from that decision. No date has yet been set for the appeal to be heard.

DR. CARLOS HUERTO - *Appeal From Suspension Ordered By The Executive Committee*

The Executive Committee of the College of Physicians and Surgeons considered two complaints by patients of Dr. Huerto that alleged sexual impropriety by Dr. Huerto. The Executive Committee also considered information that Dr. Huerto may have inappropriately prescribed medications to a third patient.

Following a suspension hearing, Dr. Huerto was suspended from practice. He appealed to the Court of Queen's Bench from that decision.

The court concluded that the standard of review was reasonableness. The court concluded that the reasons provided by the Executive Committee would be reviewed to consider whether the Executive Committee had properly considered what harm or damage might occur to the public and Dr. Huerto's patients by a suspension. The court concluded that the reasons provided by the Executive Committee would also be reviewed to consider whether the Executive Committee had properly considered whether lesser steps than a suspension from practice could be taken to adequately protect the public.

The Executive Committee had concluded that no steps short of total suspension would adequately protect the public. The court decided that this conclusion was unreasonable.

The court concluded that Dr. Huerto's suspension would be set aside provided he entered into an undertaking with the court that:

a) he would not conduct pelvic or breast examinations on any female patient;
b) he would have a specified female third party present during his examination of female patients;
c) he would not prescribe medication for the third patient except with the written concurrence of another physician;
d) he will post in his office and any examination room a copy of the undertaking.

Dr. Huerto provided the undertaking and returned to practice.

DR. CARLOS HUERTO - *Appeal From The Finding Of Unprofessional Conduct In Prescribing Drugs To A Patient Not Intended For Her, And In Having A Sexual Relationship With Her*

In the year 2003, a discipline hearing committee found Dr. Huerto guilty of three charges. These were maintaining a sexual relationship with a patient, prescribing drugs in a patient's name not intended for the patient, and making a false statement in an affidavit to the College.

The Council revoked Dr. Huerto's licence. He was required to pay $52,500 towards the costs incurred by the College in connection with his discipline. The Council made certain recommendations that should be met before he would be granted a licence to practice.

Dr. Huerto appealed to the Court of Queen's Bench against the decision, against the penalty, and against the cost award. He has alleged that the decisions of the discipline hearing committee and the Council were unreasonable. He has also argued that the search done by the College of Physicians and Surgeons was unreasonable and contravened the *Canadian Charter of Rights and Freedoms.*

The appeal was heard in June 2004 but no decision has been given at the date of this report. By court order, Dr. Huerto is allowed to remain in practice pending his appeal.

DR. RONALD YOUNG - *Appeal From Finding Of The Discipline Hearing Committee*

A discipline hearing committee found Dr. Young guilty on a charge that he had made comments directed towards another physician that were threatening, or could reasonably have been interpreted to be threatening.

Dr. Young appealed to the Court of Queen's Bench.

The court concluded that the discipline hearing committee's decision was unreasonable. The court concluded that the discipline hearing committee had not examined whether Dr. Young intended to communicate a threat, or whether a reasonable person would have regarded the statements he made as threatening.

The College of Physicians and Surgeons obtained leave from the Court of Appeal to appeal this decision. The College has taken the position in the appeal that the court adopted an incorrect standard in the appeal, and erred in law. No date has yet been set for the appeal to the Court of Appeal.

DUKE v. PUTS - *Defamation Action*

Dr. Marc Puts was formerly a physician practicing in Broadview, Saskatchewan. He filed a letter of complaint with the College of Physicians and Surgeons in which he alleged wrongdoing by Dr. Jones, who was then a physician practicing in Broadview, and Mr. Harvey Duke, a pharmacist who operated a pharmacy in Broadview.

Mr. Duke successfully sued Dr. Puts for defamation. Dr. Puts was found to have made a number of defamatory statements about Mr. Duke. The only statement that was of concern to the College was the statement made in the letter of complaint to the College.

When Dr. Puts appealed the court decision to the Court of Appeal, the College sought and was granted intervenor status to argue that the statements made to the College of Physicians and Surgeons could not be the subject of an action in defamation. The College's position was that statements made to the College in connection with a complaint are absolutely privileged and cannot be the subject of a defamation action.

Mr. Duke's argument was that the comments made about him in the complaint to the College were not relevant to the complaint against Dr. Jones. Mr. Duke's argument was that Dr. Puts had included irrelevant information about a person who was not a physician in the letter of complaint. Mr. Duke's argument was that this meant that Dr. Puts could be sued for defamation for including irrelevant statements in the complaint.

The court dismissed Dr. Puts' appeal with respect to the issues not involving the College. However, the court supported the College's position with respect to the letter of complaint filed with the College.

The court concluded that the complaint to the College and the statements made to the College's preliminary inquiry committee were the subject of absolute privilege. That is, statements in a complaint that have some connection to a complaint against a physician cannot be used to sue the complainant for defamation. In deciding whether statements are made "with reference to the inquiry" a wide and comprehensive meaning will be adopted.

This was a very important decision for the College, and for professional regulation. It confirms that a complainant cannot be sued in defamation for statements made in a complaint to the College if the statements have some relationship to a complaint against a physician.

II. CHANGES TO *THE MEDICAL PROFESSION ACT, 1981*

The Saskatchewan Legislature amended *The Medical Profession Act, 1981* to:

a) Allow the College to change the electoral boundaries for election of Council members so that the electoral boundaries will correspond with the boundaries of the Regional Health Authorities;
b) Allow the College to pass bylaws to require physicians to meet the requirements of the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of

Canada in their Maintenance of Certification and MAINPRO programs;

c) Clarify that the Council may authorize the deputy registrar to perform the functions of the Registrar if the Registrar is absent or incapacitated;

d) Clarify the ability of the College to grant educational licences to physicians to allow them to participate in an assessment program.

III. CHANGES TO COLLEGE BYLAWS

A number of changes to the College bylaws were made during the past year. These were:

a) To change the basis upon which temporary licences (*locum tenens* permits) are issued by the College. Among the changes is that family physicians who have not received residency training in a family medicine program accredited using standards similar to the standards of the College of Family Physicians of Canada will be required to challenge the CAPE evaluation in Winnipeg as a condition of maintaining a temporary licence;

b) To require physicians who operate chelation clinics to pay the inspection costs for such clinics;

c) To allow physicians who practice on a provisional or special licence to ask for an exemption from the requirement that they obtain the LMCC;

d) To allow the College to register podiatric surgeons.

IV. *THE HEALTH INFORMATION PROTECTION ACT*

The primary purpose of The Health Information Protection Act (HIPA) is to protect the privacy of patient information. The College and the SMA have worked together to prepare a physician toolkit (available on the SMA website) to assist physicians to comply with the legislation.

Working with this legislation, and assisting physicians to comply with the legislation, has required a great deal of College staff's time over the past year.

Physicians should be aware of this legislation and the privacy toolkit, as there are a number of things physicians must do to comply with the legislation. Among the more important provisions for physicians are the following:

a) Physicians should not disclose patient information to others unless with patient consent or unless authorized by the legislation;

b) Physicians must provide patients access to their medical record unless there is a compelling reason to deny access. There is also a requirement that if the patient requests a copy of their file, the physician must generally provide a copy within 30 days;

c) Physicians must advise patients of the expected use of their information and the circumstances in which they may disclose that information. This can be done with posters and/or brochures in the physician's office;

d) Physicians must establish policies and procedures to advise patients of their rights under HIPA and to advise patients of their right to access their information. This can be done with posters and/or brochures in the physician's office;

e) Physicians must establish policies and procedures to protect against loss of patient information and unauthorized access to patient information;

f) Physicians must limit which employees can access patient records or other personal health information. Only employees who need to know patient information for patient care, or who need to know such information for some other purpose authorized by the Act (such as billing) can have access to that information;

g) Physicians cannot use a file storage facility, nor can physicians use an

organization to destroy files, unless there is a written agreement in place that protects the information and governs access to and use, disclosure and destruction of the information;

h) Physicians who use another person or organization to provide information technology services respecting records that contain patient information (this includes MSP information) must have a written agreement in place governing the use, disclosure and destruction of that information.

The Diagnosis of Pervasive Developmental Disorders: A Retrospective Analysis

Deobald, Raymond G, Aizeddin A. Mhanni, Vaneeta K. Grover, Edmond G. Lemire

ABSTRACT

We conducted a retrospective study on pervasive developmental disorders (PDD) patients to evaluate the type of assessments and investigations being performed. A cohort of 103 PDD patients was identified through institutional records. Only 41% of our cohort had a genetic assessment and most did not have any genetic investigations. Despite this, secondary PDD was identified in 11% of patients. Our results support previous recommendations that PDD patients require a genetic assessment and investigations to rule out secondary causes.

Pervasive developmental disorders (PDD) are a group of neurodevelopmental conditions characterised by impairment of social interaction, communication skills and behaviour (1,2). Mental retardation and epilepsy are often associated features (1,3). The preva-lence of PDD is estimated to be at least 27.5/10,000 individuals and there is an observed male sex predilection (4).

PDD can either be primary or secondary. Primary PDD is believed to be multifactorial where genetics has an important but not exclusive role (5). Secondary PDD is present when a causal determinant is identified such as a specific genetic disease (3). Primary PDD remains a diagnosis of exclusion. Debate exists over the prevalence of secondary PDD with various studies reporting ranges of 0-37% and in many instances, there is an association with genetic disorders (2,5,6,7,8).

Previously a medical evaluation of PDD patients including karyotype analysis, fragile X testing and a clinical genetic assessment was recommended (9,10). We conducted a retrospective study to determine the nature of assessments and the type of genetic investigations performed in PDD patients at our centres.

Approval to conduct the study was obtained from the University of Saskatchewan Biomedical Research Ethics Board and the Royal University Hospital Research Services Unity. A search was conducted of the hospital records for patients with a diagnosis of autism/PDD (ICD-9 code 299 and ICD-10 code F84) admitted between April 1, 1993 and March 31, 2004. This search identified 78 records. The Kinsmen Children's Centre (KCC) assesses children with confirmed or suspected PDD through their Communication and Interaction Disorders program. As the number of records from our initial search was small, we randomly selected 25 records obtained from a search of KCC records for 2003. This yielded a total sample size of 103. The RUH and KCC records were statistically similar with respect to sex, age of presentation and family

history (data not shown). Supplementary data was obtained from Medical Genetics and KCC outpatient records when available. Data was tabulated in an Access database and Excel spreadsheets (Microsoft version 1997). Tables and statistics were generated using SPSS (SPSS Inc. release 11.5.0) and SAS (SAS release 8.2). Fisher's exact test, Chi square analysis and the Mann-Whitney U test were used for statistical analysis. A *p* value <0.05 was considered statistically significant. Continuous data is reported as mean +/- SD and categorical data as count (%).

Primary PDD was diagnosed in 91 patients, 11 patients had a diagnosis of secondary PDD and in one patient the diagnosis was pending (Table 1). There was a male to female ratio of 2.7 to 1 for our cohort of 103 patients and this was maintained in the primary PDD group. Data on age of presentation was only present for 89 patients. The mean age of presentation was 19.8 ± 10.2 months in 9 patients with secondary PDD. Most patients presented by age 3 years and all patients had presented by age 5. The mean age of diagnosis was 6.1 years for both primary and secondary forms with the majority of patients in the two groups being diagnosed between ages 3 and 6 years. These demographic parameters were consistent with the published data (4,11).

Family history was recorded in only 51% of cases. Of these, less than 1/3 had a negative family history for behaviour and/or learning problems. In over 25% of cases, there was one or more relatives reported to be affected with PDD. In all the remaining records, there was a positive family history of behaviour and/or learning problems. In over 70% of primary PDD cases, the family history was positive for behaviour and/or learning problems, again consistent with the findings previously published (9).

Patients having genetic assessments were more likely to have genetic testing, but only about 40% of our cohort were referred to Medical Genetics. We found that 72 of 103 (69.9%) PDD patients did not have chromosome studies and almost 90% did not have Fragile X testing. When karyotype analysis was performed, cytogenetic abnormalities (trisomy 21 and fragile site at Xq27.3) were identified in 2 of 31 cases (6.5%). Molecular testing for Fragile X syndrome was normal in all 15 patients screened. Other genetic investigations were only requested when clinically indicated. Two of four patients tested for Rett Syndrome carried identifiable MeCP2 mutations.

PDD in association with a genetic disorder comprised over half of the cases of secondary PDD, the latter accounting for 10.7% of our cohort. This likely under-estimates the proportion of secondary PDD cases, as genetic studies were not routinely performed in our cohort. We support the previous recommendation that all individuals being evaluated for a diagnosis of PDD have a genetic assessment, which should include some basic genetic investigations to exclude secondary forms. The provision of genetic counselling is also important in these families because of the increased family history of behaviour and learning problems.

TABLE 1. DISTRIBUTION OF DIAGNOSIS

Final Diagnosis	PDD Type	Frequency (%)
Asperger Syndrome	Primary PDD	19(18.45)
Autistic Disorder	Primary PDD	68(66.02)
Childhood Disintegrative Disorder	Primary PDD	1(0.97)
PDD-NOS	Primary PDD	3(2.91)
Fragile X Syndrome	Secondary PDD	1(0.97)
Rett Syndrome	Secondary PDD	5(4.85)
Down Syndrome	Secondary PDD	1(0.97)
Perinatal Complications	Secondary PDD	4(3.88)
NYD* (Not yet diagnosed)	NYD	1(0.97)
Total		103(99.99)

References on request. Correspondence to: Dr. E.G. Lemire, Division of Medical Genetics, RUH, 103 Hospital Drive, Saskatoon SK S7N 0W8; Fax (306) 655-1736; e-mail Edmond.lemire@saskatoonhealthregion.ca

Clinical Practice Guidelines for Administration of Rh Immune Globulin (Rh Ig)

The SOGC (Society of Obstetricians & Gynaecologists of Canada) has released Clinical Practice Guidelines for administration of Rh Immune Globulin (Rh Ig). The Transfusion Medicine Quality Assurance Committee of the College of Physicians and Surgeons supports these recommendations as a standard of practice for our province.

A summary of the key recommendations are as follows:

1. All pregnant women (D-negative or D-positive) should be typed and screened for alloantibodies with an indirect antiglobulin test at the first prenatal visit and again at 28 weeks.
2. When paternity is certain, Rh testing of the baby's father may be offered to all Rh-negative pregnant women to eliminate unnecessary blood product administration.
3. A woman with "weak D" (also known as Du-positive) should not receive anti-D.
4. Anti-D Ig 300µg should be given routinely to all Rh-negative nonsensitized women at 28 weeks' gestation when fetal blood type is unknown or known to be Rh-postivie.
5. Anti-D Ig 300µg IM or IV should be given within 72 hours of delivery to a postpartum nonsensitized Rh-negative woman delivering an Rh-positive infant. Additional anti-D may be required for fetomaternal hemorrhage (FMH) greater than 15mL of fetal red blood cells (about 30mL of fetal blood).
6. If anti-D is not given within 72 hours of delivery or other potentially sensitising event, anti-D should be given as soon as the need is recognized, for up to 28 days after delivery or other potentially sensitising event.
7. The SOGC presents a position that is somewhat different from the Canadian Society for Transfusion Medicine (CSTM) and the CSA (Canadian Standards Association) CN Z902. The SOGC states there is poor evidence regarding inclusion or exclusion of routine testing for postpartum fetomaternal hemorrhage (FMH), as the cost-benefit of such testing in Rh mothers at risk has not been determined. However, both the Canadian Society for Transfusion Medicine (CSTM) and CSA CN Z902 state that the Rh-negative women at risk shall be tested to determine the amount of fetomaternal hemorrhage (FMH) in an eligible candidate and an appropriate dose of Rh Ig be given if a fetal bleed is detected.
8. A repeat antepartum dose of Rh immune globulin is generally not required at 40 weeks, provided that the antepartum injection was given no earlier than 28 weeks' gestation.
9. After miscarriage or threatened abortion or induced abortion during the first 12 weeks of gestation, nonsensitized D-negative women should be given a minimum anti-D or 120µg. After 12 weeks' gestation, they should be given 300µg.
10. At abortion, blood type and antibody screen should be done unless results of blood type and antibody screen during the pregnancy are available. In which case antibody screening need not be repeated.

For more information, access the SOGC website at www.sogc.com. Should you have any questions or concerns, contact Ms. G. Hearn, Director, Lab QA at: ghearn@health. gov.sk.ca.

Committee Annual Reports:

Advisory Committee on Medical Imaging

This has been a very busy and challenging year for the Committee. A total of 21 audits were performed, based on the standards and questionnaires developed. The experience and lessons learned have been implemented in an effort to improve the process.

A second round of audits has been created and will begin early in 2005. An ambitious schedule includes 33 per year, with a three year projected timeline.

The Committee has adopted the *Canadian Standards for Echocardiography* and is currently reviewing the requirements for CAR accreditation for mammography.

As the process develops, there will be a need to secure radiologists and specialists who wish to serve as auditors.

The Committee would like to recognize the work of Dr. S. Biem, who resigned after two years of service, and welcome Dr. D. Chizen to the Committee.

The College would like to acknowledge the work of Dr. I. Suchet (Chair), Dr. S. Biem, Ms. C. Craig, Dr. E. Dudzik, Mr. D. Hickey, Dr. J. Hillis, Ms. D. Hladun, Ms. C. Hunt, Dr. G. Stoneham, Mr. W. Tiefenbach, Dr. I. Waddell, Ms. G. Yaroshko.

Respectfully submitted by Dr. L. Loewen (Medical Manager) and Ms. G. Hearn (Director, Lab QA Program).

Anaesthetic and Operative Deaths Study Committee

In 2004, the Committee met four times to review and conclude 344 cases – 1 from 2000, 4 from 2001, 53 from 2002, 243 from 2003, and 40 from 2004. The Committee reviewed 322 new cases, and 22 that were carried over for completion from the previous one-year period. There are 13 cases still under review awaiting further information for finalization. Of the cases completed, 321 were classified non-preventable, 6 non-preventable but with areas of concern, and 8 were classified as potentially preventable. These cases were further classified for contributing factors i.e. error in judgement/technique, inadequate equipment/ facilities, and concerns regarding care provided by non-physician medical, etc.

The Committee provides individual feedback to physicians in cases that generate discussion at the Committee or require the physician to respond with additional information, or are found to be preventable or potentially preventable.

In addition to individual feedback in these situations, the Committee provides additional educational commentary in areas where they think there is benefit to the physician population as a whole. The Committee noted that there continues to be clinical situations where prophylactic Heparin and coagulation therapy is not used, and the Committee would recommend that documentation on the hospital record be considered with the appropriate indications or contraindications noted. Consideration of perioperative beta blocker therapy has also generated some discussion with the Committee. Again the Committee thinks it is reasonable to provide documentation on the chart that this therapy was considered and the appropriate indications or contraindications noted.

An area that generated significant discussion within the Committee was the area of optimization prior to surgery with respect to

adequate preoperative investigation of other comorbidities. The Committee recognizes that there is pressure for these cases to proceed due to the long waiting time. However, the Committee still believes that it is appropriate to consider preoperative investigation of comorbidities if they might impact adversely on the patient's outcome. The Committee is cognizant that this is a judgement call; however, documentation on the chart should provide evidence that the concern was reviewed and appropriate communication with the patient had been undertaken.

The Committee would also emphasize that transfer of care between physicians requires clear communication. Lack of appropriate communication between physicians with respect to accepting transfer of care has resulted in delays in treatment. Once the transfer of care has been accepted, arrangements should be made to review the patient in a timely fashion when they arrive at the facility.

The Committee noted other systemic concerns with respect to problems with timely access to necessary facilities.

The Anaesthetic & Operative Deaths Study Committee does its reviews mainly by review of the written record. When there is a lack of appropriate documentation of history and physical examination or physician progress notes, the physicians involved might be required to provide additional information. The Committee noted that there is still a problem with a lack of appropriate documentation regarding history and physical examination, and physician progress notes on a number of charts. This not only makes it difficult for the Anaesthetic & Operative Deaths Study Committee to do its quality assurance work, but places physicians at risk should they ever be involved in any legal proceedings. Although the Committee recognizes the chronic time pressure physicians face, the few minutes it takes to produce the contemporaneous, concise factual note is much less than the time required to review something at the request of a quality assurance committee and/or legal proceedings.

The Committee would like to extend its appreciation to outgoing members: Dr. J. Javier, Dr. F. Lee, Dr. G.B. Miller and, Dr. L. Taranger, for their effective service as members of the Committee.

The Committee is pleased to welcome Dr. M. Bohn, an internal medicine specialist from Regina, and Dr. Saul Gonor, a urologist from Saskatoon.

On behalf of the College, we would like to acknowledge the current members of the Committee: Dr. G.B. Gilliland, Chair, Dr. M.T. Jurgens, Dr. A. Akhtar, Dr. D.R. Loback, Dr. M. Bohn, Dr. J. Carter, Dr. D.J. Thomson, Dr. W.M. Ezzat, Dr. S. Vuksic, and Dr. S. Gonor.

Respectfully submitted,
Dr. K. Shaw, Medical Manager
and Mrs. K. Bergstrom,
Coordinator.

Complaints Committee

The College of Physicians and Surgeons has a statutory obligation to investigate complaints against physicians. Complaints are accepted when a complainant has a concern about the care or conduct of a physician. If the complaint is amenable to resolution by enhanced communication or by providing information, the College staff resolves these concerns in that manner. If the complaint cannot be resolved by that interaction, the complainant is asked to identify their concerns in writing using the Complaint Reporting and Authorization Forms provided by the College.

In the 2003 calendar year, the College received approximately 1015 expressions of concern, the

majority of which were dealt with by the administrative staff. One hundred twenty-seven formal written complaints were registered in 2003 and reviewed by the Complaints Resolution Advisory Committee at its seven meetings. The 127 complaints in 2003 contained 365 allegations, with the most common allegations being: delayed diagnosis, incorrect or missed diagnosis, insensitive care, and communication error/lack of communication. Of these 365 allegations, the committee determined 107 to be founded, 175 unfounded, 50 partially founded, and 9 were determined to be the patient's responsibility. Another 19 were categorized as no determination, and included such allegations as rudeness, inappropriate comments and roughness.

The purpose of the committee's review of complaints is to provide educational suggestions to physicians in cases where their care or conduct could be improved. The Committee also attempts to provide the complainants with a better understanding of the care they received.

The College has surveyed the complainants and respondent physicians of the complaint cases closed by the Committee during the years 2002 and 2003. One hundred nineteen questionnaires were sent to the complainants for 2002, with 44 completed questionnaires returned. During the same period, 160 questionnaires were sent to physicians, with 89 returned. In 2003, 126 questionnaires were mailed to complainants, with 47 returned; 164 were sent to physicians, with 78 returned. As a result of the responses received, changes have been made to the College's communications with both patients and physicians. Feedback from individual physicians regarding the initial letter advising them of a complaint was considered "too legalistic" or "cold". The initial letter to physicians now begins with the following explanation:

"The College of Physicians and Surgeons has a legal obligation to review complaints lodged against physicians. In the course of a physician's career, there will be times when it is necessary to respond to complaints that have been lodged against them. Often complaints are registered when the patient or patient's family do not have a full understanding of the care provided. Sometimes the problem was not what happened, but what was perceived by the patient or their family to have happened."

Acknowledging the complainant's concerns and providing a factual, dispassionate explanation of the care provided often brings resolution to the complaint.

The review of these types of complaints is educational, both to the physician and the complainant. The complaints process is confidential. At the present time, complaints through the Complaints Resolution Advisory Committee process do not form part of the physician's personal record and are not reported on a Certificate of Good Standing.

It is hoped that the complaints process will be viewed by physicians as an educational exercise, and assist them in understanding that it is often the patient's perception of the interaction that leads to a complaint rather than any care issue. Thoughtful reflection by physicians often results in changes in their practice or communication style, and often results in avoiding similar complaints in the future.

Feedback in the complaints process is confidential and is provided to the complainant (when legally appropriate) and the physician(s). The Committee, however, does raise systemic issues to the attention of the appropriate parties when identified within the complaints process as a part of the overall continuous quality improvement strategy. The Committee also provides

educational information via the College's *Newsletter* under the column "Quality Assurance Commentary" on issues that may affect the broader physician population.

The appended table outlines the allegation codes and determinations for those cases registered in 2003.

The Complaints Resolution Advisory Committee is fortunate to have a membership that is both dedicated and constant. On behalf of the College, we would like to thank the members of the Committee: Dr. J. Kriegler (Chair), Dr. L. Baker, Dr. M. Harington, Ms. V. LaCroix, Mrs. A. Brayshaw and Mrs. S. Lougheed.

Respectfully submitted, Dr. K. Shaw, Medical Manager, and Mrs. C. Dunlop, Coordinator, Ms. J. Wolan, Patient Advocate/Intake Officer.

Allegations and Determinations - 2003

Anaesthetic Misadventure - 1 unfounded
Communication Error/Lack of - 21 alleged: 12 founded, 2 unfounded, 6 partially founded, 1 withdrawn
Complication of Investigation - 1 founded
Complication of Treatment - 1 partially founded
Contraindicated Medication - 2 unfounded
Delayed Diagnosis - 25 alleged: 13 founded, 6 unfounded, 3 partially founded, 1 patient responsibility, 2 withdrawn
Delayed Reporting - 4 alleged: 2 founded, 2 unfounded
Delayed Treatment - 9 alleged: 1 founded, 5 unfounded, 3 partially founded
Excessive Charge - 1 founded
Failed Procedure - 1 unfounded
Failed to Refer - 12 alleged: 5 founded, 7 unfounded
Failure to Attend - 6 alleged: 2 unfounded, 2 partially founded, 1 no determination, 1patient responsibility
Failure to Treat - 9 alleged: 7 unfounded, 1 partially founded, 1 patient responsibility
Fragmented Care - 10 alleged: 7 founded, 3 patient responsibility
Inaccurate Reporting - 8 alleged: 1 founded, 6 unfounded, 1 no determination
Inadequate Communication - 21 alleged: 12 founded, 7 partially founded, 1 patient responsibility
Inadequate Examination - 14 alleged: 4 founded, 8 unfounded, 1 partially founded, 1 no determination
Inadequate Follow Up - 9 alleged: 5 founded, 3 unfounded, 1 partially founded
Inadequate History - 6 alleged: 3 founded, 2 unfounded, 1 partially founded
Inadequate Investigation - 18 alleged: 4 founded, 14 unfounded
Inadequate Records - 11 alleged: 4 founded, 1 unfounded, 5 partially founded
Inadequate Treatment - 17 alleged: 2 founded, 13 unfounded, 2 partially founded
Inappropriate Comments - 6 alleged: 2 unfounded, 2 partially founded, 2 no determination
Inappropriate Communications - 1 no determination
Inappropriate Examination - 1 unfounded
Inappropriate Heroic Treatment - 1 unfounded
Inappropriate Medication - 16 alleged: 1 founded, 12 unfounded, 2 partially founded, 1patient responsibility
Inappropriate Referral - 1 partially founded

continued next page...

Inappropriate Tests - 1 unfounded
Inappropriate Treatment - 6 alleged: 1 founded, 3 unfounded, 2 partially founded
Incorrect/Missed Diagnosis - 24 alleged: 9 founded, 14 unfounded, 1 partially founded
Insensitive Care - 22 alleged: 7 founded, 13 unfounded, 1 partially founded, 1 no determination
Lack of Informed Consent - 5 alleged: 1 unfounded, 4 partially founded
Medical Mismanagement - 16 alleged: 3 founded, 10 unfounded, 2 partially founded, 1 patient responsibility
Overmedicating - 9 alleged: 1 founded, 7 unfounded, 1 partially founded
Record Transfer Delay - 2 alleged: 1 unfounded, 1 partially founded
Refused Treatment - 6 alleged: 5 unfounded, 1 no determination
Roughness - 3 alleged: 2 founded, 1 no determination
Rudeness - 15 alleged: 3 founded, 2 unfounded, 10 no determination
Surgical Misadventure - 3 alleged: 2 founded, 1 unfounded
Surgical Mismanagement - 1 unfounded
Undermedicating - 8 alleged: 1 founded, 7 unfounded
Unethical Conduct - 11 unfounded

ECG Committee

The College administers the ECG examination for family practitioners and foreign medical specialists. In order to bill for the interpretation of ECGs, a physician must receive a minimum passing mark of 75% in the open-book examination. Canadian-certified specialists in Internal Medicine, Cardiology, Cardiovascular Surgery and Pediatrics are qualified to interpret ECGs by means of their specialty.

During 2004, 14 physicians wrote the ECG exam, one of whom was a foreign-trained specialist. Eight passed the exam (57%) and 6 failed (43%). Four were rewrites (with 3 passing and 1 failing). One Ontario physician and three Manitoba physicians wrote and passed the exam. The Saskatchewan ECG exam is recognized in Manitoba.

In order to maintain competency in interpreting ECGs, the ECG Committee had set a standard that physicians must interpret 40 ECGs in three years, and 60 in five years. Letters were sent to all physicians who had previously passed the College's ECG examination. It was suggested to those physicians who had not billed the required number of readings that they maintain a record of the numbers of ECGs interpreted.

A number of physicians contacted the College to have their names removed from the list of those eligible to read ECGs. Other physicians advised that they interpret ECGs but do not bill Sask Health. These physicians include Emergency Room Physicians and Cardiac Care Associates in salaried positions, and physicians who direct bill for their services.

The Council of the College discussed ECG interpretation competency at a meeting following the dissemination of information to the physicians, as the Council received an expression of concern from a College member that the quota was not sufficient to maintain competency. Mandatory repeat skill testing was considered.

After consultation between the ECG Committee members and the Registrar, the Council of the College at its meeting of September 18, 2004, approved a policy on Revalidation of ECG Interpretation Skills. The policy states:

That to maintain eligibility to interpret ECGs and receive payment for that service,

members of the College of Physicians and Surgeons of Saskatchewan who lack certification from the Royal College of Physicians and Surgeons of Canada in cardiology, internal medicine, or paediatrics shall either:

1. *Maintain a minimum ECG interpretation volume of 100 per year or 500 in five years,*

and

2. *Provide evidence of participation in a College approved ECG or advanced ECG course within the same five-year cycle,*

or

Undergo and achieve a pass standing on a test of ECG interpretation skills developed and administered by the College of Physicians and Surgeons of Saskatchewan.

The College would like to thank the members of the Committee: Dr. R. Chernoff, (Chair), Dr. R. Balakrishna, Dr. P. Schwann, and Dr. A. Unger.

Health Care Facilities Credentialling Committee

In the last year, the Health Care Facilities Credentialling Committee met twice. It reviewed applications for hospital and health care facility privileges from 19 physicians who have commenced practice in areas of the province served by facilities with less than 100 beds. In addition, requests for specific privileges made by 7 physicians have been reviewed at their request. In each case, recommendations have been made to the appropriate RHA.

The Committee underwent three significant changes in its credentialling advisory service this year. The following changes were implemented on August 1, 2004.

1. The service is now limited to applications for anaesthesia privileges and procedural privileges beyond category one.
2. Advice is offered to a regional health authority (RHA) once a physician application has been vetted by the senior medical executive of that RHA to determine if the privileges requested are consistent with the RHA's service delivery plans, local technology and human resource supports, and the Chief of Staff has signed a form confirming these stipulations.
3. The service is offered on a cost recovery basis of $400 per application.

An educational package of appropriate guidelines to assist RHAs in providing their own credentialling services was developed by the Committeee. A package was distributed to all the Chief Executive Officers and their Chiefs of Staff with the intention of achieving a provincial standard. The College staff continues to be available for assistance, advice, and information.

Responses to a letter the Committee sent out to the RHAs in October, which inquired about any problems or concerns that were encountered, indicated that the health regions were managing level one privileging.

The refresher/orientation course that Dr. Gary Morris, the specialist anaesthetist on the Committee, helped put in place last year has proved successful. It provides an assessment of how comfortable the physician is at providing anaesthesia, what their knowledge base is, and how they interact with the patients. It also gives the physician an introduction to what practice is like in Saskatchewan, as well as an opportunity to learn how the system works, and to meet people in the centres they will be referring to. Dr. Morris is evaluating options to improve the assessment process for the international medical graduates.

As part of the Committee's focus on continuous enhancement of health service quality, it is striving to develop a surgical

skills enhancement program. Many international medical graduates arrive with surgical experience that cannot be utilized without appropriate assessment which is not available in Saskatchewan.

Guidelines and protocols pertaining to the Health Care Facilities Credentialling Committee for improved practice continue to be an important part of the Committee's focus. The Committee reviewed and updated the Thrombolytic Therapy Protocol to include Tenecteplase and Enoxaparin, as adjunctive antithrombin therapy for ST-Elevation Myocardial Infarction. The Guidelines for Infection Control in the Physician's Office were also updated.

The College would like to recognize the members of the Health Care Facilities Credentialling Committee: Dr. P.T.R. Saunders (Chair), Dr. R. Cardoso, Ms. I. Denis, Dr. G. Morris, Dr. A. Nel, Dr. F. Oleniuk, Dr. I. Pillay, and Dr. M.D.G. Thomasse.

Laboratory Quality Assurance Program

Two thousand and four was both a challenging and rewarding year. Laboratories are clearly on track to adopt a Quality Management System which will allow them to have a process in place to identify errors and to systematically eliminate sources of error and near misses.

The scope and mandate of the program includes:

- Monitoring external quality assessment (EQA or EPT)
- Enhancing educational support through seminars, forums, and guidelines
- Promoting standardization of laboratory practices

Our database has dramatically changed over the years:

POLs (category 1, 2, 3)	211
Basic (category 4-6)	138
Speciality (category 7-8)	2
Miscellaneous (collection sites)	15
TOTAL	366

Healthcare continues to be faced with the challenge of a lack of human and financial resources, and laboratories are no exception. This, coupled with a more demanding public, creates a greater expectation for a higher level of services.

Laboratories are becoming more standardized with RHAs, and this has created an opportunity to provide more efficient and effective services for the public. The smaller laboratories are the benefactors, gaining experience from the regional centers.

Accreditation continues to be a major focus, and we are entering into our third round of audits. In general terms, laboratories in Saskatchewan achieve a very high standard of performance – an indicator that the Laboratory Quality Assurance Program provides value, and is functioning well. The benefits of accreditation are apparent, and the program continues to strive for excellence in 2005.

The College would like to recognize the work of the various committee members. They are as follows:

Program Management Committee: Dr. B. Murrary (Chair), Dr. E.C. Alport, Ms. S. Clarke, Dr. R. Deveraj, Dr. R. Seno, Dr. G. Horsman, Dr. E. Jones, Dr. L. Massey, Mr. B. Young, and Ms. B. Neumeier.

Biochemistry QA Committee: Dr. L. Massey (Chair), Mr. E. Serediak, Ms. E. Trask, and Ms. M. Currie.

Hematology QA Committee: Dr. R. Deveraj (Chair), Ms. B. Flowers, Dr. A. Saxena, Ms. C. Bear, and Ms. N. McPeek.

Anatomy/Pathology QA Committee: Dr. E. Jones (Chair), Ms. S. Fromback, Dr. K. Pauw, Ms. S. Pierce, and Ms. S. Nardin.

Microbiology QA Committee: Dr. G. Horsman (Chair), Dr.

E. Thomas, Ms. B. Borgford, Dr. M. Kanchana, Ms. P. Southgate, Ms. D. Aschim, and Dr. P. Leavitt.

Transfusion Medicine QA Committee: Dr. I. Etches (Chair), Ms. L. Purcell, Ms. J. Hoff, Ms. S. Shimla, Mr. I. Peterson, Ms. L. Baryluk, Dr. R. Seno and Dr. E.C. Alport.

Clinical Input Committee: Dr. B. Huber (Chair) and Dr. M. Davidson.

Lab Licensing: Mr. B. Havervold (Manager).

Respectfully submitted, Ms. G. Hearn, Director, Lab QA

Perinatal and Maternal Mortality Study Committee

The total number of births in Saskatchewan for the period April 2003 to March 2004 was 12,198. The Committee met twice in 2004 and reviewed a total of 70 new cases and 13 cases carried over from 2003. Of the 83 cases reviewed, five were classified as preventable, two as ideally preventable, and four cases were carried over awaiting further information to be finalized in 2005.

Individual feedback is provided to the individual physicians involved in these cases. Although the number of cases reviewed that are classified as preventable and ideally preventable is small, the Committee seizes the opportunity to disseminate information more broadly regarding areas of concern that benefit the physician community as a whole. Dissemination of this educational information is done through the College's *Newsletter*. In this year's review, there were several areas that the Committee thought worthy of broader educational commentary.

Appropriate assessment of maternal and fetal well-being appears to be one of these areas that would benefit from further education. The Committee will draft recommendations with respect to what constitutes appropriate monitoring for the assessment of maternal and fetal well being.

The Committee will also provide an educational article regarding what constitutes appropriate surveillance of intrauterine growth restriction. The Committee has partnered with the Advisory Committee on Medical Imaging to set provincial standards for the use of Doppler in the management of fetal growth restriction.

Assessment of gestational age is another special area of concern that is particularly important when the fetus is near the age of viability. Attending physicians must take into consideration gestational age when determining whether intervention is appropriate and what that intervention might be. However, one must be cognizant that if the pregnancy continues and reaches the stage of viability, that there must be a reassessment of the management plan. For example, a pregnancy that is complicated but the fetus is not at the age of viability may well be managed at the local institution, as the tertiary institution would not offer any further advantage at that stage. However, if the pregnancy continues and the fetus becomes viable then there must be reassessment of the management plan including consideration of transfer to a facility that would offer additional support now that the fetus is at the stage of viability. The Committee is drafting an article regarding viability and assessment of gestational age, which will be published in the College *Newsletter*.

The Committee continues to review cases where there is a lack of patient compliance in a variety of areas such as following general medical advice, failure to attend prenatal visits or failure to follow through with appropriate investigations. This, of course, jeopardizes the health of both the mother and the fetus. The Committee recognizes this is

not a problem physicians can resolve themselves; however, the Committee encourages physicians to continue to support their patients in order to encourage compliance, and also to support any initiatives, local or regional, that are attempting to address these problems.

The Committee also notes that morbid obesity in a patient is a risk factor for complications during delivery. The Perinatal and Maternal Mortality Study Committee and the Anaesthetic & Operative Deaths Study Committee jointly drafted an article published in the College *Newsletter* regarding the need for prepartum obstetrical anaesthesia consultation for pregnant women that weigh more than 92 kilograms. (Fall 2004)

Frequently, documentation is poor or absent regarding the assessment of a patient who arrives to the labour and delivery floor. The Committee developed a labour sheet that was meant to be a fast and uniform record of the most pertinent information necessary to plan and provide appropriate care. It captures the primary assessment of the patient since the last prenatal visit and indicates the rationale for the intended management. It was sent to all hospitals that do obstetrics with the recommendation that either this form be used, or that the hospital have some other form that is regularly used that incorporates this information.

The Perinatal/Infant Health Scientific Advisory Committee, funded by Saskatchewan Health and coordinated by the Saskatchewan Prevention Institute in partnership with the College of Physicians and Surgeons and the Children's Advocate Office, facilitated a child death review forum held March 9, 2004 in Saskatoon. The Committee's coordinator, medical manager, and chair took part in that forum. Dr. George Carson (Chair) presented an outline of the work of the Perinatal and Maternal Mortality Study Committee. Dr. Carson and Dr. Shaw have had an opportunity to influence the ongoing work with respect to a potential model for child death review by their participation on the working group of the Perinatal/Infant Health Scientific Advisory Committee. The Committee previously decided to expand its mandate to include review of all perinatal deaths to the end of the perinatal period (28 days). This will go ahead when the appropriate bylaw changes have been made.

On behalf of the College of Physicians and Surgeons of Saskatchewan, we would like to extend our sincere thanks to the members of this Committee: Dr. G.D. Carson (Chair), Dr. J. Hey, Dr. C.E. Clark, Dr. M.J. Martel, Dr. K.C. Fong, Dr. N. Wonko, Dr. M.A. Halyk and Ms. S. Staseson, for their hard work and continued support in the endeavour of quality assurance.

Respectfully submitted, Dr. K. Shaw, Medical Manager and Mrs. K. Bergstrom, Coordinator.

Practice Enhancement Program

The Practice Enhancement Program continues the assessment of the practices of randomly selected doctors with the goal of providing further improvement to the already high quality of care that is generally provided. These assessments continue for family doctors and now include an increasing number and range of specialists. The specialties that are being assessed include psychiatry, ophthalmology, and nephrology.

Dermatology is finished. Assessors have been selected and are currently being prepared to start assessments in surgery, pediatrics, and obstetrics and gynecology.

FINAL REPORTS COMPLETED: JANUARY - NOVEMBER 2004

	TYPE OF ASSESSMENT					CLASSIFICATION				
	G.P.	G.P Revisit	Specialty	Specialty Revisit		Cat. 1	Cat. 2	Cat. 3	Non-Legible	***2004 TOTAL***
Completed/ Classified	42	9	9	0		47	10	1	2	60
Completed/ Not classified	12	2	6	0						20
	54	11	15	0						80

Specialty assessments (2004): 6 Ophthalmology; 8 Psychiatry and 1 Nephrology
Assessments completed to date: 720

Description of PEP Assessment Categories:
1. Consistent good care, no concerns re; patient care or records.
2. Necessitates planned follow-up.
3. Referral to College of Physicians & Surgeons.

Follow-Up Action Per Category:
1. Full accreditation; no review for five years.
2. Necessitates planned follow-up.
3. Referral to College of Physicians & Surgeons.

All statistics available in more detail on the PEP website: www.lights.com/pep/Statistics.html

Regarding program effectiveness, most physicians who have had a Practice Enhancement Program Assessment have said in the follow-up questionnaire that they have found the process to be satisfactory, and the enhancements suggested for their practice to be useful. Of the small portion of physicians with significant practice deficiencies that warranted a Category 2 Assignment (meaning that there are identified significant deficiencies and that Program Assessors will be back to be sure that progress has been made) almost all have, in fact, achieved enhancement in their practice and moved to Category 1.

What is really impressive and should be known and appreciated by the public of Saskatchewan is the generally very high quality of care that is provided for the citizens of Saskatchewan. This high quality is confirmed by the findings of the Practice Enhancement Program.

ASSESSOR'S CONFERENCE 2004

The fifth annual PEP Assessor's Conference was held at the Radisson Hotel in Saskatoon on November 13 & 14. Educational sessions and topics for discussion at the conference included the following:

Dr. C. Campbell, Director of Professional Learning, RCPSC, was the guest speaker. He spoke on the topic of personal learning projects and how knowing about the attributes of the successful physician can be integrated into an assessment and enhancement program.

Ms. J. Peat gave an update of PEP activities in 2004. Dr. P. Davis presented the results of the Inter-assessor Variability research study conducted over the last two years. Dr. D. Greve offered suggestions to assessors for ensuring randomization

of chart selection during assessments. Dr. A. Endsin led a discussion on assessing walk-in clinics. Dr. G. Carson and Dr. B. Laursen performed a role-play session on physician-patient communication.

Mr. B. Salte presented information on the HIPA privacy legislation and introduced the new Privacy Toolkit developed by the CPSS and the SMA. He also offered possible tools for assessing privacy in physicians' offices. Ms. C. Klassen presented on meeting the privacy challenge while providing quality care from a tertiary region's perspective.

As always, a session was dedicated to updating assessor knowledge, application of assessment tools and processes and to discussing concerns and suggestions from PEP assessors.

CATEGORY 3 ASSESSMENTS

The Practice Enhancement Program recently had the occasion to find and inform the College of Physicians and Surgeons of a second physician (out of greater than 700 who have now been assessed) to whom a Category 3 classification was assigned.

Reporting of the identity of the physician to whom a Category 3 has been assigned as a result of a PEP Assessment is required under the bylaws that govern the Practice Enhancement Program. There has previously been some difference of opinion with the College of Physicians and Surgeons as to the nature and extent of further information that should be provided in these circumstances. Legal advice has been obtained for the Program from Mr. Reynold Robertson and this will be used when required in the future.

MEDICAL RECORD KEEPING EDUCATION

The Practice Enhancement Program in conjunction with Continuing Professional Learning held the first Saskatchewan Medical Record Keeping Course in Saskatoon in April of 2004. The purpose of the course was to offer local education to physicians for maintaining good medical records. Emphasis was on charting patient care and management and the importance of good records in providing good quality of care. The course outline included reasons to keep good medical records, problems encountered by PEP in chart assessments, record keeping 'Dos & Don'ts', medical-legal issues, types of medical records (paper/electronic) as well as information regarding the HIPA (Health Information Protection Act) privacy legislation.

Feedback from the Saskatoon MRK Course was very positive and a second similar course will be held in Regina on February 25, 2005. Visit the CPL website at http://www.usask.ca/cme/ or call 306.766.4016 for more information.

PRIVACY AND CONFIDENTIALITY

Patient awareness and new legislation (HIPA) will create additional expectations about the process and policies within physicians' practices to maintain the privacy and confidentiality of patient information and to have appropriate security in place. The Practice Enhancement Program will be amending its office facilities and policies checklist to reflect these increased expectations and requirements. We hope this will help assist physicians in Saskatchewan in meeting their obligations with respect to this issue.

THE CARE AT CERTAIN WALK-IN CLINICS

The Practice Enhancement Program has found some walk-in clinics and some extended hour family practices that are providing exemplary care. This makes it of even greater concern when deficiencies are found in some other practices. Such deficiencies include both the failure to regularly inform a patient's usual physician (unless the patient does not want this done) of the patient's attendance at a walk-in clinic and a failure to

distinguish between those patients who are receiving continuing as opposed to episodic care at a walk-in clinic. Some patients get all of their care at a walk-in clinic and patients may reasonably expect that this includes comprehensive healthcare. The expectations of the patients and physicians may not correspond. Some essential components of comprehensive healthcare may be omitted in these circumstances.

When these issues have been raised with physicians whose practices have been assessed, a not infrequent response from some practice locations has been that the individual physician just works there and has no control over the policies and practices of the clinic. Assessments done at a later time for other physicians working in the same location have often found that the previously identified deficiencies still exist.

The Practice Enhancement Program met with its three sponsoring bodies in December 2004 to address the issue of how to effectively encourage movement towards optimal practice in walk-in clinics and extended hour family practices that are not already providing such high quality care. The meeting resulted in the following conclusions:

- Physicians involved in walk-in clinics should be contacted and informed on the outcome of this meeting
- PEP's sponsoring agencies are in agreement that it is appropriate for the PEP Committee to discuss issues of a systemic nature with physicians who operate walk-in clinics to assist them to enhance the operation of those clinics
- Work should proceed on bylaws changes to allow referral to the CPSS in situations where physician managers do not make recommended changes
- Establish a system to deal with persons/ organizations who are not physicians but who may direct aspects of the care provided in walk-in clinics

CONCLUSION

We sincerely thank our assessors for their continuing contributions to the improvement of the quality of medical practice in Saskatchewan. Thank you to the Saskatchewan Medical Association, the College of Physicians and Surgeons, and Saskatchewan Health for their continued advice and financial support.

Respectfully submitted,
Dr. B. Laursen, Dr. P. Davis Co-Chair, Dr. A. Endsin, Dr. G.Carson, Co-Chair, Dr. D. Greve, Dr. S. Kukha-Mohamad, and Ms. J. Peat, Coordinator.

Triplicate Prescription Program

The Triplicate Prescription Program is jointly funded by the Government of Saskatchewan, the College of Physicians and Surgeons, the College of Pharmacists, and the College of Dental Surgeons. The program continues to serve three important functions:

1. Proactive alerts to physicians where patients are noted to be accessing narcotic and controlled drugs from multiple prescribers;
2. A resource to physicians who wish to access patient profiles in respect to patients they are professionally attending; and
3. Monitoring of physician prescribing practices and intervention where prescribing practices are worrisome and/or inappropriate.

In 2004:

- 2,709 alert letters were sent to physicians to advise them of multi doctoring activity involving narcotic and controlled drugs;
- 823 patient profiles were released to physicians in

response to physician requests for information;

- 50 letters were sent to physicians asking them to explain the rationale for their prescribing patterns; and
- 43 letters of advice and guidance were sent to physicians recommending modification of their prescribing practices.

No physicians were subjected to formal discipline activity related to inappropriate prescribing of narcotic or controlled drugs in 2004.

One physician was required to undertake remedial education focused on appropriate prescribing as an alternative to the possibility of formal discipline. This physician complied fully with the remedial education program organized by the Director of Continuing Professional Development at the College of Medicine, University of Saskatchewan.

Planning continues under the leadership of Saskatchewan Health to implement future physician access in real time to drug utilization profiles of patients under the care of those physicians. The date for implementation of such real time access remains uncertain, but updates will be provided through the College *Newsletter*.

Committee Service

The Anaesthetic and Operative Deaths Study Committee of the College of Physicians and Surgeons is recruiting for a GP Anaesthetist and a General Surgeon (preferably rural) to fill current vacancies on the Committee. Any interested parties may contact Dr. Karen Shaw, Medical Manager, A & O Committee, at (306) 667-4637 or by e-mail to shawk@shin.sk.ca, or the Program Coordinator, Mrs. K. Bergstrom at (306) 667-4623.

Membership Statistics

	Active Licensure	Inactive Licensure
Total Registered as at December 31, 2003	1670	221
Newly registered from Saskatchewan	23	0
Newly registered from other provinces	13	0
Newly registered from other countries	81	0
Reactivated to Full from Inactive	3	-5
Reactivated to Full or Inactive from Absence	4	0
Moved to Inactive In-Province Licensure	-8	8
Moved to Inactive Out-of-Province Licensure	-17	17
Licenses Expired/Invalid	-5	0
License lapsed at Request or Non-payment	-72	-36
Deceased	-5	0
Retired	-3	0
Moved from Active/Inactive to Temporary Locum	-2	0
Total Registered as at December 31, 2004	1682	205

Upcoming Conferences/Events

College of Medicine, University of Saskatchewan
Division of Continuing Professional Learning

Medical Record Keeping Course
February 25th, 2005
Pasqua Hospital Auditorium
Regina, SK

The program has been designed for family physicians and specialists. Course is limited to 40 and has been awarded 6.65 MAINPRO-M1 credits and is an Accredited Group Learning Activity as defined by the RCPSC Maintenance of Certification Program.

Faculty of Medicine – Continuing Medical Education
University of Calgary

INFLUENCING PROVIDER BEHAVIOR IN THE MEDICATION USE PROCESS
February 10th - 12th, 2005
Calgary, AB

This conference will be of interest to administrators, frontline staff, practitioners (physicians and pharmacists) and researchers within drug use management programs, RHAs, quality improvement organization, professional organizations, government & universities.

For further information contact: Janis Pearson at (403) 220-7032 - pearson@ucalgary.ca

2005 ACMC/CAME/CFPC/MCC/RCPSC
April 29th- May 4th, 2005 – Saskatoon Convention Centre

A joint meeting dedicated to common medical education issues. The theme for this meeting will be *Learning from Each Other.*

For information, contact Sue Maskill at smaskill@acmc.ca

Health Professional Seminar Series – Spring 2005
Breastfeeding When Extra Care is Needed – Kay Hoover, M Ed, IBCLC
April 25th, 2005 – Travelodge South, Regina SK

CERP Credits: 6.9
Registration forms available online at www.LLLC.ca or contact:
Susan Smith at: (306) 586-8735 or sksmith@sasktel.net

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College of Physicians & Surgeons
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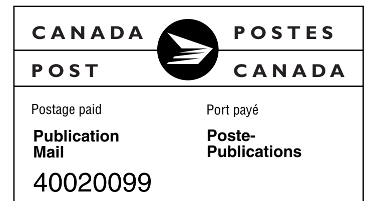
Newsletter



PREVENTION
PROGRAM
FOR CERVICAL
CANCER
A PROGRAM OF THE SASKATCHEWAN CANCER AGENCY

UPDATE

SASKATCHEWAN CANCER AGENCY

Progress to Date…

The Prevention Program for Cervical Cancer (PPCC) has been in active operation since August 2003. The PPCC is a population-based health initiative with the goal to prevent the incidence of, and mortality from, invasive cervical cancer. The main responsibilities of the PPCC are to notify women when overdue for Pap testing, provide women with their Pap test results and track follow-up of abnormal and unsatisfactory Pap test results.

Since August 2003:

- **Provincial cytology database** developed, including histology and colposcopy data.
- **Result letters** sent to women for normal, abnormal and unsatisfactory Pap test results. Result letters are mailed two weeks after health care providers are notified by the labs of the patient's result.
- Letters sent to **18 year olds** providing information about Pap testing, cervical cancer and risk factors.
- **Overdue notifications** sent to women without a Pap test history consistent with recommended clinical practice guidelines.
- **Provincial cytology requisition** developed jointly with Saskatoon and Regina cytology labs.
- **Provincial colposcopy form** developed in consultation with colposcopists.
- **Abnormal or unsatisfactory results,** without an indication of follow-up, tracked through health care providers.

Information Management Service Provider Role

Effective June, 2004, the Saskatchewan Cancer Agency (SCA) entered into an agreement with the Saskatoon Health Region (SHR) and the Regina Qu'Appelle Health Region (RQHR) to become an Information Management Service Provider (IMSP) for a common cytology database for Saskatchewan.

The common cytology database, via the PPCC database, replaced the Ontario-based private lab system previously used.

A common cytology database allows health care providers access to relevant data required for clinical assessment purposes.

Role as IMSP:

- Develop and maintain a web-based software application providing shared access by SHR and RQHR to the PPCC database.
- Warehouse historical cervical and non-cervical cytology and histology data.
- Receive and maintain current data elements for the SHR and RQHR on a daily basis.
- Provide data service of electronically non-transferable cytology and histology information and manual data fixes.
- Maintain technical functionality and ensure a secure environment for information transmission and storage.

Role as PPCC:

- Information required for the purposes of the PPCC include cervical cytology, histology, colposcopy and cancers.
- Information is used for purposes of tracking participation in Pap testing, tracking follow-up of abnormal and unsatisfactory results and for quality assurance initiatives.

Because of the IMSP role, all cytology information must be stored on the provincial database. Women may choose to decline receiving letters from the PPCC however, data will not be deleted from the system.

Common Data Errors

- Inaccurate Health Service Numbers (HSNs) on cytology requisitions
- Inaccurate Dates of Birth and/or names.
- Specimen type not identified on requisition or, inaccurate specimen type identified.
- Specimen collection date not indicated.
- Hysterectomy data incomplete.

Follow-Up Screening Guidelines

To support health care providers, the PPCC tracks patient compliance with recommended follow-up of abnormal and unsatisfactory results. If follow-up cytology/ histology information is not received at the PPCC office within the recommended time for follow-up, health care providers' offices will receive a letter from the PPCC asking for the follow-up information.

Recommendations for physician management of Pap test results can be found in Health Canada's Programmatic Guidelines for Screening for Cancer of the Cervix at:

www.phac-aspc.gc.ca/ccdpc-cpcmc/cc-ccu/pdf/screening.pdf

Abnormal Low Grade (LSIL and ASCUS)

- Repeat Pap test after 3 months, but within 6 months.
  - Repeating Pap tests before 3 months increases the risk of inaccurate results.
  - Persistent abnormalities warrant referral to colposcopy.

Abnormal High Grade (ASCH, HSIL and AGUS)

- Colposcopy should be done within 6 weeks of the abnormal Pap test.

Unsatisfactory (smear is not sufficient for analysis)

- Should be followed with a repeat Pap test after 3 months, but within 6 months
  - Repeating Pap tests before 3 months increases the risk of inaccurate results.

Patients with cytology classified by labs as:

⇨ ***"Normal"* and *"Satisfactory but limited by lack of endocervical or metaplastic cells"*, *or***

⇨ ***"Normal"* and *"Satisfactory but limited by obscuring inflammation"***

should have a repeat Pap test in one year.

Program Misconceptions

Through discussions and/or correspondence with health care providers, the following program rules require emphasizing.

- Women under the age of 18 **do not** receive result letters.
- Health care providers receive results approximately two weeks before patient letters are sent, in order that health care providers retain the primary responsibility for patient notification of results.
- The PPCC has assumed the role of tracking abnormal and unsatisfactory results, previously a function of the SHR and RQHR cytology labs.
- Women under the age of 18 and over the age of 69 are tracked for follow-up of abnormal and unsatisfactory results (also women from out of province), through correspondence with health care providers.
- Women must contact the PPCC directly to decline receiving letters from the program.
- The PPCC cannot delete women's information from the provincial database.

Future Directions…

The PPCC is now operational in terms of a dynamic database, client notifications and tracking. The database allows the PPCC and its Quality Assurance Committee to focus on:

- Increasing response rates of colposcopists submitting forms.
- Increasing response rates of health care providers submitting follow-up forms.
- Feedback to health care providers, with information that will support continuing medical education and quality performance.
- Targeting recruitment initiatives to unscreened populations and/or geographic area.