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College Newsletter

A publication of the College of Physicians and Surgeons of Saskatchewan

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Message from the President

Season's greetings! It is that time of the year when we are busy winding down our corporate projects or organization business and preparing for the arrival of the festive season. There is an anticipated sense of relief that soon we will get a little respite from the usual hectic schedule so we can enjoy the companionship of our family and friends. For most of us, it is also a time to reflect on the events of the past year and to plan for the New Year.

Dr. Edward Tsoi

Besides the usual regulatory responsibilities, Council has devoted much of it energy in this past year to addressing several key issues that have significant impact on the role of the College. These are Professional Revalidation, Physician License Renewal, Medical Manpower and the related issue of assessment of international medical graduates (IMGs).

The issue of professional revalidation has been a much discussed topic throughout North America, United Kingdom and Australasia. It is now generally agreed in our profession that revalidation is necessary for patient safety. While the tools used to ensure the standard of practice and competence of physicians may vary across the individual jurisdictions, there is a general agreement that life-long learning is an important and necessary requirement for professional revalidation. At present, physician members must satisfy certain education program requirements of the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada in order to be eligible for re-registration.

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There is a consensus that the old CME credit/hour is an outdated tool and does not accurately reflect what physicians have accomplished in these activities. A much more practical approach is practice assessment with built-in quality assessment to ensure that physicians' knowledge is up to date and that physicians apply what they learn in the management of patient problems. As electronic technology becomes more mature and patient chart audit more practical, practice assessment will likely become a reality and standard tool for revalidation in the future.

The issue of Physician License Renewal is an important one. Physicians renewing their license to practice in 2007 are asked to respond to a set of questions. These questions are the final product of a working group of the College Council and the result of

extensive consultation with the Saskatchewan Medical Association. Fitness to practice depends on satisfactory physical and mental health as well as ethical integrity of the physician. If any of these areas in a physician is impaired, it is the responsibility of the regulatory and licensing authority to investigate and address it with the physician(s) concerned in order to fulfill the College's mandate of public protection. Our profession enjoys the privilege of professionally lead regulation. Such privilege must be jealously guarded and the only way to guard this privilege is to inspire public confidence. Senior council members and College staff frequently attend national and international meetings with our sister Colleges across Canada and other jurisdictions in the United States, United Kingdom and Australasia to share experiences and information that may benefit all participating member countries in this regard.

Medical Manpower has always been a concern as our population ages and many of our own medical graduates continue to leave Saskatchewan after training. Traditionally, our provincial health care relies heavily on international medical graduates to provide services not just in rural communities but also in specialty services in urban areas. As foreign governments especially those in the under-developed countries indicate their displeasure that developed countries are poaching their much needed physicians and plead with the developed countries to leave their physicians alone, the pressure is on for our province to train and retain our physicians. Our provincial government has indicated that effort is being made to reallocate more resources for the training of physicians. The College of Medicine has also made a commitment to assist. In the mean time, the College of Physicians and Surgeons must continue to seek assessment tools to ensure eligible IMG's meet the standards of practice in order to fulfill its statutory duties to protect the people of Saskatchewan. Such task is no easy task as it must secure the understanding and cooperation of the patients, regional health authorities, international medical graduate community, the professional medical association and the Department of Health. The College is engaged in ongoing dialogue with the Department of Continuing Medical Education and Professional Development of the College of Medicine. It is also participating in a joint effort with our sister Colleges in Western Canada to develop assessment tools for IMG's. The goal is to develop a uniform standard and process to harness the available resources in the IMG community.

Finally, the College Council continues to examine its own organization purpose and governing style and policies. It is my hope the maturation of our new strategic planning committee in the next few years will become a valuable aid to the Council in providing vision and leadership to this organization.

Registrar's Report

D. Kendel, MD, Registrar

An International Perspective on Medical Regulation

On November 11th to 14th, 2006, Dr. Tsoi, Dr. Shaw and I had the privilege of attending an international conference that brought together medical regulatory agencies from around the world. Although there are some significant differences between professional regulatory processes in other parts of the world, there is also remarkable commonality in the issues which confront these agencies worldwide.

The opportunity to learn more about professional regulatory processes in other nations has two distinct benefits. It offers us an opportunity to learn about innovations we might do well to emulate. On the other hand, it also causes us to be more appreciative of some of the systems and policies in our own country. I'd like to share some of the more significant observations and insights I gleaned from this international conference.

Across the world there is significant variance in the extent to which the medical profession enjoys some measure of self-regulation. In some countries medical regulatory processes are much more directly controlled by governments than is the case in Canada. Physicians in some parts of the world are very envious of the fact that physicians in Canada generally get to elect two-thirds or more of their colleagues who govern the Colleges of Physicians and Surgeons. In some countries all of the individuals on the governing body of the medical regulator are hand picked by the state or national government.

Around the world there is a growing recognition that if medical regulation is to effectively serve the public interest, the public must be actively engaged with the medical profession in the regulatory process. Regulatory bodies in different parts of the world are using many different strategies to enhance public engagement in the regulatory process.

I'll reference just one example of a very interesting public engagement strategy that has developed in New Zealand. About seventeen percent of New Zealand's population is of aboriginal ancestry (Maori). Like aboriginal people in our country, the Maori have a concern that healthcare practices are often insensitive to their culture, values, and beliefs. So, the New Zealand Medical Council has established a position for a Maori elder to attend all Council meetings and participate in dialogue that generates Council policies. The Maori elder brings to these discussions insights and perspectives with respect to how any policy may impact the Maori people and be received by them.

As is the case in Canada, in most developed countries there are between 25 to 30 different regulated healthcare disciplines. As the educational framework for the disciplines evolves there is growing overlap in their competency profiles and their authorized scope of practice. This causes some tension between the healthcare disciplines and some disciplines tend to use their regulatory privileges as a turf protection mechanism rather than a mechanism that serves the public interest. In some countries governments have established a body with authority to resolve scope of practice disputes between healthcare disciplines and to foster more collaborative inter-disciplinary practice.

Where professional regulation is conducted exclusively at the provincial or state level rather than at the national level, there is strong evidence that this regulatory fragmentation in a nation creates barriers to inter-provincial workforce mobility. There is also near universal recognition that relatively small groups of professionals struggle to establish and maintain regulatory processes that are both effective and efficient.

In response to these observations some countries are significantly reforming their professional regulatory processes to remedy the problems caused by fragmentation. We learned that it is quite possible, if not probable, that Australia may abandon its state-based medical regulation model in favour of a national model.

We also learned a great deal about the regulatory reforms introduced in New Zealand a number of years ago which have very significantly integrated the regulatory processes for all healthcare disciplines. In New Zealand complaints about the conduct or performance of any healthcare professional are now handled by a single agency. When charges of unprofessional conduct are laid against any healthcare professional, the evidence is heard through a uniform hearing process with each hearing panel including peers of the professional who faces such charges.

There is a perception in New Zealand that these reforms have yielded significant efficiency gains and also assured greater uniformity of regulatory standards between all healthcare disciplines.

In the United Kingdom, the General Medical Council (GMC) continues to undergo significant reform in response to some very high profile public reviews of its effectiveness. The extent of public participation in physician regulation in the United Kingdom has been vastly increased, and

the GMC is continuing its quest for a strategy that will assure the public that all physicians maintain competency throughout their career cycles.

In previous articles I've expressed my admiration for the superb work of the GMC in its development and dissemination of a document known as "Good Medical Practice". In very simple and straightforward language this document defines what a member of the public might reasonably expect in his or her interface with any physician. Over the years since this document was developed in the United Kingdom it has had a profound impact on the culture of medicine and has positively influenced the education of future doctors. The GMC has just released a revised version of its "Good Medical Practice" document. The document is readily accessible on the internet at www.gmc-uk.org/guidance. I would strongly encourage every physician to download and read this document.

During the course of this conference we also learned how other regulatory bodies deal with impaired physicians and those who fail to maintain a satisfactory level of professional competence. I believe there is much we can adapt from the models other countries have developed to help physicians maintain and refresh their professional competence.

We also heard some very sobering messages about how the medical profession around the world might and should modify its approach to practice in the fact of inadequate medical human resource supply. The dominant message we heard is that doctors need to increasingly focus their professional time and energy in those domains where they are most uniquely and highly skilled. They need to actively identify tasks that do not really require physician expertise and support the transfer or delegation of these tasks to other health service providers.

Finally, I should report that the conference devoted a full day to the issue of global medical workforce supply and demand with an emphasis on ethical trans-national medical recruitment practices. Representatives from the developing nations pleaded with those from the developed nations to reduce the poaching of their medical workforce which is even more thinly stretched that in virtually every developed country.

Given the fact that we live in a "global village" the point was emphasized that agencies which portend to serve and protect the public interest should be sensitive to the interests of the global public rather than only the interests of the citizens in their own backyard.

In response to these concerns the medical regulatory agencies from the developed world noted that they are not themselves involved in recruitment of international medical graduates, but only register those applicants who meet their registration standards. The rebuttal was that regulatory agencies in the developed world can and should seek to influence the policies and practices of those agencies that do aggressively recruit physicians from developing countries.

A physician leader from the Philippines made a presentation which served to emphasize how strong the economic forces are that bleed physicians from developing nations to careers in the developed world. There is a very strong demand for registered nurses in the United States and foreign trained nurses who emigrate to the United States are assured they can bring their families with them. In response to this reality several thousand Philippine physicians have elected to be re-educated as registered nurses and have migrated to the United States. As a registered nurse in the United States they earn three to four times as much as they might hope to earn as a physician in the Philippines.

All of the presentations at this conference will eventually be posted on the website of the International Association of Medical Regulatory Agencies (IAMRA) at IAMRA.com. Anyone wishing to gain a better understanding of medical regulation from an international perspective may wish to log on to that website.

Public Members' Report

E. Van Olst, Public Council Member

The Council of the College of Physicians and Surgeons of Saskatchewan is comprised of both physicians elected by the membership of the College and non-physician public members appointed by the government of Saskatchewan. The writer has had the privilege of being an appointed public member of the Council for almost six years. My appointment to Council is ending in February 2007. I wish to thank the government, other members of Council, the staff of the College and all of the medical professionals licensed by the College for the opportunity to serve as a member of Council.

As one of a number of public members on Council, we hold roles similar to public members of other self-regulating professional bodies. Physicians who are members of the College enjoy the societal gift of self-regulation. The College, as a professional self-regulator, must have as its primary role that of protecting the public. One method of insuring such protection is the appointment of "public representation" on the governing Council of a professional regulating body. It has been said that as a public member of Council, our role is similar to that of the other elected physician members, that is to safeguard the public interest, yet we may bring forward a "consumer" point of view on issues of concern that come before Council.

In my experience, the appointed public members to the Council of the College have also come with unique community experiences and expertise to assist the role of Council. In my case, I bring to Council my experience as legal counsel for the Saskatoon Regional Health Authority. I believe I bring some knowledge and experience with respect to legal issues in health care and assist Council as a whole on legal and procedural issues as they arise, in an informal way. I do not act as counsel or as a lawyer for the College nor am I "the lawyer" for the Council. However, during the deliberations of Council, my experience and background can be useful to assist Council. This is in addition to providing input as a general member of the public. Members of the College can be assured however that I have diligently attempted to avoid any appearance of conflict of interest between my position as legal counsel for the Saskatoon Regional Health Authority and as a public member of Council, routinely excusing myself from matters where I might potentially have input both in my real job and in my role as public member.

In my six years experience, I can indicate that the present and past elected physician members and present and past public members of Council have all taken their roles seriously and have put public protection first in their deliberations. I have been privileged to work with a committed and dedicated contingent of elected members of Council and public members.

Being a member of Council, whether a public member or not, brings as well many challenges. From the perspective of a public member, we do not bring clinical expertise to our decision making tasks. We do strive to capture with each issue that comes before Council what is the public perspective on the issue. In my experience, though there have been many well publicized disciplinary matters before Council that are of major importance particularly to the member subject to discipline, the difficulties in such decisions by Council are overshadowed by the complexity and policy decision-making required in licensure and other policy decisions. Council is always mindful of the balance needed to be crafted between the need for the recruitment and retention of physicians in this province and the need to ensure baseline competence. Many difficult decisions have been made by Council with respect to individual applications for licensure and in the decision making of the overall licensing policies and bylaws. I foresee this difficult balancing act continuing well into the future.

The public members and elected physician members receive input from the community and attempt to keep up to date on relevant documents provided to all Council members for their

review. As well, at each Council meeting there is an environmental scan by way of a round table that allows each member to bring up broad contextual matters to Council as a whole.

In closing, I believe public members provide real value to the work of Council and I hope that I, in some tangible way, have also provided value to the workings of Council. I wish to thank my fellow public members Ms. P. L. Gatin, Ms. J. MacKay, Ms. B. Righetti and thank particularly the administrative staff of the College for their assistance in allowing the Council to do its important work.

2006 Legal Report

B. Salte, LLB, Legal Counsel

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

Two years ago 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.

I. Discipline, Competence and Related Matters since the last Newsletter

1. **Dr. Jagdish Mitter Sood - ability to perform surgery and certain ophthalmic procedures**

   The Executive Committee appointed a competency committee to determine if Dr. Sood had the skills and knowledge to perform certain ophthalmic procedures. When Dr. Sood did not appear for a medical examination, the Executive Committee suspended his right to perform surgery and certain ophthalmic procedures.

   The Council scheduled a suspension hearing to address the concern about his skills and knowledge to perform surgery and the certain ophthalmic procedures and to address Dr. Sood's failure to appear for the medical examination. Dr. Sood was suspended from practice, but with the proviso that if he provided an undertaking to the College that he would not perform surgery or the ophthalmic procedures of concern, that suspension would be rescinded.

   The matter was resolved when Dr. Sood provided a written undertaking that he would not in future perform surgery or the ophthalmic procedures of concern.

2. **Dr. Arthur Eldemire - prescribing of psychoactive medications and information provided to the College**

   Dr. Eldemire was charged with unprofessional conduct. The charges alleged that he prescribed psychoactive medications in a manner that did not meet the standards of the profession, and that he provided information to the College that was untrue.

   The matter was resolved when Dr. Eldemire provided a written undertaking that he would not practise medicine after 2006, and would not renew his licence to practice after 2006.

3. **Dr. Bruce Zimmerman - response to the College**

   Dr. Zimmerman acknowledged that he was guilty of four charges of unprofessional conduct for failing to respond to correspondence from the College.

   He received a fine of $1,500 on each charge, for a total of $6,000.

4. **Dr. Carlos Huerto – application for licensure**

   Dr. Huerto's licence was revoked in 2005 following his unsuccessful appeal to the Court of Queen's Bench. The discipline committee concluded that he had maintained a sexual relationship with a patient, prescribed drugs in a patient's name not intended for the patient, and made a false statement in an affidavit to the College. There were also other, previous, findings of unprofessional conduct.

   Dr. Huerto applied to have his licence restored. The Council rejected his application.

   The Council concluded that revocation was and remained appropriate given his proven past disciplinary record and lack of evidence as to rehabilitation.

II. Court Actions involving the College

1. **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 that statements he made as threatening.

   The College of Physicians and Surgeons obtained leave from the Court of Appeal to appeal that decision.

   The Court of Appeal concluded that the judge of the Court of Queen's Bench had wrongly decided the appeal. The Court of Appeal restored the finding by the Discipline Committee and the Council that Dr. Young was guilty of unprofessional conduct.

III. Changes to College Bylaws

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

a) **Questions on Renewal** - The College bylaws were changed to require all physicians who seek to renew their licences to answer a series of questions. Those questions are similar to the questions that are asked of new applicants. The bylaw was only passed after considerable consultation.

   The purpose of asking those questions is to alert the College to situations where the College may be required to take public protection measures – where there are concerns about a physician's conduct or performance.

   If a physician discloses a matter that may indicate concerns about performance or conduct, the College will review the information to determine what action, if any, is required.

   Physicians are entitled to renewal of their licences even if they disclose something that is an issue of concern.

   The College has implemented a privacy policy to ensure confidentiality for information provided by physicians in response to the questionnaire.

b) **Revalidation** - The College bylaws were changed to require all physicians, other than physicians registered only on a temporary licence or an educational licence, to enroll in either the Maintenance of Competence program of the Royal College, or MainPro of the College of Family Physicians of Canada. That requirement becomes effective in 2007.

In order to renew their licences for the 2008 year, physicians will have to confirm that they are enrolled in one or the other of these programs.

When physicians reach the end of their five year cycle in the Maintenance of Competence program or MainPro they will be required to provide proof that they have met the requirements in order to renew their licences.

Physicians can apply for exemptions from the requirement. Such exemptions are likely to be very difficult to obtain if the physician is in clinical practice. If a physician has not met the requirements of the program at the end of his/her cycle, she/he can apply to the Registrar, with an appeal to the Council, for an extension of time to meet the requirements.

c) **Prescription Review Program** – this program, previously known as the Triplicate Prescription Program, was significantly changed. Benzodiazepines, amphetamines, barbiturates, chloral hydrate and anabolic steroids were added to the program. There is no longer a requirement to write prescriptions on a special prescription pad. The bylaw requires physicians to put specific information on each prescription for a drug covered by the program.

Physicians must ensure that the script contains the following information:

i) A statement that the prescription is only valid for three days;
ii) The patient's date of birth;
iii) The patient's address;
iv) The total quantity of medication prescribed, both numerically and in written form;
v) the patient's health services number; and,
vi) the prescriber's name and address.

At the most recent Council meeting, the bylaw was amended to remove the requirement that the prescription state that it is valid for only three days. That change has not yet been approved by the Minister of Health and consequently is not yet in effect.

There continue to be problems between pharmacists and physicians where physicians write scripts that do not follow the requirements of the program. This is creating tension between doctors and pharmacists, as well as creating some problems for patient care.

d) **Licensing bylaws** – Licensing requirements for physicians received a great deal of Council attention during the past year. The registration bylaws were thoroughly reviewed. Among the changes were:

i) A change to allow a physician, who had failed Royal College examinations, to receive an extension of his/her licence for a limited period longer than one year. Before such an extension can be granted, there must be extraordinary circumstances, and other conditions must be met. This provision was used once during the past year, to deal with a physician who had been unable to find additional training to meet the Royal College's requirements in 2006, but had been accepted for training in 2007;
ii) A change to more clearly define failure to complete a commitment given as a condition of obtaining a special or provisional licence as unprofessional conduct. A physician who has been refused permission to relocate by the Council can defend a charge of unprofessional conduct on the basis that the College's refusal to grant permission to relocate was unreasonable.
iii) Other changes, primarily of a grammatical nature, or to more clearly reflect established practice.

IV. The Health Information Protection Act

The primary purpose of The Health Information Protection Act (**HIPA**) is to protect the privacy of patient information. In 2005, the College and the SMA worked together to prepare a physician

toolkit (available on both the College and the SMA websites) 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 time over the past year. There continue to be physicians who are unaware of the requirements, or who do not follow the requirements, of the legislation.

One issue that the College previously addressed, and that now has the attention of the Privacy Commissioner, is the failure of some physicians' offices to have information available for patients about their rights under the legislation. This can be done in a number of ways, including posters, pamphlets and acknowledgements that patients are required to sign. Sample posters and pamphlets are available in the Privacy Toolkit.

A physician's office that does not provide this information to patients breaches the legislation and could be subject to prosecution under **HIPA**.

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 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 uses 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.

V. Review of Disciplinary Procedures

The Council conducted a thorough review of how the College deals with discipline matters. It reviewed the processes used by other Colleges in Canada, and brought in representatives of two other Colleges to determine if there should be changes to how the College conducts disciplinary investigations and discipline hearings.

After considering all of the information, the Council determined that there were no changes required to the current processes used by the College.

VI. Concluding Comments

The issues that the College must address become more complicated every year. This is caused, in part, by a great number of competing interests.

Some physicians contact the College expressing concern about certain College processes and policies. That can be very helpful in reviewing what the College does, and in determining whether changes are required.

It has been my privilege to work with the College during the past year.

We encourage physicians with specific questions to contact Bryan Salte at the College by e-mail to salteb@shin.sk.ca or telephone (306) 244-7355.

Readiness for Residency Training and Practice in Saskatchewan: Assessment of International Medical Graduates IMGs

Ms. R. Palfy, Research Co-ordinator, College of Medicine

If you are an International Medical Graduate currently living in Saskatchewan (or know of one), we would like to interview you regarding where you are at in the application process so that we can explore how we might be able to help you. Please contact Randa Palfy, Research Co-ordinator, College of Medicine, Regina, SK at (306) 766-3873 or randa.palfy@rqhealth.ca. If you live outside of Regina, you may call collect for further information.

Participation in this research study will be through an interview, which will take approximately one hour and will be conducted by an individual who is not directly linked to either the CARMS Match or to the Saskatchewan College of Physicians and Surgeons.

A second goal of this study is to identify and survey by email Saskatchewan residents who are studying medicine outside of Canada. If you know of any such people, we also request that you ask them to contact us.

Thank you for your interest in the research endeavour.

Next ECG Exam

Monday, January 8th and Monday, March 5th 2007, 1:15 p.m. – 4:15 p.m.
College of Physicians and Surgeons,

To register contact:
Ms. C. Dunlop
Telephone: (306) 667-4622
or email: dunlopc@shin.sk.ca

Fetal Heart Rate Monitoring in Labour

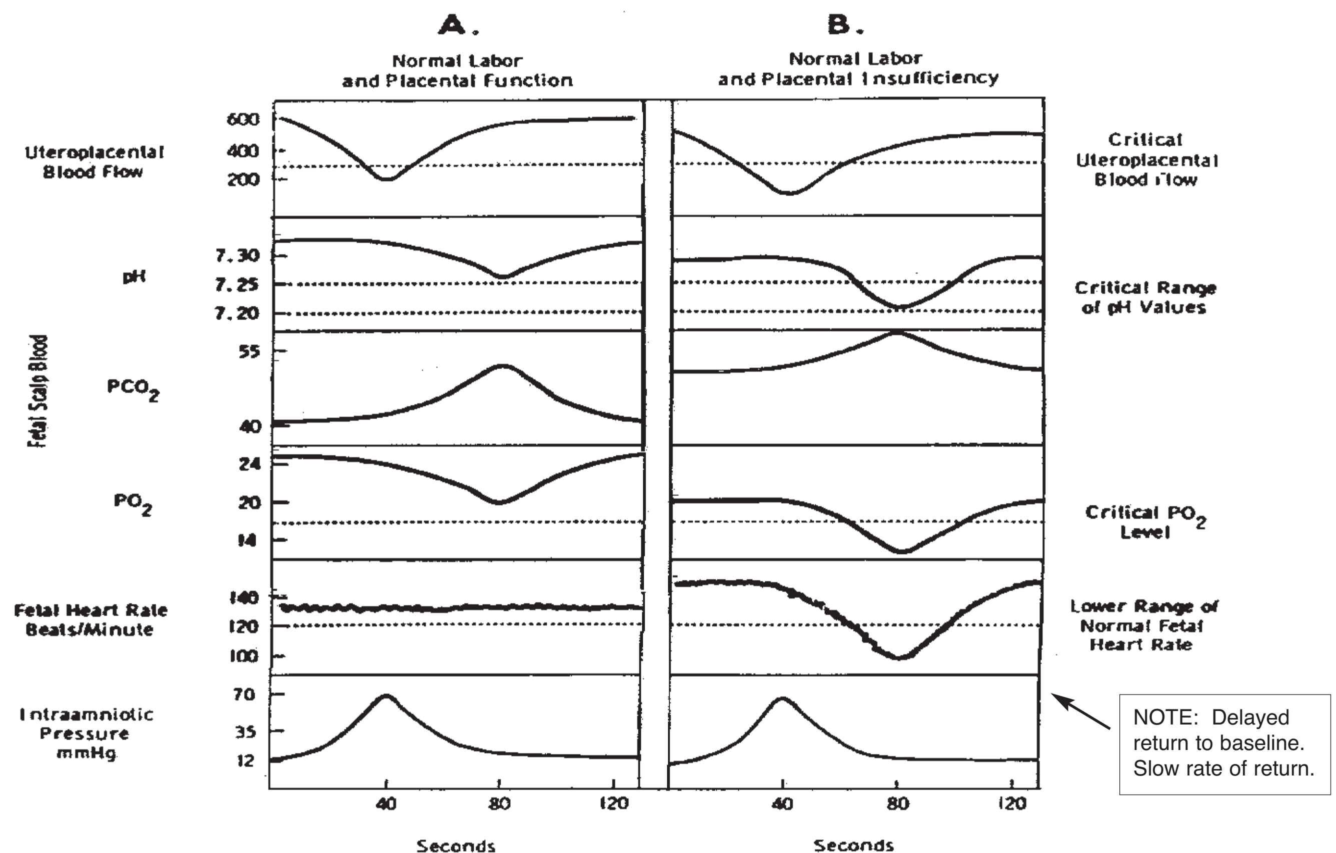
G.D. Carson, M.D.

With reduction of placental blood flow during each contraction there is a reduction of the delivery of oxygen to and removal of carbon dioxide from the fetus. Usually this reduced oxygenation still allows ample supply and the fetus tolerates labour well. Sometimes, particularly if there is any pre-existing limitation of placental function, the reduction of oxygen is more than can be tolerated by the fetus. In response to this decreased oxygenation there is slowing of the fetal heart rate. When the contraction is over flow is restored and fetal oxygen increases. The fetal heart rate recovers. It does so with a lag at the end of the contraction and at a gradual rate as the fetus re-oxygenates. These features – a delay in return to the base line, taking more than 30 seconds after the contraction is over, and a gradual rate of return are the defining characteristics of a "late deceleration" due to hypoxia. In the absence of such decelerations the fetus is not hypoxic. All the alleged complexity of monitoring can be reduced to this:

- There are late decelerations, indicating hypoxia and the possibility of injury to the fetus, or
- There are no late decelerations and the fetus cannot be currently hypoxic

The late decelerations can be recognized at electronic monitoring of the fetal heart rate or by intermittent auscultation.

Adapted from: Vorherr H, Am J Obstet Gynecol 1975; 123: 67-68



Prenatal Form Improvements

The Perinatal and Maternal Mortality Study Committee assists Saskatchewan Health with changes to the Prenatal form.

Any physician's who may have suggestions as to areas for improvement (whether additions or deletions), please send them to Ms. K. Bergstrom coordinator PMMSC at bergstk@shin.sk.ca by Jan 15th, 2006.

Committee Annual Reports:

Advisory Committee for Medical Imaging Annual Report

The ACMI met quarterly to consider a number of issues in 2006, in addition to finalizing audits of Imaging Physicians. This is the third year of the audit process. The first round of audits should be completed by March 2007.

The committee is working cooperatively with the Practice Enhancement Program in their evaluation of imaging physicians. This eliminates the need for two separate assessments of imaging physician records. PEP will continue to carry out the patient and physician satisfaction surveys. Using the same numbering system as PEP the ACMI program will provide PEP with the results of their audits. Both committees will issue a final report to the physician.

The committee is in the process of determining the status of tele ultrasound in the province. It is the expectation of the committee that tele ultrasound will be conducted in real time. While the technologists may be in another community the radiologist must be able to see the image and patient in real time and be able to converse with the technologist and patient in real time. This is achievable but not inexpensive. Providing ultrasound service in this fashion allows for on site service in the smaller regional centres in our province.

Considerable time was spent with respect to CAR accreditation of mammography facilities. The committee offered to assist mammography sites in the process of accreditation.

The ACMI remains a committee of the college but has been asked to be a sub-committee of the Provincial Diagnostic Imaging Committee (DIN). From time to time, the DIN will ask the committee's opinion on issues, such as prioritizing times to obtain an imaging procedure by category. The committee may also be asked to provide their opinion to the Operational Information and Technology Sub-committee (OITS) of the DIN. This is a new and exciting role for the ACMI.

The ACMI continues its educational work to improve imaging practices across the province.

Ms. Dawn Marten will be leaving the committee in 2006. Her input will be missed.

On behalf of the College, we would like to extend thanks to the members of the Committee:

Dr. I. Suchet, Chair	Dr. D. Chizen	Ms. D. Hladum	Mr. W. Tiefenbach
Mr. P. Au, DIN	Dr. E. Dudzic	Ms. D. Martin	Dr. I. Waddell
Mr. D. Calder, DIN	Dr. J. Hillis	Dr. G. Stoneham	

Respectfully submitted by: Ms. G. Hearn, Director Quality Assurance, Dr. L. Loewen, Medical Manager

Anaesthetic and Operative Deaths Study Committee

The Anaesthetic & Operative Deaths Study Committee of the College of Physicians and Surgeons reviews all deaths occurring within ten days of surgery and/or anaesthesia in the province of Saskatchewan. This is one of the means by which the College works to improve the quality of care delivered to Saskatchewan residents. The Committee's aim is to be educational

and to provide feedback to the physicians on the quality of care provided and to make recommendations for improvement.

The Committee communicates with surgeons and anaesthetists but also communicates with other caregivers such as the family physician and/or the critical care associate or house officer if the recommendations are pertinent to the care they provided.

Over the last several years, the Committee has limited its feedback communications to those physicians who have been asked for additional information in order to deliberate a case or to those physicians involved in the cases that were assessed as potentially preventable. Those cases that are found to be non-preventable without comment are not communicated to the physicians. Any physician interested in knowing the outcome of a specific case they were involved in may direct that inquiry to the coordinator of the program. In those cases where physicians are asked for additional information and their awareness has been raised to the fact that the case is being reviewed, physicians will receive a letter even if the case is found to be non-preventable. The decision to go with this method of communication was to decrease the number of letters received by physicians when no significant information was being relayed.

The Committee's work is set out in the bylaws of the College of Physicians and Surgeons. There were several amendments to the bylaw with respect to the working of the Anaesthetic & Operative Deaths Study Committee to more accurately reflect how the Committee does its work. Bylaw changes included changes to allow access to physician progress notes, nurse's notes, as well as any other relevant documents required to complete a case. In addition, a contributing factor, which was previously referred to as "nursing error", was changed to "non-physician health care provider concern". The manner in which the outcome of the review was to be communicated to the appropriate individuals was also articulated. These bylaw changes were made and endorsed by Council after input from appropriate stakeholder agencies such as the Saskatchewan Medical Association and Saskatchewan Health.

Last year there was a concern raised in the annual report that the College of Physicians and Surgeons had questioned whether it should continue to do its quality assurance work in the same manner as it had previously done, which is by reviewing the work of individuals. The College had wished to insure that its statutory obligation to monitor individual performance was not fostering the "name and blame culture" that may inhibit a more open approach to patient safety issues. The quality assurance work of the College of Physicians and Surgeons is protected under Section 60 of the Medical Professions Act, which speaks to the issue of the process being held "in camera" with no information to be provided to any parties outside of the process. On one hand, this provides important protection for the opinions of the Committee. On the other hand, it does not allow for sharing of any information with any other quality assurance processes such as those of the regional health authorities. At times it seems counter productive not to have the provision to share some information with another quality assurance agency to work towards the common goal of improving patient safety. In order for the College to have the ability to provide limited information to another agency if it is seen to be in the best interests of the public, it would require a change in Section 60 of the Medical Professions Act; therefore, the College has alerted Saskatchewan Health to its concerns and awaits its consideration of this matter.

In 2006, the Committee met four times to review a total of 362 cases. Four were from 2003,127 were from 2004, 231 were from 2005, and there were no cases reviewed from 2006.

Of the cases completed, 332 were classified as non-preventable, 2 were non-preventable but with areas of concern, and 4 were classified as potentially preventable. There were 22 cases unclassified that will be carried over to 2007. The potentially preventable cases were further classified for contributing factors such as error in judgement/technique, and inadequate equipment/facilities.

Some of the concerns identified with the potentially preventable cases were:

1. The need for more timely transfer of patients when there is a possibility of intracranial injury and when the diagnostic investigations are not readily available to provide a definitive diagnosis.
2. In the setting of a hypotensive patient with signs of right ventricular strain, the differential diagnosis should include pulmonary embolus in addition to that of anterior myocardial infarction.
3. Enhancement of communication between care givers to ensure physicians are alerted to nursing concerns about patients in a timely fashion.
4. Consideration of deep vein thrombosis prophylaxis in high risk patients.

A number of cases reviewed identified high risk patients that were not provided deep vein thrombosis prophylaxis. The Committee expects documentation of the reasons deep vein thrombosis prophylaxis was not considered. In some cases it appears that alternatives to Heparin and low molecular weight Heparin such as antiembolitic stockings or pneumatic stockings were also not considered.

One of the general concerns the Committee identified was a lack of documentation. As the Anaesthetic & Operative Deaths Study Committee does its review mainly by the review of the written record, when there is a lack of appropriate documentation on the chart with respect to the history, physical examination or physician progress notes, the physicians involved may be requested to provide additional information.

The Committee would report that there is an ongoing problem with lack of appropriate documentation regarding pertinent information on a number of charts that were reviewed. Again, progress notes that explain what happened to a patient are missing at critical times such as when the patient is transferred from an intensive care unit to a ward, and then deteriorates. Also, there is lack of documentation with respect to discussion around the decision to take a patient for surgery. In several cases reviewed, the Committee questioned why there was a decision to proceed with surgery when compassionate terminal care with appropriate pain management may have been an acceptable alternative. When additional information was sought from the physicians, the physicians reported feeling pressured by family to proceed with surgery. The Committee feels that documentation of these conversations is exceedingly important, and if documentation had been adequate in these cases it would have been unnecessary to have contacted the physician for additional information. Again, it is equally important to document conversations with the family and/or patients with respect to compassionate terminal care and to provide enough information in the chart to allow another caregiver to understand what ‘compassionate terminal care’ or’ the do not resuscitate’ order actually means in the context of care to that individual patient.

There are a number of cases where there is no obvious history and physical documented on the chart. The explanation for this is often that the consult report takes the place of the documentation of the history and physical examination. The Committee would remind physicians that unless the consult includes all the elements that would be found in a history and physical examination, it does not suffice to replace the documentation with respect to a history and physical.

The Committee would encourage physicians to reflect on their documentation and make the necessary improvements. A contemporaneous, concise, and factual note in the chart provides adequate documentation that in balance takes less time than the time to review something at a later date at the request of a quality assurance committee and/or legal proceedings.

The Committee acknowledges that many physicians already provide a good standard of documentation that results in straightforward review by the Committee without the requirement to request additional information. The Committee thanks those physicians for their efforts.

Perioperative beta blockade was another area the Committee noted where there was inconsistent documentation of whether it was considered. Although the Committee acknowledges the literature is somewhat controversial, consideration of this therapy and documentation of that decision is appropriate.

The Committee noted in a number of cases surgery was undertaken in cases which the Committee was concerned were "somewhat" futile. The Committee believes that it is appropriate for physicians to enter into discussion with a patient and/or patient's family with respect to the reasonableness of the surgery in the context of the overall condition of the patient and the expected prognosis. The Committee believes that it is important to acknowledge the limitations of the surgery and that those limitations be acknowledged by the physicians, the patients, and the patients' relatives. In cases where the discussion has taken place and surgery is thought to be futile and not in the patient's best interest, appropriate progress notes should be made indicating the nature of the discussion and who was involved in the decision.

The Committee reported a trend in last year's annual report that appears to be continuing. At times large surgical procedures are undertaken with the consent of the patient and the patient's family, but early in the postoperative period patients or families are making decisions to discontinue supportive care. The Committee firmly believes prior to consenting to an operation the patient or patient's families should be informed of some of the care concerns that might be involved in the immediate postoperative period, so that their decision to accept surgery would extend to accepting the supportive care necessary to assist them with the medical concerns that arise in the first few postoperative days.

Another area of concern identified by the Committee was the review of several cases that involved resuscitative thoracotomy in situations where the patient had no signs of life for an extended period of time prior to arriving at the emergency facility. The Committee questioned the reasonableness of performing resuscitative thoracotomies on patients with prolonged "downtime" and no vital signs upon arrival to the facility. The Committee believed in situations like this, resuscitative thoracotomy was inappropriate, as the prognosis for these patients is very poor, and there may be considerable risk to health care workers involved in these procedures. The Committee determined that this was an area that required further discussion with other stakeholders. The Committee through the medical manager will arrange to have the issue raised with appropriate emergency department\trauma team personnel so as criteria can be set for the appropriate indications for this procedure. Setting criteria will assist in avoiding inappropriate attempts in futile situations and hopefully decrease potential risk to health care workers.

The Committee also noted during the review of some cases it was impossible to determine with certainty the actual cause of death. The Committee questioned why an autopsy was not requested or at least consideration given to a limited autopsy, which may assist in answering some of the outstanding questions. In some cases, the Committee was not in a position to determine whether an autopsy was considered but declined, as documentation was scanty with no reference to the reasons why autopsy was not done. The Committee thought the consideration of limited autopsies would be a reasonable compromise, especially in situations where the exact cause of death is in question and cannot be determined by any other means.

The Committee would continue to encourage physicians to become comfortable in asking and allowing the families to provide the gift of life through organ donation.

The Committee would like to welcome two new members to the Committee, Dr. J. Benoit and Dr. B. DuVal.

On behalf of the College, we would like to extend thanks to the members of the Committee: Dr. B. Gilliland (Chair), Dr. J. Akhtar, Dr. J. Benoit, Dr. M. Bohn, Dr. J. Carter, Dr. B. DuVal, Dr. W. Ezzat, Dr. S. Gonor, Dr. M. Jurgens, Dr. D. Loback, Dr. V. Olsen, Dr. M. Plewes, Dr. D.

Thomson, and Dr. S. Vuksic for their dedication and efforts in improving the quality of care provided to Saskatchewan citizens through the work of this Committee.

Respectfully submitted by: Dr. K. Shaw, Medical Mgr. Ms. K. Bergstrom, Coordinator.

Complaints Committee

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

Complaints are accepted when the complainant is the patient, and also when a third-party complains on behalf of a patient with the patient's knowledge and consent or without the patient's knowledge and consent. The complaints that are registered by third parties without the knowledge or consent of the patient are reviewed but the responses from the physicians are not provided to these third parties, and the final letter of deliberation contains only information that would not breach the patient's privacy.

The Complaints process of the College of Physicians and Surgeons has to be mindful of the requirements of The Health Information Protection Act (HIPA), in particular that privacy extends beyond death. Section 27(4)(e) of HIPA states:

if the subject individual is deceased:

(i) where the disclosure is being made to the personal representative of the subject individual for a purpose related to the administration of the subject individual's estate; or

(ii) where the information relates to circumstances surrounding the death of the subject individual or services recently received by the subject individual, and the disclosure:

  (a) is made to a member of the subject individual's immediate family or to anyone else with whom the subject individual had a close personal relationship; and

  (b) is made in accordance with established policies and procedures of the trustee, or where the trustee is a health professional, made in accordance with the ethical practices of that profession.

The Committee provides as much information as it can to the complainant to allow them an understanding of the circumstances surrounding the death of their loved one without breaching the deceased patient's privacy.

The purpose of the Committee's review of complaints is to provide educational suggestions to physicians in cases where their care and conduct could be improved. The Committee also attempts to provide complainants with a better understanding of the care provided. The Committee hopes that the review of these types of complaints is educational, both to the physicians and to the complainants. The process is confidential, and 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 Standing.

Often times it is the patient's perception of the interaction that leads to the complaint rather than any specific care issue. Thoughtful reflection by physicians often results in changes to their practice or communication style, therefore avoiding similar complaints in the future.

In addition to providing feedback to the individual physicians, the Committee will provide general educational articles in the College's Newsletter to raise physicians' awareness to certain problems and/or to potential educational tools.

Complainants/physicians who are dissatisfied with the Complaints Resolution Advisory Committee's resolution of a complaint may articulate their dissatisfaction to the Medical Manager of the Complaints Resolution Advisory Committee, who takes their concerns to the Complaints Resolution Advisory Committee for consideration. If the complainant/physician remains dissatisfied after the Committee has an opportunity to address the areas of dissatisfaction, they may address their concerns to the Registrar for review. The Registrar may raise the issue as an appeal to the Council of the College. The appeal is based on process issues only.

It should be noted that the Committee's review of cases extends beyond the calendar year. In 2006 the Committee met on seven occasions and reviewed 31 cases that had been registered in 2005 and not completed by the end of the 2005 calendar year, and 54 cases that had been registered in 2006 up to the end of October. The December 2006 meeting of the Complaints Committee is expected to review an additional 18 cases. As the work cycle does not match the calendar year, for statistical purposes the Committee reports on the most recent **completed** year of review.

In the 2005 calendar year, the College received approximately 1,164 expressions of concern, the majority of which were dealt with by the administrative staff. There were 99 formal complaints registered in 2005, and these were managed by the College's Complaints Resolution Advisory Committee process.

In the 99 written complaints, there were 252 allegations. The most common allegations were communication error/lack of, complication of treatment, failed to refer, failure to treat, inaccurate reporting, inadequate examination, inadequate investigation, inappropriate medication, incorrect/missed diagnosis, insensitive care, medical mismanagement, and rudeness. Of these 252 allegations, 108 were founded, 32 were partially founded, 97 were unfounded, 6 were found to be patient responsibility, and there was no determination in 9 of the allegations.

The appended table outlines the allegation and determination codes for those cases registered in 2005. The average number of days to close a case was 123. Although the Committee strives to complete cases in a timely fashion, there are limitations such as the number and timing of the meetings of the Committee, as it recesses over the summer months. The majority of physicians subject to a complaint respond promptly. On occasions there are long delays in receipt of a physician's response. Physicians are reminded that it is a requirement to respond within 14 days or formally request an extension if necessary. Failure to respond in a timely fashion results in a more lengthy process than necessary with additional stress for all parties, including the patient/complainant and other colleagues who may be involved in the complaint.

With respect to the no determination code, this code is used when the Committee is unable to determine with any degree of certainty what the situation was. In such a case, the Committee's feedback to the complainant and to the physician focuses on what the "expected behavior" or "expected care" should be in such a situation.

One of the issues the Committee has struggled with over the past several years is how to resolve complaints raised against physicians who work for the Workers' Compensation Board (WCB). The Committee does review complaints registered by WCB clients against physicians who provide services to the WCB, but limits its review to the conduct and care provided by the physician in the context of the physician's role within WCB. WCB clients who place complaints with the College of Physicians and Surgeons are made aware of the limitations of the review process and the fact that the College of Physicians and Surgeons has no jurisdiction with respect to the policies and procedures of the Workers' Compensation Board.

The Complaints Committee has continued to make improvements to its process based on informal feedback from both complainants and physicians. The Committee continues to search for an alternative vehicle that would be superior to the previous tool used (the satisfaction questionnaire that was sent out over a number of years), to gain feedback on the Complaints process.

The Committee would acknowledge the work of Ms. J. Wolan, previously the Patient Advocate and Intake Worker of the Complaints Process, who resigned her position with the College in June of 2006. Ms. Wolan was replaced by Ms. V. Marsh, who holds the title of Regulatory Services Coordinator. One of Ms. Marsh's roles is that of intake person for the Complaints process.

The Complaints Resolution Advisory Committee consists of three public members and three physician members. Input from the public members ensures the necessary public perspective in the Complaints process. The public members are Mrs. A. Brayshaw and Ms. V. LaCroix of Saskatoon, and Mrs. S. Lougheed of Pinehouse Lake. The medical members are Dr. L. Baker (family physician in Rosthern), Dr. M. Harington (general surgeon in Saskatoon), and Chair, Dr. J. Kriegler (family practitioner in Saskatoon).

On behalf of the College, we would like to thank the Committee members for their dedication and hard work in reviewing complaints.

Respectfully submitted by: Dr. K. Shaw, Medical Manager, Mrs. C. Dunlop, Complaints Coordinator, Ms. V. Marsh, Regulatory Services Coordinator, Complaints Intake.

Allegations and Determinations – 2005

Allegation	**Number of Cases**	Founded	Partially Founded	Unfounded	Patient Responsibility	No Determination
Breach of Confidentiality	4	3		1		
Communication Error/Lack of	15	11	3		1	
Complication of Treatment	10	8		2		
Delayed Diagnosis	5	4	1			
Delayed Referral	3	2		1		
Delayed Reporting	3	2	1			
Delayed Treatment	5		5			
Failed to Investigate	1			1		
Failed to Refer	10	3		7		
Failed to Attend	6	1	1	3	1	
Failure to Treat	15	2	2	7	4	
Fragmented Care	1	1				
Inaccurate Reporting	12	2	1	9		
Inadequate Communication	8	6	2			
Inadequate Examination	12	7	2	3		
Inadequate Follow Up	8	5	1	2		
Inadequate History	2	2				
Inadequate Investigation	10	4		6		
Inadequate Records	3	2	1			
Inadequate Treatment	8	5		3		
Inappropriate Behavior	2	1				1
Inappropriate Comments	9	6	1	1		1
Inapprop. Communications	4	3	1			
Inappropriate Medication	11	3		8		
Inappropriate Treatment	3			3		
Incorrect/Missed Diagnosis	23	9	5	9		
Insensitive Care	13	5	4	3		1
Lack of informed Consent	4	1	2	1		
Medical Mismanagement	10	3		7		
Overmedicating	1	1				
Refused Treatment	3	1		2		
Roughness	4		4			
Rudeness	10	3		1		6
Surgical Misadventure	2	2				
Surgical Mismanagement	3			3		
Undermedicating	3			3		
Unethical Conduct	6			6		
TOTAL	**252**	**108**	**32**	**97**	**6**	**9**

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 bill for interpretation of ECGs by virtue of their specialty.

The College of Physicians and Surgeons of Manitoba recognizes our ECG examination, and allows Manitoba physicians who have passed our ECG examination to bill for interpretation.

During 2006 six physicians wrote the ECG examination, two of whom were from Manitoba. Of those six, four passed and one failed to earn the 75% passing mark. Of the Saskatchewan physicians who passed, two are Emergency Medicine physicians who work in hospital Emergency Departments, and one is a foreign medical graduate in Internal Medicine. One of the Manitoba physicians passed the exam, and the other failed to achieve a passing mark.

The College continues to receive notification from physicians of their participation in an ECG refresher course in compliance with the College's revalidation policy. That policy was accepted in 2004, and 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 pediatrics 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 is pleased that the membership of the ECG has remained constant as three members have been on the Committee for more than 10 years, and the fourth joined the Committee in 2005 on the retirement of one of the previous members.

The Committee membership consists of Dr. R. Chernoff (chair), Dr. R. Balakrishna, Dr. P. Schwann, and Dr. J. Akhtar.

Health Care Facilities Credentialing Service

The College continues to offer all Regional Health Authorities physician credentialing advisory services on a cost recovery basis for all physicians who apply for GP anesthesia privileges and/or any other privileges beyond Level 1. Level 1 privileges are those privileges that would generally fall within the scope of competence for most physicians who have maintained active medical practice in the relevant practice domains.

The demand from RHAs for credentialing advice has progressively declined, which is probably a measure of growing RHA confidence in the reliability of internal advice from regional MACs or medical staff credentialing committees. As a consequence of the diminished demand for this service, the Council reviewed the need to maintain regularly scheduled meetings of the Health Care Facilities Credentialing Committee.

At a meeting on November 24, 2006 the Council adopted a bylaw amendment that modified

how the Health Care Facilities Credentialing Committee will function in the future. The committee will now serve as a repository of expertise that College staff can tap into as needed to address atypical credentialing issues. In most instances the College staff are well positioned to provide advice to the RHAs based on existing College policies.

I want to thank all the physicians and RHA management personnel who have faithfully attended Health Care Facilities Credentialing Committee meetings in the past. We will continue to rely upon and value the assistance that committee members will provide in the future on a standby basis.

Respectfully submitted: Dr D. Kendel, Registrar

Laboratory Quality Assurance Program

The Laboratory Quality Assurance Program is focused on providing high quality laboratory accreditation, external assessment and education services. Quality management principles ensure laboratories deliver efficient and effective laboratory services.

Accreditation is process based on a model that meets goals and requirements developed by the Program. To enhance their process, the Program has revised the checklist documents and QA policies to bridge the gap between mediocrity and the pursuit of excellence.

To date we have successfully completed 21 audits in 2006. We find that these peer review audits have achieved a high level of success, where inspectors and those sites inspected receive benefit and value the process. The participation demonstrated is acknowledged in a positive manner, especially in a time of a recruitment / retention issues.

The Program is active on the national scene providing a strong contingent to the Canadian Coalition for Quality in Laboratory Medicine (CCQLM) that includes President, and Chair of Anatomical Pathology and Haematology working groups. We are also represented on the CSA National Committee for Medical Laboratory Quality Systems.

Many thanks for another successful year to all who served as an inspector, or on a QA Committee, or as a resource to the Program.

Anatomical Pathology Committee

Dr. E. Jones, Chair
Dr. R. Kanthan
Ms. L. Karnes
Ms. D. McHardy

Biochemistry Committee

Mr. E. Serediak, Chair
Dr. S. Angel
Ms. M. Currie
Ms. D. Hanrieder
Mr. M. Qureshi

Hematology Committee

Dr. A Saxena Chair
Ms. C. Bear, Chair
Dr. R. Deveraj
Ms. B. Flowers
Ms. N. McPeek

Microbiology Committee

Dr. G Horsman, Chair
Ms. B. Borgford
Ms. D. Aschim
Dr. P. Levett
Ms. P. Nyholt
Dr. S. Robichaud

PMC Committee

Dr. B. Murray, Chair
Dr. E.C Alport, SMA
Ms. S. Clarke, SSMLT
Dr. R. Deveraj
Ms. P. Dupont, SACLXT
Dr. I. Etches
Dr. G. Horsman
Dr. E. Jones
Ms. D. Mcleod, Lab Lic.
Mr. E. Serediak
Mr. B. Young, SAHO

Transfusion Medicine Committee

Dr. I. Etches, Chair
Ms. L. Baryluk
Ms. J. Hoff
Mr. I. Peterson
Ms. L. Purcell
Dr. R. Seno

The Program welcomes two new staff, Ms. T. Brown and Ms. C. Swan. We say good-bye and good luck to Ms. V. Marsh and Ms. J. Bush.

Respectfully submitted by: Ms. G. Hearn, Director Lab QA Program.

Perinatal and Maternal Mortality Study Committee

The Perinatal and Maternal Mortality Study Committee of the College of Physicians and Surgeons of Saskatchewan is one of the means by which the College works to improve the quality of care received by the citizens of Saskatchewan.

The Committee does this by a multidisciplinary review of individual cases of perinatal and maternal mortality and by the recognition of systemic problems that become evident from these reviews.

The Committee reviews perinatal deaths including stillbirths and early neonatal deaths currently up to seven days but has committed to review those up to 28 days of life. In addition, the Committee reviews maternal deaths during pregnancy or within 42 days of termination of pregnancy.

The Committee provides feedback to individual physicians involved in the case with recommendations for improvement of care when appropriate. When there are issues identified that would benefit physicians more widely, the Committee provides this information by way of a newsletter article.

In addition to interacting with the physician members with respect to any recommendations the Committee may make, the Committee also serves as a resource to other agencies with respect to standard expectations.

The Committee also corresponds with other professional regulatory bodies or health regions to provide suggestions and/or to raise concerns that the Committee has been unable to address itself. As part of obstetrical care is provided in a team environment with both physicians and nurses, the Committee is fortunate to have a registered nurse, Ms. S. Staseson, with obstetrical expertise who assists in the review of these cases.

The work cycle of the College's review Committee does not match any particular calendar year and the cases reviewed may be from a number of years. In 2006, the Committee met twice to review a total of 80 cases. Ten of these cases had been carried over from 2005 for further review (four had occurred in 2004 and six in 2005). There were 70 new cases reviewed with four occurring in 2004, 39 in 2005, and 27 in 2006. Of the 80 cases reviewed, two were classified as preventable; however, one was preventable related to a non physician health care provider's failure to recognize an abnormal electronic fetal monitor tracing. Two were identified as ideally preventable, one for failure to have an adequate management plan for fetal surveillance at the point of diagnosis of a gestational hypertensive patient requiring pharmacotherapy for management of the blood pressure, and the second related to an error in communication regarding the transfer of a high risk patient to a tertiary care centre for delivery. Two other cases were found to be non-preventable by the physicians but worthy of comment as the Committee found them to be ideally preventable by the patients due to non-compliance with medical advice.

The issue of interpretation of electronic fetal monitor tracings was discussed at length by the Committee due to the fact that it had two preventable cases, one related to physician failure to recognize an abnormal electronic fetal monitor tracing and the other related to a non physician health care provider's failure to recognize an abnormal electronic fetal monitor tracing. The Committee questioned what the educational requirements were for physicians and non physician health care providers involved in labour and delivery for ongoing competence for interpretation of electronic fetal monitor tracings and whether there was a requirement for NALS. The Committee is seeking this information from the appropriate regions.

Timely access to ultrasound was identified as a concern by the Committee. The Committee acknowledged that there was at least one case of delayed access to ultrasound after maternal serum screening results indicated an increased risk. The Committee believes delayed access is unacceptable in this clinical situation as it may limit the patient's options.

The Committee also noted a concern with the content of some ultrasound reports. In particular, the Committee noted that ultrasound of a twin pregnancy should note chorionicity, which is important in the clinical management of a twin pregnancy. It was also noted that some ultrasound reports give only a gestational age and do not comment on the "markers" of aneuploidy. It should be noted by practitioners involved in obstetrical ultrasound that the requirements for the reports are outlined in the *Standards for Obstetrical Ultrasound* set by the diagnostic imaging quality assurance review process.

The Committee also noted concerns with the quality of the ultrasound when performed on obese patients. Often times the report will indicate the ultrasound was somewhat limited because of the body habitus. The Committee questioned whether a more objective measure would be the documentation of uterus to skin measurement. The Committee has alerted the Advisory Committee on Medical Imaging to its concerns for further discussion on this issue.

In follow up to the Committee's concern with respect to the assessment of fetal monitoring tracings by both medical and non physician health care provider staff, Ms. S. Staseson along with Dr. E. Clark published an article with case studies to be used as a guideline for assessing the fetus by electronic fetal monitoring or auscultation. This was published in the College's *Newsletter* in Spring 2006, Volume 22, Number 64. A follow up article written by Dr. G. Carson is an article on physiology in monitoring called *"Fetal Heart Rate Monitoring in Labour"* will be published in subsequent pages of this *Newsletter*.

The Committee is still awaiting national guidelines on the limits of viability prior to drafting an article for the *Newsletter*. At its most recent meeting, the Committee determined that it may write a preliminary article to assist the membership during the period of time in which it awaits the national guidelines.

Although the Committee's work during the year does not represent the work of one calendar year, the Committee would report on a year of data where its statistics were complete and could be compared with Saskatchewan Vital Statistics data. *The 2003 Annual Report on Saskatchewan Vital Statistics* indicates that there were 12,113 live births (12.2 crude rate per 1,000 population), 119 perinatal deaths (500 grams or more or 20 + weeks gestation) (9.8 crude rate per 1,000 total births [live births and stillbirths]), with 78 of them being registered as stillbirths (6.4 crude rate per 1,000 live births). The Perinatal and Maternal Mortality Study Committee however reviewed only 83 perinatal deaths including 59 stillbirths registered in 2003. Of those reviewed by the Committee, three were found to be preventable and one ideally preventable.

Last year the Committee reported that there was a discrepancy in the total number of perinatal deaths including stillbirths reviewed by the Committee versus those registered by Vital Statistics for the year 2002, and it appears that there is a discrepancy in the data for 2003. Up until the last few years, the Saskatchewan Vital Statistics provided the information with respect to stillbirth and perinatal deaths directly to the College. In more recent years, the regional health authorities have provided the information. The Committee through its medical manager has interacted with Saskatchewan Vital Statistics and the provincial epidemiologist to determine why it is not receiving notification of all perinatal deaths and stillbirths. Continued work in this area hopefully will rectify this problem.

Physicians are reminded that the Perinatal and Maternal Mortality Study Committee endorses the obstetrical guidelines and policies of the Society of Obstetricians and Gynaecologists of Canada. Physicians are encouraged to visit the website as www.sogc.org for review of these.

A subcommittee has been named which will review the prenatal sheet Saskatchewan Health publishes and distributes. The Perinatal and Maternal Mortality Study Committee will in this *Newsletter* request input from interested physicians and other parties who wish to provide recommendations for change and revision to the prenatal record. Anyone wishing to propose changes for the prenatal record may provide those changes directly to Ms. K. Bergstrom, Coordinator for the Perinatal and Maternal Mortality Study Committee at bergstk@shin.sk.ca.

With regret the Committee announces the resignation of the long serving Chair Dr. G. Carson. Dr. Carson has written in his letter of resignation, "The Perinatal and Maternal Mortality Study Committee is an outstanding example of medical professionalism at its best. We engage in objective and critical analysis of our work as a part of self-regulation to enhance the quality of patient care. We do this for individual cases and, as appropriate, we recognize and comment upon systemic issues in care. Happily, and reassuringly, in most instances we discover that the unfortunate adverse outcome was not avoidable and that the quality of care provided was appropriate. Our approach in other circumstances has been educational and I believe that we have contributed to improving the quality of care and the safety provided for pregnant women and their fetuses/neonates in Saskatchewan."

On behalf of the College, we would like to take the opportunity to thank Dr. Carson for his long service and also the other Committee members for their hard and valued contribution to quality assurance. They are Dr. C.E. Clark, Dr. K.C. Fong, Dr. M.A. Halyk, Dr. J. Hey, Dr. M.J. Martel, Dr. N. Wonko, and Ms. S. Staseson.

The Committee would also like to announce the appointment of Dr. D. Shepherd to replace Dr. Carson.

Respectfully submitted by: Dr. K. Shaw, Medical Mgr. Ms. K. Bergstrom, Coordinator.

Prescription Review Program

D. Kendel, MD, Registrar

The Prescription Review Program continues to be funded jointly by Sask. Health, the College of Physicians and Surgeons, the College of Pharmacists, and the College of Dental Surgeons and operated by the College of Physicians and Surgeons.

The four organizations involved in joint sponsorship of this program are engaged in dialogue with Sask. Health to explore the potential advantages and/or disadvantages of reconfiguring the program under distinct legislation such as is the case in Nova Scotia.

Similar programs designed to mitigate public risk associated with drugs that have a high risk of abuse currently exist in British Columbia, Alberta, Manitoba, Nova Scotia, and Newfoundland. The government in New Brunswick is considering the establishment of a program similar to that in Nova Scotia.

To help us determine the best course of action for Saskatchewan on November 21st we hosted a meeting of representatives from all provincial programs to discuss the strengths and weaknesses of different models. The meeting yielded a very useful exchange of information that will assist the partner agencies in Saskatchewan to chart our future.

On another front, representatives of the four western Colleges of Physicians and Surgeons are exploring the development in Western Canada of an "appropriate prescribing" course for physicians similar to that offered by the College of Physicians and Surgeons in Ontario and Caste Western University in the United States. Dr. Janet Wright from the College of Physicians and Surgeons of Alberta has agreed to coordinate the continuing exploration of this option.

Effective November 1, 2006 the Prescription Review Program in Saskatchewan has contractually engaged Mr. D. Spitzig, a pharmacist, on a part-time basis to help the program

develop greater analytical capability and to develop some educational resources for prescribers and dispensers of drugs subject to review in this program.

Although Doug has just begun his analysis of the Prescription Review Program database, he has already identified some high-risk patterns of prescribing and drug utilization and will help to develop strategies for mitigating risks associated with those practices. It is our hope that we will be able to engage physicians and pharmacists jointly in some risk mitigation initiatives.

At its meeting on November 24, 2006 the Council of the College amended the bylaw governing the Prescription Review Program to eliminate the requirement that drugs prescribed under this program must be dispensed within three days of the prescription being issued. We need to await Ministerial approval of this bylaw before it comes into effect. We will notify the profession when the “three-day rule” is no longer in force.

A. Lee continues to serve very competently as the only fulltime employee of the Prescription Review Program. Over the past twelve months Amanda has sent out 3,643 “alert letters” that are intended to alert physicians to situations in which they are one of three or more physicians prescribing monitored drugs to the same patient. This information, which is often unknown to one or more of the prescribers, is intended to help physicians provide safer and more appropriate care to their patients while reducing the risk of drug diversion and abuse.

Complete and current physician awareness of all drugs that are being dispensed to a patient under that physician’s care is now possible on a 24/7 basis through the Pharmacy Information Program (PIP). Physicians who have Internet connectivity and who register with the program have real time access to the drug utilization history of patients they are attending.

We would strongly encourage all physicians to register with the PIP and to utilize the information available to them through this program to assist them in providing safe high quality pharmacotherapy to their patients. Physicians who have a proportion of patients in their practice with a history of drug abuse and/or physicians who provide episodic care to patients not well known to them are particularly urged to utilize the PIP.

In conclusion, I have asked A. Lee and D. Spitzig to include in this report some non-nominal statistical information from the Prescription Review Program that may be of interest to physicians. If this statistical information prompts any questions or feedback to the College you are welcome to direct your questions or provide your feedback to me, A. Lee or D. Spitzig.

There were 15 “explain” letters and 4 “educational” letters sent out from December 2005 to December 2006.

For the month of September 2006 there were 1,675 prescriptions related to double doctoring. Out of these, 155 patient profiles were selected for review. 45% of the profiles reviewed included patients who were concurrently on Methadone for chemical dependency.

The overwhelming proportion of double doctoring occurred in five distinct geographical areas, including Saskatoon, Regina, Yorkton, North Battleford and Prince Albert. An early indicator of duplicate prescribing appearing to be a major issue of double doctoring is for benzodiazepines.

Respectfully submitted: Dr. D. Kendel, Ms. A. Lee and Mr. D. Spitzig.

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. Most of the eligible family doctors have now been assessed and, therefore, PEP will begin a second round of family physician assessments rather than depriving

this group of the benefit and value of assessment while waiting for the completion of specialty assessments. PEP is continuing to emphasize common problems managed by family physicians and identified by them as asthma, cardiovascular risk factor, depression, diabetes, and hypertension. Experts are consulted for updates in what PEP will expect as the Clinical Practice Guidelines in each area evolve.

PEP is conducting an increasing number and range of specialist assessments. These continue in the sections of Psychiatry, Ophthalmology, and Nephrology. Assessments have begun in the sections of Obstetrics and Gynecology and Pediatrics. New assessors are currently being evaluated and trained to begin conducting assessments in the section of General Surgery. Assessment tools are being developed for the subsection of general Internal Medicine.

2006	To Be Reviewed	Category 1	Category 2	Category 3	No Category (Illegible)	Total
Age Group: A (<50)	5	22	7			**34**
B (50-64)	4	7	3		1	**15**
C (>64)		4	2			**6**
Gender: Male	4	24	10			**39**
Female	5	9	2			**16**
Urban: Regina & Saskatoon	7	10	1		1	**19**
Rural: All Others	2	24	10			**36**
Family Practice:	5	24	7		1	**37**
Family Practice Revisit:		2	1			**3**
Specialist:	4	8	2			**14**
Specialist_Revisit:			1			**1**
2006 January - September:	**9**	**34**	**11**	**0**	**1**	**55**
Total Assessments to Date:	**9**	**635**	**137**	**3**	**3**	**787**

Specialty assessments (January - September): 1 Pediatric / 3 Ophthalmology / 5 Psychiatry / 5 O&G

Description of PEP Assessment Categories:

1. Consistent good care, no concerns re; patient care or records.
2. Acceptable with significant need for improvement in specific areas.
3. Immediate cause for concern, serious risk of harm to patients.

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.

Some Category 2 assessees with significant deficiencies have done intensive work with the PEP Committee and Continuing Professional Learning. This has resulted in them achieving

Category 1 status on re-assessment. This illustrates the benefit for Saskatchewan physicians of a close working relationship with PEP and CPL.

ANNUAL PEP ASSESSOR'S CONFERENCE

The seventh annual PEP Assessor's Conference was held in Regina on the last weekend of September. The purpose of the conference is to provide ongoing education to the assessors and committee members of the Saskatchewan Practice Enhancement Program. It is also one of the important opportunities to receive feed back from the assessors and to continue to improve PEP. Opportunities are provided for discussion of various assessment-related topics, for instructional sessions and as well as to review the progress of PEP to date. Attendees included members of the PEP Committee, assessors from the sections of family practice, psychiatry, ophthalmology, pediatrics, obstetrics and gynecology, and general surgery as well as representatives from the College of Physicians and Surgeons and Saskatchewan Health. The keynote speaker was Dr. Richard Handfield-Jones, Director of CME at the University of Ottawa. He presented on the subject of "Changing Behaviour to Enhance Practice".

"Revalidation - direction for physicians to maintain status" was a major conference topic. Representatives from the College of Physicians and Surgeons, Continuing Medical Education, the Royal College, Saskatchewan College of Family Physicians, and the Regina-Qu'Appelle Health Region were invited to present their individual requirements and expectations. A session of questions and discussion was then held.

PEP assessors will be better able to assist physician assessees with questions and concerns about revalidation requirements. It was felt that PEP assessments may identify areas for physicians to recognize learning needs and thus help direct specific CPD for individuals.

It is the opinion of PEP that participation as an assessor or an assessee should qualify for Maintenance of Certification (MOC) with the Royal College for specialists and may be claimed by assessors and assesses at their discretion. This includes the actual assessment which fits in Section 5 "Personal Practice Review" as one credit per hour spent and may include a "Personal Learning Project in Section 4 if a learning need is identified in the assessment and that need is acted upon as a learning project. Requirements are different for acquiring MainPro credits with the College of Family Physicians and PEP is working with the CFPC to enable assessors and assessees to be able to claim the appropriate credits.

Educational sessions were dedicated to updating knowledge and application of assessment tools and processes. Attendees voiced concerns, comments and suggestions for improving the program and positively impacting medical practice in Saskatchewan.

WELCOME NEW PEP ASSESSORS:

Dr. G. Cuddington, Regina (General Surgery)   Dr. J. Steenkamp, Cutknife (Family Practice)

Dr. S. Martin, Saskatoon (Pediatrics)

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 continued advice and financial support.

Further information is available on the PEP Website: www.pepsask.ca

Respectfully submitted by: Dr. G. Carson, Co-Chair, Dr. B. Laursen, Co-Chair, Dr. P. Davis, Dr. A. Endsin, Dr. M. Fowler, Dr. S. Kukha-Mohamad, Ms. J. Peat, Coordinator

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

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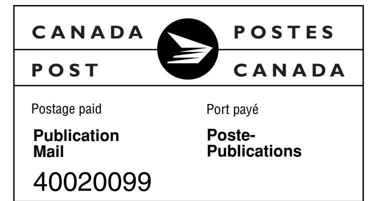

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