



College of Physicians & Surgeons of Saskatchewan

Newsletter



Dr. S. Kassett, Herbert

Message From the President

A substantial portion of the challenges that the College Council faced in 2007 were a direct reflection of physician manpower shortage. For example, demands for special registrations or exemptions from certain registration requirements were high. With the expectation of a population growth within our province, these types of requests are once again anticipated for 2008.

The efficacy of an organization is often measured by how well it deals with problems as they develop. On the other hand, measuring success, based on an organization's ability to anticipate problems before they arise, is often more difficult. On this note, the development of a comprehensive strategic plan, as well as, the implementation of Continuing Medical Education requirements for registration, were two major proactive achievements made by Council over the past year.

This past year the College council was able to take advantage of the robust real estate market and, after initial reservations, sold the College's long time office building. The Staff is finding their new accommodation much more adequate to their needs and operational costs are not projected to rise.

We bid farewell to Council members, Dr. William Albritton and Mrs. Jean McKay, who have completed their term on Council, and to Dr. Michael Nsisi, who is moving on to Alberta. On behalf of the College Council I would like to sincerely thank you for your dedication and hard work. We wish you all the best in your future endeavours.

On behalf of Council, I would like to wish you and yours the very best for 2008.

Dr. Suresh Kassett
President

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2007 Council Members—College of Physicians and Surgeons of Saskatchewan

Name	Community	Specialty
Dr. Suresh Kasset - President	Herbert	Family Physician
Dr. Geraldo Fernandes - Vice President	North Battleford	Otolaryngology
Dr. Edward Tsoi - Past President	Estevan	Family Physician
Dr. Sheila Harding	Saskatoon	Dean of Post Graduate Medical Education
Dr. Michel Salib	Yorkton	Anesthesiology
Dr. Alanna Danilkewich	Saskatoon	Associate Professor of Family Medicine
Dr. Sylvester Ukabam	Regina	Gastroenterology
Dr. James Fritz	Regina	Otolaryngology
Ms. Peggi-Lynn Gatin	Prince Albert	Public Member
Dr. Pierre Hanekom	Melfort	Family Physician
Ms. Karen Prisciak	Saskatoon	Public Member
Mr. Graeme Mitchell	Regina	Public Member
Dr. Tilak Malhotra	Prince Albert	Pediatrics
Dr. Grant Stoneham	Saskatoon	Diagnostic Radiology
Dr. Fred Morris	Moose Jaw	General Surgery
Dr. Michael Nsisi	Macklin	Family Practice
Ms. Millie Reynolds	Saskatoon	Public Member
Ms. Brenda Righetti	Regina	Public Member

Executive Committee

Name	Community	Speciality
Dr. Suresh Kasset - President	Herbert	Family Physician
Dr. Geraldo Fernandes - Vice President	North Battleford	Otolaryngology
Dr. Edward Tsoi - Past President	Estevan	Family Physician
Dr. Pierre Hanekom – Member-At-Large	Melfort	Family Physician
Ms. Karen Prisciak	Saskatoon	Public Member

At the outset of each New Year people often make several "resolutions" to change one or more things in their life. Because the College of Physicians and Surgeons operates on a calendar fiscal year, it's logical we might also define some change goals for 2008. I'm pleased to share with you some of the goals we've established for the coming year.

Enhancing Our Organizational Effectiveness and Efficiency

We've embarked on an internal learning exercise with the goal of understanding and applying LEAN Principles to the College's operations. In December 2007 Mr. Keith Willoughby from the Health Quality Council and Mr. Dan Florizone from the Five Hills Health Region partnered with Barb Porter, a member of our staff, to introduce us to LEAN Principles.

We've elected to apply those principles first to our registration procedures and services. In January 2008 Keith Willoughby led us in a "process mapping" exercise related to registration services. Now that we've explicitly mapped all the procedures that we follow in registration processes, we've begun the search for efficiencies in that process. As we realize the benefits of LEAN operating principles in our registration process, we will extend those principles to other aspects of our operation.

Enhancing Our Information Management Capacity

As is the case in clinical medical practice, we significantly lag other industries in our adoption and utilization of information technologies. Many of our processes are very labor intensive and consequently inefficient.

We've adopted two strategies to enhance our information management capacity. First, we're building upon our

positive working relationship with the Saskatchewan Health Information Network. Secondly, we've made budgetary provision to engage dedicated in-house IT expertise.

We have two very explicit information technology goals for 2008. We are committed to having a state-of-the-art online registration renewal option functional by October 2008 so it can be applied to the 2009 registration renewal cycle. We are also committed by year end to having a web based initial physician registration process in place. This latter goal is particularly critical as we face an ever expanding volume of applications from physicians around the world.

Building Partnerships to Advance Patient Safety

The College of Physicians and Surgeons is just one of many organizations committed to making health care in Saskatchewan as safe as it possibly can be. Historically we, and most other organizations, have pursued patient safety agendas and goals in isolation from one another. We've not effectively seized opportunities to build safety enhancement capacity by working together. We hope to change that history in 2008.

There are some very exciting and challenging changes occurring in the field of patient safety. Issues related to patient safety are moving "out of the shadows" to become part of the public agenda.

The Canadian Institute for Health Information (CIHI) is now routinely measuring standardized mortality rates (HSMR) in hospitals across Canada and making this information available to the public. For the first time in Canada we now have an objective means of identifying hospitals that are leaders in patient safety and those that have considerable room for improvement.

If hospitals with poor patient safety performance are to be successful in improving that performance, all health care professionals will need to be involved in that change process. Physicians have a long history of mortality review conducted in confidential peer review meetings. However, most physicians have very little experience with a more open search for patient safety risks that includes the entire health care team. If physicians are to make an optimal contribution to patient safety in the future it will be essential that they engage in more team based approaches to safety enhancement at the local level. We are prepared to do whatever we can to help physicians successfully make that transition.

No single organization owns or ought to control the patient safety agenda. However, that agenda is often stalled by a lack of organizational leadership. In 2008 the College of Physicians and Surgeons will demonstrate leadership by advancing inter-organizational dialogue in Saskatchewan about patient safety and building effective partnerships between organizations committed to working together to make health care in Saskatchewan as safe as it possibly can be.

2008 promises to be a very busy and exciting year for the College of Physicians and Surgeons. We're looking forward to both the opportunities and challenges we will encounter in the months ahead.

Dennis Kendel, M.D.

Canadian Consensus Documents for Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) and Fibromyalgia Syndrome (FMS)

The National ME/FM Action Network has provided the College with complementary copies of the overview of the Canadian Consensus Documents for Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) and Fibromyalgia Syndrome (FMS). The National ME/FM Action Network is a registered, Canadian non-profit organization dedicated to advancing the recognition and understanding of ME/CFS and FMS through advocacy, support and research.

Health Canada selected Expert Consensus Panels including world leaders in the research and clinical management of these illnesses. Their mandate was to develop clinical definitions that addressed a broader spectrum of the pathogenesis of these illnesses, as well as to provide diagnostic and treatment protocols for medical practitioners. The Consensus Documents received 100% consensus by the

member of their respective panel and the documents were then published in peer review journals.

The Canadian College of Family Physicians recommended that Overview of the Consensus Documents be produced to further assist busy practitioners. Dr. Bruce Carruthers, FRCP(C), principal author of the ME/CFS Consensus Document and Co-Editor of the FMS Consensus Document, and Marjorie van de Sande, Consensus Coordinator of both consensus documents, wrote and published such overviews. Physicians are encouraged to look up the consensus documents and the overviews at www.mefmaction.net.

In addition, patient brochures, based on the consensus documents have been developed and the Network has indicated they may be reproduced in their entirety and distributed.

Anesthetic and Operative Deaths Study Committee

ANNUAL REPORT

The Anesthetic and Operative Deaths Study Committee strives to foster high quality anesthesia and surgical services in the province through peer review of deaths that occur within 10 days of anesthesia or surgery, identifying deaths that may have been potentially preventable, and providing educational feedback and guidance to physicians from the insights gained through such review.

The A. & O. Committee met four times in 2007. It reviewed 374 deaths that occurred within 10 days of surgery and/or anesthesia. Because there's considerable time delay in accumulating the essential information about these deaths, the deaths reviewed in each annual cycle are predominantly from previous years. Of the 374 cases reviewed this year, 7 were from 2004, 172 were from 2005, 183 were from 2006, and 12 were from 2007.

Of the 374 cases reviewed in 2007:

- (1) 367 were classified as non-preventable
- (2) 2 were classified as non-preventable but with issues of concern
- (3) 5 were classified as potentially preventable
- (4) 5 were classified as non-assessable as the committee had insufficient information to classify the cases at year end.

Even when the committee does not regard a death as potentially preventable, it may in the course of its review identify opportunities for future improvement in anesthesia and surgical care. In such instances it provides recommendations to physicians about such opportunities for

health care quality improvement. It did so in 59 instances over the past year.

While this form of peer based mortality review clearly has some potential to enhance patient safety, there is compelling evidence that greater patient safety gains can be achieved through interdisciplinary case review with broader powers to identify and remedy systemic safety risks. The College therefore discontinued this form of mortality review effective December 31, 2007 so that it can redirect its resources to patient safety initiatives that are more in interdisciplinary and systemic focused.

The College wants to extend its gratitude to all of the physicians who have served on the Anesthetic and Operative Deaths Study Committee over several decades, and particularly to the physician leaders who have chaired this committee during its history.

The committee membership in 2007 included Dr. B. Gilliland (chairperson), Dr. J. Akhtar, Dr. J. Benoit, Dr. M. Boen, Dr. J. Carter, Dr. B. DuVal, Dr. S. Gonor, Dr. M. Jurgens, Dr. D.R. Loback, Dr. V. Olsen, Dr. M. Plewes, Dr. D. Thompson, and Dr. S. Vuksic.

The members of this committee gave unstintingly of their time and expertise in service of patient safety goals through the A & O. Committee. We are hopeful they will continue to devote time and apply their expertise in new patient safety strategies that will emerge.

D. Kendel, MD, Registrar

**A CURRENT COPY OF THE COLLEGE BYLAWS ARE AVAILABLE ON
OUR WEBSITE www.quadrant.net/cpss**

Perinatal and Maternal Mortality Study Committee

ANNUAL REPORT

The Perinatal and Maternal Mortality Study Committee strives to foster the safety and quality of medical care provided to pregnant women and their newborns during their first 28 full days of life.

The committee reviews:

- (1) *All maternal deaths that occur during pregnancy or within 42 days following termination of pregnancy*
- (2) *All stillbirths*
- (3) *All neonatal deaths within the first 28 days of life*
- (4) *Other matters referred to the committee by the Registrar.*
- (5) *The committee met twice in 2007 and reviewed 102 cases, 6 of which were deaths that occurred in 2005, 63 from 2006, and 33 from 2007.*

Of the 102 cases reviewed in 2007:

- (1) *2 were classified as preventable*
- (2) *11 were classified as ideally preventable*
- (3) *1 was classified as ideally preventable with preventability related to the patient's non-compliance with medical advice.*

Factors contributing to preventable and ideally preventable deaths included:

- Delay in recognition of abnormal electronic fetal monitor tracings
- Inadequate ultrasonography
- Failure to recognize inter-uterine growth restriction
- Inadequate fetal surveillance following decreased fetal movement
- Inadequate medical management of gestational hypertension
- Failure to recognize and treat maternal diabetes
- Delay in physician attendance at a birth

Even when the committee does not classify a death as preventable or ideally

preventable it may identify opportunities for future health care quality improvement. When it does so, it provides recommendations to physicians, other health service providers and/or health system managers. In 2007 the committee provided such recommendations in 38 instances.

For most of its history the membership of this committee has included physicians only. In recent years the membership of the committee included a single registered nurse appointed by the Council on recommendation from the Saskatchewan Registered Nurses Association.

While this form of mortality review does have some potential to enhance patient safety, there is compelling evidence that greater safety gains can be achieved through more broadly based interdisciplinary review with enhanced power to identify and remedy systemic safety risks. The College therefore made a decision to discontinue this form of mortality review effective December 31, 2007 so that it may redirect its resources to new patient safety strategies that are emerging.

The committee membership in 2007 included Dr. J. Martel (chairperson), Dr. C.E. Clark, Dr. K. Fong, Dr. M.A. Halyk, Dr. J. Hey, Dr. D. Shepherd, Dr. N. Wonko, and Ms. Sharon Stasseson. These individuals gave generously of their time and expertise in service to the public and the profession through the Perinatal and Maternal Mortality Study Committee. We are hopeful they will continue to serve the cause of patient safety through new patient safety strategies that are emerging.

D. Kendel, MD, Registrar

Standards for Prescribing of Buprenorphine

Suboxone – a new medication for opioid addiction/dependence. It is expected that Suboxone will be available later this year for the treatment of opioid addiction/dependence. This is a combination of Buprenorphine and Naloxone. It has been used for a number of years in Europe and the U.S.A.

The drug has been allowed on the market with several restrictions by Health Canada.

1. *Physicians must undertake an educational program and be on a list as having completed the course; and*
2. *Patients must be daily witnessed for a minimum time period before being allowed carries.*

In addition the College has passed a bylaw which has additional requests and is appended for your reference. Finally, the Schering Drug Company is developing an online education program which should meet Health Canada's requirements and allow physicians easy access to the program. Physicians will receive CME credits for completing the course.

If you have any questions you may call me at 653-0586.

Lowell Loewen, MD

COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN—REGULATORY BYLAW AMENDMENTS

The bylaws of the College of Physicians and Surgeons of Saskatchewan are amended by adding paragraph 61 as follows:

61. Standards for prescribing of buprenorphine

- (1) For the purpose of this bylaw, "buprenorphine" shall include all products containing buprenorphine.
- (2) No physician shall prescribe buprenorphine unless:
 - (a) The physician has taken an educational program on prescribing of buprenorphine approved by the Council; and

- (b) The physician has a relationship with one or more addiction counselors and one or more pharmacists to offer opioid addicted patients the full range of treatment options; and
 - (c) The physician has established a program for the regular testing of patients receiving buprenorphine for drugs of possible abuse; and
 - (d) The physician has access to the Pharmaceutical Information Program to permit monitoring of drugs prescribed to those patients for whom the physician has prescribed buprenorphine.
- (3) No physician shall prescribe buprenorphine unless:
 - (a) The physician has received an exemption from Health Canada to allow that physician to prescribe methadone for the purpose of treating addiction; or
 - (b) The physician has spent a minimum of one day with another physician who has received an exemption from Health Canada to allow that physician to prescribe methadone for the purpose of treating addiction, who has met the requirements of this bylaw to prescribe buprenorphine and who prescribes buprenorphine as part of his/her regular practice.
- (4) Physicians who prescribe buprenorphine shall, as a condition of prescribing buprenorphine, participate in a program of continuing medical education which includes a minimum of six hours every two years in addiction medicine.
- (5) Physicians who wish to prescribe buprenorphine shall, as a condition of doing so, sign an undertaking in which they agree that:
 - (a) Their prescribing of buprenorphine may be audited on such terms and at such times as may be required by the College of Physicians and Surgeons; and
 - (b) They will co-operate with any such audit or audits; and
 - (c) They will follow the requirements of this bylaw pertaining to the prescribing of buprenorphine.
- (6) Failure to follow this bylaw shall be unbecoming, improper, unprofessional or discreditable conduct under *The Medical Profession Act, 1981*.

(Certified a true copy of a bylaw passed by the Council of the College of Physicians and Surgeons on June 22, 2007).

Complaints Resolution Advisory Committee

2006-2007 ANNUAL REPORT

The College of Physicians and Surgeons of Saskatchewan 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 and providing information, the College staff resolves the concern in an informal manner. If the complaint cannot be resolved by this type of interaction, the complainant is asked to identify their concerns in writing. Depending on the nature of the allegation, complaints are directed to two streams: (1) Complaints Resolution Advisory Committee review, and (2) Formal Investigation.

Complaints accepted through the Complaints Resolution Advisory Committee process are complaints with respect to the standard of care provided by the physician or low level conduct complaints registered by the patient or a third-party on behalf of the patient. The process is educational and does not result in formal sanctions.

Complaints referred to the more Formal Investigation process are complaints registered by the patient or a third-party on behalf of the patient, that question unprofessional conduct of a physician (i.e. sexual boundary violation) and/or global lack of skill and knowledge (competency). The outcome of this process may result in formal sanctions.

Concerns from third parties, such as regional health authorities or other outside agencies such as the police, and physician-to-physician complaints are not reviewed by the Complaints Resolution Advisory Committee and are usually referred to the Registrar for determination of what review process is appropriate.

The following report is limited to the work of the Complaints Resolution Advisory Committee review process.

The Complaints Resolution Advisory Committee process seeks to resolve complaints by exchanging information between the complainant and the physician in order to determine what may have led to the alleged problem. The purpose of the Committee's review is to provide educational suggestions to the physicians in cases where their care and conduct could be improved, and to provide complainants with a better understanding of the care provided and any recommendations that are made to the physician and/or the system for improvement in the provision of health care for themselves or others. The process is confidential between the College, the physician(s) and the complainant(s). 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. Review of complaints through the Complaints Resolution Advisory Committee does not lead to any formal sanctions. If, at the end of a review the Committee feels that the matter before it is not amenable to educational recommendations, it may refer the matter to the Registrar for additional consideration.

Complainants and/or 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 Committee for consideration. If complainants/physicians remain dissatisfied after the Committee has had an opportunity to address the areas of dissatisfaction, they may address their concerns to the Registrar for review. The

Registrar will review the case, and may direct further review, vary the Committee's decision, or raise the issue as an appeal to the Council of the College. An appeal is based on process issues only.

The yearly work of the Complaints Resolution Advisory Committee is comprised of cases registered in two calendar years. In 2007 the Committee met on seven occasions and reviewed approximately 18 cases that were registered in 2006 and not completed by the end of the 2006 calendar year, and reviewed an additional 92 cases registered in 2007. As cases reviewed do not match the calendar year, for statistical purposes the Committee reports statistics only on the most recent completed year of review.

The College received approximately 1100 expressions of concern or requests for information, the majority of which were dealt with by the administrative staff. There were 105 formal complaints registered through the Complaints Resolution Advisory Committee process in 2006 and 134 formal complaints registered in 2007. Of the 105 written complaints in 2006 there were 276 allegations. Of the 276 allegations for the 2006 cases, 82 were founded, 50 were partially founded, 119 were unfounded, 8 were found to be patient responsibility, and no determination was made in 10 of the allegations. The appended table outlines the allegation and determination codes for those cases registered in 2006. The average number of days to close a case was 113.

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 occasion there are long delays in the receipt of a physician's response, and

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. Physicians are reminded that failure to respond to requested information is a breach of Bylaws 31 and 32:

31. The Registrar, the Deputy Registrar, the Executive Committee, the Council and the Standing Committees referred to in paragraph 18 of these bylaws frequently request information and explanations from physicians. Prompt response to such requests are required if the College is to expeditiously and effectively regulate the practice of medicine and comply with the objects of the Act.
32. (1) Upon receipt of a written request from the Registrar, the Deputy Registrar, the Executive Committee, the Council or a Standing Committee for information a physician shall:
 - (a) respond substantially to the request;
 - (b) provide the information or explanation requested to the best of the physician's ability to do so;
 - (c) provide originals of documents requested, if originals are requested, or legible copies of documents if copies are requested;
 - (d) provide a printed record if the requested information or documents are stored in an electronic computer storage form or similar form.
- (2) A physician shall provide the requested information, as referred to in the paragraph (1) within 14 days of receipt of the request, or such additional time as may be granted by the Registrar or Deputy Registrar for the response.
- (3) A physician who is requested to provide information to the College of Physicians and Surgeons or to any individual or committees associated with the College of Physicians and Surgeons under paragraph (1), or under any other provision of the Act or these bylaws relating to the provision of information and documents including, without limiting the generality of the foregoing, paragraphs 18, 33,

39, 40, 42 or 52 of the bylaws and Section 55.3 of the Act, shall provide the information, explanation or documents contemplated by the request whether the consent of any person with an interest in the information, explanation or documents has, or has not, been sought or obtained.

- (4) Information obtained pursuant to this paragraph or under any other provision of the Act or these bylaws relating to the provision of information and documents shall be treated confidentially and, unless otherwise directed by the Executive Committee, or the Council, shall not be used except for the purpose of complying with the objects of the Act or the duties of the committee or individual which obtains such information or documents.
- (5) A physician who fails to comply with paragraph 32(1)(a), (b), (c), or (d) or paragraph 32(2) and 32(3) is guilty of unbecoming, improper, unprofessional or discreditable conduct.

Of particular note in the statistics reported for the completed 2006 year, there was an increase in the number of complaints where “fragmented care” was identified by the Committee. In a number of cases reviewed, patient care was negatively affected by the fact that a number of physicians were involved in the provision of care, yet there seemed to be a lack of coordination amongst the physicians, resulting in a less than optimal outcome due to a delay in assessment, diagnosis and/or treatment.

Another area of concern noted was the number of allegations related to communication concerns. In 2006, 9 of 14 allegations with respect to “lack of or error in communication” were founded with 4 being partially founded. There were 22 allegations of “inadequate communication” with 5 being founded and an additional 12 being partially founded. Physicians are reminded that the manner in which they communicate with a patient will influence the final outcome of care and also will often determine how satisfied the complainant is with their care. Even if the medical care provided is appropriate, without adequate communication

with respect to patient follow up and assurance of the patient’s understanding of their diagnosis and treatment plan, the outcome may not be optimal. The Committee has provided physicians with a number of common sense recommendations with respect to improving their communication with patients. Often a simple question at the end of the interaction, asking the patient what they have understood of the interaction that day with respect to their diagnosis and management plan, is helpful. When the question is asked at the end of the visit, it provides an opportunity for the patient to ask additional questions. If there has been any miscommunication during the visit, it can be clarified at that time. This is also a useful technique when the physician senses that an interaction with a patient has not gone well. Often, if the physician asks a patient at the end of the interaction if they have any additional concerns, physicians and patients can “clear the air” at that time and hopefully avoid a complaint being lodged later.

Complaints processes of the regulatory bodies across Canada have come under scrutiny of late. Much criticism is levied at regulatory agencies suggesting a lack of transparency and confusion around the complaints processes.

The manner in which “complaints” are managed by the College of Physicians and Surgeons of Saskatchewan is two-fold as has been alluded to: the Complaints Resolution Advisory Committee process which is the educational review stream for issues of physician care and low level conduct issues; or Formal Investigation for concerns regarding possible unprofessional conduct and global lack of skill and knowledge. At present the college’s staff provides information to the public about the complaint processes available to them, telephonically, in writing, and on the

website. Improvements are being made to the website to freshen and enhance the site. Physician members are also provided information on the complaints processes of the College through personal communication, the *Newsletter* or through the website. Care is taken by College staff to assist the complainant and the physician in understanding the nature of the process that is being used to review the complaint.

The Complaints Resolution Advisory Committee process involves public members as 50% of its membership. This insures a public perspective to the review of complaints. The process seeks to be transparent with the exchange of information between the complainant/patient and the physician; however, there are limitations imposed on the process by the legislation under which the College must work and respect. For example, a complainant may receive the physician's response if the complainant is the patient or has the patient's permission to receive it. Privacy rights of a patient survive beyond death. So, unless the request for the patient's information fits with one of the exceptions [under Section 27(4)(e) of *The Health Information Protection Act*], the physician's response may not be released to the complainant. In addition, the College must respect Section 60 of *The Medical Profession Act, 1981*, that restricts the complaints process to be in camera and confidential. This does not allow the College to provide any information to outside parties regarding the complaint. The College and the Complaints Resolution Advisory Committee recognize this is counterproductive to the desire to make improvements within the broader health care system. The College has identified this as a concern to Government and has suggested consideration of an additional clause that would allow the College discretion in releasing limited information to other agencies such as

the regional health authorities in order to assist in improving the system issues identified in the College's review of complaints.

The College staff involved in this part of the College's complaints process, with the assistance of the Committee members, will continue to review the processes involved in this educational stream of reviewing complaints, in order to improve the efficiency of this work and provide additional clarification to the public and the physician members to reduce any confusion that may exist regarding how complaints are reviewed.

The Committee would acknowledge the work of Ms. Virginia Marsh who resigned her position at the College in June of 2007. Ms. Marsh held the title of Regulatory Services Coordinator and was involved in the intake aspect of the complaints process. The Committee welcomes Ms. Tracy Hastings into the role of Regulatory Services Coordinator. Ms. Hastings started in this position in September 2007. The Committee would also like to recognize the work and support provided to the Committee by Ms. Camille Dunlop, Complaints Coordinator.

On behalf of the College, I would like to thank the Committee members for their dedication and hard work. Public members are Ms. A. Brayshaw and Ms. V. LaCroix of Saskatoon, and Ms. 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. Kreigler, family physician in Saskatoon.

Respectfully submitted,
Dr. Karen Shaw, Medical Manager
Ms. Tracy Hastings, Regulatory Services
Coordinator
Ms. Camille Dunlop, Complaints Coordinator

2007 ANNUAL REPORT

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.

During 2007 six family practitioners wrote the ECG examination, with five achieving the 75% passing mark. One of the successful physicians challenged the examination to meet the criteria for revalidation. Two of the examinees were from Manitoba. The College of Physicians and Surgeons of Manitoba allows their physicians to bill for interpretation if they have passed the Saskatchewan ECG examination.

The College continues to receive notification from physicians of their compliance with the College's policy on minimum number of readings to ensure

proficiency in interpreting ECGs. 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 ECG Committee membership consists of Dr. Roy Chernoff (chair), Dr. Rangappa Balakrishna, Dr. Paula Schwann, and Dr. Jawed Akhtar.

Clinical Practice Redesign School

Are you out of breath from running behind all day? Feeling congestion...in your waiting room? Maybe you need some CPR – Clinical Practice Redesign.

Clinical Practice Redesign (CPR) includes principles also found in Planned Care, Advanced Access, Clinical Office Redesign, and Open Access models of care. The benefits of CPR include: reduced wait lists and no-shows; improved office efficiency; increased patient/staff satisfaction; and, improved clinical outcomes.

CPR School is presented by the Health Quality Council. It is for people interested in facilitating a practice, department, or unit in using CPR. Program starts April, 2008 and continues until November, 2008. It includes four workshops, webinars, learning materials, and expert support.

The fee is \$3,000 + GST for Saskatchewan participants. **Deadline for registration is March 3, 2008.**

For more information on CPR School, please contact:

Tracey Timmerman: 306-668-8810 ext 104 /
ttimmerman@hqc.sk.ca

Or visit our website at: www.hqc.sk.ca/cpr

**Clinical Practice
Redesign**

*Getting to the heart
of your practice*



Health Quality Council—coming on March 25, 2008...

Help shape the future of quality measurement in Saskatchewan

The Health Quality Council is developing a made-in-Saskatchewan approach to ongoing measurement of and reporting on health system quality. The aim of the measuring and reporting program is to help health care professionals and organizations learn from one another in order to continually improve patient care.

Join us at a Telehealth site near you on March 25, 2008 to learn more about this new initiative and to provide your input.

What you'll hear from us:

An overview of the role of measurement in learning and quality improvement.

An explanation of what a “cascade” of quality indicators is, including how each level relates to the others, and how the different levels are relevant to boards, managers, front-line providers, and patients.

HQC's plan for involving health care stakeholders in developing the Saskatchewan health care quality measurement and reporting program.

A preview of the look and feel of the baseline quality report that HQC will release in fall 2008 (examples to include reporting on heart attack care,

patient experience survey, drug management of seniors, and wait times for breast cancer care.)

How HQC is building capacity for and supporting quality improvement among health care managers and providers in Saskatchewan.

What we would like to hear from you:

Your feedback on our plan for developing a quality measurement and reporting program for Saskatchewan.

Your thoughts on what is needed to make quality indicator reporting useful to your role in improving health care quality.

How you would like to be involved and/or kept informed as we develop an ongoing health care quality measurement program for Saskatchewan.

The meeting will be broadcast to Telehealth sites around the province. Watch the HQC web site (www.hqc.sk.ca) for further information on the location of the event, or contact Jack Wallace, HQC Special Projects Analyst by phone (668-8810, ext. 139) or email (jwallace@hqc.sk.ca).



Saskatchewan Institute of Health Leadership

The Saskatchewan Institute of Health Leadership (SIHL) is an initiative of the Centre for Continuing Education, University of Regina in partnership with the:

- College of Physicians and Surgeons of Saskatchewan
- Registered Psychiatric Nurses Association of Saskatchewan
- Saskatchewan College of Pharmacists
- Saskatchewan Registered Nurses' Association

The aim of the Institute is to bring together professionals from all disciplines and all levels within the healthcare system to foster leadership potential, skills and the creation of a leadership community that works together to promote, support and sustain good health.

The Saskatchewan Institute of Health Leadership supports the goals of the provincial government by:

- building upon leadership and professional development within an interdisciplinary context
- ensuring a new generation of skilled healthcare leaders

It is the first of its kind in Canada.

This six month program begins in May, 2008 and will conclude in November, 2008. A four-day “Institute Retreat” will take place in Regina, Saskatchewan, May 12-16, 2008 with SIHL Course Presenters and Facilitators. A two-day Project Retreat will take place November 13-14, 2008.

For Further information about the ISHL 2008 Program, contact:
Phone: 306.585.5853 or email: bpd@uregina.ca

For paper brochures contact:
Karen Smith, Program Assistant
Business & Professional Development Centre
For Continuing Education, University of Regina

2nd Annual Interdisciplinary Conference



SASKATCHEWAN
COLLEGE OF
PHARMACISTS



Call for abstracts - Deadline April 15, 2008
2ND ANNUAL INTERDISCIPLINARY CONFERENCE

“Ensuring Patient Safety with Citizen Engagement” Radisson Hotel, Saskatoon, September 19 and 20, 2008

The Interdisciplinary Conference Planning Committee invites abstract submissions for paper or poster presentations focused on the “Ensuring Patient Safety with Citizen Engagement” theme. This is an opportunity to attend and present to a provincial audience of health care providers. Presentations should highlight changes that have improved patient safety or demonstrated reductions in risk or harm and/or have successfully utilized citizen engagement. The intent of this session is to advance the dissemination of patient safety with citizen engagement success stories and showcase organizations’ work in patient safety and/or quality, with the hope that others may implement similar changes. Abstracts accepted as papers will be presented on Saturday, September 20, 2008. Poster presentations will be on display throughout the day.

Abstract Guidelines

- Oral presentations: 50 minutes (includes presentation and question period):
Poster presentations: 4 x 8 free standing neutral color bulletin board.
- Abstracts should be no more than 250 words single spaced.
- On page one, include: abstract title, name of presenting author, title, affiliation, mailing address, phone/fax numbers, and e-mail address.
- On page two, include: abstract title, abstract, preferred mode of presentation (paper or poster) and audio-visual requirements. Please include in your abstract how you will address the theme.
- All abstracts must be received at the SRNA no later than 4:00 pm, April 15, 2008. You are encouraged to submit the abstract via e-mail, in Microsoft Word or text format to: colson@srna.org.
- Selected abstracts will be announced in May, 2008.
- All presenters are expected to register for the conference and assume responsibility for registration, accommodations and transportation expenses.

Abstract proposals will be evaluated by a representative abstract selection committee who will be taking into account practicality in implementation, creativity and innovation, interdisciplinary collaboration and transferability across organizations. The committee will also take into account whether it has led to concrete improvements in patient safety, the degree to which citizen engagement was utilized and to what extent it has been tested. Proposals that do not follow the guidelines, are incomplete, or that are received after the deadline will not be considered for review.

Co-hosted by:

Saskatchewan Registered Nurses’ Association (SRNA)
Saskatchewan College of Pharmacists (SCP)
College of Physicians and Surgeons of Saskatchewan (CPSS)

Management of Hypertension in Pregnancy

Hypertensive disorders of pregnancy can be associated with both maternal and fetal complications. The goal of antihypertensive medication in these cases is to decrease the risk of maternal cardiovascular complications. The blood pressure should be brought down gradually using medications known to be safe in pregnancy. The aim of antihypertensive medication is to bring the diastolic blood pressure down to less than 110 mmHg and the systolic blood pressure down to less than 160 mmHg. Decreasing the blood pressure to below these numbers will effectively decrease the risk of maternal complications of hypertension (end organ damage, cardiovascular complications, stroke, seizure).

The fetus of the mother with a hypertensive disorder in pregnancy is at risk for fetal growth restriction, placental insufficiency, and asphyxia. Reasonable placental perfusion must be maintained to allow sufficient nutrients, fluid and oxygen to be transferred to the fetus. Maternal diastolic blood pressure in these cases should not be less than 80 mmHg.

Fetal surveillance for growth restriction and well being must be instituted on a regular basis once hypertension is diagnosed. Ultrasound assessment of fetal growth should occur every 3-4 weeks. Assessment of fetal well being should occur weekly from early third trimester (or the

diagnosis of hypertension if later) until delivery. In an appropriate for gestation size fetus and mild to moderate hypertension, weekly NST, biophysical profile, or Doppler would be appropriate. In the fetus identified as growth restricted or in situations of severe hypertension, NST alone is not sufficient and BPP or Doppler (ideally both) should be performed on a weekly basis to evaluate fetal health. Sometimes twice weekly fetal surveillance is indicated. Maternal daily fetal movement counts is not sufficient. Normalization of maternal blood pressure either by pharmacological or non-pharmacological means does not mean that the fetus does not require surveillance.

References:

1. von Dadelszen P, Magee LA. 2002. Fall in mean arterial pressure and fetal growth restriction in pregnancy hypertension: an updated meta-regression analysis. *JOGC* 24(12): 941-5.
2. Magee LA, Ornstein MP, von Dadelszen P. 1999. Fortnightly review: management of hypertension in pregnancy. *BMJ* 318(7194):1332-6.
3. ACOG. 2001. Chronic hypertension in pregnancy. *ACOG practice bulletin* #29.
4. Sibai BM. 2003. Diagnosis and management of gestational hypertension and preeclampsia. *Obstetrics & Gynecology* 102(1):181-92.
5. Working group report on high blood pressure in pregnancy. National Institutes of Health, Washington, DC 2000. p 18.

*J. Martel, MD, CRCS, Chair –
Perinatal and Maternal Mortality Study
Committee*

CMPA Guidance to Physicians on Participation in Clinical Research Studies

The Canadian Medical Protective Association has produced an excellent guideline for physicians who anticipate engaging in any clinical research involving patients. The guidelines are accessible on the CMPA website at www.cmpa-acpm.ca. The College of Physicians and Surgeons would very strongly recommend that any physicians currently engaged in clinical research or anticipating such engagement would access these guidelines and follow them.

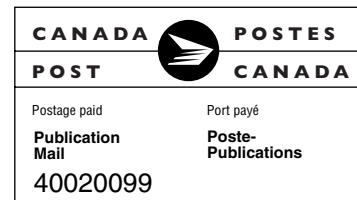
Please Return All Undeliverable Canadian Addresses To:

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Tracy Hastings, Regulatory Services Coordinator

And In Regina - Diagnostic Imaging & Lab Quality Assurance:

Georgia Hearn, Director, Diagnostic Quality Assurance
Tracy Brown, Lab Proficiency Testing Consultant
Angela Wiebe, Executive Assistant
Margie Zahorski, Executive Assistant

Take Note ...

ECG EXAM

COLLEGE OF PHYSICIAN AND SURGEONS:

Monday, March 3, 2008 and
Monday, May 5, 2008
1:15 pm - 4:15 pm

Contact Camille Dunlop,
Tel: (306) 667-4622

2008 COUNCIL ELECTIONS

President—Dr. Suresh Kasset
Vice President—Dr. Gerry Fernandes

Executive Committee:

President—Dr. Suresh Kasset
Vice President—Dr. Gerry Fernandes
Past President—Dr. Edward Tsoi
Member-at-Large—Dr. Pierre Hanekom
Public Member—Ms Karen Prisciak