

DocTalk

A PUBLICATION OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN

MESSAGE FROM THE PRESIDENT

Dear Colleagues

At the President's Dinner on the evening of November 19th, 2010, nine physicians were honoured for 40 years of dedicated service to the people of Saskatchewan and the Medical Profession. As in previous years, it was extremely interesting and very moving to hear about the various life-stories and careers of these dedicated physicians. The members who received Senior Life Membership in the College of Physicians and Surgeons at the Presidential Dinner included:



Dr. Grant Stoneham,
President

- Dr. Zaheer Alvi, Saskatoon
- Dr. Dianne Bekolay, Saskatoon
- Dr. Uddhav Bhalerao, Saskatoon
- Dr. Jyotirmoy Datta, Saskatoon
- Dr. Howard Hopkins, Regina
- Dr. Daniel Kirchgessner, Humbolt

- Dr. Ernest Klassen, Saskatoon
- Dr. Amir Shenouda, Saskatoon
- Dr. Michael Tyrrell, Saskatoon

Dr. Mervin Johnson from Meadow Lake was also awarded Senior Life Membership but was, unfortunately, unable to attend the Presidential Dinner to receive this award in person.



New Senior Life Members

It has indeed been a privilege to serve as President of the College of Physicians and Surgeons over the past year. During the last year, the Council of the CPSS has been involved in many activities and discussions. Some of the major activities that the College has participated in over the past year include, among other things:

- Council has actively participated in discussions with the Federation of Medical Regulatory Authorities of Canada (FMRAC) regarding the development of a National Standard of licensure.
 - The College has been in discussions with the Ministry of Health regarding all of the necessary legislative and regulatory amendments that will be required to ensure that Saskatchewan's medical licensure policies align appropriately with any National standards that are adopted.
 - The College has adopted a bylaw requiring CFPC certification as a prerequisite for first time, or initial, full licensure for Family Physicians.
 - Council has adopted a bylaw requiring the Medical Council of Canada Evaluating Exam (MCCEE) as a prerequisite for eligibility for licensure for all IMG's – to align with National standards.
 - The College has been actively involved in developing the “made in Saskatchewan” IMG Assessment program in collaboration with – the Government, the College of Medicine, the SMA and Regional Health Authorities. The program will assess IMG's prior to starting their practices in Saskatchewan, thereby avoiding physicians having to leave their practices to be assessed, and avoiding disruptions associated with physicians subsequently requiring remediation or having their licenses terminated.
 - Council performed a review and update of all the Governance Policies of Council at a Council Retreat in April.
 - Council removed the 3 year service requirement for IMG's embedded in the bylaws for registration.
- Council changed the distribution of Open Council meeting Agendas to ensure public media have the Agenda in advance of Open Council meetings, in an effort to increase our public presence.
 - Council started planning for the CEO succession that will occur on July 1st, 2011, including engaging an Executive Search firm to ensure due diligence.
 - Council met with the Minister of Health, and separately with the Deputy Minister of Health twice, in an effort to improve communication regarding issues of mutual concern – very important in these times of changes in licensure. The dialogue has focused on the legislative and regulatory amendments necessary to align Saskatchewan Medical licensure policies with National Standards.
 - Council reviewed (confirmed, modified or deleted) the current College policies that relate to the practice of medicine.
 - Council started looking at future options for the location of the College, including setting up a committee to guide us in that process.
 - Council started discussions with the Government and the SMA on developing a process to deal with Abandoned Medical Records.
- ... nine physicians were honoured for 40 years of dedicated service to the people of Saskatchewan and the Medical Profession. As in previous years, it was extremely interesting and very moving to hear about the various life-stories and careers of these dedicated physicians.
- Council changed the Annual Physician Registration Renewal date to avoid certain

logistical problems inherent in the current system.

- Council approved a plan to make on-line physician registration mandatory for the 2012 registration cycle.
- Council determined that decisions made by the Council or the Executive Committee to lay charges of unprofessional conduct against a physician should be publicly accessible on the College website in the future.
- Plus, Council performed all the ongoing statutory disciplinary and regulatory work dealing with physician competency and professional issues that occur throughout the year.

I would like to thank all the Council members and the College Staff for their dedication and hard work over the past year. We have worked collaboratively and dealt with many interesting and sometimes complicated issues. I sincerely appreciate the opportunity to serve in the role of President of Council, and look forward to our ongoing activities.

**2011 Council Members
College of Physicians and Surgeons
of Saskatchewan**

Ms. Joanna Alexander, Regina	Public Member
Dr. James Carter, Regina	General Surgery
Dr. Mark Chapelski, Lloydminster	Family Medicine
Dr. Alanna Danilkewich, Saskatoon	Family Medicine
Dr. Gerry Fernandes, North Battleford	Otolaryngology
Dr. James Fritz, Regina	Otolaryngology
Rev. John Fryters, Prince Albert	Public Member
Dr. Pierre Hanekom, Melfort	General Practice
Mr. Ron Harder, Moose Jaw	Public Member
Dr. Sheila Harding, Saskatoon	Internal Medicine
Dr. Dan Johnson, Kindersley	Family Medicine
Dr. Suresh Kasset, Herbert	General Practice
Ms. Margaret Kuzyk, Saskatoon	Public Member
Dr. Tilak Malhotra, Prince Albert	Pediatrics
Mr. Graeme Mitchell, Regina	Public Member
Dr. Mukesh Mirchandani, Yorkton	Psychiatry
Dr. Grant Stoneham, Saskatoon	Diagnostic Radiology
Dr. Edward Tsoi, Estevan	Family Medicine
Dr. Gerrit Van Wyk, Moose Jaw	Urology

from the Registrar's Desk

Rocking Your Boat

All human beings appreciate the capacity for self-determination in their lives. There is something in our nature which resents any constraints on our liberty to do what we want, when we want and how we want.



Dr. Dennis Kendel,
Registrar

Either as a consequence of self selection and/or as a consequence of their education and socialization as a group, doctors seem to cherish self-determination more than most people. Some physicians seem to believe that the acquisition of an MD confers some form of divine right to absolute self-determination under the rubric of “professional autonomy”.

Physicians often respond very defensively when suggestions arise from any quarter that their professional autonomy may need to yield to more rigorous regulation of medical practice to accommodate evolving public expectations of the medical profession. Physicians react particularly adversely when calls for more rigorous regulation arise from within the “house of medicine”.

The New England Journal of Medicine (NEJM), a highly respected icon within the house of medicine, has just “rocked the boat” of medicine with a very thought-provoking article on “Sleep Deprivation, Elective Surgical Procedures, and Informed Consent”.

The article cites well established research evidence that sleep deprivation impairs psychomotor function in the same manner as alcohol intoxication. We have zero tolerance for a surgeon operating while suffering from alcohol intoxication. If we’re truly committed to patient safety, why would we consider it acceptable for a surgeon to operate while sleep deprived?

As a profession, medicine also places a high value on professional self regulation or “professionally-led” regulation. This may be driven substantially by self-interest or by a genuine belief that physicians are best positioned to observe, understand, and mitigate the risks of public harm associated with medical practice.

For the purposes of this article, I’m going to assume that our profession’s persistent claim to the privilege of professionally-led regulation is entirely altruistic. I’m going to assume that it is based upon the premise that doctors are in the best position to observe, understand, and mitigate risk of patient harm associated with medical practice.

To their great credit, through selfless participation in local medical leadership/management roles in RHA’s or through participation in the public protection work of the College of Physicians and Surgeons, some physicians do make a very positive contribution to patient safety through professionally-led regulation.

However, it is with great regret that I observe that many physicians are utterly failing to discharge their public protection obligations under the social contract which is the basis for professionally-led regulation. Their failure to discharge these obligations puts our continuing privilege of professionally-led regulation at great risk.

Like the NEJM, I feel obligated to “rock the profession’s boat” by shining a light on our

profession's failure to deal responsibly with situations that do place patients at risk of preventable harm.

Just like alcohol intoxication and sleep deprivation can adversely impact physician performance, so can physical and mental illness, cognitive impairment of any cause, the effects of aging, uncontrolled stress, and excessive workloads.

Physicians are indeed well-positioned to observe suboptimal performance by medical colleagues through direct observation of their work, through referrals, through shared care arrangements, through the "hand-offs" associated with on-call duty, and a host of other ways.

If asked to respond in absolute confidence, virtually every physician will be able to identify one or more colleagues whom he/she regards to be performing so sub-optimally that they would never accept the involvement of those physicians in their care or the care of their immediate family members.

The Code of Ethics of the College speaks very forthrightly to the situation in which any member has reasonable concerns that a colleague may be practising at a level that is not an acceptable level of care. The Code of Ethics clearly directs physicians to report those concerns to "an appropriate authority".

It might be reasonable to first report such concerns to the Head of a Division, the Head of a Department, the local Senior Medical Officer, or the RHA CEO. However, if local reporting does not result in resolution of the concerns, there is clearly an obligation to report such concerns to the College. Indeed, where the concerns focus on questions of professional competence, even the SMA agrees that such concerns ought to be reported promptly to the College since the College is the only authority with

a statutory mechanism to objectively assess competence.

So, what is our experience at the College with members reporting concerns about the performance of colleagues? In two words, I would have to say that it has been "abysmally poor"!

It is not at all difficult to list a host of reasons why physicians might be disinclined to report concerns about the performance of a colleague. The colleague may be a practice associate or long term friend. The physician with concerns may be very junior in the profession and the colleague may be a senior member of the profession who may have held

In terms of protecting patients from harm arising from suboptimal physician performance, every member of our professional fills a position of great public trust ...

distinguished leadership roles. It feels like "ratting". "What if he or she retaliates by reporting on a past indiscretion of mine?"

"There, but for the grace of God, go I." "I just don't want to get involved in any dealings with the College." "I think he or she might retire soon and it would be unkind to cast a cloud over his or her final months or years in practice."

While all this reticence to report performance concerns to the College is very understandable, the "excuses" for not reporting all skirt around our profession's declared individual and collective commitment to the safety and welfare of patients. If we are either unwilling or unable to honour this commitment to the public, we ought to voluntarily give up any claim to the privilege of professionally-led regulation before we are publicly humiliated by involuntary loss of that privilege.

The College, working in very close collaboration with the Physician Health Program (PHP) of the SMA, always strives to maintain opportunities for ill or aging physicians to remain in practice so long as their continuing practice is safe.

We have a remarkable track record of making arrangements for chemically dependent physicians to remain in practice under strict public protection controls. That is largely due to the fact that the profession seems to have realized that it does physicians no favour by “covering up” or failing to report concerns about possible physician impairment.

Our collective track record as a profession in dealing with the risks associated with chronic relapsing physician illness and/or the effects of aging is not so stellar. In a very large part, this is attributable to the failure of front line physicians to report these situations to the College in the early stages of concern. We often become involved only after some patient harm has occurred and the issue can no longer be ignored locally.

In closing, I’d like to share a story that has relevance to the issue at hand. Just before Christmas, my wife and I enjoyed a vacation in Beijing that included a visit to the Great Wall. We learned that every tower on that amazing structure was manned 24 hours a day by sentries who were to be vigilant for any evidence of enemy attack. At the very first sign of threat from an enemy, the sentry was to ignite the combustible roof of the tower so the fire would alert the Chinese army and it could mobilize for defence of the country.

While the Wall itself offered some protective capacity to China, it could have been easily breached in many locations if there was not a strong defence response mounted on the Chinese side of the Wall. The real protective power of the Wall

relied upon the vigilance of the sentries and their prompt alerts of impending danger.

In terms of protecting patients from harm arising from suboptimal physician performance, every member of our profession fills a position of great public trust akin to that of the sentries on the Great Wall.

If our profession has any hope of sustaining the degree of individual and collective self-determination we currently enjoy, we must not abrogate our sentry duty as protectors of patients from harm associated with suboptimal physician performance.

Sorry, to rock your boat. But, if we don’t improve our performance as “patient safety sentries”, our boat is likely to sink.

Yours truly,



Dr. D. Kendel
Registrar

A Unique Learning Opportunity NOT to be missed!

Optimally safe high-quality health care requires effective communication and collaboration between a wide array of health care professionals.

Because of the key roles that physicians, nurses, and pharmacists play in health care, effective communication and collaboration between these health professionals is particularly vital.

You may be a physician who already works in a collaborative relationship with nurses and/or pharmacists, but may be interested in strengthening the effectiveness of those relationships.

You may be a physician who is encountering tension and conflicts in your working relationship with nurses or pharmacists and would like to learn about options for overcoming such tension and conflict.

You may be a physician, who has had no prior experience in a collaborative working relationship with nurses or pharmacists, but would like to explore how such relationships might offer you better work-life balance and enhance the safety and quality of care you provide to your patients.

If you are a physician in any of these situations, I would strongly encourage you to participate in a very innovative one-day learning experience that will be offered at Hotel Saskatchewan in Regina from 8:30 a.m. to 4:00 p.m. on Saturday, March 12, 2011.

This is NOT a traditional conference during which you would passively listen to speakers. This is a

facilitated interactive learning experience that will bring together up to 200 practicing Saskatchewan physicians, nurses, and pharmacists to share their experiences and acquire new insights about ways they might strengthen their working relationships in ways that enhance their professional lives and the care they provide to patients.

This event has been jointly planned and organized by The College of Physicians and Surgeons of Saskatchewan, The Saskatchewan College of Pharmacists, and The Saskatchewan Registered Nurses Association. The format and content for the event is based upon a needs assessment survey which yielded valuable input from hundreds of Saskatchewan physicians, nurses, and pharmacists. We listened to you and have created a learning opportunity based upon your expressed preferences.

Interdisciplinary dialogue at this event will be facilitated by Communimed, a national agency with a proven track record of delivering high quality interprofessional learning events.

The SRNA has graciously volunteered to manage the registration services for this event. You can learn more about the event and register for it by logging onto www.srna.org.

Please also consider registering for and attending the banquet at the Hotel Saskatchewan on the evening of March 11, 2011.

I hope we'll see you at this event in Regina in March. See ad on Page 8 of this issue.



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Physician Prescribing and Electronic Medical Records

The College has been made aware of several problems when physicians use an EMR for prescribing. Some physicians are creating the majority of their prescriptions with “no substitute” ticked. As a result, the pharmacists may ignore this, as they know in most cases a substitution would be acceptable. As a result of this action, when a physician really **WANTS** to have “no substitute,” it may be ignored by the pharmacist. If there is no valid medical reason in which to request “no substitute,” substitution should be allowed in order to afford the patient the least expensive option.

Physicians occasionally record an incorrect dosage on a prescription. The pharmacist detects the problem and calls the physician to advise them. However, if the physician is not fixing the original prescription dosage in their EMR, the problem gets repeated when the patient returns to their physician and asks for a renewal of the existing prescription. It is imperative that physicians correct the mistake verbally with the pharmacist at the time, but also correct the error in their EMR to avoid this problem being repeated.

Physicians using digital signatures to create a prescription, who provide the prescription directly

to the patient without cosigning in ink, should be aware that this is not a valid prescription. Prescriptions may be generated by the computer and if provided directly to the pharmacy, by way of electronic means, (secure email, fax), there is no need to cosign. However, if the prescription is generated by the computer with a digital signature of the physician and provided to the patient, **it must be cosigned in ink**. The College has had reports of patients making duplicates of a prescription with a digital signature and presenting them to multiple pharmacies for dispensing. It is imperative that physicians cosign in ink, computer generated scripts with a digital signature if they are providing them to the patient and not providing them **directly** to the pharmacy by secure email or fax.

By Dr. Karen Shaw,
Deputy Registrar and Complaints Manager

Doctors not Performing Pelvic and Pap Examinations

A document called *Key Principles and Values for Family Physicians in Primary Care Model Development*, was produced by a working group of the College of Family Physicians of Canada (CFPC) to facilitate the development and assessment of newer models of primary care practice, by outlining the key principles and values on which they should

be based as viewed through the lens of family physicians and other primary care providers.

Within that document, it is noted that patients want timely access to, and appreciate continuity with their own personal physician. It references evidence in the literature that supports better health outcomes for those patients in communities with better access to comprehensive services provided by family physicians working with other primary healthcare professionals (Starfield et al, 2002).

The working group defined comprehensive care as: providing a full spectrum of health services to meet the needs of patients, families and their communities throughout the lifespan of a patient.

A comprehensive family practice includes:

Primary care in a variety of settings that can include family practice offices, patient's homes, long term care institutions, hospitals, emergency departments and maternity care settings.

The delivery of services to patients at all ages and stages in life for acute and chronic diseases, prevention and health promotion, support and self-care, and referral to other sub-specialty services when required.

Organized chronic disease prevention and management programs. (Key Principals and Values for Family Physicians and Primary Care Model Development Working Group, CFBC).

The College has had reports of family practitioners refusing to perform pelvic or pap examinations.

Sexual health assessments and the provision of pap smears would be considered part of the skill set required of a family physician in order to provide comprehensive care. Physicians who feel they require additional training in the provision of pelvic assessments should seek that training through a trusted colleague, or make inquiries of the Continuous Professional Learning Department for assistance.

Physicians who decline to perform pelvic or pap smear examinations because of the lack of availability of a chaperone, should make arrangements to train an appropriate chaperone. Except in rare circumstances, it would be the expectation that a family physician would be able to provide these services. If there is a compelling reason in which the physician is unable to perform the services, then referral to an appropriate colleague who can perform the examination, is the minimum requirement.

References:

Starfield B, Shi L. Policy relevant determinants of health: an international perspective. *Health Policy*. 2002 Jun;60(3): 201-18.

Working Group, CFPC *Key Principles and Values for Family Physicians and Primary Care Model Development*. Accessed from the [HTTP://toolkit.CFPC.ca](http://toolkit.CFPC.ca)

By Dr. Karen Shaw, Deputy Registrar and Complaints Manager

Complaints Resolution Advisory Committee Annual Report 2009 – 2010

The College of Physicians and Surgeons of Saskatchewan has a statutory obligation to review 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 the exchange of 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) The Complaints Resolution Advisory Committee review (educational with no formal sanctions), or (2) Formal Investigation (potential formal sanctions).

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

The College received approximately 1778 expressions of concern or requests for information in 2010, the majority of which were dealt with by the administrative staff. The yearly work of the Complaints Resolution Advisory Committee is comprised of cases registered in two calendar years. In 2010, the Committee met on seven occasions and reviewed approximately 151 cases comprised of 39 cases not completed in 2009 and 112/163 registered in 2010.

Of the 163 cases registered in 2010, four were withdrawn and two were handled outside the complaints process.

The detailed statistics included represent the cases reviewed in 2010. Of the 151 cases reviewed in 2010, there were 262 allegations. Of the allegations, 67 were founded, 46 were partially founded, 114 were unfounded, 12 were found to be patient responsibility, and no determination was made in 14 of the allegations. Although a number of allegation codes can be used by the Complaints Resolution Advisory Committee to describe the nature of the problem raised by the complainants, if one were to subgroup the allegations, into treatment and management, communication, ethical concerns and systemic issue, the following is a summary:

Allegation	Resolved without Committee	Withdrawn	No Determination	Patient Responsibility	Partially Founded	Founded	Unfounded	Total
Treatment and Management	5	0	0	1	33	44	69	152
Communication	2	0	14	11	13	21	31	92
Ethical conduct	2	0	0	0	0	1	14	17
Systemic issues						1		1

Allegations	% of Total Allegations	% of Founded and Partially Founded
Treatment and Management	58% (152/262)	50.1% (77/152)
Communication	35.1% (92/262)	37% (34/92)
Ethical Concerns	6.5% (17/262)	6% (1/17)
Systemic Issues	.4% (1/262)	100% (1/1)

In the statistics reported for the completed 2010 year, complaints about “Treatment and Management” included allegations of inadequate history, inadequate examination, inadequate investigation, inadequate treatment, complication of treatment and incorrect or missed diagnosis.

There continues to be a number of complaints where fragmented care and inadequate communication were identified by the Committee. Patient care is negatively affected when there is a lack of coordination between caregivers. Patients should be provided an opportunity to identify a primary care physician, even if a number of physicians work collaboratively within a clinic. Problem sheets, identifying the patient’s main problems, can assist other physicians in providing “holistic care,” when they are seeing the patient in the absence of the “primary physician.”

This year there were a number of cases where fragmentation of care was thought to be the responsibility of the patient. Physicians should encourage patients to choose one primary care physician when possible, in order to receive comprehensive care and decrease the problems associated with fragmented care.

The Complaints Resolution Advisory Committee has noted that even when the medical aspects of care are provided appropriately, the manner in which a physician communicates with a patient will influence the final outcome of care. If communication is less than adequate regarding expected patient follow-up or assurance the patient understands their diagnosis and treatment plan, the health outcome may not be optimal. The Committee would recommend that physicians ask patients, at the end of the interaction, whether they have any additional concerns or questions with respect to the information that has been provided to them. This provides an opportunity for patients to ask additional questions and if there has been any miscommunication, it can be clarified at that time. The Committee would also remind physicians this is also a useful technique when a physician senses that the interaction with the patient has not gone well. It affords the patient an opportunity to voice their concerns and for the physician to respond, hopefully resolving the misunderstanding at the time, and reduce the risk of a complaint being registered later.

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, in bylaw, 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.

The College staff and committee continue to make improvements to the review process of complaints. Input from physicians and complainants assists in improving the process.

The number of telephone inquiries has risen (1778 in 2010 compared to 1553 in 2009) as has the number of requests for information (380 forms in 2010 sent out compared to 188 in 2009) on the complaints process. The number of total complaints received per year has also risen (total 163 in 2010, versus 115 in 2009).

Although receiving a complaint can be a disappointment for physicians, those who view and use the experience as an opportunity for improvement, are less frustrated and are more likely to avoid similar complaints in the future.

The Committee would like to acknowledge the work of Ms. Ashley Tomiak in her role of Complaints Coordinator and to thank the Regulatory Service Coordinators, Ms. Tracy Hastings and Ms. Leslie Frey for their hard work and patience in assisting the public in resolving their concerns, and in their support of the Complaints Committee work.

On behalf of the College, I would like to thank the current Committee members for their dedication and hard work. Public members are Ms. A. Brayshaw of Saskatoon; Ms. V. LaCroix of Saskatoon (Chair); and Mrs. S. Lougheed of Beechy. The medical members are Dr. L. Baker, family physician in Rosthern; Dr. M. Plewes, family physician in Moosomin; and Dr. V. Olsen, general surgeon in Prince Albert. The Committee thanks Dr. Randy Friesen for his contribution over the past several years.

Anyone wishing to review a more detailed account of the allegations can find the report on the College website at www.quadrant.net/cpss

Respectfully submitted,

Dr. Karen Shaw, Medical Manager
Ms. Tracy Hastings, Regulatory Services Coordinator
Ms. Leslie Frey, Regulatory Services Coordinator
Miss Ashley Tomiak, Complaints Coordinator

Patient Records - Physicians Leaving Practice

Physicians leave their practices for a number of reasons. When planning their departure, they need to be aware of their obligations to secure their patient records and to ensure those records are available to their patients.

Both the bylaws of the College of Physicians and Surgeons and **The Health Information Protection Act** of Saskatchewan impose obligations on physicians.

The ideal solution for a physician leaving practice is to transfer those records to another physician who will be responsible for the records. The physician receiving those records then is responsible to deal with them.

In some circumstances physicians are unable to find another physician who will accept responsibility for their records. This article addresses the responsibility of physicians for their records after they leave practice, if they are unable to find another physician who is willing to assume responsibility for their records.

The primary obligations of a physician in such a situation are the following:

- 1) To secure those records in a way that the records are protected;
- 2) To ensure that the records are available so that patients can obtain a copy of their record on request. **The Health Information Protection Act** requires the physician to

provide a copy of the record within 30 days of the patient making the request;

- 3) To retain the records for the period of time required by College bylaws. College bylaws require physicians to keep records for adult patients for six years after the patient was last seen. College bylaws require physicians to keep records for child patients until the patient is 20 years of age, or six years after the patient was last seen, whichever is the longer.
- 4) To advise the College where the records will be maintained.

Some physicians have sought to meet those obligations by storing their records in a commercial storage facility.

There are several things physicians should consider before storing their records in a commercial storage facility.

- 1) The physician must have a written agreement with the storage facility that is compliant with **The Health Information Protection Act**;
- 2) The physician remains a "trustee" under **The Health Information Protection Act**, and consequently remains responsible to take reasonable steps to ensure compliance with that Act. There can be significant consequences for a trustee who fails to meet the obligations imposed by that legislation;
- 3) Despite the fact that the records are stored at a commercial facility, it is the physician's responsibility, and not the facility's responsibility, to ensure that patients can access their records;
- 4) Despite the fact that the records are stored at a commercial facility and there is a signed

agreement with that facility, the physician remains responsible to ensure that the cost to patients to obtain a copy of their records does not exceed what is reasonable. The government has on several occasions suggested that it will pass regulations limiting the amount which can be charged for access to patient records. Physicians may be placed in a difficult position if the storage facility charges more than the amount which may be prescribed in Saskatchewan regulations, or which is more than the Privacy Commissioner considers reasonable. If that happens, the physician may be required to pay the difference between what the physician is entitled to charge the patient, and the amount which the storage facility charges to access and copy the record.

The website for the Privacy Commissioner for Saskatchewan contains a document that provides guidance to physicians who intend to store medical records in a storage facility. The document, entitled *Advisory for Saskatchewan Physicians and Patients Regarding Out-Sourcing Storage of Patient Records*, can be accessed at:

<http://www.oipc.sk.ca/What's%20New/Advisory%20to%20Saskatchewan%20Physicians%20and%20Patients%20regarding%20out-sourcing%20storage%20of%20patient%20records,%20March%2010,%202010.pdf>

Physicians remain the trustee of their records even after they store their records in a commercial facility. The College encourages physicians to review the Privacy Toolkit, available at either the website of the College of Physicians and Surgeons, www.quadrant.net/cpps, or at the SMA website,

www.sma.sk.ca which discusses the responsibilities that Saskatchewan legislation imposes on trustees.

College bylaw 23.1 sets the following requirements for physicians who leave a practice:

- (g) A member who ceases to practise shall:
 - (i) transfer the records to a member with the same address and telephone number; or
 - (ii) transfer the records to:
 1. another member practicing in the locality; or
 2. a medical records department of a health care facility; or
 3. a secure storage area with a person designated to allow physicians and patients reasonable access to the records, after publication of a newspaper advertisement indicating when the transfer will take place.

If you have specific concerns about patient records when winding down a practice, please contact Bryan Salte at the College, (306) 244-7355 (telephone), (306) 244-0090 (FAX) or Bryan.Salte@cps.sk.ca (email) to discuss those concerns.

Bryan E. Salte, B.Ed., LL.B.
Associate Registrar and Legal Counsel

Changes to Annual Registration and Corporation Renewal Effective in 2011

2011 brings a number of changes in registration and corporation renewal.

You will recall that 2010 was the final year that the annual registration cycle ends on December 31. Effective 2011, all licences with the exception of educational and locum tenens (or temporary licences) end November 30, 2011.

This means that in the fall of 2011, physicians will be required to renew their registration and their corporations electronically. You will not be provided with a paper registration or corporation renewal package. Instead, physicians will be advised by email and letter that the registration renewal system is open; the correspondence will provide the necessary information to permit physicians to log onto the system and renew their registration. Renewal for both corporations and registration must be completed by submitting information and fees to the College by no later than November 1, 2011.

Please diarize this date for 2011 to ensure that you do not miss the registration deadline and that there are no interruptions in your licensure for 2012. You will need an email address in order to participate in on-line registration and corporation renewal. If it is your intent to renew for 2011 you should ensure that you have an email account or make the

necessary arrangements to obtain one now. You should also ensure that the College has your email address on file as we plan to issue email reminders of the renewal deadlines.

If you have questions or concerns as to how these changes may affect your registration please contact Barb Porter Director, Physician Registration at 1-306-244-7355.

By Barb Porter, Director of Physician Registration

On-Line Electronic Death Registration

RE: Proclamation of The Vital Statistics Act, 2009 and the establishment of the On-Line Electronic Death Registration and Burial Permit Process

With the introduction of the Electronic Death Registration and Burial Permit, the Funeral Homes are now entering page 1 of the Registration of Death form into the on-line application. All hospitals and care homes in the province have been sent the Medical Certificate of Death which must be completed by the physician before the Funeral Director can apply for the burial permit through the electronic application. I would ask that the physicians co-operate in assisting the funeral homes process the death registration by promptly completing the Medical Certificate of Death and ensuring that their name and address is included on the Medical Certificate as it is very difficult for funeral home staff and Vital Statistics staff to read signatures of physicians when the name and address are not printed above the signature of physician.

Questions? Please call 306-787-3110 or toll free 1-866-275-4721

from Vital Statistics, Joy Lascue, Registrations Unit, ISC

A Guide to ALS Patient Care for Primary Care Physicians

Our goal is to ensure no patient in Saskatchewan with the diagnosis of ALS is left without any support, group, education or referral services. We would like to supply the physicians in Saskatchewan with the DVD "*A guide to ALS patient care for primary care physicians*" and be accessible to them if any questions arise. Please contact:

Lisa Pluhowy, President (306)757-7896,
lisa.pluhowy@alssask.ca



Linda Schmidtheisler,
Client Services
Coordinator (306)543-4570, linda8@sasktel.net

From the ALS Society of
Saskatchewan

Denise A. Figlewicz, Ph.D.,
Vice President of Research,
ALS Society of Canada
will be presenting:

"ALS - Research Update and Directions for Therapy"

Friday, May 13th, at 11:00 a.m.
Regina General Hospital Auditorium

Highlights:

- What we have learned from the last 20 years of basic research
- Genetics
- Cellular and intracellular mechanisms
- Animal models
- Therapies which have been developed related to pathogenetic mechanisms
- Recent / upcoming clinical trials
- Registration fee: \$25.00. Tax receipt. Refreshments available. Contact your local association if continuing education credits are applicable.
- For further information please contact Peg 729-3074 or Lisa 757-7896 or by email pluhowy.lisa@gmail.com

Prescribing Guidance Rx

Highlights of New Canadian Guidelines for Safe and Effective Use of Opioids in Chronic Non-Cancer pain.

The recommendations are organized into five clusters for ease of reference.

The last edition of the college's newsletter featured clusters 1 and 2 which were recommendations for deciding to initiate opioid therapy and conducting an opioid trial.

This issue will present recommendations from **Cluster 3: Monitoring Long-Term Opioid Therapy (LTOT)**.

CLUSTER 3: MONITORING LONG-TERM THERAPY

R12: When monitoring a patient on long-term therapy, ask about and observe for opioid effectiveness, adverse effects or medical complications, and aberrant drug-related behaviors. (Grade C¹)

In order for an opioid to be effective it must improve function or reduce pain by 30% to justify continuation. Physicians should monitor for neuroendocrine dysfunction, erectile dysfunction, sleep apnea, opioid induced headaches, and opioid induced hyperalgesia, in addition to the more common side effects. To confirm opioid effectiveness, periodic dose-tapering or cessation of therapy should be considered.

Addiction and drug misuse may be indicated by aberrant behaviors such as altering the route of delivery, double doctoring, taking the drug from friends or family members, and regular requests for early refills.

R13: For patients experiencing unacceptable adverse effects or insufficient opioid effectiveness from one particular opioid, try prescribing a different opioid or discontinuing therapy. (Grade B¹).

Convert the daily dose to oral morphine equivalents first when switching from one opioid to another. A conversion table is located at appendix B of the guidelines.

If the previous dose was high, the suggested new dose is 50% or less of the previous opioid dose. If the previous dose was low or moderate, the suggested new dose is 60% to 75% of the previous opioid dose.

If a patient's pain remains unresponsive after a trial of several different opioids then a tapering and discontinuation of opioids is indicated. Patients who receive high doses and remain incapacitated by pain should be considered treatment failures. Do not continue opioid therapy in high doses if only regulation of mood occurs rather than pain control.

R14: When assessing safety to drive in patients on long-term opioid therapy, consider factors that could impair cognition and psycho-motor ability, such as a consistently severe pain rating, disordered sleep and

concomitant medications that increase sedation. (Grade C¹).

Cognitive and psycho-motor ability are functions required for driving a motor vehicle and these functions need to be assessed. Severe pain, sleep disorders, some pre-existing medical conditions and sedating medications such as benzodiazepines all may contribute to the cognitive impairment of opioids.

The Canadian Medical Association has a book available free of charge to CMA members called *Determining Medical Fitness to Operate Motor Vehicles (2009)* which can be of assistance in deciding whether a patient's medical condition should result in a report. This is available from the CMA Member Service at 1-888-855-2555 or email cmamsc@cma.ca

In Saskatchewan, Section 283 of *The Traffic Safety Act* requires physicians to report the name, address, and clinical condition of every patient who is 15 years of age or over and suffering from a condition that will make it dangerous for that person to operate a vehicle. The reporting requirement is not dependant upon whether the patient has a driver's license or is actually driving.

R15: For patients receiving opioids for a prolonged period who may not have had an appropriate trial of therapy, take steps to ensure that long-term therapy is warranted and dose is optimal (Grade C¹).

It is particularly important for physicians who have "inherited" patients on long-term opioids to

review appropriate steps for an opioid trial. Maintaining the “status quo” just because the patient has been receiving the same high dosage of an opioid consistently for an extended period of time and is “the only thing that works” for the pain is not a indication or justification for continuation of therapy.

It is advisable for physicians to address and document the following: current diagnosis of the pain, agreed upon goals, use of opioid risk screening, treatment agreements, appropriate opioid selection, and ongoing evaluation of effectiveness with the use of pain scales and pain diaries.

This approach can not be accomplished all at once but spread over time. The *Opioid*

Manager is recommended as a practice tool to guide and track your prescribing.

The *Opioid Manager* can be downloaded from the National Pain Centre website at: <http://nationalpaincentre.mcmaster.ca/opioidmanager/> .

Feedback is welcomed on the website if you have suggestions for improving this tool.

R16: When referring patients for consultation, communicate and clarify roles and expectations between primary-care physicians and consultants for continuity of care and for effective and safe use of opioids (Grade C¹).

For complex pain patients or when aberrant behavior is detected, it is important to seek consultation

from a multidisciplinary pain program such as The Chronic Pain Centre in Saskatoon, and/or an addiction treatment program.

When care is collaborative, it is important to clarify the roles and responsibilities of the various team members to ensure opioid prescribing is optimized.

Next issue:

Cluster 4: Special populations, and

Cluster 5: Managing Opioid Misuse and Addiction in Chronic Non-Cancer Pain.

Submitted by Doug Spitzig, Contract Pharmacist, Prescription Review Program, College of Physicians and Surgeons of Saskatchewan

The complete guideline and practice tools are available on the National Pain Centre website at McMaster University ². Practice tools can be downloaded or printed for clinical use.

If you have feedback or comments on this month’s Prescribing Guidance, contact Mr. Doug Spitzig, Contract Pharmacist, Prescription Review Program at: 306-667-4640 or email doug.spitzig@cps.sk.ca

References::

¹ McMaster University; National Pain Centre website, Recommendation Grading (http://nationalpaincentre.mcmaster.ca/opioid/cgop_a10_literature_search_methods.html#table_a10_03_02).

² McMaster University; National Pain Centre website (<http://nationalpaincentre.mcmaster.ca/opioid/>).

³ The Messenger, CPSA, Dr Susan Ulan, Sep 2010.

Prescribing Guidance Rx

Saskatchewan Transfusion Resource Manual

December 2010 Update: Health Canada is developing a new regulatory framework to establish minimum quality and safety standards for blood and blood components (CSA Z902-10). These regulations will identify requirements for the collection, processing, storage and use of human blood and blood components for transfusion. Saskatchewan currently transfuses in approximately 78 facilities across the province. Once the federal government has proclaimed these regulations, all health professionals and facilities that perform transfusion activities will need to comply.

Although Health Canada has not provided official notice of its timelines for implementation of this new regulatory framework, it is encouraging health facilities to follow the practices and procedures outlined in the CSA Z902 standards. These standards will impact a variety of health providers including physicians, RNs, RN(NP)s, LPNs, MLTs and CLXTs.

For the past nine months, transfusion service managers from the health regions have been working closely with Saskatchewan regulatory bodies, including the College of Physicians and Surgeons of Saskatchewan, and the Ministry of Health to develop a provincial resource manual that will serve as a template for health care facilities and regional health authorities as they take steps to meet or exceed the CSA standards. The provincial resource manual will cover areas such as: informed consent, physician orders, receipt and storage of blood products, blood administration and record keeping.

The anticipated completion date, for this Transfusion Medicine Working Group project, is spring 2011.

Prepared by the Transfusion Medicine Working
Group of Saskatchewan

Take Note . . .

ECG Exams

ECG exams are scheduled for the third Wednesday of each month, from 1:30 p.m. to 4:30 p.m. in the CPSS Boardroom at 500 - 321A 21st Street East, Saskatoon, SK, S7K 0C1. For information or to book a sitting contact Tracy Hastings by phone (306) 244-7355 or by email tracy.hastings@cps.sk.ca.

The
3rd Annual
Palliative Care Lecture
sponsored by
Regina Palliative Care Inc.
And
The University of Saskatchewan, College of Medicine
presents
Robin L. Fainsinger, MD
Contact Sandra Hubenig at Regina Palliative Care Inc., 306-766-2300.

inspire

Health Care Quality Summit 2011

Time to Fly...

Health care leaders in Saskatchewan are engaged in an unprecedented, coordinated drive to build a more responsive, effective and efficient health system. Hear directly from North America's experts about the transformational power of quality improvement, and learn about local successes in designing top notch health care services and processes.

Opening keynote: Maureen Bisognano,
President and CEO, Institute for Healthcare Improvement

Who Should Attend: Administrators and professionals, board members, staff at all levels, patient representatives, and anyone interested in transforming everything from single processes to whole organizations in health care and other sectors.

Do you have a quality improvement story to share?

The Health Care Quality Summit 2011 is looking for speakers, digital and/or hard-copy poster presentations and table top displays on quality improvement successes. *Help spread the word about the transformational power of quality improvement!*

Deadline for submissions: January 14, 2011.

SAHO's Green Ribbon Awards

Have you considered submitting your quality improvement success to the Green Ribbon Awards program?

Deadline for submissions: January 14, 2011.

Awards will be presented on the evening of Wednesday, April 20.

New award categories for 2011!

- Access to Care
- Patient/Client/Family Centred Care
- Leading for Quality
- Improvement Behind the Scenes
- Saskatchewan Surgical Initiative
- Health Promotion/Community Involvement
- Seeing the System with Fresh Eyes

Visit qualitysummit.ca

Or call SAHO at 347-5593 or e-mail qualitysummit@saho.org

Summit Partners:



Saskatchewan
Ministry of
Health

April 20 - 21, Delta Regina Hotel, Regina, Saskatchewan

qualitysummit.ca

Executive Opportunity:

Protecting the public. Guiding the profession. Profound change in the delivery of healthcare is redefining professional roles, responsibilities and relationships. With its mission of regulatory stewardship, the College is actively participating in the evolution of Saskatchewan's healthcare system. Embrace both the mission and complexity of this essential organization and serve the public interest as . . .

Registrar and CEO

College of Physicians and Surgeons of Saskatchewan

As the current Registrar retires, you will assume the leadership mantle and continue to press forward with program development in licensing and physician assessment. Stimulate the development of clinical practice standards that will serve the profession and the public. Be a proactive and valued advisor to government. Continue to build relationships across the healthcare continuum to keep the College strong, relevant and effective, and seize this opportunity to make a difference in health care on a truly large scale.

You are a physician who is eligible to practice in Saskatchewan preferably with at least ten years of clinical practice. You have earned leadership credentials and peer respect in a health district, a hospital, academic or private sector setting through your experience in human resources, communication and with your sound judgment. Bring your wisdom, integrity, and your strategic vision for the medical profession to a highly rewarding, career-capstone position based in Saskatoon. All responses to the Caldwell Partners are confidential. Please indicate your interest in Project 9337 through the "Executive Opportunities" section of www.caldwell.ca or by e-mail to resumes@caldwell.ca.

Table of Contents

Rocking Your Boat	4
A Unique Learning Opportunity Not to be Missed	7
Inter D4	8
Physician Prescribing and Electronic Medical Records	9
Doctors Not Performing Pelvic Examinations	9
Complaints Resolution Advisory Report	11
Patient Records – Physicians Leaving Practice	14
Changes to Annual Registration and Corporation Renewal Effective in 2011 .	16
On-Line Electronic Death Registration ..	16
A Guide to ALS Patient Care for Primary Physicians	17
ALS – Research Update and Directions for Therapy	17
Prescribing Guidance Rx	18
Saskatchewan Transfusion Resource Manual	20
Palliative Care Lecture.....	21
Health Care Quality Summit 2011.....	21
Executive Opportunity	22
Our Staff	23
Contact Us	24

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 Dr. Karen Shaw, Deputy Registrar
 Mr. Bryan Salte, Associate Registrar/Legal Counsel
 Ms. Barb Porter, Director of Physician Registration

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