DocTalk

Prescribing Opioids and the New Canadian Guidelines

Physician Burn-Out

The Role of Chaperones in Your Practice

Cultural Humility

Kendel Award 2017

Dr. Susan Shaw Honored

21 Senior Life Recipients Celebrate 40 Years

College of Physicians and Surgeons of Saskatchewan cps.sk.ca Volume 4, Issue 3, 2017

In this issue

Articles in this issue featuring information relating to Cultural Humility in medical practice are marked with a colorful snowman.

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From the President

From the Registrar

Legally Speaking

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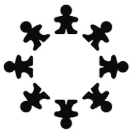
REGISTRAR: Dr. Karen Shaw

Registration Times

Addressing Quality of Care

CPSS Programs and Services



Council News

Sask Leaders in Health Care

Physician Update

We're Working for You

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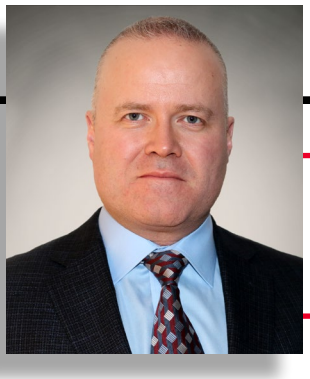


FROM THE PRESIDENT

Dr. Alan Beggs
President, CPSS

Council's Work for 2018

2017 is rapidly coming to a close, and with it my second term as President of Council. I have been honored to represent the public of Regina for the last 6 years as a Councillor elected by my colleagues. As my term comes to an end, I would like to take just a moment to thank my fellow councillors for their patience as I tried to navigate this role. I would also like to extend my most sincere thanks to Dr. Karen Shaw and the staff at the College for their help throughout my terms. Of particular note is Ms. Sue Waddington, who is the hard-working Executive Assistant to the Registrar and Council. Without Sue's diligence, the work of Council could not proceed. I would also like to specifically mention Dr. Julie Stakiw who has served as Vice President during my term as President. Julie has been a very strong voice on Council and has helped me immeasurably during the last two years.

The Last Two Years

The past two years have been interesting to say the least. Medical Assistance in Dying, medical marijuana and now the potential legalization of marijuana, a new home for the CPSS, the ever-increasing discipline and quality of care cases, etc., etc. There has been much work to do, but much good work has been done. I am constantly amazed by the diligence of my fellow Councillors in approaching complex and time consuming questions with a degree of compassion and care while balancing the needs of both patients and physicians.

Council's Work for 2018

The next year will see at least six new Councillors take up this challenge. I hope that each of us takes the time to identify our local Council representative and offer words of encouragement and support. For the last Council meeting there were over 400 pages of documentation for review and consideration on a variety of issues of policy and discipline. This heavy load of work is done at the expense of time with family or practise. The seemingly endless work done was greatly appreciated by myself, as I hope it is appreciated by each member of the College.

As we approach 2018, several key priorities remain at the forefront:

1. The ongoing crisis with **opioid abuse** remains an area of strategic importance both nationally and provincially. The CPSS is proud to have co-hosted a hugely successful conference, "Current Options for Managing Pain and Addiction." Hundreds of physicians and allied health professionals gathered in Saskatoon to explore this complex problem and share from their own perspectives how to navigate this difficult area of care. Feedback from this conference has been overwhelmingly positive, and I believe it will serve as a model for CPSS-sponsored educational events moving forward. Congratulations to the organizing committee on a job well done.

2. Reorganization of the delivery of health care provincially will dominate the next year or two. While there are certainly going to be some bumps along the way, the membership of the College can remain confident that the College will remain a stable reference and support for the delivery of only high quality care during this period of transition and moving forward.

3. Legalization of cannabis looms in the near future. The Federal Government has not provided the provinces with a robust strategy and therefore each province is working independently to determine the best path forward. This change in legislation will alter the medical environment as it introduces a previous drug of abuse onto legitimate retail shelves. Wide access to commercially available cannabis will also completely alter the dynamic of cannabis for medicinal purposes. It is challenging to predict how this will shake out, but it will certainly require close review by the College to ensure the profession has guidance as to how to proceed.

With so many challenges on the horizon, I can only seek to reassure both the public and profession, that the Council approaches each new and complex issue with the thoughtfulness and diligence that it has been my pleasure to observe during my tenure on Council. As a parting comment, I thank you again for the opportunity with which you have entrusted me. Please take the opportunity to get some much deserved rest and family time during the holidays to come.

FROM THE REGISTRAR

A Time to Reflect and Recharge

Dr. Karen Shaw
Registrar, CEO

As we approach the end of the year, it is always a time to reflect on what we have accomplished in the year, and an opportunity to look at what's left to be accomplished. I would like to comment on what we have been working on to try to lessen the ***Opioid Crisis,*** *what we are discussing about how we as a regulator can improve the* ***care to Indigenous peoples,*** *and lastly to raise to your attention the concern that I have about* ***Physician Stress and Burnout***

The Opioid Crisis

In previous DocTalk articles you have been provided with an overview of the Opioid Crisis, as well as some of the national strategies to stop the harm that is occurring.

The CPSS has taken multiple approaches over the last year to address this complex issue. Our partners in eHealth are developing a different database that will enable our Prescription Review Program (PRP) to have better analytical capacity to look at the data we receive about the PRP panel of medications and produce a "report card". This new program should provide specific prescriber data and information about the prescribing patterns of individual physicians compared to their colleagues. What we need to decide is what information will be helpful to physicians, and what educational tools can we provide or facilitate, that will ultimately improve the care provided to patients with chronic pain. *If you are interested in assisting with this work please let us know.*

Poor prescribing accounts for some of the harm. In this edition of DocTalk you will find an article about the *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain*. Please read it and put a copy of the recommendations in a handy spot on your desk so you can refer to and share with your patients. Take advantage of the free tools such as the "Opioid Manager™" (https://thewellhealth.ca/pain/), a tool designed to support health care providers prescribe and manage opioids for patients with chronic non-cancer pain. Resources are also available for patients on the topic of opioid tapering (MyOM) at https://www.opioidmanager.com/my-opioid-manager.

The use of *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* will hopefully decrease the number of inappropriate new starts of opioids for chronic non-cancer pain. However, we still have the problem of how to help the "legacy" patients; those who have been started on opioids inappropriately and/or at higher doses than is now considered safe.

Our recent educational event **Current Options in Pain and Addictions Conference** (COMPAC) was our attempt to provide a multidisciplinary approach to chronic pain and to address some of the addictions issues. More information about this conference is also contained within this edition of DocTalk.

FNIHB-SK Funding for Mitigating Prescription Abuse and Misuse

The CPSS has a contribution agreement with the province's First Nations and Inuit Health Branch (FNIHB-SK) to assist in mitigating the risk of prescription drug misuse and abuse in Saskatchewan Indigenous communities.

We have chosen to support and leverage existing good work around the province, rather than reinvent the wheel. The funding from the FNIHB-SK contribution agreement managed by the CPSS has supported the HIV Benchmark work, and the work to build capacity in providers in rural and remote areas who are providing care to those patients affected with HIV, Hep C and who may also have a substance use disorder.

Other projects include:

- increasing capacity in one region for opioid substitution therapy with access to an Elder;
- support of the Northern Alcohol Strategy in providing an educational opportunity on alcohol and opioid abuse for 192 healthcare workers,
- support of the printing of a methadone booklet developed for patients by the Saskatoon Community Clinic, enhanced with First Nations art work; and
- support for education of Sanctum workers so they may train others in communities considering this approach.

During 2018, we will be:

- providing a second year of FNIHB-SK funding for some of the projects;

- developing an ECHO project to allow networking of the providers that treat chronic pain and addictions access to education and support;
- we have agreed to support a multidisciplinary clinic which provides care for patients with chronic pain and addictions in a culturally sensitive manner; and
- working with law enforcement to facilitate a community workshop from a mental health and community development consultant who has worked with Indigenous communities on healing from trauma.

Indigenous Health and Wellbeing

Council has reviewed the health recommendations of the Truth and Reconciliation Report - ***Honouring the Truth, Reconciling for the Future*** and a working group has started to think about what we as a regulator can do.

SEEKING EXPERTISE ON INDIGENOUS HEALTH NEEDS

We are reaching out to local experts for education for Council and the membership on the health needs of Indigenous people.

We are considering facilitating a course on cultural sensitivity and humility that will assist physicians in meeting the needs of the Indigenous population.

I was recently provided a link to a You Tube video entitled ***Call for Equitable Indigenous healthcare in Canada: Nation to Nation Collaboration.*** It can be accessed at https://www.youtube.com/watch?v=6xgo49HmD84&feature=youtu.be

This video was developed by students and is a wonderful introduction to how we need to work together. I would encourage you to watch it.

Physician Stress and Burnout

Lastly, I want to comment on physician stress and burnout. Over the last year we have interacted with a number of physicians who appear to be under considerable stress and even distress in their professional and personal lives.

Healthcare is a tough place to work these days. We are faced with increasing workloads, the burden of keeping up with the latest diagnostic tests, procedures and best practices which seem to change at lightning speed, and we are challenged by the new ways our patients expect to be provided care (telehealth) or access to service (extended hours). This doesn't take into account the challenges in your personal lives with your immediate or extended family.

Stress is inevitable. Sometimes it can be the positive impetus for one to be motivated to do better and can result in fulfillment. Other times stress becomes distress, that may include both physical and mental strain or tension. If it is persistent and not relieved by coping mechanisms or adaption, it can lead to anxiety, depression, substance abuse/addiction, compassion fatigue, or burnout.

Burnout has been characterized as a triad of emotional exhaustion, depersonalization and decreased sense of personal accomplishment.

Do you feel this way or do you know someone who does?

Burnout left unaddressed will ultimately have a negative effect on every aspect of a physician's life, including negative consequences for your family and your social life. Physician burnout also has a detrimental effect on patient care, colleagues and work environment. If I can paraphrase what Brenda Senger, Director of the SMA Physician Health Program reminds us: "The last thing to go (implode) in a physician's life is his or her work."

Ensure you are managing your stress well. Develop healthy habits by making exercise, good nutrition, sleep and activities to relax a priority. You may never achieve a "true balance" between work and personal life, but If you can achieve harmony between your work and your home life, you will stay healthier. We cannot provide good care to patients if we are not well ourselves.

If you need help or someone you know needs help, reach out to Brenda at the Physician Health Program. She is a terrific resource and can facilitate what you need. If you are an employed physician you may have access to an Employee Assistance Program. There are many online resources - ephysicanhealth.com also has some online resources you might find helpful. Don't wait until you or your colleagues are in dire distress. Ask for help and/or support your colleagues to reach out if you notice they are distressed!

Make this New Year's resolution a promise to keep well, for your sake and that of your family, your patients and your colleagues. Have a happy, healthy and restful holiday season!

When can a physician refuse to provide a patient information from their chart?

Bryan Salte
Associate Registrar
and Legal Counsel

The Health Information Protection Act, the Canadian Medical Protective Association and the CPSS Guideline provide answers to this very question, and the responsibilities of the physician in doing so.

Physicians are generally aware that they have an obligation to provide a patient access to their chart, or provide a copy of their chart, if the patient requests it. The physician can charge a reasonable fee for doing so.

Physicians are generally not aware of circumstances in which they can, or should, refuse to allow a patient access to a portion of their chart.

The exceptions are contained in section 38 of *The Health Information Protection Act*, available at http://www.publications.gov.sk.ca/freelaw/documents/english/Statutes/Statutes/H0-021.pdf. The most common exceptions are:

a. *in the opinion of the trustee, knowledge of the information could reasonably be expected to endanger the mental or physical health or the safety of the applicant or another person;*

b. *disclosure of the information would reveal personal health information about another person who has not expressly consented to the disclosure;*

c. *disclosure of the information could reasonably be expected to identify a third party, other than another trustee, who supplied the information in confidence under circumstances in which confidentiality was reasonably expected;*

The **Canadian Medical Protective Association** (CMPA) describes the onus on the physician to justify refusing to disclose information *(Releasing a patient's personal health information: What are the obligations of the physician? https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2012/releasing-a-patient-s-personal-health-information-what-are-the-obligations-of-the-physician)*:

> *In exceptional situations, physicians can refuse to disclose the information in the record to the patient, but only if they reasonably believe there is a significant likelihood that disclosing the information will have a substantial adverse effect on the patient's physical, mental, or emotional health, or cause harm to a third party. The onus in such circumstances is on the physician to justify denying a patient access to information in their medical record.*

Physicians will sometimes gather information from family members or other third parties to assist in providing appropriate care to their patients. That can include information from family members about the patient, medical histories of family members, etc.

If physicians obtain information from or about others that is contained in a patient chart, a physician should consider whether that information should be withheld from the patient.

If information is to be withheld, it is important to redact only that information and provide the remainder of the patient chart to the patient.

If a physician refuses to provide a patient access to all or a portion of their personal health information they are required to advise the patient of the reasons for refusal and the patient's right to request the Information and Privacy Commissioner review the decision.

The College has published a comprehensive document on its website – *Guideline – Confidentiality of Patient Information* - http://www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Confidentiality_of_Patient_Information.aspx

Referring patients to a specific pharmacy

There have been a number of recent complaints to the College that physicians have encouraged or required patients to fill their prescriptions at specific pharmacies. The College has also received complaints that physicians have discouraged patients from filling their prescriptions at specific pharmacies.

Some complaints have alleged that there is a family relationship between a physician and a pharmacy that has influenced the physician's recommendations. Other complaints have alleged that because of a disagreement between a physician and a pharmacist, the physician has discouraged patients from filling prescriptions with that pharmacy.

Referring a patient to a specific pharmacy to have their prescriptions filled, or discouraging patients from having their prescriptions filled at a specific pharmacy is inappropriate unless there is a valid medical reason.

If there is a financial or other connection between the physician and the pharmacy, referring a patient to a specific pharmacy can be a conflict of interest and can constitute unprofessional conduct. Physicians should be aware of College bylaws defining conflict of interest. Regulatory bylaw 9.1 is available at the College website https://www.cps.sk.ca/iMIS/Documents/Legislation/Legislation/Regulatory%20Bylaws%20-%20September%202017.pdf

Additionally, the College has a Conflict of Interest Guideline, available at https://www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Conflict_of_Interest.aspx. Among the statements in that guideline are:

> *A conflict of interest arises where a reasonable person could think that a physician's duty to act in the patient's best interests may be affected or influenced by other competing interests. Conflicts of interest can be real, potential or perceived. Conflicts of interest may arise in a variety of circumstances including financial, non-financial, direct, and indirect transactions with patients and others. Financial gain by the physician is not necessary to establish a conflict of interest. As well, the physician does not need to directly profit from the relationship. A conflict of interest may arise where the benefit is accrued by the physician's family, close friends, corporation or other businesses, and business partners.*

Physicians should be aware of both the bylaw and the guideline. Physicians should also be aware that if there is a complaint that alleges they have steered patients to a specific pharmacy or away from a particular pharmacy, they may be required to demonstrate that there was a valid medical reason to do so.

Chaperones:

Have you considered instituting a policy in your practice, or providing training to your chaperones?

By Sheila Torrance, CPSS Legal Counsel

The topic of chaperones (sometimes called "practice monitors") is familiar to most physicians, but have you considered why instituting a chaperone policy in your practice environment may be a good idea? Of course in this context we are referring to voluntary or non-mandated chaperones, as opposed to chaperones mandated by the College as may follow a finding of unprofessional conduct for a boundary breach.

Increasingly, physicians are offering chaperones to their patients, primarily for their patients' comfort and security, but with a secondary role of protecting the physician against false allegations of improper conduct. Chaperones are most commonly offered in the context of intimate examinations (generally understood to include examinations of the breasts, genitals or rectum), but there are also proponents of a universal policy that would apply equally to all patients and for all clinical encounters. Part of the reasoning for this approach is that the policy can then be universally applied, rather than suggesting a chaperone to particular patients in particular clinical situations. It should also be noted that in some cultures, any physical examination might be considered sensitive and the patient may be comforted by the presence of a chaperone in those circumstances. The physician must be aware of and respect cultural differences and religious beliefs that may impact on a patient's reaction to being offered a chaperone. Currently, while the routine use of chaperones is not mandatory in any Canadian jurisdiction, it is recommended by the Canadian Medical Protective Association (CMPA) and most of the Canadian Medical Regulatory Authorities to varying degrees, and primarily in the context of intimate or "sensitive" examinations (for example independent medical examinations, patients with reduced capacity or a history of abuse, etc.).

The UK General Medical Council instituted a helpful guidance in 2013 stating that the option of a chaperone should be offered prior to an intimate examination, regardless of whether the physician is the same gender as the patient.

It stated as follows:

> *9. A chaperone should usually be a health professional and you must be satisfied that the chaperone will:*
>
> *a. be sensitive and respect the patient's dignity and confidentiality*
> *b. reassure the patient if they show signs of distress or discomfort*
> *c. be familiar with the procedures involved in a routine intimate examination*
> *d. stay for the whole examination and be able to see what the doctor is doing, if practical*
> *e. be prepared to raise concerns if they are concerned about the doctor's behaviour or actions*
>
> http://www.gmc-uk.org/guidance/ethical_guidance/30200.asp

There is a general acceptance in the literature that chaperones are only effective if properly trained and present in the room during the entire patient interaction. Some might wonder why training is necessary. Issues that could be covered during training include:

- what is the nature of an intimate examination?
- what will an appropriate intimate examination consist of?
- where should the chaperone be positioned?

- should the chaperone avert his/her eyes from the sensitive examination, or should he/she be watching the entire interaction?

The College is aware of a chaperone training program initiated by the College of Physicians and Surgeons of Alberta in conjunction with MacEwan University in Edmonton. This is a 7 hour in-person program intended for medical office assistants, licenced practical nurses (LPNs), registered nurses (RNs), or personal care aides. While the course is currently only offered in Alberta and does not have an online option, the program coordinator has advised that they would consider providing customized programs.

The College has identified several UK-based online courses, ranging from one-hour to a half day. While the College is not able to endorse these courses, they may be an option to explore in the event that Saskatchewan physicians wish to offer training to a staff member who will serve as a chaperone. Examples of such courses are those offered by ECG Training (http://ecgtraining.co.uk/all-courses/online-courses/chaperoning/) and Annie Barr Associates (https://www.anniebarr.com/course/chaperone-training-online).

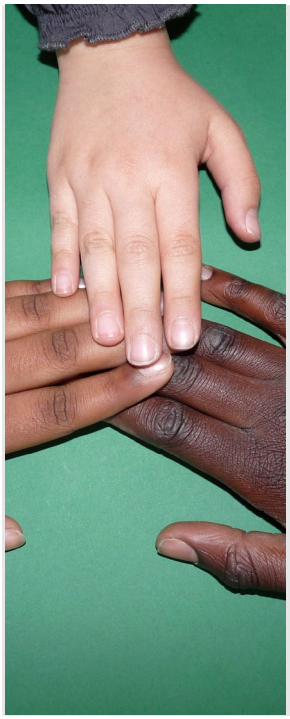
From a best practises perspective, it is recommended that physicians at least consider instituting a chaperone policy, and informing patients of any policy instituted. It is recommended that a chaperone be offered to patients, particularly for intimate examinations. However, the patient has the right to decline a chaperone or to have his or her own support person attend (either in place of or together with a chaperone).

Of course, the presence of a chaperone does not obviate the physician's ongoing obligation to obtain informed consent prior to the examination and to explain the examination to the patient as it is being conducted. It is also suggested that the presence of a chaperone, and the chaperone's identity, be recorded in the medical chart. Likewise, if a chaperone is offered and declined, that fact should be recorded as well.

Additional information compiled by the UK Medical Protection Society is available at http://www.medicalprotection.org/docs/default-source/pdfs/factsheet-pdfs/ni-factsheet-pdfs/chaperones.pdf?sfvrsn=7 and http://www.medicalprotection.org/uk/resources/factsheets/england/england-factsheets/uk-chaperones.

NHS England has prepared a useful document relating to chaperones which includes a sample chaperone policy. https://www.lmc.org.uk/visageimages/guidance/2007/Chaperone_model%20framework.pdf

If you have any questions about instituting a chaperone policy or training options, please feel free to contact the College.



2017 Revised Child Abuse Protocol (CAP)

The 2017 revised Child Abuse Protocol (CAP) was released in October. The goal of the update was to ensure that the Protocol meets all requirements under law and best practice as it relates to child abuse investigations in order to promote a coordinated and integrated approach to child abuse investigations.

According to Max Hendricks, Deputy Minister of Health, "The Protocol emphasizes every individual's duty to report suspicions of child abuse and clarifies roles and responsibilities for all involved. Signatories commit to endorsing and adopting the CAP for use within their sectors of responsibility and commit to making it an essential part of regular operations. All signatories are responsible to engage those that fall under their mandates to ensure they have access to the CAP, training and that policies and procedures are in place that are consistent with the Protocol."

For more information: https://www.saskatchewan.ca/residents/justice-crime-and-the-law/child-protection/child-abuse-and-neglect.

Policy, Standard and Guideline Updates

Council regularly reviews the policies, guidelines and standards which are then made available on the College's website.

Since the last Newsletter, Council has adopted or amended a number of these documents. The title of the documents and a summary of their content follows:

GUIDELINE – 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain

At its meeting on September 30, 2017 the Council of the College of Physicians and Surgeons endorsed the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain as a guideline for Saskatchewan physicians when considering whether to prescribe opioids to patients who have chronic non-cancer pain.

The adoption of the guideline means that the content of the document is generally recommended by the Council of the College as part of providing quality medical care in a professional manner. Physicians licensed with the College are encouraged to follow these recommended courses of action and should exercise reasonable discretion in their decision-making based on this guidance.

Click here to view full policy

POLICY - College Newsletter (Editorial Policy)

Council reviewed the requirements for membership to the College's Newsletter Publication Advisory Committee and approved a change that would allow either a Public Member of Council OR a member of the public at large to be nominated to the Advisory Committee.

Click here to view full policy

GUIDELINE - Providing Care to Employees or Co-Workers

Council reviewed the policy to include guidelines regarding the provision of care to employees to also include co-workers, and has made a few minor revisions to the policy.

A new sunset date of 5 years was set for the next policy review.

Click here to view full policy

The full versions of all CPSS Policies,
Standards and Guidelines
are available on the College Website at

www.cps.sk.ca

TOEFL Exam No longer Accepted by CPSS as Proof of Language Proficiency

Results Valid Only Until June 2018

Council's bylaw relating to English Language proficiency for licensure was amended in September 2017 to state that the TOEFL Exam will only be accepted by the College until June 30, 2018. After this date, physicians will be required to demonstrate that they have passed the IELTS or provide other acceptable proof of English language proficiency.

MCCEE to be Phased Out in Fall 2018

Proposed Changes to Bylaw

The Medical Council of Canada is planning to discontinue the provision of the Evaluating Exam (MCCEE) after the fall of 2018; only the Medical Council of Canada Qualifying Exam 1 will be available after this time. This decision will have an impact on the College's current requirements for licensure.

In preparation, Council reviewed possible bylaw amendments at its November meeting with respect to the Medical Council of Canada phasing out of the MCC's Evaluating Examination. A tentative bylaw amendment was approved to state that the MCCEE is only acceptable if a physician achieves licensure by June 30, 2019.

The proposed changes are to be sent out to the membership and stakeholders for consultation.

Fee to support pan-Canadian Practice-Ready Assessment coming in 2018

MCC looking to ensure sustainability of PRA

The Medical Council of Canada (MCC), on behalf of the National Assessment Collaboration (NAC), will begin charging a candidate fee of $1,750 as of January 1, 2018 to support the ongoing work and ensure sustainability of the Practice-Ready Assessment (PRA) initiative. The fee will be incurred whenever a candidate enters the PRA clinical over-time assessment period.

The NAC, a group of national and provincial organizations with a stake in the assessment of international medical graduates (IMGs), has created a pan-Canadian model with a set of common standards, tools and materials for PRA programs across the country. These materials have been developed in an effort to ensure that all PRA programs operate in a consistent and comparable manner across provinces and territories.

For more information, please visit the NAC PRA webpage and their latest web article at

http://mcc.ca/projects-collaborations/practice-ready-assessment/,

or write to: communications@mcc.ca

Address & Other Changes to Medical Corporations

More than one field to double check!

Registration Staff would like to remind registrants to be sure to check that **ALL** address fields in their online corporations profile list the correct address.

Any additional changes that are made to your corporation during the year, such as additions/changes to trusts or sub-corporations must also be filed with our office when they happen. Thank you for helping us ensure a smooth exchange of information!

Ordering Diagnostics

Why your name needs to appear on requisitions

Dr. Micheal Howard-Tripp
Deputy Registrar

By Dr. Susan Shaw (Saskatchewan Medical Association) and Dr. Micheal Howard-Tripp (CPSS)

CASE STUDY

A family physician receives an alert in her EMR on a Saturday morning.

She is alarmed to see a young girl that is unknown to her has a white blood count of 30 along with a manual differential showing neutrophils.

The doctor is extremely worried about this child who is not one of her patients.

She calls the laboratory to ask who ordered this test so it can be redirected to a physician with a relationship to this child and is very surprised to learn that she is actually the ordering physician on record.

The family doctor calls all the local hospitals trying to locate the child but has no luck. Through considerable effort, her office staff makes contact with the parents on the following Monday. To everyone's relief, the child is well.

The family doctor then learns that the child was recently seen in a local emergency room where the doctor who saw the child ordered the test using the family doctor's name as the ordering physician in an attempt to create follow up.

Preamble

This article is the fruit of a joint effort between the College of Physicians and Surgeons of Saskatchewan and the Saskatchewan Medical Association in an effort to raise awareness among practitioners that what may seem to be a harmless alteration of a chain of communication and liability process can lead to wasting critical resources and impact the delivery of healthcare as a whole.

Irrespective of the circumstances, it is never acceptable to write an order, prescription or laboratory request without appending the name of the actual individual writing the order, prescription or laboratory test. If there is the expectation that another physician will provide follow-up for the patient, at a later date, then that physician can be copied on the laboratory request, after obtaining confirmation that the physician is available and prepared to accept responsibility.

From a legal standpoint it is fraudulent to write a prescription or order a laboratory test under someone else's name and, if brought to the attention of the criminal justice system, could lead to difficulties for the physician or other health-care worker who wrote the original order.

The College of Physicians and Surgeons has also addressed the above situation through a number of policies.

The first of these policies is the policy on Medical Practice Coverage. Paragraph 3 of the policy states that "physicians who transfer coverage of patients in their practice to another physician should have the agreement of the physician before doing so." This would imply that if there is the expectation that another physician will follow-up on the tests ordered, then that physician has to be notified of the

expectation and has to agree to it. Any such agreement should be documented in the patient record.

The second policy is Standards for Primary Care which states that physicians who provide primary care must:

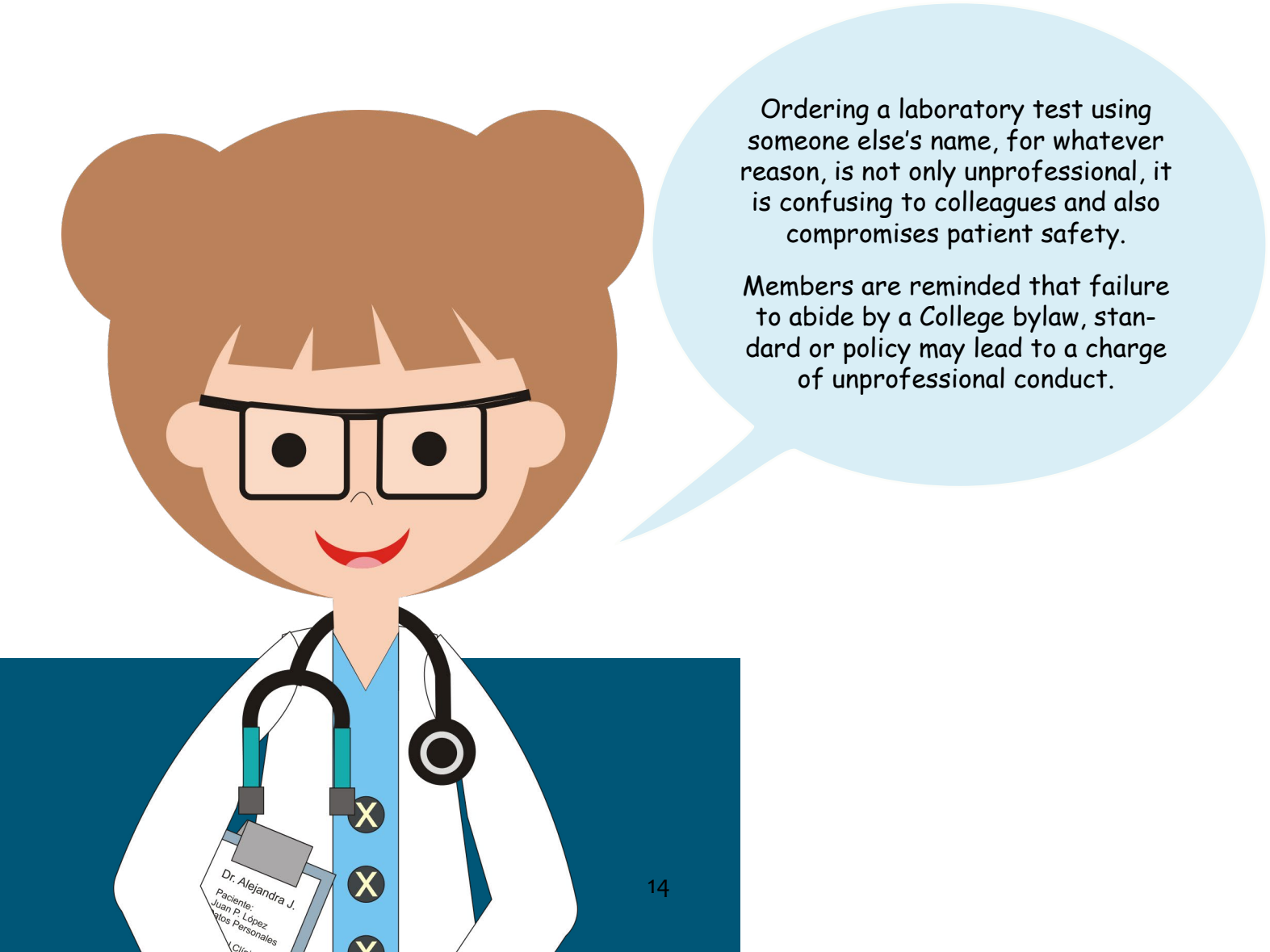
1. Ensure that any practice location in which they work has appropriate systems in place to review and, if appropriate, provide follow-up care in response to any investigations ordered by the physician. When possible, the results of such investigations should be reviewed by the physician who has ordered the investigations and, when not possible, investigations results will be reviewed by a qualified medical colleague;

2. Ensure that any practice location in which they work has appropriate systems in place to review and, if appropriate, provide follow-up care in response to consultant's reports requested by the physician. When possible, consultant's reports should be reviewed by the physician who requested the consultation and, when not possible, such reports will be reviewed by a qualified medical colleague;

3. Ensure that any practice location in which they work has appropriate systems in place to contact a patient when follow-up care is necessary and to document all contacts and attempts to contact the patient;

4. Ensure that any practice location in which they work has appropriate systems in place to respond to "critical" diagnostic test results reported by a laboratory or imaging facility for urgent attention after regular working hours or in the absence of the ordering physician;

5. Remain responsible for any follow-up care required as a result of any investigations ordered or consultations requested by the physician unless another physician has accepted the responsibility to provide the follow-up care.



College Disciplinary Actions

The College reports discipline matters in the next issue of the Newsletter after the disciplinary action is complete. The College website also contains information on discipline matters that are completed, and matters where charges have been laid but have not yet been completed.

Four (4) cases were completed since the last issue of DocTalk.

Dr. Anil Kumar

Dr. Kumar admitted to two charges of unprofessional conduct. The first stated that Dr. Kumar failed to obtain informed consent from a patient before blood products were provided to the patient. The patient was opposed to receiving blood products. The second charge stated that Dr. Kumar failed to adequately advise a patient of the risk of paralysis associated with the surgery that he performed and that he utilized a surgical technique which exposed the patient to an increased risk of compromise of the spinal cord. The patient was paralyzed after surgery.

The Council accepted a joint recommendation for penalty from counsel for Dr. Kumar and the Registrar's Office which included a reprimand, a two-month suspension, an ethics course, and costs in the amount of $20,153.30. He is also prohibited from performing posterior or posterolateral thoracic corpectomy or vertebrectomy with application of reconstructive interbody cage for an indefinite period.

Dr. Pierre Louwrens

A discipline hearing committee found that Dr. Louwrens failed to maintain the standards of the medical profession by remaining in the room while the patient undressed and dressed and by not draping or offering draping to her.

Council reprimanded Dr. Louwrens, ordered him to complete a boundaries course and pay costs of $19,659.30.

Dr. Boniface Lubega

Dr. Lubega admitted to unprofessional conduct for sending inappropriate e-mail messages and leaving a handwritten note to another physician which could reasonably have been interpreted by that physician as threatening.

Council reprimanded Dr. Lubega, ordered him to complete an ethics course and pay costs in the amount of $2,820.

Dr. Carlo Stuglin

Dr. Stuglin admitted to unprofessional conduct for failing to respond to College communications.

Council imposed a fine of $1,500.

PEP celebrates major enhancement

*Funded jointly by Saskatchewan Health, the Saskatchewan Medical Association and the College of Physicians and Surgeons of Saskatchewan, the **Practice Enhancement Program** (PEP) offers physicians a positive means of assessing their medical practice by providing specific information identifying deficiencies and advice on how to correct them.*

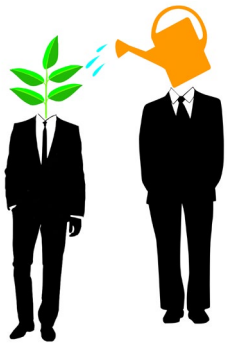
We are so pleased to have this opportunity to tell you about recent achievements and exciting new changes coming to the Practice Enhancement Program (PEP)!

New PEP Web-Based System

We are working on a dynamic enhancement of our own at the PEP office – the transferral of our relatively out-dated database software to a **contemporary interactive web-based system**.

This advancement will utilize existing technology to significantly automate our assessment process. Physicians selected for assessment will be able to access a secure and confidential login to electronically complete and submit all the forms, questionnaires, and "paperwork" required in the pre-assessment progression. Assessors will similarly have protected online access to specific assessment information prior to their conducting onsite visits.

Forms and questionnaires utilized by assessors to observe and outline quality of care, practice organization, and conduct chart reviews will also be available for electronic completion and submission to the PEP office. The new PEP database system will compile all the assessment information collected and generate a detailed Final Report for assessees, eliminating the need for assessors to further compose a narrative report. Overall navigation, structure, and workflow will be easy, mobile-friendly and accessible on smart phones, tablets, laptops, and desktops with an internet connection.



www.pepsask.ca

PEP Assessment Statistics

	1996-2016	Category 1	Category 2	Category 3	TOTAL
Age Group:	A (<50)	335	36	0	371
	B (50-64)	526	65	2	593
	C (>64)	202	61	6	269
Gender:	Male	735	131	7	873
	Female	328	31	1	360
Urban:	Regina/Saskatoon	613	76	5	694
Rural:	All Others	450	86	3	539
Family Practice:		830	148	7	985
Specialty:		233	14	1	248
Assessments to Date:		**1063**	**162**	**8**	**1233**
Reassessments to Date:					**130**
TOTAL:					**1363**

PEP Assessment Categories:

Category 1 - Consistent good care, no concerns re: Patient care or records
Category 2 - Acceptable, but significant need for improvement in areas listed
Category 3 - Immediate Cause for Concern - Serious risk of harm to a patient

Follow-up action per category:

Category 1 - Full accreditation, no review for 5 years
Category 2 - Necessitates planned follow-up
Category 3 - Referred to the College of Physicians & Surgeons

New PEP Coordinator

There is a new PEP Coordinator in town! Chantelle Kurtz will take over the position from the present Coordinator, Joanne Peat, who is retiring at the end of 2017.

Chantelle comes to PEP with a background in non-profit management and human resources. We look forward to fresh and innovative ideas from her as she settles into her new role. Joanne started with PEP during the first few years of its inception and, after 20 years with PEP, says that it has been a very rewarding experience to be part of a team providing practice enhancement province-wide and to see the program progress to what it is today.

She is looking forward to more cottage time with her Black Lab and more miles 'n' smiles on her Harley-Davidson as she seeks out new adventures!

The PEP Committee

Dr. Brian Laursen, Co-chair
Dr. George Carson, Co-chair
Dr. Karen Holfeld, Committee Member
Dr. Andries Muller, Committee Member
Dr. Yellepeddy Nataraj, Committee Member
Dr. Ivelin Radevski, Committee Member

The PEP Staff

Ms. Chantelle Kurtz, Coordinator (Incoming)
Ms. Joanne Peat, Coordinator (Outgoing)
Ms. Jody Semenoff, Program Assistant

We anticipate cost savings from reduced printing and postage and an increase in assessments conducted as a result of prompt information exchange and streamlining the efforts required of all participants in the assessment process (committee members, PEP staff, assessors, assessees). Design and development have already begun and we expect to test and roll out the new system in early 2018!

Report on PEP Assessors Conference

The 13th PEP Assessors Conference was held this last October at Temple Gardens in Moose Jaw. There was a focus on EMRs in terms of current physician usage, future incentives/challenges, the potential for remote electronic chart reviews in PEP assessments, and CDMQIP flowsheet usage/development in the EMR. Mr. Bryan Salte presented several topics: PPEP (BC Physician Practice Enhancement Program) and a comparison to PEP, and an overview of CPSS guidelines regarding prescribing practices in addressing Canada's opioid crisis. Dr. Andries Muller led a review/ revamp of a chart review guideline for COPD which will replace the assessment of Asthma.

Assessments for Specialty Sections

As we strive to bring the benefit of onsite PEP assessments to more specialty sections in Saskatchewan, we are delighted to announce that the next two sections to be assessed will be Neurology and Plastic Surgery. Members from each of those sections are currently working on developing specialty-specific assessment tools that will be used in the assessment of their peers. Potential assessors are being selected and trained and scheduling of these specialist assessments will begin in 2018. These will be the first two specialty sections to be assessed using the newly automated PEP database.

On Cultural Competency

The PEP Committee has noted that physicians are sometimes criticized by their patients for rudeness or disrespect. It is our sense that these concerns arise not from intent but from a lack of understanding amongst patients and physicians alike. Saskatchewan is alive with many different cultures, not just in our communities, but also in our physician population. A better recognition and understanding of such differences should result in a significant reduction in such criticisms. This has prompted us to have a conversation with our assessors in order to identify any challenges, develop a plan for growth, and seek out educational resources.

Wishing you a very safe and happy holiday season
with friends and family . . .

The PEP Committee & Staff

Prescriptions in Review

By Amy Wiebe

Resources available from the *Insitute for Safe Medication Practices Canada* (ISMP) to support prescribing of opioids

Take a moment to review the *Essential Skills for Opioid Prescribers at https://www.ismp-canada.org/download/OpioidStewardship/Opioid-Prescribing-Skills.pdf?%0d%0a%0d%0autm_source=prodserv&utm_medium=email&utm_campaign=ps171017*.

This two-page document provides an overview on:

- Appropriate patient selection for initiation of opioids for acute or chronic use
- Suggested starting doses and upward titration
- When to taper downward and how
- Who may be a candidate for a naloxone kit
- Features of opioid use disorder
- Counselling patients on reduction of overdose risk
- How to initiate and dispense buprenorphine/naloxone (Suboxone)

A great reference for supporting clinical decision making around dose escalation of opioids, as well as an infographic which can be used as a tool to discuss the risk of increasing doses and the rationale for lowering doses with patients.

- Helping Patients and Practitioners to Understand Opioid Potencies and Overdose Risk: https://www.ismp-canada.org/download/OpioidStewardship/opioid-handout-bw.pdf

Before deciding to initiate opioids for chronic non-cancer pain, consider referring patients to the following resources.

The user-friendly information in short one to two minute videos provides preliminary information on:

- What are opioids
- What are the different pain treatment options
- How to use and store safely
- The difference between tolerance, dependence and addiction
- How to protect from/respond to overdose
    - Patient information sheet: https://www.ismp-canada.org/download/OpioidStewardship/opioid-handout-bw.pdf
    - 8-video series: ***Question Opioids***: https://www.safemedicationuse.ca/newsletter/question-opioids.html?%0d%0a%0d%0autm_source=prodserv&utm_medium=email&utm_campaign=ps171017

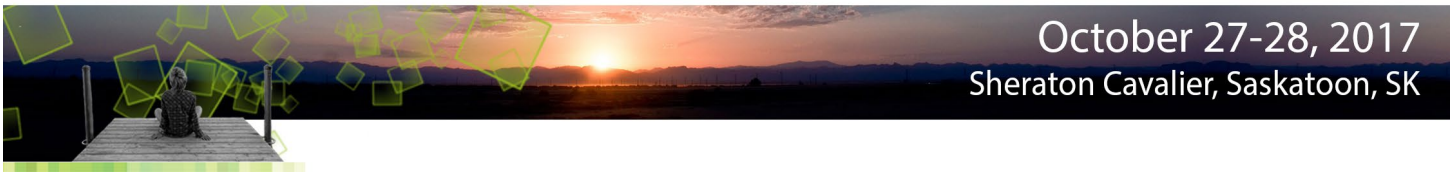
CCENDU RCCET
Canadian Community Epidemiological Network on Drug Use
Réseau communautaire canadien d'épidémiologie des toxicomanies

CCENDU IS ON FACEBOOK!

Stay updated on drug news in Saskatchewan and across Canada!

Be sure to like the "CCENDU Saskatchewan" Facebook page.

The Canadian Community Epidemiology Network on Drug Use (CCENDU), is a nation-wide network of community partners that informs Canadians about emerging drug use trends and associated issues.



2017 COMPAC Conference Provided Critical Strategies on Managing Pain and Addiction Safely

By Julia Bareham, CPSS Prescription Review Program

*On October 27th and 28th, the Sheraton Cavalier in Saskatoon hosted the first **Current Options for Managing Pain and Addiction** Conference (COMPAC). Over 250 healthcare providers from across Saskatchewan and beyond attended. The event was a collaboration between CPSS and the Health Sciences Continuing Education Group at the University of Saskatchewan. The Royal University Foundation's Peter and Anna Zbeetnoff Memorial Fund also provided support to the event. Numerous provincial services and programs also had display booths to promote their organizations as valuable resources to those in attendance.*


(L-R) Brenda Senger (SMA) and Dr. Vivian Gooding: Session on Forgeries, Stories & Setting Boundaries

Day one of the conference kicked off with greetings from Scott Livingstone, the CEO of the newly formed Saskatchewan Health Authority, and Vice Chief of the Federation of Sovereign Indigenous Nations (FSIN) Kim Jonathan. The first keynote speaker, Dr. Norm Buckley who is the Director of the Michael G. DeGroote Institute for Pain Research and Care, delivered the first plenary session on the topic of Canada's New Opioid Guideline. The day continued on with presentations from various Saskatchewan practitioners who discussed topics including inter-professional collaboration, non-drug measures for chronic pain, interventional procedures for chronic pain management, alcohol use disorder, and the challenges related to prescription forgeries and patient behaviours that can trigger countertransference. The day finished off with the second keynote speaker, Dr. Mark Ware, who has many roles including being the Executive Director of the non-profit Canadian Consortium for the Investigation of Cannabinoids. Dr. Ware discussed cannabinoids and medical cannabis while reviewing the evidence for this treatment in pain management.


Scott Livingstone (SHA)

Despite a busy first conference day packed full of valuable information and great speakers, day two of the conference did not disappoint. Day two featured the final keynote speaker, Dr. Hakique Virani, who is a Royal College specialist in Public Health and Preventative Medicine and a Diplomate of the American Board of Addiction Medicine. Dr. Virani discussed opioid use disorder and the various considerations for the management of this condition.


Dr. Norm Buckley

Following Dr. Virani's talk, Dr. Colleen Dell of the University of Saskatchewan took to the podium to discuss culture, as well as the connection to humans, animals and the environment in the context of healing from addiction. Dr. Dell's co-presenter Subie, who is one of her therapy dogs, certainly challenged the audience for their attention while he sat on the front stage with his flawed smile capturing everyone's hearts.

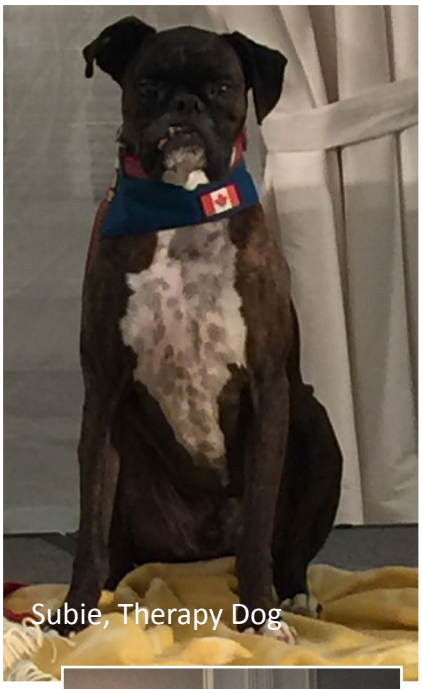
The concurrent sessions then followed and conference participants were again given the opportunity to explore various topics in greater depth while in a more interactive and intimate environment. Lastly, the final two plenary speakers of the day certainly evoked an emotional response from the audience. Marie Agioritis had most of the audience fighting back tears as she described the story of her son Kelly and how he lost his life to an opioid overdose at the age of 19.

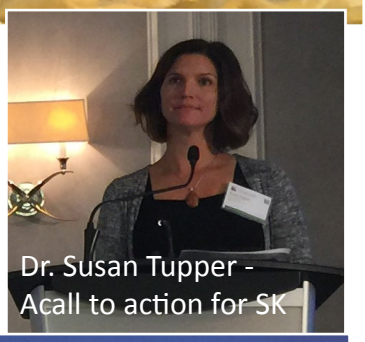
After this heartbreaking talk, Constable Mike Johnson closed the conference by providing the perspective of law enforcement in regard to prescription drug abuse. Audible gasps could be heard as Constable Johnson described the value of prescription medications on the street. He spoke about how one capsule of Hydromorph Contin 30mg could fetch anywhere from $100 to $120, and explained the challenges that law enforcement faces when dealing with diverted prescription medications.

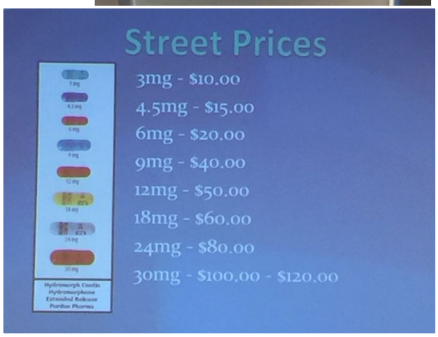
Overall the conference provided attendees with quality information delivered by a variety of experts from Saskatchewan and across Canada. The talks were delivered by speakers from various health and non-health disciplines and focussed on practical tips for the assessment and management of chronic pain, as well as substance use disorders, in addition to other valuable pearls, facts, and evidence.

But now the hard work begins.

Providers must now take that information and apply it to their practice and to their patients. Hopefully the connections that were made, the resources that were discovered, and the information that was provided will help facilitate the implementation of best practices for patients with chronic pain and/or a substance use disorder.


Subie, Therapy Dog


Dr. Susan Tupper - Acall to action for SK



NAS 2017 Education Session a success!

From October 23-26, a total of 192 residents of La Ronge and surrounding area, including physicians, pharmacists, nurses, business management representatives, law enforcement, and members of the public attended the event "Changing the Story".

The object of the Education Session was to provide the community with evidence-based cross-sector tools on mentoring, education and management of alcohol and opioid use disorders, on the premise that when communities address the issue, every sector is positively impacted.

The event was held at the Eagle Point Resort and was well received by the community. Keynote speakers came from the Women's College Hospital in Toronto: Dr. Ashok Krishnamurthy, Leslie Molnar and Irene Njoroge.

Election Results Are In!

Congratulations to the newly elected and re-elected members of Council!

Below are the official election results for the 2017 Council elections held in November. Council would like to thank each and every candidate for their interest and willingness to contribute to serving the public in guiding the profession to achieve its highest standards of care. Thank you also to all the voters who took the time to send in their ballots. Your participation is important!

The first Council meeting for new members will take place in January 2018.

- District 1 – Prince Albert Parkland/Mamawetan Churchill River/Athabasca – **Dr. Oladapo Mabadeje**
- District 3 – Saskatoon – **Dr. Grant Stoneham**
- District 5 – Cypress – **Dr. Narasimha Venkata**
- District 7 – Regina Qu-Appelle – **Dr. James Fritz**
- District 9 – Kelsey Trail – **Dr. Pierre Hanekom (by acclamation)**

Thank You for Your Service

Dr. Suresh Kassett

Council would like to thank **Dr. Suresh Kassett** (left) for his long-standing contribution in upholding the mission, vision and values of the College while serving as a Member of Council (Cypress Region) over many years.

Mr. Ron Harder

On November 24, 2017, Council presented an award of recognition to Mr. Ron Harder (left), for his valuable contribution in upholding the mission, vision and values of the College during his appointment as Public Member of Council.

Dr. Dennis A. Kendel Distinguished Service Award

Dr. Susan Shaw
2017 Kendel Award Recipient

Dr. SUSAN SHAW RECOGNIZED FOR OUTSTANDING LEADERSHIP

at the 6th annual Dr. Dennis A. Kendel Distinguished Service Award Reception

During a special awards banquet held in Saskatoon on November 24th, 2017, the Council of the College of Physicians and Surgeons of Saskatchewan presented Dr. Susan Shaw, a critical care physician and anesthesiologist in Saskatoon at the time of the presentation, and now Chief Medical Officer for the new Saskatchewan Health Authority, with the prestigious Dr. Dennis A. Kendel Distinguished Service Award for her outstanding contributions to physician leadership and/or to physician engagement in quality improvements in health care in Saskatchewan.

"I consider myself incredibly privileged that my work allows me to move back and forth from my patients' bedside to meeting and boardrooms. This gives me the chance to see both the challenges our patients, families and staff experience within the system, and all the opportunities we have to improve health and care by working together as partners," stated Dr. Susan Shaw. "I am very grateful for the coaching and support I have received from my patients and colleagues over the years."

Dr. Alan Beggs, President of the College Council, was onsite to present Dr. Shaw with the award: "It gives Council great pleasure to present this award to a physician who has, and continues to provide a positive influence on the quality of healthcare dispensed to patients across Saskatchewan.

To be identified by one's colleagues as deserving of specific recognition as a leader or innovator in our common profession is probably the greatest honor a physician can receive." More details on Dr. Susan Shaw are available on the College website in the news release distributed on Nov. 24, 2017:
http://www.cps.sk.ca/iMIS/Documents/Media_Documents/171124-CPSS_KendelAward-SusanShaw.pdf

NOMINATE A COLLEAGUE FOR 2018!

Nomination packages for 2018 are available on the homepage of the College website or at

http://www.cps.sk.ca/iMIS/Documents/Dr%20Kendel%20Service%20Award%20-%20Nomination%20Package.pdf

or by contacting Sue Waddington at

OfficeOfTheRegistrar@cps.sk.ca

Nominations are OPEN until September 30 of each year

21 Physicians Honored with Senior Life Designation

During a special awards banquet held on November 24th, 2017, the Council of the College of Physicians and Surgeons of Saskatchewan honored twenty-one (21) recipients with Senior Life Designation 2017 (for having held a license to practice medicine in Saskatchewan for a cumulative total of 40 years) for their lifelong contribution, as per the Medical Profession Act.

This confers the privilege of lifetime membership to the College, regardless of licensure status.

The recipients for 2017 are:

- **Dr. Shahabuddin Ahmad**
- Dr. Qureshi Ahmed
- **Dr. Enrico Cabigon**
- Dr. Beverly Coates
- **Dr. Steven Goluboff**
- **Dr. Rizqi Ibrahim**
- **Dr. Daniel Johnson**
- Dr. Brian Laursen
- Dr. Dwight Loback
- **Dr. Lalita Malhotra**
- Dr. Tilak Malhotra *(In Memoriam)*
- **Dr. Alan Miller**
- **Dr. Hasan Moolla**
- **Dr. Mohammed Raffath Sayeed**
- **Dr. Sushama Shukla**
- Dr. Narinder Sood
- Dr. Om Sood
- Dr. Betty Spooner
- Dr. Kenneth Stakiw
- **Dr. Boyd Stewart**
- Dr. Terrence Zlipko

Of these, 11 participants (in bold) were able to join us in person to receive their award.

Front Row, L – R: Dr. Alan Beggs (President, CPSS Council), Dr. L. Malhotra, Dr. Cabigon, Dr. Shukla, Dr. Stewart.

Back Row, L-R: Dr. Moolla, Dr. S. Ahmad, Dr. Ibrahim, Dr. Goluboff, Dr. Sayeed, Dr. Johnson, Dr. Miller, and Dr. Karen Shaw (Registrar, CPSS)

L-R: Dr. Karen Shaw, Dr. Alan Beggs, Dr. Lalita Malhotra

Dr. Karen Shaw, Registrar, presented a Senior Life Designation award posthumously in honor of Dr. Tilak Malhotra to his wife, Dr. Lalita Malhotra, who also received her own Senior Life Designation award at the same time.

Full biographies for the Senior Life Designation recipients listed in the group photo above can be accessed at http://www.cps.sk.ca/iMIS/Documents/Media_Documents/171124-CPSS_KendelAward-SusanShaw.pdf

SENIOR LIFE: LEARNING MOMENTS over a LIFETIME in a CAREER

"Having the honour of caring for patients from the delivery throughout their lives, and seeing multiple generations come across my path has truly been a privilege."

- Dr. Steven Goluboff, (pictured above in the company of his two daughters)

(Above, L-R) Dr. Lalita Malhotra and Dr. Shusma Shukla pose with their awards.

Dr. Ernesto Cabigon (above) is proud to have been a part of the Department of Pathology/Cytology at the Pasqua Hospital for the last 34 years, working with "the nicest colleagues, lab techs and secretaries!"

"A patient with alcoholism came in one afternoon and asked me to remove his appendix. He had symptoms of acute appendicitis but his WBC was normal. I asked him why he thought it was appendicitis. He told me "It is my body! I know! You are just guessing!". I performed the appendectomy. It was an acutely inflamed appendix. Since then, my motto has been: *THE PATIENT is right until proven wrong. LISTEN TO THE PATIENT*!"

- Dr. Raffath Sayeed (pictured above with his wife, Zuhy)

"I remember one morning, 15-20 years ago, giving an anesthetic for an open cholecystectomy, then going down the hall to our ICU and performing an elective cardioversion and then going to the ER to treat a child with a fractured radius. It left me thinking – how many big city anesthesiologists treat fractured bones? How many orthopods would cardiovert and how many cardiologists would like to give an anesthetic?? The joys and challenges of living and working in rural Saskatchewan in the 20th century!"

- Dr. Boyd Stewart

"A few days before I retired from family practice one of my young female patients presented for a final visit. After we dealt with her medical needs, she became quite emotional. She was in her early thirties. She said to me "Dr. Miller, do you know that you have been the only physician that I have ever seen since I was born? What am I going to do?" We were both overcome by the significance of our long-term professional relationship."

- Dr. Allan Miller

SENIOR LIFE: LEARNING MOMENTS - continued

"In February 1978, during a 5-day blizzard, I responded to a patient in labor. I travelled with the RCMP and a department of highways truck 27 miles that took 3-1/2 hours. On arrival, she was 6-7 cm and membranes were bulging. I made the decision to deliver her at home (which is safer than in the back seat of a police cruiser). After ARM, the baby girl was born at 8 pm, an uneventful delivery. The memorable part was that this lady and her husband provided a delicious supper; roast beef, green peas, baked potatoes and homemade sour cream. I remember that vividly! By the way, that baby remains under my care until this day." - Dr. Rizqi Ibrahim (left).

"I had just done a prostate examination. While my back was turned, I heard a moan, followed by a crash. My associate burst into the room as the patient was regaining consciousness. The patient had a slight memory loss and I admitted him to hospital. He was discharged the next day. Meanwhile, where his head hit the wall, there remained a depression to remind me of the incident. Then, about a year later, I was called to the hospital to suture a fellow's scalp at 3 AM. I went to the hospital with my usual 3 AM humour. I walked in and the fellow said "Hello, Dr. Johnson". It was the same fellow as the year before!!" - Dr. Daniel Johnson (above).

Dr. Hasan Moolla has been practicing as a physician in Battleford since 1976.

(Above, L-R) De. Shahabuddin Ahmad receives his award from Dr. Al Beggs, President, CPSS Council.

Dr. Tilak Malhotra
(Presentation In Memoriam)

Culturally Competent Care: A Patient's Perspective

by Tanjalee Kuhl, Saskatchewan Intercultural Association

Through surveys and discussion at Saskatchewan Intercultural Association, newcomer and indigenous participants voiced their experiences and suggestions to offer a patient's perspective on how physicians can be effective at working with culturally diverse patients. Several common themes arose.

1. Learn about the patient's culture

"When I met my doctor for the first time, she asked me about my country, my culture…. she was very excited to know about my culture. It helped me feel very comfortable."

It is impossible to learn everything about other cultures, but a little bit of **curiosity and respect** for another person's culture can go a long way. Taking a little bit of time to ask open-ended, respectful and non-judgemental questions can bring understanding and establish trust.

2. Don't make assumptions

"I believe that racism is a big issue in the medical profession… making deductions about people's personal traits on lying and drug abuse should be based on behaviour they actually possess rather than assumptions that were made."

"Don't assume you understand when there is any form of communication barrier, language or accent barrier."

The starting point for developing a culturally competent practice is **self-awareness**. It's important to be aware of one's own perceptions, stereotypes, biases that may be influencing interactions with patients in order to interrupt patterns that may lead to discrimination.

3. Be patient

"Don't be in a hurry when assisting a patient… if necessary, get an interpreter to help you understand what your patient is saying."

Many clients felt as though their experience in the health care system is consistently rushed and that the doctor didn't have time to really **listen**, or was impatient with their inability to speak English fluently. Those who received assistance through interpreters or whose doctor used a system to translate were very grateful.

It is important that the services offered to residents **reflect and acknowledge** the vast cultural perspectives that exist in our province to be able to provide the most effective care. With increased self-awareness, greater knowledge of other cultures and the ability to adapt behaviour, health care professionals can better address the needs of our increasingly diverse population.

Photo courtesy of the Saskatchewan Intercultural Association

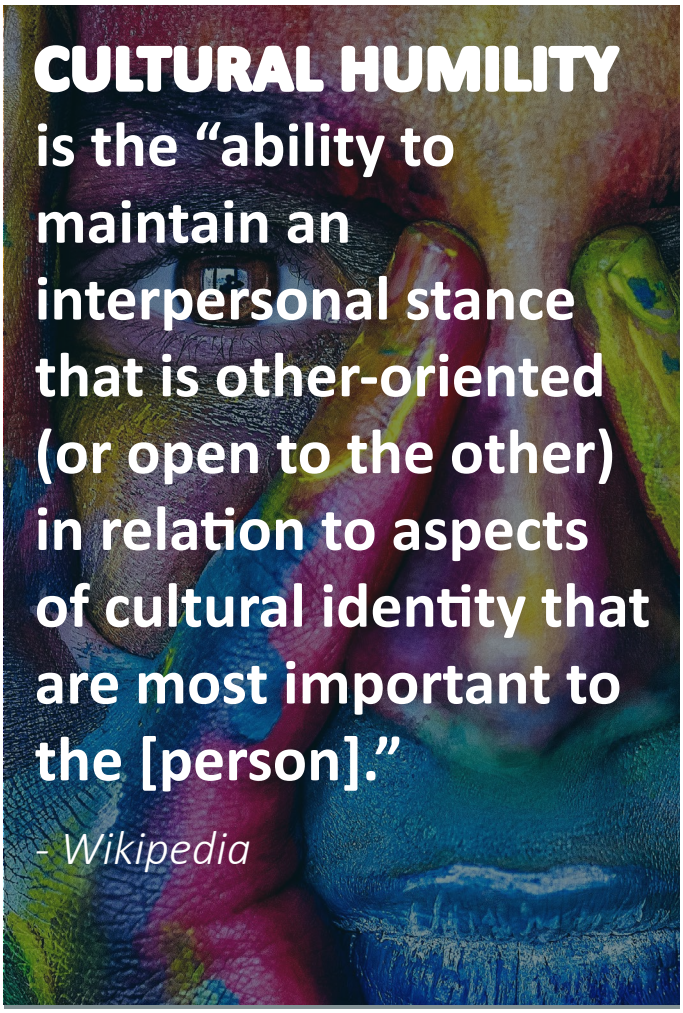
Cultural & Linguistic Humility and Patient Needs: Understanding with your Heart

Some things to consider when experiencing language & cultural barriers

by Caro Gareau, CPSS.

* *Special thanks to Sharon Clarke, First Nation and Métis Health Services, Saskatchewan Health Authority, for her input.*

A woman close to my heart whose first language and culture is not English, yet has lived in Saskatchewan for several decades, prefers to seek care from a local physician who speaks her first language wherever possible. She often says "When I am sick, I can't explain it in English. The words don't come." Although otherwise a very intelligent and well-spoken woman who is knowledgeable with regards to health conditions in general, when she is ill, she finds difficult and frustrating to retrieve the vocabulary (some of which she may not have acquired) to explain in English what can be very personal health issues or abstract yet worrisome symptoms.



Illness and pain, whether mental or physical, will often bring out a sense of vulnerability and frustration in people, which in turn makes them seek familiar things that will bring them a sense of comfort in order to overcome or deal with health issues that can be difficult or even downright scary.

For some, comfort simply means homemade chicken soup, a hug from a loved one, flowers, and perhaps a small religious prayer object, or a special pillow from home.

For others, that can include being able to express what you feel in your first language wherever possible as well as familiarity with and respect of cultural and religious traditions, rituals, beliefs and/or special objects.

Some will also interpret body language differently from what you are accustomed to, and come out of a consultation feeling slighted by perceived "rude" behaviour or words when that was not your intention.

For some, this barrier can be extremely frustrating, and lead to the patient delaying obtaining the necessary care. This is not to say that that such patients can only be tended to in their native tongue or by physicians from their native culture, but that they may require extra care and effort to create the climate of confidence that will help them understand the physician and feel that their medical needs are understood.

Knowing that there is an openness and curiosity to go that extra mile to find solutions to breaking down those barriers helps build trust within the patient - healthcare provider relationship.

Such needs may not always make sense to you if you are from a background different from your patient, but if they are important to your patient, they should be respected and tended to wherever possible.

Continued on p. 28...

... continued from p. 27

What can you, as a physician, do?

Show Cultural Humility!

- Be open to learn about their culture and adapt to your patient's needs! Don't judge!
- Respect their beliefs and traditions, and make an effort to accommodate and incorporate them wherever possible, and propose safe alternatives if they object to a particular course of care.
- Don't assume you know.

Be a resource!

- Add your spoken (other than English) languages to the CPSS database at **https://www.surveymonkey.com/r/cpss_language_survey**! This is made available to patients on your physician profile.
- Do research! Take courses! Familiarize yourself with the diverse cultural and linguistic groups to which your patients belong.
- Let your workplace know if you have specific knowledge or experience working with certain cultural or linguistic groups.

Pay attention to language & body language!

- Speak slowly and clearly enough to ensure your patient can understand what you are saying. If they do not appear to understand, it may be time to access an interpreter.
- Observe your patient's body language - if they appear uncomfortable, afraid, jumpy or silent, try asking if there is anything you can do to help them feel more at ease. Keep in mind trauma informed care and realize that your patients may be residential school survivors, or have experienced war, torture or other abuses.
- Comments that may be acceptable in one culture can be perceived as rude and improper in others. Be aware that certain gestures and even eye contact in one culture don't always mean the same in another. You may need to be aware of male-female cultural boundaries. Your own body language may give the wrong impression, too. Be open to learn and talk sincerely with your patient to gain a better understanding of their reactions!
- Chances are, learning how to say a few key words to your regular patients, such as *Hello!,* or even *Where does it hurt?* in your patient's native tongue (whether they speak English or not!) and being open to learn more can put a smile on their face.

Use an interpreter if there is a language barrier!

- Using a qualified interpreter can be a valuable tool.
  - Telephone Interpretation Services are available through the Saskatchewan Health Region by calling the hospital Switchboard.
  - First Nation and Metis Health Services offers in-hospital translation & interpretation in Cree, Dené and Saulteaux and other cultural and knowledge keeper (Elders) services for physicians and Indigenous patients. Call 306-655-0158 (SPH), 306-655-0166 (RUH) or Switchboard to access services.
  - In Regina, the Native Health Service provides patient flow supports such as health navigation, liaison, cultural and spiritual care in the tertiary sites. These services can be accessed through Switchboard or by calling Regina General Hospital 306-766-4155 or Pasqua Hospital 306-766-2232.
  - The Health Accompagnateur Interpretation Services program offers in-person services in French, including interpretations for patients wishing to be accompanied (see. p. 35 for details).

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Do you speak, write or understand a language other than English?

How about sign language?

Register your language proficiencies online with the College at:

https://www.surveymonkey.com/r/cpss_language_survey

Write to communications@cps.sk.ca if you are experiencing difficulty entering your information online.

Mifegymiso - Update for Prescribers

Health Canada has made some changes to the dispensing regulations for Mifegymiso as follows:

- *Mifegymiso can now be prescribed up to nine weeks (63 days) into a pregnancy , rather than the previous limit of seven weeks (49 days).*
- *Mifegymiso can now be dispensed directly to patients by a pharmacist or a prescribing health professional. Directions for use remain the same. Patients should take the medication as directed by their health professional, either at a health facility or at home.*
- *Health professionals should have appropriate knowledge about the medication before prescribing Mifegymiso. Education programs are available. However, health professionals are no longer required to complete an education program before they can prescribe Mifegymiso.*
- *While dialogue and information sharing between patients and health professionals is always important, the requirement for written patient consent to use Mifegymiso is being removed.*
- *Health professionals will no longer be required to register with Celopharma in order to prescribe or dispense Mifegymiso.*

Source: http://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/65034a-eng.php

The College has published an information sheet for physicians prescribing Mifegymiso. This resource is available at http://www.cps.sk.ca/iMIS/Documents/Mifegymiso%20-%20info%20for%20physicians%202017.pdf

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Keep in mind, however, that there are pitfalls to avoid in ensuring good communication with your patient when using an interpreter.

1. *Speak to the patient*, not the interpreter. Make appropriate eye contact when communicating with your patient (except in cases where it is culturally insensitive to do so).
2. Give time for the interpreter to interpret your words. If you don't, important parts of your physician-patient care dialogue may be missed. Remember, the patient may see their care as complex and confusing.
3. Don't rely only on the interpreter's words. Body language is important and can provide additional information and clues to help guide the provision of quality health care.
4. Family members may not always be the best choice for an interpreter. They may be reluctant to convey bad or sensitive news, or unable to translate the correct terminology, or may also have difficulty communicating in English and could have misinterpreted the information provided.
5. Indigenous languages in Saskatchewan have many dialects and one word may have different meanings from one side of the province to the other. The FNM interpreters know this and use different techniques to make sure the patient understands.

Sometimes, an interpreter is not readily available in the required language combination. Did you know some free online multilingual dictionaries containing health-related phrases for some of the languages spoken in Saskatchewan today are:

- *Cree:* www.creedictionary.com
- *Dene:* www.ssdec.nt.ca/ablang/ablanguage/chiptionary/Chipewyan%20Dictionary.pdf
- *Languages from overseas:*
  - www.linguee.com
  - http://www.salanguages.com/dictionaries.htm
  - https://en.bab.la/dictionary/

Don't take it personally if a patient chooses to see a different physician.

- Understand that patients may sometimes seek out a different practitioner or an interpreter where they feel they can more adequately express themselves and be better understood in their native tongue, and that this choice does not necessarily reflect on you or the quality of your services.

Learning about Indigenous Wellness

Stay tuned! Our next issue will feature articles on Indigenous Wellness as well as updates on Council's actions in following the recommendations from the Truth and Reconciliation Committee Report.

Prescribing Opioids and the New Canadian Guidelines

Part 1 of a 3 part series

by Dr. Laura Lee McFadden, Senior Medical Advisor, CPSS
Julia Bareham, Pharmacist Manager, Prescription Review Program, CPSS

There has been a lot of press about the current "opioid crisis" and the role that prescribers have taken in not only contributing to that crisis but as part of the solution to it. Physicians understand more than anyone what a challenge chronic pain can be to manage; constantly trying to balance an improved quality of life while minimizing risk.

The recent **2017 Opioid Prescribing Guideline for Chronic Non-cancer Pain** *outlines 10 recommendations for prescribing opioids. We will summarize some of those recommendations and offer resources for physicians.*

1 **When considering therapy for patients with chronic non-cancer pain, optimize non-opioid pharmacotherapy and non-pharmacological therapy first before initiating a trial of opioids.**

RxFiles has published the "Pain Mini-Book" and provides a summary of therapies for various non-cancer chronic conditions requiring pain management (available at www.rxfiles.ca). These include exercise, behavioural therapies, acupuncture, massage, and psychosocial interventions. Non-opioid pharmacotherapy for pain includes acetaminophen, NSAIDS, TCA's, SNRI's, anticonvulsants, capsaicin topical, etc.

2 **For patients with chronic non-cancer pain, without current or past substance use disorder and without other active psychiatric disorders, who have persistent problematic pain despite optimized non-opioid therapy, consider adding a trial of opioids rather than continuing therapy without opioids.**

What does an appropriate trial of opioids look like?

- Duration of at least 3 months.
- Low dose [e.g. morphine 5 mg po q 6 h (or weak opioid tramadol), keeping the number of tablets to be taken per day as well as the interval between prescriptions small].
- Reassess and titrate (every 3 to 14 days as tolerated), then monthly. "Start low, go slow".
- Limit number of dose escalations to 2-3 x during trial.

Set Expectations

- Advise of potential harm and be clear that prescription is in the context of a trial.
- Confirm through Pharmaceutical Information Program (PIP) and a baseline urine screen (UDS) that patient is opioid naïve.
- Assess risk of harm (other CNS depressant use, comorbidities).
- Treatment agreement and informed consent (www.rxfiles.ca).

3 When beginning long term opioid therapy for patients with chronic non-cancer pain: Restrict the prescribed dose to less than 90mg morphine equivalents daily (MME/d) rather than no upper limit or a higher limit on dosing.

- There is a clear dose response relationship for non-fatal and fatal overdose.
- There is not a similar dose response relationship between opioid dose and pain, physical function, and gastrointestinal side effects.
- Patients who are already over 90 mg MME/d should be considered for a taper to the lowest effective dose. Conversion table available from RxFiles.

4 The guidelines suggest that for chronic non-cancer pain in patients who are beginning opioid therapy that the dose be restricted to less than 50mg MME/d.

- It is acknowledged that there are likely to be some patients who would be ready to accept the increased risks associated with a higher dose (i.e. >50mg MME/d) in order to potentially achieve improved pain control.
- This recommendation highlights the importance of setting functional goals with your patients prior to initiating opioid therapy, and reassessing progress to determine if the medications are providing a significant benefit. Remember, complete pain resolution is often an unrealistic goal of therapy when treating chronic non-cancer pain.
- You may want to consider a dose of 50mg MME/d as a marker for reassessment and discussion with your patient about the risks of opioids.
- Once the daily dose surpasses 50mg MME/d, there is a 5x increase in overdose risk. This risk remains about the same up to 100mg MME/d.
- Once the daily dose falls within 100mg to 200mg MME/d, the risk of overdose is increased 9x as compared to lower doses and is more likely to be fatal.

MORPHINE EQUIVALENCE TABLE

A morphine equivalence table is available on page 3 of the Opioid Manager guide, downloadable at thewellhealth.ca/pain/
The document also provides a great deal of very useful information to guide safe prescribing of opioids.

Still not sure about prescribing opioids?

The Prescription Review Program (PRP) can answer your questions!

The PRP is an educationally-based program that monitors prescribing to assist in the optimization of the use of monitored medications. Opioids, benzodiazepines, stimulants, gabapentin, and other medication classes are monitored by the PRP. The PRP usually corresponds with prescribers in writing. The most common forms of written correspondence from the PRP to physicians are Double Doctor Letters, Explain Letters and Alert Letters.

Double Doctor Letters are system generated on a monthly basis.

- These letters report patients who have seen three different prescribers (including dentists and nurse practitioners), at three different practice sites (based on the addresses provided to the College), within a calendar month.
- They are intended to alert physicians to other prescribers involved in the care of their patients who are also providing PRP medications to help lessen the risk of medication-related adverse effects.
- In 2016, **6925 Double Doctor Letters** were sent out to Saskatchewan physicians.

Explain Letters require a response from a physician.

- They may be sent to a physician when large quantities are being prescribed or when brand name medications are being dispensed despite a generic being available (e.g. Ritalin [brand name not covered by NIHB] or Dilaudid).
- They are used if the patient has an unexpected UDS results, when risky medication combinations are being used (e.g. opioid plus a benzodiazepine), and when the PRP receives information about diversion or medication abuse.
- Explain letters are not sent out because the prescriber is doing something wrong or improper, but rather to gain more information about the rationale for the medications being used.
- The PRP team does NOT have access to PIP or the eHealth Viewer, and as such, must often request information available through these sources directly from the physician.
- Explain letters allow the PRP to work with prescribers to address any potential prescribing concerns by offering recommendations and management strategies.
- In 2016, **433 Explain Letters** were sent out to Saskatchewan physicians.

Alert Letters are sent to physicians when the PRP has received information that the patient is potentially misusing or diverting medications.

- These tips may come from the public (friends, family), from other health care providers (pharmacists, nurses), or law enforcement.
- These letters are not intended to have you immediately stop prescribing to your patients but rather to ensure you have the proper safeguards and boundaries in place.
- When you receive an Alert Letter stating that law enforcement is actively investigating your patient for drug trafficking, that is an ideal time to call in the patient in for a RANDOM UDS, have the pharmacy do a RANDOM pill count, and/or decrease the amount of medication dispensed at each interval (e.g. one week at a time, versus one month).
- Law Enforcement cannot always arrest an individual for trafficking so they look to physicians to assist in addressing the inappropriate use of the medication.

If you receive one of these letters, and you have any questions, do not hesitate to call (306-244-7355) or e-mail the PRP at prp@cps.sk.ca.

Are you treating a complex case?

The knee jerk reaction from many physicians is to fire these patients from practice. This is not always the best option for the patient.

In the next issue of Doc Talk, we will be addressing specific case by case challenges on non-compliant patients and asking some of the experts in the field to weigh in on management of difficult scenarios (early refills, street drugs on UDS, suspected diversion).

We will explore both the pros and cons of dismissing non-compliant patients from your practice and offer solutions to support you in keeping your patients safe.

We would love to hear from you!

Email some of the challenging cases you or your colleagues have had to prp@cps.sk.ca.

We don't require names of patients and your cases will be kept confidential. We want to address real issues that our physicians are facing.

Licensing for Point of Care Testing

Recently, it has come to the Medical Laboratory Licensing Program's attention that a point of care hepatitis C test has been distributed to physicians by a drug company for use in their offices. Though point of care tests have improved dramatically over the last few years, the act of taking of this sample and testing it would be considered a laboratory test as described in *The Medical Laboratory Licensing Act*.

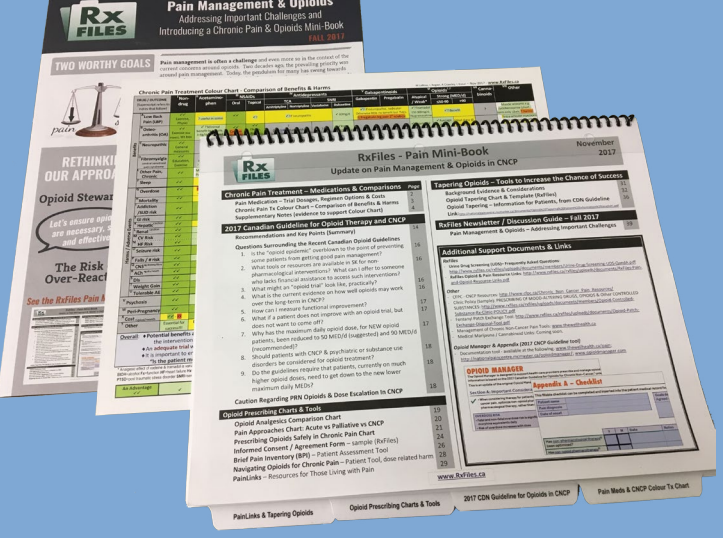
Based on the legislation, before a test of this nature can be offered:

- the test must be validated;
- a quality assurance process must be employed (including proficiency testing); and
- the site doing this test must be licensed.

As an example, those providing HIV point of care testing across the province are all licensed to perform this test. The testing is routinely validated (a random sample of the point of care tests from each lot number are tested for accuracy by a referral laboratory) and proficiency testing is required by all licensed providers. This ensures consistent, high quality results from the test.

It is a requirement that any physicians considering employing new point of care tests, understand their responsibilities under *The Medical Laboratory Licensing Act*.

If you have questions regarding this, please contact the Medical Laboratory Licensing at 306-787-3130.



Up next from RxFiles

New Resources for Managing Pain with Opioids

The RxFiles Academic Detailing Service has just launched a two-part series on the Pain Management & Opioids. In addition to the newsletter, we have compiled an RxFiles - Pain Mini-Book which we will provide with the office visits. To book an office visit discussion on Pain/Opioids with one of our team, contact your local RxFiles pharmacist or email us at info@RxFiles.ca, fax 306-655-7980 or phone 306-655-8505. Thank you for your participation & support!

Loren Regier BSP, BA on behalf of the RxFiles Team

New RxFiles Pain Resources

The Pain Mini-Book

The 2017 Canadian Opioid Prescribing Guideline was released earlier this year, and the CPSS Council has recently endorsed the guideline. Prescribers are now faced with the challenge of reviewing the new guideline and determining how to appropriately apply it to their patients.

To help support prescribers, RxFiles has released a new pain resource entitled ***The Pain Mini-Book*** and it is available on their website www.rxfiles.ca. All Saskatchewan health care providers can access RxFiles digital resources (yes, there's an app!) for free.

The Pain Mini-Book is packed full of valuable resources to help prescribers evaluate drug therapies used to treat chronic pain to ensure they are optimized. The resource provides a comparison of the medications available for various chronic pain indications (e.g. fibromyalgia, osteoarthritis, low back pain). The Pain Mini-Book will also help tackle the tough and/or commonly asked questions surrounding the 2017 Canadian Opioid Prescribing Guideline. As well, there is a tool to assist in the tapering of opioids, along with links to various valuable resources.

RxFiles academic detailing visits will commence in November 2017 across Saskatchewan. Excerpts from The Pain Mini-Book will be used to support the conversations between RxFiles Detailers and prescribers during office visits on the topic. Due to the complexity of the topic of chronic pain, RxFiles will provide additional academic detailing visits in the New Year to continue to discuss this challenging practice area where the focus will be opioid tapering and switching.

If you can't wait for an academic detailing visit to start delving into the topic, visit the RxFiles website to access many valuable tools including treatment agreements, newsletters, practice tools, and evidence summaries.

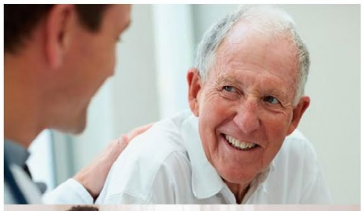
INFECTION PREVENTION

News Updates

The **IPAC Link Letter** is a monthly review of highlights and linked updates from the ever-changing world of Infection Prevention and Control to help you stay current and informed:

http://www.ipac-canada.org/IPAC-SASKPIC/PICNSlinkletter.php

Réseau Santé en français de la Saskatchewan



HEALTH ACCOMPAGNATEUR

INTERPRETATION SERVICES IN FRENCH

As health professionals, you may come across Francophone Newcomers who are:

- Unable to navigate the Saskatchewan health system;
- Needing to consult a health professional but cannot do so because they have no or limited capacity to explain their health issues in English;
- Unable to understand your explanations in English.

You may also come across Saskatchewan Francophone Seniors and Families:

- Needing to use French in their interactions with health professionals.

This free and confidential service has been established to help you as a health professional interact more effectively with your patients.

Patients who need an interpreter are encouraged to call **1-844-437-0373.**
(Toll free)

Saskatoon Health Region

Assemblée communautaire fransaskoise

Société Santé en français

FAF

apf Association des Parents Fransaskois

University of Saskatchewan

Santé Canada Health Canada

We're Working for You

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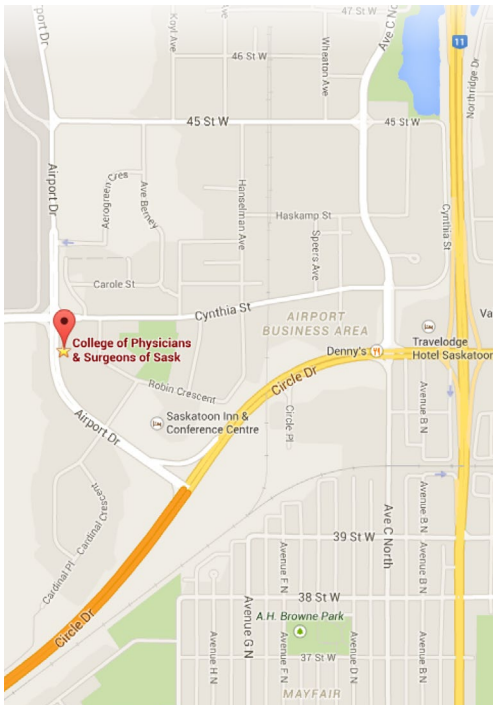

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