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Smile, You May Be On Camera!

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IMPORTANT ***PRESCRIBING METHADONE TO PALLIATIVE CARE PATIENTS***

NEW ***BYLAW CHANGES - CODE OF ETHICS, CODE OF CONDUCT & MORE***
POLICY - SEXUAL BOUNDARIES

New Drugs Added for PRP Monitoring

College of Physicians and Surgeons of Saskatchewan cps.sk.ca Volume 7 Issue 1 2020

This newsletter is automatically forwarded to every registered member* of the College of Physicians & Surgeons of Saskatchewan and made available to members and the public through its website and social media. Important decisions of the College on matters of bylaw, policy, regulation, registration and practice updates etc., are published in the newsletter. The College's expectation is that all members shall be aware of the content of each publication.

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** Registered members of the College are automatically subscribed to DocTalk as part of their duty to keep up with College updates to policies and other important information relative to practising medicine in Saskatchewan.*

DocTalk

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Do you have feedback to provide or a suggestion for an article to include in the next issue of DocTalk?

Submit your ideas & articles at any time to COMMUNICATIONS@cps.sk.ca
(Deadline for the next issue is **May 13, 2020**)

Dr. Brian Brownbridge
President, CPSS

Dr. Karen Shaw
Registrar, CEO

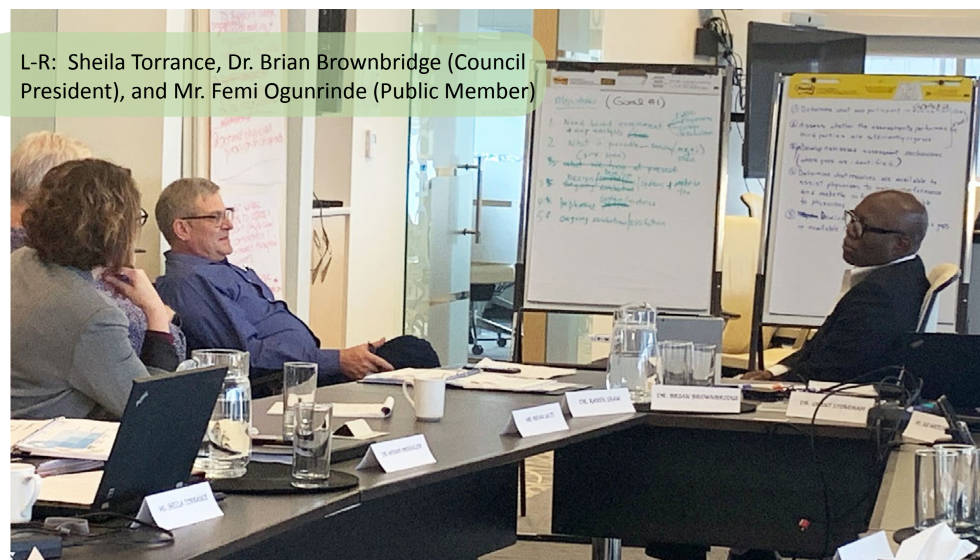
FOR ACTION: Navigating the Road Ahead

Strategic Plan Development Activities

At its November Council meeting, the College Council and staff worked with Ms. Laura Edgar, a facilitator from the Institute of Governance to develop the framework for a new strategic plan.

Council reviewed an environmental scan and considered the comments provided by the public and its members. Our current health care environment is one that exhibits constant change, which provides both opportunities and some challenges. Patient related issues identified included more focus on mental health and addiction, including the opioid crisis, a desire for better and more timely access to care, and greater integration between healthcare providers. Identified pressures on the health care system included demographic changes, the increased need for geriatric care, and the need for culturally sensitive Indigenous health care. Additional pressures noted were around the requirement for secure management and transfer of data, the need to accommodate the provision of virtual healthcare and novel technologies.

The regulation of medicine also faces some challenges, with increased expectations of the public, the desire for more transparency about its processes and an ongoing trend of an increased number of registered complaints, both standard of care issues that are reviewed through the Quality of Care process and those related to potential unprofessional conduct that are investigated through the formal discipline route. Governments are paying closer attention to how professionally-led regulatory authorities are performing across the country, and are responding to commissioned reports, such as the Cayton report that outlined incidents of failed regulation, or are instituting legislative changes to address what they perceive as regulatory shortcomings such as increasing penalties for sexual misconduct when the regulator's approach was deemed not to be appropriate. We continue to be mindful about physician burnout and the challenge to remain up to date in an environment where service needs are great. While challenges were recognized there was also acknowledgment of increased opportunities to collaborate with our partners such as our sister health professions and the Saskatchewan Health Authority, as well an opportunity to improve our communication and engage with the public, our patients and our members.



L-R: Sheila Torrance, Dr. Brian Brownbridge (Council President), and Mr. Femi Ogunrinde (Public Member)

Continued on p. 5...

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Council's brainstorming resulted in the following four goals being identified as Council priorities:

Goal #1

An integrated Information Technology and Information Management platform to effectively support College decision-making, program evaluation, and engagement with members and the public.

Having a solid and integrated information technology and information management platform is imperative in this environment where data drives performance. Such a system will support College decision-making and allow appropriate program evaluation. It will also strengthen our ability to engage and more effectively communicate with the public and our members.

Goal #2

A robust College-led process to assess and support physicians for competence and performance throughout their careers.

Council recognizes the challenge to remain up to date while meeting the heavy demands of service. It wishes to audit currently available assessment processes that support physician performance improvement and consider developing risk-based assessment mechanisms, in addition to identifying resources to support physicians in improving performance. The desired end point is a cohesive College-led process that provides assessment and support for physicians on an ongoing basis, utilizing many of the processes and tools that exist today.

Goal #3

Enhanced College supervision, assessment and support of International Medical Graduates (IMGs) moving from provisional to a regular licence.

Council wants to ensure the processes currently used to assess and supervise IMGs are enhanced in order to identify deficiencies early and provide an earlier opportunity to address them. It will consider the development of a risk assessment tool to identify where additional supports will be needed to ensure success. There is a desire to recruit and retain more supervisors and assessors and ultimately a hope that there can be adequate preparation to achieve certifying examinations rather than undergoing a summative assessment process.

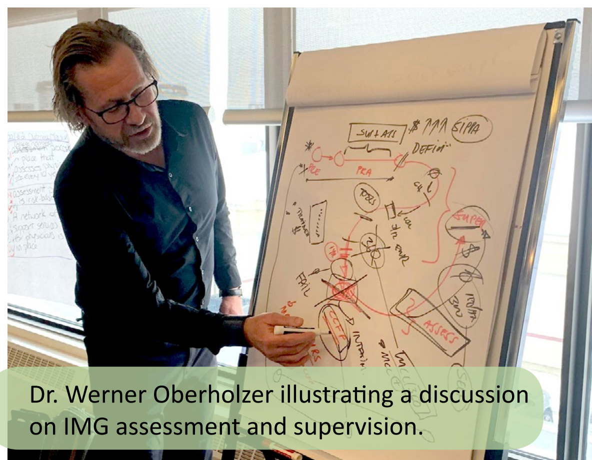
Goal #4

Optimal physician prescribing of opioids.

Council wants to continue its efforts in stemming the opioid crisis. Council seeks to engage more physicians and to assist physicians using best practices when prescribing by obtaining appropriate education and utilizing practice specific tools.

A new strategic plan is always an exciting opportunity. It will be a challenge to operationalize this new plan and we look forward to working with you on these goals that ultimately contribute to our mission to "To serve the public by regulating the practice of medicine and guiding the profession to achieve the highest standard of care."

L-R: Council Members and College Staff discussing possible initiatives during a plenary session.



Dr. Werner Oberholzer illustrating a discussion on IMG assessment and supervision.

Update on Council Activities

By Dr. Brian Brownbridge on behalf of Council

Sexual Boundaries Education Session

The Council was fortunate to have two expert speakers from the Regina Sexual Assault Center explain the common neuro-psychological responses of survivors of sexual assault. A common misconception is that assault is about the sexual activity. Most times, it is about asserting power over another individual. A real or perceived power imbalance between victim and perpetrator is a common finding and, certainly with the physician-patient relationship, is almost always present. It is estimated that one in three females and one in five males are sexually assaulted in their lifetime in Canada, with marginalized individuals at highest risk. The perpetrator is known to the victim in most cases.

One of the common findings, when physicians sexually assault a patient, is a period of denial and disbelief by the patient, where they may not be sure if it really happened. This happens in many forms of sexual assault where memories are not stored in the usual manner. It can be difficult for those investigating to get an accurate assessment of events because of this trauma phenomena, as unfortunately, the victim may not remember events in a concise manner. It is important to understand that this does not mean the event did not occur.

Council would like to thank Ms. Lisa Miller and Ms. Sarah Ridley of the Regina Sexual Assault Centre for presenting this very useful session.

Council Election Results 2019

Congratulations to the four newly elected Physician Council Members

- **Dr. Annamarie Snyman** (NorthWest Region);
- **Dr. Jurgen Maslany** (Regina Region);
- **Dr. Sarah Mueller** (Saskatoon Region); and
- **Dr. Aqeel Ghori** (SouthWest Region).

Council also welcomes a New Public Member – **Mr. Femi Ogunrinde** of Saskatoon. Public Members are selected by Order-in-Council issued by the Lieutenant-Governor.

A sincere thank you to Dr. Adegboyega Adewumi (SouthWest Region) for his contribution during his term on Council.

Executive Committee Election 2020

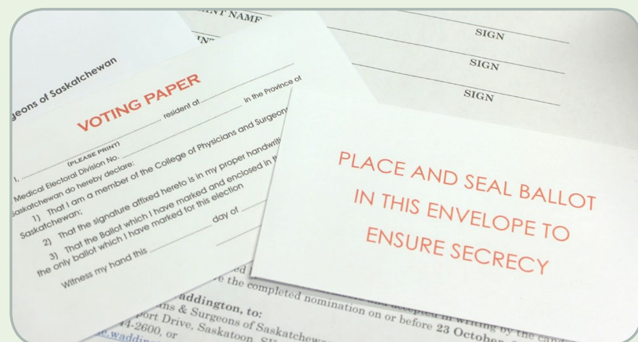
During the January 2020 Council meeting, Council elected the new Executive for 2020. Dr. Brian Brownbridge was re-elected President. Dr. Alan Beggs was elected Vice President, Dr. Mark Chapelski, Mr. Burton O'Soup and Mr. Ken Smith were elected as Members-at-Large.

Council Election Voting Statistics

Saskatchewan, By Area
(Not all areas vote each year)

2019
South West Area – 38%
Saskatoon – 23%
Regina – 26%

2018
South West Area – 30%
South East Area – 52%



Dr. Val Olsen
Senior Medical Advisor

SMILE! YOU MAY BE ON CAMERA!

How should we approach recordings by patients?

The widespread use of electronic devices in our society presents physicians with unique challenges in maintaining their privacy and that of their patients and staff. There are very few interactions remaining in our busy lives which are not documented in some manner, whether or not we are aware of it. Until recently, the patient-physician encounter was not subject to this surveillance. However, it is becoming more frequent that patients want to record discussions, and even procedures.

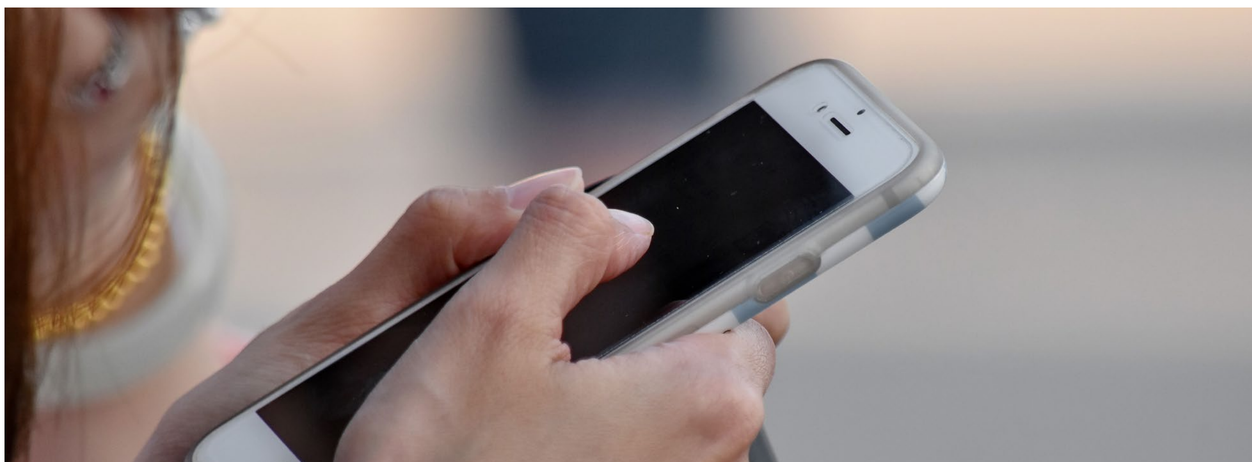
Although patients may record a discussion without the knowledge of the physician, it is preferable to have an office policy encouraging patients to discuss this first. It is also preferable to make it clear to patients that audio or video recordings in any public area, including waiting rooms or outpatient departments, have the potential to violate the privacy rights of other patients and staff members.

If a patient records identifiable information about patients or staff, it could result in an allegation of a privacy breach against a physician.

In its document Smartphone recordings by patients: Be prepared, it's happening, the CMPA notes that, while a recording can be useful to a patient in understanding and complying with their care plan, it also may lead to misunderstanding, has the potential to be shared inappropriately in social media, and can be used in legal action.

A physician can refuse a recording, and may, in some cases, decide not to proceed with the consultation if the patient does not accept this.

Finally, while there might be instances where patients and their families record your discussions without your knowledge, a physician does not have the right to record an encounter without the patient's consent.



Sheila Torrance
Legal Counsel

College seeking physician applicants for Discipline Committee

As many of you are aware, the College has experienced an increasing volume of disciplinary complaints over the past few years, and those complaints have also become more complex. As a result of this and other factors, the College anticipates a higher than usual number of contested disciplinary hearings over the next few years. In order to ensure the College is able to convene Discipline Hearing Committees in a timely manner, we are seeking applications from interested individuals to be considered for the College's Discipline Committee.

The Discipline Committee is comprised of individuals who essentially form a pool from which members are appointed for Discipline Hearing Committees, which are convened whenever there are charges of unprofessional conduct that proceed to a contested hearing. These hearings can vary in length depending on the issues and number of witnesses, but typically they are scheduled for 2-3 days.

Whenever a Discipline Hearing Committee is required, one of our office staff members, in conjunction with the Chair of the Discipline Committee, contacts physicians on the Discipline Committee to see who might be available and willing to sit. Whether or not the physician agrees will depend on 1) whether there is any conflict or concern that there may be an apprehension of bias given that physician's prior knowledge of/ relationship with the charged physician or other witnesses, and 2) the physician's availability and schedule. There is no obligation to sit on any particular panel. There are currently approximately 17 physicians named to the Discipline Committee, and each panel is typically comprised of two or more physicians and one administrative lawyer who acts as the Chair for the panel.

In terms of time commitment, there may be some infrequent training offered, which typically would not be mandatory. If you agree to be appointed to a Discipline Hearing Committee, your time commitment will potentially include some preparation time (if documents are provided in advance) and/or discussion of preliminary matters, the actual hearing days, and time spent participating in discussions with other committee members to formulate a decision. Typically, the Chair of the committee prepares a draft of the reasons for decision, and then the physician members will review/revise/further discuss the decision in order to finalize it.

All time spent by physicians on a Discipline Hearing Committee is compensated in accordance with Council Governance Policy GP-8.

Are you interested in contributing to the College's work?

Consider applying to the College's Discipline Committee.

If you are an open-minded, thoughtful, and ethical individual who might be interested in an appointment to the Discipline Committee, please submit a short letter/email expressing your interest together with your CV to OfficeOfTheRegistrar@cps.sk.ca.

Your application will be considered by the Council at its next meeting. Applicants must be physicians.

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.

There were **THREE** discipline matters completed since the last Newsletter report.

Dr. Naveen Tandon

Dr. Tandon's ability to practise medicine in Ontario was restricted following a review by the College of Physicians and Surgeons of Ontario. Pursuant to section 54.01 of *The Medical Profession Act, 1981*, the CPSS Council imposed similar restrictions on Dr. Tandon's ability to practise medicine in Saskatchewan, prohibiting him from providing primary care and from providing any insured services.

Dr. Jordan Velestuk

Dr. Velestuk admitted to unprofessional conduct in the 10 charges laid by the Council. The conduct which he admitted included billing for services not rendered, sending email messages in the names of other persons, failing to maintain appropriate medical records, providing a false urine drug sample, and prescribing drugs which he used himself. The penalty order included a reprimand, a suspension for a seven-month period which was served during the time that he was not in medical practice, a requirement to take an ethics course, a fine of $15,000, an order to pay costs, and a requirement to enter into an undertaking related to the supervision of his practice, a prohibition against prescribing Prescription Review Program medications, and continuing to receive appropriate medical treatment.

Dr. Mishack Zwane

Dr. Zwane admitted to unprofessional conduct in the 2 charges laid by the Council. The conduct which he admitted was causing or permitting excessive billing for his services, and failing to meet the standards of the profession and the requirements of the College bylaw related to prescribing marihuana. The penalty order included a reprimand, a fine of $15,000, a requirement to take courses in ethics, prescribing and medical record-keeping, and an order to pay costs.

Restoration of Licence

Dr. Amjad Ali

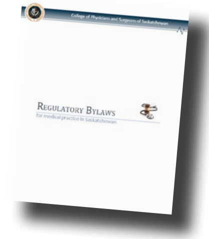
Dr. Ali applied to Council at its November 2019 meeting to restore his licence to practise medicine. The Council agreed to restore Dr. Ali's licence to practise medicine provided that he sign a detailed undertaking including requirements to continue to receive appropriate medical treatment, to continue to receive counselling, to see only adult male patients, to ensure appropriate signage in his office advising that he will only attend to adult male patients, to restrict the number of patients seen on a daily and weekly basis, to not prescribe opioid medications, and to have his practice monitored on an ongoing basis by a physician approved by the College.

Dr. Ali will not be in a position to return to practice until he has complied with the requirements of Regulatory Bylaw 4.1.

IMPORTANT - PLEASE READ

Changes to Regulatory Bylaws

By Sheila Torrance, Legal Counsel, CPSS



The College's Regulatory Bylaws establish expectations for physicians and for the College. They establish practice standards, establish a Code of Ethics, define certain forms of conduct as unprofessional and establish requirements for licensure.

There were **FOUR** changes to College Regulatory Bylaws since the last edition of the Newsletter.

Bylaw 7.1 – The Code of Ethics

Bylaw 7.1 was amended to adopt the *2018 Canadian Medical Association Code of Ethics and Professionalism* (with two minor amendments) as the *Code of Ethics* that Saskatchewan physicians are expected to uphold. This replaced the *2004 CMA Code of Ethics* that had previously been adopted and contained within bylaw 7.1.

Bylaw 8.1 – Bylaws Defining Unbecoming, Improper, Unprofessional or Discreditable Conduct: amendments relevant to sexual misconduct and failing to respect patient privacy

The bylaw was amended based upon the recommendations from the Committee established by the Council and the responses to the broad consultation with the profession and the public. The changes included a better definition of what makes an individual a "patient" for the purpose of determining whether a physician has engaged in sexual misconduct with a patient. The definition of what constitutes sexual misconduct was updated and is now consistent with legislation in other provinces.

The bylaw was also amended to define "failing to respect patient privacy" and to add it as a defined form of unprofessional conduct.

Bylaw 9.1 – Conflict of Interest

Paragraph (e)(iv) was amended to clarify that the sale or supply of a drug, medical appliance, medical product or biological preparation to a patient at a profit is a conflict of interest unless it is done in accordance with the policy *Sale of Products by Physicians*. This amendment was required to ensure consistency with the policy which was adopted by the Council in March 2019.

Bylaw 18.1 – The Prescription Review Program: amendments to the panel of monitored drugs

The list of medications that are subject to the Prescription Review Program was updated. The program now applies to:

- **Diacetylmorphine,**
- **Sufentanil,**
- **Remifentanil,**
- **Tapentadol,**
- **Diphenoxylate,**
- **Tramadol & tramadol-containing products,**
- **Pregabalin,**
- **Zopiclone,**
- **Zolpidem,**
- **Oxybutynin,**
- **Baclofen,**
- **Ketamine,** and
- **exempted Codeine products**

in addition to the medications that were listed in the bylaw before the amendment.

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 ONE new policy and amended TWO policies and TWO guidelines. Several other policies and guidelines were updated to include reference to the 2018 CMA Code of Ethics and Professionalism and the Code of Conduct.

NEW!

POLICY – Alternative Dispute Resolution

Council has approved a policy that sets out the principles to be applied by the Council and Executive Committee in exercising their discretion to consider whether alternative dispute resolution (ADR) may be appropriate in any particular disciplinary matter. The policy identifies the applicable Governance Policies, defines the relevant terms, establishes guiding principles, and provides examples of situations in which ADR may be appropriate and the types of ADR to be considered. The policy also addresses the general rules regarding publication of an alternative dispute resolution, both with respect to publication on the CPSS website and in Certificates of Professional Conduct requested by another medical regulatory authority.

Click here to view full policy

POLICY – The Practice of Telemedicine

Council approved amendments to this policy as recommended by the Council committee following stakeholder consultation. The amendments followed recommendations made by the telemedicine working group of the Federation of Medical Regulatory Authorities of Canada (FMRAC).

The amendments include an updated definition of telemedicine and provide considerably more guidance with respect to the standards of practice of telemedicine.

Click here to view full policy

POLICY – Sexual Boundaries

Council approved substantial amendments to this policy as recommended by the Council committee following broad consultation with the profession and the public. The amendments include a statement of the College's position on the fiduciary relationship between a physician and patient, and the expectation that physicians will always maintain professional boundaries with a patient. The document provides guidance to physicians on how to maintain those boundaries and provides examples of inappropriate conduct.

The amendments update the College's expectations with respect to current patients as well as former patients. With respect to former patients, the amended policy provides additional guidance on the factors that should be considered in determining whether it would be unprofessional for a physician to engage in sexual conduct with a former patient. While there are a number of factors to consider, including the fact that in some circumstances (such as a psychotherapeutic relationship) this would never be acceptable, in most cases a "reasonable period" would be a minimum of one year after the individual last received medical care from the physician.

The amended policy also addresses penalties for sexual misconduct. Given the change in societal attitudes and the increased penalties mandated in several other provinces, Council has decided that presumptive penalties for the most serious forms of sexual misconduct are appropriate. The presumptive penalty for de-

Continued on p. 12...

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fined forms of sexual misconduct (such as sexual intercourse and sexual touching) includes revocation with an inability to apply for restoration for a minimum period of three years, together with a requirement for a detailed assessment. While the Council may impose a shorter or longer period of ineligibility to apply for restoration, this presumptive penalty provides guidance to the Council and membership in considering this type of conduct.

Click here to view full policy

GUIDELINE – Confidentiality of Patient Information

This guideline underwent a sunset review, and Council has approved a number of updates. These include referencing the 2018 CMA Code of Ethics and Professionalism that is now contained within bylaw 7.1, adding reference to the Code of Conduct now contained within bylaw 7.2, and updating references to legislation and various other resources.

Click here to view full policy

GUIDELINE – Transfer of Patient Records

This guideline also underwent a sunset review and has been amended to add reference to the 2018 CMA Code of Ethics and Professionalism. As this document was developed jointly by the College and the Saskatchewan Medical Association, the amendments were approved by the SMA prior to being adopted by Council.

Click here to view full policy

REFERENCE UPDATES

Several other policies and guidelines were updated to include reference to the 2018 CMA Code of Ethics and Professionalism as now contained in bylaw 7.1, and to the Code of Conduct now contained in bylaw 7.2. Amendments also included updated links to the resources/references contained in these policies and guidelines. The additional policies and guidelines that have been updated include:

POLICIES

- Clinics that Provide Care to Patients who are not Regular Patients of the Clinic
- Complementary and Alternative Therapies
- Conscientious Objection
- Physicians at Risk to Patients
- Standards for Primary Care

GUIDELINES

- Patient-Physician Communication
- Patient-Physician Relationships
- Patients who Threaten Harm to Themselves or Others
- Providing Care to Employees or Co-workers

The full versions of all CPSS Policies, Standards and Guidelines, Regulatory Bylaws and Administrative Bylaws are available on the College Website at www.cps.sk.ca

Planning to Be a Doc in 2020?

If you are a Resident Completing Training in 2020, APPLY NOW!

Residents nearing the end of their training program (and intending to practise medicine in Saskatchewan) must apply for a licence with the College of Physicians and Surgeons of Saskatchewan.

Applicants are encouraged to apply as early as possible to avoid delays at the end of the academic year.

Qualifying for a Regular Licence in SK
(Family Medicine or Specialty Practice)

Applicants must have:

- obtained the LMCC and have official results available*;
- satisfactorily completed their postgraduate training program *and* have access to the completion certificate;
- certification with the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada *and* have results available.

**Registration Services will confirm your pass results on lists received from the CFPC and Royal College - timing of receipt of these lists may impact your practice start date.*

Qualifying for a Provisional Licence
(with restrictions)

Residents who DO NOT meet the requirements for REGULAR licensure may be eligible for a PROVISIONAL LICENCE (with restrictions). Applicants must have:

- successfully completed the MCCEE or MCCQE1;
- satisfactorily completed their postgraduate training program and have access to the completion certificate;
- continued eligibility with the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada.

On a PROVISIONAL LICENCE (with restrictions), the physician is restricted to practising under supervision**. Supervision includes:

- reviews of charts;
- mentoring and discussion following review of charts with the physician being supervised;
- reports to the CPSS at regular intervals on a form provided by the CPSS.

Obtaining some of the required documentation for licensing can be time-consuming.
Please allow ample time between the date of your program completion and your practice start date.
We cannot guarantee a start date to your licence.

A licence will not be issued until:

- all of the necessary arrangements for practice supervision are complete
 AND
- all of the required documentation has been received by the CPSS Registration staff.

Either licence will require you to:

- renew annually online on or before November 1
- be enrolled in a CME program and provide us with the cycle dates of this program

For more information, call the College's Registration Services at (306) 244-7355.

**** Physicians are responsible for the cost of the supervision and may be required to assist the College in locating a willing supervisor.**

Physicians with Regular Licences:

Consider Practice Supervision

If you are approached to support the new physicians of Saskatchewan by acting as a practice supervisor, ***please consider accepting this responsibility*** if you have been practising with a regular licence for a period of three years or more.

New graduates who have not passed all their examinations cannot practice medicine independently unless a practise supervisor is willing and able to accept this responsibility.

Practice supervision includes:

- a review of charts;
- mentoring and discussion following review of charts with the physician being supervised; and
- reports to the College at regular intervals on a form provided by the College.

Has any of your contact information changed?
Let us know!

If any of your contact information changes — office, corporation or personal — ensure that you update it with the CPSS. You can do this by email: **cpssinfo@cps.sk.ca**, by fax: 306-244-0090, or by phone: 306-244-7355.

Please notify us of changes as they occur.

IT Update

by Tim Edwards, Manager, IT and Office Administration, CPSS

We have heard our members loud and clear regarding their continued frustration stemming from issues with the website during registration.

Council and the College are committed to improving the user experience for our members and the public.

Some of the initiatives that are currently being worked on are:

- New hardware for the backend infrastructure to increase the performance of all services and limit downtime;
- Review of the online registration process to reduce load times, and errors and to implement new functionality; and
- Overall design of the website for better navigation and a modern experience.

We value the feedback from our member community to assist us in identifying areas for continuous improvement. The College recognizes that there is work to be done, but we want to assure you that we are on it!

Nicole Bootsman
Pharmacist Manager,
Prescription Review Program/
Opioid Agonist Therapy Program

Be aware of prescription abuse and forgery when prescribing codeine liquid preparations.

The Syrup That May Not Be So Sweet:

Codeine Liquid Preparation Concerns

Amidst cold and flu season, some patients are making specific and frequent requests for codeine liquid preparations like cotridin (triprolidine + pseudoephedrine + codeine).

While codeine use tends to raise fewer red-flags compared to more potent opioids appearing higher on the analgesic ladder[1], liquid preparations are causing safety concerns with non-medicinal drug use, addiction, prescription forgeries and pharmacy robberies which has prompted rescheduling and additional prescribing requirements in British Columbia[2].

Saskatchewan is no stranger to cotridin prescription forgeries as of late.

Year	Total # of Prescription Forgeries Reported (SK)	# of Cotridin Forgeries (SK)	# of Forged Cotridin Prescriptions Presented in SK with British Columbian Prescribers
2018	21	9	1
2019	29	11	5
2020 (Jan)	7	3	3
Thank you to the Saskatchewan College of Pharmacy Professionals for providing forgery data.			

Popularized by some rappers and celebrities as "purple drank", liquid preparations are being mixed with alcohol, soda and candy, and consumed in large quantities for euphoria and relaxation[3, 4]. Termed "lean" because of the physical positioning following consumption[5], recreational use, especially in combination with alcohol and other central nervous system depressants, can be fatal.

Cotridin (including CoActifed and Teva-Cotridin Expectorant) Prescriptions Filled in Saskatchewan[9]

Year	# of Prescriptions Filled	# of Patients	Total Quantity (mL)
2017	5,791	5,092	952,102
2018	5,836	5,039	918,639
2019	5,300	4,564	823,767
Thank you to the Saskatchewan Drug Plan for providing dispensing data.			

Tips for Prevention of Misuse

1. Be aware that codeine can be a gateway drug.
2. Codeine's efficacy as an antitussive agent is unclear[6]. Avoid use unless non-opioid treatments are ineffective, not tolerated or inadequate (reminder: non-opioids like dextromethorphan can also be misused)[7,8].
3. Dose as PRN, not scheduled, at the lowest effective dose for the shortest duration[7].
4. Avoid concurrent prescribing with other CNS depressants.
5. Check PIP! Some patients are "doctor shopping", visiting numerous walk-in clinics for prescriptions.
6. Fax prescriptions or prescribe through PIP.

Continued on p. 16...

FRIENDLY REMINDER

Please ensure that **only one copy** of a prescription is active (especially PRP prescriptions). Prescriptions faxed to a pharmacy and also provided as hard copies to patients may be filled by the patient at one pharmacy and filled again at a later date at the faxed pharmacy as prescriptions are valid for 1 year. If a prescription is faxed and the patient decides to obtain the medication from a different pharmacy, please cancel the original fax.

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REFERENCES

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Call for Providers

PATIENTS NEED YOUR HELP!

Learn to Prescribe

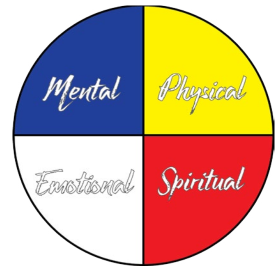
Opioid Agonist Therapy (OAT)

The top reasons for not prescribing Opioid Agonist Therapy include:

- lack of education,
- lack of multidisciplinary supports,
- lack of mentorship, and
- busy practices.

In Saskatchewan, we are facilitating education and mentorship opportunities and advocating for more multidisciplinary supports, with initiatives such as the **Opioid Agonist Therapy Conference**.

Write to **oatp@cps.sk.ca** for details on how you can help.



NEW - CPSS Website Resource on Indigenous Wellness & Care: Yes, Communication, Culture, & History DO Matter in Healthcare

By Caro Gareau, CPSS

Have you ever thought that language, culture and past experiences are social determinants that play an important role in health & wellness? We at the CPSS definitely do!

The role of quality communication and culture in Indigenous Wellness can no longer take a back seat in the delivery of quality healthcare. The CPSS has been working diligently to find new ways to help physicians fine-tune the way they deliver care to patients. And one of those ways is with a better understanding of the realities faced by Indigenous patients in particular.

In the spirit of Truth and Reconciliation, and thanks to valuable input from Ian Thomas, Consultant – First Nations & Métis Relations at the Saskatchewan Health Authority, the CPSS has gathered content for two new sections on the CPSS website aimed at improving communication and building bridges for healthier relationships between Indigenous patients and physicians. One section deals with accessing quality care from a patient/public perspective, and the other offers key information and resources for physicians. More information is also in the works!

Visit the new For the Public and the For Physicians sections of the CPSS website to view the new content and learn more about how physicians can improve their own practice, and some resources that are available for Indigenous patients!

PHYSICIANS & PATIENTS: *We are continuously looking to improve the website to better serve Indigenous patients and families. Is there something else you would like to see on our website?*

We're listening!

Patient-Physician Dialogue is Important for Quality of Care to Indigenous Patients!

We encourage First Nations Health Services, healthcare providers working with First Nations, and First Nations individuals to submit their ideas, articles, or information on services, their experience with successful programs, as well as upcoming projects that encompass Indigenous Wellness and to stimulate further inquiry about Indigenous health issues.

Write to communications@cps.sk.ca for details on how you can contribute to DocTalk or to the CPSS website.

FREE WORKSHOPS FOR HEALTHCARE PROVIDERS

Cultural Conversations

Saskatoon & WebEx

Creating Ethical Space- Responding to the TRC
Presenter: Andre Letendre, Cultural Systems Advisor
March 18, 2020 Time 1:00—3:00
St. Paul's Hospital Auditorium & WebEx

Health Equity & Cultural Safety
Presenter: Erin Beckwell, Knowledge Translation Specialist
Date April 01, 2020 Time 9:30—11:00
St. Paul's Hospital Auditorium & WebEx

LGBTQ & Two Spirit—Out Saskatoon
Presenters: Amanda Guthrie & Jack Saddleback
April 16, 2020 Time 9:00—12:00
Westwinds Theatre—3311Fairlight Dr. & WebEx

Trauma Informed Care
Presenter: Erin Beckwell, Knowledge Translation Specialist
WebEx only: May 12, 1—2:30
In person only: May 21, 2020 Time 1:00—4:00
Location St. Paul's Hospital Auditorium

Cancer Care & FNM
Presenters: Phoebe Fosseneuve, Consultant FNMR & SCA
June 10, 2020 Time 1:00—3:00
Saskatoon City Hospital, Asher Auditorium & WebEx

IN PERSON: please register with Julie.Haubrich@saskhealthauthority.ca
First Nation & Métis Health or 306-655-2600

WEBEX OPTION: contact wendy.rosebluff@saskhealthauthority.ca
First Nations & Métis Relations, 306-766-6995

Saskatchewan Health Authority

saskhealthauthority.ca

Unvaccinated Children: Physician Obligations?

By Dr. Werner Oberholzer, Deputy Registrar, CPSS

A few physicians have contacted the College of Physicians and Surgeons of Saskatchewan (CPSS) regarding a physician's ethical and legal obligations related to care of children who are unvaccinated due to parental or caregiver concerns.

While the CPSS does not have any specific policies or guidelines related to this, it does have a Code of Ethics which would serve as the standard to which physicians are held accountable.

This Code has been prepared by the Canadian Medical Association as an ethical guide for Canadian physicians, including residents and medical students. Its focus is the core activities of medicine – such as health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education and research. It is based on the fundamental principles and values of medical ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability. The Code, together with CMA policies on specific topics, constitutes a compilation of guidelines that can provide a common ethical framework for Canadian physicians.

The first fundamental responsibility listed in the Code of Ethics is to consider the well-being of the patient, and by continuing to care for the child and the family, the physician can continue promoting immunization and will continue providing other recommended health and safety guidance and relevant interventions.

The Canadian Paediatric Society Guideline forms the basis of our guidance to physicians: https://www.cps.ca/en/documents/position/working-with-vaccine-hesitant-parents

What should you do if an unvaccinated child presents to you at your clinic?

The following excerpt is from the Guideline:

Checklist: Physician approaches to vaccine hesitancy

- Never dismiss a child from practice: Every office encounter is an opportunity to revisit and discuss vaccines
- Set aside extra time to counsel vaccine-hesitant parents
- Identify specific parent concerns and make a list
- Be non-judgemental and non-confrontational
- Start with assuming that a child will be vaccinated as needed (i.e., be presumptive)
- Be ready to discuss both the benefits of vaccines and the risks of vaccine-preventable diseases and vaccines
- Validate parental concerns and correct misconceptions, fairly and accurately
- Be careful to frame data clearly and positively. For example, it is better to say "99% safe" rather than "1% risk" of side effects
- Keep the book *Your Childs Best Shot: A parent's guide to vaccination* on hand to help answer questions

When discussing the risks of vaccine-preventable diseases:

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- Tell compelling stories. Use Immunize Canada as a resource.
- Ask parents who have been spared from serious childhood diseases, such as polio, because of vaccines whether they want the same protection for their child?
- Remind parents that some complications from disease are serious and untreatable, even today.

Address pain management for vaccines based on guidance found here: (www.cmaj.ca/content/early/2015/08/24/cmaj.150391) or on the CPS Caring for Kids website.

When addressing community protection:

- Explain that current levels of vaccine uptake are not high enough to prevent all vaccine-preventable disease outbreaks.
- Point out that waiting for an outbreak before vaccinating a child is often too late to ensure protection.
- Stress personal responsibility: that choosing not to vaccinate puts vulnerable people at risk. Refer to the CPS Caring for Kids information for how best to do this.

Key points:

- "Clinicians who dismiss vaccine-refusing families seem to focus excessively on the interests of their own practice at the expense of their responsibilities to contribute to collective public health efforts."
- Never dismiss a child from practice: Every office encounter is an opportunity to revisit and discuss vaccines
- Patients or legal guardians have the right to accept or refuse the vaccine. Be patient and empathetic to their needs and beliefs on vaccines and keep lines of communication open
- Doctors could focus on measures to keep sick kids separate, or out of the waiting room until a doctor is available. And if your concern is that these infected kids are going to go out and infect other kids — if you fire them from your practice, there would be more unimmunized kids in the world.

Literature that would be of further benefit to review:

1. CMPA: How to address vaccine hesitancy and refusal by patients or their legal guardians
2. When is it permissible to dismiss a family who refuses vaccines? Legal, ethical and public health perspectives: NCBI article 2007: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2532570/pdf/pch12843.pdf
3. Should We Reject Unvaccinated Patients?: AAFP article 2016: https://www.aafp.org/news/blogs/freshperspectives/entry/should_we_reject_unvaccinated_patients.html
4. Canadian Paediatric Society: Working with vaccine-hesitant parents: An update, 2018: https://www.cps.ca/en/documents/position/working-with-vaccine-hesitant-parents
5. AAP policy on patient dismissal for vaccine refusal: https://www.infectiousdiseaseadvisor.com/home/topics/prevention/new-aap-policy-on-patient-dismissal-for-vaccine-refusal-may-erode-solidarity-among-pediatricians/
6. Responding to Parental Refusals of Immunization of Children: https://pediatrics.aappublications.org/content/115/5/1428.full
7. Characteristics of Physicians Who Dismiss Families for Refusing Vaccines: https://pediatrics.aappublications.org/content/pediatrics/136/6/1103.full.pdf
8. Refusal to vaccinate: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunizations/Pages/refusal-to-vaccinate.aspx
9. Should Pediatric Practices Have Policies to Not Care for Children With Vaccine-Hesitant Parents? https://pediatrics.aappublications.org/content/pediatrics/138/4/e20161597.full.pdf
10. How to limit your risk of legal liability: https://www.contemporarypediatrics.com/pediatric-practice-improvement/how-limit-your-risk-legal-liability

Methadone Prescriptions for the Management of Pain in Palliative Care Patients

By Dr. Werner Oberholzer, Deputy Registrar, CPSS

It has come to the attention of the College of Physician and Surgeons of Saskatchewan that physicians (mostly family physicians) are sometimes reluctant to continue prescriptions for methadone in the management of pain for palliative patients, once instituted by the Palliative Care Teams and Palliative Care Physicians.

We wish to remind physicians that **prescribing methadone for pain does NOT require CPSS approval**.

The CPSS bylaw 19.1, "Standards for prescribing of methadone or buprenorphine for addiction" states as follows:

> *(e) A physician is not required to obtain approval from the Registrar to prescribe buprenorphine in its transdermal form, nor is a physician required to obtain approval from the Registrar to prescribe methadone or buprenorphine solely for the purpose of pain control.*

We are asking that physicians consider continuing the prescriptions issued by Palliative Care Teams, as these teams simply do not have the capacity to follow up on each patient for prescription renewals. The patients will present to their Family Physicians with detailed instructions about dose and frequency of methadone, and it is in the best interest of the patient to have care provided by their own provider, including palliative pain management.

CPSS APPROVAL for prescribing methadone is NOT REQUIRED for managing pain in palliative care patients.

Due to the complexity of methadone prescribing, we can understand that physicians may feel that they do not have the knowledge or experience to manage the methadone prescriptions, but the situation is different from initiating methadone for pain – these patients require maintenance and continuity of care, and as physicians it would be our ethical obligation to do our best to facilitate the care they deserve.

The College can offer assistance via its Prescription Review Program – PRP staff can be contacted by telephone: 306-244-7355, Email: prp@cps.sk.ca (Pharmacist Manager: Nicole Bootsman).

Should physicians require more resources, **Methadone4Pain.ca** is a series of three education modules for physicians, nurses and pharmacists seeking to improve their knowledge in prescribing and managing patients prescribed methadone for pain in palliative care.

Articles include:

Practical Guide for Using Methadone in Pain and Palliative Care Practice

Methadone for Pain in Palliative Care

Stress is inevitable. Struggling is optional.

If you are a physician struggling with mental health concerns, please know there is a safe, confidential place for you to contact.

Call Brenda Senger, Director,
Physician Health Program at 306-657-4553
Saskatchewan Medical Association

The BIG 3 in Chest Pains

Recognizing acute coronary syndrome: Challenges faced when a patient presents with chest pain

By Jacobus Stefanus de Villiers MB ChB FRCPC FACC
Assistant Professor, University of Saskatchewan, Royal University Hospital, Saskatoon, SK

The CMPA published a recent article (December 2019) outlining the diagnostic challenges faced when a patient presents with chest pain. This article lists 197 legal actions between 2014 and 2018, highlighting how common this problem is. Of these, the vast majority of cases involved diagnostic errors (missed, delayed or inaccurate diagnosis). The article described two main themes relating to deficient assessment:

1. lack of consideration of patient risk factors, and
2. inadequate diagnostic testing decisions.

In Africa, we often refer to the "Big 5" as the lion, leopard, rhino, elephant and cape buffalo. Similarly, in medical practice, I refer to the "Big 3" chest pain syndromes that kills: Pulmonary Embolus, AO dissection and Myocardial infarction. All of these clinical entities should be kept in mind when seeing any patient with chest pain, and when doing so, consider the company that it keeps:

1. **Pulmonary embolus:** recent travel, previous DVT, or history of hypercoagulable state, etc;
2. **AO dissection:** history of hypertension, the patient with any previous AO surgery and the patient with history of a Bicuspid AO valve;
3. **Myocardial infarction:** patient with cardiac risk factors for premature coronary artery disease, and those with history of previous MI.

Of the "Big 3", my focus in this piece is on myocardial infarction. As medical students we are taught to be systematic: first take a good history, then do a detailed, focused examination, followed by review special tests. Only then should one generate a differential diagnosis applicable to the presenting complaint. I have found that adhering to these fundamental principles helps in even the most challenging diagnostic cases.

> Tips for recognizing acute coronary syndrome for safer patient care and reduced medico-legal risk.
>
> Can you recognize the "Big 3"?

When evaluating someone for chest pain, the cardiac risk factors that can lead to premature coronary disease should be considered as part of the history. These factors include a history of smoking, hypertension, dyslipidemia, diabetes, chronic kidney disease and a family history of premature coronary artery disease (CAD). A premature history of coronary artery disease is considered present, if established CAD is present in first-degree relatives age < 55 (men) or < 65 (women).

The criteria for cardiac chest pain (angina) include:

1. retrosternal heaviness,
2. worse with activity/emotional stress and relieved by rest or nitroglycerine, and
3. the pain might radiate to the left arm, jaw or neck.

Classic angina is present when the chest pain meets 3/3 criteria. Atypical symptoms are often self labelled by the patient as indigestion. Diabetic patients may have no pain at all, and female patients often do not describe classic angina despite having ischemic chest pain. When a patient describes associated diaphoresis and or nausea, the level of concern should be elevated.

A focused cardiac examination has low sensitivity for detecting an acute coronary syndrome, but

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once completed, the next most critical step to consider is appropriate risk stratification. Risk stratification will be based on the pre-test probability of ischemic pain. Patients with 2-3/3 chest pain criteria should have the highest priority for ruling out acute ischemia or cardiac injury and a 12-lead ECG and laboratory testing are needed.

Three points are important with respect to the 12-lead ECG:

1. the initial ECG may be normal, and that does not rule out cardiac ischemia;
2. serial ECGs are critical, especially when the first ECG appears normal in the setting of classic angina, as the ECG changes could evolve over time; and
3. most importantly, the ECG must be reviewed by a physician with ECG interpretation expertise, in a timely fashion.

The urgency of 12-lead ECG review is dependent on patient's presentation and is a critical first piece of the puzzle that must take priority in the assessment of acute chest pain. Further risk stratification may require referring the patient to the nearest emergency room where serial ECGs and appropriate bloodwork can be done. The minimum bloodwork required includes but is not limited to: CBC, electrolytes, urea, creatine and troponin. Depending on the specific troponin assay, a minimum of two troponin may be needed, taken a minimum of 2-4 hours apart. It is important to understand the specific troponin assay used in your own facility and the time frame needed for a repeat test to rule out disease.

The Bottom Line

Recognizing acute coronary syndrome remains a common and challenging task.

Remember the "Big 3" chest pain scenarios that could result in serious mortality. Follow the steps of taking a good history, including cardiac risk factors, perform a focused examination and ensure that a 12-lead ECG is done and interpreted by a physician with expertise in ECG interpretation in a timely fashion. Those patients with classic angina (2-3/3) chest pain criteria warrant your closest attention. Choosing clinical risk stratification and serial testing in the emergency department will result in safer patient care and reduced medical-legal risk.

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.

Dr. BRUCE CLOAD presented with the Dr. Dennis A. Kendel Distinguished Service Award for 2019

During a special awards banquet on November 29th, 2019, the Council of the College of Physicians and Surgeons of Saskatchewan presented Dr. Bruce Cload, an Emergency Department physician leader in the three hospitals of Saskatoon, with the prestigious *Dr. Dennis A. Kendel Distinguished Service Award* for outstanding contributions to physician leadership and to physician engagement in quality improvements in health care in Saskatchewan.

According to Dr. Brian Brownbridge, President of the College Council, "Dr. Cload has demonstrated outstanding physician leadership through the development of medical protocols, emergency department flow initiatives, physician and human resources development, and exemplary hard work. Congratulations on receiving this well-deserved award."

For more details and to read Dr. Cload's biography, see: *https://bit.ly/2T1QZZ0*

Photo, L-R: Dr. Karen Shaw, CPSS Registrar,
Dr. Bruce Cload, 2019 Kendel Award recipient,
Dr. Brian Brownbridge, CPSS President.

Nominate a colleague you admire for the 2020 Kendel Award!

The Dr. Dennis A. Kendel Distinguished Service Award is a prestigious award presented to an individual (or group of individuals) who has made outstanding contributions in Saskatchewan to physician leadership and/or to physician engagement in quality improvements in healthcare.

The award is presented during a special annual banquet organized by the Council of the College of Physicians and Surgeons of Saskatchewan.

KENDEL AWARD Nominations are open until September 30th of each year

Nomination packages for 2020

are available in the *For Physicians -> Awards and Recognition* section of the College website at

www.cps.sk.ca

or by writing to

OfficeOfTheRegistrar@cps.sk.ca

Have you been licensed on a form of postgraduate licensure in Saskatchewan for 40 years or more?

You may be eligible for

SENIOR LIFE DESIGNATION

If you have been licensed on a form of postgraduate licensure in Saskatchewan for 40 consecutive years or more, or if the only interruptions in your practice were for service in the armed forces or to take postgraduate training, and you have not yet received your Senior Life Designation, please let us know!

Physicians eligible to receive this designation are presented with an award at an official Council Banquet in November of each year.

CONTACT

OfficeOfTheRegistrar@cps.sk.ca
or at **306-244-7355**

2019 Recipients

In recognition of 40 years of fully licensed practice of medicine in the Province of Saskatchewan, 17 recipients were presented with Senior Life Designation in 2019.

Recipients who were able to attend the 2019 Evening Gala Reception (see photos to the right in alphabetical order) were:

Dr. Isaac Caburao
Dr. Intravadan Dattani
Dr. Carol Geddes
Dr. Berwyn Larson
Dr. Arun Nayar
Dr. Donald Stefiuk
Dr. Esther Stenberg
Dr. Shashi Suri

Additional Recipients for 2019:

Dr. John Alport
Dr. Wallace Clarke
Dr. Zarin Kalepesi
Dr. Sara Mahood
Dr. Joseph Michel
Dr. George Miller
Dr. Robert Murray
Dr. Chiranjib Talukdar (2017)
Dr. Jack Urton

*Service with the Canadian and/or Allied forces and postgraduate training after registration are included.

To read the recipients' biographies in the Senior Life Designation evening program, see the CPSS news release at https://bit.ly/2T1QZZ0

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:

https://saskpic.ipac-canada.org/picns-link-letter.php

A core service of the Réseau Santé en français de la Saskatchewan (Saskatchewan Francophone Health Network)

HEALTH ACCOMPAGNATEUR INTERPRETATION SERVICES IN FRENCH

French-speaking newcomers | Seniors | Families

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.

A Health Accompagnateur may be present at your patient's point-of-care and will act as an interpreter between you and your patient.

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

This is not an emergency service

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.

We're Working for You

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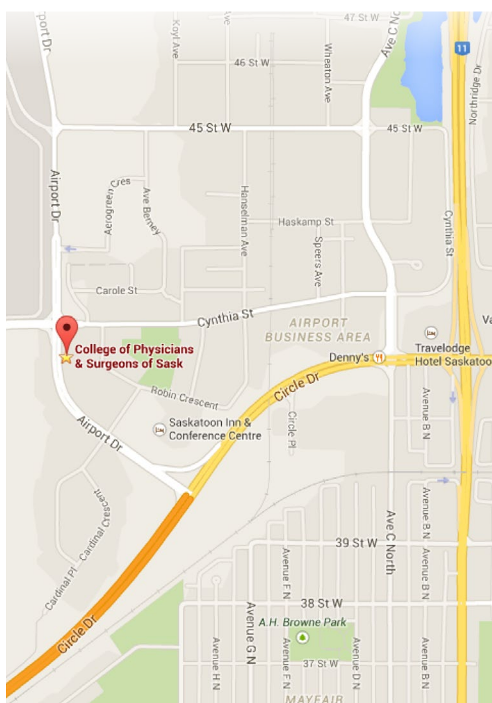

Senior Staff

Dr. Karen Shaw	Registrar
Dr. Werner Oberholzer	Deputy Registrar
Mr. Bryan Salte	Associate Registrar/Legal Counsel
Vacant	Director, Registration Services

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Media Inquiries	communications@cps.sk.ca

Quality of Care (Complaints)

Saskatoon & area calls	1 (306) 244-7355
Toll Free	1 (800) 667-1668
Inquiries	complaints@cps.sk.ca

Diagnostic Imaging & Lab Quality Assurance (Regina)

Office Address	5 Research Drive, Regina, SK S4S 0A4
Telephone	1 (306) 787-8239
E-mail	cpssinfo@cps.sk.ca

Prescription Review Program (PRP) & Opioid Agonist Therapy Program (OATP)

Telephone	1 (306) 244-7355
Anonymous Tip Line	1 (800) 667-1668
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	oatp@cps.sk.ca

Registration Services

Telephone	1 (306) 244-7355
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