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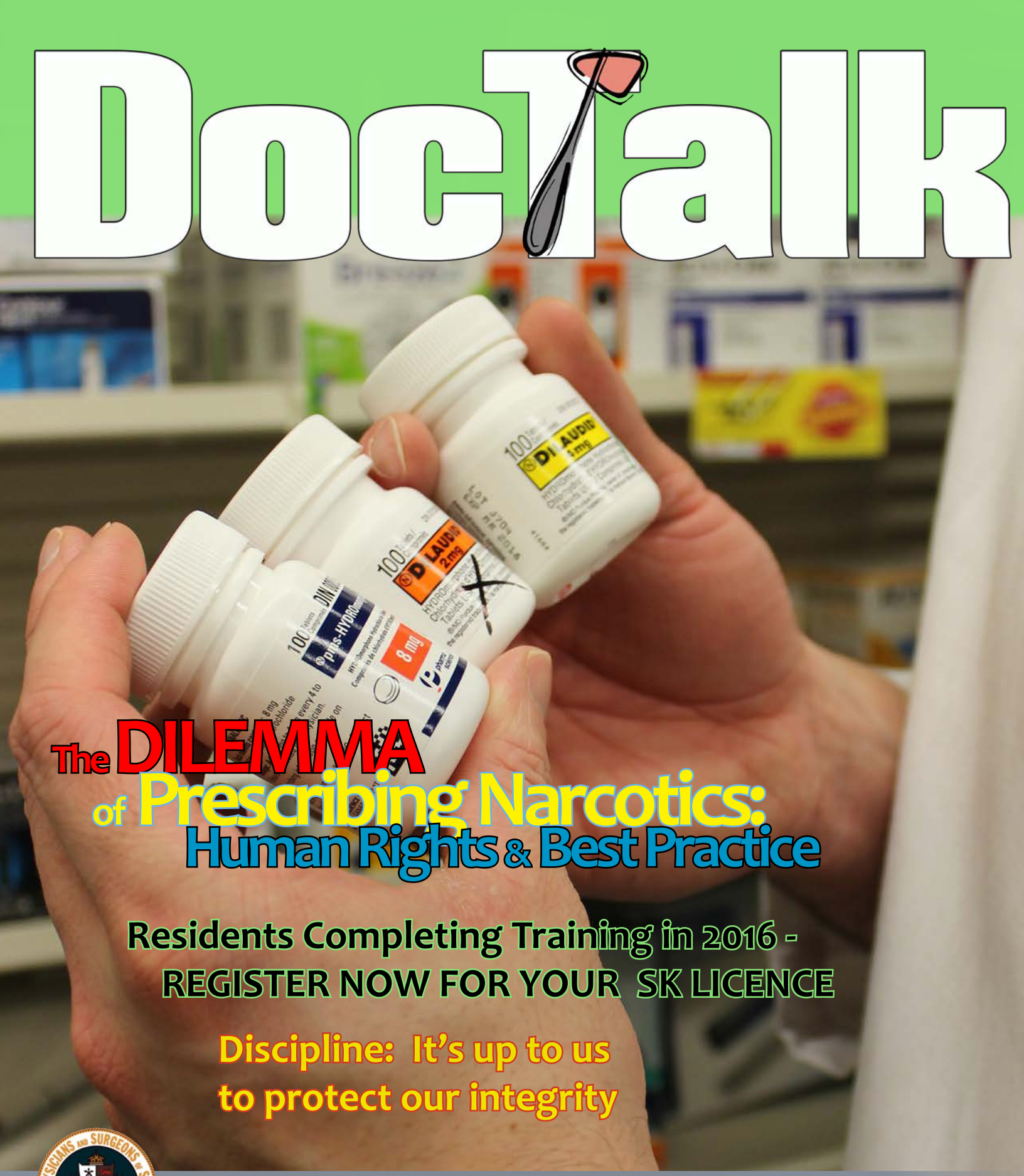

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FROM THE PRESIDENT

The Discipline Process: It's up to us to protect our integrity

As we enter 2016, the work of the Council continues. This promises to be an interesting and challenging year in many respects. Council continues to work diligently on policy review and development. Major issues such as physician-assisted dying take a prominent place on the national stage and we continue to work with stakeholders to develop policy and bylaws that protect the rights of both patients and physicians. While these discussions consume a lot of valuable time and effort, the other essential roles of the College continue. With so many demands on the resources of the College, we strive to engage all physicians to help with our efforts and to play an active role in the College activities.

As members of a self-regulating profession we are guided by national and provincial legislation in addition to our own bylaws. This framework allows the College to continue in its primary mission of protecting the public. As with all regulatory bodies, one of the unfortunate mandates that we face is that of professional discipline. A rigorous process exists to provide a complaints process aimed at identifying areas where patients have been exposed to potential or actual harm due to unprofessional conduct on the part of a physician in whom they have placed their trust.

Many of the complaints received by the College are effectively resolved through the hard work of the Quality of Care department (QoCD). Under the direction of Deputy Registrar Dr. Micheal Howard-Tripp, the QoCD works tirelessly with the guidance of the Quality of Care Advisory Committee (QoCAC) and the Office of the Registrar. For complaints that are not resolvable by this process, matters are brought before the Council.

It is absolutely imperative that complaints of professional misconduct are investigated thoroughly and that the matter proceed in a timely fashion in order to ensure fairness to both complainants and those physicians involved.

As you can imagine, matters before the College mandate a level of medical expertise in the investigation process. Despite a number of truly exceptional investigators providing services to the College in these matters, there remains a critical shortage of physicians who are willing to aid their own profession in the investigative process. In general, willing physicians can participate in this process in a couple of ways.

Following initial investigation by College staff, claims of professional misconduct may be presented to Council. In many such cases, further investigation is required, and Council directs the appointment of a **Preliminary Inquiry Committee** to investigate the veracity and details of the claims in addition to evidence presented in defense of the physician. These committees require physician input and therefore we rely on an overtaxed list of physicians who are willing to commit the time and effort required to either advance the claim of the patient or exonerate the physician.

Further, for those cases that are investigated and result in Council charges, physicians are afforded the right to deny the charges and to defend themselves vigorously. The bylaws of your College will then provide the physician the opportunity of defence before a tribunal of peers at a formal discipline hearing. Once again, this is an essential function of the College, which relies heavily on the willing participation of physician members.

The College remains indebted to those physicians who serve as members of Preliminary Inquiry Committees or Discipline boards. Our work continues, but it is becoming challenging for the College to process complaints in a timely fashion due to a relative scarcity of new physician members to these investigative and discipline roles. As with similar matters managed in a court of law, there is a mandate to provide timely investigations and hearings, so as to be fair to all parties concerned.

"Help ensure the good standing of the profession by volunteering in the discipline processes of the College."

The Council of the College would like to implore our colleagues to consider seriously, their responsibility to the maintenance of high quality delivery of care in the Province of Saskatchewan. We each endeavor to treat our patients based on current evidence and best practice guidelines. Many of us actively engage in quality assurance initiatives or research. We all recognize that **only through giving of our time to such initiatives can we move forward as a profession**. I would argue that it is equally essential that we dedicate a proportion of our time toward ensuring the good standing of the profession by volunteering in the discipline processes of the College.

The College Council has directed the Registrar and the Senior Staff to distribute information to all physicians in the province detailing the processes in which they may consider participating. Please take a few moments to read the documentation, or attend one of the planned information sessions. If you feel that you wish to contribute your time to helping your College meet its obligations to the public, please contact the College office, or your local member of Council to advance your name to the Registrar's office.

Thank you for your support in this area of need.

Dr. Alan Beggs
President, CPSS

FROM THE REGISTRAR

Physician Practice Improvement

How can the public be assured that the physician they are seeing is "up to date" and practises in a professional manner?

The public trusts the medical profession to ensure that this is the case, however we know by scanning regulatory websites or media articles this is not always the case. The question many medical regulators around the world are grappling with is how we can establish a process to assure the public on an ongoing basis that their practitioner is "up to date".

Levels of assurance

We know that in order to practice medicine there are certain requirements that offer public assurance of competence. The first level of that assurance for Canadian graduates is **successful graduation from medical school**. In addition to successful completion of the undergraduate medical school program, medical students must also successfully complete the requirements of the Licentiate of Canada – MCCQE1 and MCCQE2. Part I is taken at the end of clerkship prior to starting residency and Part II is taken in the latter part of the physician's first residency year or during the second year of residency.

Post graduate or residency training programs vary in length depending on the specialty and may require additional training of up to two to five years.

The next level of assurance that trainees have reached a level of competency is at the **post residency certification** process, with either the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada.

The granting of licensure requires the physician to meet certain criteria. International medical graduates from medical programs outside Canada can access licensure in Canadian jurisdictions including Saskatchewan but they must meet certain **pre licensure criteria** and may have to meet certain additional requirements over time before they achieve regular licensure.

Over the past number of years, medical regulatory authorities including ours, have also required licensed physicians to "revalidate" by joining one of the specialty medical education programs and being compliant with the certifying body's requirements for **continuous professional learning**. Both Mainpro (CFPC) and Maintenance of Certification (RCPSC) require documented evidence of ongoing learning.

In a rapidly changing environment, in order to practice effectively physicians must continuously refresh their knowledge abd update their skills. This can be accomplished through continuous reading of scientific papers and journals and attending conferences, however, we know it isn't enough to just "report" hours. Although requiring continuous learning is a step in the right direction, many regulators in the world have been working on models/strategies to ensure physicians remain practising at a high level of competency throughout their entire careers.

Over the past few years we have also seen Regional Health Authorities adopt more rigorous processes that require physicians to demonstrate and document continuous learning and participation in quality assurance programs. They have developed a variety of **quality improvement processes** including Lean initiatives.

Physician Practice Improvement – the future

The Federation of Medical Regulatory Authorities of Canada (FMRAC) (national association of the Colleges) has developed a framework for physician practice improvement to replace what was originally referred to as revalidation. Canada is not unique in adapting a new approach to ensuring professional competence. The Medical Regulators in the United Kingdom, New Zealand, Australia, the United States and Canada are all at various stages in working on redesigning their respective "revalidation" programs.

The Canadian approach to refreshing "revalidation" and ensuring competence throughout the physicians' career is the introduction of the **Physician Practice Improvement (PPI) Framework**.

...continued on p. 6.

FMRAC's Physician Practice Improvement's vision is:

"Canadians assured of the competence of physicians and physicians supported in their continuous commitment to improve".

The framework lays out a plan for a new approach to assess and enhance competence. The framework is underpinned by *seven principles of physician practice improvement*.

1. **Transparent.** Standards and processes for physician practice improvements are clear and understandable to all stakeholders and the public.
2. **Relevant.** Physician practice improvement applies to physician's competence within the scope of his or her practice, using fair and consistent tools and processes.
3. **Inclusive.** Physician practice improvement applies to all licensed physicians. Participation is mandatory.
4. **Transferrable.** Participation in physician practice improvement will be mutually recognised by all medical regulatory authorities in Canada and will not inhibit mobility within Canada.
5. **Informative.** Physician practice improvement is meant to be constructive and educational.
6. **Efficient.** A physician practice improvement considers cost and the administrated burden to the physician, and minimizes redundancy amongst stakeholder organisations.
7. **Integrated.** Physician practice improvement relies in collaboration by and among the stakeholders.

The framework starts with the understanding that each physician has unique learning needs which are largely determined by the nature of his or her individual practice. It recognises that up to now there has been no requirement to ensure that the CME physicians undertake is based on the needs that have been identified that are required for the physician's specific practice and patient population/community.

Under the new physician practice improvement framework individual physicians will use the principles of continuous quality improvement to assess their own practice. The following five steps will be undertaken in a cyclical pattern:

1. **Understand your practice.**
2. **Assess your practice.**
3. **Create your learning plan.**
4. **Implement your learning plan.**
5. **Evaluate the outcomes.**

The physician practice improvement framework is designed to cover all aspects of the physician's practice including clinical practice, administrative duties and educational or research oriented duties.

Physician practices and performance requires assessment for a variety of reasons. These include ensuring good care and patient safety and promoting best practices in response to changes in scientific knowledge and approach to treatment. The shift to physician practice improvement will require the Federation of Medical Regulatory Authorities of Canada to work closely with a wide range of stakeholders to develop a pan-Canadian strategy that will assist medical regulatory authorities, physicians and stakeholder groups to implement the PPI system. In addition to the Federation of Medical Regulatory Authorities of Canada and the individual medical regulatory authorities the following associations have been assisting with the work:

The Association of Faculties of Medicine of Canada

The Canadian Medical Association

The Canadian Medical Protective Association

The College of Family Physicians of Canada

HealthCareCan (which is a merger of the former Association of Canadian Academic Healthcare Organisations and the Canadian Healthcare Association)

The Medical Council of Canada

The Royal College of Physicians and Surgeons of Canada

We expect that all participants involved in the practice improvement will assume specific responsibilities. It will also be important to hear from those who will be affected by practice improvement.

In summary, although there are many options for physicians looking for ongoing professional learning, what is currently lacking in our system today is a comprehensive requirement to ensure the knowledge, skills, competency and attitudes acquired through professional development contribute to continuous practice improvement. The intention of the PPI system is that physicians who have followed the practice improvement model will be able to demonstrate that their professional development activities have indeed improved their practice.

Over the next number of years physicians will be asked to provide input to the development of this system. We hope as those opportunities unfold that you will be a willing participant.

Included in future issues of DocTalk will be more detailed descriptions of the 5 steps of the process that are anticipated.

Dr. Karen Shaw
Registrar, CEO

Physician-Assisted Dying

Bryan Salte
Associate Registrar and Legal Counsel

This is an update on the current status of Physician-Assisted Dying in Canada. The term "physician-assisted dying" is used in this article. The Parliamentary Committee which provided its recommendations to Parliament (referenced below) suggested that the term "medical aid in dying" is more appropriate.

Background – the Supreme Court of Canada's decision in Carter v. Canada

In February 2015, the Supreme Court of Canada declared that the laws which prohibit physicians from assisting patients to die are unconstitutional, provided the patient meets certain requirements:

1. The patient must have a grievous and irremediable medical condition;

2. The medical condition must not be treatable using treatments the patient is willing to accept;

3. The patient's suffering must be intolerable to the patient;

4. The patient must clearly consent to their death.

The court initially suspended the declaration of invalidity for a period of one year, to February 2016, to allow governments time to pass laws to regulate physician-assisted dying that are consistent with the Supreme Court's decision.

The court subsequently gave an extension of that period to June 2016. The current laws in the Criminal Code which prevent a physician from assisting a patient to die will be invalid in June 2016. We expect that the Government of Canada will likely pass a new law or laws to regulate physician-assisted dying prior to that time. However, if the Government of Canada does not do so, the only guidance in Saskatchewan will be the policy adopted by the Council at its November 2015 meeting, which is available on the College's website.

When the court granted the extension to June 2016, it did so on the basis that individuals who sought physician-assisted dying can apply to the Superior Court in their province for a constitutional exemption to allow the individual to receive the assistance of a physician to die. Such orders have been granted in Alberta, Manitoba and Ontario. Quebec's law permitting physician-assisted dying has been in effect since December 2015 and a number of Quebec patients have received physician assistance in dying.

The College of Physicians and Surgeons suggests that a Saskatchewan physician who receives a request from a patient to assist that patient to apply to the court for a court order to allow physician-assisted dying, or a Saskatchewan physician who is asked to assist a patient to die based upon a court order, would be wise to seek assistance from the Canadian Medical Protective Association during this period of uncertainty.

The Special Joint Committee on Physician-Assisted Dying has released its report to Parliament. The report is available at **http://www.parl.gc.ca/content/hoc/Committee/421/PDAM/Reports/RP8120006/pdamrp01/pdamrp01-e.pdf**

Some of the notable recommendations in that report include:

1. Patients should not be excluded from physician-assisted dying based on the fact that they have a psychiatric condition.

2. The capacity of a person requesting physician-assisted dying to provide informed consent should be assessed using existing medical practices, emphasizing the need to pay particular attention to vulnerabilities in end of life circumstances. There should not be a prior review and approval process.

3. Physician-assisted dying should be made available to mature minors within three years. There should be a study period to evaluate what criteria should be used to determine whether a person under the age of 18 should be able to access physician-assisted dying.

4. In certain circumstances an advance directive should provide the necessary informed consent for a patient to access physician-assisted dying. The directive must have been signed after a patient has been diagnosed with a condition that is reasonably likely to cause loss of competence or after a diagnosis of a grievous or irremediable condition.

5. There should be a consultation process to reconcile physicians' freedom of conscience and the needs of patients who

seek physician-assisted dying. At a minimum, the objecting practitioner must provide an effective referral for the patient.

6. The Government of Canada should work with the provinces and territories to ensure that all publicly funded health care institutions provide physician-assisted dying.

7. Physician-assisted dying can only be provided after two physicians who are independent of one another have determined that the person meets the eligibility criteria for physician-assisted dying.

The legislation which will be introduced may, or may not, be consistent with the report's recommendations.

The College will carefully review the legislation that is introduced into Parliament to assess the implications for Saskatchewan physicians. We will provide additional information when that becomes available.

Policy, Standard and Guideline Updates

The Policies, Standards and Guidelines adopted by the Council are reviewed regularly and are updated as required. They are available on the College's website. Physicians should review the list of policies which may apply to them to ensure that they are aware of the College's expectations. At the March Council meeting, the Council updated two policies:

Physician Obligations Regarding Medical Certification of Death

One of the challenges for the College and for many physicians is determining when a physician should complete a Medical Certification of Death. In some circumstances a physician is required to report a death to a coroner before a death certificate can be completed. In other circumstances a physician may be unsure whether the physician has sufficient information to state a cause of death. There can't be a funeral until a death certificate has been completed, which can cause significant distress to grieving family members.

Those are among the issues which are addressed in this updated policy.

The policy states that it is both a legal requirement and an ethical expectation that physicians will complete a Medical Certification of Death unless:

a. The death arose in circumstances which has resulted in a report to a coroner; or
b. The physician is unable to make a "reasonable determination of the medical cause of death".

There is no legal requirement that a physician must view the body before signing the death certificate. If the physician does not view the body, the physician must be satisfied as to the medical cause of death according to sound medical practice and judgment.

Among the changes to the policy is recognizing that recent changes to Saskatchewan legislation allow nurse practitioners to sign death certificates, although many may be reluctant to do so until they receive training from the SRNA relating to this new (to them) authority.

The policy reproduces the legislation and regulations relating to completion of medical certificates of death and medical certification of stillbirths.

Any physician who may be asked to complete a death certificate or a medical certification of stillbirth should be familiar with the policy to assist them to understand their obligations.

Withdrawal of Physician Services During Job Action

This policy addresses the ethical expectation of physicians who are considering whether to withdraw their medical services as part of a job action.

A Council committee reviewed the existing policy and provided its recommendations to the Council. The committee's review included a review of similar policies by other Canadian Colleges of Physicians and Surgeons. The Council adopted the updated policy at its March meeting.

The only change of significance to the previous policy was to more clearly state that a physician's obligations are not limited to their own patients but can extend to other patients who do not have access to medical care.

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

Do you Know a Resident who is Completing Training in 2016?

Residents

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

Applicants should apply a minimum of six weeks prior to the date they wish to start to practice. We encourage these applicants to apply now to avoid delays at the conclusion of the academic year. New graduates considering licensure outside Saskatchewan must contact the appropriate provincial College of Physicians & Surgeons or licensing authority in other jurisdictions.

Family Medicine Licence Qualifications for Saskatchewan

To obtain a **Regular Licence** to practise family medicine in Saskatchewan, applicants must have:

1. passed Parts I and II of the Medical Council of Canada's Qualifying Examination (LMCC)
2. satisfactorily completed their postgraduate training program (this includes completion of any projects) certification with the College of Family Physicians of Canada

Residents who *do not* meet the requirements for regular licensure may be eligible for a **Provisional Licence** to practise family medicine. A provisional licence:

- is restricted to practising under supervision;
- may be renewed annually prior to November 1;
- the physician must be enrolled in the CME program of the College of Family Physicians of Canada

Specialty Practice Licence Qualifications for Saskatchewan

To obtain a **Regular Licence** to practice a specialty in Saskatchewan applicants must have:

- passed Parts I and II of the Medical Council of Canada Qualifying Examination (LMCC);
- satisfactorily completed their postgraduate training program; and
- possess certification with the Royal College of Physicians & Surgeons of Canada.

When postgraduate trainees *have not been successful* with the certification exam on their first attempt, they may still be eligible for a **Provisional Licence** to practise as a specialist. A provisional licence:

- is restricted to practising under supervision;
- may be renewed annually prior to November 1;
- the physician must be enrolled in the CME program of the Royal College of Physicians and Surgeons of Canada

Barb Porter
Director,
Physician Registration

Physicians with Regular Licences

If you are approached to support the new physicians of Saskatchewan by acting as a practice supervisor *please consider accepting this responsibility*.

New graduates cannot practice medicine independently unless a practice supervisor is willing and able to accept this responsibility.

Practice supervision includes a review of charts, chart stimulated discussion with the physician being supervised and reports to the College at regular intervals on a form provided by the College.

Please contact Barb Porter at the College office if you have questions or concerns:

barb.porter@cps.sk.ca
(306) 244-7355

Continuing Medical Education

Professional Development Opportunities for your Learning Cycle

The College website features a section on its website with links to several different conferences and other educational opportunities which may be of interest to you.

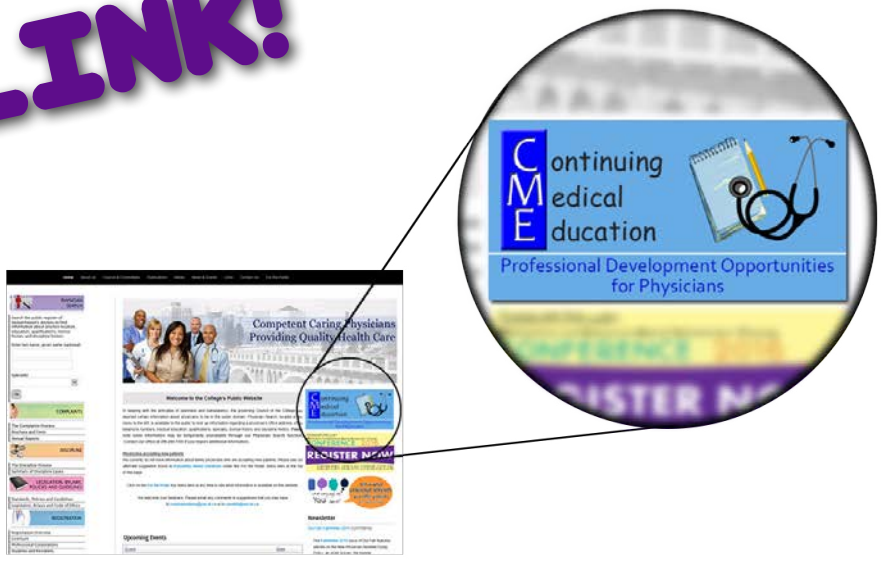
Physicians must remember that they are obligated to complete a certain number of educational credits over a learning cycle period in order to be eligible to renew their licence.

The College's website features some information concerning educational opportunities for your convenience. Several of the conferences and workshops listed are accredited.

For the lastest list of upcoming continuing medical education opportunities, see our website homepage at cps.sk.ca and click on the new and improved CME-Professional Development Opportunities link as illustrated below.

Finding PD opportunities just got easier!

NEW LINK!



cps.sk.ca

Complaints Department Adopts New Name

As the department expands to include infection prevention and control (IPAC) and service quality improvement through education, a more suitable name was sought.

Dr. Micheal Howard-Tripp
Deputy Registrar

In previous Doctalk articles I have addressed various issues relating to the complaints process at the College. Over the past two years, the complaints process has been undergoing a number of changes, to align with the College's Strategic Plan and in an effort to improve timelines and outcomes, for both complainants and physicians alike.

During the process of restructuring and reorganising the complaints processes it was decided to rename the educational, non-punitive process known as the Complaints Resolution Advisory Committee Process, and the department associated with this process, to **Quality of Care.** The Complaints Resolution Advisory Committee, a committee consisting of three physicians and three public members, will now be known as the **Quality of Care Advisory Committee.**

The rationale behind these changes is for the name of the department, and the advisory committee, to better reflect the non-punitive, quality improvement educational focus of the process.

In addition to dealing with complaints relating to the quality of care delivered by physicians the department will also be responsible for resolving issues relating to infection prevention and control (IPAC) in physician offices.

NEW BROCHURE

Be proactive:
show your patients you care about the services you provide by printing out some copies for your waiting room!

Doctor? Patient? Talk to us!

If you have questions or a complaint regarding medical services you've received or a situation you're not comfortable with, we'd like to help.

1-800-667-1668

Our revised brochure contains new information on our Quality of Care and complaints processes. Download your copy here:

http://www.cps.sk.ca/Documents/Complaints/Brochures%20and%20Forms/QOC-Complaints_Processes-2016-web.pdf

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 several discipline matters completed since the last Newsletter report.

Dr. Mohammed Abed

Dr. Abed admitted unprofessional conduct by breaching an undertaking he provided to the College of Physicians and Surgeons that he would not perform obstetrical or pelvic ultrasound without receiving the approval of the College of Physicians and Surgeons to do so.

Dr. Abed was suspended for two months commencing February 21, 2016. He was also required to take an Ethics program in a form acceptable to the Registrar.

Dr. Alfred Ernst

Dr. Ernst admitted unprofessional conduct for providing inaccurate or misleading information to the Heartland Health Region on two occasions when applying for reappointment to the practitioner staff. In 2013 and 2014 he completed forms in which he replied "No" to the questions:

- Has your license to practice been limited, suspended or revoked or does any action or proceeding exist which could lead to that result?
- Have you been, or are you now, subject to disciplinary action or proceedings by your professional licensing body?

Dr. Ernst had been subject to disciplinary proceedings by the College of Physicians and Surgeons at the time that he completed the applications for reappointment.

Council accepted a joint recommendation for penalty and imposed a fine of $2,000 and costs of $600.

Dr. Tshipita Kabongo

Dr. Kabongo admitted unprofessional conduct by causing or permitting excessive billing for his professional services. He admitted improperly billing for special call surcharges, respirometry, partial and complete assessments and counseling services. Dr. Kabongo's billings had been reviewed by the Joint Medical Professional Review Committee and he was ordered to repay $119,867.06. The Council imposed penalty on the basis that the inaccurate billings were due to inadvertence on his part. His billings were done by a billing clerk. He did not review those billings and failed to exercise appropriate oversight related to his billings to the Medical Services Plan.

Dr. Kabongo also admitted unprofessional conduct by maintaining medical records which contained information that did not accurately reflect the care which he provided to patients and failing to exercise due diligence to ensure that the information in his patient records accurately reflected the care which he provided to patients. Dr. Kabongo utilized an electronic medical record, with which he was not familiar. He utilized a pre-populated template for his medical records. As a result of his failure to change the template based upon his interaction with the patient, the charts for some patients contained incomplete and misleading information about the patient's medical condition. This included a description of examinations that were not done and created a misleading clinical picture of findings that were not specific to the patient.

Dr. Kabongo was fined $5,000, required to pay costs of $11,425.82, was reprimanded, required to take an ethics course in a form acceptable to the Registrar and required to take a records keeping course in a form acceptable to the Registrar.

Dr. Olabisi Olubajo

Dr. Olubajo admitted unprofessional conduct by failing to make appropriate arrangements when closing her medical clinic. Dr. Olubajo admitted that she:

1) failed to provide adequate notice to some of her patients that she intended to close the clinic;
2) failed to make adequate arrangements to allow some of her patients to seek medical care from another health care provider;
3) failed to provide adequate continuity of care for some patients for whom she had provided care;
4) failed to make adequate arrangements to follow up 7 pap smear results for her patients;
5) failed to make adequate arrangements for access to her patient records.

Dr. Olubajo was fined $2,500, required to pay costs of $780, issued a reprimand and required to take an Ethics program in a form acceptable to the Registrar.

Dr. Barry Rieder

Dr. Rieder admitted unprofessional conduct by failing to respond to communications from the College.

Council accepted a joint recommendation for penalty and imposed a fine of $1,500.

Am I at Risk of a Complaint?

The Code of Ethics, the Saskatchewan Human Rights Code and the Prescribing of Narcotic Medications

The College has noted from lists of Family Physicians Accepting New Patients, maintained by various Health Regions, that an increasing number of practices state that they will not accept patients who require narcotics.

The College is currently writing to all physicians who have been identified as stating that they will not prescribe narcotics to express concern that **such a decision may be a breach of *The Saskatchewan Human Rights Code* and of the *Code of Ethics*.**

Paragraph 17 of the *Code of Ethics* states:

> *In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation or socioeconomic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons.*

The Saskatchewan Human Rights Code defines "disability" and "prohibited grounds" in the following terms:

> *(d.1) "disability" means: (i) any degree of physical disability, infirmity, malformation or disfigurement and, without limiting the generality of the foregoing, includes …:*
>
> *(m.01) "prohibited ground" means …: (vii) disability;*

The Saskatchewan Human Rights Code prohibits discrimination on the basis of a disability:

> ***Discrimination prohibited in places to which public admitted***
>
> *12(1) No person, directly or indirectly, alone or with another, or by the interposition of another shall, on the basis of a prohibited ground:*
>
> *a. deny to any person or class of persons the accommodation, services or facilities to which the public is customarily admitted or that are offered to the public; or*
>
> *b. discriminate against any person or class of persons with respect to the accommodation, services or facilities to which the public is customarily admitted or that are offered to the public.*

The College is concerned that physicians who make a pre-determination that they will not prescribe narcotics to patients, or make a pre-determination that they will not accept patients who are receiving narcotic prescriptions, may be breaching the *Code of Ethics* and potentially become subject to a complaint to the Human Rights Commission of Saskatchewan.

Not accepting patients who require narcotics may be a breach of The Saskatchewan Human Rights Code *and of the* Code of Ethics.

While patients who have received narcotics for a lengthy period of time can be challenging to manage, there are medical conditions that may require the use of narcotics. A physician who will

not assess patients to determine if narcotic treatment is appropriate for them may be discriminating on the basis of a patient's disability as defined in **The Saskatchewan Human Rights Code**.

The College of Physicians and Surgeons sought an opinion from the Saskatchewan Human Rights Commission related to this issue. The response from the Commission stated the following:

"I have been asked by the Chief Commissioner to respond to your correspondence of April 7, 2015. I understand that some physicians specifically advise potential patients that they will not prescribe narcotics. I am not aware of the Commission ever having considered the ramifications of this practice under the Code. Nevertheless, I will give you some guidance based on case authority from another jurisdiction and, legal principles governing discrimination under the Code.

As you may appreciate it can be difficult to address a question of discrimination based on a hypothetical case. Legal liability under the Code is dependent on the specific facts underlying a complaint. The Commission investigates a complaint to determine if the facts establish a prima facie case. A prima face case is established if the facts alleged contain the elements of discrimination under the Code. If a prima facie case is established, the Commission will consider whether the respondent can establish a defence to the complaint.

I conducted a review of our database but did not identify a decision which fully addresses your concern. The case of Burns v. Lakeland Medical Clinic (No. 2) 2008 BCHRT 367 involved an alleged refusal of treatment based on a number of prohibited grounds, including disability. The Lakeland Medical Clinic contained a sign which purported to refuse the issuance of narcotic prescriptions. Upon seeing the sign, the complainant initially expressed an intention to leave the clinic. However, the nurse on staff encouraged the complainant to wait and speak to a physician. The respondent physician ultimately provided pain medications to the complainant on more than one occasion. It appears that these factual circumstances rendered the sign insignificant in assessing the denial of public services on the basis of disability. The complaint was ultimately dismissed because he was unable to establish that any refusal of service based on a prohibited ground under British Columbia's legislation.

Case authority recognizes that physicians have considerable discretion in determining appropriate patient treatment. However, I believe there is some risk that the practice of purporting to limit treatment options prior to attending on a patient would be considered discriminatory. For example, a sign may prevent a patient with chronic pain, who medicates with narcotics, from seeking treatment from a specific physician.

Medical services are public services under s. 12 of the Code. Disability is a prohibited ground of discrimination under paragraph m.01 of subsection 2(1) of the Code. Pursuant to section 12 of the Code, public services must be provided without discrimination based on a prohibited ground. Furthermore, subsection 14(a) of the Code prohibits publications which "tend to deprive, abridge or otherwise restrict the enjoyment by any person or class of persons, on the basis of a prohibited ground, of any right to which that person or class of persons is entitled under law ... "

If the Commission were to receive a complaint as set out above, it is likely that the respondent physician would be required to explain why he or she deemed it necessary to notify prospective patients of a limitation on prescribing narcotics. Without information from a respondent physician it is not possible for me to provide a proper assessment of potential liability under the Code."

It seems possible that a statement that a physician won't prescribe narcotics to patients may put the physician at risk of a complaint to the College of Physicians and Surgeons and may also put the physician at risk of a complaint to the Human Rights Commission.

The College encourages all physicians considering taking up the position that they won't prescribe narcotic medications to obtain advice as to whether their actions are consistent with the *Code of Ethics* and whether they may be at risk of a complaint to either the College or the Human Rights Commission. The Canadian Medical Protective Association is one of the sources which may be consulted to obtain advice.

New Guidelines for Opioid Use in Chronic Pain

The Centers for Disease Control and Prevention (CDC) published the CDC Guideline for Prescribing Opioids for Chronic Pain in March 2016.

This new guideline addresses:

1. when to initiate or continue opioids for chronic pain;
2. opioid selection, dosage, duration, follow-up, and discontinuation; and
3. assessing risk and addressing harms of opioid use.

It can be found at **http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm**

In addition to the guideline, the CDC also published various easy-to-read resources that will help improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death.

These resources are available at:
http://www.cdc.gov/drugoverdose/prescribing/resources.html

Julia Bareham
Pharmacist Manager - PRP

Opioid Management Tips

Helping Manage Prescription Drug Abuse

Canada is the world's second-largest per capita consumer of opioids, second only to the United States. Prescription drug abuse is a significant Canadian problem and is present in communities big and small. Canadians have much work to do to address this increasing problem.

So how can we start to tackle such a huge problem? One small step at a time!

Below are some tips and management strategies to keep in mind to help optimize the treatment of chronic pain when choosing to prescribe opioids.

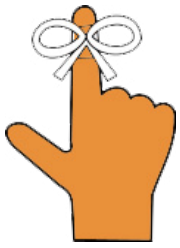
- The goal of opioid therapy for chronic non-cancer pain is rarely the elimination of pain, but rather an **improvement in function or a reduction of pain intensity by at least 30%**. By attempting to achieve complete pain resolution, patients may be put at risk for serious adverse events that will negate the potential benefits of therapy.

- Long-term opioid use has **risks**, and patients should be informed of these potential risk. These include: neuroendocrine (hypogonadism and amenorrhea), sleep apnea (central sleep apnea or worsening of obstructive sleep apnea), and opioid-induced hyperalgesia.

...continued on p. 16

Changes to Opioid Substitution Therapy Standards and Guidelines

The recently updated Saskatchewan Opioid Substitution Therapy (OST) Standards & Guidelines for the Treatment of Opioid Addiction/Dependence (formerly Saskatchewan Methadone Guidelines & Standards) will soon be available on the CPSS website.



As of September 1, 2016, Saskatchewan physicians will be expected to be compliant with the OST Standards & Guidelines.

REMINDER!!

Prescription Requirements for PRP Medications

Did you know that if a PRP medication is not written in accordance with provincial and federal regulations, and a pharmacist fills that prescription, that the claim for that prescription can be 'clawed back' from the pharmacy by the payer (e.g. NIHB)?

To avoid numerous phone calls and faxes from your pharmacy colleagues, please ensure you do your best to write prescriptions for PRP medications accurately. Some helpful tips to keep in mind: only part-fills of medications can be written (i.e. no refills) and the total quantity, amount to be dispensed each time, and the time interval between fills must be specified; unless transmitted electronically, the totally quantity of medication prescribed must be written both numerically and in written form (e.g. 34 and thirty four); gabapentin and benzodiazepines are PRP medications, but are often not written in a manner that meets the requirements of bylaw 18.1.

See Regulatory bylaw 18.1 for all the requirements:

https://www.cps.sk.ca/Documents/Legislation/Legislation/Regulatory%20Bylaws%20-%20November%202015.pdf

...continued from p. 15

- **Controlled-release opioids** such as Morphine SR or Hydromorph Contin should be dosed every 8 to 12 hours – not at any shorter intervals (e.g. QID).

- When a patient is receiving a regularly scheduled controlled-release opioid preparation, **immediate-release products** should be provided on an as-needed basis for breakthrough pain, not scheduled QID every day. A need for three or more breakthrough doses in a day is an indication for the need to re-evaluate the dose of the controlled-release preparation. This approach will minimize the number of tablets provided to a patient while optimizing his/her pain treatment.

- Every patient receiving an opioid should sign a **treatment agreement** and provide random urine drug screens. This is the only way to effectively monitor adherence, yet is not completely fool proof.

- If misuse is suspected, you may choose to have the pharmacy dispense the medication every two weeks, every week or even every few days. The time between dispenses must be clearly indicated on the prescription, but the dispensing schedule can be whatever timeframe best serves the patient.

For the full Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, visit: **http://nationalpaincentre.mcmaster.ca/opioid/**

Misused Medications that Might Surprise You

It would seem that more and more medications are being misused. It is often difficult to stay on top of the latest trends.

While some medications remain those most commonly misused, such as opioids, benzodiazepines, stimulants and gabapentin, other medications are becoming more frequently abused. Some of these include:

- **Quetiapine (Seroquel)** – used to decrease benzodiazepine withdrawal; used as a sedative or anxiolytic; used to amplify the effect of heroin

- **Dextromethorphan (DM)** – used to achieve euphoria

- **Dimenhydrinate (Gravol)** – a highly anticholinergic medication, can cause hallucinations, can be sedating

- **Oxybutynin (Ditropan)** – same as dimenhydrinate

LAST CHANCE TO REGISTER!

The Saskatchewan Methadone and Suboxone Opioid Substitution Therapy Conference 2016 is fast approaching! Registration is nearly filled and seating is limited.
The conference registration package and registration form are available on the CPSS website.

Saskatchewan
Methadone and Suboxone Opioid Substitution Therapy
CONFERENCE 2016

BUILDING BRIDGES FOR PATIENT SUCCESS

Friday & Saturday
April 22 & 23, 2016
Galaxy A - Travelodge Hotel
106 Circle Drive West
Saskatoon SK

Seating is limited, reserve your spot TODAY!

Who should attend?

Physicians*, pharmacists, nurses, pharmacy technicians, counselors and other individuals working with patients undergoing methadone and suboxone opioid substitution therapy would benefit from the valuable information and presentations that will be offered at this conference.

** Professional accreditation is pending.*
Certificates will be remitted with proper attendance at the end of the 2-day conference.

Building Bridges for Patient Success

UNDERSTAND	LEARN HOW TO	LEARN HOW TO	APPRECIATE	APPRECIATE
the importance of an integrated, multi-disciplinary approach to the continuum of care.	manage and monitor methadone and Suboxone safely, in the context of a Substance Use Disorder.	manage co-morbid physical and psychological conditions.	the benefits of Opioid Substitution Therapy to enable the transition to recovery.	the value of a coordinated community-based approach to Substance Use Disorders.

For more information: email - prp@cps.sk.ca , website - www.cps.sk.ca or call Nicole at 306-667-4655

http://www.cps.sk.ca/Documents/Conferences/SK_SMSOST_Conference-delegate_package%202016-no_hotel.pdf

DON'T WAIT, REGISTER TODAY!

Dr. Dennis A. Kendel Distinguished Service Award

Do you have a colleague you admire?

Consider nominating them for this prestigious 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 in November of each year.

Nomination packages are available on the College website or by contacting Sue Robinson at:

OfficeOfTheRegistrar@cps.sk.ca

** The Dr. Dennis A. Kendel Distinguished Service Award was named in honour of Dr. Dennis Kendel, who retired in 2011 after a long career as Registrar of the College of Physicians and Surgeons of Saskatchewan.*

Congratulations!

The College of Physicians and Surgeons of Saskatchewan wishes to congratulate

Mr. Bryan Salte

Associate Registrar and Legal Counsel to the College, on being selected as recipient of the

2016 Distinguished Service Award

from the Canadian Bar Association, Saskatchewan Branch in Feburary 2016.

Photo Credit: The Canadian Bar Association

This award is presented to individuals who have made exceptional contributions involving a significant law-related achievement for the benefit of residents of Saskatchewan; or to the legal profession in Saskatchewan; or to the jurisprudence in Saskatchewan or Canada; or to the law or development of the law in Saskatchewan.

Senior Life Designation: an achievement worth celebrating!

Have you or someone you know been practicing medicine in Saskatchewan for 40 years or more?

Each year, the College of Physicians and Surgeons of Saskatchewan celebrates its physician members who have been fully licensed to practice in Saskatchewan for forty years (or more). New inductees to **Senior Life Designation** are honoured at Council's Christmas (holiday) banquet which is held in November of each year, and receive a certificate and commemorative plaque depicting 100 years of medicine in the province of Saskatchewan.

Senior Life Designation is for honourary purposes only. It conveys no right to practice medicine in Saskatchewan, to hold office, or to vote. Members, including inactive members, are still required to pay registration fees* to retain their licensure status. As a result, a physician may concurrently hold a Senior Life Designation and another form of licensure.

If you have practiced 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 contact:

Sue Robinson at 306-244-7355 or at sue.robinson@cps.sk.ca

** A previous edition of DocTalk indicated that inactive registration was available at no cost. However, Council recently affirmed that all members with Senior Life Designation, including Inactive Members, are required to pay registration fees if they wish to continue to be licensed.*

Avon Medical Centre physician celebrates 50 years of patient care

Photo Credit: Avon Medical Centre

Dr. Donovan Brown

After being licensed in Ireland in 1956, Dr. Donovan Brown moved his family first to Kenya, then to Saskatchewan in 1964. In 1965, he and Dr. Tom Lee opened the Avon Medical Centre in Regina. Incredibly, he has now reached 50 years of practising medicine in this province, where he attends some third generation patients in a clinic that is also 50 years old. He has been assisted by longtime staff and colleagues whose ages and years of service total centuries.

Dr. Brown's interest in treating athletes led him down an interesting path. In 1982, he became the team doctor for the Saskatchewan Roughriders until the end of the 2007 season, which earned him two Grey Cup rings.

Dr. Brown volunteered as the team doctor for Thom Collegiate until 2008. He attended all home games right after seeing his patient load for the day at the Avon Medical Centre and he received the Award of Merit from the Regina High School Athletic Association in 1993.

Dr. Brown has taught medical students in the past, some of which are in practice in Regina to this day. He stopped doing obstetrics in 1996 but still practises more than part time at the Avon Medical Centre. Dr. Brown received his Fellowship from the College of Family Physicians of Canada in 2010.

50 years is a long time. Congratulations!

Do you know know someone else who has reached an remarkable milestone in their practice? We'd be happy to hear about it! Write to communications@cps.sk.ca and tell us the story!

Interested in

Medical Regulation?

Looking to take on an active role?

We need you!

The College of Physicians and Surgeons of Saskatchewan is often looking for both public and medical professional individuals to serve on its varying committees:

- ***Advisory Committee on Medical Imaging (ACMI)***
- ***Competency Assessment and Maintenance***
- ***Quality of Care Advisory Committee***
- ***Discipline Committee***
- ***Healthcare Facilities Credentialing Committee***
- ***Laboratory Quality Assurance Program Committee***
- ***Practice Enhancement Program (PEP) Advisory Committee***
- ***Joint Medical Professional Review Committee (JMPRC)***

For information on
current and future committee openings
and the commitment required
to be a committee member,
contact Sue Robinson at

OfficeOfThe Registrar@cps.sk.ca

or call (306) 244-7355

CONSIDER
THE ENRICHING
EXPERIENCE
AS A
COMMITTEE
MEMBER

Physicians Responding to College Correspondence

The College requests information from physicians in a number of circumstances. Over the last while a number of physicians have failed to respond to the College despite several reminders. College bylaws require physicians to respond substantially and in a timely fashion to requests for information from the Registrar, Deputy Registrar, the Executive Committee, the Council or any of the College's standing committees.

The physician must respond to the request for information or documents to the best of the physician's ability to do so. If the College asks for documents, the physician must provide original documents if requested, or legible copies of document if copies are requested. If the documents are stored in electronic form they should be provided in a printed format.

If there is a reason a physician cannot respond within the required time, a physician or his or her legal counsel must ask for an extension in writing.

The standing committees of the Colleges that may request information include:

- The Advisory Committee on Medical Imaging
- The Quality of Care Advisory Committee (formerly called the Complaints Resolution Advisory Committee;
- The Health Facilities Credentialing Committee

Although the Prescription Review Program is not a standing committee of the College, the requests for information are signed by either the Deputy Registrar or the Registrar and therefore are captured under this Bylaw.

Failure to comply with Bylaw 16.1 or Bylaw 16.2 may result in a formal investigation. In the recent past, several physicians have been charged with unprofessional conduct for failing to meet the requirements of these bylaws.

To avoid falling afoul of the Bylaw, please ensure you have a secure way of receiving College correspondence. Check to see if the email and mailing addresses you have provided the College is where you want College correspondence to be sent. If it is your office address, ensure your staff is aware any College correspondence needs to be brought to your attention in a timely manner. If you cannot respond in the time provided, request an extension in writing at the earliest opportunity and provide the reason you are unable to respond.

Please take the time to read the Bylaws on the following page to ensure you are familiar with your obligation to respond to the College.

Bylaw 16.1 College Requests for Information states the following:

16.1 College Requests for Information

(a) The Registrar, the Deputy Registrar, the Executive Committee, the Council and the Standing Committees referred to in the bylaws of the College frequently request information and explanations from physicians. Prompt response to such requests is required if the College is to expeditiously and effectively regulate the practice of medicine and comply with the objects of the Act.

Bylaw 16.2 Response to College Requests for Information states the following:

16.2 Response to College Requests for Information

(a) Upon receipt of a written request from the Registrar, the Deputy Registrar, the Executive Committee, the Council or a standing committee for information a physician shall:

(i) respond substantially to the request;

(ii) provide the information or explanation requested to the best of the physician's ability to do so;

(iii) provide originals of documents requested, if originals are requested, or legible copies of documents if copies are requested;

(iv) provide a printed record if the requested information or documents are stored in an electronic computer storage form or similar form.

(b) A physician shall provide the requested information, as referred to in the paragraph (a) within 14 days of receipt of the request, or such additional time as may be granted by the Registrar or Deputy Registrar for the response.

(c) A physician who is requested to provide information to the College of Physicians and Surgeons or to any individual or committees associated with the College of Physicians and Surgeons under paragraph (a), or under any other provision of the Act or these bylaws relating to the provision of information and documents including, without limiting the generality of the foregoing, the Administrative bylaws establishing the standing committees, 4.1, 16.1, 18.1, 19.1, 21.1, 22.1, or 25.1 of the bylaws and Section 55.3 of the Act, shall provide the information, explanation or documents contemplated by the request whether the consent of any person with an interest in the information, explanation or documents has, or has not, been sought or obtained.

(d) Information obtained pursuant to this paragraph or under any other provision of the Act or these bylaws relating to the provision of information and documents shall be treated confidentially and, unless otherwise directed by the Executive Committee, or the Council, shall not be used except for the purpose of complying with the objects of the Act or the duties of the committee or individual which obtains such information or documents.

(e) It is unbecoming, improper, unprofessional or discreditable conduct for a physician to fail to comply with paragraph 16.1 or 16.2.

Do you Speak Some French?

In partnership with the College of Medicine, Department of Community Health & Epidemiology, the Saskatchewan Network for Health Services in French/ Réseau Santé en Français de la Saskatchewan (RSFS) is in the process of updating the directory of health professionals who are willing to speak at least some French when providing health services in Saskatchewan.

We are also seeking to add professionals who are new to the province, recently graduated or simply newly interested. Professionals are added to the directory on a volunteer basis and there are no legal obligations associated with being listed.

If you would like more information or are willing to be listed please contact

Katie Pospiech
at
katie.pospiech@usask.ca
or (306) 966-1270

Infection Control Corner

New IPAC Standards and Guidelines

The College of Physicians and Surgeons of Saskatchewan is finalizing its adaptation to Ontario's Infection Prevention Control for Clinical Office Practice.[1] This document is intended to give direction and support for physicians working in clinical office settings. Integrating best practices into your routine care will decrease disease transmission, improve the quality of care you provide and the safety of the public, health care practitioners and office staff. The following recommendations address three practice areas that put patients and others at risk in physician offices.

Routine Practices: The Cornerstone of Safe Care

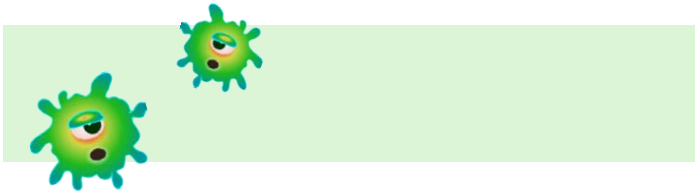
In today's health care milieu, Routine Practices are the infection prevention and control fundamentals that should be used during all patient care encounters and in all health care settings. During the HIV epidemic, basic standards of care became known as "universal precautions"[2] as the emphasis was on practices that would prevent the spread of diagnosed or undiagnosed bloodborne pathogens (e.g. HIV, Hepatitis B or C).

As health care procedures and settings have evolved, and patients have become increasingly vulnerable, guidelines have changed to focus more broadly on concerns about transmission of any type of pathogen. In 1996, the CDC changed the name from "universal" to "standard precautions" – meaning that like a standard minimum, they should be used for all patient encounters and in all settings. In Canada we call them **Routine Practices**.

Routine Practices[1] are based on the premise that all patients are potentially infectious, even when asymptomatic. To prevent the spread of microorganisms, these practices must be used routinely with all patients to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items. Adherence to these practices not only protects the health care provider, but also staff and patients who may subsequently be in contact with the health care provider or surfaces/equipment in the environment of care.

Elements of Routine Practices

These are the areas of practice that would be audited if a patient or the Public brought forward a concern related to Infection Control at your clinic to the CPSS. Knowing and implementing best practice is your best protection.



A few examples are :

1. *Risk assessment* of the patient and the health care provider's interaction with the patient

    - Are patients being screened for infectious symptoms on the phone? Upon arrival? On assessment only?

2. *Hand Hygiene* according to the "4 Moments" as described in your Regional Hand Hygiene protocols (or the PHAC Hand Hygiene Practice documents).

    - Do you have alcohol-based hand rub and hand hygiene sinks accessible at point-of- care?

3. *Control of the Environment*, including appropriate accommodation, equipment reprocessing, environmental cleaning, safe handling of sharps and injectable medications, issues related to construction and renovation.

    - How often are your examination tables being cleaned and with what? Are sharps containers safely secured and available at point-of-care?

4. *Administrative Controls* (i.e., management of staff health and practices), including encouraging staff immunization, respiratory etiquette and audits of practice

    - What is your protocol and what supplies are available to safely manage patients with upper respiratory symptoms?

5. *Personal Protective Equipment* (PPE) to protect all staff

    - Do you have gloves, gowns or aprons and facial protection for staff to easily access and do they know how to use appropriately?

Gwen Cerkowniak RN BSN CIC
Provincial Infection Control Coordinator (Central)

1. *Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Disease Advisory Committee. Infection Prevention and Control for Clinical Office Practice. Toronto, ON: Queen's Printer for Ontario, June 2013.*

2. *Infection Control Today. Standard Precautions: the cornerstone of Effective Care. April 11, 2015. Retrieved from: http://www.infectioncontroltoday.com/articles/2015/04/standard-precautions-the-cornerstone-of-effective-care.aspx*

The most recent IPAC Link Letter is included in this issue for your convenience.

The IPAC Link Letter

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.

Mark Your Calendars:

2016 IPAC Canada Conference, May 2016 in Niagara Falls. "Wisdom Begins with Wonder" is now open for registration and hotel reservations. Preliminary program is **here.**

Submission of monthly SSI Surveillance data ⇨ Wednesday March 31st

SASKPIC education session—*Basics of Surveillance and Epidemiology for Infection Prevention and Control (IPAC)* and meeting ⇨ Wednesday April 13th– 1:30-3:00

Medical Device Reprocessing Advisory Group Meeting ⇨ 3rd week of April TBD

National Immunization Awareness Week—April 23-30th

World Hand Hygiene Day—May 5, 2016

Highlights from the World of Infection Control:

Drs. David Butler-Jones and T. Wong have written a great article in the recent CCDR supplement (Canada Communicable Disease Report) on the need for intersectoral action to deal with Infectious Disease management (page 18-20). What struck me most was his advice on how to work together – with respect, making it practical and the rule of three. **Click to find out more.**

Infection Control is also in the business of Risk Management. Public Health Ontario has posted a tool on the Fundamentals of Risk Communication. They address the different types of risk and the goals of communication and how to best engage audiences. One of the references used in the tool really caught my eye, "***Watch Out!" – How to warn apathetic people***. The example used by the author was employees not wearing PPE and it provided a checklist of ideas to consider in your messaging and education. **Click here for the risk management document**.

The Zika Virus continues to be in the news and SDCL(Saskatchewan Disease Control Laboratory) recently sent out guidelines for testing in this province. Public Health Ontario now has an **Information page with links to** current recommendations regarding the management of Zika Virus Infection

Did you know that low economic status doubles your chances of hospitalization with Influenza complications. **Click here** to read the whole article.

I know some people are having difficulty finding family physicians but this is unbelievable. **Click here for more info**.

Are your facilities and staff safely managing their injections, infusions and medication vials? **Here** is an updated best practice document from APIC as a reminder, just in case you or your facility staff need a refresher.

Looking for an example of a great 1 pager for a unit in-service or orientation on Infection Control. I know this has American language and uses the ***don't*** word, but I still think it is a great template to build on if you are interested in adapting it. **Click here!**

If you have a great resource that you can share or want to let others know about, let us know - ProvincialInfectionControlGroup@saskatoonhealthregion.ca

Connections

Public Health Ontario (PHO) has launched its new Reprocessing in the Community Course
This course is an overview of reprocessing practices. It does not teach reprocessing, but will provide the guiding principles required for best practices in reprocessing. This is a self-paced, interactive course targeted to healthcare providers in clinical office practice, family health teams, and other community settings who perform the tasks related to the reprocessing of reusable medical equipment or devices. **Nine learning modules** demonstrating cleaning, disinfection and sterilization (table-top sterilizer) best practices for effective and safe reprocessing are included in this course. To access the course modules you are required to create an account and login. If you do not have an account, **you must register and then return to the course page to login.**

Upcoming Webinars http://www.webbertraining.com/schedulep1.php

Don't forget if you miss the live Teleclass, you can always go back and watch/listen at a later date.
The February 17th Teleclass on SSI prevention was great and VERY relevant to surgeons, with a 10 step poster.

Thursday March 3: **MERS-CoV: IMPLICATIONS FOR HEALTHCARE FACILTIES**

Thursday March 10**: BARRIERS TO TB INFECTION CONTROL IN DEVELOPING COUNTRIES**

Wednesday March 16**: THE GLOBAL MYCOBACTERIUM CHIMAERA OUTBREAK IN CARDIAC SURGERY**

Thursday March 17**: INFECTION PREVENTION AND CONTROL WITH ACCREDITATION CANADA QMENTUM PROGRAM**

Thursday March 31: **SUCCESSFUL IMPLEMENTATION OF CATHETER-ASSOCIATED URINARY TRACT INFECTION BUNDLES: LESSONS LEARNED**

Regional Roundup

Click here to find the hyperlink to the new TB Prevention and Control Saskatchewan Tuberculin Skin Testing Policy and Procedure and associated documents such, as the revised *Tuberculin Skin Test Screening Record* and *Tuberculin Skin Test Result Cards* along with the new *Recommended Management for Persons with a Positive TST.*

Are you thinking about writing your CIC in the near future? APIC has a new online course to help you prepare or you can purchase the 6th edition of the certification study guide which is a great tool. Click here for more info.
Are you interested in finding someone you could study with ? Contact your SASKPIC executive for assistance as one of their goals is to increase the number of certified ICPs in the province.

Answers to Questions You May Need in the Future:

What are the air exchange requirements for a new or renovated Triage Area in the Emergency Department? And should it be positive or negative pressure?
The answer to this question and other CSA space requirements for all areas in Healthcare Facilities (acute, LTC & community) are in the PHO – Construction, Renovation, Maintenance and Design (CRMD) tool kit - planning phase.
Click here, then print it off to have it ready to take with you to for those design requirement meetings that come up unexpectedly!

If you have a burning question or a great answer to a question you'd like to share send it to:
ProvincialInfectionControlGroup@saskatoonhealthregion.ca

Government of Saskatchewan

Family Physicians and Nurse Practitioners Working Together for Patient-centered Care

A Collaborative Statement

Vision

Family physicians and nurse practitioners are committed to successful collaboration to provide the people of Saskatchewan with high quality health care that is safe, compassionate and efficient.

Values

The following values are fully shared by both family physicians and nurse practitioners:

- Care that is focused on the needs of patients and their families.
- Collaborative approach for the best patient outcomes.
- Interprofessional care that is continuous and comprehensive.
- Trust and mutual respect for the unique role each profession brings to the team.
- Accountability and the interdependency of both professions.

Goals

Family physicians and nurse practitioners work collaboratively to achieve:

- Effective team based care: enable an approach to patient/family-centered care that also supports the development of the interprofessional team.
- Role clarity: optimize understanding and respect of Family Physicians and Nurse Practitioners' role distribution in patient management.
- Professional communication: foster clear and timely communication among healthcare professionals including referral and consultation.

Collaboration - "It involves the continuous interaction of two or more professionals or disciplines, organized into a common effort to solve or explore common issues, with the best possible participation of the patient" (Interdisciplinary Education for Collaborative Patient-Centred Practice, University of Toronto et al., Health Canada, 2004).

Collaborative practice – "an inter-professional process of communication and decision- making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided" [Implementation Strategies: Collaboration in Primary Care – Family Doctors and Nurse Practitioners Delivery Shared Care (Toronto: The Ontario College of Family Physicians, D. Way et al., 2000, p 2)].

Interdependency - "Refers to the fact that professionals are interdependent, rather than autonomous, because of a common desire to fulfill patients/clients' needs. When teamwork is successful, synergy occurs and the output of the whole is much larger than the sum of the individuals involved" (Enhancing Interdisciplinary Collaboration in Primary Health Care, 2005, p 3).

Autonomous - licensed autonomously but practice interdependently.

Patients Medical Home, 2011. http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf

Enhancing Interdisciplinary Collaboration in Primary Health Care, 2005
http://www.eicp.ca/en/resources/pdfs/enhancing-interdisciplinary-collaboration-in-primary-health-care-in-canada.pdf

Implementation Strategies: Collaboration in Primary Care – Family Doctors and Nurse Practitioners Delivery Shared Care. Toronto: The Ontario College of Family Physicians, D. Way et al., 2000
http://www.eicp.ca/en/toolkit/management-leadership/ocfp-paper-handout.pdf

Maternal mental health matters

May 4, 2016
is
World Maternal Mental Health Day

BACKGROUND: An international task force met in late 2015 to start making plans for the first ever World Maternal Mental Health Awareness Day. The group decided that the event should be held each year on the first Wednesday of May, close to "Mother's Day" and "Mental Health Week" in many countries. Before long the task force had grown to include representatives from around the globe, all with a common goal of increasing awareness of maternal mental health issues.

WHY WE NEED WMMH DAY? In many countries, as many as 1 in 5 new mothers experiences some type of perinatal mood and anxiety disorder (PMADs). These illnesses frequently go unnoticed and untreated, often with tragic and long-term consequences to both mother and child. It is cited as the #1 obstetrical complication by prevalence.

RAISING AWARENESS: Women of every culture, age, income level and race can develop perinatal mood and anxiety disorders. Symptoms can appear any time during pregnancy and the first 12 months after childbirth. There are effective and well-researched treatment options available to help women recover.

INFLUENCING POLICY: The goal of the task force is to increase awareness of maternal mental health issues that will ultimately increase resources to diagnose and treat PMADs.

CHANGING ATTITUDE: Increasing awareness will drive social change with a goal toward improving the quality of care for women experiencing all types of PMADs, and reducing the stigma of maternal mental illness.

World Maternal Mental Health Day
wmmhday.postpartum.net
#maternalMHmatters

Saskatchewan Comprehensive Epilepsy Program

Since 2008, the Saskatchewan Comprehensive Epilepsy Program, a comprehensive program that cares for adult and pediatric patients with epilepsy, has been organizing activities such as International Purple Day (held annually on March 26th), demonstrations of Seizure Response Dog Guides, seizure clinics, and fundraising events at the Royal University Hospital in Saskatoon.

The events have been used to fundraise equipment for the Saskatchewan Epilepsy Program.

This year we created a **newsletter** that describes our services as a program.

Unfortunately, referrals for patients with epilepsy is often made late, especially for cases that could have seen a benefit with epilepsy surgery.

Our newsletter provides information about clinics and doctors from our program, which involves pediatric and adult doctors.

For more information on our program, visit:

https://www.saskatoonhealthregion.ca/locations_services/Services/Epilepsy

To download our most recent newsletter, visit:

http://josetellezzentenoepilepsy.com/Our/22-SaskEpilepsyNewsletter2016Final.pdf

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

How about sign language?

Patients, especially children and the elderly, usually feel more comfortable expressing themselves in their mother tongue, and even more so when they are not feeling well.

They will often seek medical care from physicians who are able to communicate, at least to some degree, in their language.

They may feel better understood by the individual on whom they depend for quality medical care. Familiarity, trust and a sense of connection with a medical provider can also help reduce stress with regards to procedures that can otherwise seem strange or even frightening.

From a physician's viewpoint, speaking the mother tongue can also be useful for ensuring informed consent.

The College of Physicians and Surgeons of Saskatchewan is encouraging physicians and specialists to **register their language proficiencies** by filling out a survey form. This information will be entered into our database, and will be made available in your public profile on the College's website at www.cps.sk.ca.

(Please allow a few weeks for the information to appear online.)

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 having difficulty entering your information online.

We're Working for You

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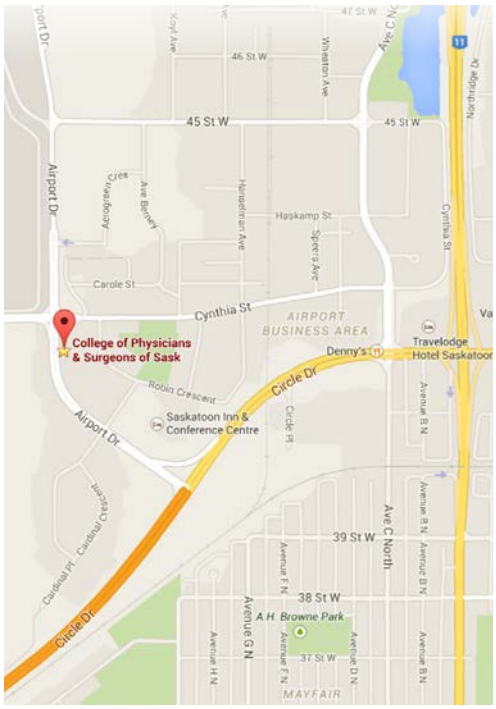

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