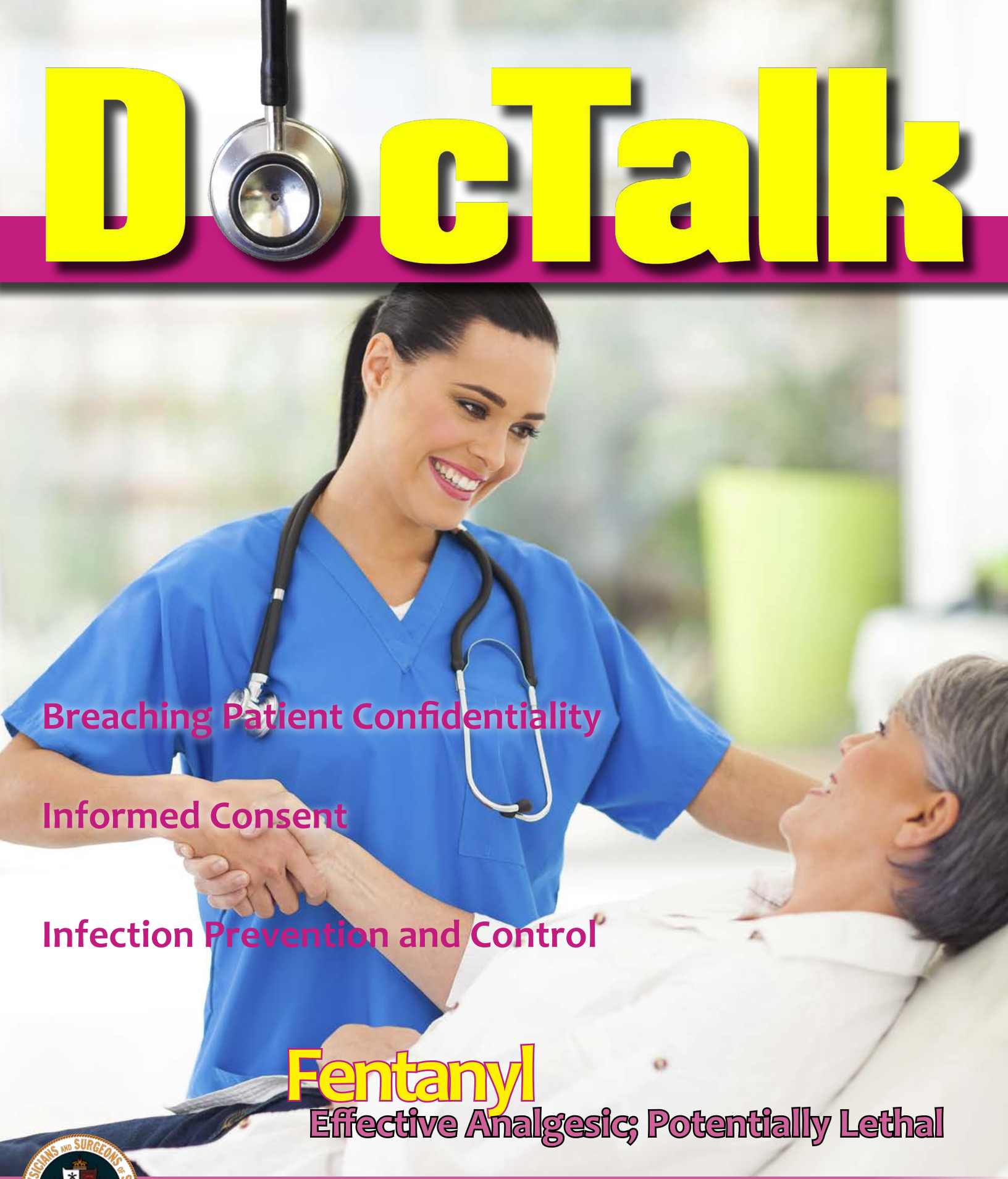
DocTalk



Breaching Patient Confidentiality

Informed Consent

Infection Prevention and Control

Fentanyl
Effective Analgesic; Potentially Lethal

Council Elections - Call for Nominations

DocTalk
Summer 2015

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In this issue






OUR VALUES

Service Oriented
accountable
transparent
progressive
Collaborative
Integral

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

Submit your ideas & articles by November 15, 2015, to COMMUNICATIONS@cps.sk.ca

From the President

Conscientious Objection Physician-Assisted Dying, and AGM presentations

This continues to be an extremely interesting time to be involved with the issues facing Medical Regulatory Authorities (MRAs) across the country.

At our Council meeting in June, we received the latest recommendations from the Working Group on the policy pertaining to **Conscientious Objection.** The Working Group had reviewed the extensive feedback provided to the College and made recommendations to modify the policy based on that feedback. Council considered a number of options with respect to expectations related to provision of information by physicians to patients, as well as related to providing or arranging access to healthcare services for timely care of patients. A new draft of the policy was agreed upon, and this new document will again be circulated to obtain feedback from interested stakeholders. It is anticipated that a final version will be available for possible adoption by Council at the September Council meeting. We would like to thank all those who provided input into this important policy.

Another important issue Council is addressing relates to creating a framework to deal with **Physician Assisted Dying** in response to the Supreme Court of Canada decision in Carter v. Canada. At the June meeting, Council reviewed a draft guidance document from the Federation of Medical Regulatory Authorities of Canada (FMRAC) related to Physician Assisted Dying. This topic was also discussed by the provincial MRA's at the Annual FMRAC meeting in early June. Council endorsed this document as a draft guidance document to support the work of the College's Working Group on Physician Assisted Death. This Working Group includes three members of Council (public and physicians), two senior staff from the Registrar's Office, two members of the SMA, and physicians with expertise in palliative care, oncology, medical ethics, psychiatry and medical education. The College will also seek input from the Government of Saskatchewan to assist with having a coordinated response to this issue. The Working Group will be reviewing practices from other jurisdictions and plans to have recommendations for Council later in this year, in advance of February 2016 when the current law prohibiting physician assisted suicide will no longer be in effect.

The **CPSS Annual General Meeting*** and Educational Session was conducted on the afternoon of Saturday, June 20th, 2015, at St. Paul's Hospital in Saskatoon and via videoconference and was very successful. Attendees heard presentations related to "Effective Communication" including; Communication Tools and Situational Awareness by Dr. Neil Cowie, Professional Boundaries by Ms. Brenda Senger, and Disclosure of Patient Health Information as well as an Update on Physician Assisted Death by Mr. Bryan Salte. Council hopes that these educational sessions are helpful to the College members, and would certainly appreciate any suggestions for future educational topics or themes.

I would like to take this opportunity to thank all those involved in the activities of the College. We appreciate and value your input and hope you will continue to be actively involved.

Dr. Grant Stoneham
President, CPSS

**The AGM 2015 presentations are available on the College's website at www.cps.sk.ca*

From the Registrar

Prescription Drug Abuse

Prescription drug abuse is an issue of increasing concern in Canada.
The statistics about prescription drug abuse are alarming.

Prescribing Practices Forum – Steps Towards a National Best-Practice in Prescribing Opioids

In May of this year, a forum was funded by the Health Canada and hosted by Michael De Groot National Pain Centre at McMaster University in Hamilton, to bring together a group of concerned individuals which included regulatory authorities, health professionals, provinces, territories and experts to identify steps to improve prescribing practices with the ultimate goal of reducing the abuse of prescription drugs.

Mr. Robert Eves, Director of Strategic Partnerships and Knowledge Mobilization, **Canadian Centre on Substance Abuse** (CCSA) provided an overview on the work of the CCSA and provided the following reasons why the work of the CCSA matters:

Health: CCSA sees the impact of substance abuse in many areas especially in health where it contributes to diseases such as cancer, heart disease, diabetes and HIV/AIDS.

Economics: Substance abuse costs over 40 billion per year in Canada

Public Safety: As many as 80% of the federal offenders have a history of substance abuse.

Prescription Drug Misuse in Canada

- Shield et al, 2013 reported that 4.8% of Canadians aged 15+ had reported non medical prescription opiate use during the past year;
- 2.8% of Canadian students in Grades 7 to 12 reported past year use of pain relievers to get high;
- Students in grade 12 had the highest rate of non medical opiate use (16.1% - Health Canada 2012 - 2013 Use Smoking Survey);
- First Nations individuals reported that 4.7% of First Nations individuals 18 years or older living on reserve or northern First Nations communities had reported past year use of opiates without a prescription (FNIGC 2012);
- 1.3% of First Nations youth aged 12 to 17 reported using Opiates without a prescription during the previous 12 months (ACHA, 2013).

Prescription Drug Misuse Harms in Canada

- Dramatic rise in opioid-related deaths in Ontario from 2004-2011 (Office of the Coroner);
- Rise in Emergency room visits in Ontario from opioid-related mental and behavioral disorders form 2008-2009 and 2010-2011 (MOHLTC, 2012);
- In 2010, 12.1% of all deaths among those aged 25-34 years in Ontario were opioid-related; up from 5.5.% in 2001 (Gomes et al., 2014)
- Prescription-related admissions to Ontario Substance Use treatment programs doubled from 2004-2009 (Fischer et al., 2010);

We are just starting to receive opioid related death data in Saskatchewan. There is no national data available for drug related mortality in Canada.

The forum was an opportunity to review what is happening across the country since 2012, when the Canadian Centre for Substance Abuse (CCSA) invited stakeholders and partners across the country to come together and talk about Canada's prescription drug crisis.

The **First Do No Harm** strategy was released in March 2013. The forty partners from across the country represented were willing to act collectively to move the initiative forward as Canada's first pan Canadian strategy.

This first pan Canadian strategy included 58 recommendations across seven areas:

- ***Prevention***
- ***Education***
- ***Treatment***
- ***Monitoring and Surveillance***
- ***Enforcement***
- ***Legislation and Regulations, and***
- ***Evaluation and Performance Measurements.***

Work has begun on a number of these strategies: identifying core competencies for accredited healthcare practitioners continuing education programming, academic detailing programs, clinical point of care, decision support tools and local and long distance clinical networks that provide healthcare practitioners with prompt and easily accessible clinical advice and information.

There has been a focus on using evidence informed guidelines, validating risk assessment tools and developing policies that promote appropriate prescribing practices including regulatory bodies. There has also been support to establish prescription monitoring programs in all provinces and territories.

Along with the Canadian Centre for Substance Abuse update on the First Do No Harm strategy, representatives from medicine, nursing, dentistry, pharmacy, and the Federation of Medical Regulatory Authorities of Canada participated in a **forum** to inform those present on the strategies that regulatory agencies are currently implementing to measure the extent of prescription drug abuse and to mitigate the issue, as well as potential opportunities to share best practices.

CPSS and Prescription Drug Abuse

The College of Physicians and Surgeons of Saskatchewan reported on the **Prescription Review Program** (PRP) which it operates to monitor the prescribing by physicians to patients of a discreet panel of medications that have a potential to be diverted or misused. Physicians are fortunate to have access to such a program which assists them in understanding what has been prescribed and dispensed for particular patients. During this forum a physician, who had moved from Saskatchewan to practice in another province that does not have a prescription monitoring program, stated she missed access to the PRP program information and acknowledged the value of having a Prescription monitoring program.

Our College continues to provide information to physicians around the prescribing and dispensing of a certain panel of medications that have a risk of being misused or diverted. The program also offers some educational resources to assist the physician in improving prescribing practices.

The introduction of the **Canadian Guideline for Safe and Effective Use of Opiates for Chronic Non Cancer Pain** has been helpful to establish some general guidelines and principles to follow. It was also announced during the May forum that Health Canada has agreed to fund the Michael G. De Groot National Pain Centre to update the Canadian Guideline for Safe and Effective Use of Opiates for Chronic Non Cancer Pain.

The College of Physicians and Surgeons staff continue to be involved in these national strategies through the work of Mr. Doug Spitzig who has been involved in some of the working committees on the First Do No Harm strategy.

Partnering with First Nations and Inuit Health Branch-SK

Recently the College was approached by the **First Nations and Inuit Health Branch of Saskatchewan** to work with its Prescription Drug Abuse committee to support its work within this province and with its provincial partner – Manitoba. CPSS has agreed to partner with the First Nations and Inuit Health Branch Saskatchewan to decrease the prescription drug abuse in First Nations individuals and communities within Saskatchewan.

Each of us has a role to play in decreasing prescription drug abuse. Those of us who prescribe should do so by prescribing using best practices and after careful, thorough assessment.

Opioids

The use of the Canadian Guideline for Safe and Effective Use of Opiates in Chronic Non Cancer Pain supports safe practice. A point of care tool for providers is the *Opioid Manager*. It condenses the key elements from the Canadian opioid guideline. It can be accessed at http://nationalpaincentre.mcmaster.ca/opioidmanager/opioid_manager_registration_search.html. Prescribers should also apply the universal precautions principles noted in "Universal precautions in pain medicine: a rational approach to the treatment of chronic pain." (Gourlay, DL et al Pain Med. 2005 Mar-Apr; 6(2):107-12.)

Dr. Andrea Furlan and Amy Robidas (RN), have developed a new mo-

bile app called **MY Opioid Manager™** (MyOM) available for iOS (iPhone/iPad), and Android devices. The app is accompanied by the iBook content as an educational and informational resource to help patients suffering from chronic pain understand and manage their pain with opioid use. This resource is free of charge and can be accessed at www.opioidmanager.com. It is an excellent tool to help engage the patient in their care.

Poppy pod with incision showing white opium latex seeping out

Stimulants

The use of the **Canadian ADHD Resource Alliance (CADDRA) Practice Guidelines** for the prescribing of stimulants supports best practice. It can be accessed at http://www.caddra.ca/pdfs/caddraGuidelines2011.pdf and all forms are available for download and use.

Benzodiazepines

The use of the **Benzodiazepine Learning module** developed by Medicines and Healthcare Products Regulatory Agency (MHRA) will assist physicians in the appropriate prescribing of benzodiazepines, another category of medications that can be misused and diverted. It can be located at http://www.mhra.gov.uk/benzodiazepines-learning-module/index.htm. An additional resource such as the manual written by Dr. Heather Ashton ***Benzodiazepines – How they work and how to withdraw*** is also helpful when reviewing appropriate prescribing for benzodiazepines.

In addition to operating the Prescription Review Program, the College of Physicians and Surgeons of Saskatchewan also operates a Methadone Program on behalf of the Ministry of Health. One of its main functions is to develop capacity for methadone prescribers, as part of a harm reduction strategy for the treatment of patients with dependency issues within the province of Saskatchewan. The Methadone Program has also recently developed new standards and guidelines for the prescribing of methadone for dependency (based on the Alberta guidelines) which have now been approved by Council. The new standards/guideline document can be accessed on the CPSS website.

In our efforts to contribute to decreasing prescription drug abuse we will be calling on each of you to monitor your prescribing, use best practices and to put safeguards in place to ensure patients are using their medications safely. We may also be reaching out to you to assist in educating the communities in which you live. We will also be encouraging those with an interest in addictions medicine to step forward and assist us in tackling this problem.

Prescription drug abuse is a complex issue which affects us all. It will require many different approaches.

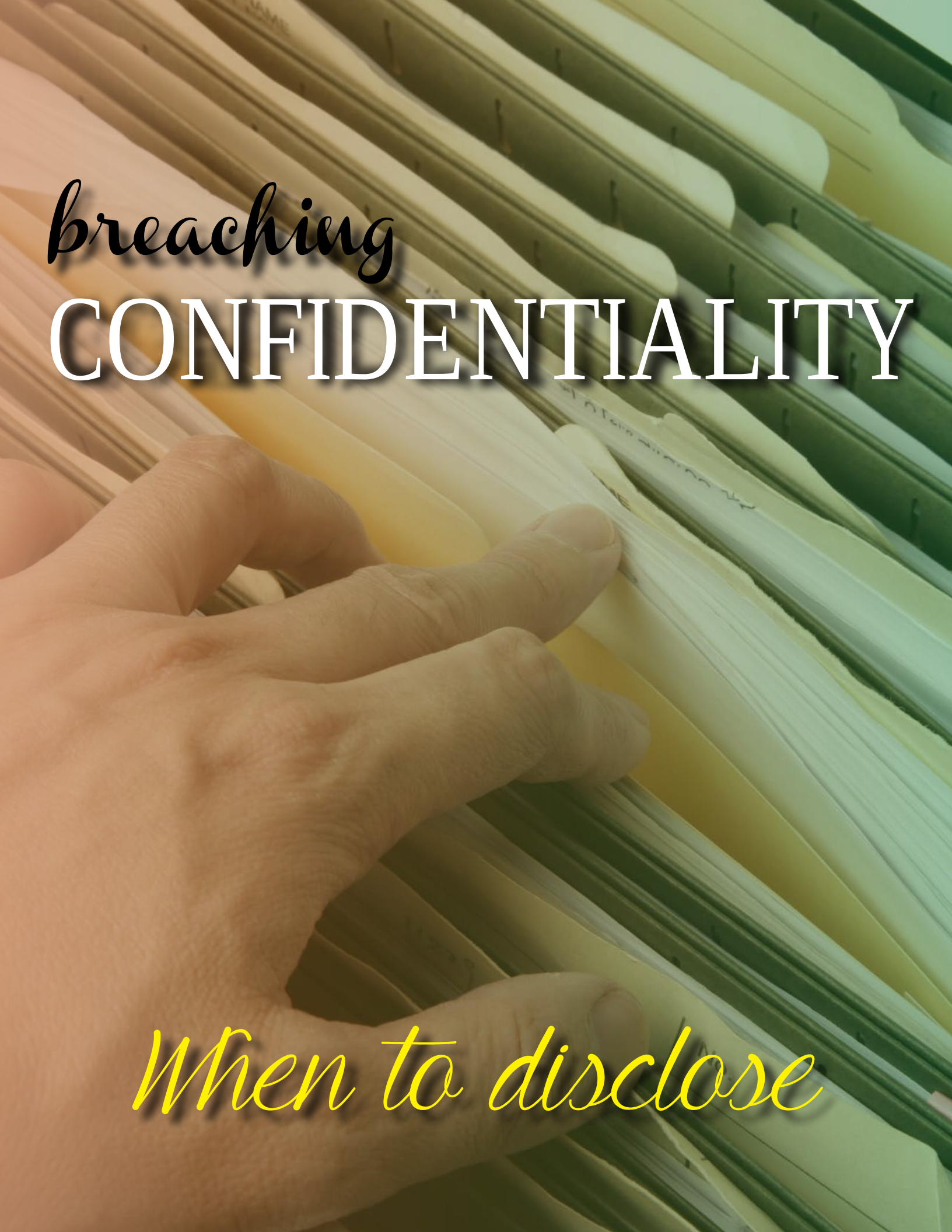
Seeking PRP Manager

In addition to our new work with the First Nations communities we will also be looking for a new ***Prescription Review Program Manager*** *as Mr. Doug Spitzig has announced his retirement. Any interested individuals may contact me for more information by writing to:*

OfficeOfTheRegistrar@cps.sk.ca

Dr. Karen Shaw
Registrar, CEO

The Canadian Centre for Substance Abuse (CCSA) is a national organization that has been working for about 25 years with stakeholders across the country to deal with the issue of substance abuse. This national agency is dedicated to reducing the harms of alcohol and other drugs on Canadian society. The CCSA was created by an Act of Parliament in 1988 and has provided national leadership and advanced knowledge and solutions to address alcohol and other drug related harms. This organisation works collaboratively with all levels of Government and the not for profit and private sectors.


breaching
CONFIDENTIALITY
When to disclose

Breaching Patient Confidentiality

Bryan Salte
Associate Registrar and Legal Counsel

*One of the most fundamental principles of the practice of medicine is that physicians will keep information confidential and only release patient information to a third party with patient consent. However, there are **exceptions** to that principle.*

In some circumstances physicians are permitted to disclose patient information to third parties without patient consent. In some circumstances the law requires physicians to disclose information about their patients to third parties without the patient's consent.

This article summarizes those two situations. The College Guideline ***Confidentiality of patient information*** which is available on the College's website – www.cps.sk.ca provides additional information.

Situations where physicians are **PERMITTED TO DISCLOSE** patient information without patient consent

The Health Information Protection Act sets out several situations in which physicians are permitted to release information without the consent of the patient. In each of the following situations a physician must decide whether it is ethically appropriate to release patient information, even if the legislation permits the physician to do so.

This is not a complete list of exceptions to patient confidentiality, but addresses situations which arise most frequently.

1) Patient confidentiality can be breached if the physician believes, on reasonable grounds, that the disclosure will avoid or minimize a danger to the health or safety of any person. The Council of the College approved a guideline ***Patients Who Threaten Harm to Themselves or Others*** – available on the College Website – which can assist physicians to decide when that is appropriate.

2) Patients who are not competent to make their own decisions respecting disclosure of their health information are generally entitled to confidentiality of their health information in the same way as competent patients.

   An exception to that is where the information is provided to a proxy in order to make a health care decision on behalf of the patient. The proxy is entitled to the same information as the patient would receive in order to make an informed health care decision.

3) Deceased patients are generally entitled to confidentiality of their health information in the same way as living patients, with two exceptions:

   a) A physician can disclose information to the executor or administrator of the patient's estate for a purpose related to the administration of the estate;

   b) A physician can provide information to a member of the patient's family or to someone else with whom the patient had a "close personal relationship" subject to two restrictions:

      A. The information is limited to the circumstances surrounding the patient's death or services recently received by the patient; and

      B. The physician must make the disclosure "in accordance with the ethical practices of the physician's profession".

4) There are limited circumstances in which a physician can disclose patient health information to the police without a court order requiring them to do so. The **Health Information Protection Act Regulations** permit physicians to provide the following information to the police:

   a) "Registration Information" (i.e. the patient's address or telephone number) in connection with a criminal investigation;

   b) Information about the nature and severity of a patient's injury requested by a police officer in connection with a criminal investigation;

   c) Where the physician has provided health services related to conduct that is the subject of a criminal investigation. That can arise if, for example, a physician has treated an injured motorist and the police ask about signs of impairment, or the physician has

prescribed a narcotic to a patient and the police are conducting a double-doctoring investigation.

The information given to the police should be limited to information about the patient that relates to the police investigation. The police should not be given the patient's medical history.

The regulations allow a physician to provide information to the police in response to a police inquiry. They do not allow a physician to initiate contact with the police to report a suspected crime.

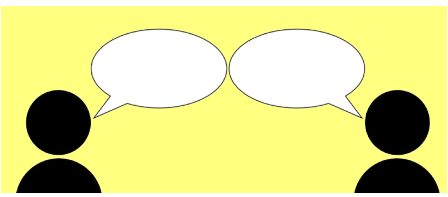
5) Information can be disclosed to a quality of care committee so that the committee can evaluate health services.

6) Information can be disclosed to the College to allow the College to regulate the medical profession.

7) Information can be disclosed to a third party to obtain health or social services for the patient if, in the physician's opinion, disclosure will benefit the patient, but only where it is not practicable to obtain patient consent.

If a third party asks a physician to disclose patient information without the patient's consent, the ***starting point*** usually should be to ask that third party to set out the basis on which the third party thinks that patient consent is not required.

We encourage physicians to consult with the College, CMPA or the Privacy Officer in their Regional Health Authority to obtain advice if they are unsure whether patient information should be released without patient consent.



MANDATORY REPORTING - Situations where physicians are **REQUIRED TO DISCLOSE** patient information without patient consent

The section above described some of the more common situations where physicians are able to disclose patient information to third parties without the consent of the patient.

Some legislation requires physicians to disclose certain information to third parties and overrides patient's rights to confidentiality:

1) **Communicable Diseases** – Physicians are required to report Category 2 communicable diseases (e.g. STIs, tuberculosis) to a medical health officer as soon as possible and after no more than 72 hours. Physicians are required to report Category 1 communicable diseases (e.g. measles, pertussis) to a medical health officer within 48 hours.

2) **Child Abuse or Neglect** – Physicians are required to report to a social worker or to police if they conclude that there are reasonable grounds to believe that a person (whether the person is, or not a patient) who is under the age of 16 is in need of protection. The most common reasons to conclude that a child is in need of protection are if the child:

a) Is likely to suffer physical or mental harm; or

b) Is being denied medical treatment; or

c) No adult person is available to provide for child's needs.

3) **Child Sexual Abuse** – Physicians are required to report to a social worker or a police if they conclude that there are reasonable grounds to believe that a person (whether the person is, or not a patient) who is under the age of 18 has been or is likely to be a victim of sexual abuse. The most common reasons to conclude that a child has been a victim of sexual abuse are if the child:

a) Has been involved in prostitution;

b) Has been sexually assaulted;

c) Has engaged in sexual conduct while under the age of consent (any child under the age of 12, a child who is 12 or 13 if the other person is 2 or more years older than the child, a child who is 14 or 15 if the other person is 5 or more years older than the child, a child who is 17 or younger if the other person is in a position of trust or responsibility with the child).

4) **Reports to the Coroner** – Physicians are required to report to a coroner if, in the physician's opinion, a patient's death:

a) Resulted from an accident or violence or was self-inflicted;

b) Resulted from a cause other than disease or sickness;

c) Was a result of negligence, misconduct or malpractice on the part of others;

d) Was sudden and until the death the person appeared to be in good health;

e) Was as a result of engaging in employment or an occupation;

f) Occurred in circumstances that require investigation.

5) **Stillbirths outside hospital** – Physicians who attend a stillbirth outside hospital are required to complete a certificate and deliver it to the Director of Vital Statistics.

6) **Patient deaths** - A physician in attendance at the time of a patient's death

or the last illness must deliver a certificate of death to the funeral director if the matter has not been reported to the coroner and the physician is able to make a reasonable determination of the medical cause of death.

7) **Fitness to Drive** – A physician is required to make a report to Saskatchewan Government Insurance if a patient who is 15 years of age or older has a medical condition that will make it dangerous for that person to operate a vehicle. The book *Determining Medical Fitness to Operate Motor Vehicles* from the Canadian Medical Association is the best available guide to what medical conditions should be reported.

8) **Responding to requests from Saskatchewan Government Insurance** – A physician who has treated a patient for injuries from a motor vehicle accident is required to respond to SGI's request for information relating to the physician's assessment or treatment.

9) **Responding to requests from the Workers' Compensation Board** –– A physician who has treated a patient for conditions related to a workplace injury is required to respond to WCB's request for information relating to examination or treatment that is relevant to the injury.

10) **Notifying the police of gunshot or stab wounds** – The Chief Executive Officer of a health region is obligated to report gunshots or stab wounds that are treated in a hospital or a regional health authority facility. The CEO can delegate that responsibility to someone else and, if a physician is delegated to make a report, must report a gunshot or stab wound to the police.

11) **Pilots or flight crews** - Patients are required to advise physicians if they are a pilot or a member of a flight crew. If a physician is aware that a patient is a pilot or a member of a flight crew, the physician is required to report to a medical adviser designated by the Minister of Transport of Canada if the physician concludes that the patient has a medical or optometric condition that is likely to constitute a hazard to aviation safety.

12) **Railway workers in safety sensitive positions** - Patients are required to advise physicians if they are a railway worker in a position designated as critical to safe railway operations. If a physician is aware that the patient is in such a position, the physician is required to notify a physician designated by the railway company if the physician concludes that the patient has a condition that is likely to pose a threat to safe railway operations.

13) **Reporting another physician to the College** – College bylaws require physicians to report to the College if they conclude that another physician has engaged in unprofessional conduct, is practising medicine below an acceptable medical standard or if the physician's ability to practice medicine competently is affected by a chemical dependency or medical disability.

While physicians should have a basic understanding of their confidentiality obligations, some situations are complex.

If you're not sure about patient confidentiality, ASK US for advice...

- The College is available to provide advice to physicians who are unsure of their obligations or options relating to patient confidentiality. The College Guideline **Confidentiality of patient information,** available on the College's website, is another resource available to physicians.
- The Canadian Medical Protective Association; and
- Privacy Officers in regional health authorities

Changes to College Bylaws

Council regularly reviews and changes its bylaws to reflect changes in medical practice. College bylaws are regularly updated on its website, www.cps.sk.ca.

In 2015, College bylaws were amended to:

1. **Authorize physicians to delegate specific activities to registered nurses;**
2. **Limit the application of the buprenorphine bylaw so that it applies only to buprenorphine prescribed for treatment of addiction;**
3. **Remove the requirement that physicians report their prescribing of marihuana to the College.**

Delegation to Registered Nurses
Bylaw 23.3

*Until recently there was nothing in T***he Medical Profession Act, 1981** *which authorized physicians to delegate activities that are within the practice of medicine to a member of another profession. The College's interpretation of its legislation, and the legislation regulating other professions, was that a non-physician could only perform an activity that was within the scope of medical practice if that activity was also within the scope of practice of the non-physician professional. Thus a physician could not delegate an activity to a registered nurse unless that activity was within the scope of practice of registered nursing.*

The College asked the Government of Saskatchewan to amend the legislation to permit the College to pass bylaws to allow physicians to delegate specific activities to non-physicians. The Government amended **The Medical Profession Act, 1981** *as the College asked.*

Bylaw 23.3 authorizes delegation of specific activities from physicians to registered nurses. The activities which can be delegated are:

1. Services provided by a registered nurse while acting as a member of a Registered Nurse Neonatal Intensive Transport Team;

2. Services provided by a registered nurse while acting as a member of a Registered Nurse Pediatric Transport Team;

3. Services provided by a registered nurse while acting as a member of an Air Ambulance Team;

4. Services provided by a registered nurse while acting as a member of a STARS (Shock Trauma Air Rescue) team;

5. The administration of laser radiation for a medical purpose, but only when the physician has first assessed the patient and established a treatment plan for the administration of laser radiation and the physician is present in the same location as the laser therapy is provided;

6. The injection of agents which have an effect on or elicit a response from living tissue (bioactive agents), but only when the physician has first assessed the patient and established a treatment plan for the injection;

7. Services when acting as a surgical assistant in an operating room, but only when the registered nurse has been given privileges to act as a surgical assistant by the Board of the regional health authority where the registered nurse provides those services;

8. Services provided by a registered nurse when acting as a member of the Saskatchewan Transplant Program.

9. A physician delegating a task to a registered nurse must be satisfied that the registered nurse has the appropriate knowledge, skill and judgment to perform the delegated act.

Unless the delegation occurs in an emergency situation, the delegation must be in writing. The physician must remain generally available to provide oversight and advice to the delegate and must provide appropriate supervision to ensure that the act is performed properly and safely.

This is a summary of the bylaw only. A physician who is considering delegating an activity to a registered nurse should review and be familiar with the bylaw requirements before doing so.

Amendment to buprenorphine bylaw
Bylaw 19.1

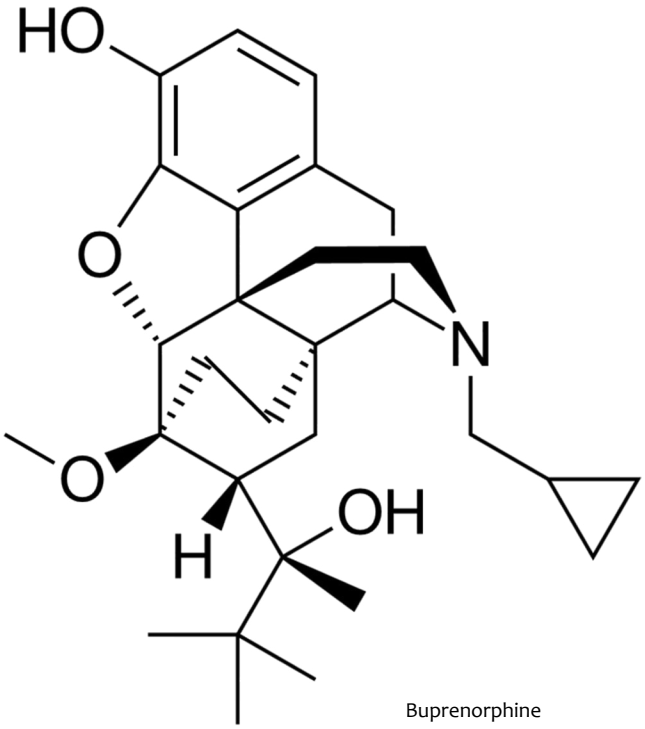
Until the buprenorphine bylaw was amended, it applied to prescribing buprenorphine for pain control as well as prescribing buprenorphine for addiction. The amendment means that bylaw 19.1 no longer applies to prescribing of buprenorphine for pain control.

Buprenorphine is a drug covered by the Prescription Review Program so a physician who prescribes buprenorphine must comply with the Prescription Review Program requirements in bylaw 18.1. The bylaw requirements in bylaw 18.1 for prescribing buprenorphine are the same as the bylaw requirements for prescribing opioids, benzodiazepines and other medications in the Prescription Review Program bylaw.

Physicians who prescribe buprenorphine for addiction are required to:

1) have a methadone exemption from Health Canada;
2) spend at least one day with a physician who prescribes buprenorphine as part of that physician's regular practice;
3) participate in at least 6 hours every two years of continuing medical education in addiction medicine; and,
4) sign an undertaking with the College that they will participate in audits of their buprenorphine prescribing and follow the requirements of the bylaw.

This is a summary of the bylaw only. A physician who is considering prescribing buprenorphine for addiction should review and be familiar with the bylaw requirements before doing so.



Buprenorphine

Amendment to marihuana bylaw
Bylaw 19.2

Recent changes to government regulations allow the College to ask licensed marihuana producers about marihuana prescriptions issued by Saskatchewan physicians. That change has made it unnecessary for physicians to provide annual or semi-annual reports in relation to their prescribing of marihuana. The bylaw was amended to remove the requirement that physicians provide such reports to the College.

Physicians who prescribe marihuana should be familiar with the requirements of bylaw 19.2. While the obligation to send reports to the College has been removed, the obligation to retain a separate record of marihuana prescriptions that is available for inspection by the College remains.

College Policies & Guidelines - New & Updated in 2015

Stay informed! Look for updates on the CPSS website and in DocTalk!

Several years ago the Council began the process of reviewing the College's existing policies and guidelines. Policies and guidelines that were no longer relevant were rescinded. Policies and guidelines which were relevant were updated. New policies and guidelines were developed to address gaps in the existing documents.

All of the policies and guidelines in existence when the review began have either been updated or rescinded. A number of new policies and guidelines have been developed.

The College's policies and guidelines set out expectations or guidance for physicians. It is important that physicians are aware of the policies and guidelines which pertain to their practices. All policies and guidelines which the College has developed are available at the College's website http://www.cps.sk.ca .

The following policies and guidelines have been either updated or developed in the past year:

Policies

Certifying Illness

- Provides guidance to physicians who are asked for reports relating to a patient's ability to return to work and what measures an employer should take to accommodate limitations on a patient's ability to perform work.

Clinics that Provide Care to Patients who are not Regular Patients of the Clinic

- Replaces the College's previous document on walk-in clinics and describes the College's expectations of physicians who provide episodic care to patients.

Contents and Access to Information in Physician's College Files

- Describes the right of physicians to examine the contents of files which the College maintains about them, and situations where such access may be refused.

Medical Practice Coverage

- Describes the expectation that physicians will provide 24-hour coverage of patients currently under their care and how that expectation can be met.

Public Access to Council Meetings

- Describes public access to observe Council meetings and procedure for Council to meet in camera.

Role of Legal Counsel, Investigation of Unprofessional Conduct or Lack of Skill and Knowledge

- Describes the role of legal counsel when investigating cases potentially relating to discipline matters.

Standards for Primary Care

- Describes the expectations of physicians who provide primary care. It applies to physicians in all practice settings.

Scope of Practice Change

- Describes the College's expectations of physicians who intend to make a scope of practice change by changing the patients the physician cares for, the procedures performed, the treatments provided or the physician's practice environment.

Guidelines

Confidentiality of patient information

This document provides a comprehensive guide to confidentiality of patient information, including situations where physicians do not require patient consent to disclose patient information and situations where physicians are required to breach patient confidentiality

Patient-Physician Communication Guidelines using Electronic Communication

This document provides guidance to physicians who use FAX or email to communicate patient information and guidance on physicians' use of social media.

Patients who Threaten Harm to Themselves or Others

This provides guidance to physicians dealing with a situation where a patient threatens harm to themselves or others.

Saskatchewan Methadone Guidelines

This document summarizes the College's expectations of physicians who seek an exemption from Health Canada to permit them to prescribe methadone and establishes standards for prescribing methadone .

Transfer of Patient Records

This document was developed jointly by the College and the SMA and provides guidance to physicians who receive requests to transfer paper or electronic patient records to patients, third parties or other physicians.

Standards for Continuing Education

Revalidation and Maintenance of Membership

Saskatchewan physicians who are licensed on a full, provisional or special licence are required to enroll in a continuing professional learning program (5-year cycle) with the **Royal College of Physicians and Surgeons of Canada** (RCPSC) or the **Canadian College of Family Physicians of Canada** (CCFPC) in order to renew their professional registration for the upcoming year. This process is known as ***revalidation***.

During completion of your on-line registration renewal form you will be required to indicate the start and end dates of your current learning cycle. If you are not enrolled in a program or do not have a learning cycle you will not be able to complete your registration renewal.

Current members of the CCFPC and individuals who hold FRCP or FRCS designations with the RCPSC will need to **meet the requirements** of **Mainpro** or **Maintenance of Certification** at the end of their cycle, and provide proof that this has been done. If you are not currently enrolled in either Mainpro or Maintenance of Certification, you will need to **enroll prior to applying to renew your licence** for the upcoming year.

Non-members of the CFPC can enroll in Mainpro and have their Continuing Medical Education (CME) activities tracked in the same way as members have their CME activities tracked. *Physicians who don't hold fellowship at the RCPSC* can enroll in the Maintenance of Certification program and track their CME activities in their on line account.

At the completion of your learning cycle, you will be required to **provide the CPSS with a certificate** from your program confirming that you successfully completed your learning cycle. The certificate may be obtained from the program website (Mainpro or Maintenance of Certification) and must be submitted during registration renewal.

You are encouraged to attend to this matter promptly. Failure to comply and enroll may result in a refusal by the Registrar to renew your registration. Please be aware that indicating that you are enrolled in a program when you are not may result in disciplinary action.

You must ensure that you meet the minimum credit requirements as established by the program in which you are enrolled or fees will be imposed as outlined below.

Fees for Non-Compliance

The Registrar's Office will administer fees to ensure cost recovery from physicians who fail to meet CME requirements and who fail to comply with regulatory bylaw 5.1.

Contact information for program enrollment is as follows:

The College of Family Physicians of Canada
2630 Skymark Avenue
Mississauga, ON L4W 5A4

1-866-224-8104
or toll free 1-800-387-6197 ext 204
http://www.cfpc.ca

The Royal College of Physicians and Surgeons of Canada
Department of Professional Affairs
774 Echo Drive
Ottawa ON Canada
K1S 5N8

1-613-730-6243
or toll free 1-800-461-9598
http://rcpsc.medical.org

Barb Porter
Director of Physician Registration

5.1 Standards for Continuing Education and Maintenance of Membership:

a. *A physician who fails to enroll in Mainpro or Maintenance of Certification, or who fails to maintain enrollment in Mainpro or Maintenance of Certification as required by regulatory bylaw 5.1, will be required to pay a fee of $500;*

b. *A physician who has failed to enroll in Mainpro or Maintenance of Certification, or who fails to maintain enrollment in Mainpro or Maintenance of Certification as required by regulatory bylaw 5.1 and who is required to comply with any of the conditions in regulatory bylaw 5.1(h) shall, in addition to the $500 fee in paragraph (a), be required to pay a fee of $500;*

c. *A physician who has enrolled in Mainpro or Maintenance of Certification as required by bylaw 5.1, but who has failed to meet the requirements of the program, or has failed to provide the evidence required by paragraph (d) (iv) and who is required to comply with any of the conditions in regulatory bylaw 5.1(h), shall be required to pay a fee of $500.*

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

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

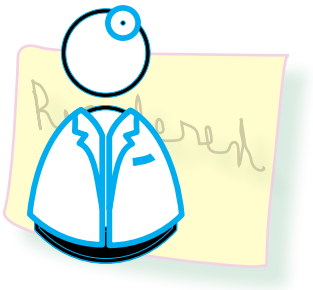
Registration Renewal

Physician Licences

Registration renewal is approaching very quickly. You will soon be receiving your registration renewal notice in the mail.

You are encouraged to follow the instructions in the letter to promptly renew your registration for the period of December 1, 2015 – November 30, 2016.

All registration renewals are due **no later than** **November 1, 2015** to ensure that College staff has sufficient time to process renewal for all physicians. Act promptly to ensure that there is no interruption in your licence and to avoid additional fees for restoration to the register.



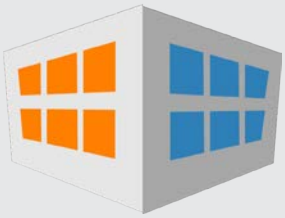
Medical Corporation Permit Renewal

Medical Corporation renewal is approaching very quickly. Physicians with medical professional corporations will soon be receiving their renewal notice in the mail.

This year the College is pleased to introduce an option for **online medical corporation renewal**. You are encouraged to follow the instructions in the renewal notice letter to promptly renew your medical corporation registration for the period of January 1, 2016 – December 31, 2016.

In order to renew online, you will require:

- Access to a **computer**;
- An **email account**. If you do not have one you should create an email account now;
- **Credit card** for payment of fees – we accept Visa or Master Card;
- Your User ID for corporation renewal - this will be provided in the letter that the College provides to you;
- Your **personal account password for corporation renewal** - this will be provided in the letter that the College provides to you.



DUE DATE

All medical corporation renewals are due no later than **November 1, 2015**, to ensure that College staff has sufficient time to process renewal for all medical professional corporations. Act promptly to ensure that there is no interruption in your medical professional corporation and to avoid additional fees for restoration to the register.

Entry Standards for the Selection of SIPPA Candidates

The **Saskatchewan International Physician Practice Assessment** (SIPPA) program assesses International Medical Graduates on their education and clinical ability before allowing them to practice medicine in the province. This made-in-Saskatchewan program is offered in January, May and September each year and can assess up to 72 physicians annually.

In Fall 2014, the Ministry of Health coordinated a Rapid Process Improvement Workshop focused on improving the recruitment process for family physicians.

One recommendation from the workshop was to consider increasing entrance requirements for candidates, which would require them to pass the Medical Council of Canada Qualifying Examination Part I (MCCQE I) prior to being granted entry to the program. Research from the Medical Council of Canada[1] suggests that the MCCQE I is a strong predictor of success through practice ready assessments. An independent review of the SIPPA program by an external statistician indicates that the greatest single predictor of performance was successful completion of the MCCQE I (report available on request).

Following consultation with stakeholders, the motion to require potential candidates to pass the MCCQE I prior to applying to SIPPA was brought forward at the June 19, 2014, College of Physicians and Surgeons Council meeting, where it was approved. It will take effect in January 2016. We believe this will improve the success rate of International Medical Graduates going through the SIPPA process, while ensuring that recruitment efforts are focused on those who are more likely to be successful through licensure and assessment.

Jon Witt, MD
Medical Director, SIPPA Program
www.usask.ca/cme/SIPPA

[1] *De Champlain, A., Streefkerk, C., Tian, F., Roy, M., Qin, S., Brailovsky, C., Rainsberry, P., Allen, T., Slade, S., 2014. Predicting Family Medicine Specialty Certification Status Using Standardized Measures for a Sample of International Medical Graduates Engaged in a Practice-Ready Assessment Pathway to Provisional Licensure; available at: http://mcc.ca/wp-content/uploads/Reports-Predictive-Validity-Journal-Article.pdf*

Continuing Medical Education

Professional Development Opportunities

The College website features a section on its home page 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 period of 5 years 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, although some are not.

For the lastest list of upcoming continuing medical education opportunities, please see the News & Events section on our website homepage at cps.sk.ca and click on **Upcoming Conferences and Calls for Abstracts.**

Informed Consent

The Complaints Resolution Advisory Committee (the Committee) has noticed an increasing number of complaints relating to the lack of consent for medical treatment. This is a worrying trend and can lead to College complaints or even civil litigation. Two documents which address obtaining informed consent from a patient, ***Determining Capacity to Consent*** *and* ***Policy Statement: Informed Consent***[1]*, are available on the College's website.*

Introduction

Physicians have both an ethical and a legal responsibility to take reasonable steps to obtain informed consent from patients before examining or treating them.

The Canadian Medical Association's **Code of Ethics** is part of the College's bylaws. The Code of Ethics establishes some ethical expectations related to informed consent.

21. *Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.*
22. *Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.*
23. *Recommend only those diagnostic and therapeutic procedures that you consider to be beneficial to your patient or to others. If a service is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law.*
24. *Respect the right of a competent patient to accept or reject any medical care recommended.*

CASE STUDY

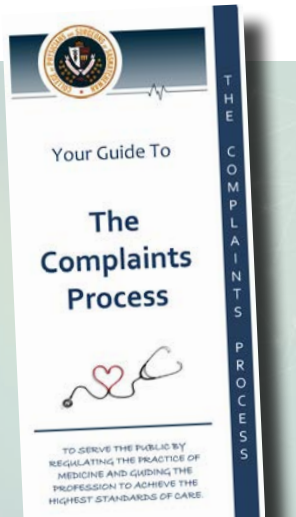
An 82- year -old male farmer was admitted for surgery for colon cancer. The patient understood that he was going to have a lump removed from his stomach and signed the standard hospital consent.

The day after the surgery, the patient asked the surgeon why he had a hole in his abdomen. The surgeon explained that he had performed a colostomy and sutured the end of the intestine to his abdomen. He explained that the patient would now defecate through this hole and into a bag attached to the end of the intestine.

The patient was extremely angry about the colostomy and stated that he would rather have died than have a colostomy. The patient subsequently complained to the College alleging that the surgeon did not explain what he was going to do and that he had not consented to a colostomy. The patient maintained that if he had been informed about the possibility of a colostomy he would have foregone the procedure; at his age he was not scared of dying.

Comment: The Committee found that fully informed consent for the procedure, including the colostomy, was not obtained and was critical of the surgeon. The Committee further advised that a signed standard hospital consent is not a substitute for a documented consent discussion, during which the patient must be provided with the opportunity to ask questions and decline the procedure, or aspects of the procedure, if they so wish.

A physician must "respect the right of a competent patient to accept or reject any medical care recommended", irrespective of whether a physician believes that they are acting in the patient's best interest.



The Elements of Obtaining Informed Consent

Obtaining consent to treatment requires a discussion between the physician and the patient. The responsibilities of the physician include:

1. Disclosing the nature of the proposed procedure, any material risks and any special or unusual risks attendant related to the treatment;

2. Discussing options to the procedure, including the risks and benefits of doing nothing;

3. Answering any specific questions posed by the patient as to the risks involved.

4. Informed consent is required for all patient examinations or treatment, including prescribing medications, developing a plan of treatment or a surgical intervention.

What is a Material Risk?

1. The more frequent the risk occurs, the more likely that risk is material;

2. The more serious the consequences of the risk, the more likely it must be disclosed (i.e. the risk involves paralysis or death);

3. If the physician is aware of particular circumstances that would make a risk particularly important to the patient, it is more likely that the risk must be disclosed.

Communicating with the patient

A physician has a duty to take reasonable steps so as to be relatively satisfied that the patient understands the information being provided, particularly where there may be language difficulties or emotional issues involved.

Determining Capacity to Consent describes the steps which a physician should follow in determining capacity. In general those steps involve:

Step 1
Consider whether in the context of a particular clinical situation a patient is capable of providing informed consent.

Step 2
In order for a patient to have the capacity to make a decision respecting a proposed treatment, the patient must be able to understand the information that is relevant to making the decision.

Step 3
If the person is able to understand the information, you must go on to assess whether the person is able to appreciate the reasonably foreseeable consequences of a decision.

Delegating the Responsibility to Obtain Informed Consent

A physician is responsible to ensure that informed consent is obtained so, while that can be delegated to another physician or other health care professional, the physician remains responsible if that person does not take the necessary steps to obtain an informed consent. A physician who delegates responsibility to obtain informed consent should be confident that the person to whom the task is assigned is able to adequately perform that task.

Situations where particular care should be taken

There are certain situations where a physician must take additional care to obtain informed consent. That most frequently arises if a patient is immature, or vulnerable, or is not fully conversant in English. One method used by many physicians to assess whether a patient has fully understood the information provided is to ask the patient to repeat what they have been told using language that is appropriate for them. If a patient is able to do that, it is a significant indication that the patient has understood the information. If the patient is unable to do that, additional care may be required to obtain informed consent, or the patient may not be capable of providing informed consent and it may be necessary to obtain consent from a substitute decision-maker who is authorized to consent on behalf of the patient.

CASE STUDY

A 62 year old male patient suffered from unstable hypertension and chronic obstructive pulmonary disease. He also suffered an acute myocardial infarction nine weeks previously and was treated by stenting the two main coronary arteries. He took low dose aspirin postoperatively.

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 have been no discipline matters to report since the last Newsletter.

He was admitted to hospital with acute left femoral artery thrombosis. On admission, since he refused interventional treatment, only medical treatment with heparin, thrombolysis medication and vasodilating agents was provided. The treatment was unsuccessful and eventually necrosis of the distal part of his left leg developed. The consulting surgeon recommended left leg amputation. The patient consistently refused the proposed treatment despite warning of the possible lethal outcome. As the infection progressed, the patient became delirious and was no longer able to communicate intelligibly. His wife asked the surgeon to perform the operation regardless of lack of consent from the patient and complained to the College when the surgeon declined her request.

Comment

The Committee reviewed the surgeon's response to the complaint and the patient's hospital record, and found that the surgeon had acted appropriately. Consent discussions with the patient were fully documented, including the results of an independent capacity assessment. It was ascertained that the patient was capable of understanding the consequences of his refusal to have his leg amputated and appreciated the limitations of continued medical treatment. Despite the patient no longer being able to communicate his wishes, he had been very clear that he did not consent to amputation of his leg, under any circumstances, and his wife's request did not override his known wishes.

Consent must be free of coercion

Consent to treatment is only valid if the patient freely consents, without coercion. That can be a particular concern if the patient is dependent on others, such as with dependent children and older adults. Physicians who seek informed consent from such patients should be particularly careful to ensure that the patient has not been coerced to make a treatment decision.

It is important for physicians to understand that a patient's signature on a consent form may be evidence of informed consent, but is not informed consent by itself. If the patient did not receive the information necessary to provide informed consent, or did not understand that information, informed consent has not been given.

Substitute Decision-Makers

If a patient does not have capacity to consent, consent must be obtained from a substitute decision-maker.

The **Health Care Directives and Substitute Health Care Decision Makers Act**[2] is Saskatchewan legislation which establishes who is entitled to make a health care decision on behalf of a patient who is not competent to do so.

If a patient has signed a health care directive, that will generally state who is authorized to make health care decisions on the patient's behalf. If there is no health care directive, the legislation sets out who has priority to make health care decisions – first priority is a spouse, second an adult child, etc. If a health care decision is to be made by a substitute decision-maker, that person should receive all of the information which would have been given to the patient, if the patient had been capable of making the health care decision.

Other Sources of Information

- The Canadian Medical Protective Association has a comprehensive guide to Informed Consent – ***Consent: A Guide for Canadian Physicians.*** [3]
- ***The Basics of Informed Consent,*** Dr. Lorraine LeGrand Westfall, FRCSC, CSPQ, Canadian Medical Association website. [4]

[1] Determining Capacity to Consent and Policy Statement: Informed Consent, College of Physicians and Surgeons of Saskatchewan Website https://www.cps.sk.ca/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Policies_page.aspx?Legislation_PoliciesCCO=1

[2] The Health Care Directives and Substitute Health Care Decision Makers Act is available at the Queen's Printer's website http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/H0-001.pdf

[3] Consent: A Guide for Canadian Physicians Canadian Medical Protective Association, https://www.cmpa-acpm.ca/en/handbooks/-/asset_publisher/TayXf91AzWR2/content/consent-a-guide-for-canadian-physicians

[4] The Basics of Informed Consent, Dr. Lorraine LeGrand Westfall, https://www.cma.ca/Assets/assets-library/document/en/practice-management-and-wellness/2015-Chapter5_Medical_law-e.pdf#search=The%20basics%20of%20informed%20consent

New Standards for Infection Prevention and Control in Saskatchewan

On July 7, 2015, the Registrar of the College, Dr. Karen Shaw, circulated a document, **"Infection Prevention and Control for Clinical Office Practice"** to all physicians in Saskatchewan. The circulated document is an Ontario Public Health document developed by its Provincial Infectious Disease Advisory Committee (PIDAC). Public Health Ontario has approved the CPSS adopting its document and Council has approved in principle the adoption and adaption of this document for use by Saskatchewan physicians in managing infection prevention and control practice (IPAC) within their offices.

The document was circulated in its Ontario centric form, pending adaptation for Saskatchewan circumstances, as a "heads up" to the profession with the expectation that physicians and their office staff ensure that infection prevention and control practises in their offices and clinics meet the required standard. Once the adapted document has been adopted by Council it shall be the standard required for all physician offices and clinics in Saskatchewan. In the interim copies of the Ontario document can be accessed at http://www.publichealthontario.ca/en/BrowseByTopic/InfectiousDiseases/PIDAC/Pages/Infection-Prevention-and-Control-for-Clinical-Office-Practice.aspx.

Also to be found at the link above is a list of the ***PIDAC Top Five High Risk Practices*** to watch out for and reproduced below for ease of reference.

...the expectation is that physicians and their office staff ensure that infection prevention and control practises in their offices and clinics meet the required standard...

Practice 1: Using lancets, insulin pens and glucometers

- Lancets must be single-use only.
- Lancet hubs (hold the lancet) must be single-use only.
- Insulin pens must be single-patient-use only.
- Blood glucose monitoring devices (glucometers) and other blood-testing devices should not be shared between patients.
- If glucometers must be shared, they must be designed for multi-patient use and cleaned and disinfected after each use, as per the manufacturer's recommendations. If the manufacturer does not specify how the device should be cleaned and disinfected, the device must not be shared.

Practice 2: Blood collection tube holder

- Single-use blood collection tube holders are preferred.
- If a blood collection tube holder must be reused, it must be cleaned and disinfected after each use as per manufacturer's instructions.

Practice 3: Using tonometers

- Tonometers and other ophthalmologic equipment that touch the eye must undergo high-level disinfection (for example, glutaraldehyde) between patients. Cleaning with alcohol is not sufficient.

Practice 4: Using syringes, needles and vials for intramuscular/intravenous medications and vaccines

- All needles must be single-patient-use only.
- All syringes must be single-patient-use only.

Dr. Micheal Howard-Tripp
Deputy Registrar

- Single-use vials are preferred and should be used only once on a single patient.
- When it is necessary to use a multi-dose vial, never re-enter the vial with a used needle or used syringe.
- Once a medication is drawn up from a vial, the needle should be immediately withdrawn from the vial. A needle should never be left in a vial to be attached to a new syringe.

Practice 5: Maintaining sterilization logs

Note: Before sterilization, meticulous cleaning must first be done

- Sterilization logs, including indicators documenting successful sterilization, are required for all office/desktop autoclaves.
- Logs must document the time, temperature and pressure (physical indicators) at the completion of each load.
- An external chemical indicator must be used with every packaged item to indicate that the item has been sterilized.
- An internal chemical indicator must be placed inside every packaged

item to be sterilized.
- Daily testing of biological indicators (BI) is required when a sterilizer is in use.
- SCOPE disinfection and sterilization logs must be kept, including test strip monitoring, concentration and exposure time, and disinfectant temperature for automated endoscope reprocessors (AER).

Since the start of their IPAC program in 2007/2008, the Alberta College of Physicians and Surgeons has identified **10 common deficiencies:**

- Lack of training for staff doing the reprocessing and/or no written procedures for staff to follow
- Medical device was cleaned in patient care areas with patients present
- Not using biological indicators in autoclaves
- Not logging autoclave cycles – time, temperature, and pressure
- Manufacturers' instructions for cleaning and sterilizing medical device were not available on site
- Reprocessing staff were not wearing required Personal Protective Equipment (PPE)
- Not wrapping medical devices in approved wrap for autoclaving
- Not using chemical indicators in autoclaves (on the outside or the inside of the packaging)
- If using a chemical sterilant, not using quality control checks on the solution in use
- Improper care of cleaning accessories (such as brushes) which must also be disinfected

Many items in the above lists would appear to be common sense and just good practice. Paying attention to the small details, such as replacing and disinfecting the light used for illumination on disposable speculums between each patient would improve the level of care, and safety, for patients attending community clinics and offices.

Would ***your*** office or clinic **PASS** an infection prevention and control inspection?

DIQA Role in Facility Accreditation

ACMI providing accreditation recommendations for private Health Facilities

In addition to the regular business of performing medical imaging physician audits, the College's **Advisory Committee on Medical Imaging** (ACMI) has been designated the "Accreditation Program Operator", by the Ministry of Health, to inspect and make recommendations on Health Facility License applications for private CT and MRI facilities. This process, coordinated by the **Diagnostic Imaging Quality Assurance Program (DIQA)** at the College of Physicians and Surgeons of Saskatchwan, involves an on-site visit to the facility, followed by a review of cases to assess image quality. Based on the outcome of those reviews, the ACMI makes a recommendation, to the Ministry, as to whether the facility meets the standards required for licensure. To date, two MRI facilities and one CT facility have been required to undergo this type of inspection.

Lab QA Shared Standards and Assessors a Possibility

Agreements Reached in Western Canada for Diagnostic Accreditation: WCDAA

The Laboratory Quality Assurance Program (LQAP) has been collaborating with the western provinces to develop the Western Canada Diagnostic Accreditation Alliance (WCDAA). The purpose was to look for opportunities in laboratory accreditation. It was evident that, assessors could be shared and that a common set of standards could be used for laboratory assessments in Western Canada. There was also agreement to develop overarching collaboration to: assist with development and maintenance of the standards, assist with provision of consistent training for assessors and to use cross jurisdictional assessors.

A gap analysis of provincial standards was completed and it was determined that the most recently developed standards would be used as the common standard. These were developed by the College of Physicians and Surgeons of Alberta, are evidence based, reference best accepted practices, are ISQua accredited and ISO compliant.

The WCDAA currently maintains the following standards for the assessment of medical laboratories: General, Anatomic Pathology, Chemistry, Fertility Assessment, Flow Cytometry, Hematology, Microbiology, Molecular Diagnostics, Genetics and Transfusion Medicine.

LQAP is very pleased to be part of this WCDAA and will be using the new standards in the spring of 2016.

Fentanyl

Effective Analgesic for Severe Chronic Pain But Potentially Lethal When Misused or Prescribed Inappropriately

Overdose deaths from fentanyl have been reported as of epidemic proportion. The current CCENDU bulletin from the Canadian Centre on Substance Abuse states that:

- Between 2009 and 2014, there were at least **655 deaths** in Canada where fentanyl was determined to be a cause or a contributing cause. This represents an average of **one fentanyl-implicated death every three days** over this time period. This figure is likely an underestimate.

- Between 2009 and 2014, there were at least **1,019 drug poisoning deaths** in Canada where post-mortem toxicological screening indicated the presence of fentanyl. More than half of these deaths occurred in the latter two years, 2013 and 2014. On average, this represents almost **two deaths every three days** over these two years. This figure is likely an underestimate.

Many of these deaths have occurred as a result of the misuse of fentanyl originating from illicit sources such as clandestine labs within and outside of Canada. However, some of the fentanyl of abuse comes from prescriptions that are handed out by physicians. Additionally, as a result of the high potency of fentanyl, there has been a significant number of deaths to patients who have been prescribed this drug for severe pain.

The medical community needs to be aware of the illicit misuse of this drug. For this reason, a review of appropriate prescribing guidelines for this drug is important.

The information in the tables and excerpts below is from **The Canadian Guideline for the Safe And Effective Use of Opioids for Chronic Non-Cancer Pain** (http://nationalpaincentre.mcmaster.ca/opioid/) and deals with the the effective prescribing and use of fentanyl. It can be used by physicians in an effort to minimize the risk of harm from its use.

Fentanyl is a second line drug behind morphine, oxycodone, and hydromorphone for severe pain.

By Doug Spitzig, Pharmacist Manager Prescription Review Program

Safety Issues to Consider When Selecting Opioids

Note: This table highlights safety issues for specific agents; for comprehensive information, prescribers should consult the individual drug monographs

Fentanyl	1) Before starting fentanyl, obtain a complete history of opioid use within the last 2 weeks to ensure the patient is fully opioid tolerant. Tolerance can be assumed if the patient is on a moderate, stable dose of a strong opioid, i.e., a total daily dose of at least 60–90 mg/day morphine equivalence daily for at least 2 weeks. This dose should be scheduled rather than p.r.n. (at least b.i.d. for CR or q.i.d. for IR). See Supporting Evidence item 4.) 2) Do not switch from codeine to fentanyl regardless of the codeine dose, as some codeine users may have little or no opioid tolerance. 3) Maintain the initial dose for at least 6 days: use extra caution with patients at higher risk for overdose, e.g., elderly, patients on benzodiazepines. 4) Advise the patient as follows: • Be alert for signs of overdose: (e.g. slurred or drawling speech, emotionally labile, ataxia, nodding off during conversation or activity) if detected, remove the patch and seek medical attention. • Apply as prescribed: do not apply more than one patch at a time or change more often than directed. • Avoid heat sources such as heating pads, electric blankets, saunas, heated waterbeds, hot baths, sunbathing. • Dispose of patches securely: a used patch contains large amount of fentanyl and could be dangerous to others. e.g., children or abusers could "recycle" by cutting into small pieces and sucking the pieces.

R 08 Supporting Evidence

4. Fentanyl

4.1 Fentanyl can cause significant cognitive impairment in non-tolerant opioid patients.

Experimental studies in volunteers have found that cognitive impairment caused by acute intravenous fentanyl administration was greater than that caused by moderate doses of alcohol (Zacny 1992, Schneider 1999).

4.2 Fentanyl has contributed to numerous overdose deaths.

Fentanyl was a **contributing cause in 100 overdose deaths** in Ontario between 2002 and 2004. In 54 of the deaths, fentanyl intoxication was the sole cause of death. Deaths occurred from both therapeutic and illicit use (Martin 2006).

Fentanyl-laced heroin appeared simultaneously in various parts of the United States, beginning in 2005. In Chicago, in the first half of 2006, 55 drug overdose cases (resulting in 12 deaths) have been attributed to fentanyl-laced heroin (Fodale 2008). Fentanyl toxicity is related in 92% of fentanyl-related deaths and is attributed partially due to cytochrome P450 3A4*1B and 3A5*3 variant alleles, resulting in variable fentanyl metabolism: the homozygous CYP3A5*3 have impaired metabolism of fentanyl (Fodale 2008). In July 2005, the FDA issued a public health advisory calling attention to an increase in the number of fentanyl patch-related overdoses and deaths, particularly among patients ignoring the product's boxed warnings and instruction for use (Federal Drug Administration 2007).

R13. Discussion

1. Switching Opioids

Because of unpredictable and incomplete cross-tolerance from one opioid to another, **suggested** initial doses of the new opioid are as follows:

If previous opioid dose was:	Then, SUGGESTED NEW OPIOID DOSE IS:
High	50% or less of previous opioid (converted to morphine equivalent)
Moderate or low	60–75% of the previous opioid (converted to morphine equivalent)

If switching to fentanyl, see Appendix B-8.1: Oral Opioid Analgesic Conversion Table.

There is no evidence to support the practice of combining different types of opioids.

Appendix B-8.1
Oral Opioid Analgesic Conversion Table

- The table is based on oral dosing for chronic non-cancer pain.
- The figures are based on the Compendium of Pharmaceutical & Specialties (Canadian Pharmacists Association 2008) and a systematic review by Pereira (2001). Wide ranges have been reported in the literature.
- These equivalences refer to analgesic strength of oral opioids, and not psychoactive effects or effectiveness in relieving withdrawal symptoms.

1. **Equivalence to oral morphine 30 mg:**

Table B Appendix 8.1
Oral Opioid Analgesic Conversion Table

	Equivalence to oral morphine 30 mg	To convert oral morphine equivalent, multiply by:	To convert from oral morphine, multiply by:
Morphine	30 mg	1	1
Codeine	200 mg	0.15	6.67
Oxycodone	20 mg	1.5	0.667
Hydromorphone	6 mg	5	0.2
Meperidine	300 mg	0.1	10
Methadone and Tramadol	Morphine dose equivalence not reliably established		

2. Equivalence between oral morphine and transdermal fentanyl:

Transdermal fentanyl* High Moderate or low	60–134 mg morphine = 25mcg/h
	135–179 mg = 37 mcg/h
	180–224 mg = 50 mcg/h
	225–269 mg = 62 mcg/h
	270–314 mg = 75 mcg/h
	315–359 mg = 87 mcg/h
	360–404 mg = 100 mcg/h

** Formulations include 12, 25, 50, 75 and 100 ucg/hour patches, but the 12 ucg/hour patch is generally used for dose adjustment rather than initiation of fentanyl treatment.*

In addition to following the guideline when prescribing in cases where there may potential risk such as:

- Patients with history of opioid misuse
- Patients in an environment where others living with them are at risk of misuse
- Others that are unknown to the prescriber who may have access to the drug

In these cases, a patch for patch exchange at the pharmacy or the used patches are put on a sheet of paper and returned to the pharmacy prior to further dispensing would also be helpful to prevent misuse.

An **Opioid Patch Exchange Disposal Tool** can be found under Pain Management at the Rx Files website: **Rxfiles.ca**

Even though the recommendations from the guideline are for chronic non-cancer pain, most of them pertain to the prescribing of Fentanyl for all indications.

Have you been practicing medicine in Saskatchewan for 40+ years?

Senior Life Membership

A **Senior Life** member is a member of the College of Physicians and Surgeons of Saskatchewan who has been fully licensed to practice in Saskatchewan for forty years.

For the purpose of Senior Life status, service in the Armed Forces has been accepted as meeting that requirement.

The Council recently expanded eligibility to include physicians who left Saskatchewan to obtain postgraduate training and then returned to Saskatchewan when that training was completed. That means that some physicians who were previously not eligible to receive a Senior Life designation are now eligible.

Senior Life members are honoured at Council's Christmas banquet which will be held on Friday November 20, 2015, and receive a certificate and commemorative plaque depicting 100 years of medicine in the province of Saskatchewan.

Inactive Senior Life members are entitled to inactive registration at no cost.

*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 received your Senior Life designation, please contact:*

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

Dr. Dennis A. Kendel Distinguished Service Award

This prestigious award is 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.

WHO WILL BE the 2016 recipient?

Missed the 2015 deadline?
Nominations are already being accepted for 2016.
Get your nomination in early!

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.

Council Elections

Call for Nominations

Nominations are being sought in 6 of the 10 Electoral Districts for colleagues to serve on the Council of the College.

Elections for members of Council for the Electoral Divisions 2 (Keewatin Yatthe & Prairie North), 3 (Saskatoon), 4 (Sunrise), 6 (Five Hills), 7 (Regina-Qu'Appelle), and 8 (Sun Country) will take place as defined in The Medical Profession Act, 1981 and College bylaws. The current Councilors whose terms expire at the end of 2015 are:

Dr. Mark Chapelski (Keewatin Yatthe/Prairie North)
Dr. Grant Stoneham (Saskatoon)
Dr. Oluwole Oduntan (Sunrise)
Dr. Daniel Glaeske (Five Hills)
Dr. James Carter (Regina Qu'Appelle)
Dr. Edward Tsoi (Sun Country)

These physicians may be re-elected for another three-year term or you may wish to elect a new representative….. the choice is yours……. make your voice heard!

Shortly, if not already, you will be receiving an email from the College requesting nominations for your electoral division and instructions on the process required and eligibility. The closing date for receipt of **nominations is October 27, 2015**. If there is more than one candidate in a division then a secret ballot will be held shortly after with the closing date for **receipt of your vote November 24, 2015**. Ballot counting will take place the day after. If there is only one nomination in a district then that person will be acclaimed. All successful members elected in each division will be announced to the membership shortly thereafter.

CONSIDER
AN ENRICHING EXPERIENCE
AS A MEMBER OF COUNCIL

For information on
the commitment required
to be a Councilor,
or the requirements to run for
next election,
contact Sue Robinson at
sue.robinson@cps.sk.ca

Newly Appointed Public Member for Council

Congratulations to **Charles Arthur (Art) Battiste** who has been appointed by the Ministry of Health as the new public member of Council.

Art has also recently been appointed as the Coordinator of Programming for the Saskatoon Seniors for Continued Learning and the College of Arts and Sciences at the University of Saskatchewan. He is a retired teacher, civil servant, businessman, and community volunteer.

He will be replacing Joanna Alexander, longtime board member who served for a period of 6 years. Joanna will continue on in an advisory capacity for the DocTalk Publication Advisory Committee.

Dosing Guideline for Antibiotic Prophylaxis for Surgery: A Helpful Tool for Physicians

A new **physician support tool** is available for Saskatchewan surgeons to use as a quick reference on appropriate dosing for surgical antibiotic prophylaxis. Antibiotic prophylaxis prior to surgery is one of the five components of the Surgical Site Infection (SSI) Prevention Bundle, an evidence-based package of care processes that can reduce SSIs.[1]

The SSI Prevention Bundle is endorsed by the *Canadian Patient Safety Institute / Safer Healthcare Now!* and employed in a number of Canadian provinces, including Alberta, British Columbia, and Ontario.

Why is this important for physicians?

1. **This is best practice.**

The guidelines in the physician support tool (http://www.patientsafetyinstitute.ca/en/toolsResources/Weight-Based-Dosing-Summary-SSI/Pages/default.aspx) specify appropriate evidence-based dosing for surgical antibiotic prophylaxis, and are consistent with the 2013 American Society of Health-System Pharmacists guidelines (the accepted best practice for antibiotic dosing in surgery).[2] The final page of the physician support tool concisely details the studies, including study design and sample size, that form the basis for these guidelines.

2. **Others are dosing according to these guidelines.**

- In Saskatchewan, the Saskatoon, Kelsey Trail, and Sunrise health regions have standardized pharmacy guidelines or order sets in place that specify antibiotic dosing for surgery that are consistent with best practice.
- A number of Canadian healthcare facilities, including Vancouver General Hospital, Sunnybrook Health Sciences in Toronto, Jewish General Hospital in Montreal, and hospitals in Alberta, are dosing for antibiotic prophylaxis according to these guidelines.
- Since 2011, in response to concerns about SSI rates following colorectal surgery, the Mayo Clinic has encouraged weight-based dosing of antibiotics for surgery as one component of their SSI Prevention Bundle. SSI Prevention Bundle implementation resulted in a 5.8 percent reduction in their overall rate of colorectal surgery SSIs from the 2009-2010 baseline.[3]

3. **This is a time-saver.**

This resource allows physicians to consult one place for appropriate dosing for antibiotics for surgery. Many regions do not have up-to-date pharmacy guidelines or order sets that are consistent with these best practice guidelines.

For more information, please contact:

Jocelyn LeBlond
Project Manager, Patient Safety Unit
Ministry of Health
Email: jocelyn.leblond@health.gov.sk.ca
Phone: 306-798-0347

1. *Safer Healthcare Now!," Prevent Surgical Site Infections Getting Started Kit, 2014" [http://www.patientsafetyinstitute.ca/en/toolsResources/Documents/Interventions/Surgical%20Site%20Infection/SSI%20Getting%20Started%20Kit.pdf].*
2. *Bratzler, DW et al (2013). American Journal of Health-System Pharmacy 70: 195-283.*
3. *Cima, R et al (2013). Journal of the American College of Surgeons 216(1): 23-33.*

Photo courtesy Ministry of Health, Government of Saskatchewan

Surgical Site Infection Surveillance in Saskatchewan

A new provincial protocol is helping Saskatchewan make progress on its goal to eliminate preventable surgical site infections (SSIs) resulting from clean and clean-contaminated surgeries (Class I and Class II wounds) by March 2017.

Under the Saskatchewan Infection Prevention and Control Program, an SSI surveillance working group was established consisting of a team lead (Provincial Infection Control Coordinator, Ministry of Health Patient Safety Unit) and a representative Infection Control Professional (ICP) from each regional health authority (RHA). The provincial SSI Surveillance Protocol was established[1], and data collection began in April 2015.

What are we measuring?

- Number of surgical site infections that occur following caesarean section procedures (Class I and Class II wounds).

How are we measuring surgical site infections?

- ICPs collect numerator and denominator data for caesarean sections and submit data to the Provincial Infection Control Coordinator.
- The Saskatchewan SSI Surveillance Protocol contains the required elements of a successful surveillance program, as indicated by the Center for Disease Control and Prevention/ National Healthcare Safety Network (CDC/NHSN).[1]

How are surgeons and other stakeholders notified about SSIs?

- Following confirmation of an SSI, individual surgeons are notified through receipt of an SSI Report for Surgeons and Memorandum for Surgeons.[2]
- Quarterly charts will be posted on the Provincial Strategic Wall and sent to stakeholders in each RHA for posting on regional visibility walls.

For more information, please contact:

Lisa Holovach
Provincial Infection Control Coordinator
Patient Safety Unit
Ministry of Health
Email: lisa.holovach@fhhr.ca
Phone: 306-691-7679

1. *National Healthcare Safety Network, "Procedure-associated Module SSI," (Atlanta, GA: Centers for Disease Control and Prevention, April 2015) [http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html].*

2. *Saskatchewan Infection Prevention and Control Program, Ministry of Health, "SSI Infection" and "SSI Surveillance Tools" (2015) [http://www.saskatchewan.ca/live/health-and-healthy-living/health-care-provider-resources/treatment-procedures-and-guidelines/infection-prevention/infection-prevention-and-control-program].*

Reporting Medical Conditions for Pilot Licences

Excerpts of a letter from D.A. Salisbury, director of Medicine, Civil Aviation, Transport Canada

"Following the recent tragic events of the German Wings accident, the department would like to take the opportunity to reiterate the mandatory obligations of physicians in Canada in accordance with the Aeronautics Act to report any conditions, diseases or treatments that may be incompatible with holding a pilot licence (certificate)."

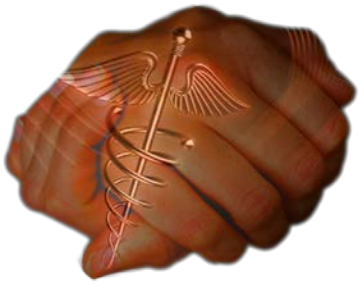
"When a report is received by the department, Transport Canada's Civil Aviation Medicine Branch will investigate each report and determine the application of the medical standards of fitness outlined in the Canadian Aviation Regulations based on the results of our investigation and not just the contents of the report. Please rest assured that such reports viewed by fellow physicians are treated with the same professional standards of care and regard for privacy as any other interaction in health care."

For more information:
1 (800) 305-2059

6.5 (1) Where a physician or an optometrist believes on reasonable grounds that a patient is a flight crew member, an air traffic controller or other holder of a Canadian aviation document that imposes standards of medical or optometric fitness, the physician or optometrist shall, if in his opinion the patient has a medical or optometric condition that is likely to constitute a hazard to aviation safety, inform a medical adviser designated by the Minister forthwith of that opinion and the reasons therefor.

Medicare and the 1962 Saskatchewan Doctors' Strike: A Survey Seeking your Memories of this Era

Submitted by: Julia Adamson, Saskatchewan Gen Web



It is quite natural that Canadians used to medicare are bringing up the controversy regarding the United States Obamacare program in their conversations. It is an interesting time, observing the reactions, positive or negative that Americans are having with these new insurance policies.

We, as Canadians may indeed be wondering how anyone could be against it.

However, in Canada when medicare was introduced, there was in fact, a 23 day strike against Canadian medicare that made international headlines. In contemporary times, few remember the inauguration of medicare, and the strike in health care service that lasted three weeks, a time in the summer of 1962 not to be critically ill.

There is a need to preserve personal memories of these events, especially as those who can remember through these times are now at least in their sixties.

We have initiated an online survey https://eSurv.org?u=Medicare

Please help us, Julia Adamson and Marilyn Decker (rmdecker@sasktel.net) granddaughter of Matthew (Matthias) Anderson reach out to anyone who could contribute by filling in this survey and remembering the events around medicare and the 1962 Doctor's Strike.

Interested in Medical Regulation?

Looking to take on an active role?

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

To find out about current and future committee openings, write to:

OfficeOfTheRegistrar@cps.sk.ca
or call (306) 244-7355

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

Call for French-speaking Health Professionals Registry

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

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Or visit us at: www.cps.sk.ca

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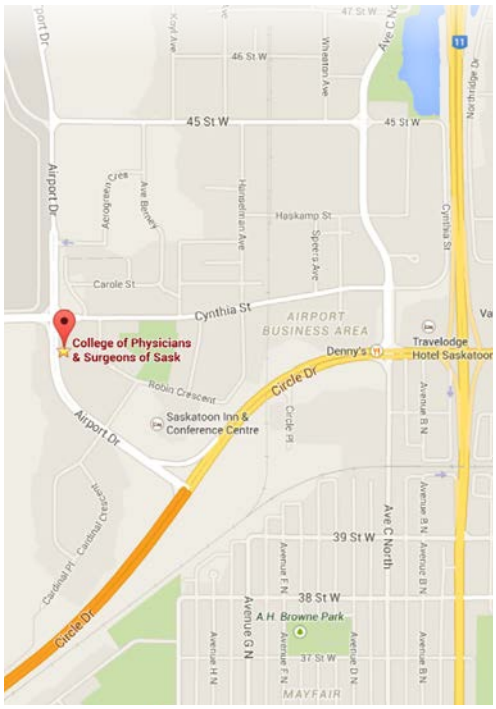

Senior Staff

Dr. Karen Shaw	Registrar
Dr. Micheal Howard-Tripp	Deputy Registrar
Mr. Bryan Salte	Associate Registrar/Legal Counsel
Ms. Barb Porter	Director of Physician Registration Services

OUR DEPARTMENTS

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Saskatoon & area calls	1 (306) 244-7355
Toll Free	1 (800) 667-1668
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Diagnostic Imaging & Lab Quality Assurance (Regina)

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

Prescription Review Program (PRP) and Methadone Program

Direct line	1 (306) 667-4640
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