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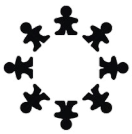

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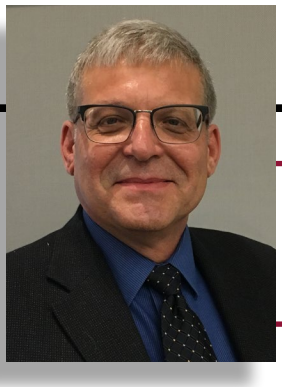
Do you have feedback to provide or a suggestion for an article to include in the next issue of DocTalk?

Submit your ideas & articles by **March 15, 2019** to COMMUNICATIONS@cps.sk.ca



FROM THE PRESIDENT

Dr. Brian Brownbridge
President, CPSS

Perspective on Boundary Violations and Physician Overbilling

Boundary violations and "creative billing" are issues which have come to Council for deliberation repeatedly this year. Both dismay me a great deal because of the profound negative effect to the patient-physician relationship and the public trust that physicians are granted.

Perspective on Boundary Violations

All professionally-governed organizations are under increased scrutiny and pressure by the public and government to reduce sexual boundary violations by their members. Ontario , Quebec, Prince Edward Island and Alberta have all passed legislation that dramatically changes the severity of punishment that physicians will receive if they are found guilty of sexual abuse or sexual misconduct.

In Ontario, if a physician is found guilty of unprofessional conduct due to sexual boundary violations, which can be either or both physical actions and verbal actions, their license will be revoked for a minimum of five years. If a physician has a sexual relationship with a patient within one year of having them as their patient, they can be charged and found guilty and their license to practise will be revoked for a minimum of five years. There is no discretion by the College in Ontario to decide on the vulnerability of the patient in these relationships. This means that if an Emergency physician begins a sexual relationship with a patient who that physician saw 11 months prior in an Emergency Department, they can lose their license for five years if this is reported. If psychotherapy or counselling was involved in the patient-physician relationship, there is no time limit when a sexual relationship is considered acceptable between a physician and a patient.

Alberta has passed three significant changes in Bill 21. The first is permanent revocation of the physician's licence with no ability to apply to have their licence restored for sexual abuse, which is defined by Alberta legislation as actual physician actions involving many aspects of sexual intercourse but also including sexualized touching and sexualized talking. The second requirement is any physician who is found guilty must have this information publicly displayed on a website indeterminately. The third measure in the bill is financial support for psychological support services must be set aside to assist those that have complained to the College of sexual boundary violations by physicians.

Sexual boundary violations are the most severe form of ethical breaches with patients. Even thousands of years ago, the Hippocratic Oath forbade sexual relationships between patient and physicians. The power inequality that occurs in this relationship is far too easy to manipulate to allow these relationships between patients and physicians. Patients who have been sexually abused by physicians are often permanently scarred and may never seek medical care again because of this trauma. The long-term consequences of these relationships cannot be over stated and even in my short time as President have heard of women who suffer the rest of their lives with psychological consequences.

Over the next year, Council will be deliberating on this issue and it is highly likely that most provinces including Saskatchewan will adopt similar penalties and hopefully support programs for those patients who report these violations. Saskatchewan will likely be under pressure to accept similar durations of revocation or suspension. Whether this prolonged period of suspension will reduce the incidence of these violations is yet to be seen.

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Keep in mind, however, that once a physician is out of practise for more than three years they may need to re-train - and finding someone to retrain them is not an easy task. This can easily be the end of a physician's career.

Perspective on Physician Overbilling

Let me begin by saying that it is my strong opinion that physicians need to be fairly compensated for their time and often difficult and stressful work.

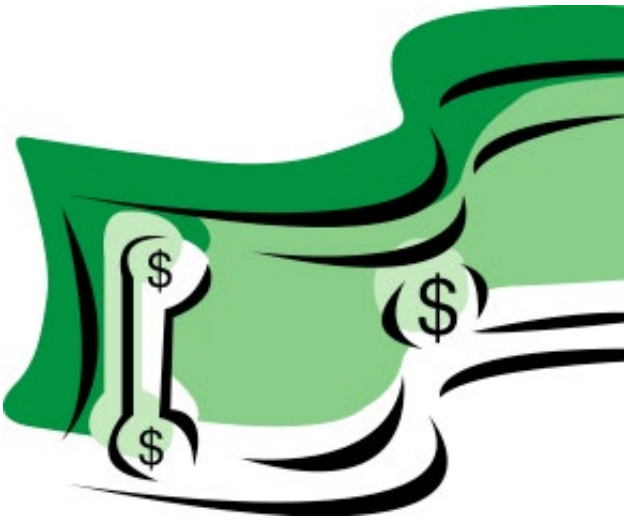
Unfortunately, there are physicians in our province who have been mandated to pay back hundreds of thousands of dollars for overbilling. The problem is small, but there are a significant number of physicians who are so far out of the normal in billing, it is difficult for the College to understand how they even have time to live, let alone deliver quality care to patients. This does not mean there are not physicians who are gifted in their field and can deliver quality of care faster than other physicians, because these individuals do exist.

Presently in Saskatchewan, questions of inappropriate billing are handled by the Joint Medical Professional Review Committee (JMPRC), which has representatives from the Medical Care Insurance Branch (MCIB), Saskatchewan Medical Association (SMA) and College of Physicians and Surgeons of Saskatchewan (CPSS). The problem with the present system is that the review process is very restricted in the scope, duration and penalties that may be placed on physicians who are so far outside the normal. I am told that only about eight cases are reviewed each year by this committee and the window is very short for review. The JMPRC consists of physicians who will decide whether billing is excessive and then refer the cases to the College because of quality of care concerns. This then means that a duplicate and parallel system must now look at quality of care concerns. This is a very expensive and wasteful system, considering that very competent physicians with expertise on quality also sit on the JMPRC.

The College's responsibility is to protect the public. One does not have to stretch reason very far to suggest that abuse of the public purse by some physicians must be curtailed, because this abuse may affect the quality of care that can be delivered, takes funds out of the system that could be used in a more positive manner, and erodes the public trust in the medical profession.

Lawyers are frequently disbarred in our province for much smaller trust account transgressions and we allow physicians who take hundreds of thousands of dollars from the system to continue practising. We pride ourselves as physicians on being very ethical, but one wonders whether it is the Law Society who has it right in this case?

The solutions to overbilling and "creative billing" are not simple, but we need to address them as a profession. This needs to be a concerted effort by the Ministry of Health, the physician association and the College. In my opinion, it is time to deal with this issue head on and fix it.



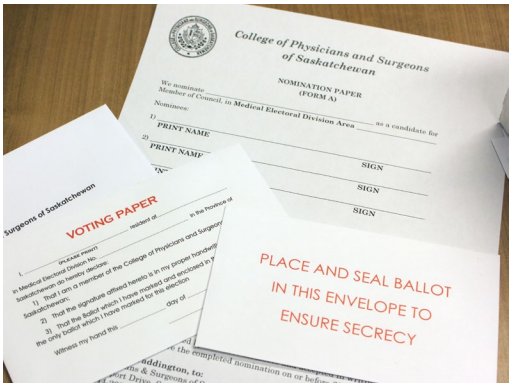
Council News

Election Results Are In!

Congratulations to the successful candidates for their election to Council!

Below are the official election results for the 2018 Council elections held in November. Council would like to thank each and every candidate for their interest and willingness to contribute to serving the public in guiding the profession to achieve its highest standards of care. Thank you also to all the voters who took the time to send in their ballots. Your participation is important!

The next Council meeting will take place on January 18-19, 2019.



Election results - November 2018

REGION*	SUCCESSFUL CANDIDATE	ELECTION RESULT
Regina	Dr. Alan Beggs	Elected by Acclamation
Saskatoon	Dr. Brian Brownbridge	Elected by Acclamation
North West Area & Athabasca	Dr. Mark Chapelski	Elected by Acclamation
North East Area	*No nominations received*	New call for nominations
South West Area (1 year term only)	Dr. Adegboyega Adewumi	Re-elected
South East Area	*No decision*	Tie

* A current full list of Council Members is available on the College website. **Click here for more details.**

South East Area - New Election Date

The November election in the South-East resulted in a tie between candidates Dr. Yusuf Kasim and Dr. Edward Tsoi. A new election date of **7 January, 2019** has been fixed.

North East Area - Call for Nominations

No nominations were received for the November election. Nominations for a new election are due **24 December, 2018**. If it goes to ballot, the election date will be 30 January, 2019.

Please encourage physicians in your community to put their names forward for election to Council.

Thank You for Your Service

Council would like to thank Dr. James (Jim) Carter of Regina for his longstanding contribution in upholding the mission, vision and values of the College while serving as a Member of Council (Regina Qu'Appelle Region) over many years. Dr. Carter is retiring from practice in December 2018, and had been a member of Council since January 2010.

FROM THE REGISTRAR

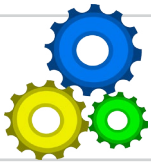
Dr. Karen Shaw
Registrar, CEO

Governance - Looking to the Future

The Council of the College of Physicians and Surgeons of Saskatchewan has been considering a number of aspects of best practice in governance.

Like many organizations across the country and the world there has been a focus on questioning whether the governance structures utilised by medical regulatory authorities have kept up with the changes in the profession. The historical rationale in support of self-regulation, or more recently termed professionally-led regulation, has been persuasive. It was felt to be an effective regulator; the regulatory body requires the support of the profession in the development and implementation of the standards of the practice, and membership participation in the host of regulatory activities including sitting on standing committees, being involved in peer review or serving on the governing body. It has always been felt that this model of regulation assists in being able to obtain expertise necessary for the regulatory body to assess or audit the profession's performance. It is recognized that there are nuances about medical care that the public may not have sufficient knowledge to be able to comment on and that peers have the ability to understand the context of the complaint or investigation.

However, over a number of years there have been some public reviews that have questioned the effectiveness of professionally-led regulation. In particular, members will remember the Bristol Inquiry in 2001 and the Shipman Inquiry in 2004 in the UK which had huge public and professional impact and called into question the effectiveness of professionally led regulation. After these inquiries there was legislative reform to professional regulation in the United Kingdom. The regulatory scheme moved away from professionally led to a more publicly-driven process with government oversight.



What skillset is needed to provide skilled leadership in regulatory organizations like the College of Physicians and Surgeons of Saskatchewan?

Regulatory activities are becoming more complex. In our own organization, we have seen a change in our registration and licensure policies to integrate internationally-trained physicians. We have made efforts to standardize the licensure process across the country with some limited success. At the present time our governing Council is required to do a number of discipline-related activities that other medical regulatory authorities have standing committees do. These activities include suspension hearings, penalty settings, etc. We currently have 5 public members who serve an important role in bringing the public's perspective to the table, although all Councilors are sitting at the table in the interests of the public. Our governing Council has wrestled with tensions around the development of policy that speaks to conscientious objection and the provision of MAiD in trying to ensure the proper balance between protecting the public's interest and being respectful of individual's rights when they have a conscientious objection. We have been challenged with ensuring transparency in our processes, while respecting the privacy of individuals. We, as part of the healthcare system, are challenged to ensure appropriate accountability of physicians while balancing that with an appropriate level of autonomy.

These regulatory governance reviews are not limited to medicine. One of the most recent reviews was done by the College of Nursing of Ontario. Its report, *A Vision for the Future*, identified a number of principles of good governances:

Accountability

- Decisions are made in the interest of public protection.
- The Board takes responsibility for its actions and processes.
- Board Directors meet all legal and fiduciary responsibilities.

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Adaptability

- The Board considers and responds to changing expectations and emerging trends.
- The Board addresses emerging risks and opportunities.
- The Board anticipates and embraces opportunities for innovation, regulation and governance.

Competence

- Decisions are evidence-informed.
- External expertise is sought where needed.
- Individual Director and collective Board knowledge and skills are evaluated to support continuous improvement as governing and regulatory body.

Diversity

- Decisions reflect diverse knowledge, perspectives, experience and needs.
- Stakeholder input is engaged to inform decisions.

Independence

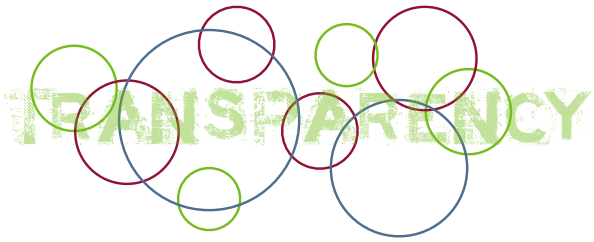
- Decisions address public interests as the Board's paramount responsibility.
- Decisions of the Board and its Directors are free of bias and special interest perspectives.

Integrity

- Members participate actively and honestly in decision-making through respectful dialogue.
- The Board fosters a culture focused on doing and saying what is right.
- The Board and its Directors act ethically and follow governance principles.

Transparency

- Processes, decisions and the rationale for decisions are easily accessible to the public.
- The Board communicates in a way that allows the public to evaluate the effectiveness of its governance.



At our November 30 and December 1, 2018 Council meeting, Council invited Mr. Graeme Keirstead, Chief Legal Counsel of the College of Physicians and Surgeons of British Columbia, to present on the work that the CPSBC is doing on governance reform. Some of the information presented to our Council identified leading practices in health regulation both domestically and internationally. In particular, they looked at leading practices from Canada, the USA and the UK. The resulting analysis and findings of their work identified three dimensions of good governance related to:

- Board/Council Model
- People, and
- Board/Council Operations

Increasingly governance reviews have focused on a reduction in the overall size and increased diversity of membership of Boards or Councils. Across Canada and other jurisdictions this has resulted in an increased number of public members and, on occasion, including members of other health professions. These governance reviews have identified a need to have the Board/Council selected on the basis of desired competencies, rather than being elected. These governance reviews have identified a need for better Board/Council evaluation.

The Medical Profession Act, 1981 has been in effect with some minor changes for the past 37 years. A number of the possible governance changes that might be considered would require a change in legislation. Physician Council members are currently elected. Should they continue to be elected or should there be competency-based appointments? A number of regulatory bodies have increased the number of public members to equal or nearly-equal the number of physicians on their Boards/Councils. Currently we have 5 public non-physicians and 15 physician members including the Dean of the College of Medicine. This ratio of public members to physician members could not be changed without a legislative amendment.

In addition, much of our discipline-related work is currently done by Council. Currently, Preliminary Inquiry Committees (PICs) report to Council and Council determines whether a charge should be laid, or the concerns resolved by Alternate Dispute Resolution (ADR). If the legislation was amended, PICs could decide whether a physician should be charged with unprofessional conduct.

In most other jurisdictions, investigators provide reports to a standing committee which then determines what dispo-

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sition should be made of a complaint; whether the physician should be charged, undergo ADR, or whether the matter should be dismissed. The standing committee provides instructions to legal counsel related to the prosecution of the complaint. This would require a change in legislation in Saskatchewan.

Council also currently imposes penalty following an admission of unprofessional conduct, a decision by the Discipline Hearing Committee that the physician is guilty of unprofessional conduct, a conviction of an indictable criminal offence or a finding of unprofessional conduct in other jurisdictions (Sections 49, 54, 55 and 54.01 of the Act). A change to the legislation would be required to allow penalty decisions to be made by a Discipline Hearing Committee.

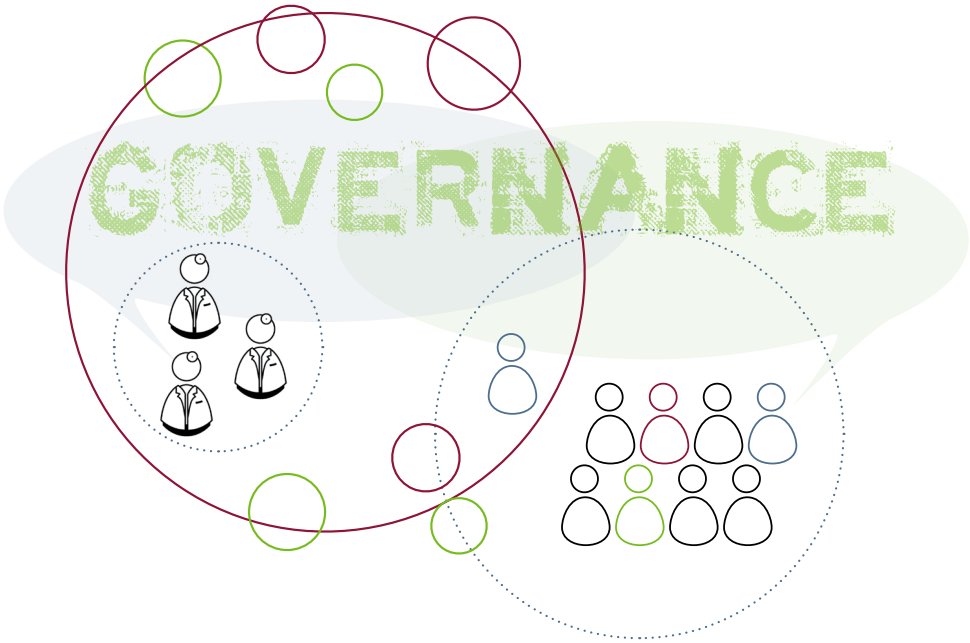
There are many tasks that our governing Council has the legal responsibility to do and to change these would require a change in legislation. Some of these may be desirable changes, others may not.

At a meeting with the President and the Senior staff after the November/December Council meeting, a number of issues were identified that will be presented to the January Council meeting for consideration as a starting point in improving our governance. Council will be reviewing the following list of potential items to work on.

- Better communication with the public.
- Better communication with physicians.
- Better recruitment of Councilors with consideration of specific skills and competencies.
- Better evaluation of Council's work.
- Whether to establish a standing committee to focus on policy development.

There are many improvements in governance that need to be considered. Over the next year Council will consider a number of matters to determine whether what we are currently doing is best practice and has kept up with changing times. In particular, we need to focus on how well we govern and how well we execute our regulatory obligations in addition to maximizing both our effectiveness and efficiency in operations.

We look forward to working with you on this continued journey of improvement.



How to Approach the Inherited High-dose Opioid Patient

By Dr. Laura Lee McFadden, Medical Manager, Quality of Care
Julia Bareham, Prescription Review Program Manager

This is the third and final part of our series, Prescribing Opioids: Challenging Scenarios*. We have listened to your concerns when it comes to practical cases. We acknowledge that chronic pain patients can be very complex and challenging to treat safely and effectively. In this article, we have used examples of inheriting a chronic pain patient on high dose opioids as this is a significant challenge facing more and more physicians. These cases are inspired by actual patient scenarios.*

CASE #1

Visit 1

Mr. Early Eddie (EE) is 29 years old and comes to you for his first visit after his regular family physician has left the province. Mr. Eddie presents and tells you that he has severe lower back pain and leg pain and is currently taking hydromorphone and duloxetine for his pain. Below is Mr. Eddie's profile for the past 6 months.

Date	Schedule	Drug & Strength	Quantity	Daily Dose	MEQ Daily Dose
Jan 12 2017		DILAUDID 8 mg	360 tabs	12/day	480mg MEQ
Jan 19 2017		HYDROMORPH CONTIN 24 mg	90 caps	3/day	360mg MEQ
Feb 8 2017	(3 days early)	DILAUDID 8 mg	360 tabs	12/day	480mg MEQ
Feb 14 2017	(4 days early)	HYDROMORPH CONTIN 24 mg	90 caps	3/day	360mg MEQ
Feb 14 2017	(24 days early)	DILAUDID 8 mg	360 tabs	12/day	480mg MEQ
Mar 8 2017	(8 days early)	DILAUDID 8 mg	360 tabs	12/day	480mg MEQ
Mar 8 2017	(8 days early)	HYDROMORPH CONTIN 24 mg	90 caps	3/day	360mg MEQ
Apr 4 2017	(3 days early)	DILAUDID 8 mg	360 tabs	12/day	480mg MEQ
Apr 4 2017	(3 days early)	HYDROMORPH CONTIN 24 mg	90 caps	3/day	360mg MEQ
May 1 2017	(3 days early)	DILAUDID 8 mg	360 tabs	12/day	480mg MEQ
May 1 2017	(3 days early)	HYDROMORPH CONTIN 24 mg	90 caps	3/day	360mg MEQ
May 27 2017	(4 days early)	HYDROMORPH CONTIN 24 mg	90 caps	3/day	360mg MEQ
May 27 2017	(4 days early)	DILAUDID 8 mg	330 tabs	11/day	480mg MEQ

Learning Point #1

You should always verify the medication history by checking PIP, the eHR viewer, speaking with the dispensing pharmacist, or speaking with the patient's previous prescriber. You cannot identify an individual with an opioid use disorder by his/her physical appearance, by the clothing he/she wears, nor by any other characteristic. Be sure – verify the information with a reliable source.

Upon reviewing the medication profile you note three things:

1) the patient is receiving a very high dose of opioids;
2) the patient has frequent early refills;
3) the patient is getting brand name Dilaudid when a generic brand is available.

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Learning Point #2

Brand name formulations have a higher street value than their generic counterparts. Hydromorphone is a common drug of abuse in Saskatchewan and Hydromorph Contin 24mg capsules have a street value of up to $100 per capsule. Mr. Eddie could potentially get $9000 per month for his Hydromorph Contin alone. This kind of value can certainly motivate patients who are diverting to continue to do so.

So what do you do????

1. **Take a deep breath** and tell yourself "You CAN do this"! Remember this patient deserves continuity of care & safe and effective medical care.

2. **Establish boundaries** at the first visit, have EE sign a treatment agreement, and establish goals of therapy.

3. **Continue gathering information** and ask EE about his reason for consistent early refills. He tells you that he is travelling back and forth to another province because his grandmother is ill and is dying.

4. **Perform an assessment** of the pain to determine if the current medication therapy is effective and appropriate.

You have EE fill out a Brief Pain Inventory where he rates his pain at anywhere from 7 to 10 (mostly 10) on many of the scales. EE indicates that pain interferes with general activity, mood, normal work, relations with other people, sleep, and enjoyment of life.

At this point you begin to wonder if EE's pain is sub-optimally controlled by his current medication regimen, if he is receiving the wrong medication for his pain, or if he is potentially drug seeking.

5. **Check the eHR viewer to see if any recent UDSs** have been performed.

The Urine Drug Screen results are as follows:

UDS May 2017: + hydromorphone, + diphenhydramine, + THC

The results indicate that EE is taking the medication that he is prescribed (well, at least some of it). But he is also using marijuana and either dimenhydrinate (Gravol) or diphenhydramine (Benadryl). [Note: diphenhydramine is a metabolite of dimenhydrinate]. Both drugs are known drugs of abuse (for their anticholinergic properties), but it is possible that EE suffers from frequent nausea or severe allergies – add that to the assessment list.

End of Visit 1

At this point you realize this is going to be a tough case and you do not have adequate time to address it appropriately today. You may want to consider providing a refill of his medications for 2 weeks (maybe less, maybe more – use your judgement), and request that EE return then for further assessment. In addition to this, you also prescribe a naloxone kit due to the high-dose opioids.

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Visit 2

1. Discuss UDS (contained hydromorphone, diphenhydramine, THC)

Learning Point #3

One failed urine drug screen is a talking point and not a reason to fire a patient or to refuse to prescribe (unless perhaps the prescribed medication is absent from the result). It is an opportunity to discuss possible addiction and failure of current therapy to manage pain. It is an opportunity to review your treatment agreement.

2. Introduce the concept of a taper and the rationale: His pain is not well controlled, he rates everything as a 10.

GOAL: Taper sustained-release hydromorphone due to high dose and discontinue immediate-release hydromorphone since the indication is chronic pain.

3. Calculate the daily morphine equivalents (or MME) – 840MEQ

Hydromorph Contin 24mg x 3 caps/day = 72mg hydromorphone/day

+

Dilaudid 8mg x 12 tablets/day = 96mg hydromorphone/day

1mg of hydromorphone = 5mg of morphine

168mg hydromorphone/day x 5 = 840mg morphine equivalents/day

4. Based on repeated early refills you can determine that there is either an opioid use disorder, trafficking/diversion occurring, or both. How can you determine if these are occurring? See DocTalk Vol 5 Issue 1: *Prescribing Opioids: Challenging Scenarios: Part 2 of a 3 part series* (p. 22) about Random Urine Drug Screens (RUDS) for more information.

End of Visit 2

Where to start when decreasing the dose? There is no one right answer to this question. See **RxFiles Opioid Tapering** [http://www.rxfiles.ca/rxfiles/uploads/documents/members/Opioid-Tapering-Strategies.pdf] for more information or call MedSask at 1-800-667-DIAL.
To start, consider cutting the immediate-release hydromorphone quantity in half for this patient scenario. Have EE return in 2 to 4 weeks to see how he is doing.

Continued on p. 13...

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Visit 3

You will face 1 of 3 scenarios post-taper:

1. Patient reports increased pain.

   Management Strategy: Optimize non-opioid medications (e.g. NSAIDs, acetaminophen), determine if there is an untreated neuropathic component.

2. Patient attempts to manipulate you into continuing to prescribe the dose he was receiving pre-taper.

   Management Strategy: Refer back to the treatment agreement; re-establish boundaries; hold firm; decrease prescription quantity to 1-week supply. Call for help/support – colleagues (physician, pharmacist), CPSS, MedSask.

3. Patient returns with no complaints, has no increase in pain, and is engaged in the tapering process (these patients do exist!!!)

A few months later you find out that EE was incarcerated for drug trafficking. *HINT: The only way you might find out about this is after identifying a gap in the dispensing history on PIP.* Perhaps you feel a bit of relief that this complex patient is no longer in your practice?

But then a few more months pass and EE returns requesting the same medications you had prescribed to him four months earlier.

What do you do??? Repeat the process outlined above.

CASE #2

Visit 1

Mrs. Breakthrough Betty (BB) is 70 years old. She complains of chronic low back pain, R knee pain, L hip pain (total hip arthroplasty in 2015). She has had a back surgery for fusion. Degenerative knee disease (gets cortisone injections in R knee), awaiting knee replacement (bone on bone) – affecting daily activities & thus quality of life; severe OA in R knee.

Your first step after taking the above history is to…….check her medication profile!!

OPIOID				
Date	Drug & Strength	Quantity	Daily Dose	MEQ Daily Dose
Jan 14 2017	oxycodone 20mg	360	12/day	360mg MEQ
Jan 15 2017	morphine SR 15mg	60	2/day	30mg MEQ
Feb 13 2017	morphine SR 15mg	60	2/day	30mg MEQ
Feb 13 2017	oxycodone 20mg	360	12/day	360mg MEQ
Mar 13 2017	oxycodone 20mg	360	12/day	360mg MEQ
Mar 13 2017	morphine SR 15mg	60	2/day	30mg MEQ
Apr 12 2017	oxycodone 20mg	360	12/day	360mg MEQ
Apr 12 2017	morphine SR 15mg	60	2/day	30mg MEQ
May 10 2017	morphine SR 15mg	60	2/day	30mg MEQ
May 10 2017	oxycodone 10mg	60	2/day	30mg MEQ
May 18 2017	oxycodone 20mg	360	12/day	360mg MEQ
Jun 10 2017	morphine SR 15mg	60	2/day	30mg MEQ
Jun 16 2017	oxycodone 20mg	360	12/day	360mg MEQ

Continued on p. 14...

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BB has been prescribed Morphine SR 15mg BID and oxycodone 20mg 2 to 3 tablets QID PRN.

There are no 'red flags' with BB (no early refills, no last-minute appointments, no requests for escalating doses, willing to try alternative treatments).

This patient has a clear indication for opioids (even though opioids are generally not recommended for low back pain, pain is severe and other therapies are assumed to have failed).

You identify the following concerns:

1. The concomitant use of two different opioids (morphine and oxycodone).
2. The high volume of immediate-release opioid being used for chronic pain.

You determine that your treatment goal will be:

GOAL: To optimize the opioid regimen by using only one chemical and minimize the need for immediate-release preparations for breakthrough pain.

Step 1 – Reassure patient that you are not going to leave her without adequate pain treatment.

Step 2 - Ask, are there other non-opioid options that can be implemented (both pharmacological and non-pharmacological). Acetaminophen and NSAIDs can be opioid sparing. Consider if TCAs, SNRIs or topicals are appropriate.

Step 3- Calculate current opioids dose in morphine equivalents.

You calculate the daily morphine equivalent and find it to be 390mg MEQ.

*NOTE: Cross tolerance can occur. Be careful when switching, rotating opioids!
See link for more information:
http://rxbriefcase.com/Sandoz/assets/pdf/Tool%201_Opioid%20Rotation.pdf

Step 4 - Increase the morphine to SR 30mg BID (30mg of sustained-release morphine per day to 60mg). You have doubled the dose! Compensate by decreasing the immediate-release. Consider switching to a short-acting morphine as well, and eliminate the oxycodone.

What really happened?

Morphine SR 30mg BID + Statex 10mg x 60 tabs x 1 month

Then, the doctor got the patient down to Morphine SR 30mg BID

Impaired Driving and Physician Responsibilities

Bryan Salte
Associate Registrar
and Legal Counsel

It can be difficult for physicians and hospitals to know what to do when dealing with drivers who may have been impaired and who have been injured in an accident. Recent changes to the Criminal Code have given the police additional authority to demand blood samples to detect whether a driver was impaired by alcohol or a drug. That may be particularly relevant as it applies to the use of cannabis by drivers. My perspective is the following:

What can/should a physician disclose?

1. A physician cannot initiate a police investigation by breaching a patient's confidentiality. Physicians can only disclose patient information without a patient's consent in limited circumstances. That will not generally allow a physician to disclose a possible crime. Physicians can, in some circumstances, respond to police inquiries but cannot initiate them.

2. If police attend hospital and ask physicians for information whether a patient has shown indications of impairment, the physician can, but is not required to, respond to their inquiries.

What about blood or urine samples?

3. The Criminal Code authorizes police to demand a breath sample, a urine sample or a blood sample from a person who is suspected of driving while impaired by alcohol or a drug. If a patient consents to providing a blood sample following such a demand, either a physician or a registered nurse can obtain a blood sample and provide it to the police. The physician or RN must be satisfied that taking the blood will not endanger the patient's life or health.

4. If a patient consents to providing a urine sample or a saliva sample at a hospital, there is no requirement for a physician to be involved. The police can obtain that sample.

5. In some circumstances, a police officer may be able to obtain a court order (a warrant) which requires a physician to obtain a blood sample and provide it to the police. A physician must believe the person is unable to consent to a blood sample being taken. That inability must be caused by the person's impairment or as a result of an accident. The physician must believe that taking the blood sample would not endanger the patient's life or health. Such a warrant requires the physician to take a sample of blood or to have a registered nurse acting under the physician's direction take a sample of blood.

6. Physicians should only take blood samples with patient consent, as required by a warrant, or for medical purposes. Physicians should not take blood samples from a patient in any other circumstances.

7. If police request a blood sample that has been taken for medical purposes, it should only be provided if police obtain a warrant authorizing the seizure of the sample.

Responding to police inquiries vs. initiating police inquiries

The Saskatchewan Government has adopted The Health Information Protection Regulations. Those regulations state that a trustee (including a physician) can provide a patient's personal health information to the police without the patient's consent in certain limited circumstances. The three primary limitations that are relevant to this issue are that:

1. There must be a lawful investigation into possible criminal conduct;

2. The investigation must be related to the health services that were provided;

3. The information disclosed must be limited to current information and cannot include the patient's history.

Continued on p. 16...

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The College's guideline document – Confidentiality of patient Information provides additional information about the circumstances in which a physician is permitted to provide information to police without the patient's consent. Two sample case scenarios in the FAQ section of that document state:

Case Scenario "Number 2"

The patient was the driver, injured in an automobile accident. The police suspect that the patient was impaired and have asked whether the patient's injuries affect the patient's ability to be tested by breathalyzer, or affect the patient's ability to respond to questions.

Can the physician give this information?

Answer: Yes. A physician is permitted, but not required, to provide information about the patient's injuries to assist the police in their investigation.

Case Scenario "Number 4"

The patient was the driver, injured in an automobile accident. The police suspect that the patient was impaired. They have asked the physician to describe the physician's observations of the patient to assist in deciding whether the patient may have been impaired. (Was an odour of alcohol detected on the patient's breath? Did the patient state that he had been drinking? etc.).

Can the physician give this information?

Answer: Yes. The physician is permitted, but not required, to provide the patient's current information to assist the police in their investigation. The physician is not, however, permitted to provide any information about the patient's history.

MEDICAL CANNABIS: How does it fit within a landscape of legal recreational cannabis?

As you are no doubt aware, recreational cannabis became legal across Canada in October 2018. With this change, the prevalence of cannabis use may increase, and patients may also be more willing to discuss with their physicians their use of cannabis. As part of routine history-taking, physicians should discuss recreational cannabis use with their patients, similar to the manner of discussing alcohol use or cigarette smoking.

Although recreational cannabis is now available in government approved retail operations, the legislative scheme addressing medical cannabis remains unchanged. Medical cannabis still requires an authorization and can be obtained only through a licensed commercial provider, or by registering to produce cannabis for your own medical purposes or to designate a person to produce for you.

As a reminder, the College of Physicians and Surgeons of Saskatchewan (CPSS) in Regulatory Bylaw 19.2 has established Standards for Prescribing Marihuana. These stan-dards are mandatory, not optional, and a failure to com-ply can result in charges of unprofessional conduct. An example of this can be seen on the CPSS website under "Summary of Discipline Cases."

The standards set out in Regulatory Bylaw 19.2 continue unaltered despite the legalization of recreational cannabis. Regulatory Bylaw 19.2 can be accessed on the College website.

Some highlights of the requirements established in Bylaw 19.2 include:

- A physician may only prescribe cannabis/marihuana for a patient for whom the physician is the primary treating physician for the condition for which the cannabis is prescribed;
- Prior to prescribing cannabis, the physician must review the patient's medical history, review relevant records and conduct a physical examination;
- The patient must sign a written treatment agreement;
- The physician must maintain records that comply with Bylaw 23.1 as well as specific requirements in bylaw 19.2(e);
- The physician must also maintain a single record, separate from patient records, containing information about all prescriptions the physician has made for medical cannabis;
- The physician may not be in a conflict of interest with a licensed producer.

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Additional resources can be found here:

CPSS:
http://www.cps.sk.ca/imis/CPSS/CPSS/Programs_and_Services/Medical_Marijuana/Medical_Cannabis.aspx

College of Family Physicians of Canada
https://www.cfpc.ca/ProjectAssets/Templates/Category.aspx?id=12164&terms=Cannabis

Government of Saskatchewan:
http://www.saskatchewan.ca/government/cannabis-in-saskatchewan/cannabis-resources-for-health-care-providers

Health Canada:
https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/information-medical-practitioners/information-health-care-professionals-cannabis-cannabinoids.html

Canadian Medical Protective Association (CMPA):
https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2014/medical-marijuana-new-regulations-new-college-guidance-for-canadian-doctors

Acknowledgment: The CPSS gratefully acknowledges the work of the College of Physicians and Surgeons of Manitoba for providing information included in this article.

REMINDER TO PHYSICIANS PRESCRIBING CANNABIS

Prescribing physicians must retain a **single record, separate from other patient records**, which can be inspected by the College, and which contains:

(a) The patient's name, health services number and date of birth;

(b) The quantity and duration for which cannabis was prescribed;

(c) The medical condition for which cannabis was prescribed;

(d) The name of the licensed producer from which the cannabis will be obtained, if known to the physician.

MORE DETAILS ON PHYSICIAN RESPONSIBILITIES FOR PRESCRIBING CANNABIS AVAILABLE HERE

New Cannabis Toolkit to Educate Health Professionals Now Available from CPHA

The Canadian Public Health Association (CPHA) has recently developed an information toolkit, ***Cannabasics***, especially designed for health professionals:

"*Health professionals play an important role in communicating to the public about the health and safety risks of cannabis in all forms of use. To this end the Canadian Public Health Association (CPHA) recently developed Cannabasics, in collaboration with members of the CPHO Health Professional Forum. Cannabasics is an information package on cannabis tailored to health professionals. The toolkit provides a set of fact sheets and links to key resources that give an overview of cannabis plants and products, methods of consumption, and approaches to harm reduction. It also links to resources produced by partner associations.*"

Source: *Statement from the Chief Public Health Officer Health Professional Forum on New Cannabis Toolkit to Educate Health Professionals.* https://www.newswire.ca/

A link to this information is also available on the College Website under the menu item "Medical Cannabis"

New Policies and Bylaw Applicable to Office-based Procedures

By Sheila Torrance, Legal Counsel, CPSS

At its September 2018 meeting, Council approved 2 new policies and 1 new bylaw that apply to in-office procedures:

1. POLICY - Performing Office-based Non-Insured Procedures
2. POLICY - Performing Office-based Insured Procedures
3. BYLAW 23.4 – Delegation to Duly Qualified Laser Technicians

These documents were the culmination of several rounds of stakeholder consultation. While the work was initially focused primarily on cosmetic office-based procedures such as the administration of Botox®, dermal filler and laser or light-based therapies, the policies that were adopted by Council are much broader in scope. They apply to all procedures performed in-office, whether insured or non-insured. Please note that Bylaw 26.1 continues to apply to procedures performed in Non-Hospital Treatment Facilities.

The College recommends that any physician who performs office-based procedures review the policies to ensure compliance. However, a summary of some of the pertinent expectations follows:

1) **Non-insured procedures** include cosmetic/aesthetic procedures and also those aimed at the treatment of pathology. Examples include the application of laser energy and light-based therapies, hair transplantation, the use of neuromodulators (injectable), soft tissue augmentation, peripheral stem cell injections, and platelet rich plasma injections.

- Physicians must ensure they have sought and obtained CPSS approval for the appropriate scope of practice if the procedures performed are not within the physicians' existing scope of practice (section 1 of the policy);
- Physicians must comply with the CPSS guideline on infection prevention and control (section 2);
- Physicians must obtain proper informed consent from the patient and there are limits on when this can be delegated (section 3);
- There are specific expectations in relation to the authorization of non-physician providers (Section 4). Physicians are not able to authorize non-physician providers to perform any procedure that the physician is not qualified to perform. They cannot authorize non-physician providers to perform any procedure that is considered the practice of medicine unless delegation is authorized in the CPSS regulatory bylaws or the provider is a regulated health professional acting within the scope of their profession;
- The policy establishes obligations of a medical director or the physician performing, authorizing or supervising a procedure (section 5). This includes the obligation to provide adequate and effective direction and supervision, and to ensure the availability of a procedures manual;
- Other issues addressed include liability coverage (section 6), advertising (section 7) and honesty in financial dealings (section 8).

2) **Insured procedures** include minor surgical procedures that do not require general anaesthesia. Examples include joint injections or aspirations; removal of "lumps and bumps", moles or warts; vasectomies; inserting IUDs.

- Issues addressed are similar to those described above in the context of non-insured procedures with minor variations.

3) Bylaw 23.4 permits a physician to delegate to a "duly qualified laser technician" the **administration of laser and light-based technologies for a medical purpose**, but only if certain expectations are met. These include the following:

- The physician must assess the indications and potential contraindications for each patient;

Continued on p. 19...

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- The physician must personally assess each patient undergoing invasive procedures including ablative laser skin resurfacing or vascular procedures;
- The physician must be available to attend at the location where the laser or light-based therapy is provided (details of what constitutes 'availability to attend' are included in the bylaw);
- Prior to delegating as permitted in the bylaw, the physician must be satisfied that the person to whom he/she is delegating has the appropriate knowledge, skill and judgement and is able to carry out the act as competently and safely as the physician;
- The general requirements for a delegation mirror those for delegation to a registered nurse as detailed in Regulatory Bylaw 23.3.

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 four discipline matters completed since the last Newsletter report.

Dr. Anjena Gandham

Dr. Anjena Gandham admitted unprofessional conduct for providing false or misleading information to a College representative and to a preliminary inquiry committee. Dr. Gandham denied to a College representative and then to a preliminary inquiry committee that she had signed a prescription.

Council imposed a penalty consisting of a reprimand and a one-month suspension effective January 1, 2019. Dr. Gandham will also have to successfully complete a medical ethics course and pay costs of $1471.36.

Dr. Sarah Oberholtzer

Dr. Oberholtzer admitted to unprofessional conduct for inappropriately implicating a colleague when obtaining a prescription for her own use. Council imposed a penalty on Dr. Oberholtzer which consisted of a reprimand and a requirement to take a medical ethics course.

Dr. Mohammed Sayeed

Dr. Sayeed admitted to unprofessional conduct for committing acts of sexual impropriety with a patient, which included sexual intercourse.

Council revoked Dr. Sayeed's licence, ordered a reprimand and ordered him to pay costs of $1237.48.

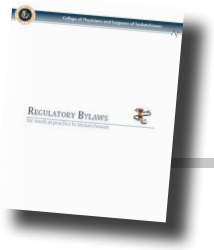
Dr. Sayeed will not be eligible to apply to have his licence restored until his licence has been revoked for at least 9 months and the Council has received a report from a person or organization approved by the Council which confirms that he has undergone counseling and has achieved a measure of rehabilitation which protects the public from risk of future harm.

Dr. Sylvester Ukabam

Dr. Ukabam was charged with unprofessional conduct with two patients. The charges included boundary breaches and failure to protect the patients' privacy during physical examinations.

The matters were resolved when Dr. Ukabam agreed to relinquish his licence effective December 9, 2018. He agreed that he will never practise medicine anywhere in the world in the future. Dr. Ukabam was allowed 2 months to wind down his practice and transfer his patients. He agreed that during that time he would have a practice monitor present for any interactions with female patients, that he would not perform any physical examinations on female patients, and that he would not undertake any procedures which require physical contact with female patients.

Changes to Regulatory Bylaws



By Bryan Salte, Senior Legal Counsel, CPSS

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

During 2018 the Council adopted several changes to the College's Regulatory Bylaws:

1. The Medical Council of Canada Qualifying Examination Part 1 (MCCQE1) will be a minimum requirement for licensure.

The Medical Council of Canada no longer offers the Medical Council of Canada Evaluating Examination. Effective June 30, 2019 MCCQE1 will be the minimum requirement for licensure in Saskatchewan. MCCEE will no longer be accepted.

2. The Regulatory bylaws were amended to make it clear that a physician whose postgraduate training was taken outside of Canada can attain a regular licence with MCCQE1 and 5 years of successful practice.

Bylaw 2.4 was amended to make this clear. That was not a change in the intention of the bylaw. Rather, the amendment was made to make the Council's intentions clear.

This applies to physicians who were licensed on a provisional licence prior to the 2014 changes to the regulatory licensing bylaws, as well as physicians who were licensed after that date.

3. A physician on a provisional licence who has chosen to seek regular licensure by a summative assessment, but who attains FRCP/FRCS/CCFP, will no longer be eligible for a summative assessment.

Bylaw 2.5 was amended as a result of a concern that a summative assessment is no longer appropriate for a physician who has attained certification with one of the two Canadian certifying bodies.

In order to attain a regular licence, the physician will be required to either:

a. Attain the LMCC; or

b. Attain MCCQE1 and complete 5 years of successful practice.

4. Retaliating against a person who has filed a complaint or participated in a regulatory proceeding has been defined as a form of unprofessional conduct.

Bylaw 8.1 was amended by defining what constitutes "retaliating or discriminating against a person for taking part in a regulatory proceedings" and by stating that is unprofessional conduct.

5. Responsibilities of Medical Directors of Diagnostic Imaging Facilities

Bylaw 25.1 was amended to clarify and expand the duties and responsibilities of a medical director of a diagnostic imaging facility.

6. Delegation to laser technicians

Bylaw 23.4 was added to allow physicians to delegate the ability to perform certain laser procedures to non-physicians. The delegation must meet the requirements of the bylaw, including an obligation for the physician to assess each patient, be available to attend at the facility where the laser therapy is provided and exercise an appropriate degree of supervision over the person to whom this is delegated.

7. Prescribing of methadone or buprenorphine

Until April 2018, a physician could only prescribe methadone if that physician received an exemption from Health Canada to do so. That exemption was no longer required, or available, after April 2018.

Council amended the existing Bylaw 19.1 to require physicians to obtain permission from the Registrar to prescribe methadone or buprenorphine for addiction. A physician is not required to obtain the permission of the Registrar to prescribe in an Emergency Department, during a patient's short-term admission to hospital or to a patient in a correctional facility. The bylaw establishes some of the requirements for a physician to obtain the Registrar's permission to prescribe buprenorphine or methadone for addiction. Those include training requirements, availability of support for the practice, etc.

Council also updated its standards, guidelines and policies related to Opioid Agonist Therapy. Physicians who provide Opioid Agonist Therapy, or who are considering doing so, must be aware of and follow those standards, guidelines and policies.

Policy, Standard and Guideline Updates

Council regularly reviews the policies, guidelines and standards which are then made available on the College's website. Since the last Newsletter, Council has adopted two new policies and amended two policies.

POLICIES – Prescribing of Opioid Agonist Therapy STANDARDS/GUIDELINES – Opioid Agonist Therapy Program (OATP) Standards and Guidelines for the Treatment of Opioid Use Disorder

The previous policies on methadone prescribing have been rescinded and replaced by the new Opioid Agonist Therapy policies. These policies, and the OATP standards and guidelines, have been amended due to legislative changes abolishing the previously required Health Canada exemptions to prescribe methadone. The College has established its own expectations for physicians to prescribe methadone and buprenorphine for opioid use disorder.

The policies act as the "application form" a physician must complete in order to be approved by the Registrar for prescribing the designated medications for opioid use disorder. There are 6 policies, one each for maintaining physicians and initiating physicians for 1) prescribing of Opioid Agonist Therapy (OAT) (both methadone and buprenorphine/naloxone), 2) prescribing of only methadone, and 3) prescribing of only buprenorphine/naloxone. The policies also act as a checklist of the primary requirements and expectations of physicians prescribing these medications, and must be signed by the physician. Additional expectations are outlined in the OATP Standards and Guidelines as well as in the amended Regulatory Bylaw 19.1.

Click here to view full policy
Click here to view full standards/guidelines

POLICY - Medical Assistance in Dying

The Government of Canada has imposed reporting requirements for physicians who receive a written request for MAiD, who participate in assessing patients for eligibility for MAiD, or who provide MAiD.

Council updated the MAiD policy to include this requirement and to update the forms to be used for physicians who participate in MAiD.

Click here to view full policy

POLICY - Performing Office-based Insured Procedures

This document was adapted from similar documents established by the UK General Medical Council and the College of Physicians and Surgeons of Manitoba.

- The policy establishes expectations for physicians performing in-office insured procedures including minor surgical procedures not requiring general anaesthesia.
- Expectations are similar to the policy described below, but with slight variations.

Click here to view full policy

POLICY - Performing Office-based Non-insured Procedures

This document was adapted from similar documents established by the UK General Medical Council and the College of Physicians and Surgeons of Manitoba.

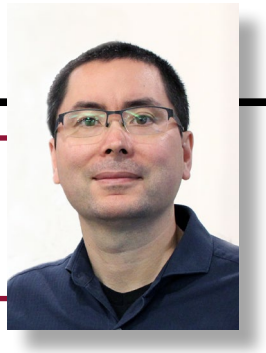
- The policy establishes expectations for physicians performing in-office non-insured procedures including cosmetic/aesthetic and those aimed at the treatment of pathology.
- The physician requires CPSS approval of the appropriate scope of practice.
- The physician cannot authorize a non-physician provider to perform any procedure which the physician is not qualified to perform. Physicians cannot authorize non-physician providers to perform any procedure that is considered the practice of medicine unless delegation is authorized in the CPSS regulatory bylaws or the provider is a regulated health professional acting within the scope of their profession.

Click here to view full policy

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

2018 Renewal Report

Mr. Ed Pas
Director, Registration Services



Physician Licensure Renewal

College Staff worked diligently to process nearly **3000** physician renewal applications for the 2018-2019 year.

This number includes processing for all types of active and inactive licences (except students and residents), as well as incoming notices of intent to lapse licensure.

MOC Credits need to be reported prior to December 31st!

- **400 credits (minimum)** are required to be reported during a 5 year MOC cycle.
  - *At least 25 credits* to be reported in each section of the MOC Program.
  - *40 credits* are required to be reported on an annual basis.

For more information on what CPD activities you can record, see: http://www.royalcollege.ca/rcsite/cpd/moc-program/cpd-activities-can-record-e

If you are a Specialist licensed to practice in Saskatchewan:

- It ***is a requirement*** of your licensure to be enrolled in the MOC Program.
- If you hold eligibility to challenge the Royal College exams – you are ***still required*** to enroll in the MOC Program.
- Physicians ***who do not*** comply with CPSS CME requirements may be liable for a non-compliance fee of $500.

Corporation Permit Renewal

Renewal this year progressed quite smoothly for the Medical Professional Corporations (MPC), with over 1700 renewals processed by College Staff.

We believe that many physicians referred to the Online Guide from our website under *Professional Corporations, Annual Renewal,* to help them through the online renewal.

Most difficulties encountered this year were:

- Changes made during the year to a sub-corporation or trust (deletions or additions) not reported prior to renewal;
- Changes to corporation address or shareholder addresses;
- Moving corporation to another province without notifying the CPSS.

Please notify us of changes when they occur during the year.

??????

Update Your Clinic/ Office Address

REMINDER! When changing clinic and/or offices, make sure to update your new contact information with the College of Physicians and Surgeons of Saskatchewan.

Instructions on how to properly fill out a prescription for PRP medications.

Prescribing Requirements for PRP Medications

A Reminder from the Prescription Review Program (PRP)

By Julia Bareham, Prescription Review Program Manager

Remember: the prescribing requirements for Prescription Review Medications differ from those of non-PRP medications, and are often overlooked.

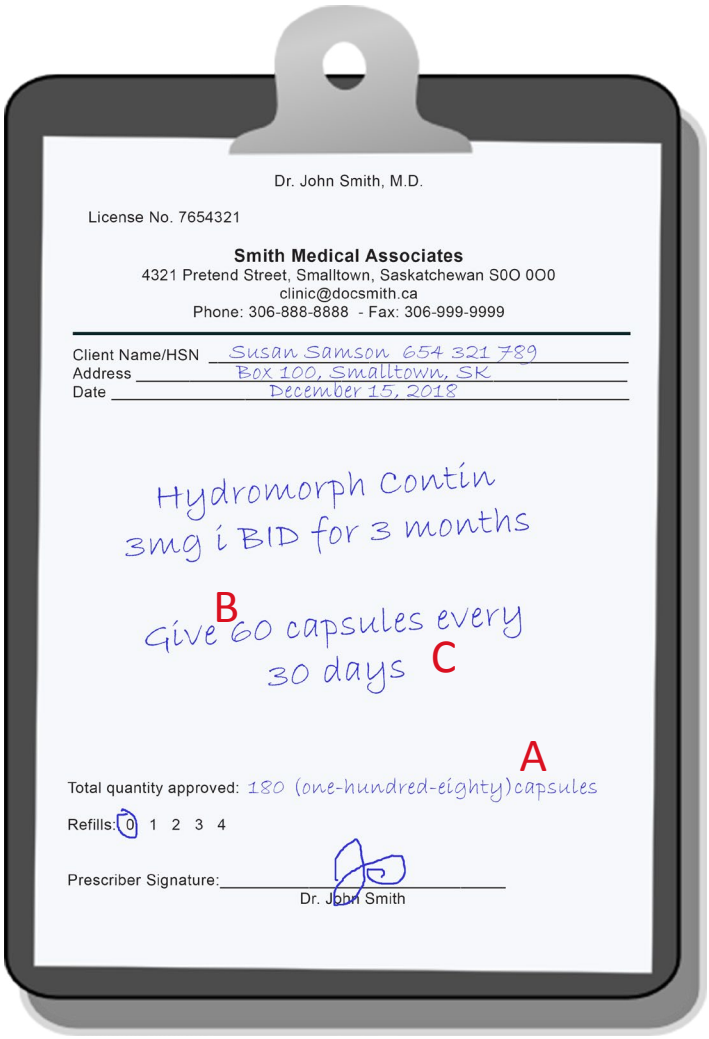
According to the CPSS Bylaw 18.1(g) pursuant to *The Medical Profession Act, 1981*, in order to prescribe a drug to which the Prescription Review Program applies, physicians shall complete a written prescription which meets federal and provincial legal requirements and includes the following:

> *Physicians shall only prescribe part-fills of medications to which the Prescription Review Program applies if the following information is specified in the prescription:*
>
> *I. The total quantity (A);*
>
> *II. The amount to be dispensed each time (B); and*
>
> *III. The time interval between fills (C) .*

This requirement is often forgotten, resulting in delays to patient care as the dispensing pharmacy must contact the prescriber to have this information added to the prescription. **Prescriptions failing to meet the Prescription Review Program requirements <u>cannot</u> legally be filled by pharmacies.**

It is one extra small step to add this information into a prescription, but it is necessary.

<u>For EMR-generated prescriptions</u>: This information can be added in the *Dosages* or *Comments* section, or more simply, you can 'check' the Triplicate box. (see examples on the following page).


Dr. John Smith, M.D.

License No. 7654321

Smith Medical Associates
4321 Pretend Street, Smalltown, Saskatchewan S0O 0O0
clinic@docsmith.ca
Phone: 306-888-8888 - Fax: 306-999-9999

Client Name/HSN Susan Samson 654 321 789
Address Box 100, Smalltown, SK
Date December 15, 2018

Hydromorph Contin
3mg i BID for 3 months

Give B 60 capsules every
30 days C

A
Total quantity approved: 180 (one-hundred-eighty) capsules

Refills: 0 1 2 3 4

Prescriber Signature: _____
Dr. John Smith

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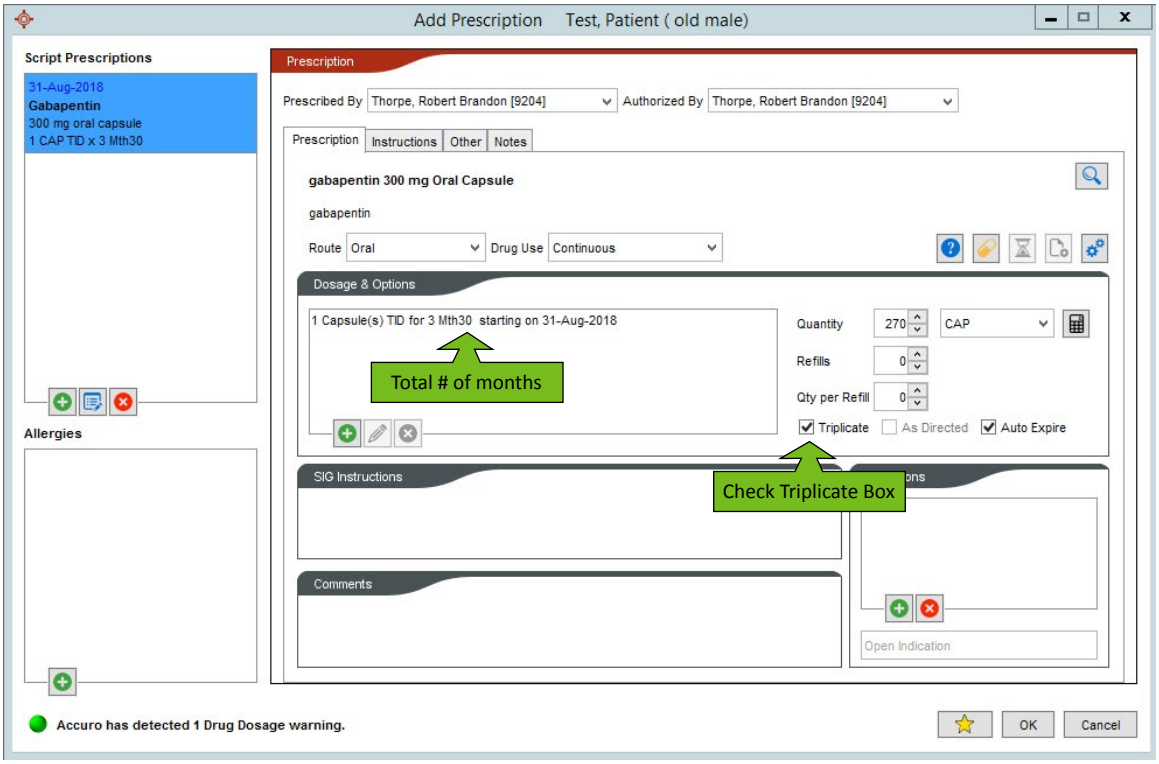
In Accuro, there is a better way to meet PRP requirements

1

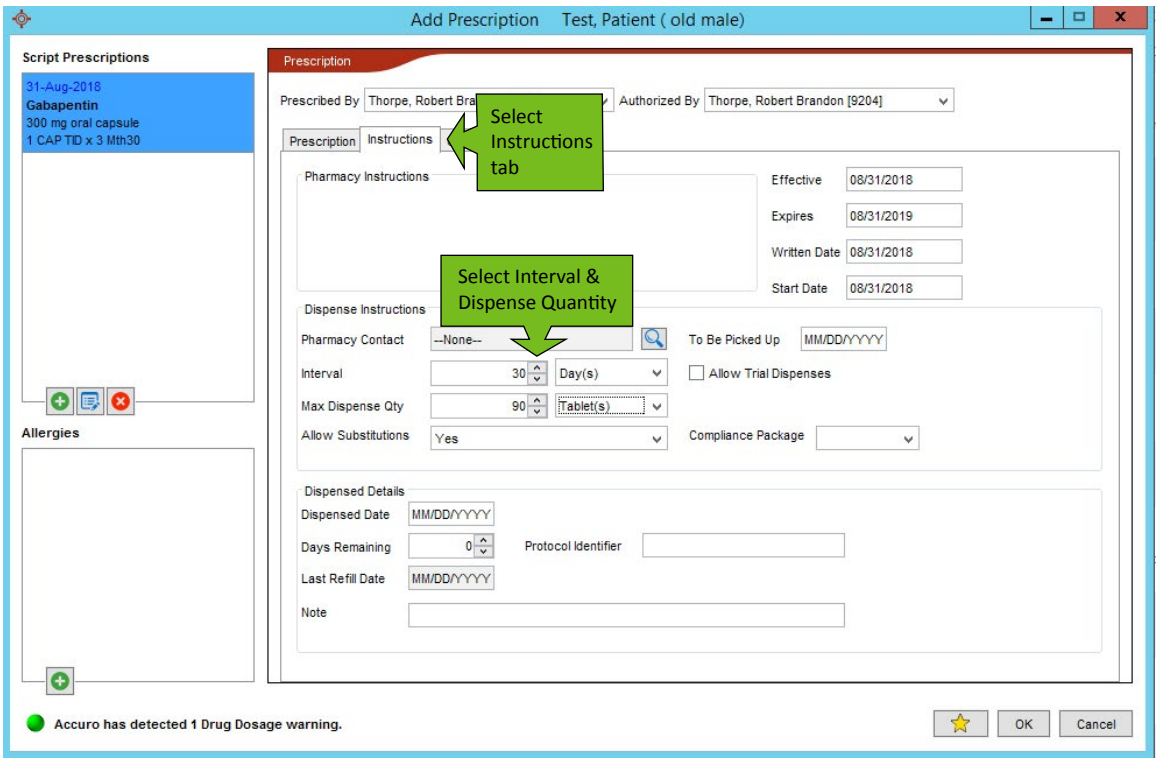
Be sure to check **Triplicate** - prescribe the full amount (e.g. 3 months).

Checking the Triplicate box will ensure the software prints all requirements on the actual prescription document.



2

Then, check **Instructions** tab and select interval and dispense quantity.



Special thanks to Dr Brandon Thorpe for his help with the Accuro visual representations*

While these requirements are not always forgotten, incomplete PRP prescriptions most commonly occur with **benzodiazepines** and **gabapentin**. Remember to ensure that all your prescriptions for Prescription Review Program medications contain all of the information elements described in bylaw 18.1.

Bylaw Changes for the Prescribing of Methadone for Pain

Did you know that Bylaw 19.1 Standards for prescribing of methadone or buprenorphine for addiction *has been updated and that physicians no longer require Registrar approval (i.e. a "methadone exemption") to prescribe methadone for the indication of pain?*

Methadone Exemption no longer required to prescribe Methadone for pain.

Bylaw 19.1 (e) states:

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

It is assumed that when prescribing methadone for pain, most prescribers would select the Metadol® products as opposed to a compounded methadone suspension which is required in the treatment of opioid use disorder (Registrar approval is still required when prescribing for this indication!).

When writing a prescription of methadone for pain, it should be written no differently than any other opioid and is subject to the requirements of the Prescription Review Program (see CPSS Regulatory Bylaw 18.1).

The CPSS Regulatory Bylaws can be accessed on the College website at: https://www.cps.sk.ca/iMIS/Documents/Legislation/Legislation/Regulatory%20Bylaws.pdf

If you have any questions about these changes, you can e-mail the Prescription Review Program at prp@cps.sk.ca or call 306-244-7355.

LINK The "VIRTUAL" Physician Lounge

Child Psychiatry specialists have joined LINK!

Effective September 17, 2018, **Child Psychiatry** specialists will start providing telephone consultations to colleagues via LINK (*Leveraging Immediate Non-urgent Knowledge*).

LINK gives primary care providers and their patients rapid access to specialists to discuss less serious patient conditions.

Available 8:00 AM - 5:00 PM, Monday - Friday, excluding statutory holidays

Specialties providing the LINK service:

Adult Psychiatry
Palliative Care
Nephrology
HIV and HCV
Child Psychiatry (starting 2018/09/17)

Call: 1-844-855-LINK (5465)

For more information on LINK:
Visit the LINK Brochure or email LINK@health.gov.sk.ca

Government of Saskatchewan

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

How about sign language?

Register your language proficiencies online with the College at:

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

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

How can you, as a physician, help provide quality care to Indigenous patients in a culturally safe and welcoming environment? This section of DocTalk aims to give you some ideas!

Traditional Medicine in Today's Health Care System

Eagle Moon Health Office explains its role in bridging traditional medicine and today's healthcare system, as well as in removing inequities in health outcomes.

A collaborative text submitted by the Eagle Moon Health Office

Background

A unique part of the Saskatchewan Health Authority (SHA) is the Eagle Moon Health Office (EMHO). EMHO has been working quietly behind the scenes for over fourteen years, seeking to improve inequities in health outcomes faced so disproportionately by First Nations and Métis people. The SHA, along with the likes of the World Health Organization, acknowledges the importance of traditional medicine in improving the health of Indigenous peoples.

EMHO believes the knowledge and healing ways from both health systems can be utilized – side-by-side – in a way that takes into consideration a person's holistic needs. This is patient-centred care.

What is Traditional Medicine?

Traditional medicine involves working with a person to help them heal, **not just physically, but mentally, emotionally and spiritually** as well. Traditional medicine people not only have an extensive knowledge of many medicines found in nature to help with physical ailments, but also of healing ceremonies to help with all ailments. Traditional medicine is open to all people, regardless of background or ethnicity.

What is EMHO's Role?

With this in mind, one of EMHO's greatest challenges has been learning how to support and resource traditional medicine, healing and culture within a western-styled health authority. Early on – through its own experiential learning – EMHO recognized that for traditional knowledge

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to be maintained and developed, it has to be consistently practised. Moreover, given that knowledge of traditional healing and medicine is passed on orally, EMHO took the position that direct experience with medicine men, traditional medicine, ceremonies and culture is essential in understanding the nature and processes of traditional healing ways. Creating opportunities for traditional practices to take place, especially with First Nation communities, is where EMHO has found much of its work and how it has developed much of its knowledge and strength.

After dozens of projects, hundreds of meetings, and thousands of ceremonies, EMHO continues to develop relationships and partnerships that are helping the SHA make traditional medicine available. EMHO hosts or supports healing gatherings, for both single and multiple days, where people are able to see a number of different medicine men and healers. The office also hosts or supports other ceremonies such as sweat lodges and sun, horse, chicken and ghost dances. EMHO has a network of medicine men and healers ready and willing to work with the SHA. Together, they are creating an environment where people can access medicine men and traditional healing ways at EMHO and other locations in the Regina area.

EMHO works with a range of SHA teams, community organizations, individuals and other stakeholders. Currently, a project with SHA's Meadow Primary Health Care Clinic is supporting the inclusion of traditional medicine as part of the services offered to patients of the Meadow Chronic Pain Clinic.

EMHO hears traditional requests from people seeking help with mental illness, addiction, COPD, cancer and a long list of other health issues. Some already seek health care from both health systems, such as seeing both a medicine man and a psychiatrist to deal with mental health issues or working with both a medical doctor and a medicine man to deal with diabetes.

Looking Forward

As the two health systems explore the possibilities of working closer together, a deeper level of respect and understanding for each discipline is gained. Their co-existence in a modern health-care system will undoubtedly serve to improve the health and wellness of all people. Indeed, EMHO is working towards creating a healing lodge, as called for in the Truth and Reconciliation Commission of Canada (TRC) report, Honouring the Truth, Reconciling for the Future.

Envisioning a time when traditional health care is as available as western health care, EMHO is proud to be working towards making it a reality.

EMHO is located at 400 Broad Street, Regina, SK and can be reached at 306-766-6995.

TELL US!

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

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

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

Where are My Medical Records?

<u>Physicians leaving practice or moving</u>: Remember to call or write the College to let us know where your files will be kept, and who to contact to gain access!

In 2010, the College established a process and database to collect information regarding location of medical records once a physician relocated, retired, moved outside the province, etc.

Patients/or Physician's offices can call the College at (306) 244 7355 to obtain information regarding access and location of medical records.

It is important to note the College of Physicians and Surgeons of Saskatchewan is <u>not</u> a repository of medical records.

MoH Seeking Physicians to Serve as Recognized Authorities Recommending Insured Services for Gender Reassignment Surgery

To all licensed family practitioners in Saskatchewan:

The Saskatchewan Physician Payment Schedule (Section N preamble) states that gender reassignment surgery (GRS) is insured only if performed on patients for whom surgery has been recommended by an authority recognized by the Medical Services Branch.

The Ministry of Health is interested in expanding the number of Saskatchewan physicians serving in the role of recognized authority.

If a physician has an interest in serving in this capacity, the Ministry would like to discuss the current process with you. Please contact Ms. Janet Jurcic, Senior Insured Services Consultant, and Ms. Denise Grad, A/Director Insured Services at 306-787-3475 or by email at janet.jurcic@health.gov.sk.ca or denise.grad@health.gov.sk.ca

TAKE-HOME NALOXONE KIT ACCESS

Wondering about naloxone access and coverage for your patients?

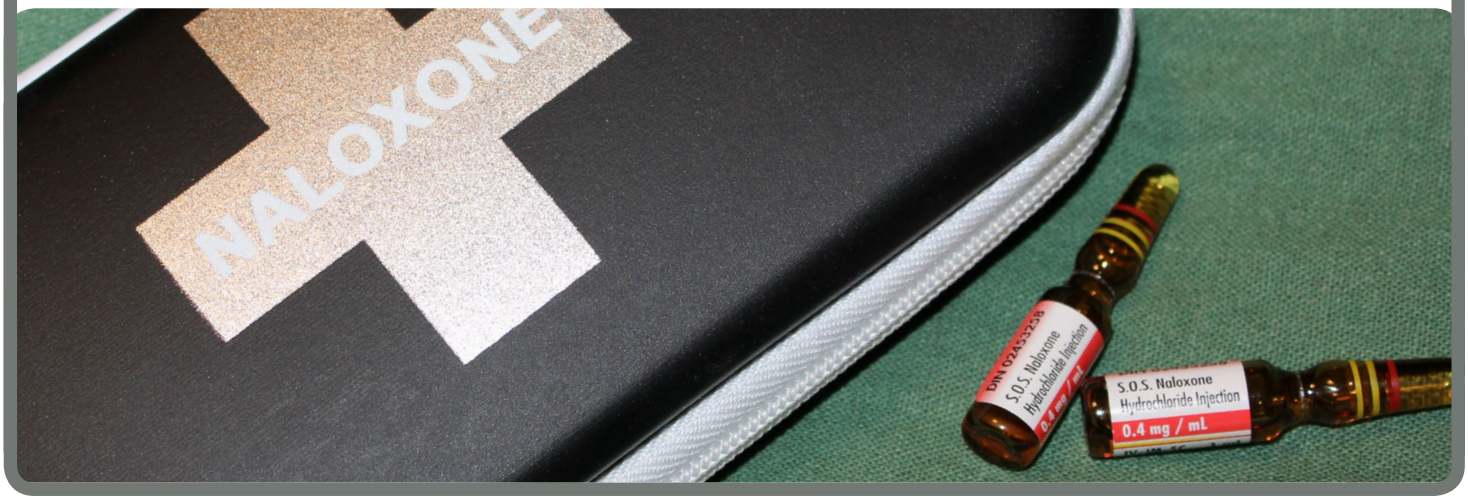
In Saskatchewan, naloxone is available free of charge (funded by the provincial government) at various sites across the province. Community pharmacies also carry naloxone kits and they are available for purchase, or can be billed to a drug plan. Below are the criteria for naloxone coverage for the two main drug plans in Saskatchewan (NIHB and Sask Health).

	NIHB Beneficiaries	Sask Health Beneficiaries	Cost when no coverage available
Injectable naloxone kit	Covered (open benefit) • Can be prescribed or pharmacist recommended • May be requested for personal use or to protect an at-risk person • Client requesting naloxone does not have to specify who it is for, but must be billed under the client who is requesting it	Funded through the provincial Take Home Naloxone (THN) Program at approved sites • Covered for Saskatchewan residents who are at risk of an opioid overdose and/or who might witness an opioid overdose, such as friends and family of people who use opioids • Must complete training	~$60
Narcan Nasal Spray		Not Covered	~$210 ~$225 for kit
Distribution locations	Any community pharmacy (with available stock) *Naloxone Registry:* https://www.skpharmacists.ca/uploads/media/5ba13220f1317/pas-naloxone-registry.pdf?token=[M2234	See link below for a list of distribution sites across the province. http://publications.gov.sk.ca/documents/13/109322-THNK-Directory-Nov18.pdf	

Of note, both the Department of National Defense and Veterans Affairs Canada covers both the injectable and the nasal spray for their beneficiaries.

Questions? Email: TakeHomeNaloxone@health.gov.sk.ca.

Staff at the THN program can provide information on the program to the general public, healthcare professionals, Community Based Organizations, and other interested parties. They can help connect people to their nearest distribution site and assist organizations who are interested in becoming Placement Sites (CBOs that might have an overdose on location, like a shelter) or Training & Distribution Sites (including SHA satellite sites, CBOs, clinics, pharmacies).



Saskatchewan Health Authority

Pharmacy Services
Saskatoon

Medication Management

Best practice for safe medication use

Date:

June 12, 2018

Issue:

- Medication Safety

Distributed by:

Medication Use Quality Committee (MUQC)

Chair

Angela Butuk

Medication Safety Officer

655-2263

Angela.butuk@saskhealthauthority.ca

For the information of:

Physicians

Pharmacy

PLEASE POST/ DISTRIBUTE

Texting Orders

The Issue:

Institute for Safe Medication Practices (ISMP) has identified a concerning trend towards using SMS or texting technology to communicate patient information including the use of texted medication orders. This practice has been reported in the Saskatoon area.

Background:

ISMP has identified significant patient safety risks with this practice including unintended auto corrections, privacy, confusing abbreviations, potential for patient misidentification, inability to document orders, spelling errors and incomplete orders. Please see the accompanying pdf document from ISMP for more information.

Action:

The use of texted medication orders is a patient safety concern and is not supported in the Saskatoon Area.

SASK LEADERS IN HEALTH CARE

Dr. Dennis A. Kendel Distinguished Service 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 each year.

During a special awards banquet held on November 30th, 2018, the Council of the College of Physicians and Surgeons of Saskatchewan presented Dr. Morris Markentin, an inner city Saskatoon-based family physician with a special interest in addictions and infectious diseases, with the prestigious award.

According to Dr. Brian Brownbridge, President of the College Council, "Dr. Markentin is a leader and visionary dedicated to his field of practice. He has freely given countless hours of his time to provide care and develop dedicated services for an at-risk, vulnerable and marginalized segment of the population. It gives Council great pleasure to present this award to a physician who endeavors to provide such a positive influence on the quality of healthcare dispensed to patients."

"I am both humbled and honoured to accept this award. It is a privilege to be able to practice medicine and to serve the people of Saskatchewan. My patients and team members continue to teach me and push me to do better - for that I am grateful. I do not do this work alone. I have great respect for Dr. Kendel, and it truly is an honour to receive this - it was totally unexpected," said Dr. Markentin.

Dr. Morris Markentin
2018 recipient

Dr. Markentin holds several positions of leadership among multiple healthcare organisations but prefers to lead by example. He has personally led fundraising efforts for the establishment of transitional housing of HIV patients by Sanctum Care Group, a group he co-founded.

As one co-nominator, Lisa Clatney, Executive Director of the Saskatoon Community Clinic, states: "Morris is a passionate and tireless advocate for the clients he works with. He 'gets' social determinants of health, and how history and colonization, residential schools, Sixties scoop, etc., have had lasting impacts and intergenerational trauma in many of the patients he works with. He advocates and lobbies to all levels of the government to ensure that appropriate resources are directed, and redirected to our vulnerable and at-risk populations, many of whom don't have a voice to speak up."

Click here for news release & full biography (available at https://bit.ly/2PvUVx7).

NOMINATE A COLLEAGUE FOR 2019!

Nominations are open until September 30th of each year

Nomination packages for 2019 are available on the homepage of the College website at www.cps.sk.ca, or by writing to Sue Waddington at OfficeOfTheRegistrar@cps.sk.ca.

Senior Life Designation is awarded to physicians who have been licensed on a form of postgraduate licensure in Saskatchewan for a cumulative total of 40 years*.

Senior Life designation is honorary only. It conveys no right to practise medicine in Saskatchewan, to hold office or to vote.

A physician may concurrently hold Senior Life Designation and another form of licensure.

40 Years

In recognition of 40 years of fully licensed practice of medicine in the Province of Saskatchewan

14 participants (pictured below) were able to join us in person during the College's Annual Awards Banquet to receive their Senior Life Designation Award. Their full biographies can be accessed in the event's news release on the College website at: https://bit.ly/2PvUVx7.

Additional recipients for 2018 are:

Dr. Deirdre Andres
Dr. Joan Baldwin
Dr. Malcolm Banks
Dr. Joe Chin
Dr. Michael Dickson
Dr. Ronald Kostyniuk
Dr. Estanislao Maciel
Dr. Michael Montbriand
Dr. Kulwant Rai
Dr. John Reilly
Dr. Victor Thackeray


Dr. Linda Baker


Dr. Donald Cockcroft


Dr. Alanna Danilkewich


Dr. Neil Devitt


Dr. Anne Doig


Dr. Vernon Hoeppner


Dr. James Irvine


Dr. David Kemp


Dr. James McHattie


Dr. Abraham Ninan


Dr. Lorne Pilot


Dr. John Shewchuk


Dr. Margaret Tysdal

INFECTION PREVENTION

News Updates

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

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

Réseau Santé en français de la Saskatchewan

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

HEALTH ACCOMPAGNATEUR INTERPRETATION SERVICES IN FRENCH

French-speaking newcomers | Seniors | Families

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

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

You may also come across Saskatchewan Francophone Seniors and Families:

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

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

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

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

This is not an emergency service

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

CCENDU IS ON FACEBOOK!

Stay updated on drug news in Saskatchewan and across Canada!

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

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

We're Working for You

College of Physicians and Surgeons of Saskatchewan

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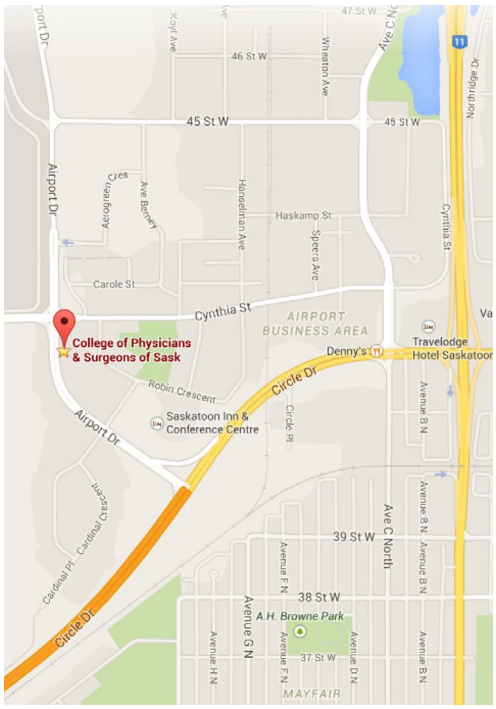
Fax: (306) 244-0090
E-mail: cpssinfo@cps.sk.ca
Visit us at: www.cps.sk.ca

KEEP IN TOUCH

OUR LOCATION:



Senior Staff

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

OUR DEPARTMENTS

Office of the Registrar

Telephone	1 (306) 244-7355
E-mail	OfficeOfTheRegistrar@cps.sk.ca

HR & Finance

Telephone	1 (306) 244-7355
E-mail	amy.mcdonald@cps.sk.ca

Communications

Telephone	1 (306) 667-4638
Media Inquiries	communications@cps.sk.ca

Quality of Care (Complaints)

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

Diagnostic Imaging & Lab Quality Assurance (Regina)

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

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

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

Registration Services

Telephone	1 (306) 244-7355
Assessment/Supervision	cpssreg-assess@cps.sk.ca
Registration Inquiries	cpssreg@cps.sk.ca
Corporate Inquiries	cpssreg-corp@cps.sk.ca
Certificate of Professional Conduct/Good Standing	cpssreg-cpc@cps.sk.ca