DocTalk

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Yours truly, Law Enforcement - What physicians need to know

Feedback wanted for Strategic Plan!

College of Physicians and Surgeons of Saskatchewan cps.sk.ca Volume 6 Issue 2 2019

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DocTalk

Volume 6, Issue 2

ISSN 2368-0628
ISSN 2368-0636 (Online)

2019

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

Submit your ideas & articles at any time to COMMUNICATIONS@cps.sk.ca
(Deadline for the next issue is **December 6, 2019**)

Dr. Brian Brownbridge
President, CPSS

Council Chooses Five Governance Initiatives

The fundamental role of the College of Physicians and Surgeons of Saskatchewan is to ensure, to the best of its abilities, that physicians practice in a manner which is safe, and the public is protected.

The College receives its legislative mandate from *The Medical Profession Act, 1981* of Saskatchewan which outlines the responsibilities and powers of the College and the organizational structure and composition. Over the last year, Council has examined the governance model of the College and has chosen five initiatives to study with hopes of improving its present processes within the restrictions of its governing legislative mandate. These five areas are:

- How to develop better communication with the public
- How to develop better communication with physicians
- Developing expected competencies for councillors and establishing a process to assist with recruitment
- Developing a better method for councillor assessment
- Should there be additional standing committees? If so what committees? How should they be constituted?

Council with input from the senior leadership team felt that these five areas were the priorities. Each area was assigned to a sub-committee of council and a representative of the senior leadership team.

How to develop better communication with the public

Some of the initiatives the committee has explored is examining the websites of other Colleges across the country. Many of these colleges have a more robust public education section. Some Colleges have created videos that demonstrate and explain appropriate physical examinations of sensitive areas. Some have used links to educational material that has been created by other governing bodies and professional organizations. It is apparent that we can use many of these ideas to improve our interaction with the public.

How to develop better communication with physicians

The committee examined how other provincial Colleges communicate with their registrants. Certainly, electronic medium was by far the preferred method. All Colleges are struggling with the correct balance of sharing information with busy physicians and busy email inboxes. How do you prioritize emails from the College? How can we ensure that physicians receive and read important policy and guideline changes that may affect their practice? Can we create a private electronic mailbox that reminds physicians that they have important information in their inboxes? What do we do with the physicians who have not fully embraced electronic communications? These questions will be considered as Council proceeds with its work.

Developing expected competencies for councillors and establishing a process to assist with recruitment

The Medical Profession Act, 1981 outlines the composition of Council, including the electoral nature of selecting physician representatives and how public members will be appointed. Electoral processes have many positives, but an elected council may not represent the actual makeup of the registrants. As an example, the present Council has no elected female or Indigenous physicians. Many areas of Council's deliberations require some degree of expertise in different practice areas and

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having a council with diverse abilities is beneficial. Council's work is becoming more legalistic and some councillors with previous legal experience can be an asset rather than seeking outside legal counsel to advise Council on disciplinary matters, which drives up the costs of governance. These are just two examples of possible improvements that may improve the function of Council. While Council must work within the limits of its legislative framework, it is considerong how to encourage registrants with specific abilities to run and to hopefully be elected in our present structure. This is a very important question.

Developing a better method for councillor assessment

The primary responsibility of Council must always be what is best for the public; sometimes that comes into conflict with what is best for the profession. Councillor preparedness and active participation are two suggested priorities that Council should concentrate on. Both areas are fundamental to fulsome discussion and the understanding of complex issues. A potential 360 degree review process is one option. A structured assessment tool of councillor performance will be trialed in the next few months.

Should there be additional standing committees? If so what committees? How should they be constituted?

A great deal of Council work is policy and guideline development and review. Would Council be more effective if there were standing committees of Council assigned to different aspects of policy development? How would these be populated and what areas of policy development are better suited to this approach? Do all Council members want to be involved in policy development?

The area of governance is a complex field and the College is actively deciding if there is better structure and responsiveness to lead the College forward. Governance models are somewhat constrained by *The Medical Profession Act, 1981*, but Council does feel that there are improvements that can be achieved within this framework that hopefully will serve the public and registrants more effectively. I personally welcome any ideas on these issues from the public and registrants. An organization that does not strive to improve will become ineffective in its mandate and likely will be replaced.

Council and Senior Staff of the College of Physicians and Surgeons of Saskatchewan 2019

Back row (L-R): Ms. Caro Gareau, Dr. Preston Smith, Dr. Adegboyega Adewumi, Dr. Yagan Pillay, Dr. Mark Chapelski, Dr. James Fritz, Dr. Olawale Igbekoyi, Mr. Bryan Salte, Dr. Werner Oberholzer, Mr. Ken Smith, Mr. William Hannah, Mr. Burton O'Soup, Mr. Ed Pas, Dr. Yusuf Kasim, Dr. Pierre Hanekom. *Front row (L-R):* Dr. Alan Beggs, Ms. Sue Waddington, Dr. Grant Stoneham (Vice-president), Dr. Karen Shaw (Registrar), Dr. Brian Brownbridge (President), Ms. Sheila Torrance, Dr. N. Prasad Bhatala Venkata, Dr. Oladapo Mabadeje, Mr. Lionel Chabot.

Council Activities and Plans for Improvement

By Dr. Brian Brownbridge on behalf of Council

Understanding the Treaties

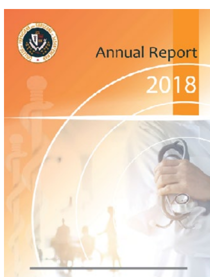
Recently, Council was fortunate to welcome a well-known Indigenous academic to lead an educational session pertaining to Indigenous health and social wellness, including understanding Treaties from an Indigenous perspective, the importance of spiritual well-being in the Indigenous culture, and how past treatment had a very detrimental effect on traditional spirituality in their culture. European descendants believed that there was little benefit in traditional Indigenous medicine; this is likely very far from the truth and a great deal of potentially beneficial medicines may be available throughout Canada. More on page 26.

Sexual Boundary Violation Policy Review

Council is actively reviewing sexual boundary violation policies. Council has approved in principle recommendations for bylaw amendments from a committee studying this issue and has asked that it be vetted by the larger community. Please see the website for more information. One area that will represent a significant change is the concept of presumptive penalties for serious sexual boundary violations. The exact amount of time that a physician will have to wait before applying for reinstatement of licensure following revocation will likely be significantly longer than the time that has been directed to date. This is in line with new practices in many provinces in the country, and will be considered by Council at its upocoming meeting.

Trends in Quality of Care & Complaints

Council continues to see an increase in the number of complaints by the public. This trend is not unique to Saskatchewan and is occurring across the country. The reasons why this is occurring are not clear, but it is a worrisome trend to Council.



Annual Report

Council published its 2018 Annual Report in September. The document is available on the College website or by **clicking here.**

Progress in Policy Revision

The Council has managed to progress on many policy revisions and development of new policies. This endeavour occupies a significant amount of time for the Senior Leadership Team and Council.

Some of the recent key policies are: Sale of Goods and Services by Physicians, Code of Professional Conduct, Sexual Boundary Violation revisions, The Practice of Telemedicine, Conflict of Interest and the adoption of the Canadian Medical Association (CMA) Code of Ethics with revisions. More details are available on page 17.

Governance and Strategic Planning

In November, Council will spend a significant amount of time in developing a strategic plan which will lead the College forward for the next five years. Members of College staff and Council are filling out a questionnaire which will help guide the direction of the strategic plan.

Council Elections 2019

Council Elections will soon be underway for the **Regina**, **Saskatoon** and **South-West** areas. Ballots will be sent out by conventional mail to physicians in those areas and must be retuned to the Office of the Registrar by December 3, 2019 to be counted.

Strategic Plan - Member & Public Surveys

Your feedback is needed!

Council is providing members and the public with an opportunity to provide input to the College of Physicians and Surgeons of Saskatchewan as it develops its new strategic plan. We are asking that you please take the time to provide your feedback to the survey questions as your answers will be very helpful to inform Council as it works through its new strategic plan. Please click on the appropriate link to access your survey:

Survey questions for CPSS Members Only

Survey questions for the Public

Thank you very much for your assistance in this important work.

Dr. Karen Shaw
Registrar, CEO

How are we doing with the Opioid Crisis?

Dear Colleagues,
As you read this edition of Doctalk you will get a glimpse of some of the work the College has completed on your behalf over the last number of months in fulfilling our mandate to protect the public.

At the next Council meeting, Council will be engaged with a facilitator from the Institute of Governance to lead us through the development of a new strategic plan. Thanks to those who filled out the survey. Your suggestions, along with stakeholder consultation comments, will inform the discussion. Some of the themes coming forward include: the challenges of regulating new technologies, new ways of delivering health care services through artificial intelligence and virtual healthcare, and how to support continued competency and fitness to practice throughout a physician's career. Stay tuned in the New Year to see how the strategic plan is shaping up.

In this edition of Doctalk I have provided you an overview of our continued efforts in addressing the opioid crisis from our perspective as it has been the central focus of the work of several agencies within the healthcare system.

The Opioid Crisis – Our Continuing Efforts

Two of the factors that have contributed to the opioid crisis are the high rates of opioid prescribing for conditions including chronic pain, and the emergence of strong synthetic opioids in the illegal drug supply.

The Saskatchewan Provincial Auditor's 2019 report (Chapter 7 - Health- Monitoring Opioid Prescribing and Dispensing) noted the following*:

1. Physicians prescribe 95% of the opioids prescribed in the province of Saskatchewan.

2. The number of individuals receiving prescribed opioids dispensed in Saskatchewan has decreased by about 3.3% from 2017-18 to 2018-2019. 441,354 opioid prescriptions were dispensed to 98,947 patients; the majority being for hydromorphone (45%), codeine (32%) and morphine (10%). These numbers exclude hospital dispensed opioids.

3. For the six most common opioids prescribed in Saskatchewan (codeine, hydromorphone, oxycodone, tramadol, morphine and fentanyl), Saskatchewan's 2017 defined daily doses of 6,616 doses per 1,000 population is above the national level of 5,479 per 1,000 population.

4. Among the 19 cities with populations above 100,000 in Canada, Regina had the highest rate of opioid poisoning hospitalizations with a rate of 28.3 per 100,000 people in 2016-2017. Saskatoon's rate was 26.1 per 100,000 people as compared with 20.5 per 100,000 people for Vancouver and 7.9 per 100,000 people for Toronto.

5. The Chief Coroner's April 2019 report noted Saskatchewan had 119 deaths due to opioid drug toxicity in 2018, and 117 in 2017. It was noted that most of the deaths in 2018 were due to overdoses of fentanyl (32), Hydromorphone (31), methadone (26) and morphine (25).

Original references for these can be accessed in the full report at* **www.auditor.sk.ca

Continued on p. 8...

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While we have little control over the illicit supply of opioids, we do have some control over what we prescribe, so optimizing our prescribing of opioids seems a good place for us to continue our efforts.

What have we focused on?

Prescription Review Program

Many of you will know that the Prescription Review Program (PRP) is an educationally-based program administered by the CPSS on behalf of the Ministry of Health that monitors medications with known misuse, abuse and diversion potential for possible inappropriate prescribing by physicians, and possible inappropriate use by patients. The list of medications monitored by the PRP is listed in the CPSS Regulatory Bylaw 18.1.

The PRP's funding partners include the Ministry, the College of Physicians and Surgeons of Saskatchewan, the Saskatchewan College of Pharmacy Professionals, and the Saskatchewan College of Dental Surgeons. The Saskatchewan Registered Nurses Association (SRNA) has recently expressed interest in becoming a funding partner. SRNA will be a great addition to our funding partners to collaborate with the Saskatchewan Health Authority (SHA) to build synergies in addressing the opioid crisis.

Some highlights of the recent work of the CPSS and the PRP follow:

1. Our College Council has authorized funding to hire a half time pharmacist for two years to focus on increasing profile reviews and educational outputs of the Prescription Review Program (PRP). This funding is in addition to the funding that is already provided to the PRP as a funding partner.

2. The PRP and the CPSS are working with the Ministry and the other funding agencies to update the list of opioid medications monitored through the PRP. These changes will be reflected in the revision of Bylaw 18.1.

3. PRP is currently using the new MicroStrategies program developed by the Ministry to identify potential inappropriate prescribing. This new program provides some analysis of the data and the PRP staff are actively learning what reports can be generated to assist in the review of the profiles and ultimately to assist physicians in optimizing prescribing.

4. The PRP and the CPSS have worked with the Coroner's office to develop an information sharing agreement so information pertaining to opioid related deaths can be shared for the purposes of review. We are interested in identifying those deaths related to prescription misuse.

5. Council has a working group established to look at several issues related to the opioid crisis, such as forged prescriptions, the review of the Pharmaceutical Information Program (PIP) and the EH-Viewer prior to prescribing PRP medications, consideration of educational requirements, etc.

6. The PRP staff and the CPSS staff are working with provincial and national agencies/bodies who have an interest in the opioid crisis to develop synergies with these agencies and identify best practices. We have focused in the province in participating in several opioid advisory/stewardship committees, so that our efforts are collaborative, duplication of efforts is reduced, and resources are utilized wisely. We are interested in the opioid stewardship mentorship that is being supported by the SHA in the Regina area.

7. The PRP and the CPSS had been working on a number of improvements in the delivery of the PRP program over the last year and have responded to the Provincial Auditor's recommendations in a number of respects: a) to improve the currency of the list of opioids monitored (stakeholders meeting to update the list of opioids in Bylaw 18.1), b) decreasing the time in notifying physicians of prescribing concerns (the addition of a half time pharmacist) , and c) developing better methods to document activities related to follow up on prescribing concerns (creation of additional databases). Some of these improvements in process will assist us in understanding whether our work is making a positive difference in the opioid crisis.

8. The PRP staff and the CPSS are working with the Ministry to request access to the PIP and

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eH-Viewer which would decrease the information requests of the physician.

9. Educational opportunity to update knowledge for chronic pain management through ECHO modules (described below).

A concern I wish to raise to the profession is that some physicians have taken issue with receiving letters from the PRP staff. It seems that some are offended with the questions that are being asked about their prescribing. They question why the PRP staff are requesting information about the patient's diagnosis, urine drug screens or other medications that have been tried, citing that some of the information is on PIP or the eH-Viewer. The PRP staff does not have access to diagnostic information and does not currently have access to either the PIP or the eH viewer. Although our previous requests for access have been declined, one of the recommendations from the Provincial Auditor (Chapter 7 Health- Monitoring Opioid Prescribing and Dispensing) was to recommend the Ministry provide the PRP access to patient information and a functional IT system that would facilitate PRP's work. This access would allow PRP to look at previous prescribing and urine drug screens without requiring the physicians to provide this information. We are optimistic that the Ministry is addressing this issue.

In the meantime, however, when you are asked for information, please provide a substantial response to the PRP staff. Further, we would ask that any advice or recommendations for improvement offered by the PRP staff be taken in the educational spirit intended – a quality improvement opportunity.

First Nations Inuit Health Branch- SK Funding

Funding from the First Nations Inuit Health Branch -SK (FNIHB-SK) has allowed for support for increased access to education about chronic pain.

A Statement of Collaboration was signed with the University of New Mexico (UNM) Project ECHO® on December 1, 2017 to allow CPSS to use the platform to run a pilot in Saskatchewan. The CPSS Project ECHO® Management of Chronic Pain Pilot began offering sessions in January 2019 and ended in May 2019. The program was delivered online via Zoom, a distributed learning platform. A total of ten sessions were delivered with an average of 29 participants attending each session. Physicians comprised the greatest number of participants overall equaling between 27%-50% of participants per session.

Topics all focused around chronic pain, and included: assessment skills; CBT and other counselling approaches to chronic pain; prescribing exercise and other physical strategies; gabapentinoids; opioid tapering; headache assessment and management; pharmacological treatment of chronic nociceptive and neuropathic pain; overview of the use of cannabinoids; supporting self-management; and aberrant drug-related behaviors. Plans are underway for additional sessions in early 2020.

FNIHB -SK funding has also facilitated increased access to a multidisciplinary clinic, The Meadows, in Regina, and to some opioid agonist therapy services on the Beardy's and Okemasis First Nation and the Kamsack Stepping Stones project.

The Opioid Agonist Therapy Program - A Call for Providers

The CPSS has received funding from the Community Care Branch of the Ministry of Health since 2001 to administer the Opioid Agonist Therapy Program (OATP). The PRP staff support the activities of the Program. The OATP Medical Manager, Dr. Morris Markentin, provides clinical expertise to the program on a contracted basis.

In April 2018, Health Canada removed the federal exemption process required for physicians to seek approval to prescribe methadone for either pain or opioid use disorder. As a result, the CPSS updated Regulatory Bylaw 19.1 to reflect these changes. Two major changes to the bylaw include the addition of buprenorphine/naloxone, and the elimination of approval required to prescribe for the indication of pain. Approval by CPSS is still required to prescribe for addiction. In addition to the Health Canada change, the CPSS OATP Standards and Guidelines were also updated in December 2018 to include the newly approved Hospital-Based Temporary Prescribers (HBTP) and Corrections-Based Temporary Prescribers (CBTP).

Continued on p. 10...

Recently our Pharmacist Manager at the PRP attended a conference where a physician from an inner-city clinic in Ontario reported finding that physicians weren't prescribing OAT, and so they surveyed why. The top reasons for not prescribing Opioid Agonist Therapy included: lack of education, lack of multidisciplinary supports, lack of mentorship, and busy practices. In Saskatchewan, we are facilitating education and mentorship opportunities and advocating for more multidisciplinary supports.

Dr. Francine Lemire in her address to family physicians in Volume 65: June 2019 Canadian Family Physicians, *The Opioid Crisis: Getting to "better"* pointed out these things:

"Our best chance to have an effect is with intervention at the community level",

"Family doctors can and should play an important role in opioid agonist therapy",

and

"Don't do this alone – a critical mass of FPs, with support from other providers, where possible, facilitates the provision of good care…….".

We support her approach.

We would encourage you to take on this challenge.

Physicians interested in being approved as OAT providers can contact OAT Program staff regarding the requirements and approval process at **oatp@cps.sk.ca**. Physicians can train to be an OAT prescriber to initiate therapy or to provide maintenance therapy. Even if family physicians are willing to train to become a maintenance provider for their own patients this would free up some of the experts to initiate therapy for more patients. This would help immensely.

Become an approved OAT Provider!

A challenging yet rewarding area of work, there is a need for more OAT prescribers in all areas of the province. The process is straightforward and brief.

The **OAT Standards and Guidelines** will provide all the information you require as an OAT Provider. Different educational and training requirements are offered depending on the chosen level of approval, *Initiating* or *Maintenance*.

Both levels require the completion of one of the online courses below. (Other courses may be considered - please send the link to **oatp@cps.sk.ca** for approval.) The first three courses below are more comprehensive and cover both methadone and buprenorphine/naloxone and the last one is for buprenorphine/naloxone only.

As an Initiating Provider for methadone **and** buprenorphine/naloxone, you will also be required to spend up to two days with an experienced and approved OAT provider who will then recommend you for approval. For **only** buprenorphine/naloxone, only one day is required.

Approval for Maintenance only requires an ongoing relationship with an experienced mentor who will serve as a resource to you. Formal mentorship is not required.

You will need to read and sign the OAT Policy as part of the process. A mentorship approval document must also be signed by your mentor once they are confident you have gained the necessary skills required to be a successful OAT Provider.

As part of the approval process, the OATP will also look at your prescribing of Prescription Review Program (PRP) monitored drugs to see if there is any advice or education we can provide. The PRP is educationally-based and advice/education is provided by our Pharmacist Manager and program Pharmacist.

Please write to **oatp@cps.sk.ca** for more details.

Approved Courses

https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program (8 credits)

https://ubccpd.ca/course/addiction-care-and-treatment (15 credits)

https://machealth.ca/programs/opioids_clinical_primer/p/oud?utm_source=Campaign%20Monitor&utm_medium=Email&utm_campaign=OCP%20Course%206%20Email%20Blast

www.suboxonecme.ca

Dr. Val Olsen
Senior Medical Advisor

Preventing Patient Complaints

Complaints against physicians are increasing. Last year, almost 300 formal complaints were submitted and reviewed at the College. Many of the complaints fall into a few common areas, and many are potentially avoidable (meaning that both patient and physician would be happier!).

Years of combined experience reviewing complaints in our department have yielded a few suggestions for reducing the chance of a patient complaint.

LISTEN • EXPLAIN • RESPECT • FOLLOW UP • DOCUMENT

1. INFORMED CONSENT

There have been a number of recent complaints related to electronic signatures and the patient's belief that they have not signed a consent form, although the consent discussion did occur. It would be a reasonable step to explain this to a patient instead of just asking them to sign a blank tablet.

In obtaining informed consent for a procedure, it is essential that the expected outcome as well as the common and the most serious complications be discussed. With Electronic Medical Records (EMR) consents, the patient may not have the opportunity to read through the standard consent, which usually includes a paragraph stating that alternate or additional procedures may be performed to address any serious and unforeseen findings or complications. This possibility must be noted. The possibility of blood transfusion and the possibility of blood borne infection testing in the event of a health care worker injury should also be discussed with the patient.

It is good practice to allow the patient the time to read through the written consent form on the screen, or preferably to have a printed copy for the patient to read.

As with any patient interaction, there should be confirmation that the patient understands and has the opportunity to ask questions.

See: CMPA Consent Guide

2. COMMUNICATION

As in previous years, there have been a significant number of complaints related to poor communication. This includes the following types of concerns:

- Patients feel that their concerns are dismissed or not taken seriously
- Patients do not understand the expected outcome or side effects of treatment
- Patients are not given time to ask questions
- The physician is perceived as being insensitive or rude

Always confirm that you understand what bothers the patient, even if you do not think it is important. The "customer" is not always right, but does have a right to express concerns. Then, explain what you think is important, and why. The reason for the treatment and its expected effects should be outlined. Even though complaints refer to adverse outcomes, it is usually the UNEXPECTED outcomes that prompt complaints. Ask if the patient understands, and invite questions.

Treat the patient respectfully.

At least a quarter of all complaints against Saskatchewan physicians this year have been related to some aspect of communication. Taking these steps potentially would have prevented many of those complaints.

See: Physician-Patient Communication

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3. FOLLOW-UP

Failure to follow up on abnormal results, failure to provide follow-up after treatment or procedures, and failure to follow up on recommendations from specialists (including radiologists) form a category of complaints based on omissions rather than actions.

Adequate follow-up is expected by patients and by the College. Whether or not the outcome for the patient was influenced by the lack of action, a complaint can be founded against a physician who has been shown to have missed appropriate steps in follow-up.

Every office should have a mechanism to track, acknowledge, and follow-up on test results. This can and should be built into EMR systems to avoid missing results and to ensure that the patient is informed and the necessary referral or follow-up care is documented. One method is to task the physician when tests are ordered, and complete the task when the result is viewed.

The action (recall, change in management, referral) should be documented.

See: Effective Follow Up

According to the College policy on Medical Practice Coverage, physicians must be available to patients currently under their care, or arrange alternate coverage. This also applies to specialists who have initiated a course of treatment or performed a procedure, until they have concluded the treatment or transferred responsibility to another physician. Ideally, clear arrangements should be made for the patient to be reviewed when a new treatment or procedure is to be followed up. It is not acceptable to leave the arrangements solely up to the patient.

4. DOCUMENTATION

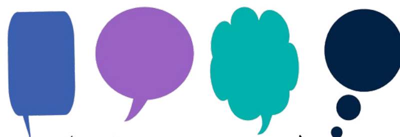
The statement "If it is not in the chart it didn't happen" is most significant in the case of complaints and lawsuits, but also relates to poor patient care and follow-up. Every finding, including relevant negative findings in the history and physical exam, should be accurately recorded. Be careful of template EMR documents, which may inaccurately indicate that something was done when it was not. These need to be modified to reflect what was actually done, and other items removed. Dosages, allergies, consent discussions, treatment plan and follow up plans are frequently omitted from medical records. Remember that the chart should allow another physician to take over care of your patient at any time if necessary.

With EMR more common now, the problem of legibility is not as common, but there are still paper documents. If they are not legible they are not adequate.

It is also prudent to document discussions, especially where there was some conflict, and patient refusal of treatments.

CPSS Bylaw 23.1 outlines the minimum requirements for medical records. See: Regulatory Bylaws

The College would like to see a decrease in complaints against physicians. Let's all be sure to take the steps that are necessary to make that happen!



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.

Sheila Torrance
Legal Counsel

New Policy Applicable to Uninsured Services

At its September 2019 meeting, Council approved a new policy addressing the provision of uninsured services by physicians. This policy can be accessed on the College website at the following link: https://bit.ly/31FLzox

The policy is intended to guide physicians in billing patients for services that are not covered within the public health system. 'Uninsured services' is defined to include professional services provided by physicians that are not publicly funded by the Medical Services Branch (MSB); medically required services provided to persons who are not insured by the Saskatchewan public health care system; and medically required services that are available on a private pay basis.

In section 4, the policy establishes expectations of physicians providing uninsured services. These include the following: fees must be reasonable, and physicians are directed to the SMA Fee Guide (uninsured services) for guidance; the patient must be informed of the fee in advance, and the physician remains responsible to ensure this is done; and physicians are not permitted to charge a fee in exchange for a promise of preferential access to services. While block fees (fixed fees for all designated uninsured services during a specified time period) are not commonly used in Saskatchewan at present, the policy establishes expectations in the event a physician wishes to offer a block fee option to address payment for uninsured services.

Prior to its approval by Council, feedback on this policy was sought from stakeholder organizations, as well as from all members (through an email blast) and interested members of the public (through a survey accessible on the College website and Facebook page). More than 60 responses were received (almost all from physicians), and the majority were in favour of the implementation of a policy addressing the provision of uninsured services by physicians. There was, however, a range of perspectives with respect to the appropriateness of this type of policy. At one end of the spectrum, several respondents felt that the College was overstepping its mandate and intruding on the jurisdiction of the Medical Services Branch and the Saskatchewan Medical Association. At the other end of the spectrum were several respondents who felt that the College should go further and establish suggested fees for certain procedures.

It is important to note that while the Guiding Principles set out in section 3 of the policy require a physician to consider the availability of publicly-funded options prior to offering a private pay option, the policy does not require a physician to exhaust publicly-funded options prior to doing so. This seemed to be a misperception of several respondents; as such, the Registrar's Office wished to highlight this discrepancy.

Council reviewed all of the stakeholder feedback prior to approving the policy in its final form. In doing so, the Council was guided by its primary mandate of public protection and the requirement that it act in the public interest.

In the context of the provision of uninsured services to patients, physicians are reminded that CPSS regulatory bylaw 9.1 and the CPSS guideline on conflict of interest are also relevant. These documents have recently been updated to ensure consistency with the new policy addressing the sale of products by physicians.

Stem Cell Therapies / Platelet-rich Plasma Therapies

In Mr. Salte's article "Stem Cell Therapies – Health Canada Requirements" included in the Volume 6 Issue 1 2019 edition of DocTalk, he addressed Health Canada's requirements to provide stem cell therapies. Since that time, Health Canada has clarified that while platelet rich plasma ("PRP") meets the definition of a "drug" under the *Food and Drugs Act*, PRP treatments are not subject to the same restrictions as stem cell treatments, provided they meet certain criteria. The College recommends that interested physicians review the Health Canada position statement on PRP treatments.

https://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2019/70559a-eng.php

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 **NINE** discipline matters completed since the last Newsletter report.

Dr. Ahmed Belal

Dr. Belal admitted to unprofessional conduct for providing inaccurate information to Alberta Health Services while he was an employee of that organization. The penalty imposed by Council included a reprimand, a one month suspension, a requirement that he complete an ethics course, and a requirement that he pay costs in the amount of $5,201.25 .

Dr. Reynaldo Cardoso-Medinilla

Dr. Cardoso-Medinilla was found guilty by the Discipline Hearing Committee of three charges of unprofessional conduct. It was found that he breached an undertaking given to the College of Physicians and Surgeons that he would not perform ultrasound, that he inappropriately billed Medical Services Branch for the interpretation of ultrasounds performed at his clinic, and that his clinic performed ultrasound scans when there was not an arrangement in place for those scans to be interpreted in a timely manner. Dr. Cardoso-Medinilla was reprimanded, suspended for three months, ordered to take a course in medical ethics, and ordered to pay costs of $75,000. He was also fined $500 for failing to respond to communications from the Registrar. This decision is currently under appeal.

Dr. Murray Davies

Dr. Davies was charged with two charges of unprofessional conduct alleging a failure to maintain the standard of the profession concerning his prescribing practices and his medical record-keeping. The matters were resolved by alternative dispute resolution whereby Dr. Davies provided an undertaking that he would relinquish his licence as of July 18, 2019 and would never practise medicine anywhere in the world in future.

Dr. Hanan Abou El Yazid

Dr. Abou El Yazid admitted to unprofessional conduct for providing inaccurate information to Alberta Health Services while she was an employee of that organization. The penalty imposed by Council included a reprimand, a one-month suspension, a requirement that she complete an ethics course, and a requirement that she pay costs in the amount of $5,201.25.

Dr. Alfred Ernst

Discipline Matter 1
Dr. Ernst admitted to unprofessional conduct for engaging in unprofessional behaviour with employees of the local health region. He was directed to appear before Council at a future Council meeting to have a reprimand adminis-

Continued on p. 15...

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tered in person. He was also suspended for one month, required to complete courses in communications and the requirements of *The Health Information Protection Act*, and required to pay costs of $11,092.42.

Discipline Matter 2
Dr. Ernst was found guilty of unprofessional conduct by the Discipline Hearing Committee. The Committee found that he had failed to exercise due diligence to ensure appropriate billing, and that he knowingly billed certain codes and surcharges inappropriately. Council directed that Dr. Ernst appear at a future Council meeting to have a reprimand administered in person. Council also imposed a two month suspension, directed Dr. Ernst to take a course in medical ethics, and directed him to pay costs of $80,215.72. This decision is currently under appeal.

Dr. Narinda Maree

Dr. Maree admitted four charges of unprofessional conduct, including falsifying patient records provided to the College, using funds from the clinic where she practised for personal expenses, prescribing a medication in the name of a family member intended for her own use, and providing medical treatment to a family member. The Council reprimanded her, ordered a retroactive suspension of four months, imposed prescribing restrictions, imposed a requirement that she practise only under the supervision of an approved physician, and directed that she pay costs in the amount of $1,290.00.

Dr. El-fellani Mohammed

Dr. Mohammed was found guilty of unprofessional conduct by the Discipline Hearing Committee. The Committee found that a number of individual acts involving two female complainants constituted professional misconduct, and also found an escalating pattern of unprofessional conduct. The findings included inappropriate stethoscope examinations, inappropriate touching, and inappropriate personal questions. The Committee found inappropriate personal advances to both complainants. Dr. Mohammed was reprimanded, suspended for three months, directed to take courses in professional boundaries and ethics, required to have a female practice monitor present for any in-person professional encounter with a female patient, and required to pay costs of $87,467.69.

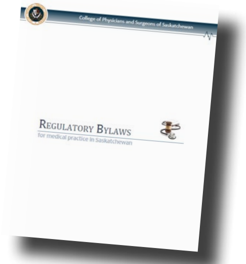
Dr. Bruce Zimmermann

Dr. Zimmermann was charged with unprofessional conduct relating to a failure to complete hospital charts in a timely manner. The matter was resolved by alternative dispute resolution, whereby Dr. Zimmermann provided an undertaking to complete a course in medical record-keeping, to cooperate in a chart audit, and to complete all hospital records including discharge summaries within 7 days of the patients' discharge.

IMPORTANT - PLEASE READ

Changes to Regulatory Bylaws

By Sheila Torrance, Legal Counsel, CPSS



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

There have been **FIVE** changes to College regulatory bylaws since the last edition of the Newsletter.

Bylaw 2.12 – Educational Licensure

Paragraph (j.1) was added to the bylaw, permitting residents to sign orders under *The Youth Drug Detoxification and Stabilization Act*, but only after consulting with a physician who will not be signing the order. The order must also be signed by a physician holding a regular or provisional licence.

This bylaw amendment arose from a request from the department of psychiatry and was intended to improve patient care.

Bylaw 23.3 – Delegation to Registered Nurses [...]

Paragraphs (a)(vii) and (b) were amended to address delegation of surgical assisting duties to a registered nurse. Surgical assisting duties can be delegated to a registered nurse in a facility operated by the Saskatchewan Health Authority (SHA) or within an accredited non-hospital treatment facility if the registered nurse has been assessed by the SHA as competent to act as a surgical assistant. In order to delegate surgical assisting duties, the physician must be satisfied that the registered nurse is capable to perform the duties as competently and safely as another duly qualified medical practitioner who has been granted privileges by the SHA to act as a surgical assistant.

This bylaw amendment was intended to bring the wording in line with current systems, as the previous wording required a registered nurse to be privileged by the health authority as a surgical assistant.

Bylaw 26.1 – Non-Hospital Treatment Facilities

Paragraph (j)(v)(13) was added to require the medical director of a non-hospital treatment facility to ensure that prior to a physician delegating surgical assisting duties to a registered nurse, the registered nurse has been assessed as competent by the SHA to act as a surgical assistant; has the appropriate knowledge, skill and judgment to perform the surgical assisting duties; and is able to perform the surgical assisting duties as competently and safely as another duly qualified medical practitioner with SHA privileges to act as a surgical assistant.

This amendment is intended to ensure that similar requirements exist to permit delegation of surgical assisting duties to a registered nurse whether at an SHA facility or a non-hospital treatment facility.

Bylaw 23.3 - Delegation to [...] Licensed Practical Nurses

Paragraphs (i) and (j) were added to allow physicians to delegate to LPNs the authority to inject bioactive agents, but only if the physician has first assessed the patient and established a treatment plan for the injection.

Bylaw 7.2 - The Code of Ethics

Regulatory bylaw 7.2 was added to include a Code of Conduct that establishes expectations for conduct by Saskatchewan physicians. The document was adapted from similar documents in effect in Alberta and Quebec. It provides additional clarity respecting the College's expectations of physicians who practise in Saskatchewan.

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 ONE policy and ONE guideline.

POLICY – Performing Office-based Non-Insured Procedures

Council approved three revisions to this policy to reference Health Canada regulations in relation to stem cell treatments and platelet rich plasma treatments. The amendments were to the paragraph providing examples of non-insured procedures directed at the treatment of pathology, and a general requirement to ensure compliance with Health Canada regulations was also added.

Click here to view full policy

GUIDELINE – Conflict of Interest

Council approved an amendment to paragraph 1 of this guideline to ensure consistency with the policy Sale of Products by Physicians. Previous reference to the 2004 Canadian Medical Association (CMA) Code of Ethics has been amended to reference the 2018 CMA Code of Ethics and Professionalism. A section listing "Other Resources" has been added to link other relevant College bylaws and policies. The reference section has been updated to ensure all links remain active.

Click here to view full policy

NEW!

POLICY – Uninsured Services

Council has approved a policy to establish expectations of physicians in relation to billing patients for uninsured professional services. It is intended to be complementary to the policy Sale of Products by Physicians, and must be read in conjunction with regulatory bylaw 9.1 and the Conflict of Interest guideline.

The policy identifies the guiding ethical principles and establishes expectations of physicians in terms of determining the amount to charge a patient for uninsured services and the process of advising patients of the applicable fee.

More detail on this policy is available on page 11.

Click here to view full policy

NEW!

POLICY -- Website Terms of Use and Privacy

The Council has approved a policy that describes the CPSS website terms of use, and the website's collection and use of information. The policy includes a content disclaimer, copyright information, and a brief description of the College's use of cookies.

This policy will be accessible by a link at the bottom left of the CPSS website home page.

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

Renewal Season is here!

Have you received your ELECTRONIC Physician Licence Renewal Notice yet?

If you have not yet received your renewal notice, it may be because we have the wrong email address on file!

Please call Registration Services at 306-244-7355 or write to **cpssreg-renew@cps.sk.ca** as soon as possible to obtain your notice so you can renew your licence seamlessly and avoid late charges or a practice interruption.

Corporation Permit Renewals

Corporation Permit Renewals have also been sent out electronically.

If you have not yet received your notice, please contact Registration Services as soon as possible at **cpssreg-corp@cps.sk.ca** to obtain your notice and update your email address!

Please note that Corporation Permit Renewals can only be filled out by a registered member of the College of Physicians and Surgeons of Saskatchewan.

REMEMBER!

The annual deadline for Renewal is **November 1**!

If you haven't renewed yet, do it today!

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

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

Please notify us of changes as they occur.

Questions on prescribing?

Contact the CPSS PRP team!

Nicole Bootsman
Pharmacist Manager

Prescription Review Program (PRP) Unscripted

A Department Update

These are exciting times for the PRP!

Firstly, we have corralled a new “Pharm Troop”:

Nicole Bootsman, BSc, BSP (Pharmacist Manager) joins the PRP from community and northern facility pharmacies with experience in opioid agonist therapy and Indigenous care. She leads the clinical realm of the Program, focusing on:

- physician education for PRP medication appropriateness and therapeutic optimization; and
- collaboration with national and provincial stakeholders to prevent prescription drug misuse.

Lorie Langenfurth (Operations Manager) comes to the PRP from the Heart and Stroke Foundation. Her role focuses on Program administrative process development and enhancement as well as financial planning.

Liisa Scherban, PhT (Analyst) is our Licensed Pharmacy Technician and Program veteran, analyzing and synthesizing PRP prescribing patterns and profiles for the past 3 years. She collaborates extensively with law enforcement and coroners throughout the province to curb prescription drug misuse.

Crystal McCurdy, BSP (Contracted Pharmacist) brings vast community pharmacy (with opioid agonist therapy experience) and correctional facility expertise to the PRP. Her PRP work focuses on physician education by assisting prescribers to align with Canadian prescribing standards and guidelines based on clinical indications.

The PRP, funded by the Saskatchewan Ministry of Health and administered by the College of Physicians and Surgeons of Saskatchewan, operates as an educationally focused prescription monitoring program. The Program alerts physicians to multi-doctoring and potential medication misuse. Physicians respond to explain letters (e.g. provide medical indication and rationale for PRP medication prescribing), enabling the Program to offer recommendations using national standards/guidelines and best practices for appropriate and safe PRP medication prescribing.

Physicians are encouraged to contact the PRP anytime for support with the management of patients with complex chronic pain.

The “Full Meal Deal” Triple Threat : Opioid-Benzodiazepine-Gabapentin

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

We are all facing the devastating effects of an opioid crisis which has led to a national public health crisis[1]. And while we tend to focus on opioids, whether prescribed or illicit, perhaps our attention needs to broaden beyond the main course to encompass the “full meal deal” (slang for opioid + benzodiazepine + gabapentin combination).

Prescribing safeguards for potentially dangerous chronic medication cocktails.

Given the multifaceted complexity of chronic pain, using a combination of medications to synergistically target the nervous system for pain management may seem quite logical[2]. Yet, polypharmacy – defined by the World Health Organization as “the administration of an excessive number of drugs” – with high-risk prescription medications can prompt cumulative and detrimental medication-related harms including addiction, drug interactions, motor vehicle accidents, neonatal drug withdrawal, and overdose[3,4,5]. Concurrent use of central nervous depressants (e.g. opioids, benzodiazepines, etc.) can potentially cause harmful and lethal respiratory effects; co-prescribing high-risk medications has even been considered “low value care”[5].

A Canadian study found that an opioid-gabapentin combination increased the risk of opioid-related death by, at minimum, 49% (compared to an opioid alone) and an opioid-benzodiazepine combination increased the risk of mortality and was involved in one in five opioid poisoning hospitalizations[5,6,7]. Canadian data has also indicated that over 80% of opioid related deaths (between January 2016 to June 2017) involved an opioid and at least one non-opioid drug (e.g. benzodiazepine)[5]. While these chronic double-drug combinations are prescribed more often than we might hope, with the opioid-benzodiazepine combination contradicting the expert guidance in the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain[9], the chronic triple-drug “full meal deal” combination is becoming alarmingly common.

Whether a prescriber has initiated a drug combination or has inherited a patient who has already been prescribed a potentially dangerous chronic medication cocktail, steps can (and often should!) be taken to ensure optimal safeguards are in place:

1. After a discussion setting expectations and boundaries from the get-go, **establish a written treatment agreement** (*Risk Mitigation Guidance Statement 7*)[9], clearly outlining the risks and benefits of high-risk drug combinations.

2. **Assess risk of harm at each visit** (adverse effects, addiction, and overdose). **Recognize and address red flags for drug-seeking behaviour** (e.g. requesting brand name, reporting allergies to non-opioids/weak opioids/sustained release preparations, etc)[10].

3. If additional medications are required that may have possible drug interactions, **consult the patient’s pharmacist**.

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4. Restrict the quantity of medication dispensed as part-fills (*Expert Guidance Statement 1*)[9].

5. Aim to prescribe for the drug's evidence-based, labelled indications for appropriate durations. **Avoid off-label use where possible**.

6. Use recommended precautions (e.g. check PIP for at least every Prescription Review Program prescription).

7. If initiating a taper, **obtain patient consent and reduce one drug at a time**. Taper guides can be very helpful to create a plan but be flexible and pause the taper as the patient requires. If necessary, **involve multidisciplinary providers** (*Recommendation 10*)[9].

8. Consider renal and hepatic function. Dosage adjustments in renal impairment are often required for gabapentin, whereas, dosage adjustments in hepatic impairment may be required for some benzodiazepines[8]. Without appropriate adjustments, drug accumulation may increase the risk of adverse effects.

9. Request random urine drug screens (*Risk Mitigation Guidance Statement 6*)[9] to ensure that you have objective clinical information required for safe prescribing. If a patient is not taking a prescribed drug, a taper isn't required (nor is a continued prescription)!

10. Limit dose escalations (*Recommendation 6*)[9].

11. If long-term opioid therapy is indicated, **prescribe controlled-release opioids** for comfort and simplicity (*Expert Guidance Statement 2*)[9]. Immediate release formulations are for breakthrough pain and should ideally not exceed 20% of the total daily morphine equivalent dose[10].

12. Do not abandon your patient! Often, these are challenging patients so anticipate and plan for setbacks.

13. Become an Opioid Agonist Therapy provider for your patients (contact CPSS for more information).

14. Document thoroughly.

References

1. Health Canada, 2017. New Federal Initiatives to Address the Opioid Crisis. Available from – https://www.canada.ca/en/health-canada/news/2017/11/new_federal_ initiativestoaddresstheopioidcrisis.html

2. Polypharmacy and Chronic Pain: Harm Exposure Is Not All about the Opioids. Pain Med. 2015;16:472-479.

3. World Health Organization, 2004. A glossary of terms for community health care and services for older persons. Aging and Health Technical Report.

4. Indiana Center for Health Policy, 2017. Polypharmacy Among Prescription Drug Users. Available from – https://scholarworks.iupui.edu/bitstream/handle/1805/16562/polypharmacy-among-prescription-drug-users.pdf?sequence=1&isAllowed=y

5. Policies to prevent harms from the co-prescribing of opioids and central nervous system depressant drugs. Ottawa: CADTH, 2018. (Environmental scan; no. 72)

6. Gomes T, Juurlink DN, Antoniou T, Mamdani MM, Paterson JM, van den Brink W. Gabapentin, opioids, and the risk of opioid related death: A population-based nested case-control study. PLoS Med. 2017;14(10) PubMed PMID: 28972983.

7. Gaither JR, Goulet JL, Becker WC, Crystal S, Edelman EJ, Gordon K, Kerns RD, Rimland D, Skanderson M, Justice AC, Fiellin DA. The Association Between Receipt of Guideline-Concordant Long-Term Opioid Therapy and All-Cause Mortality. J Gen Intern Med. 2016 [Epub ahead of print] PubMed PMID: 26847447.

8. Wolters Kluwer Clinical Drug Information, Inc. 2019; Lexicomp 4.6.0.

9. Busse JW, Craigie S, Juurlink DN, Buckley DN, Wang L, Couban RJ, Agoritsas T, Akl EA, Carrasco-Labra A, Cooper L, Cull C, da Costa BR, Frank JW, Grant G, Iorio A, Persaud N, Stern S, Tugwell P, Vandvik PO, Guyatt GH. Guideline for opioid therapy and chronic non-cancer pain. CMAJ. 2017;189(18):E659- E666.

10. RxFiles, 2017. Pain Mini-Book: Update on Pain Management & Opioids in CNCP.

Benzodiazepines: A Comeback Drug Crisis?

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

As we combat the current opioid crisis, another storm may be on its way, as witnessed by our neighbouring provinces. After appearing in street drug mixes in British Columbia and soon after, finding its way to Alberta, etizolam is showing up in some urine drug screens and at supervised consumption sites[1].

Benzodiazepines may be the next drugs to precipitate the crisis.

As we combat the current opioid crisis, another storm may be on its way, as witnessed by our neighbouring provinces. After appearing in street drug mixes in British Columbia and soon after, finding its way to Alberta, etizolam is showing up in some urine drug screens and at supervised consumption sites[1].

Etizolam, first developed in Japan, is pharmacologically analogous to benzodiazepines, providing anxiolytic, sedative, muscle relaxant, anti-convulsant, and hypnotic effects. Primarily used as a research chemical which is available online, its rapid anxiolytic properties and short duration of action provides the ideal scenario for dependence, offering both positive and negative reinforcement[2,3].

Etizolam is being mixed with other street drugs, often opioids. The danger of this combination is additive central nervous system depression, causing suppressed respiration and altered consciousness. Etizolam appears to be reversed with the antidote flumazenil, similar to other benzodiazepines[2,3]. Naloxone does not reverse the effects of benzodiazepines so when used in an overdose for an opioid-etizolam combination, at best, naloxone has provided partial overdose reversals at Alberta supervised consumption sites[1].

Regardless of the drug causing an overdose, we should still encourage the public to call 911, rescue breathe with a barrier mask, and administer naloxone in an overdose. In an emergent situation, it is not possible to determine, with certainty, what drug(s) caused the overdose. Removing possible opioids with naloxone may save a life even if the overdose is only partially reversed. If no opioids are contributing to the overdose, naloxone will have no effect.

Take Home Naloxone Kits are available for purchase from pharmacies and individuals with Non-Insured Health Benefits (NIHB) coverage may obtain fully covered kits without a prescription. Please refer to the Pharmacy Association of Saskatchewan Naloxone Registry for a list of pharmacies with kits:

https://www.skpharmacists.ca/uploads/media/5cf58919a82f8/pas-naloxone-registry.pdf?token=/uploads/media/5cf58919a82f8/pas-naloxone-registry.pdf

References

1. Calgary Herald, 2019. Health officials warn of new street drug mix that can't be reversed with naloxone. Available from - https://calgaryherald.com/news/local-news/health-officials-warn-of-new-street-drug-mix-that-cant-be-reversed-with-naloxone.

2. Pendkar C, Karnik S, SHamian B, Shankar S, Nasreen S, Kupfer Y, Kamholz S. Etizolam withdrawal: old problem new differential. Crit Care Med. 2019;47(1):333.

3. O'Connell CW, Sadler CA, Tolia VM, Ly BT. Overdose of etizolam: The abuse and rise of a benzodiazepine analog. Ann Emerg Med. 2015;65(4).

Yours Truly, Law Enforcement

What Physicians Need to Know

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

"I have lost count of the people that I have seen die." - RCMP Officer

Top 10 things officers wish physicians knew about prescription drug abuse.

The Prescription Review Program (PRP) collaborates with law enforcement from around Saskatchewan to prevent diversion and prescription drug misuse. After receiving an alert of possible misuse, the PRP notifies physicians of pertinent information and offers suggestions for management.

The PRP is fortunate to have cultivated a relationship with law enforcement, ultimately providing physicians with invaluable reports to aid with informed prescribing. We reached out to our patrolling partners to ask, "What are the top 10 things you wish physicians knew about prescription drug abuse?". Here's what local officers want you to know.

1. Some of your patients are lying to you. They are selling their prescriptions. Many of them are not using any for themselves. Parents are selling their children's Ritalin, patients with cancer are selling their pain medications...

2. Some patients on methadone who are allowed carries are selling all of their methadone. They do the urine test on Friday, sell all of the methadone over the weekend, and binge on alcohol, cocaine and crystal meth with the money. They sober up on Monday or Tuesday so they can provide a clean urine sample on Friday. Repeat.

3. Patients who live near a provincial border are often filling medications in both provinces.

4. Methadone is taken to house parties and sold in little cups (like the ones provided with over-the-counter cough medicine). People will pay $20 for a little cup.

5. Pills are often cut into quarters and sold, especially morphine pills. A 100mg morphine pill goes for $100 or more.

6. Gabapentin is sold for $2-$3 a capsule/tablet. Many people snort it. Some children have been found with it.

7. Patients are using false ID to get multiple prescriptions at one time. When someone overdoses and is unconscious or dead, his/her ID is often stolen for this use.

8. Patients are reporting to the RCMP that their medications have been stolen to get a file number which enables them to obtain medication replacements. This has become so common that some detachments have stopped providing police files for this.

9. When people are caught with pills that they have legitimate prescriptions for, how can we say (beyond a reasonable doubt) that the individual is trafficking? An individual, who filled 90 tablets of Dilaudid the day before, was arrested for trafficking with 3 tablets remaining. He was a prolific drug dealer and when he went to court, he told the judge he had lost his pills. Charges withdrawn.

10. Much of the heroin we see is actually a heroin/fentanyl mixture. Although this is tragic and terribly dangerous, it makes law enforcement easier because street drugs are illegal. No one can claim that this drug combination was prescribed by his/her doctor.

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What advice does Law Enforcement have for physicians?

Doctors need to ensure PIP is used every single time that they prescribe opioids, gabapentin, benzodiazepines, barbiturates, oxybutynin, prescription sleeping medications and stimulants. This should be mandatory and there should be consequences for not using the resource.

We need alternative treatments for chronic pain that are NOT opioids.

Addicts can be very skilled liars. Stand up when patients raise a stink and threaten to report you to the College.

There is not enough naloxone to assist with overdoses. Patients with Non-Insured Health Benefits (NIHB) coverage can obtain fully covered kits without a prescription.

Educate your patients on the Cook Your Wash Campaign to reduce HIV transmission.

Bell LJ, Puka K, Speechley M, et al. Sharing of injection drug preparation equipment is associated with HIV infection: A cross-sectional study. J Acquir Immune Defic Syndr, 2019;81(4):e99-e109.

Bell LJ, Venner C, Tirona RG, et al. Heating injection drug preparation equipment used for opioid injection may reduce HIV transmission associated with sharing equipment. J Acquir Immune Defic Syndr, 2019;81(4):e127-e134.

We acknowledge the physicians and pharmacists who are doing what they can to adhere to patient safety and care. This is not an easy matter to deal with but working together to come up with sustainable and reasonable solutions is key.

Thank you to the following Detachments for providing valuable information and indispensable advice:

Punnichy
Radville
Kamsack

Street Prices for Prescription Drugs

The following sales were recently reported on StreetRx* in Saskatchewan:

Concerta 27mg: $10
Concerta 36mg (Saskatoon): $20
Valium 10mg (Saskatoon, Regina): $10
Dilaudid 4mg (Regina): $20
Fentanyl 25mcg/hr patch: $12
Clonazepam 1mg: $5
Apo-hydromorphone 1mg: $5
Ativan 1mg (Prince Albert): $30
Ratio-lenoltec No. 3 30mg (North Battleford): $3
Kadian 20mg: $5
Adderall XR 5mg (Regina): $10
Apo-hydromorphone 8mg (Regina): $20
Alprazolam 0.5mg (Regina): $10

* https://streetrx.com/ca/en

Holistic Home Care for Indigenous Clients

By Karrie Derbyshire, Primary Health Care Manager
and Kerrie Weflen, Senior Assessor Coordinator

The Saskatchewan Health Authority runs a program to provide Home Care Services for Aboriginal, Inuit and Métis individuals.

The **Aboriginal Health Home Care Team** (AHHCT) is a multidisciplinary team, established in 2009, that provides care to Aboriginal, Inuit and Métis clients. The program aims to provide holistic care in a culturally safe environment. The services provided focus on the following:

- **Holistic Care:** The program acknowledges the interconnection of spiritual, emotional, mental and physical health of the individual, family and community.
- **Culturally-responsive Supports:** Services recognize and affirm the cultural identity of Aboriginal people, connecting clients to traditional supports.
- **Voice:** Clients have a voice in decision-making and are partners in their care.
- **Accessibility:** Health services are delivered within the home and connections are made to other supports within the community.

The AHHCT supports clients who have struggled with homecare/health services, or have expressed a wish for more holistic aboriginal health services. Many of the clients the team serves require additional supports to address the determinants of health; such as assistance completing housing applications, connections to income tax services, transportation to the food bank, assistance navigating the *Saskatchewan Assured Income for Disability* (SAID) program or Health Services Canada, and coordination of services such as foot care or finding a primary care physician.

AHHCT is a small committed group that focuses on relationship building with clients, which in turn builds trust. The team includes the following disciplines: case manager, registered nurses, occupational therapist, continuing care assistants, liaison worker, health coordinator, and an office assistant. The team combines and honours both western and traditional medicine. Clients are encouraged and supported to participate in their care planning and to express their wishes and needs. AHHCT recognizes the value in promoting independence and building supportive relationships to help clients become more engaged in their own health care. Much of the care provided by the team is in the client's home, which allows them to feel safe and comfortable in their surroundings. The goal is for clients to have improved health through services that meet their needs in their home and the community, and reduces their need to attend the emergency department.

Truth and Reconciliation Committee Update

Council adopted new Terms of Reference for the Truth and Reconciliation Committee at its June 21-22 Council meeting. This official mandate will help guide the committee's work in the future.

At its September 13-14 meeting, Council welcomed Dr. Kevin Lewis, who presented to Council an overview of the history of the Treaties and their significance. He also addressed residential schools, current aboriginal relations in Saskatchewan, as well as some of the basic principles of traditional medicine, including the harvesting of natural medicines and the use of song, drums and rattles from an Indigenous perspective.

Dr. Kevin wâsakâyâsiw Lewis is a nêhiyaw (Plains Cree) instructor, researcher and writer. Dr. Lewis is from the Ministikwan Lake Cree Nation in Treaty 6 Territory, and for the past 15 years, has been working with community schools in promoting land and language-based education and is founder of kâniyâsihk Culture Camps, a non-profit organization focused on holistic community well-being and co-developer of Land-Based Cree Immersion School kâ-nêyâsihk mîkiwâhpa. (Source: Office of the Treaty Commissioner)

Photo above (L-R): Dr. Kevin wâsakâyâsiw Lewis, Mr. Burton O'Soup, Mr. Lionel Chabot.

Presentation to Council by Dr. Kevin Lewis of the University of Saskatchewan on September 13, 2019. *Special thanks to the Office of the Treaty Commissioner for facilitating the arrangements.*

How can you, as a physician, help provide quality care to Indigenous patients in a culturally safe and welcoming environment?

We're listening!

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

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

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

PHYSICIAN BILLING:

Non-medically necessary visits for short-term refills of Prescription Review Program (PRP) medication in chronic cases

By Carie Dobrescu, Medical Services Branch

Prescription management remains a key component of medical care delivery. A lack of prescription management, including the inadequate management of chronic Prescription Review Program (PRP) medications, can lead to frequent and repeated visits with no evidence of medical necessity or value to the health care system.

Pursuant to *The Saskatchewan Medical Care Insurance Act*, Medical Services Branch (MSB) has the authority to pay physicians for **medically required services** only.

Physicians may be unknowingly billing the publicly funded system for non-medically required visits related to the provision of short-term, chronic PRP medication refills. Physicians may have a routine practice of refilling these chronic medications for short durations rather than writing longer prescriptions (in appropriate circumstances) and having the pharmacy dispense the medication at specific intervals. Patients are then required to return to the office every few days or on a weekly basis for the sole purpose of obtaining a refill. These services are often billed as partial assessments or follow-up assessments and lack the required documentation and medical necessity to support that the Payment Schedule criteria has been met.

As a health system partner, physicians must share the responsibility and stewardship of ensuring that non-medically required visits do not unnecessarily increase costs to the publicly funded system. When health care monies are inappropriately paid to physicians, it prevents efficient and effective allocation of health care dollars to areas where patients and the health care system may really benefit.

The Ministry of Health greatly appreciates physicians' ongoing efforts and cooperation in ensuring that the services they submit to the Ministry for payment meet the requirements as outlined above.

For general billing inquiries, please contact:
Claims Analysis Unit - 306-787-3454
Policy, Governance and Audit - 306-787-0496

Important billing resources physicians are expected to be familiar with can be found at this link:

https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx

The Provincial Medical Assistance in Dying (MAiD) Program is looking for clinicians

Here is some information on the Provincial Medical Assistance in Dying (MAID) Program that might be helpful to you.

Medical Assistance in Dying (MAID) has been an end of life option for patients since June of 2016. Patients and families can access information on end of life care by calling HealthLine 811 who will connect them to the Provincial MAID Program. Patients can also submit a written request to the Provincial MAID Program to be assessed for eligibility to receive MAID.

Over the last two years, changes were made to how we provide this end of life option that have improved the ease of access, provision of information, and coordination of care to both patients and their care providers. Significant changes in process include the clinicians completing the Certificate of Death and no longer using the term suicide. Also, there has been use of telehealth and other communications to allow for assessments over the great distances that are the reality in Saskatchewan.

The Provincial MAID Program coordinates all MAID related activities. Michelle Fisher is the Provincial MAID Program Manager. She provides information, support to clinicians, patients and families, and coordinates all Provincial MAID Program activities. Physicians and Nurse Practitioners are welcome to contact the Provincial MAID Program directly at 1-833-473-6243.

There is a need for clinicians across the province to consider involvement in the Provincial MAID Program as there is a significant challenge to meet the requests due to travel distance and lack of providers. The work is both challenging and rewarding. The provincial program will support, educate, and provide compensation for those willing to consider involvement in any capacity.

Physicians with questions about MAID or options for work within the provincial program can contact:

Michelle Fisher
Tel: 1-833-474-6243
Email: michelle.fisher@saskhealthauthority.ca

Dr. Rob Weiler
Medical Advisor, Provincial MAID Program at
Email: robert.weiler@saskhealthauthority.ca

Choosing Wisely Saskatchewan
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MORE IS NOT ALWAYS BETTER
Encourage your patients to ask questions about appropriate tests and treatments.
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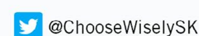 @ChooseWiselySK
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New Bilingual Advanced Illness & Grief Support for Patients & Families

LivingOutLoud.Life

ALSO AVAILABLE IN ENGLISH

Canadian Virtual Hospice launches vivreAfond.ca – New, free digital health tool to support young adult Francophones living with advanced illness.

"My friends don't want to talk about the fact that I'm scared that I'm going to die, they don't want to hear about it, it's not going to happen but it is going to happen and I want to talk about it." – Jayda Kelsall

vivreAfond.ca was developed by young adults living with advanced illness to shatter the silence and inform, educate and support other young people with life-limiting diagnoses, their family and their friends. It is also a resource for healthcare providers to improve their capacity to understand the unique needs of young adults with advanced illness and deliver quality care. On vivreAfond.ca, 14 young adults living with advanced illness share deeply personal stories to help other young people. Their stories deal with the following topics: pursuing education and careers, navigating impacts on sexuality and fertility, managing relationships, decisions about their care or treatments, dealing with symptoms and confronting end of life. Leading health experts from Canada and the U.S. have also contributed content to the site.

vivreAfond.ca was developed in collaboration with Young Adult Cancer Canada, Hope & Cope, and Team Shan Breast Cancer Awareness for Young Women. Funding for vivreAfond.ca was provided by the Canadian Partnership Against Cancer and the Thomas Sill Foundation.

vivreAfond.ca is also available in English at LivingOutLoud.Life.

For more information: marissa@virtualhospice.ca

MyGrief.ca

ALSO AVAILABLE IN ENGLISH

Canadian Virtual Hospice launches MonDeuil.ca

MonDeuil.ca is an online support tool for Francophones who are grieving or supporting someone who is grieving. It is a free online resource to help people work through their grief from the comfort of their own home, at their own pace. It was developed by family members who've "been there," and grief experts to complement existing community resources and help address the lack of grief services particularly in rural and remote areas. It is also an education tool for healthcare providers.

MonDeuil.ca covers a variety of topics including: grief that is experienced before a death; recognizing how grief affects you; managing intense emotions and difficult situations; navigating family dynamics; and creating a life without the person who died. MonDeuil.ca features videos by grief experts providing guidance and by people who've experienced grief and who share their stories of healing and hope. It was developed in collaboration with McGill University Palliative Care; Hope & Cope; the Nurses Association of New Brunswick; Winnipeg Regional Health Authority; Centre Renaissance Centre inc. and Health PEI. Funding for MonDeuil.ca was provided by Health Canada.

MonDeuil.ca is also available in English at MyGrief.ca.

For more information: marissa@virtualhospice.ca

Building our core of self esteem

By Brenda Senger, SMA

Underneath the "white coat", physicians are just people like everyone else possessing many of the same fears, vulnerabilities and challenges. The role of "physician" may assist in camouflaging much of this angst to the world at large, and often to ourselves, but it remains.

Historically, the profession has applauded the very traits that set us up to ignore self-care and feed our self-doubt. Medicine selects individuals with:

- high levels of perfectionism (did you get an A on today's exam?)
- the ability to delay attending to our needs in order to meet the needs of others (do you hold your bladder hostage at work?)
- competitiveness (getting into medical school, CaRMS match, starting practice?)
- high emotional investment (moral calling of our work)
- and the need for control (don't deny it!).

We then enter into unsustainable practices (excessively long hours, heavy patient loads, unrealistic availability). Although physicians covet autonomy, I often hear they feel a lack of choice/control in their work environments.

So how does one build their self-esteem?

I often share a story with those I see:

A grandfather was talking to his grandson about how he felt.
The grandfather said, "Inside of me live two wolves – one is compassionate and loving, the other is vengeful, negative and critical – every day these two wolves fight each other.
The grandson asks "Which wolf wins the fight?" The grandfather answered:
"The one I feed the most."

And so it is with each of us. I ask "Do you feed your feelings of competence? Do you celebrate your accomplishments? Do you acknowledge the things you do well? Or, "Do you feed your insecurities and doubts? Do you use the yardstick of perfection as a measure of your worth?"

According to Brene Brown, the worthy have the courage to be imperfect, have compassion for themselves first then others, seek authentic connection with other people and embrace vulnerability. People who have a strong sense of love and belonging believe they are worthy of love and belonging.

Can we change the culture of medicine so we support our colleagues and have permission to be imperfect?

Can I provide myself and others with feedback that "feeds the right wolf"?

Stress is inevitable. Struggling is optional.

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

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

Nominate a colleague you admire for the 2020 Kendel Award!

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

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

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

Nomination packages for 2020

are available on the homepage of the College website at

www.cps.sk.ca

or by writing to
OfficeOfTheRegistrar@cps.sk.ca

Have you been practising in Saskatchewan for 40 years or more?

You may be eligible for

SENIOR LIFE DESIGNATION

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

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

CONTACT

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

INFECTION PREVENTION

News Updates

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

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

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

HEALTH ACCOMPAGNATEUR INTERPRETATION SERVICES IN FRENCH

French-speaking newcomers | Seniors | Families

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

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

You may also come across Saskatchewan Francophone Seniors and Families:

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

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

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

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

This is not an emergency service

Stay updated on drug news in Saskatchewan and across Canada!

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

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

We're Working for You

College of Physicians and Surgeons of Saskatchewan

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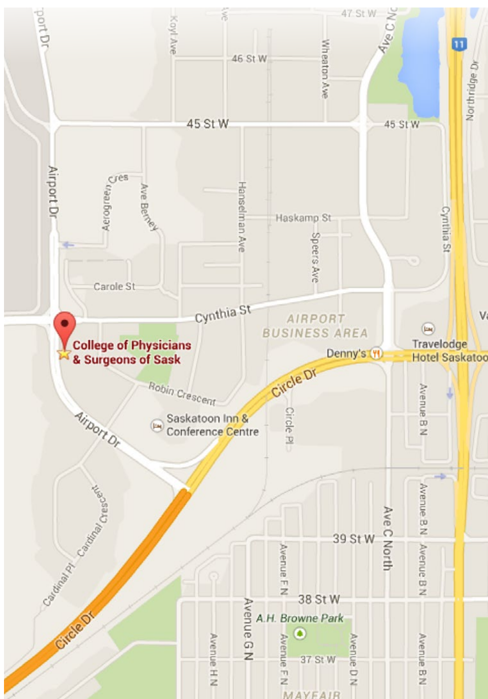

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Dr. Karen Shaw	Registrar
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Mr. Bryan Salte	Associate Registrar/Legal Counsel

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E-mail	beckie.wills@cps.sk.ca

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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