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DocTalk 2022 - Volume 9 Issue 2 **June 2022**

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The Council and the College of Physicians & Surgeons of Saskatchewan respectfully acknowledge that the land on which we live and work is Treaty 6 Territory, the traditional territory & home of the Cree, Dakota, Saulteaux and Métis Nations. We would like to affirm our relationship with one another now and for the future, and our role in guiding the profession to achieve the highest standards of care to benefit all people in this territory equally.

DocTalk Volume 9, Issue 2

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EDITORIAL ADVISORY COMMITTEE
Dr. Olawale Franklin Igbekoyi
Dr. Jurgen Maslany
Joanna Alexander (Public)
Dr. Karen Shaw (Ad hoc)
Dr. Werner Oberholzer
Caro Gareau
Alyssa Van Der Woude

EDITOR
Caro Gareau

REVISION
Caro Gareau
Dr. Werner Oberholzer
Sheila Torrance
Dr. Jurgen Maslany
Joanna Alexander
Alyssa Van Der Woude
Sue Waddington

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Do you have an idea for the next issue? Email us!

Message from the President of Council

By: Dr. Olawale Franklin Igbekoyi, President of Council

Physicians supporting a good patient experience of care

The Beryl Institute (2016a) defines patient experience as "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care."

Patient experience is an integral part of providing patient-centred care. Physicians can support a good patient care experience from the time a patient picks up the phone to arrange an appointment through to the various interactions at the clinic and encounters with care providers, up to and including follow-up care.

The burden of illness

The burden of illness could vary from very simple and mild to very serious and emotionally traumatic. This also applies to illness types and unique patient characteristics. The illness experience could bring about emotional experiences such as shock, anger, anxiety, depression, and frustration. The onset of an acute illness may disrupt patients' daily routines. Work may be affected. Depending on the patient's stage of life, illness could affect their ability to care for their family, disrupt occupation or school attendance, limit social interaction, and alter plans and

aspirations. Some diseases and conditions are an easy source of shame and stigma. It takes courage to present to the laboratory with a requisition for some blood tests.

In addition to these personal experiences, patients do not exist alone or in a void; they are part of social systems that include family, workplace, and community. The illness experience also affects the usual dynamic of this social setting and may create a ripple effect on family members, colleagues and others. In addition to this, the negative economic implications of the illness could be temporary or permanent, opening up room for some socioeconomic difficulties. Where the patient is the breadwinner for the family, the illness experience may include fear of loss of productivity and the inability to provide for the family members.

To attend to the illness and carry along with the illness experience, our patients seek medical care to obtain answers regarding the disease and resolve essential aspects of the illness experience. A patient wants to know the diagnosis; they want to experience resolution of their ill health and need to be met with an understanding and empathic heart. Patients have expectations that the health care provider should meet; they want to be listened to, have their fears allayed, and explore their hopes to improve their functionality and find ways to maintain the balance within their social milieu.

Poor patient experience of care worsens the illness experience. It heightens the burden of the illness experience and makes things worse for the patients. A patient who experiences poor care during access to the physician or health care facilities is more likely to complain to the College. It is often rewarding to patients to experience such excellent care and attention that they feel relieved with the experience afterwards, irrespective of the severity of their burden of illness.

Some best practices in patient-centred care

Physicians can support a good care experience at the entrance to care by **reducing wait times** and offering opportunities for same-day appointments. Patients will be relieved to access care sooner rather than later in our family physician and specialist offices, emergency rooms, and operating theatre for surgery. This will improve the timeliness of care and ease the anxiety that comes with the burden of illness.

Physician offices and hospitals should create a **good, clean, esthetically pleasing, and friendly environment** to welcome patients. Well-designed office space and hospital environment that produces a “wow” from patients will improve their perception of accessing reasonable, quality care. Such an excellent and welcoming environment should be supported with comfortable seats, charging ports, and electronic devices such as television or computers, which could deliver educational information while the patient is waiting.

There are great opportunities in current-day practice to utilize **technology and artificial intelligence** to support an outstanding care experience for patients. Physicians and physician leaders should explore current options and use state-of-the-art tools and facilities to make receiving care through our offices and hospitals easy, comfortable, and memorable. Physicians should pay attention to patient flow within facilities and ensure minimal time is expended during the visit by using appropriate human engineering and systems to manage the time spent at the

physician's office. Creating good access to care and reducing wait times within the office or hospital space will improve the experience of care received by patients.

Patients come into the visit with specific fears and expectations. During patient encounters, a physician should always use the **patient-centred approach** to understand the patient's fears and expectations for a visit, allay their concerns, and, when possible, meet their expectations or communicate if those expectations cannot be met. Rushing through the visit and not listening to patient or family concerns degrades their experience and may lead to a negative outcome. Good eye contact, offering support, listening to patient concerns, and negotiating a common ground with their agenda all serve to improve the care experience. Simple things like providing a warm blanket, a snack vending machine close by, culturally appropriate eye contact and touch, comfortable hospital beds, and bathing and toilet facilities may look insignificant but improve the care experience.

Patients also receive care from other providers such as nurses, pharmacists, physiotherapists, and, in the case of Indigenous patients, may also receive care from a traditional healer. Physicians should coordinate care and ensure effective communication between providers of care. If one care provider is saying one thing and the physician is saying another, this will create anxiety for the patient and deteriorate the care experience. Patient confidence in the care provided and an improved care experience is more likely where there is **well-coordinated care, good communication, and collaboration** between providers.

The burden of proof

Studies have associated good patient experiences with better clinical outcomes and safety. In a systematic review of evidence by Cathal Doyle, Laura Lennox, and Derek Bell on the links between patient experience and clinical safety and effectiveness, it was discovered that *patient experience* is positively associated with *clinical efficacy* and *patient safety* and supports the case for the inclusion of patient experience as one of the central pillars of quality in healthcare. The study finding supports the argument that the three dimensions of quality should be looked at as a group and not in isolation.

In addition to this, better patient care experiences are associated with higher levels of adherence to recommended prevention and treatment processes, better clinical outcomes, better patient safety within hospitals, and less health care utilization.[1] A study reviewing what patient complaints say about their experience reveals that patient complaints showed that communication and relationships are more valuable for the patient experience than care quality and patient safety.

Forty-one percent of complaints related to patient-provider relationships. Eighteen percent related to humanness and caring, 15 percent involved **communication**, and five percent related to patient-staff dialogue. "These attributes are a reminder that patients need comprehensive and correct information and expect it to be delivered with care, respect, and sensitivity," the researchers reported. "The records we reviewed confirmed that even one negative, unkind, or disrespectful encounter can fundamentally alter a patient's perception of care."[2]

Another study on Using Patient Complaints to improve Patient Experience also confirmed that communication and other patient-centred care principles often fall short of the needs of both patients and their families. The study found that nearly 80% of complaints were focused on patient-provider communication, including those with doctors, nurses, administrators, and any other clinical or non-clinical staff. Specific complaints data shared by the published research indicates that the nearly 80% of complaints centred on patient-provider communication deficiencies:[3]

In summary, physicians should support a good care experience for our patients. When we do this for our patients, 1) we will reduce the burden of illness; 2) we will promote access to care and compliance with recommended treatment; and 3) we will reduce the number of complaints by patients resulting from poor experience of care.

---

[1] Rebecca Anhang Price 1 , Marc N Elliott 2 , Alan M Zaslavsky 3 , Ron D Hays et al., Examining the role of patient experience surveys in measuring health care quality; 2014 Oct;71(5):522-54.Epub 2014 Jul 15

[2] Sarah Heath.https://patientengagementhit.com/news/what-patient-complaints-say-about-the-patient-experience. Accessed May 2022.

[3] Jonathan Trachtman - Using Patient Complaints to Improve Patient Experience; July 25, 2018

Dr. Olawale Franklin Igbekoyi is President (2021-present) of the Council of the College of Physicians and Surgeons of Saskatchewan and a Family Physician practising in Rosetown.

Message from the Registrar

June 2022

By: Dr. Karen Shaw, CPSS Registrar & CEO

Physician Burnout: Remembering the "Me too" in Self-Care

I would like to report that Covid is behind us, but we all know firsthand that is not true. The B-2 variant which is 10 to 50 times more infectious than the B-1 variant has replaced the B-1 variant. The sewer water viral count confirms the rampant spread through communities, peaking higher than previously experienced. While infection with the recent B-1 and B-2 variants may not be as lethal as previous variants, it is still resulting in a high death rate. These variants do not lead to as many intensive care admissions, but infection with either still results in non-intensive care hospital care for many patients. This requirement for hospitalization contributes to the stress on our emergency departments and the number of available hospital beds. When there is this need for admissions related to Covid, other non-Covid cases get delayed. This results in further stress to the providers as you struggle to do your work in less-than-optimal conditions and do your best to remain civil while navigating an increasingly difficult practice environment with an unhappy and frustrated public. Can we do more to protect our patients, staff, families, and ourselves?

We need to continue to be brutally honest with patients and the public about what it will take to curb Covid. Physicians are in a unique position to have these conversations about risk with patients. We need to continue to speak openly and remind people about the simple and effective ways that work. We need to reinforce that masking, physical distancing and avoiding large gatherings have proven to work to decrease transmission. Please continue to provide information about the importance of vaccination and let us see if we can further improve the uptake of boosters. It is a bit puzzling that we have an acceptable uptake for our first and second vaccinations, yet we have the second-lowest rate in Canada for the uptake of boosters. How can we combat complacency?

My family consists mostly of health care providers. After remaining Covid-free over the past two years we have recently experienced a 50 % Covid infection rate. One family member contracted Covid at a non-health-work-related job site. While the rest of those who contracted Covid have all worked with Covid positive patients, none of them contracted Covid through their work. All have contracted Covid through social contacts and as a direct result of relaxing the use of

masking and physical distancing. Keep reminding everyone that masking, physical distancing, avoiding large groups and vaccinations do work to reduce the transmission of Covid. Also remind those who choose not to be vaccinated to protect others by masking, practicing physical distancing and avoiding large gatherings.

Physician health has always been a priority for the College; now even more. Even prior to the pandemic, an increasing number of physicians were experiencing burnout. Physicians expressed dissatisfaction with aspects of their work, and the lack of work-life harmony. This has intensified since the pandemic. There has been a constant need to provide care despite the fact physicians are experiencing fatigue and are desperate for a break. We talk about burnout as if it is something that others experience, but not us. Providing safe care requires providers to be healthy. In an emergency we reference putting on our own oxygen masks first, but how many of us do that? We talk about it but are we vigilant in doing so? It is the only way to remain healthy and available to provide care.

We also talk about self care, but what does that mean? Our Saskatchewan Physician Health Program Director, Ms. Brenda Senger, has a wonderful definition of self care. Self care does not mean "me first" it means "me too". Too many times we witness physicians giving and giving and giving and then hitting a wall – burned out and withdrawing and at times walking away. We appreciate that physicians "stretch" that extra bit to provide care and take that extra shift because their colleague has a more urgent need to go home, however, it should be an exception, not the norm. Our work environment has also contributed to working in overdrive. While accessing patient related information electronically has resulted in positive benefits in caring for patients, it has also had a negative impact on providers in that it is harder to completely disconnect from work when the information flows in continuously.

Covid has only intensified my concern about physician wellness. Physicians like other healthcare workers have experienced potentially traumatic events during the pandemic that has resulted in significant distress. While the public displays of gratitude during the initial stages of Covid helped the providers cope with the burden of illness during the pandemic, the public is now frustrated with the healthcare system and at times this frustration results in less than civil actions towards providers. Those on the frontline during the pandemic have experienced unrelenting workloads. Experiencing traumatic events in addition to the workload raises a concern about the development of anxiety, depression, post traumatic stress disorder, compassion fatigue, moral injury, traumatic grief, and burnout.

In the Saskatchewan Health Authority (SHA) Townhalls, the Saskatchewan Physician Health Program staff provided wellness presentations on identifying and coping with burnout, compassion fatigue and moral injury along with other relevant topics. These are available on the SHA website and are excellent resources. The staff at the Saskatchewan Physician Health Program are willing and ready to help you and your colleagues: contact Brenda Senger, Director of Physician Support Programs (306-657-4553), or Jessica Richardson, Clinical Coordinator in Regina (306-359-2750).

Another impressive set of resources is the Canadian Medical Association's Pandemic Wellness Toolkit. On this site you will find the following resources:

- Support for physicians experiencing harassment.
- A Wellness Support Line that offers free confidential counselling.
- A Wellness Connection that offers free, virtual peer support sessions.
- A Physician Wellness Hub. This provides wellness tools and resources for physicians, learners, leaders, and educators to create change in the culture of medicine.
- Connect with Peers.
- Support your Team.

"Check Your Vitals" is a tool that is a modified form of the Canadian Armed Forces tool that helps you assess how you are feeling and provides recommended actions. It is an excellent tool to judge whether you are in a "healthy, reacting, injured or ill state." The Canadian Armed Forces developed this tool to assist the members of the force to manage their stress and anxiety during high stress times (combat), to allow them to focus. This is the same for physicians; we must focus when the stress is the highest. Please check the tool out and use it to keep an eye on yourself. Even the most experienced and resilient of physicians can feel overwhelmed, stressed, and anxious. These tools will help you determine whether you should be reaching out for help. Be open to seeking help for yourself, and help those who reach out to you to find the help they need.

This summer I hope you will find time to rejuvenate. You may not be able to take as long a holiday as you desire but plan short breaks that allow you to decompress and get out in nature and the sunshine with your loved ones. Even shorter days and an extended weekend help. Work with your colleagues to make sure you can find time off. Dr. Mamta Gautam, a well-known psychiatrist who works in Physician Wellness, recommends planning your next holiday as you finish your current one. It is good advice. Knowing when your next break is planned will help you to focus and get through your work week, especially if it is a tough one.

Be kind to yourself, take the time to get healthy and stay healthy. Remember the "me too" in self care advocates for you to be healthy so you can continue to care for all the others in your life who rely on you as a physician and a family member.

Dr. Karen Shaw has served as Registrar and CEO of the College of Physicians and Surgeons of Saskatchewan since 2011.

DocTalk

June 2022

Council last met on the 18th & 19th of March 2022. The next Council meeting is scheduled for the 17th & 18th of June 2022. Agendas and Executive Summaries with information about the content of the open portion of Council meetings are available here on the College website.

Highlights from the last Council Meeting

- Council approved the updated document *OATP Opioid Agonist Therapy Program Standards and Guidelines for the Treatment of Opioid Use Disorder* as Standards and Guidelines of the College of Physicians and Surgeons of Saskatchewan.
- Council approved the Cardiovascular Disease Certification Exam developed by the American Board of Internal Medicine as the basis for physicians who do not have Royal College certification in internal medicine to be approved to bill payment codes 31D and 32D for ECG interpretation.
- Council approved a new Investment Policy for adoption by the College.
- Council endorsed the *Joyce's Principle* document as a whole in the spirit of Reconciliation, as a foundational and guidance document for the alignment of Council's initiatives to its principles, and to help guide the Truth and Reconciliation Committee in its work.

Laying the Foundations to Improve Care by Physicians for Indigenous Patients in Saskatchewan

By: Burton O'Soup, Public Member of Council and Chair of the Truth and Reconciliation Committee and Caro Gareau, CPSS Communications Officer and Member of the Truth and Reconciliation Committee

To reaffirm and confirm its intent towards Reconciliation with the Indigenous peoples of Saskatchewan and its support of the Truth & Reconciliation Committee (TRC) of the College of Physicians and Surgeons of Saskatchewan (CPSS), Council rejuvenated its TRC in November 2018 and has since taken some key steps to lay a foundation for improved relationships and equal quality of care provided to Indigenous patients throughout the province.

It is important to recognize and understand the mandate of the Truth & Reconciliation Commission, which was to inform all Canadians about *what* happened in residential schools, *how* this affected First Nations, Inuit and Métis students/individuals, families, communities and *who* it involved – the Government, the churches, employees and other Canadians. Our goal is that aligning these truths to be addressed within the Mission, Vision and Principles of the CPSS and the TRC mandate will lead to improved healthcare outcomes.

It is also important that CPSS members fully understand the implications of the land acknowledgement and endorsements of the key documents outlined below. The role of Council would be one of advocacy towards the articles, educating future physicians on maintaining the equal rights to health care without discrimination and raising awareness, and thus leading to better care outcomes for Indigenous patients and their families. It is Council's hope that this will lead to more tangible workplans and pragmatic action on the part of the CPSS and its members.

KEY STEPS TAKEN BY COUNCIL

September 2019	**Council Education - First Nations Treaties** Presentation by the Office of the Treaty Commissioner - Dr. Kevin wâsakâyâsiw Lewis provided a presentation with respect to First Nations Treaties and other information relevant to Indigenous persons. (SEPTEMBER 2019)
November 2019	**Endorsement of the Truth and Reconciliation Calls to Action**

In November 2019, a number of additional Action Items and initiatives were brought forward to Council for endorsement, such as the SHA/CME Cultural Awareness Training Modules; a Flag Raising Ceremony; partnership development with strategic First Nations organizations; a presentation on the Role of Traditional Medicine; and improvements to be made on the CPSS website pertaining to Indigenous Wellness. Unfortunately, the planned Flag Raising Ceremony was postponed until further notice due to the COVID-19 pandemic, as it required a social gathering of dignitaries from various levels of Government (First Nation/Métis/Civic/Saskatchewan) and other figures of prominence. Despite this delay, the CPSS has graciously honored the Treaty 6 and Métis Infinity Reconciliation flags by flying them in their boardroom since the Fall of 2019.

January 2019 **Land Acknowledgement**

To honor the Treaties and the territory of the Indigenous peoples where the CPSS head office is located, Council developed a formal land acknowledgement that states:

> *"We acknowledge that the land on which we gather is Treaty 6 Territory, the traditional territory and home of the Cree, Dakota, Saulteaux and Métis Nations. We would like to affirm our relationship with one another now and for the future, and our role in guiding the profession to achieve the highest standards of care to benefit all people in this territory equally."*

The land acknowledgement has since been implemented as an item for reflection prior to each Council and CPSS meeting, and also appears on key CPSS documents and communications.

November 2021 **Endorsement of UNDRIP**

Council endorsed the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) [1] document as a whole in the spirit of Reconciliation, as a foundational and guidance document for the alignment of Council's initiatives to its principles, and to help guide Council's Truth and Reconciliation Committee in its work. It is important to be aware of the principles in the national and international reports on Indigenous Rights, even though some only apply to government levels, as we still need to ensure those that do are appropriately implemented at our level. Our role is to "keep the feet to the fire" to support the issue.

What is the Declaration?

The United Nations Declaration on the Rights of Indigenous People (UNDRIP) is a comprehensive international human rights instrument on

the rights of Indigenous peoples around the world. It contains 46 articles which affirm and set out a broad range of collective and individual rights that constitute the minimum standards to protect the rights of Indigenous peoples. (*See **Annex A** below for sections which apply in a healthcare context*).

These include rights related to 11 areas:

1. 1. Self-determination & self-government,
2. 2. Equality & non-discrimination*,
3. 3. Culture & language,
4. 4. Identity*,
5. 5. Religion & spirituality,
6. 6. Lands, territories, and resources,
7. 7. Environment,
8. 8. Indigenous institutions & legal systems,
9. 9. Health*,
10. 10. Education*, and
11. 11. Community

*(*Indicates an Area that is relevant to the CPSS mandate)*

The UNDRIP is about respect and promotion of the rights of Indigenous peoples as set out in the treaties, it is a framework for reconciliation, healing, and peace. The document states that implementing the Declaration is about:

- Creating a brighter future for present and future generations,
- Continuing our journey of justice, peace, and reconciliation
- Continuing our work to break down barriers and combat racism and discrimination faced by Indigenous people.

In addition, implementing the Declaration also responds to the Truth and Reconciliation Commission's Call to Action 43, which states: "We call upon federal, provincial territorial and municipal governments to full adopt and implement the United Nations Declaration on the Rights of Indigenous Peoples as the framework for reconciliation[2].

March 2022 **Endorsement of Joyce's Principle**

The *Joyce's Principle*[3] document is a Call to Action that followed the tragic death of Joyce Echaquan in Quebec. It is presented as a goal for a commitment from governments to end an intolerable and unacceptable situation – systemic racism that Indigenous people face in accessing healthcare and social services. The *Collège des médecins du Québec* endorsed

the report on Joyce's Principle[4] in denouncing systemic racism and promised to undertake steps to support this position and combat systemic racism. Council agreed that also endorsing would be consistent with Council's endorsement of the Truth and Reconciliation Calls to Action and the UNDRIP document and would help guide its work to address these issues.

This issue of DocTalk also features an introductory article by Mr. Willie Ermine, Assistant Professor at First Nations University and Researcher, to guide us on the perspective of Indigenous Medicine providers, with more on this topic to follow in the October issue of DocTalk. We strongly encourage you to read his article on Indigenous – Western Healing - An Introduction to the Indigenous Perspective and continue learning with us as we move forward on our path to guide physicians towards a better, more collaborative approach to healthcare.

As the TRC progresses and moves forward with Action items based on Reconciliation, its intentions are not to be punitive, or shaming, but rather to educate and raise awareness of the truth that was hidden for far too long. It is about ending the very personal disparities and discrimination towards and faced by First Nations, Inuit and Métis peoples in Saskatchewan and Canada within the healthcare system and the hope that maybe, *just maybe,* these actions will filter into other systems that are infected and our work may lead to concrete solutions.

Meegwetch (Saulteaux word for "Thank you")

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[1] https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

[3]https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief__Eng.pdf

[4]http://www.cmq.org/nouvelle/en/college-reconnait-principe-joyce-enrayer-racisme-systemique-reseau-sante-services-sociaux.aspx

Burton O'Soup is a Public Member of Council and Chair of Council's Truth and Reconciliation Committee. Mr. O'Soup is Saulteaux/Blackfoot and a member of The Key First Nation. He is also a Student Advisor at First Nations University in Saskatoon.

Caro Gareau is the CPSS Communications Officer and a Member of Council's Truth and Reconciliation Committee.

Annex A - Articles of the United Nations Declaration on the Rights of Indigenous People that are most relevant to healthcare

Excerpts selected by: Burton O'Soup, Public Member of Council and Chair of the Truth and Reconciliation Committee

Article 1
Indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the Charter of the United Nations, the Universal Declaration of Human Rights and international human rights law.

Article 2
Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their Indigenous origin or identity.

Article 7
2. Indigenous peoples have the collective right to live in freedom, peace and security as distinct peoples and shall not be subjected to any act of genocide or any other act of violence, including forcibly removing children of the group to another group.

Article 8
2(e) Any form of propaganda designed to promote or incite racial or ethnic discrimination directed against them.

Article 15
States shall take effective measures, in consultation and cooperation with the Indigenous peoples concerned, to combat prejudices and eliminate discrimination and to promote tolerance, understanding and good relations among Indigenous peoples and all other segments of society.

Article 22
States shall take measures, in conjunction with Indigenous peoples, to ensure that Indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination.

Article 23
Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Article 29

1. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of Indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

Article 31

1. Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions. (?)

Article 43
The rights recognized herein constitute the minimum standards for the survival, dignity and well-being of the Indigenous peoples of the world.

Article 44
All the rights and freedoms recognized herein are equally guaranteed to male and female Indigenous individuals.

Source: United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

DocTalk

By Sheila Torrance, Legal Counsel, CPSS

Recent Amendments to the Health-related Renewal Questions

The College's health-related renewal questions, included in Bylaw 3.1 of the CPSS Regulatory Bylaws, were recently amended by the Council. There were a few primary reasons for the amendments:

1. There was a concern that the previous questions violated human rights principles and legislation as they requested information beyond that which the College required in order to ensure patient safety;
2. There was a desire to align the renewal questions more closely with the health-related questions posed on the initial Application for Medical Registration (AMR) utilized by CPSS and many other Canadian medical regulatory authorities (MRAs) on the physiciansapply.ca website;
3. It was also necessary to align the questions with the College's recent shift in approach to blood-borne viruses [see the article in DocTalk 2021, Volume 8, Issue 2: "A Shift in Approach to Screening, Reporting and Monitoring Blood-borne Viruses. "Reporting of seropositive status is now only required for physicians/medical students who perform or may perform / assist or may assist in performing exposure-prone procedures (EPPs).

The amended questions are broader based and focus on disability or functional impairment rather than specific health conditions such as addiction, mental health concerns, or blood-borne

illnesses. These questions would not necessarily require disclosure of ALL physician health concerns; rather, physicians need to disclose only those that could be reasonably expected to pose a risk of harm to patients or to negatively impact their work as a physician. The amended questions are intended to balance physicians' privacy interests more appropriately with the College's obligation to protect the public.

Process followed

The CPSS Council appointed a committee to consider the issues relevant to the health-related renewal questions. The committee put forward proposed amendments that the Council considered in June 2021. Amendments were approved in principle, and the College then undertook a broad stakeholder consultation process. This included specific requests sent to the Ministry of Health, the Saskatchewan Medical Association, the Saskatchewan Health Authority, and the Physician Health Program Committee, as well as an email blast sent to all registered CPSS members and posting on the CPSS website and Facebook page. Feedback was received from many of those organizations as well as from the Canadian Medical Protective Association.

The Council considered all consultation feedback at its November 2021 meeting, and approved the following amended questions:

> 7. Do you, will you, or is there a potential that you will perform or assist in performing exposure-prone procedures?
>
> > Yes ____ No _____
> >
> > If you answered 'yes' to this question, following review of the CPSS policy "Blood-borne Viruses: Screening, Reporting and Monitoring of Physicians/Medical Students" and Bylaw 24.1 "Reporting of Blood-borne viruses", are you compliant with the policy and bylaw?
> >
> > Yes ___ No ____
> >
> > If you answered 'yes' to question 7, have you ever tested positive for a blood-borne virus such as hepatitis B virus (HBV), hepatitis C virus (HCV) or human immunodeficiency virus (HIV)?
> >
> > Yes ___ No ____
>
> 8. During the past two calendar years, have you had or has a health professional advised you that you have a physical, cognitive, mental and/or emotional condition (not including a blood-borne virus) which in any way may reasonably be expected to pose a risk of harm to patients or to negatively impact your work as a physician?
>
> > Yes____ No____
> >
> > If you answered 'yes' to this question – Do you have an attending physician for that condition(s)?
> >
> > Yes___ No____
> >
> > Are you compliant with the recommendations of your attending physician?

Yes___ No____

If you answered 'yes' to question 8, are you currently participating with the Physician Health Program of the Saskatchewan Medical Association?

Yes___ No____

Are you compliant with the Physician Health Program recommendations?

Yes ___ No ___

What to expect in the Fall 2022 Renewal platform

The bylaw amendment came into force on January 28, 2022 when it was published in the Saskatchewan Gazette. Physicians can expect to see these questions on their renewal application for the 2022-2023 renewal season [*please refer to Annual Renewal Planning*].

College staff is working to create reference information to provide assistance to physicians when responding to these questions on the upcoming renewal. This will include dropdown panels, information accessible by "hovering" over the wording, and in the guide to the renewal process that will be available prior to the renewal season.

Sheila Torrance is Legal Counsel at the College of Physicians and Surgeons of Saskatchewan.

Changes to Regulatory Bylaws

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

There were **three (3)** changes to College regulatory bylaws since the last edition of the Newsletter.

** Bylaw changes come into effect once they are approved by the Government of Saskatchewan and published in the Saskatchewan Gazette.*

Regulatory bylaw 26.1 – Operation of Non-Hospital Treatment Facilities in the Province of Saskatchewan

The Council approved an amendment to permit physicians who seek to provide medical care which involves the use of drugs which are intended to or may induce sedation requiring the monitoring of vital signs to apply for an exemption from the requirement for the facility to be

approved as a non-hospital treatment facility to utilize those drugs. An exemption granted pursuant to the amended bylaw may be subject to terms and conditions and may require the physician to provide an undertaking to the College. This amendment was intended to address situations such as physicians administering inhalation analgesia using less than or equal to 50% nitrous oxide in oxygen in a community-based setting.

Regulatory bylaw 18.1 – The Prescription Review Program

This bylaw was amended to permit physicians to prescribe part-fills of specified Prescription Review Program medications without meeting all of the requirements of the current bylaw.

Regulatory bylaw 25.1 – Operation of Diagnostic Imaging Facilities in the Province of Saskatchewan

The Council approved an amendment related to the frequency of inspection of ultrasound equipment. The previous requirement to inspect ultrasound equipment "every six months" is now a requirement to inspect "on a schedule recommended by manufacturer's instructions."

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 edition of DocTalk, Council has updated **one** *policy and* **one** *standard/guideline.*

*Click on each title below to view the complete version of the policy, standard or guideline.

UPDATED POLICY – Renewal Questions – Use of Information by the College

The policy was updated to include the health-related renewal questions recently amended in bylaw 3.1 and to update relevant paragraph references. [See article *Recent Amendments to the Health-related Renewal Questions*]. There were several other "housekeeping"-type amendments to update reference to the Quality of Care Advisory Committee and the provincial health authority.

UPDATED STANDARD/GUIDELINE (OATP) – Opioid Agonist Therapy Standards and Guidelines for the Treatment of Opioid Use Disorder

The *Opioid Agonist Therapy Standards and Guidelines for the Treatment of Opioid Use Disorder* have been updated and are available on the website. Thank you to all of the OAT providers and stakeholders who provided expertise for the revision.

Among the changes made are:

- Patient-centered and gender-neutral language

- New sections: buprenorphine implant/depot, acute and chronic pain, considerations for surgery and slow-release oral morphine
- Patient-centered and gender-neutral language
- Focus on trauma-informed care and a comprehensive harm reduction approach
- Missed dose protocol
- ECG guidance
- OAT in pregnancy
- Corrections-Based Temporary Prescribers and Hospital-Based Temporary Prescribers
- ....and more!

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.

The website contains additional details about all disciplinary actions taken by the College since 1999. That includes information about the charges, a copy of the discipline hearing committee decision if there was a hearing, and the Council decision imposing penalty. If a discipline matter was resolved through post-charge alternative dispute resolution, the information will include a copy of the undertaking signed by the physician or a summary of the terms to be completed.

There were **four (4)** discipline matters completed since the last Newsletter report.

Dr. Zimran Chowdhary

Dr. Chowdhary was charged with unprofessional conduct in 2020. The charge alleged a failure to maintain the standard of practice of the profession with respect to the management of a post-operative complication in 2012. The matter was resolved in early 2022 through post-charge alternative dispute resolution (ADR) when Dr. Chowdhary agreed to take courses in medical record-keeping and patient communication with compassion, to review certain educational modules, to pay the costs of the College investigation, and to provide to the Registrar a focused review of certain surgical complications experienced in the past 5 years and the management thereof. Provided that he completes those tasks within the specified times, the College will not proceed further with the charge against him.

Dr. Rajnikant Patel

Dr. Patel was charged with unprofessional conduct. The charge alleged that he failed to meet the standards of the medical profession in relation to prescribing methadone and that he had a conflict of interest in relation to his methadone practice. A hearing was held on March 22-31,

2021. Dr. Patel was found **not guilty** of these charges.

Dr. Jeremy Reed

Dr. Reed was criminally charged, pled guilty and was convicted for assaulting his spouse and breaching his criminal undertaking twice. He was sentenced to a conditional discharge in Provincial Court. He was also charged by the College with unprofessional conduct. The charge of unprofessional conduct was resolved through post-charge alternative dispute resolution (ADR). Dr. Reed signed an undertaking and, provided that he complies with the terms of the undertaking, the College will not proceed further with the charge of unprofessional conduct against him.

Dr. Bruce Zimmermann

Dr. Zimmermann admitted two charges of unprofessional conduct for failing to complete hospital charts in a timely manner (charges laid in 2019 and 2021) and admitted one charge of unprofessional conduct for breaching an undertaking to the College. The Council imposed the following penalty: 1) a reprimand; 2) a two-month suspension, to take effect no later than June 1, 2022; 3) a requirement that he successfully complete a medical record-keeping course and a time management course, 4) an order that he pay the College's costs of $1,740.00.

By Werner Oberholzer, Deputy Registrar

The Quality of Primary Care

The Covid-19 pandemic affected all physicians in the province, from surgeons having to cancel planned surgeries, emergency rooms filling up with critically ill patients, to primary care clinics trying to balance in-person and virtual care visits. Physicians stepped up to fulfill leadership roles, upskilled to provide services in areas of need, manned assessment centres and have participated in vaccination campaigns, amongst many other efforts to provide quality care.

What Covid has again highlighted is the concern with Primary Care and Family Physicians in our province. This opinion piece is not to exclude other specialties and the roles they play in the delivery of healthcare in the province, but to recognize that family physicians remain the cornerstone of medical care delivery, and that they are struggling to maintain the desired quality of care with the additional burdens they face.

Roughly 32% of all the physicians licensed with the College are listed as Family Physicians, but many of these registrants do not practise full-scope family medicine; many of them fulfill roles such as Emergency Room Physicians, Hospitalists and Critical care associates, for example. The number is likely much smaller.

The Saskatchewan Medical Services Branch's Annual Statistical Report for 2020-21 state the following with respect to Family Physicians:

The number of active rural general practitioners (GP) was 235 at the end of March 2021, a decrease of eight physicians or 3.3% from the previous year. Over the last five years, the number of active rural GPs has decreased on average by 1.8% per year.

The number of active GPs in metro areas (Regina and Saskatoon) at the end of March 2021 was 454, a decrease of forty-three physicians or 8.7% from the previous year. Over the past five years, the number of active metro GPs has increased on average by 0.2% per year.

The number of active GPs in other urban areas was 211, a decrease of sixteen physicians or 7.0% from the previous year. Over the past five years, the number of active urban GPs has remained constant on average.

The concern of declining numbers must be considered in the context of the September 2021 assessment of the Covid-19's toll on family doctors survey by the CFPC, where the following were highlighted:

- *Fifteen percent of survey respondents say they are feeling burnt out, which is a three-fold increase over the 5% who felt burnt out in May 2020;*
- *Fifty-one percent say they are working beyond their desired capacity, which is in stark contrast to the 76% of family doctors who had reduced their work hours due to fewer patient visits at the start of the pandemic.*

The SMA Survey reporting the impact of the pandemic on Saskatchewan's physicians, also reported staggering statistics on the impact of the pandemic.

It is evident that Family Physicians need the support and advocacy from all their colleagues.

How can we do this as a profession?

- **Look out for each other**.
  If you become aware of a physician colleague who is struggling or needs assistance, reach out to the SMA's Physician Health Program, by contacting Brenda Senger (306-657-4553 or brenda.senger@sma.sk.ca), Director of Physician Support Programs, or Jessica Richardson, Clinical Coordinator in Regina (306-359-2750 or jessica.richardson@sma.sk.ca).

- **Practice Collegiality**.
  If you are a colleague or a specialist, and a family physician phones for advice, please accept the call. Be courteous, be kind. They are not calling to find out what the weather is like in your location – they need assistance. To you it may seem trivial at times, but they are seeking help, and the reason they do so is to enhance patient care.

- **Be available**.
  If you are a colleague or a specialist on-call, please answer the page, call your colleague back. They may be just as busy as you are, possibly with less support than you have at your location. Find out what they need – advice or reassurance is invaluable, and – even more relevant – please accept a transfer when requested. There are often more aspects when reaching out to a colleague or a specialist than what meets the eye – lack of support, lack of capacity, concern about diagnoses,

inability to optimally obtain special investigation or imaging, or to treat the patient.

- **Do your part**.
  It is sometimes easier to defer a request for a form or a report to the Family Physician. Insurance and sick leave forms are often sent back to family doctor to fill in. Many of these are required after procedures or specialist involvement and really fall outside of the scope and experience of family doctors to reliably complete Likewise, think twice before including advice like "request an ultrasound and send a copy to my office" in a consult note. Think of it this way – If you knew the family physician personally, would you make this request? – or will you respect their time and expertise as much as you do your own?

- **Save a step**.
  In communication with a rural, full scope family physician I learned that during the pandemic many specialists followed patients virtually and could not supply the patients with laboratory requisitions for blood work, etc. Many resorted to asking the family physician to order specific blood work and then copy it to the specialist or even follow-up CTs, MRIs and other special investigations. The same happens with referrals to physiotherapy, occupational therapy, and speech language pathology. Some specialists will evaluate a patient and recommend a referral to another specialty – and then request the family physician to do so. It may be much more efficient for the specialist to request those investigations or make the referrals at the same visit.

- **Practice what you preach**.
  Reciprocity is mutually beneficial. All this works both ways, and all Family Physicians should practise the same principles in return.

- **Refer and consult appropriately**.
  The College's guideline "Referral-Consultation Process" sets out the principles and expectations for the process between physicians. The Referral and Consult Tools on the eHealth website contains valuable resources, including standardized referral letters and instructions on setting these up in the EMR.

- **Know the billing rules**.
  Some specialists require a yearly re-referral by the family physician to be able to see patients they follow annually and bill a consult code. This step may not be required; there is a provision is on page 19 of the April 1, 2022, payment schedule under the "Consultation" heading which states:

  9. For patients whose chronic medical conditions require a comprehensive annual review with advice back to the referring physician, it is acceptable to bill a consultation code without a formal re-referral in the following circumstances:

     a) The patient was originally referred to the consultant for this condition;

     b) The patient's medical condition requires annual review;

c) One year has elapsed since the last patient visit (consultation or other visit service);

d) The original referring physician is still the patient's family physician and is still in practice in Saskatchewan;

e) A consultation note is sent to the original referring physician.

(Unless the patient has been seen in the preceding year since the last visit, as per (c) above).

Many of the above issues were identified during discussions with Dr. Eben Strydom, the Past President of the Saskatchewan Medical Association. In addition, he had the following system improvement suggestions, which need advocacy from all physicians:

- *It would be beneficial to have a provincial and electronic medical record (EMR)-based address book with community-based support service fax numbers, phone numbers and contact details to make it easier for requisitions to be forwarded directly to the appropriate lab, the family doctor's office, the patient or to a special service.*
- *Ordering MRIs is problematic for many, if not all, family physicians. This needs to be sanctioned by a specialist, often a radiologist who has not seen the patient, but acts as gatekeeper. Examples that come to mind are significant meniscal injuries where the expectation sometimes is that an x-ray needs to be requested first, and then the radiologist can respond in a comment that an MRI would be a more appropriate investigation. These are all factors that take up significant physician time and again, are not compensated. The appropriate use of these limited resources should be addressed with education and collaboration rather than logistical roadblocks.*
- *In terms of cooperation, the family doctor also has a huge responsibility in providing accurate and up-to-date information with referrals, etc. A single instance (universal) EMR will reduce the amount of duplication and free up time for clinical work, which will benefit patients more.*
- *Having a dedicated phone line or dial option available for physician offices would save a lot of time and effort in coordinating care between physicians and physician offices. Having to wait through all the information about fax numbers, office hours and pandemic rules is painful, especially when there is no answer because the call recipient is on the phone or otherwise unavailable.*

Be collegial, be courteous, be kind. Your colleagues deserve it.

Dr. Werner Oberholzer is Deputy Registrar with the College of Physicians and Surgeons of Saskatchewan and is certified in Family Medicine, Emergency Medicine, and Care of the Elderly.

A New Addition to the Quality of Care Team

Dr. Carmel Overli-Domes has recently joined the College of Physicians and Surgeons of Saskatchewan as a Senior Medical Advisor. She obtained a Bachelor of Science degree in Biochemistry with Great Distinction from the University of Regina, her MD with Distinction from the University of Saskatchewan, and completed her family medicine residency in Regina through the University of Saskatchewan. She has CCFP and FCFP designations. In addition to her years of clinical experience as a locum family physician, she has a considerable background in medical regulation. Dr. Overli-Domes has achieved Certificates in Investigations, Physician Leadership, Health Law, and Quality and Safety. Her prior experience also includes working as a Preliminary Inquiry Committee Chairperson (CPSS), Co-Vice Chairperson for the Joint Medical Professional Review Committee, and Senior Medical Advisor in the Department of Professional Conduct with the College of Physicians and Surgeons of Alberta. Her vision is to lead with integrity, fairness, and professionalism. She has an interest in process improvement and intends to deliver regulatory excellence.

Dr. Overli-Domes replaces Dr. Heather Halldorson, who left her position with the Quality of Care team at the end of April 2022. On behalf of the CPSS, we would like to welcome Dr. Overli-Domes and thank Dr. Halldorson for her years of service as Senior Medical Advisor and wish her well in her future endeavours.

Photo (left): Dr. Carmel Overli-Domes, BSc, MD, CCFP, FFCFP

Got questions about your practice?

It's always better to be safe than sorry! AND we'd be happy to help you out!
Please phone or write the CPSS with your questions!

June 2022

Indigenous-Western Healing – An Introduction to the Indigenous Perspective

Source: Mr. Willie Ermine, M. Ed, Assistant Professor, First Nations University.
A member of the Sturgeon Lake First Nation in the north-central part of Saskatchewan, Mr. Ermine has worked extensively with Elders, promotes ethical practices of research involving Indigenous Peoples and is particularly interested in the conceptual development of the 'ethical space'– a theoretical space between cultures and worldviews.

> *"We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients."*
> - (Truth and Reconciliation Commission, 2015)

The above Call to Action presents intriguing possibilities. The possibility presented is that Indigenous and Western knowledge systems can co-exist and harmonize, and that this pluralism expands opportunities for effective disease management. Through collaborative work, this idea offers an opportunity for healers and medical practitioners to meet and exchange critical knowledge. It is an opportunity to identify innovation, inform policy and advocate for greater recognition of the role traditional medicine can play in contributing to understanding disease and where and when traditional medicines and cultural practices fit best alongside western medicine practices.

The possibility is to improve outcomes for Indigenous peoples and the next step is for primary healthcare organisations to support the development of traditional medicine services. The collaboration will work towards improving the effectiveness of interventions through culturally responsive care. It is to affirm that the range of interaction is important so that the practice of traditional medicine is not reduced to a "treatment", the moment of contact between healer and individual, but acknowledges the ongoing healing journey of an individual to acquire restoration and balance. A forthcoming paper should be a tentative step to harmonization between Indigenous and Western practices of health.

Look for a more in-depth article from Mr. Ermine on this very important topic in the next issue of DocTalk!

For information on the College's steps towards Reconciliation, see the Council News article in this issue, Laying the Foundations to Improve Care by Physicians for Indigenous Patients in Saskatchewan.

PIP Integration with the Saskatchewan Cancer Agency

Source: eHealth & collaborating organisations

In the coming months eHealth will begin capturing all patient medications from the Allan Blair Cancer Centre (ABCC) and the Saskatoon Cancer Centre (SCC) into the Pharmaceutical Information Program (PIP) record and the eHR Viewer for healthcare professionals. This is part of a patient safety initiative to improve completeness of provincial medication profiles.

An exact launch date will be communicated when finalized. Only new medication records dispensed after the launch date will populate the PIP profiles. Historical dispense records prior to launch date from ABCC and SCC pharmacy will not exist on the patient profile.

Many professionals utilize the Preadmission Medication List available in the PIP or the eHR Viewer in workflow processes. Cancer medications will display as per normal business rules on the Preadmission Medication List. No changes on the Preadmission Medication List have been made to differentiate these medications.

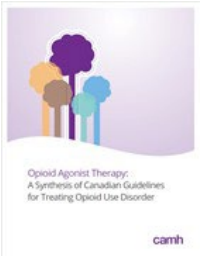
Please be advised that cancer medications will also be displayed in downstream applications such as My Sask Health Record. Therefore, residents of Saskatchewan will be able to view these new medications on their existing MSHR drug profile.

Organisations involved include:

- College of Physicians and Surgeons of Saskatchewan
- College of Registered Nurses of Saskatchewan
- eHealth Saskatchewan
- medSask
- Government of Saskatchewan

- Saskatchewan Cancer Agency
- Saskatchewan College of Pharmacy Professionals
- Saskatchewan Health Authority

Practice Tools



Source: Nicole Bootsman, OATP Program

Canadian Opioid Use Disorder Guideline

The Canadian Opioid Use Disorder Guideline, Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder is available on the CPSS website. Great collaborative work was done on this project to ensure safe standards of practice across the country! We are especially proud of the support provided by our own CPSS Opioid Agonist Therapy Program staff.

See the CAMH website for more details on the project.

Information courtesy of LINK

LINK Telephone Consultations - New Services Available

Saskatchewan primary care providers can call LINK to consult with a specialist regarding complex but non-urgent patient care. New specialties included! FIND OUT MORE

Information courtesy of CCENDU

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

Information courtesy of RSFS

Health Accompagnateur Interpretation Services

Saskatchewan primary care providers and patients can call the *Réseau Santé en français de la Saskatchewan Health Accompagnateur Program* to obtain assistance for French-speaking patients!

Trained Health Accompagnateurs act as the patient's guide to the health system and as an interpreter during consultations with various health providers: doctors, pharmacists, lab technicians, nurses, therapists, etc.

Infection Prevention and Control - Link Letter

See the latest IPAC-SPIC Link Newsletter for the latest updates on Infection Prevention.

Information courtesy of Dr. Katelyn Halpape

The MAC for Medication Assessment

The MAC is a pharmacist-led clinic at the University of Saskatchewan that offers general medication assessments and cognitive behavioural therapy for insomnia (CBTi).

The MAC for Chronic Pain

The MAC iOPS (soon to be renamed the USask Chronic Pain Clinic) provides patients the opportunity to receive care from a pharmacist, physical therapist, medical social worker, and physician with expertise in chronic pain in a team-based approach.
Details

By: Debra-Jane Wright, Director, Registration Services

Residents Completing Training - What now?

First off, congratulations! We know it has been a long and hard journey, filled with many sacrifices along the way, but you did it! If you feel unsure what to do next when it comes to registering for your licence, please refer to our Guide to Registration for Residents Completing Training, to help you navigate your way forward.

A couple of high points are summarized below:

1. Please make sure to submit your documentation well in advance of your required start date;

2. If required, please arrange for a Certificate of Professional Conduct (CPC) to be emailed the CPSS as soon as possible;

3. All changes or delays to your program must be approved by the College of Medicine;

4. Please make sure to include and share all required information through Physiciansapply.ca (verified identity documents, examination results and medical degree).

If you have any questions, please do not hesitate to reach out and speak to someone in Registration Services. Please call (306) 244-7355 during office hours (8:30am – 4:30pm) and ask to speak to someone in Registration, or email cpssreg@cps.sk.ca.

Residents! Are you interested in Moonlighting*?

Residents who plan to provide moonlighting coverage during the academic year must obtain permission from the Program Director at the Post-Graduate Medical Education (PGME) Office. To request application forms and instructions, contact Sam Curnew, PGME Electives & Administrative Processes, at sam.curnew@usask.ca.

Moonlighting may be issued for the following periods:

- May 1 to October 31
- November 1 to April 30

To learn more, visit our website.

** Moonlighting refers to residents working as an independent physician, outside of the scope of their residency training program.*

What does it mean to be "transitioning to a Regular Licence"?

If you have successfully passed that last remaining exam, or if you have received notice that you have successfully passed your Summative Assessment or completed any remaining requirement that stood between you receiving your regular licence, then it might mean that you are in a position to be transitioned to a regular licence. We expect that you are likely anxious for this transition to occur, as it is often the culmination of hard work and perseverance! Therefore, we thought it might be helpful to provide some insight on what it means to transition and why this transition does not happen instantaneously, as one would presume!
In order to transition to a regular licence, the following must be ensured:

- A final supervision report may be required from your supervisor;
- A final summary report may be required from your Area Chief of Staff or Area Department Lead;

- The Registrar or Deputy Registrar must review your file and all relevant documents to ensure there are no outstanding concerns.
- An internal security check must be completed by CPSS; and
- Any outstanding supervision payments must be finalized.

If all of the above is received, reviewed and no concerns are identified, then your file gets placed in the Licensure Queue and you will receive an email notification that your licence is being processed.

As always, if you have any questions, please do not hesitate to reach out and speak to someone in Assessment & Supervision. Please call (306) 244-7355 during office hours (8:30am – 4:30pm) and ask to speak to someone in Assessment or email cpssreg-assess@cps.sk.ca.

Annual Renewal Planning - Are you ready for Renewal?

Annual Physician Licensure and Medical Corporation Permit Renewal will begin in October 2022.

You will receive email notifications from CPSS to inform you of the start date and launch date once the online portal is open.

Important Dates:

Key Dates	Annual Licensure Renewal	Annual Medical Corporation Permit Renewal
Portal Opens	Early October, 2022	Mid October, 2022
Deadline to Renew	November 1, 2022	November 15, 2022
Penalties applied	December 1, 2022	January 1, 2023

Before Annual Renewal Season Starts:

1. Update your preferred email address for all College correspondence to ensure you will receive renewal notices. You can update your email address by sending an email to cpssreg@cps.sk.ca with your new address, along with your registered MINC# (Medical Information Number for Canada).

2. Seek out and collect the necessary documents and/or information you require as part of your renewal process.

   For Physician Licensure Renewal

   - Know your current Learning Cycle start and end dates for your Continuing Medical Education programs, MainPro+ or MainPort/MOC.

- Have copies of your Completion Certificates from your CME program downloaded, if your end dates were either December 31, 2021 (Royal College of Physicians and Surgeons of Canada) or June 30, 2022 (College of Family Physicians of Canada). For more information, please refer to DocTalk Article on Continuing Medical Education, from the March 2022 Issue.

For your Medical Corporation Permit Renewal

- Obtain copies of your Corporation Profile report from ISC Corporations Branch and the Articles of the Corporation, if you have made any changes.

3. If you plan to lapse your licence or not renew for a full calendar year, please contact the CPSS in advance of the renewal cycle, to discuss your best options.

4. To complete your renewal, have a personal computer with a good internet connection available. Mobile devices, smart phones, tablets, and iPads are not supported. Please also be aware that if you try to complete your renewal on a Saskatchewan Health Authority workstation, you may be unable to access the Renewal Portal, due to the firewall.

New Questions this year for Physician Licensure Renewal

The CPSS will be introducing new health-related questions this year. Please refer to the article titled Recent amendments to the Health-related Renewal Questions in the *Legally Speaking* section of this issue of DocTalk.

If you have any questions about any points above, do not hesitate to reach out and speak to someone in Registration Services. Please call (306) 244-7355 during office hours (8:30am – 4:30pm) and ask to speak to someone in Registration Services about your Renewal, or email cpssreg-renew@cps.sk.ca

CONTACT INFO CHECK

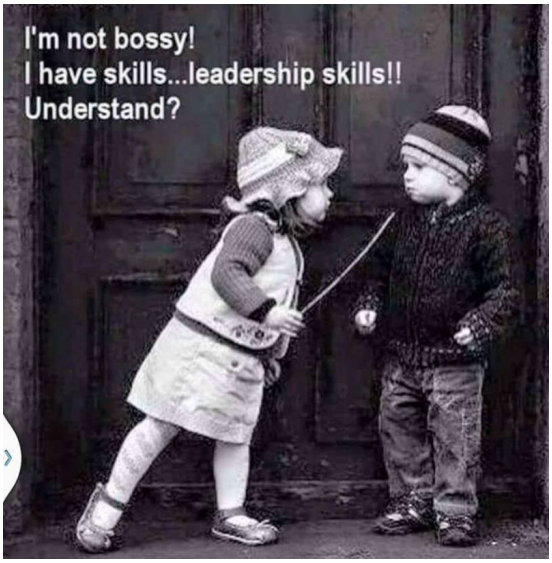
Have you moved recently?

Whether it's your personal residence or your clinic practice, please remember to reach out to the College to keep your correspondence and office address contact information up to date. This helps to ensure you do not miss any critical communications sent out by the College and to ensure information remains accurate for patients, partners and funders through the use of the Physician Directory that the College maintains!

Update contact information

Stepping in to Healthy Leadership

By Brenda Senger, Physician Health Program Director, Saskatchewan Medical Association



(Image Source: LinkedIn/Unknown)

We have heard a lot about "leadership" through-out the pandemic – disappointed by some, appreciative of others, awed by many. As physicians, many have felt burdened by this expectation and unsure of your competency in new leadership roles – reignites that imposter syndrome, doesn't it? Yet, you stepped up, filled in, spoke up and deployed where needed. Thank you.

Position does not define leaders – leaders can be found through-out a system by the characteristics they demonstrate and cultivate. Curiosity, genuine interest in others, positive energy, integrity, congruency between intent and behavior, honesty, humility, compassion, and recognition of others.

The role of a leader is not to **take** *charge, but rather to take care of those* **in our charge.**

So, to all of you who took care of those in your practice, your clinic, in your team, in your department and in your community – we owe you a debt of gratitude and hope you hear and accept our appreciation. Do not brush it off with "I was only doing my job" – you went far beyond – and we noticed!

(Image Source: Unknown)

Stress is inevitable. Struggling is optional.

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

Call the Physician Health Program at the Saskatchewan Medical Association.

Brenda Senger
Director
306-657-4553
brenda.senger@sma.sk.ca

Jessica Richardson
Clinical Coordinator (Regina/South)
306-359-2750
jessica.richardson@sma.sk.ca

CELEBRATING 40 YEARS OF PRACTICE?

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

Think you may be eligible to be a recipient in 2022?

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