ALBERTA, CANADA
COUNCIL HIGHLIGHTS

The Council of the College of Physicians and Surgeons of Alberta (CPSA) met May 28, 2004, in Edmonton. Some of the more significant items included:

Information Sharing

The Council approved, in principle, a report addressing responsible sharing of information among health professionals. The document was developed by a working group of the CPSA, Alberta Medical Association, Alberta College of Pharmacists and Alberta Association of Registered Nurses (with input from Alberta Health and Wellness, the Office of the Information and Privacy Commissioner and an ethicist from the University of Alberta). The approved document will be circulated to other health professionals for their consideration.

This document will establish a framework for the development or revision of formal CPSA policies or guidelines in this area.

Cosmetic Services

Following direction from Council and input from the profession, a working group reviewed the issues and debates surrounding cosmetic services. The Council approved, in principle, a number of policy recommendations identified by the working group surrounding advertising, consent for treatment, follow-up, training and informing the public.

The recommendations will be available on the CPSA website at http://www.cpsa.ab.ca/cosmetic_services_recommendations.pdf or by contacting the CPSA office, after July 1, 2004. More information on this issue will be distributed in future issues of *The Messenger*.

Revalidation

Revalidation is the term given to the process by which all physicians demonstrate their continued fitness to practice as a condition of remaining licensed.

With increasing discussions across Canada about invoking revalidation requirements, Council discussed the issues that would need attention — from what should be assessed and the content of a revalidation program to how it would be communicated and funded.

The Council sees the issue of revalidation as an opportunity to improve quality of care but will continue discussions to better understand its value.

Mandatory Performance Review

The Council discussed the concept of physician competency assessment that would be triggered by age. In Ontario and British Columbia, peer review programs target "at risk" physicians, including physicians beyond a certain age. Council directed the Secretariat to explore this concept further and report back to Council at its December meeting.

Certificates of Standing

The Council supported a policy to refine the information disclosed on a certificate of standing.

The most significant change is that the certificate will indicate whether the physician is the subject of an open complaint. Currently, only published disciplinary information is provided on these certificates. The College does not currently, and will not in the future, provide information about complaints that have been closed. The certificate of standing will state only that the physician is the subject of an open complaint. Details will only be provided to the requesting body at the consent of the physician.

COMPLAINTS AND DISCIPLINE AND THE HEALTH PROFESSIONS ACT

During the next 12-18 months, the medical profession will move from under the authority of the Medical Profession Act (MPA) to the Health Professions Act (HPA), a new omnibus legislation for all health professions.

Prior to being implemented for the College of Physicians and Surgeons, the Act will go through various stakeholder review processes, with final approval by the Alberta legislature.

When the College begins to operate under the HPA, a number of changes to our complaints process will occur. We will still require a written and signed letter of complaint in order to begin an inquiry. However, instead of an Investigation Chair — a member of College Council appointed annually by the Council — the College will have a Complaints Director. The Director will be a CPSA staff member who will receive and review all complaints.

Under the current MPA, the Investigation Chair has two broad options: 1) dismissal of a complaint or 2) referral to hearing before an Investigating Committee.

In practice, however, the College's complaints process is more complex and flexible. We regularly use informal resolution processes to review and resolve complaints. This may include meetings with the complainant and respondent physician to craft a mutually acceptable outcome, a process that has been extremely successful to date.

Under the HPA, the complaints process is more precise and prescriptive. For example, the Complaints Director (CD) may:

- Encourage the complainant and physician to communicate with each other and resolve the complaint.
- Refer the matter to the Alternate Complaint Resolution process.*
- Request review of the subject matter of the complaint by an expert (i.e., expert opinion).
- Request that the matter be formally investigated.*
- Dismiss the complaint if it is deemed frivolous or vexatious.
- Dismiss the complaint if there is no or insufficient evidence of unprofessional conduct.
- Direct that the physician undergo a mental or physical health assessment if there are grounds to believe the physician may be incapacitated.

The advantages of the HPA include:

- The ability to dismiss frivolous and vexatious complaints at a very early stage (an ability we do not have now).
- The potential to have a complainant and physician resolve the matter without College involvement.
- The opportunity to use a formal alternate complaint resolution process to address complaint issues. The HPA allows a wider range of options at the initial stages of complaint resolution. How the process then plays out will be the subject of future articles.

* The HPA has detailed sections outlining the process of alternate complaint resolution and investigation as referenced above. These will be explained in future articles in *The Messenger*.

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BRITISH COLUMBIA, CANADA
HOW CAN THEY FIND YOU?

The College of Physicians and Surgeons of British Columbia recently received an expression of concern from a consultant pathologist which focused on the difficulties that he encountered in contacting a physician who had ordered some blood work on a patient, but who was then unavailable to receive the results.

A young woman presented to a community laboratory late in the afternoon and was found to have very low hemoglobin [30 g/l]. By the time the result was verified, the walk-in clinic she had attended was closed and the pathologist found there was no after-hours contact number for the clinic or for the physician that the patient had seen in consultation. The patient herself had, in the meantime, left the laboratory and it was with great difficulty that the consultant pathologist was able to obtain her cell phone number from her place of work. The patient was eventually contacted and directed to attend the nearest emergency room where she was transfused and a gynecological consultation was undertaken.

While the outcome in this case was a satisfactory one, the Executive Committee of the College would remind the profession that after hours availability is an essential part of professional care. The situation could have been avoided if the clinic had complied with the professional requirement for physicians to establish a call rota and mechanism for after-hours availability. An obligation to provide continuity of care is inherent in every medical encounter.

DO NOT RESUSCITATE

It is clear from some of the complaints received by the College that many members of the public do not understand "Do Not Resuscitate" orders.

On the one hand, some people believe that their loved one will be neglected by the profession and that no meaningful further treatment will be given. On the other hand, some believe that the patient is being denied the miraculous procedure seen on television where the application of a defibrillator restores instant recovery without a hint of harm.

Discussion of DNR with the patient and the patient's family must dispel these illusions. The futility of resuscitation attempts if the collapse is not witnessed, and the inappropriateness of such attempts if the patient is at the end-stage of an untreatable disease process, should be pointed out.

Advanced old age is not in and of itself sufficient reason to consider a DNR designation, but many of the very elderly have chronic conditions that may make them proper candidates for a DNR status.

It is helpful to outline the various steps taken during a resuscitation and the possible complications and end results. The Vancouver Hospital has produced an excellent detailed document on this important topic.

DISPOSAL OF PATIENT INFORMATION

Periodically, the College receives complaints about physicians who have failed to take appropriate care with respect to patient information. Concerns can arise in a variety of circumstances, including relocation of medical offices or disposal of old files.

More recently, the College received concerns regarding a physician who was inappropriately using residential dumpsters for the disposal of his office garbage. While that was inappropriate in itself, the situation was exacerbated by the fact that, inadvertently, the garbage included items that contained patient information. For example, there were empty prescription bottles, requests for gynecological cytology, day sheets, faxes and incomplete patient sheets. The security of patient information is the responsibility of the physician. In this particular case, the physician acknowledged his conduct was unprofessional, admitted that he had failed to protect patient confidentiality, and accepted a formal reprimand on his professional record.

Aside from the inappropriate disposal of garbage in other individuals' dumpsters, this case highlights the importance of ensuring that any items discarded by physicians and their staff do not contain any patient-sensitive information. Physicians should ensure appropriate arrangements are made for the disposal of patient information.

FROM THE ETHICAL STANDARDS AND CONDUCT REVIEW COMMITTEE

Kickbacks

The College was informed that an orthotics supplier was offering physicians an "incentive program" to reward those who referred patients to him. This is a kickback and a conflict of interest. Any physician participating in such a program would be contravening the Conflict of Interest guidelines of the College. The guideline states, in part, that a member of this College is in conflict of interest if he or she "accepts a commission or rebate of any sort, including gifts, from any third party who renders a service to the member's patient."

The orthotics supplier quickly responded that he meant the "incentive program" for patients and not for physicians. Nevertheless, the caution written above stands. The offer to physicians was ambiguous.

Draft Copies

A physician was embarrassed when a draft of a report was circulated prematurely. The draft contained two paragraphs that were critical of another professional. It was decided by the physician that these two paragraphs were irrelevant to the main issue of the report and should be deleted. This was done and the final report sent off. Unfortunately, a copy of the original draft had arrived first and greatly upset the other professional. Be careful with draft documents and mark each page with DRAFT — NOT FOR RELEASE.

MAKE SURE IT IS SEALED

As the psychiatrist who received a misaddressed ultrasound report said, "The upsetting thing was that the envelope it came in was unsealed. Anyone could have read it." An error in an address can and does happen, but there is no excuse for putting an unsealed envelope that contains a sensitive report in the mail.

FROM THE SEXUAL MISCONDUCT REVIEW COMMITTEE

The Sexual Misconduct Review Committee recently reviewed a case that caused significant distress for a patient as well as considerable stress and cost in time for the physicians involved. The Committee determined much of the anguish for all of those concerned could likely have been prevented if the attending physician had personally introduced the resident at the first encounter with the patient, and if the resident had an identification tag readily visible to the patient. It is important that medical students and residents are introduced to patients, and that patients are given an opportunity to express any concern they might have about being examined by individuals other than the physician with whom the appointment was made.

MEDICAL-LEGAL LIAISON COMMITTEE

The Medical-Legal Liaison Committee is a committee which meets two or three times per year to mediate or attempt to adjudicate concerns and disagreements between members of the legal profession and the medical profession. The Committee has representation from the BCMA, the Law Society, and the College of Physicians & Surgeons. The matters reviewed include disagreements about fees for professional services such as medical/legal letters, court appearances, expert testimony, and the like. The Committee's advice and suggestions are non-binding but are an attempt to find common ground for resolution of these disagreements. The May issue of the *BC Medical Journal* included a detailed description of the Committee and its function and readers may wish to review that publication for more detail.

The Committee has been chaired for many years by Mr. Jack Webster, Q.C., a Vancouver lawyer. The Committee members and the respective organizations that they represent are grateful to Mr. Webster for his expertise and guidance in resolving many of the issues placed before the committee.

CHRONIC PAIN PATIENTS

Inappropriate treatment of patients with substance abuse is a recurring reason for complaint to the College. Patients with chronic pain syndromes, e.g., chronic abdominal pain, chronic pelvic pain, chronic daily headaches, fibromyalgia, often have developed dependencies on analgesics. In many cases, one of the reasons for their chronic pain is the dependence itself, resulting in such symptoms as chronic daily headaches.

Frequently, the patients with these complicated problems are referred to specialists. The patient often does not disclose the full extent of medication use, and the consultation then becomes flawed as a significant underlying problem has been concealed. Part of this problem could be avoided if the referring physician made the specialists aware of all the medications and the doses that the patient is taking.

When a patient enters recovery, a frequent result is a complaint to the College alleging the previous inappropriate management of his or her symptoms and the careless way in which potentially addictive medications were prescribed.

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MANITOBA, CANADA

OCCUPATIONAL HEALTH PHYSICIANS AND PATIENT INFORMATION

Members should note Guideline #117, The Physician Medical Record, has been amended to include information about a patient's occupational health record. The following information was approved:

- "Occupational health records must be kept separately from general medical records in order to ensure the integrity of the occupational health record.

- Occupational health records must continue under the authority of the Occupational Health Physician and must be transferred only to a named successor.

- Information from an occupational health record must be released to the employer or other third party only with the express consent of the patient, except where the release is necessary to protect the employee or other employees, or pursuant to other exemptions contained in The Personal Health Information Act. The Occupational Health Physician is advised to strongly encourage the employer to document and distribute to employees personnel policies describing the circumstances in which information contained in occupational health records will be released to the

employer or other third parties without the consent of the employee.

- Information from an occupational health record may only be transferred to a general medical record with the patient's consent."

Members should note the last bullet applies even if the same physician is both attending and occupational health physician. Actual patient authorization should be obtained before a physician transfers information from an occupational health record to a general medical record.

Reprinted from the Volume 40, Number 1 issue of *The Newsletter*, posted on the College of Physicians and Surgeons of Manitoba website.

NEW BRUNSWICK, CANADA
ACCESS TO PHYSICIANS

The College of Physicians and Surgeons of New Brunswick has become aware that, when some physicians or clinics are considering accepting a patient who is already seeing another physician, some have required the patient to obtain permission from their current physician. Physicians are reminded of the following form of misconduct:

40. interfering, either directly or indirectly, with the patient's freedom of choice of a physician or a patient's right to consult another physician or other professional;

As a consequence, it would be considered ethically unacceptable to require the permission of another physician to accept a patient. It would be similarly unacceptable for the original physician to refuse such a request. In addition, it is understood certain physicians or clinics will contact the original physician for information prior to accepting the patient. This may also be ethically questionable until the patient has been accepted into the new practice.

Reprinted from the College of Physicians and Surgeons of New Brunswick website.

NOVA SCOTIA, CANADA
RESPONSIBILITIES OF WALK-IN CLINICS

After reviewing concerns raised by an Investigations Committee, the College's executive committee requested on May 13, 2004, that College members be notified of the following responsibilities of physicians practicing in walk-in clinics:

- A copy of the patient record is to be forwarded to the family physician.

- Any investigations ordered by the walk-in clinic must be followed up by the ordering physician.

- Results of investigations ordered by the walk-in clinic should be copied to the family physician.

Reprinted from the College of Physicians and Surgeons of Nova Scotia website.

ONTARIO, CANADA
ACCESS TO PHYSICIANS

The College in Ontario is initiating a process to assess certain physicians who are applying for licensure that includes having an assessor visit a physician's practice, review certain charts, and observe the physician with patients. If the physician's assessment is acceptable, this will then be considered in their application for licensure. In reviewing this process, Council had many concerns. While physicians will have to obtain consent from patients for the chart review, or the direct observation, there are questions as to whether this will adequately address the patient's right to confidentiality and privacy. As a consequence, Council has requested that the College in Ontario defer any such assessments until these concerns are addressed. Council has also advised physicians considered for such assessments that it would be unacceptable for them to submit to such until such time as the Council considers the procedure ethically acceptable.

Reprinted from The College of Physicians and Surgeons of Ontario website.

SASKATCHEWAN, CANADA
CANADIAN COALITION FOR QUALITY IN LABORATORY MEDICINE

In 1991, the first meeting of the provincial authorities responsible for the accreditation of medical laboratories met in Saskatoon as the Interprovincial Quality Assurance group (IPQA). The purpose was the exchange

of information and approaches to the quality improvement of medical laboratory services. Annual meetings have occurred since that time and most recently, in Saskatoon preceding the CSMLS conference.

Some years ago, discipline working groups were created to foster national consensus and the development of standards of practice.

In 2003, IPQA changed its name to the Canadian Coalition for Quality in Laboratory Medicine (CCQLM) and received official notice of Incorporation some two days before this year's meeting on June 10-11. The Articles of Incorporation and the Bylaws will be available very shortly.

In the meantime, the Working Groups cover Hematology, Transfusion Medicine, Clinical Chemistry, Microbiology, Anatomical Pathology, Information Technology and Accreditation. Work on sharing information and conducting national surveys has been very successful. Papers for peer-reviewed publication are in active preparation and guidelines have been submitted to the National Committee on Medical Laboratory Quality Systems of the Canadian Standards Association for consideration as Standards.

Reprinted from the August 2004 issue of *QA Quips*, published by the College of Physicians and Surgeons of Saskatchewan.

LET US HEAR FROM YOU

Would you like for information from your board to be considered for publication in the *Journal*? If so, e-mail articles and news releases to Edward Pittman at epittman@fsmb.org or send via fax to (817) 868-4098.