From the College

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This newsletter is forwarded to every registered member of the College of Physicians & Surgeons of Manitoba. Decisions of the College on matters of standards, amendments to regulations, bylaws, etc., are published in the newsletter. The College therefore expects that all members shall be aware of these matters.

From Your President
DR. ERIC SIGURDSON

Let's Communicate

The start of 2018 will see several email communications sent to you from the College. These communications will be in the form of consultations with the membership. You will have already received the draft Standard of Practice for Prescribing Opioids email which has been circulated to the members, stakeholders, and public for consultation. Within the first few days we have already received numerous, excellent, thoughtful, practical, and constructive responses from you. Keep the responses coming!

The next set of consultation documents sent to members, stakeholders and the public, are the regulations for the *Regulated Health Professions Act*. I have to admit, you will likely not find it as interesting as the prescribing Opioids Standard, and perhaps not as germane to your practice, but it is applicable to our profession. While the regulations are lengthy, there will be both a Key Changes Summary document and a Frequently Asked Questions document, so I urge you to review those to understand some of the changes to the regulation of our profession. Also included in that consultation will be the Standard of Practice of Medicine which is a document every member should review periodically as these govern certain aspects of your practice. Your thoughts and comments are welcome, so please send them in.

Transitioning to adapting the *Regulated Health Professions Act* also requires the College to update its bylaws and consult with you on these documents. These documents will be communicated to you later this spring.

In this issue of the College newsletter, we have included two articles from the College of Physicians and Surgeons of Ontario, one on confidentiality and social media, the other on test and treatment overuse. These are made available to us through the consent of the Ontario College and are applicable to Manitoba members.

As a practicing psychiatrist, I try to be keenly aware that communication between my patients and myself is a two-way street. It should also be that way for the College. The College sends out a number of communications every year to all of our members, but only receives very limited communication back from you. I am struck by the many good ideas I hear in my interactions with colleagues at the hospital or even in informal settings like over-the-fence talks with my neighbour, a family physician. I can't communicate personally one on one with each of you, but I would like to hear from you. I am always struck by the commitment and passion you have for your patients, your practice, and ways to improve health care within the province. Good communication requires good listening, understanding your comments and concerns, and ensuring your concerns will be addressed.

I recently received an email from a physician thoughtfully linking current media focus on speaking out against sexual abuse to the College. The College has the framework and rules to address allegations of member's misconduct. However, unfortunately, many societal barriers and other reasons may preclude victims from reporting such misconduct to the College, or indeed other authorities. There is no excuse for members failing to report any such knowledge they have of another member's misconduct. I sincerely hope that this media focus against sexual abuse will contribute to break down any societal barriers and empower victims to come forward to the College with such very deeply personal and difficult allegations. This constructive communication and feedback from a member is highly valued by the College.

Any feedback is welcome, and I encourage you to contact me, or the Registrar, with your concerns. Although we are a small College compared with some of the other provinces, our size and availability can actually lead to a better dialogue. A dialogue is, of course, two-way communication, and not just the College sending materials out to you, but one in which you send comments and concerns and constructive feedback to the College for any improvement. I am a psychiatrist, I like to listen to you. Let's communicate!

All the best
Sincerely
Eric Sigurdson, MD MSc FRCPC

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Notes from the Registrar

As we start 2018 we look back on 2017 and all the work we have accomplished and look forward to what lies ahead.

In the month of January 2018, you received two very important notices via email from the College.

The first is the notice of the new draft Standard of Practice for Prescribing Opioids. The working group for the Standard encompassed members of the College and of other stakeholder organizations. I am very pleased with the resulting draft Standard and to date we have received feedback that will be helpful in completing the draft Standard of Practice for Council to approve at the March meeting.

The second notice was to inform you of the consultation for the Regulations under the *Regulated Health Professions Act* (RHPA). The College has been working on the RHPA since 2009 and I am hopeful that we are nearing completion and that the College will come under the new *Act* by spring 2019.

Both consultations are important and I urge you to review the documents and provide your feedback to the College by the deadline dates.

Other important initiatives at CPSM include:

Physician Quality Improvement Program
The staff in the Quality Improvement Program department have been working hard to get this program up and running. There will be a pilot starting this spring for a few physicians with the intent that the program will be fully operational by January 2019.

iMIS Member Database
We are continuing the ongoing development of iMIS – the College's new member database. As with most IT projects there have been some delays and challenges. I am confident in our staff and the developers of the iMIS database that all will be worked out in a timely manner and iMIS will be up and running within the next couple of months.

The *Regulated Health Professions Act* - Update
As noted above the RHPA is now in the consultation stage and we look forward to your feedback. We will now meet and consult with key stakeholders such as other regulatory bodies; Doctors Manitoba, the University of Manitoba, and the Provincial Medical Leadership Council. The approved draft regulations can be found on the College and Government websites as part of the 60-day public consultation which ends April 3, 2018. Once the feedback from the consultation on the regulations is received, reviewed, and, where appropriate, incorporated into revised draft regulations, the revised draft regulations will be taken back to Council and government for their formal approval. Government will then select a date to proclaim the regulations enforce, which will transition the CPSM to the statutory regime under the RHPA, rather than the *Medical Act*.

Fiscal Responsibility
Almost all expenditures incurred by the College are subject to annual inflationary increases. This results in a fundamental mismatch between these types of expenditures and College revenues which are only increased by intermittent fee increases. Over time the gap widens leading to potential deficits. This has enhanced the importance of a strategy to preserve the ongoing financial integrity of the College.

Council has reviewed this situation very carefully and will apply an annual inflationary (CPI) increase to the member license fee. This inflationary adjustment has the built-in ability to smooth rate increases over time and thereby avoid rate shock, and is a commonly used method generally accepted by businesses, ratepayers, and individuals. Council can increase the annual fee by additional amounts which is subject to management presenting to Council a budget and rationale justifying the additional increase beyond the annual inflationary (CPI) increase.

Extended/After Hours Care Working Group Phase II
As you are aware, the demonstration project was developed to study a proposed model of care that would bring together various healthcare sectors and providers in a defined area to provide extended hours care. The intent was to have two initiatives: one rural and one urban (Winnipeg). The goal of the demonstration initiatives is to establish a rural and an urban network of volunteer primary care providers available to deliver extended hours care within that network and geographical region. It will be aimed at testing the sustainability of the proposed delivery model and its applicability to physicians across the province.

Transformations within the WRHA and the health care system, and the creation of Shared Health have been underway. The desire is to build upon any opportunities that these changes may bring about. However, these changes have slowed the progress of this demonstration project. The pilots are now fully underway and are even transitioning into operational modes both within the city and the rural areas. The experiences have been very rich and favourable, yielding suggestions for further improvements and modifications to reflect the unique circumstances of different communities. At this stage, the Working Group is excited with its progress and ready to share its initial findings and tentative recommendations.

Federation of Medical Regulatory Authorities of Canada (FMRAC)
The FMRAC staff are working to plan the 2018 Annual Meeting that will be held in Charlottetown, PEI in June 2018. The theme for 2018 is “Excellence in Regulation with Risk Informed Action”.

I will continue to keep you updated on happenings at the College but also ask that if there are items you feel are relevant that should be included in the newsletter please let me know. Please feel free to contact me any time at AZiomek@cpsm.mb.ca with any comments or suggestions you may have.

Anna M. Ziomek, MD
Registrar/CEO

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Max Rady College of Medicine
Rady Faculty of Health Sciences

UNIVERSITY OF MANITOBA

Message from
Dr. Brian Postl
Dean, Rady Faculty of Health Sciences &
Vice-Provost (Health Sciences)
University of Manitoba

In June 2018, the Rady Faculty of Health Sciences will once again partner with Habitat for Humanity to construct a house for a family in need.

This marks the fourth time we have committed to raising funds and stepping up as volunteer construction workers for a Habitat home. The house will be erected on the Bannatyne campus and transported to its permanent site. I know that our students, faculty and staff across all health sciences colleges in the Rady Faculty will work side by side and put their caring values into action.

Social responsibility and accountability are core values for our Rady Faculty community of learners, health profession educators, clinicians and researchers to practice for the well-being of all members of society.

I hope I can count on all of our GFTs, lecturers and nil appointees in the Max Rady College of Medicine to help "build hope" and support this worthy endeavour as a volunteer builder or donor. You can donate online here: http://www.habitat.mb.ca/get-theme-builds-uofm.cfm

As a faculty, we are focused on enhancing collaboration among the health professions on many levels. Our inter-professional collaborative care curriculum is now in place for first- and second-year Rady Faculty students.

A student's reflection on being part of a team of learners from dentistry, medicine, nursing, pharmacy and rehabilitation sciences who jointly assessed a patient sums up the future of team-based, health-care delivery.

"Everyone had their own insight and knowledge that others may have missed, or not thought of," the student observed – a fitting comment on how inter-professional teams can enhance patient care.

Research partnerships in the faculty were highlighted at a recent announcement. Two U of M research projects focused on the brain and one that will investigate community-based rehabilitation services received inaugural grants from the Rady Innovation Fund.

The new fund is part of the $30 million gift made in 2016 by philanthropists Ernest and Evelyn Rady in support of health sciences at the University of Manitoba.

The fund will allocate a total of $1 million over three years to support collaborative research by faculty members. The one-year grants are designed to seed innovative, short-term research projects that are interdisciplinary, bringing together researchers from various departments and colleges of the Rady Faculty of Health Sciences.

The three leading-edge projects chosen for funding in this first year combine the knowledge and skills of some of our foremost researchers. We're excited to see the Rady investment driving interdisciplinary research to the point where projects are well-positioned to receive external funding. These studies have the potential to directly benefit patients in the vital areas of brain health and chronic disease.

Formal Consultation on a new Standard of Practice for Prescribing Opioids

DEADLINE FOR FEEDBACK IS FEBRUARY 16, 2018

The College has invited members, stakeholders, and the public to provide comments on the proposed new Standard of Practice for Prescribing Opioids, excluding patients with active cancer, in palliative care or at the end-of-life. The briefing notes can be found on the CPSM website, in the left had column, at www.cpsm.mb.ca. You can submit your feedback by email to cpsm-sop-op@cpsm.mb.ca or in writing to:

The Registrar
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Manitoba Physician Quality Improvement Program

The central mandate of the College is patient protection, with the goal of ensuring the safe practice of medicine. There is a legal obligation for the College to monitor the work of its members. As a result, we are embarking on a new Quality Improvement program, which will use the most effective means available. This will be phased in over 2018/2019, as the Manitoba Physician Achievement Review (MPAR), is phased out.

The QI program has been developed in Manitoba for Manitoba physicians. The College has studied other peer review and quality improvement programs, and sought input from Doctors Manitoba. We are working cooperatively with the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.

The QI program will be grounded in participants looking at their own practices and identifying areas for improvement, and then addressing how to achieve those improvement needs. Over time, this should lead to improved care for their patient populations. The College will assist with guidance around practice analysis, and provide information about practice supports. This is an educational process to help benefit you, your patients, and your work. Lifelong learning is ideally related to each of our practices, and makes it easier for us to serve our patients and communities.

The program will operate on a seven year cycle. All participants will be required to provide in-depth information about their practice, and to provide information about their CPD. It will introduce an element of peer review to Manitoba. Other jurisdictions have used this peer review process for many years. Some participants will undergo offsite chart reviews, multisource feedback, and/or onsite office visits. All participants will be required to identify one or more learning needs, and to develop a plan to address those needs. All participants will receive feedback and practice support resources.

The first group of physicians to participate will be a group of randomly selected family physicians. This will occur in the fall of this year.

We invite any questions or input that you may have. Please feel free to contact me at 204 774 4344, or msinger@cpsm.mb.ca.

Respectfully submitted,
Marilyn Singer MD CCFP
Consultant for Quality Improvement

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Confidentiality and Social Media

Provided by the College of Physicians & Surgeons of Ontario

Keeping it Confidential on the World's Biggest Elevator

Patient privacy is paramount when doctors take to social media

DOC TALK
By Stuart Foxman

You're on an elevator talking to a colleague about a patient. The doors open and a few people enter. How careful are you to respect the patient's privacy? What if this elevator holds not just a handful of people but hundreds, thousands, or tens of thousands?

Social media is the world's biggest elevator. Everyone can hear what you're saying. Some medical professionals have learned that the hard way.

In Rhode Island, an emergency room doctor lost her job, and was reprimanded by her regulator, after posting information about a patient on Facebook. She didn't mention the patient's name, but provided enough information so that others could recognize the individual.

Also on Facebook, a Missouri obstetrician criticized a patient who was always late for her prenatal visits, revealed that the patient previously had a stillbirth and (in retaliation for the patient's tardiness) joked about showing up late to do the delivery.

Doctors who use online forums to discuss cases with other practitioners may think they are protecting confidentiality, but removing patients' names is just not enough.

In one instance, a visitor to a hospital in London, England posted a picture of himself with doctors. In the shot, which went out to his 70,000 Twitter followers, a board in the background was visible. It listed patient names. The tweeter wasn't a doctor but Jeremy Hunt – the country's Health Secretary.

With social media, the platforms may be

ILLUSTRATION: SANDY NICHOLS

Dr. Karen Devon

new but the need to maintain patient privacy and confidentiality is not.

That demands a focus in the age of Facebook, Twitter, Instagram, YouTube, blogs and the like. The media itself amplify the risks and concerns.

Dr. Karen Devon, a surgeon at Women's College Hospital in Toronto, has written about social media use and doctors, including an essay for *JAMA*. She points out that the relative informality of social media, and the fact you can't see your audience, can at times make you let down your guard.

Any violation of privacy and confidentiality is problematic. With social media, "there's an exponential spread and a permanence," says Dr. Devon.

Every piece of material posted, every exchange, raises the stakes. A breach of patient rights, whether intentional or inadvertent, can have a reach and a life forever. "Think before you post," she says.

To provide guidance to physicians, the College has published a document – **Social Media: Appropriate use by Physicians** – that clarifies how doctors can meet existing professional expectations in the social media sphere.

Maintaining patient privacy and confidentiality isn't the only legal and professional consideration, but it is a primary one. Among the other obligations that the College notes regarding social media use:

- **maintain professional boundaries with patients and those close to them;**
- **keep professional and respectful relationships (with patients, colleagues, other members of the health-care team);**
- **comply with relevant legislation with respect to physician advertising;**
- **uphold the law related to defamation, copyright and plagiarism when posting content online; and**
- **avoid conflicts of interest.**

They're all important, but how to take care around privacy and confidentiality? Start with the assumption that all content on the Internet is public and accessible to all.

When posting information online that relates to an actual patient, the College urges caution. An unnamed patient may still be identified through a range of other information, such as a description of their condition, their area of residence, other details of the clinical encounter or a photo (even if blurred).

Moreover, there's an issue even if the only person who can identify the patient based on the information provided is the patient. That can still be a breach.

On private forums, like online physician support groups, the same rules apply. Don't count on the fact that these forums remain private. Any users might disseminate information beyond the group, where it can take on a life of its own. Or the forum's security could be compromised. If you haven't taken care to ensure the confidentiality of your

PHOTO: ARASH MOALLEMI

patient, their story could wind up anywhere.

Dr. Devon is active on a couple of Facebook groups, one led by physicians and another by patients. If referencing a patient, she goes beyond de-identifying; she also generally gets express written permission from the patient to share information, and states that she has that permission. It's an extra layer of precaution.

Social media offers opportunities and demands responsibility

For guidance on responsible social media use, it's helpful to review the College document on the topic, as well as other relevant College policies including **Confidentiality of Personal Health Information; Maintaining Appropriate Boundaries and Preventing Sexual Abuse**; and **Physician Behaviour in the Professional Environment**. The College has also developed an educational module about social media and it is posted on the website.

Other bodies for doctors, like the Canadian Medical Association and the Canadian Medical Protective Association, have published material on their websites about the opportunities and responsibilities around using social media.

To be sure, there are a range of other issues around social media use by doctors. Like friending patients, posting content (even personal) that might be viewed as unprofessional, and providing clinical advice to specific patients (as opposed to generic health information for educational or information sharing purposes).

Sometimes the obligations around privacy and confidentiality get extra scrutiny because social media breaches grab headlines. Several cases in other jurisdictions show how a doctor or other health-care professional has gone way over the line.

In one incident, a model/actress was admitted to emergency for excessive alcohol consumption. Without her consent, a doctor allegedly took and posted embarrassing photos on Instagram of the woman crying, dishevelled and hooked up to an IV.

An Edmonton pharmacist once landed in hot water after she got into a dispute with a group of women at her church about the romantic activities of a man in the congregation. The pharmacist posted disparaging comments about one female congregant on Facebook. When the woman complained, the pharmacist then accessed her health records and posted information about her prescription medication use online.

Other times, health-care professionals have found negative reviews of themselves on rating sites, and actually scolded the patients online and revealed details about their health.

Cases don't have to be so egregious to be serious. On social media, as elsewhere, it's paramount to always respect patient privacy and confidentiality, no matter the forum.

If patient privacy and confidentiality is breached, it may not matter if it was because of carelessness rather than intent. The words and images posted online can undermine patient trust and harm the reputation of the physician, their institutions and the profession.

For doctors, social media does have a lot to offer. It can be valuable to connect with other medical professionals on Twitter, share health-care information with the public, or comment online about difficult or interesting cases.

As Dr. Devon observes, "The world is changing how we learn and teach, and social media is a great tool." Just remember, she says, whether patients are Googling doctors or doctors are posting about patients, "people are listening – and evaluating."

From the Central Standards Committee

Metformin Toxicity

Recently the Central Standards Committee reviewed an unfortunate case of a diabetic patient with renal insufficiency who died while being treated with Metformin for the diabetes. Metformin is a popular biguanide oral hypoglycemic agent used for the treatment of non-insulin dependent diabetes. Metformin toxicity has the potential to cause fatal complications including severe lactic acidosis. Because of renal metabolism of the drug, acute or chronic renal insufficiency may allow accumulation of the drug with increasing levels. Furthermore, metformin toxicity can occur even at therapeutic dosing levels.

Lactic acidosis is a rare, but an extremely serious illness. Patients present with nausea, vomiting, and diarrhea. The outcome can be fatal.

Management of diabetes can be a complex challenge in the setting of impaired renal function. A review of the Canadian guidelines for therapy in the setting of renal impairment indicates that, where the estimated glomerular filtration rate (eGFR) is between 32 and 59 ml per minute, the dose of Metformin should be reduced. If the eGFR falls below 29 ml per minute, Metformin should be discontinued and other agents should be used. Furthermore, ongoing monitoring of renal function
should be part of the treatment of a diabetic patient, especially if there is ongoing renal impairment.

Congratulations

Dr. Cheryl Rockman-Greenberg has been selected for induction into the Canadian Medical Hall of Fame (CMHF). Canadian Medical Hall of Fame Laureates are individuals whose contributions to medicine and the health sciences have led to extraordinary improvements in human health. Their work may be a single meritorious contribution or a lifetime of superior accomplishments. Pioneers in their field, they are role models for Canadians and an inspiration to our youth.

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New Auditors Required

The College is seeking to recruit new auditors - both family physicians as well as specialists. College auditors conduct chart or interactive audits of the practices of a peer. Three departments of the College conduct audits:

- Qualifications (conditional register audits);
- Standards (Quality improvement audits, age related audits and audits of referred physicians)
- Complaints/Investigations.

Auditors may be called upon to conduct two to four audits per year. Each audit takes approximately a half day and time is remunerated.

If you are interested in joining our auditor committee, a training workshop will be held on May 25, 2018 which will provide a better understanding of the expectations of auditors. Minimum requirement of a new College auditor is having been in practise for 5 years.

Why be an auditor?

- You would be contributing to the profession, and getting to know your regulatory body a little better.
- You would be giving your colleagues a fair assessment by a peer with both of you learning more in the process.
- It would be a change of pace from your normal routine.
- You would earn CPD credits!

If interested, please call Carol Chester-McLeod, Standards Manager, CPSM at 204-786-0263 (direct line) or e-mail: cchester-mcleod@cpsm.mb.ca. Carol or Dr. Marilyn Singer, Consultant for Quality Improvement would be happy to answer any questions you may have about the College's audit process. They can be reached at 204 774 4344.

Email Address

Reminder – A current email address is mandatory under the requirements for licensure and re-licensure. You must inform the College if you change your email address. Changes may be submitted to: registration@cpsm.mb.ca.

Your email will not be made available to the public.

If you do not update your email address you will miss out on important correspondence from the College.

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Drug Impaired Driving

Driving while under the influence of drugs is recognized as a significant road safety concern. There is evidence that the use of several classes of drugs is associated with an elevated risk of vehicle crashes, that drug impaired driving is increasing among Canadians, and that many people, especially young people, are unaware of the potential risks of driving after the use of certain drugs.

With the impending legalization of recreational cannabis, the province of Manitoba has determined that finding solutions to address driving under the influence of drugs in general (and of cannabis in particular) as a major provincial priority. To this end Manitoba Public Insurance is embarking upon a number of strategies which will include encouraging drivers to discuss, with their health care providers, the effects that their medications may have on driving performance.

Manitoba Public Insurance has updated its Health Care Professional website with information about drugs and driving. The following points are highlighted:

- Driving while impaired by drugs is a criminal offence in Canada, whether the drugs are prescribed, over the counter medications, recreational or illicit drugs.
- Many drugs, whether used alone or in combination with others, can affect driving performance and patients should be advised accordingly.
- The effects of cannabis on driving typically last 3-6 hours but can persist for up to 24 hours.
- The College of Family Physicians of Canada's Preliminary Guidance Document on dried cannabis, released in September 2014, recommends that cannabis users should be advised to not drive for 4 hours after inhalation, 6 hours after ingestion, or 8 hours if euphoria is experienced, regardless of the route of administration.
- The national (and Manitoba) medical standard for drivers states that an individual with moderate to severe substance use disorder, as defined by DSM-5, is prohibited from holding any class of licence unless the condition is in remission.
- Section 157(1) of the Manitoba Highway Traffic Act stipulates that reporting of medically unfit drivers is mandatory for physicians.

For further details, please refer to the Manitoba Public Insurance website for Health Care Professionals:

http://www.mpi.mb.ca/en/DL/DL/MedCondAndDrivingForHealthCareProf/Pages/Driving-Fitness-Overview.aspx

Neil Swirsky MD FRCPC
Medical Advisor, Driver Fitness
Manitoba Public Insurance

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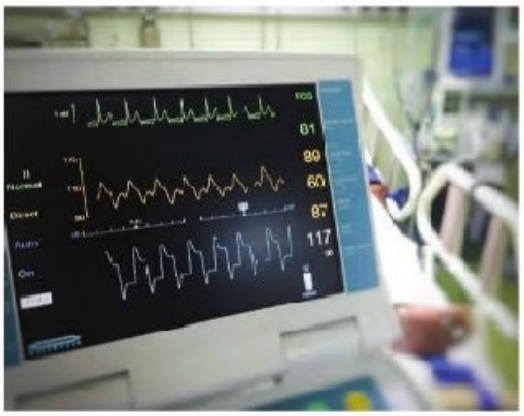
Test and Treatment Overuse

Provided by the College of Physicians & Surgeons of Ontario

Managing the Epidemic of Unnecessary Care

Landmark report offers national data on test and treatment overuse

By Stuart Foxman



Choosing Wisely Canada

It's one of the biggest areas of care in Canada, accounting for more than 1 million tests and treatments every year. Heart care? Cancer care? Emergency care? Mental health care?

None of the above. The answer is unnecessary care, says a new study by Choosing Wisely Canada (CWC) and the Canadian Institute for Health Information (CIHI).

Dr. Wendy Levinson, CWC Chair and Professor of Medicine, University of Toronto, calls it "care that doesn't add value to patients or in some cases may be harmful."

Such interventions also waste health-care resources and increase wait times for people who truly need them. That detracts from higher priorities in the system, added David O'Toole, President and CEO of CIHI, at a webinar to kick off the report in April.

The report, called "Unnecessary Care in Canada", presents data on eight tests and treatments spanning the health system. It concludes that up to 30% are potentially needless. For instance, the report notes that:

- Almost 1 in 3 low-risk patients with minor head trauma in Ontario and Alberta nevertheless had a CT head scan in an emergency department.
- In Ontario, 35% of patients undergoing low-risk surgery had a preoperative test, such as a chest X-ray, ECG or cardiac stress test.
- 22% of Canadian women age 40-49 received a screening mammogram, despite being of average risk.
- 1 in 10 seniors in Canada use a benzodiazepine on a regular basis to treat insomnia, agitation or delirium, even though this isn't recommended by experts.

The downsides can be profound. Beyond squandering resources, there's possible damage from various side effects and risks, patient anxiety and false positives.

Just citing one example, Dr. Levinson noted that long-term sedative use can lead to forgetfulness and falls. From a clinical standpoint, "We harm more people than we help when we use these drugs."

Wide regional practice variations

CWC is a clinician-led campaign. It partners with national specialty societies to develop evidence-based recommendations (over 200 to date) about unwarranted tests, treatments and procedures.

"This is the first time we have Canada-wide data of some

indicators of overuse. It's a great opportunity to learn from one another," said Dr. Levinson at the report launch.

O'Toole pointed out substantial variations within and between regions around practices. For example, in one year the rate of chronic benzodiazepine use by seniors ranged from 5% in Saskatchewan to 25% in New Brunswick. Mammogram screening rates for average-risk women goes from 13% in Quebec to almost 39% in Nova Scotia. In Alberta, just 9% of endoscopy patients have pre-op tests; the number is 17% in Saskatchewan and 20% in Ontario.

FOUR CRITICAL QUESTIONS

1) Is this test, treatment or procedure really needed?
2) What are the downsides?
3) Are there simpler, safer options?
4) What happens if you do nothing but watch and wait?

In Ontario itself, some disparities between areas were striking. Consider patients aged 18-64 who visited emergency in 2015-2016 for minor head trauma (i.e., no red flags). The rate of potentially unnecessary CT scans was 31% for the province as a whole, but among the 14 LHINs was anywhere from 13% to 46%.

Looking at Ontarians with uncomplicated low-back pain, 4.5% had a CT or MRI scan that wasn't indicated. The variations between primary care practices ranged from 0.8% of patients who had such scans to a high of 33%.

At the April webinar, Dr. Laurent Marcoux, President-elect of the Canadian Medical Association, said the culture of medicine is the biggest target for change. No doctor wants to harm a patient (or the system), yet that's what can happen with over-diagnosis. "We think that more is better than less," he stated.

Not always, and that belief is hard to break. Dr. Levinson said doctors can assume it takes much longer to discuss the reasons not to have a test or treatment. In fact, she said these conversations only take a minute on average, and can prevent return visits and longer conversations down the road.

Practitioners take action

In April 2014, Sunnybrook Health Sciences Centre in Toronto found that 69% of their catheter use lacked an appropriate medical reason. The team developed an evidence-based medical directive to empower nurses to remove urinary catheters if patients met specific criteria. As a result, urinary catheter days are down 50% in medical patients, without any inappropriate catheter removals (based on random audits). One of the doctors created a toolkit called "Lose the Tube" to support the transformation.

The report also highlighted the success of the North York Family Health Team in scaling back prescriptions of proton pump inhibitors (PPIs). These potent acid blockers may cause harmful side effects. Studies suggest that over half of people who take them probably don't need them. Antacids or other less powerful drugs can deal with simple heartburn.

The North York team identified 1,600 patients who were taking potentially inappropriate PPIs. The group flagged them for physician consultation – on indications for use, side effects, risk, other treatment options – when they came for regular appointments. Over 18 months, 60% of patients who were engaged stopped or reduced their PPI use, all from a simple intervention.

At a system level, the benefits of curbing unnecessary tests can be huge. It all comes down to conversations with patients and four critical questions (see sidebar).

"Research shows that when physicians listen deeply, understand patient concerns and worries, and have a discussion about the pros and cons, patients feel reassured," says Dr. Levinson. "That's what we're seeking."

Treating Physicians with Health Issues Do I Report?

Synopsis:

All members are required to report to the College those physician patients with health issues that may affect their fitness to practice safely. The reporting can be done professionally, with respect and dignity by providing the physician patient with the opportunity to first self-report. A follow-up must be arranged to ensure self-reporting occurred forthwith, and if not, then report to the College.

Discussion:

Example 1 – Your patient is a medical doctor and you have diagnosed them with a substance abuse disorder.
Example 2 – Your patient, a family doctor, is experiencing possible slight cognitive impairment.
Example 3 – Your patient, a surgeon, is experiencing numbness in their fingers.
Example 4 – As a psychiatrist, you have diagnosed your medical student patient as bipolar.
Example 5 – Epilepsy is the diagnosis of your patient, an anesthesiologist.
Example 6 – Exposure prone procedures are undertaken by your physician patient, who just tested positively for a blood borne pathogen.

As physicians, residents, medical students, clinical assistants, and physician assistants we are all treated for health issues by other members. Information obtained in the course of treatment may give rise to concerns about your physician patient's ability to practice medicine. What are <u>your</u> obligations to the College when treating another member for health issues?

First, a physician patient (which includes all members: physicians, residents, medical students, and physician and clinical assistants) is required to contact the College themselves to discuss their own health concerns.

> "Members who have a diminished ability to provide safe, competent medical care have an ethical responsibility to appropriately restrict practice or withdraw from practice, and report to the College." CPSM Standards of Practice of Medicine, Schedule H.

Second, if the physician patient is reluctant to report themselves (which may, in certain instances, be attributed to the diagnosis) then what are your obligations to the College when treating such a physician patient? The CPSM Code of Conduct requires:

> "A member who reasonably believes that another member:
>
> > b) suffers from a mental or physical disorder or illness that may affect his or her fitness to practice, and continues to practice despite have been counselled not to;

must disclose the belief to the Registrar, along with the name of the other member and particulars of the suspected disorder, lack of fitness to practise, incompetency or unethical behaviour."

This is further reinforced in the Standard of Practice:

"Examples of situations when a member must report another member to the College pursuant to The Medical Act or the Code of Ethics include knowledge that another member… has his or her ability to practice medicine safely impaired for any reason, including health conditions or concerns about the member's knowledge, skill, and judgement in the practice of medicine." CPSM Standards of Practice of Medicine, Schedule F.

Third, as a treating physician it is not satisfactory simply to advise a physician patient to report themselves to the College. Members are required to report the physician patient. Recognizing the importance of treating all colleagues with dignity and respect, one suggestion is to advise the physician patient:

- to report themselves to the College;
- require the patient to confirm to you as a treating doctor, within a set very short period of time, that they have done so; and
- failing their self-reporting, you as a treating doctor will be required to report the patient.

This "closing the loop" for reporting is of crucial importance for the safety of patients in a self-regulating profession.

Never assume that another treating doctor will do the reporting as each of us is required to do so. The other treating doctor may assume you will do the reporting, thereby resulting in no reporting.

Physicians often think of patient confidentiality as being paramount to their treating relationship with their patients, and inviolable. But, all members have the duty to report another member to the College, even if that other member is a patient. It is important to recognize that the self-regulation of the profession is a privilege and that each member has a continuing responsibility to meet this privilege and to support the College and the profession. If the matter is framed as one of public interest and patient safety, then this mandatory reporting is certainly justified.

What happens when a member is reported (by themselves, or by another) for health issues? The College has a Physician Health Program with the following objectives to help its members and protect the public:

1. Early identification and monitoring of a member who has a health issue which has the potential to adversely impact the member's ability to practice medicine safely.
2. Adoption of a remedial approach to dealing with a member who has health issues where the member is cooperative in the process, has insight into the member's own health status and is compliant with treatment and rehabilitation.
3. Collaboration with a member who has health issues and the member's caregivers, with the goal of creating an environment where the member can practice medicine safely.

The College works with the patient member to ensure both the member and their patients receive the best care. The College can only do so if it is advised that a physician does have a health issue, which is why it is so very important to close that loop on reporting. There are many physicians practicing with undertakings acknowledging their health issue and their obligation to continue treatment. Other physicians have specific restrictions to accommodate and facilitate their continuing practice. Some physicians come to the realization it is time to retire.

The answer to the six examples is we are required to report to the College each of those physician patients. Reporting can be done professionally, with respect and dignity by providing the physician patient with the opportunity to first self-report. A follow-up must be arranged to ensure self-reporting occurred forthwith, and if not, then report to the College.

Duloxetine and Pregabalin Now Part 1 Benefit Under Pharmacare Program

The **Manitoba Drug Benefits and Interchangeability Formulary** lists therapeutically effective drugs of proven high quality that have been approved as eligible benefits under the Pharmacare drug benefit program.

On January 25, 2018, Cymbalta® and generic formulations (duloxetine) were moved from a restricted Part 3 listing to a Part 1 benefit on the Formulary; and Lyrica® and generic formulations (pregabalin) were added to the Formulary as Part 1 benefits. Amendments to the Formulary are documented in Bulletins, and may be accessed through the "Information for Health Professionals" page of the Manitoba Health website:
https://www.gov.mb.ca/health/pharmacare/healthprofessionals.html

Patricia A. Caetano, PhD
Executive Director, Provincial Drug Programs
Manitoba Health, Seniors and Active Living

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From the Complaints Committee

The Importance of Clear Communication in Radiology Reports

The Complaints Committee recently considered a case of a missed cancer diagnosis where the committee felt that a lack of clear language in a radiology report lead to confusion about the need for follow-up. Several years before the cancer was diagnosed, this particular patient had an ultrasound where an abnormality was identified. The report contained a description of the ultrasound findings but the impression/summary did not make it clear that cancer was considered a possible diagnosis. Given that benign liver abnormalities are commonly seen incidentally on ultrasound, the receiving physician did not appreciate the need to investigate further.

Recognizing that each test has limitations and it may not be possible to positively identify a specific diagnosis, the degree of concern and the specific recommendation for follow-up should be communicated in clear language. If a benign etiology is suspected, this should be indicated so there can be further discussion between the ordering physician and the patient about the risk/benefit of further investigations.

On the other hand, if the features seen are concerning for malignancy or another serious condition, the radiologist should specifically state this as a concern, along with any recommendations for further investigation. Depending on the circumstances, a telephone call to the ordering physician could help ensure timely follow up.

If the ordering physician has any question about the report or the recommended next step, clarification should be sought by contacting the radiologist. A quick telephone conversation can be very helpful to both parties.

While this particular case involved a radiology report, the same principles apply to other written reports.

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From the Investigation Committee

Supervision of Residents

The investigation Committee recently considered the care provided to a patient admitted to hospital in a clinical teaching unit. Several resident physicians were early in their residency training and worked under the supervision of a senior resident who was in turn supervised by the attending physician. The patient's clinical status deteriorated over several days but went unrecognized by those providing care.

In this case, the Committee recognized that multiple factors led to gaps in communication, but ultimately felt that an important factor was a lack of appropriate supervision of the residents.

The Investigation Committee directed that members be reminded through the Newsletter that whereas learners can play an important role in the care of patients, the supervision provided must take into account the training level and individual abilities of medical students or residents, as well as workload and other off site educational requirements. Attending physicians maintain ultimate responsibility for patient care and need to be satisfied that responsibilities delegated to learners are appropriate and adequately monitored.

Formal Consultation on the Regulated Health Professions Act

DEADLINE FOR FEEDBACK IS APRIL 3, 2018

The College has invited members, stakeholders, and the public to provide comments on the proposed new Regulations. The consultation documents can be found on the CPSM website at www.cpsm.mb.ca. You can submit your feedback by email to cpsm-rhpa@cpsm.mb.ca or in writing to:

The Registrar
College of Physicians & Surgeons of Manitoba
1000 – 1661 Portage Avenue
Winnipeg MB R3J 3T7

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Collaborating with the Educational System to Further the needs of Patients who are Students

Issue:

Concerns have been expressed to the College, that some parents appear to be using the medical system to gain services from the educational system for their children without a proper prescription or description of the child's medical needs to be accommodated for a specified period of time. Examples are "prescriptions" written for bus services or the services of a full time Educational Assistant.

Reminder:

It is important for the medical and educational systems to work together for the best interests of patients who are also students and usually minors. It can be challenging for physicians to address the needs of their patients within the educational system. In addition, most physicians do not have firsthand knowledge of the resources available within the educational system or the criteria used by that system to determine a student's eligibility for additional or special resources.

The College has received some concerns from educators arising from physicians using "prescriptions" to ostensibly require assessments and resources to be provided by the educational system.

A physician's prescription pad should only be used to order medically warranted resources such as drugs or medical equipment or services such as physiotherapy that are within a physician's scope of practice to request. Sometimes a physician is merely making a recommendation that he or she thinks would benefit a patient but because the recommendation is written on a prescription pad or even a physician's letterhead, parents perceive the recommendation to be a demand that must be fulfilled.

When a prescription is issued it needs to meet the requirements set out in the College's Bylaw 11 at section 20 on "Prescribing" available on the College website here. When a physician is asked to provide information or an opinion to a third party, Bylaw 11 also sets out the requirements for providing medical information to third parties such as educators, starting at Section 40 "Medical Information to Third Parties and Sickness Certificates". The patient's explicit consent is required. If the patient is a minor, the consent of the minor's legal guardian is required.

Physicians are also writing notes on prescription pads or their letterhead stating that students

require bus transportation to school or fulltime services of an Educational Assistant. The educational system has its own rules about when such services can or will be provided within that system. What the educational system needs from physicians, provided the physician has the consent of the adult or the legal guardian of a minor patient, is a clear note advising of:

- The child's symptoms, characteristics or medical needs that need to be accommodated in order to safely function in the educational setting; and
- The anticipated duration of the situation. For example, if it is a temporary situation due to a broken ankle that necessitates the child having bus services or is it a long standing chronic condition (such as severe asthma) that has no immediate resolution anticipated in the foreseeable future.

The school will then use this information in their planning for how to assist the student from an educational system perspective. For example, rather than stating that a student requires the school to provide a bus to school, explain that the student has difficulty walking more than x meters at a time for a temporary period due to an ankle injury. It is anticipated the child may require assistance travelling to school for 8 weeks. The College has been advised that some physicians have written actual prescriptions for a child to take a bus to school even though the child continues to play regularly on the hockey team.

Practice Address

Reminder – A current practice address is mandatory under the requirements for licensure and re-licensure. You must inform the College if you change your practice address. Changes may be submitted to: registration@cpsm.mb.ca.

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Meetings of Council
2017-2018 College Year

Council meetings will be held on the following dates:

- March 16, 2018
- June 15, 2018 (Annual General Meeting)

If you wish to attend a meeting of Council, you must notify the College in advance. Seating is limited.

Officers of the College
2017-2018 College Year

President:	Dr. Eric Sigurdson
President Elect:	Dr. Ira Ripstein
Past President:	Dr. Alewyn Vorster
Treasurer:	Dr. Brian Postl
Registrar:	Dr. Anna Ziomek
Deputy Registrar:	Dr. Terry Babick

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Councillors

Term expiring September 2018

Associate Members Register	Dr. Shayne Reitmeier

Term expiring June 2018

Central	Dr. Ockie Persson
Interlake	Dr. Daniel Lindsay
Northman	Dr. Deborah Mabin
Parkland	Dr. Elizabeth Senderewich
Winnipeg	Dr. Wayne Manishen Dr. Michael West Dr. Nichole Riese Dr. Eric Sigurdson Dr. David Pinchuk
University of Manitoba	Dr. Ira Ripstein
Public Councillor - Elected	Mr. Richard Dawson

TERM EXPIRING JUNE 2020

Brandon	Dr. Stephen Duncan
Eastman	Dr. Nader Shenouda
Westman	Dr. Alewyn Vorster
Winnipeg	Dr. Heather Domke Dr. Brent Kvern Dr. Florin Padeanu Dr. Josef Silha
Public Councillor - Elected	Ms Priti Shah

TERM EXPIRING JUNE 2021

Public Councillor – Government Appointed	Mr. Alan Fineblit
Public Councillor – Government Appointed	Ms Marvelle McPherson

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