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FROM THE College

President's Message

Council understands there are barriers of systemic racism in health care. We recognize it as a determinant of health and see that it affects patient safety. We understand that systemic racism needs to be dismantled, and so Council has identified addressing anti-Indigenous racism in health care in Manitoba as a strategic priority.

I have practiced rural medicine in Grandview, a small Manitoba community, for the past 23 years. Our closest Indigenous community is Tootinaowaziibeeng and we are fortunate to provide physician care in-clinic there. My administrative assistant, Janaine, is Indigenous and it is through the Tootinaowaziibeeng health office that I found her.

As my journey of self-reflection around anti-Indigenous sentiment in healthcare has commenced, I catch myself talking about "The Rez," fondly on my part, but possibly hurtful to many. I wonder if this is a micro-aggression and if it is, how I would know? And whether I should apologize.

I notice myself regularly asking Janaine to handle tasks for Indigenous patients. I believe my requests come from a place of trust and efficiency, but how does this look to the other office staff, the patients, and to Janaine herself?

The healthcare system is inert, but it comes to life through the people that work in the system. It's our spirit and intentions that give it impetus. Ultimately, it is about you and me and how we choose to treat one another.

I am apprehensive to confront my own beliefs, but excited to learn how understanding and changing my behaviours can have an impact.

The journey will be uncomfortable; we will discover things about ourselves that we did not know, and do not like.

We must approach this journey with courage and boldness, grace and kindness, and I look forward to the change.

Jacobi Elliott, MD
CPSM President

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Registrar Notes

I know this summer was a difficult and stressful one for those working on the front lines, as wave four of COVID-19 approached. I hope you found opportunities to rest and to take care of yourselves. Thank you for your continued hard work.

Certificate of Practice and Medical Corporation Renewals

CPSM Registration department have been preparing for annual renewals for Certificates of Practice. This year, it will be even easier to complete your renewal as it will be done online through the CPSM Member Portal. A notice of renewal email was sent to members on September 29, 2021. Please ensure you carefully read and answer the questions required in the renewal. The 2021-2022 Certificate of Practice renewal fee is $1890.00. Other than cost of living increases, fees have remained constant in the previous six years and falls mid-range compared to other provinces.

For those with Medical Corporations, renewals will occur at the same time. The renewal fee for a Medical Corporation is $150.00. Deadline for both renewals is October 31, 2021. Late fees will apply if you do not renew by the deadline. Please refer to your renewal email for more details.

If you have any questions or require assistance, please contact CPSM at 204-774-4344 ext. 978, or by e-mail at renewals@cpsm.mb.ca.

Standards of Practice

Over the summer, four public consultations for new Standards of Practice were completed. Three are being finalized. The Standard of Practice for Virtual Medicine is effective November 1, 2021. It is critical you familiarize yourself with this Standard.

COVID-19 Update

CPSM continues to communicate with members to provide regulatory guidance on issues pertaining to COVID-19. Due to ongoing developments with vaccines, we updated the COVID-19 Vaccine FAQs and added information about ivermectin to the Prescribing During COVID-19 FAQs.

CPSM Staff Return to the Office

In September, staff returned to the office full time. We thank them for their commitment to serving CPSM members while they worked from home. The health and safety of staff is a priority and the Senior Leadership team continue to meet on a regular basis to assess the situation.

National Day for Truth and Reconciliation

CPSM honoured National Day for Truth and Reconciliation by allowing staff time during the workday on September 30, to watch The Unforgotten, a film developed in part by the Canadian Medical Association. This film explores the health and well-being of Inuit, Métis, and First Nations peoples across five stages of life: birth, childhood, adolescence, adulthood, and elderhood. Staff were also given time to self-reflect using the accompanying workbook for the film. On October 1, Dr. Goulet, a Métis family doctor, spoke to CPSM staff about an approach to creating a safer health care system in Manitoba for Indigenous People.

Acknowledging Indigenous-specific racism exists, is an important first step for CPSM as a medical regulator. As a member of the Federation of Medical Regulatory Authorities of Canada, we are committed to these six actions in our regulatory work.

Truth and Reconciliation: Addressing Anti-Indigenous Racism by Medical Practitioners

As I reported in the last newsletter, at the Council level, CPSM has made Truth and Reconciliation: Addressing Anti-Indigenous Racism by Medical Practitioners, a strategic organizational priority.

The first step is an Advisory Circle being formed and led by Dr. Lisa Monkman. The Circle will include Indigenous physicians, CPSM members, elders, knowledge keepers, and public representatives. The Advisory Circle will advise CPSM on an approach for Truth and Reconciliation. CPSM looks forward to this work and keeping members updated.

If there are items you would like to be included in the newsletter, please contact me at TheRegistrar@cpsm.mb.ca with any comments or suggestions.

Anna Ziomek, MD
Registrar/CEO

COVID-19 Testing Recommended for Patients with Cold or Flu-Like Symptoms

There have been reports of patients with COVID-19 being hospitalized without being testing for COVID-19 prior to hospitalization. Getting tested when experiencing symptoms is vital to mitigating the spread of COVID-19.

You are reminded to strongly encourage patients you are treating for cold or flu-like symptoms such as a cough, fever, runny nose, sore throat, headache, or any of the symptoms listed in the Shared Health screening tool, to isolate and get tested for COVID-19 at one of the testing sites. Anyone with symptoms of COVID-19 is eligible for testing.

Max Rady College of Medicine

Message from Dr. Brian Postl

Dean, Max Rady College of Medicine and Dean, Rady Faculty of Health Sciences

The countdown to PGME accreditation is nearing.

The Postgraduate Medical Education accreditation survey visit is now scheduled, in-person, for March 20 – 25, 2022 by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada.

The Max Rady College of Medicine PGME office, under the leadership of associate dean, PGME Dr. Cliff Yaffe and assistant dean, accreditation Dr. Kurt Skakum, and Family Medicine head Dr. Jose Francois, and their teams have been working diligently with department leadership, hospital administrators, faculty, staff, residents and our health system partners for several years now to prepare for the upcoming accreditation survey.

A total of 46 Royal College Programs and nine Family Medicine programs will be reviewed during the five-day visit. We are proud of the many positive changes we have instituted since the last accreditation in 2014 such as improvements to teaching sites, introduction of Competency By Design (CBD) curriculum, learner supports and wellness, faculty and learner evaluations in Entrada (online curriculum management system) and placing greater focus on learning environment assessments and professionalism/speak up.

Over the spring and summer, the PGME office held pre-accreditation workshops for Royal College program directors to develop the program instrument, documentation required to be submitted in advance of the accreditation survey. Pre-accreditation workshops in September helped educate and prepare senior residents (who will share the information with the other residents) as well as program administrators for the on-site reviews.

There will be an accreditation town hall on October 15 and a pre-accreditation workshop for CFPC programs (Oct. 29).

As we approach the final six months before the accreditation survey, I want to acknowledge the PGME office, the Integrated Accreditation Unit office and all of the many deans, department heads, faculty, staff and learners – and our health partners – who are continuing to perform their regular duties while contributing greatly to the PGME accreditation process and our college's continuous quality improvement.

Part of continuous quality improvement for our faculty, staff and learners is providing them with the supports they need to succeed. To that end, we have launched the Family Centre as a resource supporting students, faculty and staff – both on and off the campus – as they navigate major life changes such as parental leave, ageing parents, returning to work.

We have recently opened a Nursing Room in 290A Brodie to provide a comfortable space for breastfeeding, chestfeeding or pumping. Individuals can contact familycentre@umanitoba.ca to arrange for swipe access.

And I'm excited to announce that we have UM approval for a daycare to be built on Bannatyne Campus in the old "T" building space. While the Max Rady College of Medicine has set aside $5.5-million for this major capital project, more support will be needed to bring this long-desired daycare to reality and provide faculty, staff and learners with the appropriate child care supports in place to achieve their career and educational goals.

NEW Standard of Practice for Virtual Medicine

The arrival of virtual medicine, triggered by the pandemic, led to the development of a Standard of Practice for Virtual Medicine. While virtual medicine has been beneficial for many reasons, the pandemic has also reinforced the vital importance of in-person care. CPSM has prepared new rules on virtual medicine that every practitioner engaging in virtual medicine must read and practice. The general provision is

> Each member's practice of medicine must include timely in-person care when clinically indicated as requested by the patient. It is not an acceptable standard of care to solely practice virtual medicine. A blended model of care balancing in person and virtual medicine is required if providing virtual medicine.

The Standard is effective November 1, 2021. It includes a Contextual Information and Resources document with further details and links for virtual medicine resources. LINK

Another useful resource is the Information Sheet on Virtual Medicine Across Provincial and International Borders. This document outlines CPSM's interpretation of the legislation pertaining to the practice of virtual medicine across borders.

It includes information for physicians registered in Manitoba looking to practice medicine virtually outside of the province, and for physicians not registered in Manitoba looking to practice virtually to patients in Manitoba.

Notice to Opioid Agonist Therapy Providers:
Changes to Pharmacare Coverage Involving Generic Methadone

Important changes occurred in Pharmacare drug coverage for brand vs generic methadone products in August 2021.

According to a recent Manitoba Health and Seniors Care Bulletin (#112), effective August 5, 2021, generic methadone products are now listed as a Part 1 (open) benefit. These generic methadone products are NOT interchangeable with each other nor with the brand name methadone products.

Brand name methadone products (Methadose, Methadose Sugar Free and Metadol-D) were moved from a Part 1 benefit to a Part 2 benefit for patients being treated with the brand methadone product or who have previously been treated with two or more generic methadone products listed under Part 1.

WHAT PHYSICIANS NEED TO KNOW

A safety review completed by Health Canada found that there may be a link between switching methadone-containing products used to treat opioid use disorder and the risk of lack of effect, which may present as withdrawal symptoms, although the reason for this is unclear.

Healthcare professionals should be aware that:

- Some patients may experience withdrawal symptoms after being switched from one methadone-containing product to another; these patients should be clinically managed and monitored regularly.
- Dose adjustments may be necessary for some patients.
- Withdrawal symptoms can lead to a failure to remain in treatment and subsequent problematic substance use, which can lead to serious harm.

IMPLICATIONS FOR PRESCRIBING

Methadone products are not interchangeable from a clinical perspective nor a coverage perspective. A new prescription from an approved prescriber would be required to switch a client from one methadone product to another. If a patient in a community setting is *new* to taking methadone and presents to a pharmacy with a prescription that does not specify the brand (i.e., written as "methadone"), the pharmacist can dispense whatever generic is usually used by the pharmacy. It is good practice for the pharmacist to notify the prescriber of the generic brand that is being used. This may be done by fax. Writing new methadone prescriptions in this format (i.e., written as "methadone") is recommended, as it may prevent a delay in treatment at the pharmacy.

If the patient is *already* taking methadone and presents with a new script, consideration must be given to what brand the patient has been receiving and it may be necessary in some cases to avoid changing the brand, if possible. **If the patient receives a different methadone brand, the patient and prescriber must be made aware and arrangements for monitoring and management should be put in place. These arrangements will often require collaborative discussion and a communication plan between the prescriber, pharmacy team, and patient.**

Early withdrawal symptoms can lead to a failure to remain in treatment and subsequent problematic substance use, which may lead to serious harm. Prescribers are **strongly encouraged** to provide their cell numbers (or on-call pager number for a prescriber group) on ALL opioid agonist therapy prescriptions to facilitate timely communication regarding urgent prescription issues. These numbers can be marked as "private" to indicate to the pharmacy team that they should not be shared with patients.

RESOURCES

Further information is available Manitoba Pharmacare Program - Information for Health Professionals, specifically at the following links: Updated Methadone Claims Submission Procedure and Updated Methadone Background & Frequently Asked Questions.

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Medical Consultant, Prescribing Practices Program

Talia Carter MOT, BSc, O.T. Reg. (MB)
Coordinator, Prescribing Practices Program

Practice Address

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

Email Address

REMINDER – A current email address is **mandatory** under the requirements for licensure and re-licensure. You must inform CPSM 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.

Informed Consent & Sublocade:
Resources for Opioid Agonist Therapy Providers

With the availability of Sublocade for the treatment of Opioid Use Disorder in Manitoba, Opioid Agonist Therapy (OAT) providers are faced with new considerations while incorporating this treatment option into practice. One of these considerations is informed consent to treatment with Sublocade, especially in women of reproductive age.

BACKGROUND

Sublocade (buprenorphine extended-release injection) is a partial opioid agonist for the management of moderate to severe opioid use disorder that must be administered by subcutaneous injection in the abdominal region by a trained healthcare professional. For effective treatment, Sublocade is administered once per month.

It is important to note that thus far in clinical trials Sublocade has only been evaluated for clinical effectiveness in the treatment of Opioid Use Disorder against placebo. The effectiveness of Sublocade has yet to be compared to sublingual buprenorphine/naloxone. In short, we do not have results from a true non-inferiority study available yet. Thus, the intent of this article is not to promote Sublocade use over daily sublingual buprenorphine/naloxone treatment.

However, Sublocade is an option to consider for patients who do not have practical pharmacy access, or for whom daily or even weekly pharmacy visits are not practical or acceptable for some reason. The monthly administration of Sublocade can offer these patients more flexibility with treatment, even when clinical stability does not warrant take-home dosing of sublingual buprenorphine/naloxone.

WANT MORE INFO ABOUT SUBLOCADE?

More information on Sublocade use and administration is available for prescribers and pharmacists here:

https://cpsm.mb.ca/assets/PrescribingPracticesProgram/Sublocade-Administration-Joint-Document%20Final.pdf

Please note that physicians must hold a current, active buprenorphine/naloxone prescribing approval from CPSM to prescribe Sublocade. Approved physicians wanting to prescribe and administer Sublocade must complete the non-accredited certification program, which can be found at www.sublocadecertification.ca.

This is a Health Canada requirement.

OPASKWAYAK HEALTH AUTHORITY OAT PROGRAM

The OHA OAT Program is a northern remote program serving individuals with Opioid Use Disorder from Opaskwayak Cree Nation, The Pas, Moose Lake, Easterville, Grand Rapids and surrounding areas. Many of them do not have pharmacy access in their home communities, making daily witnessed ingestion of methadone or buprenorphine/naloxone especially challenging.

The availability of Sublocade has thus created treatment access for patients who previously did not have practical access to OAT. The OHA OAT program's clinical experience with Sublocade has highlighted key aspects of patient care and consent that require careful navigation.

SPECIAL CONSIDERATIONS IN PATIENT CONSENT

When starting any OAT medication, prescribers must counsel patients about the benefits and risks of treatment to obtain informed consent. Starting Sublocade is no different. Unique considerations with Sublocade include discussion about pregnancy and reliable contraception. **Presently, it is *not known* if Sublocade is safe in pregnancy.** Prescribers must therefore ensure that female patients of reproductive age are counselled to use a reliable form of birth control (such as an IUD or Depo Provera) prior to receiving a Sublocade injection, and for the duration of treatment with Sublocade. Two forms of less reliable birth control (such as an oral contraceptive pill combined with a barrier method) may be an alternative. Due diligence is also needed to ensure patients understand the potential implications of not using reliable birth control. While we are not aware of any teratogenicity with Sublocade use in pregnant women to date, it is not yet known if Sublocade is safe in pregnancy.

If a female patient, who understands this information, indicates that she does not require birth control for some reason, or indicates that she finds the use of birth control unacceptable, OAT providers are to use good clinical judgement. The potential benefits of treatment with Sublocade (including treatment access and retention) must be weighed against the risks of an unplanned pregnancy while on Sublocade. This conversation should be carefully documented in the patient record.

Regardless of the patient's choice around the use of reliable birth control, if the provider and patient agree to proceed with Sublocade treatment, the use of a written consent form (example linked below) is strongly recommended to facilitate further documentation of the patient's informed consent to treatment with Sublocade.

Another important aspect of informed consent is ensuring that patients understand the implications of missing their monthly Sublocade injection. If patients are more than two weeks late for a scheduled administration, this will likely necessitate restarting on daily witnessed buprenorphine/naloxone at a pharmacy, for a period, before transitioning to Sublocade again. Additionally, this may require in-person assessment and can delay restarting buprenorphine/naloxone, considering prescriber and patient availability, as well as travel and transportation issues. Missed monthly administration can have substantial negative impacts on patients' lives and responsibilities and carries a risk of relapse.

INFORMED CONSENT TEMPLATES

The OHA OAT Program has developed consent forms to manage these special considerations in clinic and offered to share their forms as a resource for other programs. These templates can be accessed at the links below and modified for specific program needs. Please contact tcarter@cpsm.mb.ca if you require forms in a more modifiable format.

The forms are available along with published chapters of the Manitoba Buprenorphine/Naloxone Recommended Practice Manual under the Prescribing Practices Program:

- Consent Form to Participate in Treatment with Sublocade General Version
- Consent Form to Participate in Treatment with Sublocade Reproductive Age Version

Respectfully, please retain the footnote acknowledgment that this work is the intellectual property of the OHA OAT program staff when adapting them for your clinical use.

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Medical Consultant, Prescribing Practices Program

Talia Carter MOT, BSc, O.T. Reg. (MB)
Coordinator, Prescribing Practices Program

Low-Dose Aspirin in Prevention of Gestational Hypertension and Pre-Eclampsia

The Maternal and Perinatal Health Standards Committee (MPHSC) has reviewed several cases of maternal and perinatal morbidity in pregnant women who were faced with severe hypertension in Gestational Hypertension or Pre-Eclampsia but who on review were found not to have received low-dose Aspirin (81-162 mg OD) during the antenatal period despite the presence of pre-existing clinical or historic risk factors for pre-eclampsia.

The risk factors for pre-eclampsia are listed in several of the national guidelines, including the Hypertensive Disorders of Pregnancy Guideline of the Society of Obstetricians and Gynecologists of Canada (SOGC) of 2014 (a new version will be published again soon). These risk factors are also documented in the American College of Obstetricians and Gynecologists (ACOG) Guideline #743 and on the Maternal-Fetal Medicine Foundation/ACOG Committee Opinion on low-dose Aspirin use during pregnancy.

The High-risk factors include:

- Prior pre-eclampsia
- Pre-existing hypertension (hypertension detected before 20-week gestation)
- Current Type I diabetes
- Chronic renal disease
- Systemic Lupus Erythematosus or Anti-phospholipid Syndrome
- Pregnancy following reproductive therapy
- Pre-pregnancy BMI >30kg/m2

The Moderate-risk factors include:

- Family history of pre-eclampsia
- Maternal age greater than 40 years
- Prior small for gestational age baby (Fetal Growth restriction)
- Prior stillbirth
- Prior Placental abruption
- Nulliparity
- Pregnancy with Multiples

The SOGC evidence-based guideline suggests that low-dose Aspirin is useful in preventing or ameliorating maternal morbidity and perinatal mortality and morbidity associated with hypertensive disorders of pregnancy. Pregnant women with **one high-risk factor or two moderate risk factors** should be advised to receive low-dose Aspirin.

Physicians involved in maternity care are reminded to identify the risk factors for pre-eclampsia and give serious consideration to the initiation of low-risk Aspirin, most effective when started prior to 16 weeks, but even at any other time if not initiated before 16 weeks. There is ongoing discussion regarding the dose of low-dose ASA. Many authorities recommend 162 mg po OD, while others note that 81 mg LD ASA is as effective in prevention. For women with a high BMI, or multiple risk factors, a dose 162 mg po OD is recommended.

Maternal and Perinatal Health Standards Committee

Discipline Summary

Cancellation of Registration and Certificate of Practice - Dr. Naseer Ahmed Warraich

Effective July 12, 2021, the Inquiry Panel of CPSM cancelled Dr. Naseer Ahmed Warraich's Certificate of Practice and registration following a hearing into his medical practice. Details of the decision can be found here.

Prescription Renewals

The Complaints Department has received an increasing number of complaints related to delays in prescription renewals. Patients are reporting excessive wait times for physicians to respond to pharmacy requests for refills of ongoing medications. They have expressed concerns about the adverse effects when medications such as antidepressants are abruptly unavailable and the potential for harm when they are without cardiac medications and antihypertensives. The increasing numbers of these concerns are troubling and CPSM reminds members that managing patients' prescriptions is a fundamental and important aspect of providing good care.

Please ensure that you are providing adequate amounts of medications. Prescriptions should be written with sufficient refills to last to the next scheduled or anticipated reassessment of the particular condition. This helps avoid the potential for gaps.

Members are also advised to review the Manitoba Health Billing Manual for the rules of billing such communication with pharmacies. Please note in relation to tariff 8005 (Communications initiated by pharmacists where the communication is regarding the renewal of a patient's prescription(s), the rules include:

i) This service is not to be used as a routine practice or to authorize repeat prescriptions for which long-term repeats would more properly have been authorized at the time of writing the initial prescription.

We appreciate that pharmacy requests for renewals in some circumstances may be inevitable, but CPSM expects its members to manage prescriptions such that it is not a regular occurrence and that when it does occur, the requests from pharmacies be handled on a timely basis.

Escalation Protocol for Management of Severe Hypertension in Pregnancy

The MPHSC has reviewed several cases of significant maternal morbidity and mortality in pregnancy associated with severe hypertension (SBP > 160 mmHg and/or DBP >110 mmHg) in the context of gestational hypertension, preeclampsia, or chronic hypertension with or without superimposed preeclampsia. A review of such adverse outcomes by MPHSC identified an absence of or delayed response in initiating effective antihypertensive agents to lower the BP to more safe levels. One contributing factor identified is the absence of escalation protocols for the management of severe hypertension by the caring team.

Maternity Health care workers are reminded that severe hypertension in pregnancy remains one of the five major causes of maternal mortality in Canada and a significant cause of severe maternal morbidity such as hemorrhagic and ischemic strokes, coma, convulsions, and cardiac events.

When faced with severe hypertension, health care workers should consider this an ***emergency*** and should initiate ***immediate intervention*** to lower the BP using intravenous alpha-beta blockers (such as labetalol), direct vasodilators (hydralazine) or oral rapid or intermediate-acting calcium channel blockers (nifedipine). On most occasions, repeat doses are required to keep the blood pressure in systole less than 140 mmHg and in diastole at 85 mmHg. In cases of severe hypertension resistant to the above therapeutic intervention, anesthesiologist involvement becomes imperative.

Following acute management, maintenance doses of oral formulations of these antihypertensive agents (labetalol, nifedipine, methyldopa) should be considered.

Maternity care centres in Manitoba should establish a **Hypertension Escalation Management Protocol** to efficiently and consistently tackle cases of severe hypertension on an emergency basis.

Healthcare workers are advised to follow the Canadian Hypertensive Disorders of Pregnancy Guideline of the SOGC of 2014 in this matter. A new version of the guideline is planned to be released later this year.

Maternal and Perinatal Health Standards Committee

CPSM Job Opportunity: Medical Consultant

CPSM seeks a physician with a minimum of 5 years of clinical experience, preferably in family medicine, for the position of Medical Consultant. Experience in hospital-based care is an asset. The main responsibilities of the medical consultant are to assist with the resolution of complaints submitted to CPSM by gathering and examining data, facilitating resolutions, and providing advice and support to the Complaints Committee in their reviews. Assistance with matters before the Investigation Committee may also be required. The position is 0.6 EFT.

Submit application and cover letter by October 29, 2021, to Recruiting@cpsm.mb.ca

View the job posting here.

Please note that we will acknowledge receipt of all applications, but only short-listed candidates will receive additional correspondence. Thank you for your interest in this position.

Consultation for Draft Standard of Practice for Exercise Cardiac Stress Testing

Council approved the draft Standard of Practice for Exercise Cardiac Stress Testing to be distributed for public consultation. Currently, there are no specific requirements for exercise cardiac stress testing in Manitoba.

The draft Standard was developed by a diverse Working Group of cardiologists, from both in the hospitals and in the community. The Working Group reviewed the regulatory approach used by other provinces.

The consultation has now launched and can be accessed HERE. Please review the draft Standard and provide feedback by Friday, October 29, 2021.

Council Meetings

Council meetings for 2021-22 are scheduled to be held on:

- December 8, 2021
- March 23, 2022
- June 22, 2022

If you wish to attend a Council meeting, please notify the Registrar at TheRegistrar@cpsm.mb.ca

Patient Safety

Greater Awareness of the Causes of Diagnostic Errors Can Help Physicians Avoid Many of Them

Most errors in clinical reasoning are not due to incompetence or a knowledge deficit, but, instead, usually have their origins in inadequate clinical assessments, loss of situational awareness or team communication breakdowns.

"It's not that people don't know how to put the puzzle together, it's that they are not looking at all the pieces of the puzzle," said Dr. Janet Nuth, an emergency physician and advisor at the Canadian Medical Protective Association (CMPA). Dr. Nuth made her observation as part of a recent educational session hosted by the CMPA, designed to help physicians identify risks associated with diagnostic decision-making and implement practical approaches to prevent patient harm.

The frequency of diagnostic error in all CMPA legal actions is approximately 21 percent, based on an analysis of 17,278 closed case files over a five-year period. Of these cases, 87 percent featured a delayed diagnosis or a misdiagnosis in which experts were critical of the treating physician's assessment of the patient.

What types of conditions are escaping physicians' detection in CMPA case files? Surprisingly, said Dr. Nuth, they are not rare disorders. It is much more likely for a common condition to be misdiagnosed or have a delayed diagnosis, such as cancer (particularly breast and colon), fractures, infections and ischemic heart disease.

Physicians work in high-pressure, fast-paced environments. Arriving at the correct diagnosis while contending with numerous complicating factors can be challenging. But maintaining situational awareness is critical, said Dr. Tino Piscione, acting director of CMPA's Safe Medical Care Learning. He describes it as a cognitive skill that involves:

- Gathering information;
- Understanding the information, including its significance in the context of the situation; and
- Applying that understanding in order to think ahead and anticipate potential complications.

In the simplest terms, situational awareness is keeping an eye on the "big picture," while managing the individual issues that arise.

But it's easy to lose situational awareness. Whether it is cognitive overload or the frailty of human thinking, physicians can drift away from methodical approaches to evaluation. For example, a physician may forget to inquire about family history during an assessment.

Situations that raise red flags – such as multiple visits from patients with unresolved concerns over a brief period of time or patients' condition not following the natural course of presumed illness or patients not responding to treatment as expected – require physicians to revisit their presumptive diagnosis. Failure to assess vital signs when appropriate, continuing abnormalities or worsening vital signs figure prominently in many medical-legal cases.

In fact, the loss of situational awareness – represented by a missed opportunity to stop and reassess the patient from a different perspective – was identified as an issue contributing to missed, wrong or delayed diagnoses in 49 percent of CMPA case files.

Dr. Shirley Lee, a physician advisor at CMPA and an emergency physician, said she recommends thinking about a "working diagnosis" when formulating an initial impression to avoid the pitfalls of anchoring bias. She said the phrase keeps her in an exploratory mindset, making her open to the possibility of alternative diagnoses when new information is discovered or the patient's condition evolves.

Communication and documentation can help put physicians back on track, said Dr. Piscione. Not only does documentation leave an intellectual footprint of a physician's reasoning and demonstrate their diligence, it can help a physician identify potential gaps in their assessment. In addition, when the diagnosis is difficult to establish or is uncertain, communicating that fact to the patient helps them understand the importance of follow-up, whether it is for consultations, reassessment visits or further testing. The process of communicating and documenting clinical reasoning and the rationale for decisions all present opportunities for physicians to be more reflective about their approach, he said.

Noting that ineffective team communication is a significant contributor to diagnostic error, Dr. Louise Dion, a senior physician advisor at CMPA, said structured team processes, such as briefings and huddles, force the team to "slow down when it should" at the preparation phase of clinical decision-making.

All health care professionals on the team should feel safe in confirming information or asking questions about the specific patient, the environment, the tasks, or the timing or urgency. "It should be made clear that there is no such thing as a stupid question," she said. These proactive efforts promote team situational awareness and highlight potential critical situations ahead.

From CMPA's Files

Percentage of cases with diagnostic error:

75% – Decision-Making

87% – Deficient Clinical Assessment

53% – Team Factors

Practical Tips

- Use structured communication tools and techniques.
- Encourage team members to speak up by providing a psychologically safe environment, i.e., "no such thing as a stupid question."
- Hold regular huddles, team meetings and briefings to leverage the expertise of the team.
- Read all key elements of the patient's medical record, including earlier entries, test results and consult reports.
- Plan proactively for contingencies by asking, "what if?"
- Engage in reflective practice by asking whether your thinking is subject to bias.
- Slow down and hone awareness.
- Document both negative and positive pertinent findings.
- Use clinical practice guidelines to assist clinical judgment in determining the need for further testing.
- Pause to reflect on a differential diagnosis.
- Close the loop on tasks.

Used with permission from CPSO's eDialogue, September 2021
https://dialogue.cpso.on.ca/2021/09/minimizing-misdiagnoses/

Managing Pediatric Asthma, Croup, and Bronchiolitis in the Context of COVID-19

You may be seeing more asthma, bronchiolitis and croup this fall, and management practices for these illnesses will need to be adapted for COVID-19. While public health measures reduced transmission of common respiratory viruses in the 2020-2021 fall/winter seasons, there are incoming reports of a resurgence of RSV, parainfluenza, adenovirus, and rhinovirus. Some jurisdictions have reported an early resurgence of RSV in children, with increased severity and disease affecting older children who lacked exposure earlier in life due to COVID-19 public health measures such as isolation at home.

The Child Health Standards Committee recommends that members who care for children review the following evidence-based management tools for managing pediatric respiratory illnesses in the context of COVID-19.

COVID-19 and Management of Asthma, Croup and Bronchiolitis

The Canadian Pediatric Society publication *The acute management of COVID-19 in pediatrics (spring 2021 update)* includes guidance on adapted management of croup and asthma, as well as COVID-19 diagnosis and management in children. Given that COVID-19 is a potential pathogen for any respiratory illness, wear appropriate PPE and choose MDI rather than nebulized medications whenever possible. Nebulization of medication is considered an aerosol-generating medical procedure (AGMP) and therefore requires AGMP precautions. Early treatment of croup and asthma can prevent disease worsening and reduce healthcare utilization. For COVID-19 testing and isolation advice for patients and families, continue to follow current Manitoba Public Health guidelines.

Asthma

Primary care and emergency department visits for children with asthma exacerbations typically peak in September with children back in school and increased exposure to respiratory viruses such as rhinovirus. For COVID-19 management considerations, see the CPS Practice Point Pediatric asthma and COVID-19.

In anticipation of a fall/winter surge in asthma, consider the following actions for your practice:

- Increase controller medications such as inhaled corticosteroids preventatively before the fall, especially for individuals with persistent asthma.
- Start or increase inhaled corticosteroids at the first sign of illness for individuals who do not preventatively increase their controller medication in the fall.
- Advise patients to use salbutamol promptly for treatment of symptoms, although these symptoms are also a sign that controller medication needs to be started or increased.
- Manage exacerbations aggressively, including oral corticosteroids when needed.
- If you provide emergency care of children, use MDI rather than nebulized medications to reduce aerosol transmission of viruses. An example of a pre-printed order set for emergency departments is the WRHA website (see *Physician Standard Order Sheets* for MDI and wet nebulization).

Croup

Early treatment of croup with oral dexamethasone can prevent physician and emergency department visits. For clinical guidance of croup, see the TREKK croup guideline. If epinephrine is required choose MDI delivery if available to reduce aerosol transmission of viruses (for access to epinephrine MDI through Health Canada's Special Access Program, consult your regional Pharmacy lead). For epinephrine dosing, see the CPS COVID-19 statement above.

Bronchiolitis

Most children with bronchiolitis can be managed at home. Tips for symptom management at home are available from TREKK in video and online formats.

For clinical management of sicker children, see the updated TREKK bronchiolitis guideline, which includes COVID-19 considerations. If using nebulized epinephrine, follow current Shared Health guidelines for AGMP procedures. Note that epinephrine MDI is not approved for bronchiolitis unless the patient is enrolled in a clinical trial.

Preventing Respiratory Illness in Children

- Advise parents to follow current COVID-19 public health recommendations and Public Health Orders; these actions will also protect children and families from other respiratory viruses.
- Masks are ***recommended*** when physical distancing cannot be maintained, including visiting and playing with friends and relatives. Masks are currently ***required*** for indoor public spaces.
- Advise parents to keep children home when they are sick.
- Recommend COVID-19 vaccination for parents and children who are eligible.
- Recommend influenza vaccination for children 6 months and older and their parents.

Not sure who to call for advice or transfer?

See the **CPSM newsletter item on pediatric advice and transfer (page 9)**.

Child Health Standards Committee

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