

DocTalk

Delegation from Physicians
to Registered Nurses

Conscientious Objection
and the Carter Decision

New Methadone Guidelines

Stress
and College Complaints



SEEKING SUPERVISORS AND SUMMATIVE ASSESSORS

REGISTRAR

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Printed by

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101-2174 Airport Drive
Saskatoon, SK S7L 6M6
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www.cps.sk.ca

ISSN 2368-0628

ISSN 2368-0636 (Online)

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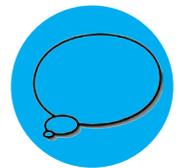
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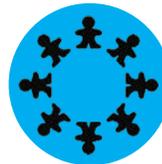




Above: At the Council banquet meeting last November, Dr. Lowell Loewen (pictured above with his wife, Mrs. Win Loewen) was presented with a portrait painting in honor of his work with the College.

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

Submit your ideas & articles by July 15th, 2015 to COMMUNICATIONS@cps.sk.ca

FROM THE PRESIDENT



Leading in uncharted waters: a new Council ready for the task

At the January 2015 Council meeting there were a few changes to the Council membership. Council thanks Dr. Dan Johnson and Dr. Andries Muller for their contributions to Council over the last few years, and welcomes Dr. Julie Stakiw and Dr. Lynda Keaveney to Council. On behalf of the Council, I would like to extend our thanks to Dr. Mark Chapelski for serving 3 terms as President, the longest serving President in the history of the College! Dr. Chapelski served with distinction in this role providing wise direction and leadership over the past 3 years. He will continue to serve on Council and on the Executive Committee. The other members of the Executive Committee elected at the January meeting include; Dr. Pierre Hanekom (Vice President), Susan Halland (public member), Dr. Alan Beggs (member-at-large), and me, Dr. Grant Stoneham (President). I am certainly looking forward to working collaboratively with the other Councilors and College Staff over the next year.

At the January meeting, Council reviewed a draft policy on Conscientious Objection. The purpose of this policy is to provide clear guidance to physicians, and the public, about the obligations which physicians have to provide care

to patients, and how to balance those obligations with physicians' wish to act in accordance with their conscience in certain circumstances. The policy was sent out for consultation, and we received many submissions which we will refer to when we formulate the final policy. On behalf of Council, I would like to thank those physicians and members of the public that took the time to provide this important feedback. Your thoughtful comments will help to assist us when reviewing and completing the final policy.

As I am sure many of you are aware, on February 6th, 2015, the Supreme Court of Canada struck down sections of the Criminal Code of Canada (Sections 241 and 2) which made it a criminal offence to assist a person to commit suicide, in *Carter v. Canada* (Attorney General). The Supreme Court concluded that these sections unjustifiably infringed on the Section 7 Charter rights of persons who meet 4 conditions;

1. The person must be a competent adult;
2. The person must clearly consent to the termination of life;
3. The person must have a grievous and irremediable medical condition (including illness, disease or disability); and

4. Which condition must cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

The law will have a suspended declaration of invalidity for 12 months, during which time the current law prohibiting assisted suicide remains in effect, unless a new law is passed. Council will have to monitor the environment to determine if any new policies or guidelines are necessary to respond to the evolving law in this area, and to respond to any new laws if they are drafted and passed. Many people, including fellow physicians, have very strongly held beliefs on the different sides of this issue, and it is certain that the Carter decision will stimulate on-going debate within Government and the medical profession.

I look forward to working with Council members and College staff over the next year as we continue to serve the public by regulating the practice of medicine and guiding the profession to achieve the highest standards of care possible.

Dr. Grant Stoneham
President, CPSS

FROM THE REGISTRAR



Upcoming Issues: Annual Report & AGM, Conscientious Objection, and Physician Assisted Suicide

The CPSS Annual Report and the Annual General Meeting and Educational Event – June 20, 2015

The Registrar's report in the first newsletter of the New Year usually provides an overview of the business of the College over the last year. Many years ago the College produced a separate annual report. We have decided to return to that practice. The Annual Report will be prepared for June, and will coincide with the date of the Annual General Meeting and educational session held by the CPSS on the afternoon of June 20, 2015.

This year's education topic will be **communication**; focusing in on situational awareness and techniques to improve communication such as closed communication and the use of *Situation Background Assessment Recommendation (SBAR)*. We will also have a presentation on boundaries and difficult interactions, an update on disclosure of patient health information and an update on Physician Assisted Death. Please **save the date** as it will be an interesting and informative afternoon.

Conscientious Objection

The draft policy seeks to provide guidance to physicians and the public about the obligations which physicians have to provide care to patients and how to balance those obligations with physicians' right to act in accordance with their conscience if they conflict.

Since the President wrote his newsletter article, the committee working on the Conscientious Objection policy has had an opportunity to provide the Council of the College feedback on its initial draft policy. The Council of the College has discussed the draft and provided further direction on how the issue of Conscientious Objection will be managed by the College. The following is some additional information on the College's progress to date.

It is important to stress that the ethical obligations of physicians are outlined in the CMA Code of Ethics which has been adopted and adapted by the CPSS. The relevant sections of the code are Section 17; Section 18; Section 19; Section 21; and Section 22 and nothing pertaining to the obligations contained in the Code of Ethics has changed. It is also important that physicians provide medical care in a way that is consistent with the Code of

Ethics but also with The Saskatchewan Human Rights Code.

The second draft of the policy is based upon the following principles relating to the physician-patient relationship:

- The fiduciary relationship between a physician and a patient;
- Patient autonomy;
- A patient's right to continuity of care, especially as recognized in the Canadian Medical Association Code of Ethics, which states "Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted, until another suitable physician has assumed responsibility for the patient, or until the patient has been given adequate notice that you intend to terminate the relationship."
- A patient's right to information about their care, especially as recognized in the CMA Code of Ethics which states "Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability" and "Make every reasonable effort to communicate with your patients in such a way that information exchanged is under-

stood.”

- Patients should not be disadvantaged or left without appropriate care due to the personal beliefs of their physicians;
- Physicians should not intentionally or unintentionally create barriers to patient care;
- Reasonable limits on a physician’s ability to refuse to provide care are appropriate unless there is a legitimate clinical reason or other good legal reason that the patient’s interests should not be accommodated;
- Medical care should be equitably available to patients whatever the patient’s situation, to the extent that can be achieved.

The second draft policy is also based on the following additional principles:

- The College of Physicians and Surgeons has an obligation to serve and protect the public interest. The Canadian medical profession as a whole has an obligation to ensure that people have access to the provision of legally permissible and publicly-funded health services.
- Physicians have an obligation not to interfere with or obstruct a patient’s right to access legally permissible and publicly-funded health services.
- Physicians have an obligation to provide full and balanced health information, referrals, and health services to their patients in a non-discriminatory fashion.
- Physicians have an obligation not to abandon their patients.
- In certain circumstances a physician will have a legitimate clinical reason to refuse to provide a service requested by a patient.
- Physicians’ freedom of conscience should be respected.
- It is recognized that these obligations and freedoms can come into conflict. This policy establishes what the College expects physicians to do in the face of such conflict.

The College has received extensive feedback on its first draft. The committee that developed the first draft then prepared a second draft of the policy which was considered by the Council at the March

Council meeting. The second draft was prepared taking the feedback received from physicians and the public into consideration.

The Council reviewed the second draft and referred the document back to committee for further development. Among the principles accepted by the Council which will form the basis for a third draft of the document are the following:

- the policy should include a statement that the policy does not apply to physician assisted death.
- the policy should require physicians to either provide full and balanced information to a patient, or, if the physician has a conscientious objection to doing so, to refer the patient to another physician or health care provider who can provide full and balanced information and make follow up arrangements as necessary.
- the policy should require physicians who are unwilling to perform a medical service to which they have a conscientious objection to either refer the patient to a physician who can provide the service, or to another physician who is willing to provide full and balanced information to the patient and, if the patient chooses the medical service, to either perform the service or refer the patient to a physician who will.
- the policy should state that a physician who is aware he/she has a conscientious objection should have a proactive rather than a reactive process in place to manage issues that might arise in their practice.

When the third draft of the document has been finalized, it will be circulated for further comment.

Physician Assisted Suicide - The Carter Decision

In his President’s report, Dr. Stoneham has noted the decision of the Supreme Court on Physician assisted suicide, the basis on which the decision was made and referenced the 12 month period of suspended declaration of invalidity.

What is important to understand is that it remains illegal for physicians to assist with suicide/death for the present time.

It is unknown whether the Federal Government will pass a new law, and if so, what that law might be. It is also unknown whether the provincial government will consider legislation. We are aware there are many discussions ongoing at both the federal and provincial level involving the federal and provincial governments, the regulatory and advocacy bodies for physicians and other interested groups. In the meantime the College is considering what we need to do to prepare as best we can.

It is also important to understand that the issue is not whether physician assisted suicide/death should be allowed – that matter has been determined by the Supreme Court.

If there are no new laws to spell out the details of how this will be managed it will fall heavily on the regulatory bodies to determine the standards of medical practice.

The College is acutely aware of the tension between the rights of the patients who may be requesting the assistance, and the rights of the physicians with a conscientious objection. As much as possible we will respect and try to balance both perspectives; however, ultimately we must respect the law.

The Council has decided to establish a committee to provide recommendations to the Council relating to the College’s response to the Carter decision. The terms of reference and the membership of that committee have not yet been established. The College will seek feedback from the membership and the public on the development of policy pertaining to this issue.

We appreciate the efforts taken by members and the public in providing the College with the feedback it has received to date.

**Dr. Karen Shaw
Registrar, CEO**



Pending Changes to the Health Care Directives Legislation

Physicians should be aware of pending changes to the existing legislation relating to health care directives (sometimes called living wills).

The government will be proclaiming new legislation, entitled **The Health Care Directives and Substitute Health Care Decision Makers Act, 2014**. No date has been set for the proclamation. Regulations will need to be developed before the legislation can be proclaimed.

One change which is likely to reduce confusion is the provision which states that a person who holds an enduring power of attorney does not have the authority to make health care decisions for the person who granted the power of attorney. The

College frequently deals with individuals who have been granted a power of attorney who think that authorizes them to make health care decisions for the person who granted the power of attorney or obtain health information about the person who granted the power of attorney. With this change it will be clear that only a health care directive gives a third person the authority to make health care decisions for another person.

In addition, after the legislation comes into effect, some caregivers will be able to give consent to day-to-day health care of incapable adults if there is no other authorized person available. Decisions that are considered to be “day-to-day” and a definition of “caregiver” will be outlined in regulations.



Bryan Salte,
Associate Registrar
and Legal Counsel

The Act will also clarify the authority to make decisions on behalf of an incapable adult respecting long-term care. Regulations will specify what kinds of care will be considered “long-term care”.

When the regulations are in place and the legislation is proclaimed the College will advise physicians and provide further details about the changes.

BYLAW CHANGES

Delegation from Physicians to Registered Nurses

One of the challenges for medical care in Saskatchewan has been the lack of authority for physicians to delegate certain activities associated with the practice of medicine to other health care practitioners, particularly nurses.

That has been the subject of discussion with government and the SRNA for a number of years. The SRNA has reviewed its bylaws and its authority so that it can define which activities fall within the scope of practice of registered nurses, and which activities do not fall within the scope of practice of registered nurses.

If an activity is not within the scope of practice of registered nursing, but is within the scope of the practice of medicine,

there has been no method that would permit a physician to authorize a registered nurse to carry out that activity.

In September, 2014 changes to The Medical Profession Act, 1981 came into effect which gave the College the authority to adopt bylaws that can allow physicians to delegate activities described in College bylaws to other health professionals.

The College has been involved in discussions with the SRNA to determine what activities that the SRNA has concluded are not within the scope of practice of registered nursing and consequently can only be performed by a registered nurse if a physician delegates the authority to that registered nurse.

After the change to the legislation, and consultation with interested stakeholders, the Council adopted a bylaw which will allow physicians to delegate certain specific activities to registered nurses. Those bylaws are now in effect.

The bylaw was based upon the following principles:

1. Delegation will be from a particular physician to a particular registered nurse. Delegation will not be by “category”;
2. The activities which may be delegated are specified in the bylaw;
3. When there is a specific program

which is identified (such as the Neonatal Intensive Transport Team, the RN Pediatric Transport Team or Air Ambulance), it is not necessary to identify the specific procedures that may be provided by an RN as part of the program;

4. It will be the responsibility of the physician who delegates the activity to assess the RN's skill and knowledge to determine if, in the physician's opinion, the RN has appropriate skill and knowledge to perform the delegated activity;
5. Delegation must be done in writing, except in the case of an emergency;
6. The physician who delegates the authority to the RN must have a process in place to provide appropriate supervision.

Any physician who is considering delegating activities to RNs is encouraged to contact the College at 306-244-7355 if they would like additional information or guidance.

This bylaw does not necessarily address all circumstances in which delegation may be appropriate. Physicians who think that there should be additional situations in which delegation to an RN should be authorized should write to the College setting out their perspective.

The bylaw which is now in effect states:

23.3 Delegation to Registered Nurses

(a) A duly qualified medical practitioner may delegate to a Registered Nurse the following activities which are the practice of medicine as defined in the Act:

(i) Services provided by a Registered Nurse while acting as a member of a Registered Nurse Neonatal Intensive Transport Team;

(ii) Services provided by a Registered Nurse while acting as a member of a Registered Nurse Pediatric Transport Team;

(iii) Services provided by a Registered Nurse while acting as a member of an Air Ambulance Team;

(iv) Services provided by a Registered Nurse while acting as a member of a STARS (Shock Trauma Air Rescue) team;

(v) The administration of laser radiation for a medical purpose, but only when the physician has first assessed the patient and established a treatment plan for the administration of laser radiation and the physician is present in the same location as the laser therapy is provided;

(vi) The injection of agents which have an effect on or elicit a response from living tissue (bioactive agents), but only when the physician has first assessed the patient and established a treatment plan for the injection;

(vii) Services when acting as a surgical assistant in an operating room, but only when the registered nurse has been given privileges to act as a surgical assis-

tant by the Board of the Regional Health Authority where the Registered Nurse provides those services;

(viii) Services provided by a Registered Nurse when acting as a member of the Saskatchewan Transplant Program.

(b) Except in the situation of an emergency, prior to delegating the authority for a Registered Nurse to perform an activity the physician must be satisfied that the individual to whom the act will be delegated has the appropriate knowledge, skill and judgment to perform the delegated act. The delegate must be able to carry out the act as competently and safely as the delegating physician.

(c) Except in the situation of an emergency, the authority to delegate must be provided in writing to the delegate, and must contain:

(i) a specific description of the activities which have been delegated;

(ii) any conditions or restrictions associated with the delegation (only to be exercised after prior consultation with a physician, only to be exercised if a patient has a specific medical condition, any time limitation on the delegated authority, etc.)

(d) A delegation is only valid if the delegate accepts the delegation.

(e) A delegation may be revoked by the delegating physician at any time.

...continued on p. 9

(f) A physician who has delegated an activity shall retain a copy of the document which authorizes the delegation.

(g) A delegation is only valid while the delegating physician is generally available to provide oversight and ad-

vice to the delegate. If the physician who has delegated the activity no longer has oversight responsibility for the delegated activity, the delegation is no longer valid.

(h) A physician delegating an activity pursuant to this by-law must provide the appropriate level of supervision to ensure that the act is performed properly and safely.

Prescribing Buprenorphine

During its March meeting, Council approved changes to regulatory bylaw 19.1 Standards for prescribing of buprenorphine.

The new wording will limit the bylaw to those situations where buprenorphine is prescribed for the treatment of addiction. *The bylaw will not apply if buprenorphine is prescribed for pain relief.*

The other change is to state that a physician must have “access to” addiction counselors rather than “a relationship with” addiction counselors.

The proposed changes are expected to come into effect this summer once the Ministry of Health has ratified the new bylaw.



POLICY AND GUIDELINE UPDATES

Changes to the following policies and guidelines have been made and can be viewed on the College website at cps.sk.ca.

- Patients Who Threaten Harm to Themselves or Others (*New*)
- Role of Legal Counsel (*Updated*)
- College Newsletter (*Updated*)
- Contents and Access to Information in Physician’s College Files (*Updated*)
- Public Access to Council Meetings (*New sunset date only*)
- Public Inquiry about Investigation of Members (*Rescinded*)

all our docs are vital

Ensuring Physician Supply: Recruitment Abroad and Retention at Home

Since **saskdocs** was established in 2010, the agency has worked effectively with all of its system partners to strengthen the medical workforce in Saskatchewan.

The agency has assisted the College of Physicians and Surgeons in the onerous task of applicants to the **Saskatchewan International Physician Practice Assessment (SIPPA)** program by pre-screening all applicants based upon criteria defined by the College. We have more recently accepted responsibility for doing reference checks on SIPPA applicants.

The SIPPA program has been very successful in expanding the supply of family physicians in the province. We are now witnessing some moderation in RHA claims for seats in the SIPPA program. Only 22 seats were claimed in the current iteration and there were 6 failures in the centralized assessment meaning that 16 IMGs will enter the workforce if they are all successful in the field assessment.

In the wake of increased enrollment at the College of Medicine at the University of Saskatchewan, we now have a growing supply of locally trained physicians available for recruitment to practice opportunities in the province. This surge in local physician supply will continue to grow as the successive waves of 100 student classes move through our residency programs.

We are hearing concerns from U of S medical students and residents about diminishing prospects for practice in Saskatchewan on completion of their training. While there is no immediate risk of over-supply, **saskdocs** does recognize the need to make integration of U of S grads into our workforce our highest priority. We have realigned our time and resources to build stronger communication links between our local grads and RHAs, NMS, the SCA and medical clinics.

We are also working collaboratively with our system partner to improve physician retention. We believe a stable medical workforce will enhance the quality of patient care.

by Dr. Dennis Kendel

saskdocs
.ca 



Application for Medical Registration

Registration Services has been actively preparing for the introduction of the Application for Medical Registration (AMR) which is now available in Saskatchewan as of April 21st, 2015. AMR is an on-line platform for physicians to submit information for a “Review of Qualifications” through a portal at the Medical Council of Canada.

The AMR will replace the Eligibility Review Forms we currently use for determining eligibility for licensure. Staff members are excited for the implementation of this new project.

Preparation for AMR required conversion of our current paper pre-licensure information to an electronic format.

This conversion has been an enormous project but has resulted in elimination of a great deal of paper from our office.

For more details, see the Registration section of our website at cps.sk.ca.



Continuing Medical Education

Professional Development Opportunities

The College website features a section on its home page with links to several different conferences and other educational opportunities which may be of interest to you.

Physicians must remember that they are obligated to complete a certain number of educational credits over a period of 5 years in order to be eligible to renew their licence.

To the right are listed some of the upcoming conferences. Several of the conferences listed are accredited, although some are not.

For the latest list of upcoming continuing medical education opportunities, please see the News & Events section of the homepage of our website at cps.sk.ca and click on [Upcoming Conferences and Calls for Abstracts](#).

[Infectious Disease Seminar for Rural SK Primary Healthcare Staff](#)
May 13-June 10

[Moving from Surviving to Thriving](#)
(APASK-Addictions Professionals Association of SK)
May 20-21, 2015

[More than Ears: Central Auditory Processing and Cognition across the Lifespan](#)
May 22-23, 2015

[New Developments in Lymphedema](#)
May 23rd, 2015

[Prevention Matters 2015 for Children, Families and Communities](#)
September 30-October 2, 2015

Currently Seeking Supervisors and Assessors...

Supervised Practice

ALL PHYSICIANS, including those educated in Canada, who do not meet the requirements for Regular Licensure are required to have a practice supervisor.

The practice supervisor must be approved by the College and must practice in the same discipline as the physician who is being supervised. Physicians must have practiced a minimum of three years to be approved to act as a practice supervisor.

The College works with the new physician and the regional health authority to identify potential practice supervisors. Where possible the College prefers that the practice supervisor and the physician who is being supervised are located in different medical practices. **Groups of physicians are encouraged to collaborate to provide supervision for an individual physician.** This arrangement provides for continuity of practice supervision in the event that a practice supervisor is unable to adhere to the review and reporting schedule.

If a physician is not practising under supervision, or the supervision does not comply with the requirements for supervision established by the Council, the Registrar will notify the physician of the intention to suspend the physician's licence within 15 days after notice is given.

The College will provide a schedule for reporting by the practice supervisor. Depending on the discipline of the physician who is supervised, supervision may include chart reviews, reviews of other documentation, interview with professional peers and/or discussion with the physician being supervised. If required, the supervision schedule may be revised to accommodate short absences from practice.

Where a physician is required to successfully complete a period of supervision, the Registrar's determination whether the supervision has been successfully completed is final, subject only to the ability of the Council to review the Registrar's decision.

Fees for Supervised Practice

The physician who is being supervised is responsible to cover all of the costs related to practice supervision. Practice supervisors are remunerated at an hourly rate as approved by Council. The physician who is supervised must submit the fees for practice supervision to the College and the fees are dispersed once the final practice supervision report has been received. Payment may be made directly to the Practice Supervisor or the Medical Professional Corporation.

A Supervisor is an individual who visits/reviews the physician's practice for the purpose of conducting a practice review at prescribed intervals set by the CPSS to ensure that the physician is meeting the expected standard of care, and that patient safety is not compromised.

The Supervisor reviews patient charts, continuing professional learning activities and identifies opportunities for learning to enhance practice. The supervisor may also assist in learning about community resources to help meet patient needs.

RESOURCES FOR SUPERVISORS AND ASSESSORS

Registration Services staff has produced several resources for supervised physicians, practice supervisors and summative assessors. These resources include handbooks and an informational charting presentation.



Summative Assessment

Internationally trained specialists and family physicians may have an option to select a **SUMMATIVE ASSESSMENT** as an alternative to writing the Canadian examinations to achieve Regular Licensure.

Such assessments are the responsibility of the physician, not the CPSS, to arrange and will occur at the physician's expense. They are subject to the College's approval. Summative assessments may not be available in Saskatchewan and consequently physicians may not have the option of qualifying for a regular licence through an assessment or qualifying for a provisional licence through an assessment.

Where such assessments are available, the Registrar's determination whether an assessment has demonstrated that a physician has met a standard to enter into supervised practice is **final**, subject only to the ability of the Council to review the Registrar's decision. In addition, the Registrar's determination whether the assessment has demonstrated that the physician has appropriate skill, knowledge and suitability to enter into independent practice is final, subject only to the ability of the Council to review the Registrar's decision.

Summative assessment involves a review of the medical practice through chart reviews or review of other documentation, survey of medical colleagues, non-medical colleagues and patients. A period of observed practice may be required on some circumstances.

All summative assessors must be approved by the College and must have practiced a minimum of three years. The College works with the physician and the regional health authority to identify potential summative assessors.

In the case of *specialist assessments*, the College requires a **minimum of two assessors** who practice in the same discipline as the physicians who is being assessed and both assessors must hold certification by the Royal College of Physicians and Surgeons of Canada.

Fees for Summative Assessment

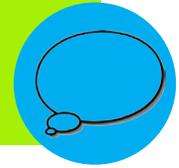
The physician who is being assessed is responsible to cover all of the costs related to summative assessment. Assessment fees are submitted to the College and the fees are dispersed to the assessor upon receipt of the final report. Payment may be made to the Summative Assessors or to the Medical Professional Corporation.

Summative assessment refers to a process by which a physician is evaluated for the purpose of conferring regular licensure. This process provides assurance to the CPSS that the physician practices in a competent manner in his/her discipline, is meeting the expected standard of care and that patient safety is not compromised.

For more information regarding practice supervision or summative assessments, or if you have an interest in becoming a practice supervisor or summative assessor, please contact:

Barb Porter
Director of Physician Registration
barb.porter@cps.sk.ca





Helping With More Than Just Complaints

Resolving Issues

The **Complaints Department** at the CPSS handles formal complaints about the care provided by, or the conduct of, a physician. Its staff also carry out a wide variety of information calls, resolution of low level complaints and physician support. Since June 2014, a number of priorities have been identified which has led to some restructuring of how complaints and other department duties are handled.

Written communication to the complainant and physician in formal complaints was identified for improvements and necessary adjustments to the content and flow of the letters was completed. When complainants and physicians receive written communication regarding a formal complaint, the language will be more easily understood and staff are available to both the complainant and physician for any assistance required.

Improving Customer Service

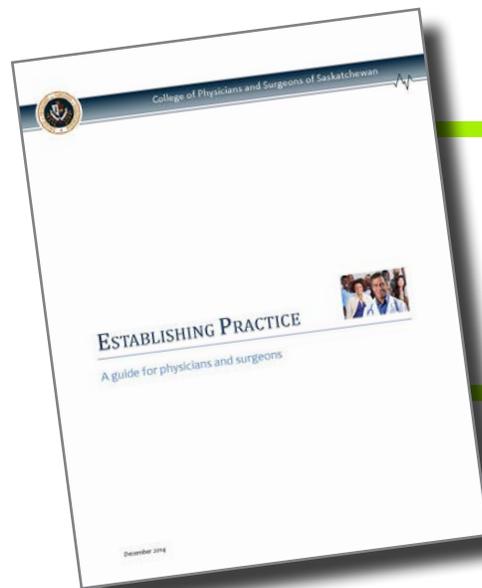
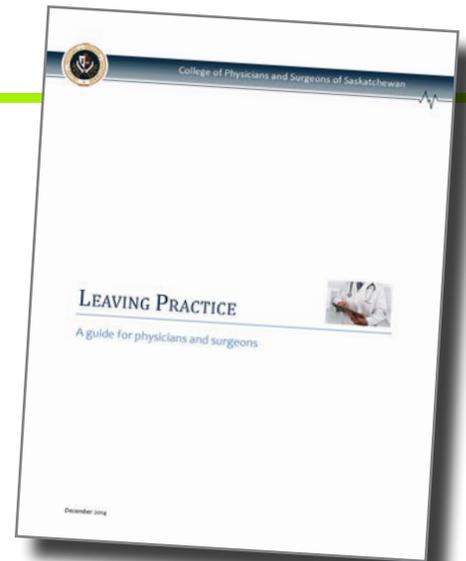
With ever-changing bylaws and process requirements, the College's staff is frequently called upon to adjust its workflows. This is why we've improved the **Complaint Reporting Form**. Recent changes are more in line with the College's branding and feature wording for third party complaints where the patient is deceased.

Whenever any changes or updates are made to department process or written communications, feedback and suggestions are always appreciated from complainants and physicians. Our goal is to improve customer service and the effectiveness and efficiency of the complaints process.

Locating Personal Health Information

A key area of considerable staff efforts is in responding to complainants that cannot locate personal health information from physicians that have moved locations, retired or passed on.

With this in mind, **Leaving Practice, A guide for physicians and surgeons**, was created that provides physicians with information on notification to patients and other parties, continuity of care, transfer of medical records, advertising and other helpful tips for a smooth transition when leaving their current practice.



A second guide, **Establishing Practice, A guide for physicians and surgeons**, was also created to inform physicians of the bylaws and other requirements for setting up a practice in Saskatchewan.

Doctor? Patient? Talk to us! Share your experience!

1-800-667-1668

College Disciplinary Actions



The College reports discipline matters in the next issue of the Newsletter after the disciplinary action is complete. The College website also contains information on discipline matters that are completed, and matters where charges have been laid but have not yet been completed.

There have been six discipline matters completed since the last Newsletter report.

Dr. Sawsan Awad-El-Kariem

Dr. Awad-El-Kariem admitted that she was guilty of unprofessional conduct for failing to maintain appropriate patient records. She admitted that her records were not maintained in a systemic way, did not allow another health care provider to identify a diagnosis or possible diagnosis for her patients and did not allow another health care provider to identify a treatment plan for her patients. She admitted that she maintained paper documents for patients in plastic bags without any organized system.

The Council of the College of Physicians and Surgeons accepted the undertaking provided by Dr. Awad-El-Kariem to address concerns relating to her medical records. The Council suspended Dr. Awad-El-Kariem from practice for four weeks, in four one-week increments, and imposed costs of \$2,510.

Dr. David Campbell

Dr. Campbell admitted that he was guilty of unprofessional conduct for failing to maintain the standards of the medical profession by leaving a patient who was under the effect of anaesthesia and engaging in a conversation with another person, unrelated to the patient.

Council accepted an undertaking from Dr. Campbell to develop a Departmental Policy regarding leaving the operating room, to be based upon the Canadian Society of Anesthesiology Guidelines.

Council reprimanded Dr. Campbell and required him to pay a portion of the costs incurred by the College in the amount of \$22,158.94.

Dr. Sujay Ishwarlall

Dr. Ishwarlall admitted that he was guilty of unprofessional conduct related to an assault on his wife and criminal proceedings in New Zealand.

The Council of the College of Physicians and Surgeons accepted the undertaking provided by Dr. Ishwarlall to engage in counseling to address concerns arising from his conduct. The Council also imposed a reprimand.

Dr. David Opper

Dr. Opper was subject to discipline proceedings in Ontario. The Ontario College of Physicians and Surgeons imposed a three month suspension following Dr. Opper's admission of unprofessional conduct related to his billings for medical services. The Ontario College also imposed additional conditions related to his practice including a requirement that he have a practice monitor, that he submit to unannounced practice inspections and that he consent to a review of his billings.

Council acted under section 54.01 of The Medical Profession Act, 1981 and imposed a suspension of Dr. Opper's right to practise in Saskatchewan ending May 24, 2015, the date that the suspension of his right to practise in Ontario ends.

Dr. Nigel Painter

Dr. Painter admitted unprofessional conduct by engaging in a sexual relationship with a patient.

The Council accepted a joint recommendation that:

- a. his name be struck from the register;
- b. he will not be eligible for restoration of his licence for a period of 12 months;
- c. he will not be eligible to apply to have his licence restored until the Council receives a satisfactory report from a professional person, persons or organization chosen by the Council which attests that Dr. Nigel Painter has undertaken counseling at his expense for sexual abuse, has gained insight into the matter and has achieved a measure of rehabilitation which protects the public from risk of future harm.

Dr. Cornelius Spies

Dr. Spies admitted that he was guilty of unprofessional conduct for sending text messages to another physician that could reasonably have been interpreted as racist or threatening.

Council suspended Dr. Spies for a period of two weeks, required him to reimburse the College for the costs incurred by the College in relation to the discipline investigation in the amount of \$1,800.00 and required Dr. Spies to participate in an ethics course approved by the Registrar unless, after reviewing the ethics course which Dr. Spies had already taken, the Registrar concluded that the course was appropriate.

Stress and College Complaints

In the last issue of DocTalk, I wrote about **Choosing Wisely Canada**, the practice of defensive medicine and College complaints. A recent article in the BMJ¹ highlighted how College complaints might be a driving force behind the practice of defensive medicine and, more seriously, how College complaints are linked to depression anxiety and suicidal thoughts in physicians.

A survey of 8,000 doctors in the UK showed that those who had received a complaint were 77% more likely to experience moderate to severe depression.

Those with current or recent complaints were also more than twice as likely to report thoughts of self harm or suicidal thoughts. The authors also reported that 80% of doctors answering the survey reported changing the way they practised as a result of either complaints against themselves, or after observing a colleague go through the complaints process. 82% to 89% of all physicians surveyed reported that they practice defensively by “hedging” (overprescribing, overreferring, and being overcautious), and 43% to 50% reported avoiding high-risk patients. It is interesting to note that “hedging” and avoiding high risk patients were present at similar levels in all groups, even the group of physicians that had never had a complaint against them.

The study did also not show causation and one could question whether stress and ‘burnout’ were factors leading up to the complaint and whether seeking

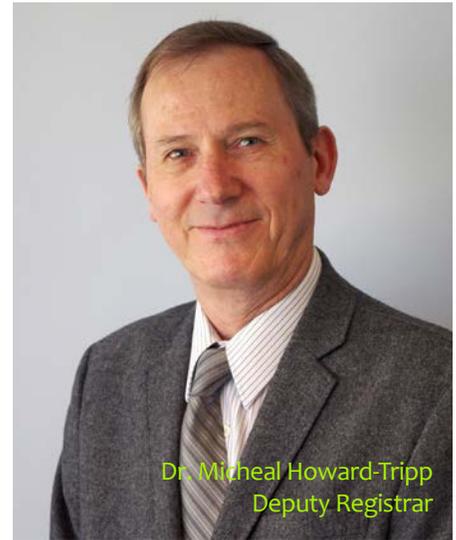
help earlier might not have prevented the complaint from occurring.

Physicians are often surrounded by sickness and death, they deal with grieving families, medical emergencies, minor ailments and ‘worried-well’ patients, often all in the same day, and are expected to remain at their peak and professional at all times. This continues week by week, year by year and, perhaps partly because of issues of patient confidentiality, physicians have little chance to debrief and muster.

Is it possible for physicians to continue to deliver personalized and compassionate care while they are themselves over-stressed, dissatisfied and burned out?

Stressed and depressed physicians practising defensive medicine can hardly be in the best interests of the patients they are caring for!

The College is not immune to these findings and acknowledges that responding to a College complaint can be a very stressful event in a physician’s career. This is the reason the College, at the time of notifying a physician of a complaint against them, advises physicians of the SMA programs available to physicians (see separate article). It is also acknowledged that there may be a reluctance to seek professional help due to concerns about privacy of information and possible repercussions to one’s career. Physicians might find reassurance in the fact that help sought outside of the College’s processes is completely



Dr. Micheal Howard-Tripp
Deputy Registrar

confidential and is not shared with the College.

As a component of the study physicians were asked how the complaints process could be improved. More than 80% of the respondents said that processes would improve with transparency, managerial competence, capacity to claim lost earnings, and action against vexatious complaints. The length of time taken to resolve a complaint also increased the odds of ‘hedging’ and 38% of physicians who had had a complaint, recently or in the past, reported feeling bullied during the investigation.

The College is obliged to investigate all complaints against physicians and is continually striving to improve the processes through which this is achieved. Some changes in the way complaints are handled by the College have already been effected and feedback from both the public and physicians is welcomed.

1. Bourne T, Wynants L, Peters M, et al. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. *BMJ Open* 2015;4:e006687. doi:10.1136/bmjopen-2014-006687

the Physician Health Program

**STRESS
IS
INEVITABLE**

Did you know the most common reasons physicians and their families contacted the **Physician Health Program (PHP)** in 2014 were:

- Mental health issues – 48.4 %
- Occupational – 20.2 %
- Family/Relational – 15.4%
- Addiction – 13.8
- Physical/Cognitive/Medical – 2.1%

Traditionally, physicians in need of care felt guilty about accepting care and ashamed for needing it. We are working hard to challenge this perception in the medical profession.

The PHP is a confidential program of the SMA offering assessment, treatment, monitoring, counselling, coaching, advocacy, support and referral to community resources. Medical students, residents, physicians, retired physicians, spouses and family members can access the program for assistance. The majority of those accessing the program in 2014 were self-referred (63.4%).

Of those who contacted the PHP in 2014:

- 49 % were physicians
- 14 % were medical students
- 21 % were residents
- 6.5 % were spouses
- 6.5 % were family members and
- 3 % were the general public

The PHP also supports wellness initiatives for medical students and residents which focus on stress management, sense of community, communication, leisure/recreation activities and good nutrition. We strive to support and assist in a preventative manner by providing educational sessions to learners and physicians upon request.

STRUGGLING IS OPTIONAL

If you are in need of assistance, want more information or would like to refer someone to the PHP, please contact:

Brenda Senger

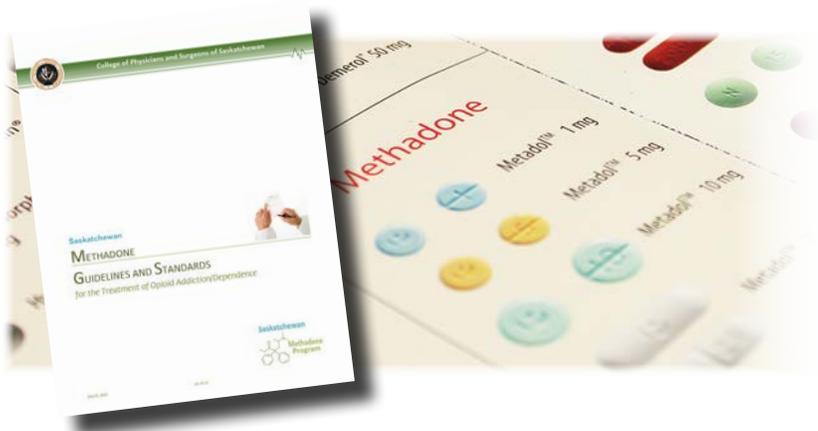
Director, Physician Support Programs

Saskatchewan Medical Association

306-244-2196 or by email at brenda@sma.sk.ca



The Methadone Program



New Methadone Guidelines

The CPSS Opioid Advisory Committee has published a new version of the Saskatchewan Methadone Guidelines and Standards. A link to the new guidelines can be found at cps.sk.ca.

Contact us at **306-667-4640** or at prp@cps.sk.ca with your questions!

Saskatchewan METHADONE AND SUBOXONE OPIOID SUBSTITUTION THERAPY CONFERENCE

Thirst for Resources on Opioid Substitution Therapy made obvious by CPSS conference success

More than 175 health care workers, including physicians, pharmacists, nurses and counselors attended an educational conference on methadone organized in April by the Opioid Advisory Committee and the CPSS Methadone Program.

The conference was part of an effort to educate and provide valuable information to health care workers in the field of addiction. Experts from around the province, including physicians, psychiatrists and grassroots workers, shared their knowledge and experience.

“The level of interest for this conference shows an obvious demand. We have had to turn people away,” said Dr. Peter Butt, chairman of the Opioid Advisory Committee. “This conference is very much about providing services to people in need across the province.



Above: Dr. Peter Butt speaks to a full house during a Q & A session on Methadone and Suboxone Opioid Substitution Therapy.

Treatment can work; people can have productive lives if we provide an appropriate level of service.”

“The College has adopted an educational approach in ensuring that Saskatchewan residents receive quality care of the highest standards. It is important to provide information, resources and an opportunity for physicians and addiction workers from across the province to network, share and find support

from colleagues in related fields to achieve these standards,” said Dr. Karen Shaw, Registrar for the College of Physicians and Surgeons of Saskatchewan.

The conference is also an integral part of the education program required for physicians to obtain exemption from the Government in order to prescribe methadone.



Dr. Dennis A. **Kendel** *Distinguished* Service Award



Dr. Albritton, 2014 recipient

Our 2014 Laureate

Congratulations to Dr. William L. Albritton of Saskatoon who was presented with the Dr. Dennis A. Kendel Distinguished Service Award for 2014 for his outstanding contributions to physician leadership and to physician engagement in quality improvements in health care in Saskatchewan. As one nomination letter affirms, "Serving others and putting their needs ahead of one's own is one of the integral components of effective leadership, as expanded in the servant leadership model. Bill has worked tirelessly for advancing our College, medical community and healthcare, even at personal cost. He truly worked selflessly. (...) He (...) believes in the concept of mutually valued relationships and worked hard to engage physicians, learners and different stakeholders to move forward towards the vision of the College and ultimately high quality healthcare." Dr. Albritton was presented with this prestigious award during a special banquet organized by the Council of the College of Physicians and Surgeons of Saskatchewan in November 2014.

ing our College, medical community and healthcare, even at personal cost. He truly worked selflessly. (...) He (...) believes in the concept of mutually valued relationships and worked hard to engage physicians, learners and different stakeholders to move forward towards the vision of the College and ultimately high quality healthcare." Dr. Albritton was presented with this prestigious award during a special banquet organized by the Council of the College of Physicians and Surgeons of Saskatchewan in November 2014.

Who will be the 2015 recipient?

Do you know an individual (or group of individuals) who has made outstanding contributions in Saskatchewan to physician leadership and/or to physician engagement in quality improvements in healthcare?

Consider nominating them for the **Dr. Dennis A. Kendel Distinguished Service Award!**

Nomination packages are available on the College website or by contacting Sue Robinson at

OfficeOfTheRegistrar@cps.sk.ca

Nominations are accepted until 30 August, 2015.

The Dr. Dennis A. Kendel Distinguished Service Award was named in honour of Dr. Dennis Kendel, who retired in 2011 after a long career as Registrar of the College of Physicians and Surgeons of Saskatchewan.

And more congratulations!

New Accredited Physician Leaders

The College of Physicians and Surgeons of Saskatchewan would like to congratulate the following individuals from Saskatchewan for having completed the requirements for the Canadian Certified Physician Executive accreditation.

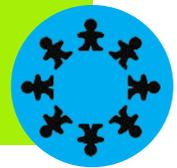
They are a part of the new cohort of accredited physician leaders honored by the Canadian Society of Physician Executives and the Canadian Medical Association at the leadership convention on April 24th, 2015 in Vancouver.

Dr. Karen Shaw, CPSS Registrar

Dr. David Stoll, formerly of Mamawetan Churchill Health Region

Dr. David Torr, Regina Qu'Appelle Health Region

Dr. Robert Weiler, Saskatoon Health Region



Congratulations to the newly elected members of Council!

At its January 2015 meeting, Council welcomed a few new faces around the table, as illustrated in the table below.

Council elected Dr. Grant Stoneham to the position of president, with Dr. Pierre Hanekom to remain as vice-president.

Executive Committee 2014-2015

Member	Position
STONEHAM, GRANT	President
HANEKOM, PIERRE	Vice President
BEGGS, ALAN	Member-at-large
CHAPELSKI, MARK	Member-at-large
HALLAND, SUSAN	Member-at-large

Council 2014-2015

Member	Position	Location	Regional Health Authority
BEGGS, ALAN*	Physician Member	Regina	Regina Qu Appelle Health Region
CARTER, JAMES	Physician Member	Regina	Regina Qu Appelle Health Region
CHAPELSKI, MARK	Physician Member	Lloydminster	Prairie North Health Region
DE LA GORGENDIERE, MARCEL	Public Member	Saskatoon	Saskatoon Health Region
GLAESKE, DANIEL	Physician Member	Assiniboia	Five Hills Health Region
HALLAND, SUSAN	Public Member	Air Ronge	
HANEKOM, PIERRE*	Vice President	Melfort	Kelsey Trail Health Region
HARDER, RON	Public Member	Moose Jaw	
KASSETT, SURESH*	Physician Member	Herbert	Cypress Health Region
KEAVENEY, LYNDA*	Physician Member	Kindersley	Heartland Health Region
MALHOTRA, TILAK*	Physician Member	Prince Albert	Prince Albert Parkland Health Region
ODUNTAN, OLUWOLE	Physician Member	Yorkton	Sunrise Health Region
SMITH, KEN	Public Member	Saskatoon	
SMITH, PRESTON	College of Medicine Representative	Saskatoon	Saskatoon Health Region
STAKIW, JULIE*	Physician Member	Saskatoon	Saskatoon Health Region
STONEHAM, GRANT	President	Saskatoon	Saskatoon Health Region
SUCHORAB, JESSICA*	Student Representative		
TSOI, EDWARD	Physician Member	Estevan	Sun Country Health Region

* Indicates a new or re-elected member.

ARE YOU INTERESTED IN SERVING AS MEMBER OF COUNCIL?

If you would like information on the commitment required to be a Councilor, or the requirements to run for next election, please contact Sue Robinson at

sue.robinson@cps.sk.ca

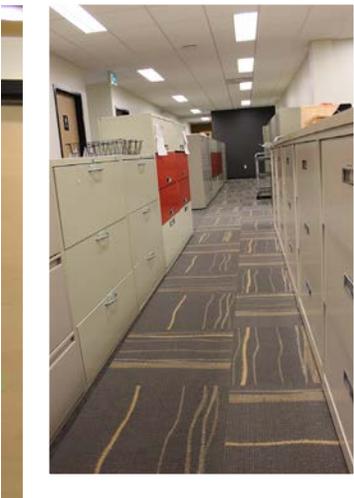
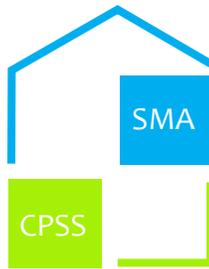
Our New Home

On Airport Drive

The College and its Council have now joined the Saskatchewan Medical Association (SMA) at our beautiful new shared home at

101-2174 Airport Drive
in Saskatoon.

Newly located in modern facilities with state-of-the-art equipment, multiple meeting rooms with ample space, free guest parking and room to grow, the College will now have the necessary resources to answer the needs of its membership in a timely fashion and to better fulfill its mission in serving the public by regulating the practice of medicine and guiding the profession to achieve the highest standards of care.



Annual General Meeting & Educational Session



College of Physicians and Surgeons of Saskatchewan

*To serve the public by regulating
the practice of medicine
and guiding the profession to achieve
the highest standards of care.*

Admission Free

RSVP by June 15, 2015 to
sue.robinson@cps.sk.ca
or (306) 667-4625

**Saturday 20 June, 2015
12:00 pm. to 5:00 pm
St. Paul's Hospital Auditorium**

- 12:00 Welcome and Introductions
- 12:05 Communication Tools and Situational Awareness
Dr. Neil Cowie
- 13:35 Questions/Discussion
- 14:05 Professional Boundaries
*Ms. Brenda Senger,
Director, Physician Support Programs*
- 14:50 Questions/Discussion
- 15:05 Annual General Meeting
- 15:35 Coffee Break
- 16:00 Disclosure of Patient Health Information
Physician-Assisted Death—Update
Mr. Bryan Salte
- 16:35 Questions/Discussion
- 16:50 Closing Remarks and Adjournment

Communication Tools and Situational Awareness

- Identify reasons why a team approach to patient care is important to patient safety;
- Demonstrate ways in which structured communication such as SBAR, Closing the Loop and Read-Back becomes useful in acute care;
- Implement assessment skills such as situational awareness, cross monitoring, and mutual support in your own practice in acute care;
- Identify barriers that prevent teams from achieving situational awareness and prevent individuals from being able to share their mental model with the team;
- Demonstrate ways in which transitions in patient care can fail, and identify skills that would enhance the receiver's understanding during patient handover.

Professional Boundaries

- Increase understanding of the need for boundaries in order to prevent the exploitation of patients;
- Stimulate thought and discussion around appropriate boundaries in various situations encountered in practice;
- Increase awareness of the vulnerabilities of patients and doctors which may lead to boundary violations;
- Develop appropriate awareness of our personal needs and recognition of warning signs in order to prevent exploitation.



Educational Session broadcast over the Saskatchewan Telehealth network.

Disclosure of Patient Health Information

- Demonstrate a general understanding of the circumstances in which patient consent is not required to disclose patient health information without the consent of the patient;
- Describe four common situations in which physicians are permitted to disclose patient health information without the consent of the patient;
- Describe four common situations in which physicians are required to disclose patient health information without the consent of the patient.

Physician Assisted Death

- Identify the legal situation for physician assisted death in February, 2016 if the Government of Canada does not pass legislation to address the issue;
- Identify two policy choices for the College of Physicians and Surgeons in addressing physician assisted death.



Saskatchewan Immune Globulin (IVIG) Optimization Program

By: Dr. Donna Leddingham

Introduction

Saskatchewan is one of the highest per capita users of IVIG across the nation. Provincial IVIG use has grown by 22.2% since 2009 (see figure below for two largest health regions). IVIG represents the single largest line item in the Canadian Blood Services budget.

Approved Use

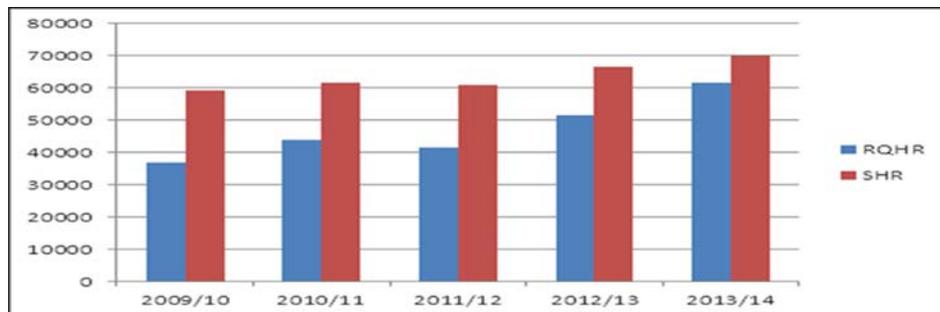
Intravenous immune globulin (IVIG) is licensed in Canada for the treatment of six medical conditions, including primary and secondary immunodeficiency diseases as well as immune thrombocytopenia (ITP) and Chronic Inflammatory Demyelinating Polyneuropathy (CIDP).

Product Availability

As IVIG is derived from human plasma processed outside of Canada, it is subject to periodic shortages and carries the risk of adverse events. There was a threat of a serious shortage in spring 2015 due to recalls.

SK IVIG Rapid Process Improvement Workshop (RPIW)

Due to the increased usage, potential shortages and risk of adverse events, a Rapid Process Improvement Workshop (RPIW) was conducted to develop a provincial plan to understand and monitor the use of IVIG in Saskatchewan. The RPIW goal was to promote appropriate, efficient and safe use of IVIG and to minimize product waste. The program is intended to be "Patient First" and practitioner-friendly.

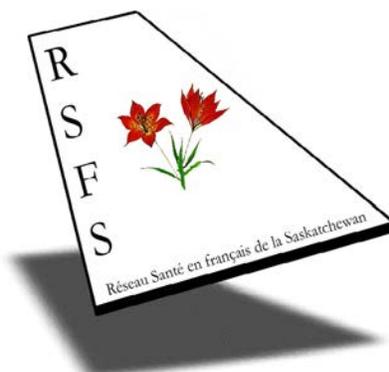


Do you speak some French?

Call for French-speaking Health Professionals Registry

In partnership with the College of Medicine, Department of Community Health & Epidemiology, the Saskatchewan Network for Health Services in French/ Réseau Santé en Français de la Saskatchewan (RSFS) is in the process of updating the directory of health professionals who are willing to speak at least some French when providing health services in Saskatchewan.

We are also seeking to add professionals who are new to the province, recently graduated or simply newly interested. Professionals are added to the directory on a volunteer basis and there are no legal obligations associated with being listed.



If you would like more information or are willing to be listed please contact

Katie Pospiech at

katie.pospiech@usask.ca
or (306) 966-1270

An Opioid-Related Death in a Small Community Hospital

* Reprinted with permission from the Institute for Safe Medication Practices Canada (ISMP Canada).

Pain management is a complex process that can involve a number of pharmacologic treatment modalities, including traditional pain medications (e.g., non-opioids and opioids) and adjunctive pharmacotherapy (e.g., anticonvulsants, antidepressants). Choosing an appropriate starting dose for an opioid, titrating opioid doses, using more than one opioid, and converting from one opioid to another are all elements of pain management wherein errors can lead to significant harm. This bulletin shares findings and recommendations from an ISMP Canada review of an unexpected death that occurred after admission to a small community hospital for management of acute pain. The system vulnerabilities identified during this analysis likely exist in other facilities, and all those affected by this case sincerely hope that the learning shared here will lead to system improvements in hospitals across Canada.

Incident Description

A woman was admitted to hospital for management of pain. Five years earlier, she had undergone back surgery for chronic pain, and her condition was reported to have improved until an injury occurred about 2 months before the hospital admission.

According to available prescription records, opioid medication had been prescribed for previous injuries, and it was believed that the patient was taking about 4 tablets of an oxycodone–acetaminophen combination tablet daily before this most recent injury. The combination tablet had been taken more frequently subsequent to the injury, and hydromorphone in both immediate-release (IR) and controlled-release (CR) formulations had also been trialed to address the patient's uncontrolled pain.

The most recent prescriptions, written and dispensed 1 week before the admission, were for CR oxycodone and IR hydromorphone. However, at the time of admission, the patient described use of

CR oxycodone only. Opioid usage for the week before admission is detailed in Figure 1. Other medications being taken just before admission included metformin, glyburide, irbesartan, and amitriptyline. After admission, the patient continued taking CR oxycodone, and several other pain medications (including fentanyl patch) were initiated, as shown in Figure 2.

On the evening of Day 14, the fentanyl dose was increased. Overnight, the patient did not sleep well and was awake for part of the night. On the morning of Day 15, she was left to sleep and was not awakened for breakfast or for usual medication administration. She was found with vital signs absent at about 11 am. Resuscitative efforts were unsuccessful.

The cause of death was determined to be “mixed drug toxicity” on the basis of autopsy and toxicology findings. This determination of mixed drug toxicity takes into

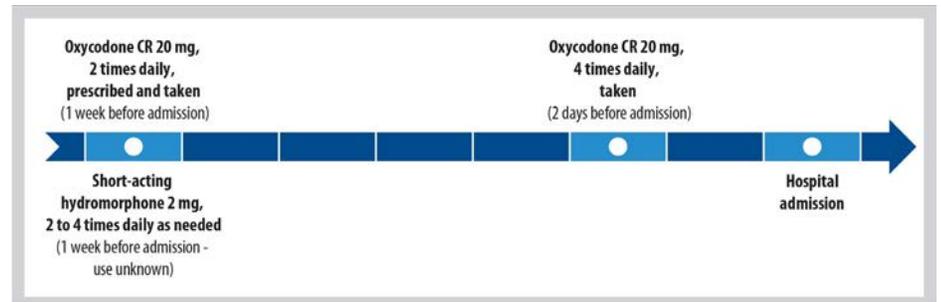
consideration the toxicological findings and the combined effects of several of the medications detected post mortem.

ISMP Canada's Findings

An interdisciplinary review identified several system-based vulnerabilities and factors potentially contributing to the patient's death. Key opportunities to prevent future deaths were thought to be related to the overall approach to pain management, including opioid selection, dose conversion and titration, and monitoring of symptoms and adverse effects. These opportunities, along with other selected factors, are highlighted in [ISMP Canada Safety Bulletin - Volume 14, Issue 10 - December 2014]. For the remainder of the article, see the following link:

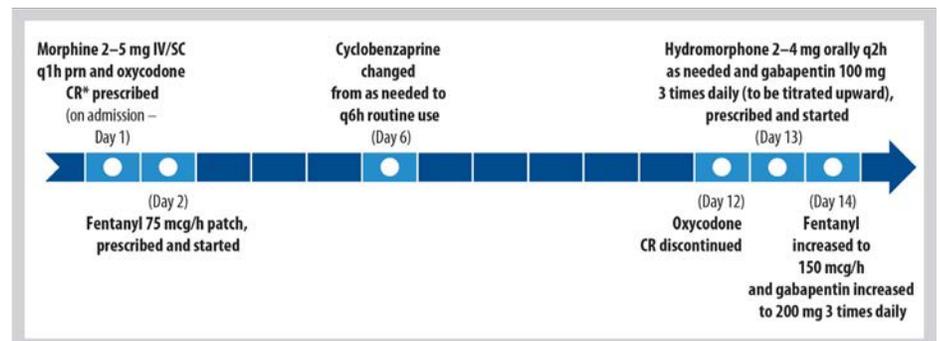
http://ismp-canada.org/download/safetyBulletins/2014/ISMPCSB2014-10_AnOpioidRelatedDeath.pdf

Figure 1. Timeline of known opioid use in the week leading up to hospital admission (according to available prescription records).



CR = controlled-release

Figure 2. Timeline of use of opioids and other regularly scheduled adjunct medications during the hospital admission



*the daily dose of CR oxycodone varied from 40 to 80 mg until it was discontinued on Day 12
IV = intravenously; SC = subcutaneously

Nurse Practitioners Now Prescribing Controlled Drugs and Substances

Submitted by: *The Saskatchewan Registered Nurses Association and the Saskatchewan Pharmacy Association*

Nurse practitioners are registered nurses with advanced knowledge, skills and education that enables them to provide leadership in health promotion and health management.

On January 13, 2015, the Saskatchewan Registered Nurses' Association (SRNA) announced that Registered Nurses (Nurse Practitioners) [RN(NP)] can now prescribe Controlled Drugs and Substances to patients in Saskatchewan.

SRNA states that this new authority and scope gives people living in Saskatchewan greater access to timely health care and a range of continuous services from RN(NP)s. As of January 13, 2015, all RN(NP)s licensed to practice in Saskatchewan will have completed education to prepare them to prescribe controlled drugs and substances.

History

In November 2012, the New Classes of Practitioners Regulations (NCPR) under Canada's Controlled Drug and Substances

Act (CDSA) was passed. This change at the federal level expanded the prescriptive authority of nurse practitioners to include, with some exceptions, medications that fell under the CDSA. In accordance with the legislation, the SRNA is responsible for the development, implementation, enforcement, and evaluation of regulations, standards and competencies to guide RN(NP) prescribing under the NCPR(2012).

Collaboration with Health Care Team

In addition to setting education standards on Controlled Substances, the SRNA acknowledges the best practice of accessing the Pharmaceutical Information Program (PIP) to verify a patient's medication history, when prescribing a monitored drug. The SRNA, as the registered nurse regulatory authority, will continue to fulfill its mandate to protect the public by regulating RN(NP)s to provide safe care. The SRNA ensures that all RNs and RN(NP)s protect the public by providing and improving health care services in col-

laboration with clients, other members of the health care team, stakeholders and policy makers.

Some Prescribing Limitations

There are some prescribing limits for RN(NP)s on Controlled Substances. At this time, RN(NP)s do not have the authority to prescribe methadone, buprenorphine or medical marijuana. In addition, testosterone (oral and intramuscular routes) is the only anabolic steroid that RN(NP)s are authorized to prescribe.

Please refer to the following documents for the list of controlled drugs and substances RN(NP)s are authorized to prescribe and other related information.

- [SRNA's FAQs*](#)
- [SRNA's RN\(NP\) Controlled Drugs and Substances Practice Guidelines*](#)
- [SRNA's January 13, 2015 News Release*](#)

**article source documents*



SASKATCHEWAN
COLLEGE OF
PHARMACISTS

SASKATCHEWAN
RN
ASSOCIATION



As part of

National Immunization Awareness Week (NIAW)

the Public Health Agency of Canada has developed new products to promote vaccination:

English:

- Boost your power. Get vaccinated. (Poster)
- Vaccines work - Infographic (Poster)

French:

- Renforcez Votre Puissance - Fates-Vous Vacciner (Affiche)
- Les Vaccins fonctionnent - Infographique (Affiche)

Print-ready versions of the posters are available online (8.5" x 11") and bilingual hard copies (11" x 17") may be ordered.

To find more information and access the products, visit:

English:

<http://healthycanadians.gc.ca/healthy-living-vie-saine/immunization-immunisation/material-materiel/index-eng.php>

French:

<http://canadiensensante.gc.ca/healthy-living-vie-saine/immunization-immunisation/material-materiel/index-fra.php>

Ordering information:

The posters for NIAW are available for order directly from the website or by contacting Health Canada's Distribution Centre:

Email: publications@hc-sc.gc.ca

Telephone: 613-957-2991

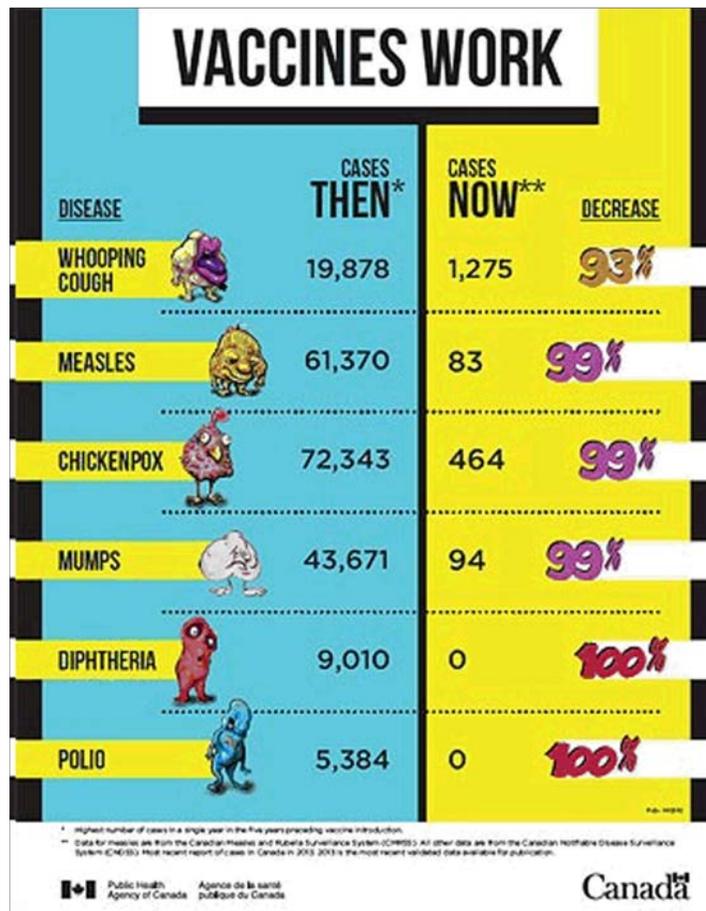
Toll free: 1-866-225-0709

Facsimile: 613-941-5366

Teletypewriter: 1-800-465-7735 (Service Canada)

CAMPAIGN RESOURCES :

<http://immunize.ca/en/events/niaw.aspx>





We're Working for You



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Registrar
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Associate Registrar/Legal Counsel
Director of Physician Registration Services

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E-mail

5 Research Drive, Regina, SK S4S 0A4
1 (306) 787-8239
cpssinfo@cps.sk.ca

Prescription Review Program (PRP) and Methadone Program

Direct line
E-mail

1 (306) 667-4640
prp@cps.sk.ca

Registration Services

Telephone
Assessment/Supervision
Registration Inquiries
Corporate Inquiries
Certificate of Professional
Conduct/Good Standing

1 (306) 244-7355
cpssreg-assess@cps.sk.ca
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OUR NEW LOCATION:

