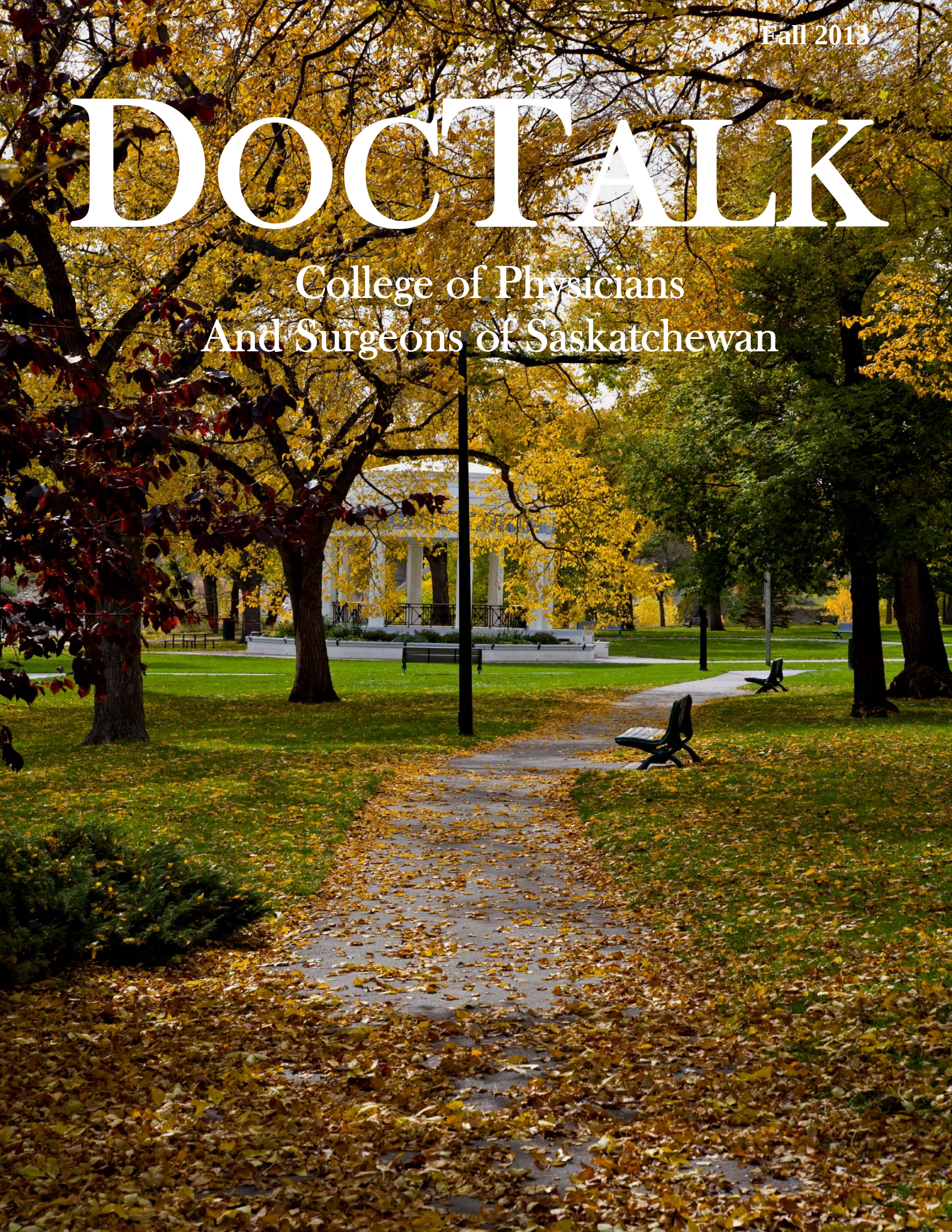
Fall 2013

DocTalk

College of Physicians
And Surgeons of Saskatchewan



IN THIS ISSUE

Executive Committee

Dr. Mark Chapelski, President
Dr. Pierre Hanekom, Vice President
Dr. Suresh Kassett, Member at large
Mr. Graeme Mitchell, Member at large
Dr. Grant Stoneham, Member at large

Council Members

Ms. Joanna Alexander, Regina – Public Member
Dr. Alan Beggs, Regina – Orthopedic Surgery
Dr. James Carter, Regina – General Surgery
Dr. Mark Chapelski, Lloydminster – Family Medicine
Mr. Marcel de la Gorgendiere, QC, Saskatoon – Public Member
Dr. Daniel Glaeske, Assiniboia—General Practice
Mr. Drew Hager – Observer SMSS
Ms. Susan Halland, Air Ronge – Public Member
Dr. Pierre Hanekom, Melfort – General Practice
Mr. Ron Harder, Moose Jaw – Public Member
Dr. Dan Johnson, Kindersley – Family Medicine
Dr. Suresh Kassett, Herbert – General Practice
Dr. Tilak Malhotra, Prince Albert – Pediatrics
Mr. Graeme Mitchell, Regina – Public Member
Dr. Andries Muller, Saskatoon – Family Medicine
Dr. Oluwole Oduntan, Yorkton – General Practice
Dr. Olufemi Olatunbosun, Saskatoon - College of Medicine, Designate
Dr. Grant Stoneham, Saskatoon – Diagnostic Radiology
Dr. Edward Tsoi, Estevan – Family Medicine

From the President, Dr. Mark Chapelski

FAXING PATIENT INFORMATION

The College has been involved in several situations recently when FAXES containing patient information were sent to incorrect FAX numbers. In one recent situation, the College published an incorrect FAX number for a physician. Despite corrections out to everyone who subscribed to the College mailing list, FAXES continued to be sent to the incorrect FAX number.

The Provincial Laboratory has attempted to confirm the FAX numbers for physicians who order laboratory tests for their patients. A number of physicians only include their name on the laboratory requisitions and not their contact information, including their FAX number. Some of the physicians who have been contacted by the provincial laboratory have not responded to requests to confirm their FAX numbers. That may compromise the ability of the Provincial Laboratory to distribute test results in a timely manner, and poses an additional risk of the information being sent to the wrong FAX number.

One of the obligations of trustees under *The Health Information Protection Act* is the obligation to take steps to protect against unauthorized disclosure of patient health information. The *Code of Ethics* requires physicians to "Protect the personal health information of your patients." Saskatchewan's Information and Privacy Commissioner is very concerned about the instances of FAXES with personal health information that have gone astray.

The document produced by Saskatchewan's Information and Privacy Commissioner – *Checklists for Trustees – Misdirected Faxes* – is reproduced in this Newsletter. It describes some practical suggestions for physicians and physicians' clinics to deal with FAXES that are either incorrectly sent, or incorrectly received. The Commissioner previously published a document - *Helpful Tips - Privacy Considerations: Faxing Personal Information and Personal Health Information* which is available at the website http://www.oipc.sk.ca/resources.htm. That document provides some practical suggestions for ways that physicians and physicians' clinics can reduce the possibility of FAXES being sent to the wrong number.

I encourage physicians to read these two documents, and to provide them to all staff members who either send or receive FAXES.

Car seat installation can be a complicated process.

The correct car seat for a child's size and weight as well as proper installation goes a long way in ensuring the child's safety.

Contact SGI Traffic Safety Promotion for educational pamphlets and car seat check information for patients at 306-775-6042 or trafficsafety@sgi.sk.ca

-Eva Bissonnette

From the Registrar, Dr. Karen Shaw

ATTENTION TO DETAIL

The College of Physicians and Surgeons requires Saskatchewan-licensed physicians to demonstrate their commitment to continued competence by participating in either the CFPC's MainPro program or the Royal College of Physicians and Surgeons' Maintenance of Certification program. The purpose of revalidation is to reaffirm that physicians' competence and performance are maintained in accordance with professional standards.

The Council of the College has recently reviewed a number of physicians who incorrectly attested that they were enrolled in MainPro or Maintenance of certification when they renewed their licences.

The Council expressed its disappointment at the lack of care and attention which led these physicians to incorrectly attest their participation. Attestations must be taken very seriously and if physicians are uncertain as to what they are attesting to, they should further clarify before completing the attestation.

Although Council determined it would not take further formal action against the physicians who had provided the incorrect attestations, it directed the Registrar to meet with those physicians who failed to meet the requirements for continuing professional development as per either the CFPC's MainPro program or the Royal College of Physicians and Surgeons' Maintenance of certification program prior to the 2014 renewal cycle.

Council further determined it will not allow physicians who do not meet the revalidation requirements at the time of the renewal cycle to renew their licences.

As we enter into the 2014 renewal cycle, physicians will need to pay attention to the questions required at the time of annual online renewal. If there is any uncertainty as to how you should answer the questions you are encouraged to call the College for further clarification.

Physicians should review the Bylaw with respect to revalidation. Physicians need to ensure that they are enrolled in one or the other of the programs, accurately report their cycle date and if the cycle changes for any reason, notify the College of Physicians and Surgeons immediately. They must also fulfill the requirements of the program they have chosen for their continuing professional development.

Some physicians have found themselves off-side with the bylaw because they failed to enroll or failed to maintain enrollment in the program due to neglecting to provide timely payment to the CFPC or the RCPSC Programs.

The relevant bylaw for revalidation is as follows:

5.1 Standards for Continuing Education and Maintenance of Membership

(a) In this bylaw:

(i) the term "Mainpro" means the program of Continuing Medical Education which the College of Family Physicians of Canada may require from time to time of its members as a condition of maintaining certification with the College of Family Physicians of Canada. The program, at the date of implementation of this bylaw, is called "Mainpro". If the name or requirements of that program shall change, the requirements of this bylaw will continue to apply to physicians licensed in Saskatchewan, despite a change in the name or requirements;

(ii) the term "Maintenance of Certification" means the program of Continuing Medical Education which the Royal College of Physicians and Surgeons of Canada may require from time to time of its members as a condition of maintaining fellowship with the Royal College of Physicians and Surgeons of Canada. The program, at the date of this bylaw, is called "Maintenance of Certification". If the name or requirements of that program shall change, the requirements of this bylaw will continue to apply to physicians licensed in Saskatchewan, despite a change in the name or requirements.

(b) All licences to practise as a regular member - active, as a provisional member - active, as a special member, or a senior life member - active expire on November 30, next following the date of issuance of the licence.

(c) This bylaw shall apply to all physicians who have been granted a licence to practise as a regular member – active, as a provisional member – active, as a special member, or a senior life member-active, whether such physician is, or is not, a certificant, member or fellow of either CFPC or RCPSC.

(d) In order to renew a licence to practise as a regular member – active, as a provisional member – active, as a special member, or a senior life member – active, a physician shall:

(i) provide a statement to the College of Physicians and Surgeons that the physician is enrolled in either Mainpro or Maintenance of Certification;

(ii) if the physician is enrolled in Mainpro, provide a statement of the date established by CFPC for the physician to meet the requirements of Mainpro;

(iii)if a physician has reached the date established by CFPC for the physician to meet the requirements of Mainpro, or the date established by RCPSC for the physician to meet the requirements of Maintenance of Certification, provide proof to the satisfaction of the Registrar that the physician has met the requirements of Mainpro or Maintenance of Certification, as the case may be;

(iv) if CFPC has established a date for a physician to meet the requirements of Mainpro, or the RCPSC has established a date for a physician to meet the requirements of Maintenance of Certification, and a new date is subsequently set by CFPC or RCPSC, the physician shall provide proof to the satisfaction of the Registrar that the physician, at the originally established date, met the requirements of Mainpro or Maintenance of Certification, as the case may be;

(v) an original certificate from CFPC or RCPSC, as the case may be, that the physician has met the requirements of Mainpro or Maintenance of Certification shall be acceptable proof that the physician has met the requirements.

(e) A physician may apply to the Registrar for:

(i) an exemption from the requirements of this bylaw; or

(ii) a direction that the physician's licence be renewed, notwithstanding the failure of the physician to meet the requirements of this bylaw.

(f) The Registrar may require a physician making such a request to provide such information or documentation as the Registrar may specify, and may refuse to consider the application until such information or documentation is provided.

(g) The Registrar may, in the exercise of the Registrar's discretion, grant or refuse a physician's request under this bylaw, or may grant the request subject to such terms and conditions as the Registrar may specify. In making a decision to grant, refuse, or grant subject to terms and conditions such a request, the Registrar may consider matters such as the following:

(i) the efforts of the physician to comply with the terms of the bylaw;

(ii) whether the physician is in substantial compliance with the terms of the bylaw;

(iii)the extent to which a physician is engaged in clinical practice;

(iv) whether the physician has applied to the CFPC or RCPSC for an extension of time to meet the Mainpro or Maintenance of Certification requirements, or for other relief with respect to the Mainpro or Maintenance of Certification requirements;

(v) if the physician has made such an application, the position of CFPC or RCPSC in response to the request;

(vi) any other matter that the Registrar may consider relevant to the request.

(h) The Registrar may, in granting such a request, include any or all of the following conditions:

(i) the physician will provide an undertaking in writing that the physician will meet such terms and conditions as may be required by the Registrar;

(ii) the physician will take such form of education or remediation as the Registrar may specify;

(iii)the physician will meet the requirements of Mainpro or Maintenance of Certification within such time as the Registrar may specify;

(iv) any other term or condition as the Registrar believes is consistent with the goals and objectives of this bylaw.

(i) If the Registrar imposes terms or conditions pursuant to paragraph 5.1(h), and a physician fails to meet those conditions, the Registrar may refuse to renew a physician's licence when the physician next requests a licence renewal.

(j) The Registrar shall not renew a physician's licence unless the physician meets the requirements of this bylaw.

(k) A decision made by the Registrar pursuant to paragraph 5.1 shall be subject to review by the Council in the same manner as provided in section 31.1 of the Act.

(l) Where a physician has been refused renewal of a licence pursuant to this bylaw, and where the physician thereafter meets the requirements of this bylaw, the physician may apply within one year to be re-registered and, upon payment of the fee and meeting the other requirements for renewal of licensure prescribed in the College bylaws, the physician's licence shall be restored.

Any physicians who have concerns about the revalidation requirements should contact the College immediately.

From the Associate Registrar and Legal Counsel, Bryan Salte

MEDICAL MARIHUANA

On June 19, 2013, the Government of Canada published new regulations which changed how patients are authorized to possess marihuana for medical purposes.

Under the previous system, physicians would complete a document which was provided to Health Canada. Health Canada would then decide whether to grant a patient an exemption to allow the patient to possess or grow marihuana. There were listed conditions for which a family physician could support a patient's use of marihuana. Other medical conditions required a specialist be involved in the decision to support a patient's use of medical marihuana.

The Canadian Medical Association, the College of Family Physicians of Canada, the Federation of Medical Regulatory Authorities of Canada and other organizations expressed serious concerns about the proposed regulations. Many organizations felt that the proposed regulations put physicians in the position of "gatekeeper" to decide whether to prescribe a substance for which there was insufficient information about risks, benefits, dosages, strengths, etc. to allow physicians to practice evidence-based medicine. Marihuana is a substance which is not subject to any of the regulatory controls which are required of all other drugs to become approved for medical use in Canada. Health Canada implemented the regulations despite those concerns.

The effect of the marihuana access regulations

1) Until March 31, 2014, patients who have been authorized by Health Canada to possess or grow marihuana continue to be able to possess or grow marihuana under the previous regulations.

2) Until March 31, 2014, physicians can complete renewal forms for patients who were previously authorized by Health Canada to possess marihuana for medical purposes. Those authorizations will expire, at the latest, on March 31, 2014. Health Canada will no longer accept renewal forms for patients after March 31, 2014.

3) The only form of authorization physicians can provide for new applicants is a "medical document" provided to the patient to obtain marihuana from a licensed producer. After March 31, 2014, the only form of authorization for existing users of medical marihuana will be a "medical document" provided to the patient.

4) Where physicians provide the "medical document" to the patient, the decision whether to authorize the patient to possess marihuana is solely that of the physician. There are no longer any categories of medical conditions for which it can be prescribed, nor any requirement to involve a specialist for any of the medical conditions for which it is prescribed.

5) The patient will then provide that "medical document" to a licensed producer. The licensed producer will ship the marihuana to the patient's address in accordance with the requirements of the regulations.

6) After March 31, 2014, Health Canada's only role will be licensing producers to grow and sell marihuana for medical purposes.

The College's concerns

The College is concerned about potential for abuse under this new system. The system does not permit the College to track the prescribing of marihuana, unlike what is available for drugs of possible abuse under the Prescription Review Program.

The College is concerned that physicians are being placed in a difficult position by being expected to make decisions whether to provide a "medical document" to patients when there is insufficient information available about risks, benefits, dosages, strengths, etc. to allow physicians to practise evidence-based medicine.

The College is concerned about potential conflicts of interests for physicians who are involved in authorizing the use of marihuana by patients.

The College's response

At its November 15 meeting, the Council will consider whether to adopt a bylaw which will regulate and set standards for prescribing of marihuana. Among the things which the Council will be asked to consider is:

1. Whether physicians who provide "medical documents" to patients should be required to maintain a log containing information about the "medical documents" which the physician issues.

2. If a log is required, should physicians be required to provide a copy of that log to the College?

3. Whether physicians who provide "medical documents" to patients should be required to have a written treatment agreement, similar to what is recommended for opiate patients.

4. Whether to impose a standard of care that physicians can only provide "medical documents" to patients for whom they are the primary treating physician for the condition for which the marihuana is authorized.

5. Whether to impose a standard of care that before a physician can provide a "medical document" to a patient, the physician must review the patient's medical history, review relevant records pertaining to the condition for which the marihuana is prescribed and conduct an appropriate physical examination.

6. Whether to impose a standard of care that in order to provide a "medical document" to a patient, the physician's medical record for the patient must state the diagnosis for which marihuana was authorized and contain a statement that in the physician's medical opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat the patient's medical condition.

7. Whether to impose a standard to limit possible conflict of interests by stating that the patient's examination cannot occur at a premises of a licensed producer or a location provided by or subsidized by a licensed producer.

8. Whether to impose a standard to limit possible conflict of interests by stating that physicians may not dispense marihuana to their patients.

9. Whether to impose a standard to limit possible conflict of interests by stating that physicians who provide "medical documents" may not hold a direct or indirect economic interest in a licensed producer.

Additional information and consultation opportunity

Health Canada maintains information about medical marihuana at its website http://www.hc-sc.gc.ca/dhp-mps/marihuana/index-eng.php. That includes general information about the program, information specific for physicians, including the form which can be used to provide "medical documents" http://www.hc-sc.gc.ca/dhp-mps/marihuana/info/med-eng.php and information pertaining to the effect of and use of cannabis and cannabinoids for medical purposes http://www.hc-sc.gc.ca/dhp-mps/marihuana/med/infoprof-eng.php Physicians who would like a copy of the draft College bylaw, or who would like to comment about the draft bylaw can email cpss@quadrant.net.

Managing Behaviours in Long-Term Care: Causes, Consequences and Solutions

November 18 and 19, 2013
TCU Place – Saskatoon, Saskatchewan

The overall objectives are to share learnings, evidence, best practices, and approaches to meet the needs of residents with responsive behaviours in LTC. This conference is for LTC care providers (including physicians), and LTC leaders.

Cost of Conference: $100.00 for one day or $200.00 for both days.

If you have any questions about the event, please contact Karen Turner at (306)683-3663 or e-mail karenturner@turnereventmanagement.com

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College Disciplinary Actions

The College reports discipline matters in the next issue of the Newsletter after the disciplinary action is complete. There have been three such matters since the last Newsletter report.

Dr. Amjad Ali

Dr. Ali entered guilty pleas to five charges related to prescribing of marihuana to two patients. The charges alleged that he had practised medicine while suspended, had overcharged the patients to complete their forms to allow them to renew their marihuana authorizations and that he provided one of the patients with his telephone numbers and encouraged the patient to refer individuals who were seeking authorization to possess marihuana for medical purposes to him.

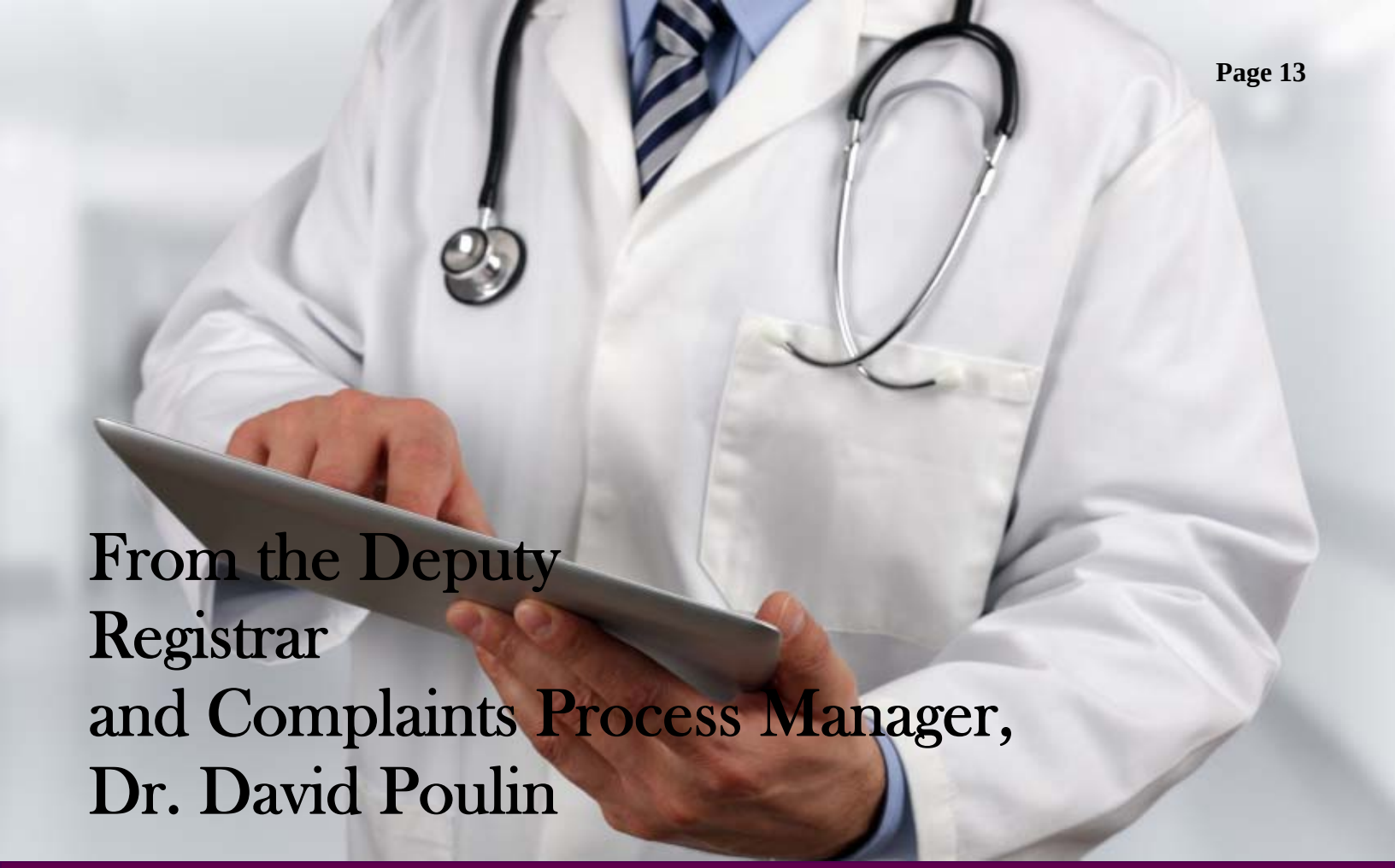
At the June, 2013 Council had revoked Dr. Ali's licence to practice on unrelated charges.

The Council imposed an indefinite suspension on Dr. Ali's ability to practice medicine.

Dr. George Miller

Dr. Miller admitted unprofessional conduct by conducting a breast examination on a female patient without obtaining informed consent for the examination.

The Council imposed a reprimand and a requirement that he pay costs of $781.15.



From the Deputy Registrar and Complaints Process Manager, Dr. David Poulin

Responding to Requests made by the College of Physicians and Surgeons of Saskatchewan for the Complaints Resolution Process

From time-to-time, the College of Physicians and Surgeons will request information from physicians. Information may be requested to address an informal or formal complaint received by a patient or a third party. Complaint resolutions are meant to be educational, to both the physician(s) and the complainant. This is the cornerstone of the professionally-led regulatory process. At the present time, matters addressed through the Complaints Resolution Advisory Committee process do not form part of the physician's College record and are not reported on a Certificate of Standing.

In order for College staff and the Complaints Resolution Advisory Committee to undertake a review of a complaint in a fair, thorough and transparent fashion, timely responses from the involved physician(s) are required. The regulatory bylaws of the College are clear that a reply to an information request must be received by the College within 14 working days of receipt of the request. In extenuating circumstances, a physician may request an extension for reasonable cause.

Most physicians respond to requests for information in a timely and professional manner. However, an increasing number of responses are taking longer than 14 working days; causing the entire Complaints Resolution Advisory Committee process to be delayed. Currently, the time for receipt of physician responses to information requests is averaging 30 days.

Failure to respond to repeated requests for information by the College will result in referral of the file to the Associate Registrar for consideration of disciplinary action for unprofessional conduct in accordance with sections 16.1 and 16.2 of the regulatory

bylaws. An excerpt of the bylaw is reproduced on the following page.

BYLAW – COMMUNICATION WITH THE COLLEGE

16.1 College requests for information

(a) The Registrar, the Deputy Registrar, the Executive Committee, the Council and the Standing Committees referred to in the bylaws of the College frequently request information and explanations from physicians. Prompt responses to such requests is required if the College is to expeditiously and effectively regulate the practice of medicine and comply with the objects of the Act.

16.2 Responses to College Requests for Information

(a) Upon receipt of a written request from the Registrar, the Deputy Registrar, the Executive Committee, the Council or a standing committee for information a physician shall:

(i) respond substantially to the request;
(ii) provide the information or explanation requested to the best of the physician's ability to do so;
(iii) provide originals of documents required, if originals are requested, or legible copies of documents if copies are requested;
(iv) provide a printed record if the requested information or documents are stored in an electronic computer storage form or similar form.

(b) A physician shall provide the requested information, as referred to in the paragraph (a) within 14 days of receipt of the request, or such additional time as may be granted by the Registrar or Deputy Registrar for the response.

(c) A physician who is requested to provide information to the College of Physicians and Surgeons or to any individual or committees associated with the College of Physicians and Surgeons under paragraph (a), or under any other provision of the Act or these bylaws relating to the provision of information and documents including, without limiting the generality of the foregoing, the Administrative bylaws

establishing the standing committees, 4.1, 16.1, 18.1, 19.1, 21.1, 22.1, or 25.1 of the bylaws and Section 55.3 of the Act, shall provide the information, explanation or documents contemplated by the request whether the consent of any person with an interest in the information, explanation or documents has, or has not, been sought or obtained.

(d) Information obtained pursuant to this paragraph or under any other provision of the Act or these bylaws relating to the provision of information and documents shall be treated confidentially and, unless otherwise directed by the Executive Committee, or the Council, shall not be used except for the purpose of complying with the objects of the Act or the duties of the committee or individual which obtains such information or documents.

(e) It is unbecoming, improper, unprofessional or discreditable conduct for a physician to fail to comply with paragraph 16.1 or 16.2.

Family Physicians who are interested in Immigrant and Refugee Health:
By: Navi Bal

My name is Navi Bal and I am currently a third year medical student. I am writing to you about the project **Students for Immigrant and Refugee Health (SIRH)**. Dr. Mahli Brindamour, Hadal El-Hadi and I are working on developing a match program for newcomer families to find physicians. As many of you are aware, the health of immigrants and refugees is poorer than the health of average Canadians, and developing over time, for many reasons.

We are looking for physicians to participate in the program by accepting a newcomer family as new patients. If you are interested and would like more information, you can contact me through e-mail at navi.bal@usask.ca.

Practical Management of Common Medical Problems Conference

November 15 – 16, 2013
Friday-Saturday

Saskatoon, Saskatchewan
Saskatoon Inn

Guest Speaker
G. Michael Allan MD CCFP
Associate Professor, Development of Family Medicine, University of Alberta
Director, Evidence & CPD Program, Alberta College of Family Physicians, Edmonton, Alberta

For more information (306)966-7787
www.usask.ca/cme

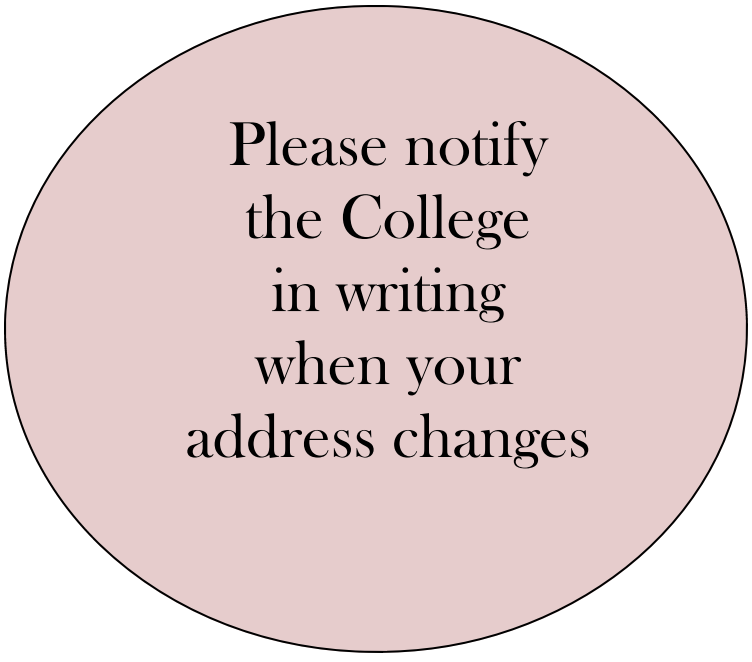
SUPPORT FOR REGISTERED HEALTHCARE PROFESSIONALS WHO CARE FOR CANCER PATIENTS AND THEIR FAMILIES

Dr. Karen Shaw

The College would like to bring to its members' attention an opportunity to enhance their cancer carers' skills. The Ontario Government created an oncology continuing education centre called de Souza Institute in 2008 to initially support nurses who cared for cancer patients and their families. Recognising that cancer care involves multi disciplinary healthcare teams de Souza Institute is now expanding its curriculum to all regulated healthcare professionals.

With courses outlining the latest standards and best practices, de Souza Institute is providing continuing education and support for specialized oncology and palliative care professionals and complex issues management whether it is administering chemotherapy, ensuring patient safety, managing anxiety or providing emotional support. These programs are now available to regulated healthcare professionals across Canada. Courses currently available to all Canadian registered healthcare professionals include advanced care planning, education in palliative and end of life care, psychosocial care education, sexual health and cancer, managing grief and loss, patient teaching and education, introduction to hospice palliative care and more……..

Interested physicians may check out these opportunities at www.desouzainstitute.com.



Vitamin D Testing is Necessary

By Susan Whiting, PhD

There has been an avalanche of vitamin D testing such that provinces have capped it. *Seems an unnecessary waste of healthcare dollars*. Why? What has happened to prevention initiatives? I will present some of the arguments that have been used for stopping testing and indicate why these are not strong enough reasons for doing so.

"People are low so why bother testing"

The rationale for Ontario to stop testing was finding almost everyone was low. Isn't that the point of testing? That, as a screening tool, the result motivates people to the next step, which is improvement in diet and/or taking a supplement.

Right now the scientific community is polarized into those who promote vitamin D recommendations of the Endocrine Society where a cut-off of 75 nmol/L is set for optimal health, or those agreeing with the Institute of Medicine/Health Canada [2] level of 50 nmol/L which has evidence as only being effective for bone health. See Table 1 for a comparison of intake

recommendations. Considering that Canadians who do not take a supplement get only ~ 200 IU of vitamin D in their diet, it is not surprising "everyone is low". However, telling Canadians to eat more foods containing vitamin D is nearly impossible and would entail ingestion of oily fish more than twice a week, lots of milk, eggs and meat, and selecting higher priced fortified foods.

"Testing is expensive"

What screening tools are not expensive, except perhaps a tape measure for waist girth? The argument, however, needs to be examined two ways. One, is that people really do not know sources of vitamin D, and therefore need testing as a way to determine risk. Two, is that the costs of testing will off-set both acute and chronic conditions that are, themselves, very costly.

Almost everyone knows that vitamin D can be made in the skin, but few realize that: it is not made in the 6 months of winter we have; it is not made in those who cover up, with long sleeves, long pants, head scarves etc; it is not easily made through sun screen and the recent article disputing this was a study of volunteers in Tenerife, Canary Islands where just a few minutes of the equatorial sun would cause some synthesis; it is not made through windows, or walls; and in Canadians with highly pigmented skin, it's as if there is no summer at all, as winter and summer values are similar. Sun safe messages have been effective in ruling out sun exposure as a source of vitamin D for many people. Thus many are deficient while following a healthy lifestyle.

"Vitamin D is just for bones"

In 2010 Grant et al. performed an evidence-based analysis of the Canadian situation for potential for economic benefit of improved vitamin D status in reducing economic burden of disease. They used newly released Canadian levels of 25-hydroxyvitamin D. Twenty-six percent of Canadians 6-79 years of age were below the IOM cut-off of 50 nmol/L; 65 % were below the Endocrine Society cut-off of 75 nmol/L. As many chronic disease and non-bone effects of vitamin D are seen at higher levels of 25-hydroxyvitamin D as it bone health alone, they used a cut-off of 100 nmol/L so that optimal health would be realized by almost all of the population. After accounting for cost of supplementation to 100 nmol/L, net savings of $14.5 billion was found.

"There are Dangers with Vitamin D supplementation"

In 2011 the Institute of Medicine increased the Upper Level for vitamin D to 4000 IU except for infants and young children. Concerns about safety had been overestimated in the past, in part to co-existence of excess vitamin A in many supplements and foods where vitamin D was found and intake was attributed to vitamin D alone. The Endocrine Society's UL levels are more in line with actual harm. And physicians should not fall victim to "more is better" or using inappropriately high doses of vitamin D. The use of 500,000 IU yearly for osteoporosis resulted in an increase in falls/fractures. Such as dose makes no physiologic sense, so caution is still needed. Testing for 25-hydroxyvitamin D levels would be beneficial for discovering and treating excessive use, just as testing can find out deficiency.

Table 1. Recommendations for Vitamin D, IU Per Day

Age/Sex Group	Endocrine Society 2011		Institute of Medicine/Health Canada 2011	
	Recommendation	Upper Level	RDA	Upper Level
0 – 6 mo	400-1000	2000	400	1000
6 – 12 mo	400-1000	2000	400	1500
1 – 3 y	600-1000	4000	600	2500
4 – 8 y	600-1000	4000	600	3000
9 – 18 y	600-1000	4000	600	4000
19 – 70 y	1500-2000	10,000	600	4000
> 70 y	1500-2000	10,000	800	4000

To convert to micrograms, divide IU values by 40.
 # includes pregnancy and lactation values
RDA = recommended dietary allowance

Valeant Canada – generic bupropion XL

On behalf of Valeant Canada, we would like to bring to your attention an important issue from the United States regarding generic bupropion XL-indicated for the treatment of major depressive disorder – and the proactive steps that our company has taken with Health Canada to help ensure that such a situation does not occur with Canadian patients.

As background, in the fall of 2012, the U.S. Food and Drug Admission (FDA) requested the voluntary recall of Budeprion XL 300 mg (Teva/Impax Pharmaceuticals) based on the results of a bioequivalence (BE) study that found that generic Budeprion XL 300 mg was not bioequivalent to Wellbutrin XL 300 mg. The FDA took the unprecedented steps of developing a BE study in a response to patient complaints concerning safety, ineffectiveness, or exacerbation of symptoms of depression with the 300 mg dose of Budeprion XL:

> "Between January 1 and June 30, 2007, FDA received 85 post-marketing reports in which patients who switched from Wellbutrin XL 300 mg to Teva's bupropion formulation (Budeprion XL 300 mg) experienced an undesirable effect. Specifically, in 78 of these cases, there was a reported loss of antidepressant effect following a switch from the branded to generic product. In addition to the loss of effect, a number of cases also reported the new onset or worsening of side effects. The reported side effects were consistent with the adverse effects of labeling for bupropion products. More than half of the patients who switched back to Wellbutrin XL 300 mg reported improvement of depression and/or abatement of side effects."

To protect patient well-being through ensuring the product's therapeutic equivalence, Valeant Canada has consulted with Canadian clinical and clinical-pharmacology experts and communicated our position to Health Canada with the following requests:

1. Ensure BE of generic bupropion XL products. Require BE studies, in both fed and fasted states, on each dosage of bupropion XL. BE standards should be estimated, not only for the parent product (bupropion), but also for its 3 active components that are metabolized (metabolites).

2. Safeguard patient safety: classify Bupropion in the "critical-dose" category, which is for drugs with narrow therapeutic index in which small differences in plasma concentration could lead to serious therapeutic failures and/or serious adverse drug reactions. The BE standards for this category should apply both to the parent product and to its 3 active metabolites.

The risk of therapeutic failure or increased adverse reactions (such as convulsions) in patients with depression are high and difficult to predict.

If you would like to discuss this matter, you can contact the following:

Doug Nanton
Market Access & Government Affairs
Western Canada & Ottawa
Valeant Canada

Maxime Barakat, MD, PhD
Executive Director, Medical & Regulatory Affairs
Valeant Canada

SENIOR LIFE MEMBERSHIP

Until Council recently changed College bylaws, a physician could only qualify for Senior Life membership if that physician had been fully licensed to practise in Saskatchewan for forty consecutive years. That excluded physicians who had been licensed on forms of licensure which were not "full" licences, and physicians who had a break in their Saskatchewan career and hence had not been licensed for forty consecutive years.

The Council has recently expanded eligibility significantly:

1. The period of forty years of practice in Saskatchewan does not need to be consecutive;
2. The period of forty years includes postgraduate training in Saskatchewan;
3. The period of forty years of licensure in Saskatchewan includes all forms of practising licences, including postgraduate educational licences, temporary, provisional and special licences;
4. The period of forty years includes postgraduate training taken outside of Saskatchewan if the physician first qualified to practise in Saskatchewan and then left the province to obtain postgraduate training to qualify in a specialty (it was a common career path in the past for physicians to take a rotating internship, practise as a family physician for a few years and they return to a residency program to qualify as a specialist);
5. The period of forty years includes service in the Canadian Armed Forces.

These changes mean that some physicians who were previously not eligible to receive a senior life designation are now eligible. One of the challenges for the College is that it is not possible for the College to identify all of the physicians who meet the criteria established by the new bylaw.

Senior Life members are honoured at Council's Christmas banquet and receive a Certificate of Merit and a wall plaque that was commissioned to commemorate the Province of Saskatchewan centenary. The painting depicts 100 years of medicine in the Province of Saskatchewan, from the past to the future, including elements of both western and aboriginal medicine. Inactive Senior Life members are entitled to inactive registration at no cost.

If you think that you meet the criteria for Senior Life membership as defined above please contact Sue Robinson at the College either by phone: 306-667 4625 or by email: sue.robinson@cps.sk.ca

Safe and Effective Use of Opioids for Chronic Non-cancer Pain Online Course

Description/Learning Objectives

This online course provides health care workers with evidence-based tools and recommendations from the *Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-cancer Pain*. This course will guide you through the Opioid Manager, a point-of-care tool that condenses key elements of the *Canadian Guideline* which you can use with your inter-professional team in clinical practice of primary care settings.

Target Audience

This course is open to health care providers collaborating in the treatment of patients with chronic non-cancer pain (e.g., physicians, pain specialists, addiction specialists, mental health clinicians, pharmacists, nurses, dentists, social workers, occupational therapists, physiotherapists, and psychologists).

Time/Date/Location

January 20 – February 7, 2014
At any location with a computer and an internet connection.

Accreditation

This course is held under the auspices of the office of Continuing Education and Professional Development, Faculty of Medicine, University of Toronto, and the Centre for Addiction and Mental Health (CAMH).

This course meets the accreditation criteria of:

- The College of Family Physicians of Canada – **12.0 Mainpro – M1 credits**;
- The Royal College of Physicians and Surgeons of Canada – **12.0 Section 1 credits**;
- The Canadian Addiction Counsellors Certification Federation (CACCF).

Register Here

January 20 – February 7, 2014 – Please click the link below to register for this date:
http://app.certain.com/profile/form/index.cfm?PKformID=0x1554543b640

Contact
Robyn Steidman
Education Assistant
Telephone: (416)535-8501 Ext. 6640
Fax: (416)595-6617
E-mail: robyn.steidman@camh.ca

WOULD YOU LIKE TO SERVE ON THE JMPRC?

The College is seeking expressions of interest from physicians who are willing to be appointed to the Joint Medical Professional Review Committee (JMPRC).

The JMPRC is a tribunal that is responsible to conduct reviews to determine whether physicians should be required to repay amounts billed to Medical Services Branch. If Medical Services Branch identifies significant concerns with a physician's billings, it can refer those concerns to the JMPRC for adjudication. The JMPRC will conduct a review, including interviewing the physician, and determine if the physician should be ordered to repay money to Medical Services Branch.

The JMPRC is established by regulations under *The Saskatchewan Medical Care Insurance Act*, which can be found at http://www.publications.gov.sk.ca/details.cfm?p=1436

Two members of the JMPRC are appointed by the Council of the College, two members are appointed by the SMA, and two members are appointed by the Minister of Health. The JMPRC operates independently of all three organizations. All of the members of the JMPRC are physicians.

The two physicians who CPSS appointed to the JMPRC are Dr. Werner Oberholzer and Dr. Brian Clapson. Dr. Oberholzer is the current Chair of the Committee and his maximum term of service has expired. The College needs to name a replacement for him. Dr. Clapson is currently serving in his second three-year term.

JMPRC members must be licensed Saskatchewan physicians who live in Saskatchewan or Lloydminster, and who practise in Saskatchewan. Members are appointed for a three year term, and can be reappointed for a second term.

The committee meets at least 10 times per year for two days on each occasion. There is a significant time involvement in attending the meetings and reading the material prepared for each meeting. Physicians are paid by the Government of Saskatchewan at the rate established by Government.

If you are interested in serving on this committee, please send your expression of interest to:

Sue Robinson, Executive Assistant to the Registrar at sue.robinson@cps.sk.ca by no later than Friday, November 8, 2013.

Checklists for Trustees: Misdirected Faxes

The use of a fax machine to send documents containing personal health information is a common practice in the health care sector and used for speed and convenience. However, trustees have a duty under *The Health Information Protection Act* (HIPA) to protect personal health information under their custody or control from unauthorized collections, uses and disclosures. Pursuant to section 16 of HIPA, trustees are required to have reasonable safeguards to protect personal health information including written policies and procedures when faxing.

A "misdirected fax" is a fax containing personal health information that is received by an individual without a need-to-know. This would result in an unauthorized disclosure of personal health information pursuant to section 27(1) of HIPA and a privacy breach. **NOTE: Even if a misdirected fax is received by another trustee, without a need-to-know it qualifies as a privacy breach.**

What to do if you receive a misdirected fax:

- Recognize that this is a significant matter with the need for some urgency to address both privacy implications and continuity of care for the subject individual.
- Determine if you have a need-to-know.
- Notify your privacy officer.
- Use the fax cover sheet or fax header to determine who the "sender trustee" is.
- Contact the sender trustee to advise of the breach so they can ensure continuity of care for the subject individual.
  - When possible, speak to the organization's privacy officer so that the incident can be logged and investigated and safeguards implemented if necessary to prevent similar occurrences.
- Discuss with the sender trustee how to contain the breach and what to do with the misdirected fax (eg. return by mail, secure destruction, etc.) When possible, give the sender trustee confirmation once the agreed upon action has been performed.
  - **Do not keep a copy of the misdirected fax.**
  - Do not attempt to forward the misdirected fax to the intended recipient as this could compound the breach. Leave that to the sender trustee.
- Consider notifying the Office of the information and Privacy Commissioner (OIPC) who has a legislated mandate to investigate privacy breaches and ensure they are properly managed. Factors to consider include:
  - Is the sender trustee identifiable?
  - Is the personal health information particularly sensitive?
  - Are there multiple faxes with apparent multiple sender trustees?
  - Is the problem recurring after proper steps have been taken to contain past occurrences?

  The OIPC will ask if you have first made attempts to contact the sender trustee and then ask that you mail in the personal health information (misdirected fax) with any relevant details to the office.

- You may also consider contacting your relevant college of professional association or the Ministry of Health for guidance. This may be beneficial in ensuring continuity of care. However, use caution to not compound the breach. Consider these bodies' mandates, need-to-know and disclosure provisions in HIPA before sharing personal health information of identifiable individuals.

What to do if you have sent a misdirected fax:

- Contact your organization's privacy officer for guidance and support. Also consult the OIPC resource Helpful Tips: Privacy Breach Guidelines.
- Contain the breach: Immediately contact the organization(s) to which the misdirected fax (es) has been sent.

- ◊ Confirm that the fax has been received.
- ◊ Explain that the fax contains personal health information and has been sent in error.
- ◊ If you have the original fax, ask the recipient if they have the capability to destroy the personal health information securely (eg. capability to shred in a cross-cut shredder). Ask for confirmation that destruction has occurred.
- ◊ Otherwise, ask that the recipient to return the personal health information by mail or send a courier for pick up.
- ◊ Request that the recipient not keep any copies of the personal health information. Ask for confirmation.
- ◊ Inform the recipient of the mandate and role of the OIPC should they have further concerns or questions.
- ◊ Document the conversation.

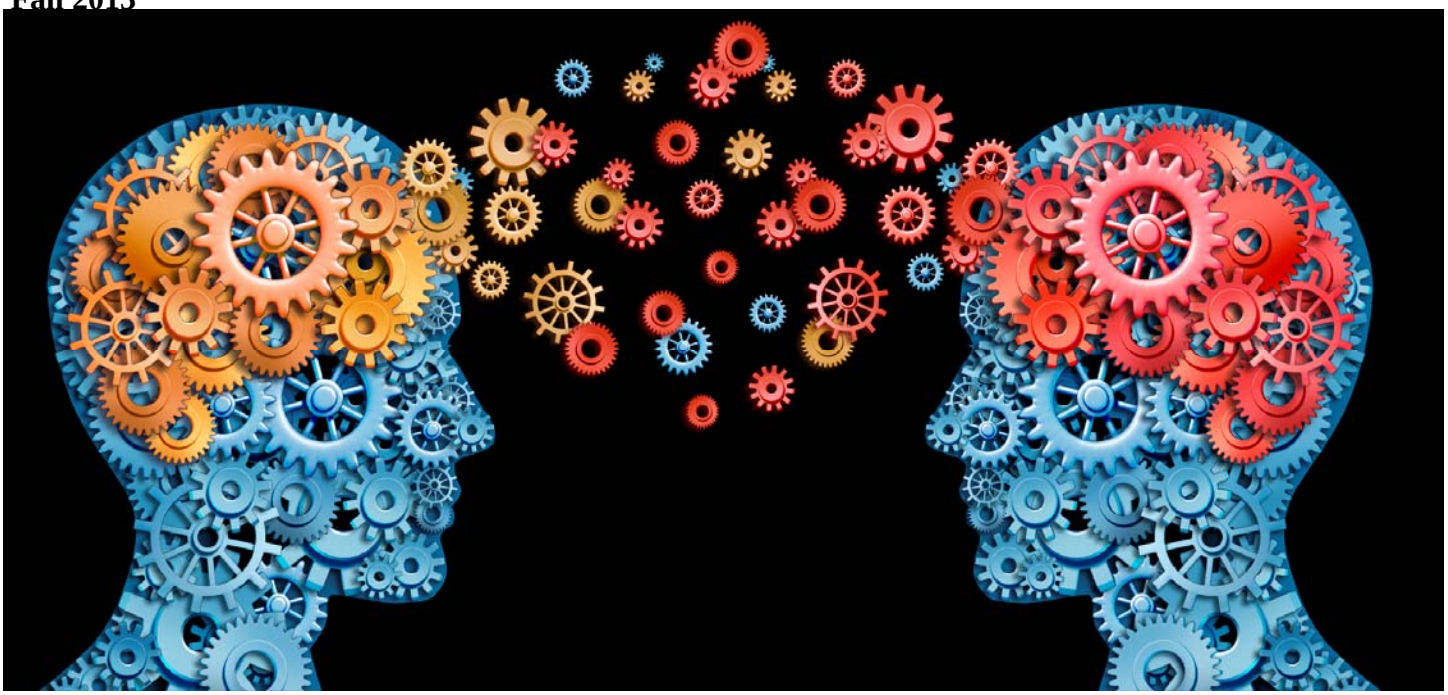
- ♦ Ensure the personal health information reaches the intended recipient.
- ♦ Once the breach has been contained investigate root causes of the breach.
  - ◊ Determine root cause of the breach. Any relevant information management service providers (IMSPs) would play a role in this stage.
  - ◊ Review written section 16 policies and procedures on faxing personal health information to ensure the best practices were followed.
  - ◊ Determine if the employees involved in the breach were aware of the section 16 policies and procedures and had received training.
  - ◊ Begin writing internal investigation report.
- ♦ Analyse the breach and consider the associated risks to both the trustee and effected individuals.
- ♦ Consider notifying the affected individuals.
- ♦ Consider notifying the OIPC. When privacy breaches are proactively reported to the OIPC, depending on the scale and severity of the breach, it will likely open a "preliminary file" to monitor the response of the trustee and ensure best practises are being followed. The file is then closed once the trustee's internal investigation has satisfactorily come to a close. If the breach is covered by the media, the trustee will have the benefit of assuring the public it is working with the OIPC.
- ♦ Complete an internal investigation report. Report should focus on ways to prevent future occurrences.

For more information:

Saskatchewan Office of the information and Privacy Commissioner (www.oipc.sk.ca).

Office of the Saskatchewan Information and
Privacy Commissioner
503 – 1801 Hamilton Street
Regina, SK S4P 4B4
Phone: (306)787-8350
Toll Free (in Saskatchewan) 1–877-748-2298
www.oipc.sk.ca

Health Information Policy and Legislation Unit
Ministry of health
3rd Floor – 3475 Albert Street
Regina, SK S4S 6X6
Phone: (306)787-2137
www.health.gov.sk.ca/privacy-statement



Leaders Among Us: How Saskatchewan Doctors and Policy Makers are Directing the Future of Health Care

Friday, November 15
12:30—4:00 p.m.
Registration & Lunch at 12:30 p.m.
Keynote at 1:00 p.m.

Location
Neatby-Timlin Theatre
Arts 241
University of Saskatchewan
(Webcasting to Regina General Hospital Auditorium)

Registration Free and Open to the Public

HTTP://HEALTHINNOVATION2013.USASK.CA

Our Staff:

Dr. Karen Shaw, Registrar
Dr. David Poulin, Deputy Registrar
Mr. Bryan Salte, Associate Registrar/Legal Counsel
Ms. Barb Porter, Director of Physician Registration

Along With:

Carol Bowkowy, Senior Registration Officer
Karen Mazurkewich, Registration/Information and Certificate Officer
Karen Mierau, Registration Officer
Amanda Nelson, Registration Officer
Lindsay Schultz, Registration Coordinator
Tracy Herzog Assistant/Registration
Jori Smith, Assistant/Registration
Amy McDonald, Manager of Accounting/Finance
Leslie Frey, Regulatory Services Coordinator
Tracy Hastings, Regulatory Services Coordinator
Melissa Hoffman, Complaints Coordinator
Alyssa Van Der Woude, Complaints/Assistant to B. Salte/Newsletter
Sue Robinson, Executive Assistant to the Registrar
Doug Spitzig, Pharmacist/Prescription Review Program Manager
Laurie Van Der Woude, PRP Coordinator
Meagan Fraser, Assistant/PRP & Methadone Program
Ferne Hand, Assistant to Accounting/Finance
Melanie Lafonde, Receptionist
Camille Dunlop, Receptionist

And In Regina:
Diagnostic Imaging & Lab Quality Assurance

Tracy Brown, Director
Jackie Ernst, Lab Proficiency Testing Consultant
Marg Zahorski, Executive Assistant
Kim Skrypnyk, Administrative Assistant
Amy Dolter, Receptionist/Data Entry

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