2009/10 Committee Report

From the

Diagnostic Accreditation Program – Committee

With a continued focus on promoting excellence in diagnostic health care, the Diagnostic Accreditation Program (DAP) completed several assessment and educational activities and continued with the development and introduction of new accreditation standards.

In June 2009, after field testing and final review by the Pulmonary Function Advisory Committee, the *Accreditation Standards for Hospital Based Pulmonary Function Testing* were approved and implemented. The draft standards for polysomnography continued to be field tested in 2009 with a final revision date to these standards planned for late 2010. Also during 2009, the 2007 *editions of the Accreditation Standards for Diagnostic Imaging and Laboratory Medicine* proceeded through the formal review and revision process. New editions of these standards will be released in 2010.

During 2009/10, the DAP completed 154 on-site peer review surveys. Included in the surveying for 2009/10 were hospital based neurodiagnostic and pulmonary function testing services being assessed to the new standards that were released in 2008 and 2009 respectively.

In February 2009, Health Canada released Safety Code 35 that outlines required radiation protection practices and safety procedures in radiological facilities. The DAP worked closely with WorkSafe BC and the Ministry of Health Services to assess the impact of this code to BC diagnostic imaging facilities; and to develop consensus regarding the interpretation and implementation of this code in BC. The DAP participated in educational forums and meetings to communicate the requirements of this new code for accreditation purposes. Recognizing the continuing need to provide education, in 2010 the DAP will be providing online education and tools specific to conducting the quality control requirements outlined in the Code and the accreditation standards.

On May 1-2, 2009 the DAP hosted the education seminar "Quality Systems in Pulmonary Function Laboratories." Over 80 technologists, managers and physicians from BC and

Alberta pulmonary function testing laboratories attended these sessions. Feedback received from participants was very positive.

In addition to conducting on-site surveys, the DAP continues its ongoing surveillance of diagnostic facilities through the monitoring of proficiency testing and quality control results. The proficiency testing performance of laboratories continues to be satisfactory, and British Columbians can be assured that effective and appropriate testing is taking place. The DAP also manages the quality control program for the category III pulmonary function laboratories and continuous feedback on their performance has resulted in these laboratories continuing to improve patient care.

Working collaboratively with the DAP staff are the many DAP surveyors and advisory committee members. We wish to extend a sincere thank you to these individuals for their commitment to improving the quality and safety of diagnostic services in the BC.

H. Huey, MD, FRCPC
Chair, Diagnostic Accreditation Committee

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Accreditation Statistics

Number of accredited facilities/locations:	**498**
Diagnostic Imaging	
Health Authority based	136
Community based	70
Vascular Laboratories	
Health Authority based	5
Laboratory Medicine	
Health Authority based	109
Community based	21
Pulmonary Function	
Health Authority based	53
Community based	33
Neurodiagnostic Services	
Health Authority based	24
Community based	36
Polysomnography	
Health Authority based	8
Community based	3
Number of initial assessments/focused visits:	**15**
Number of on-site surveys:	**154**
Number of new surveyors trained:	**66**
Total number of active DAP surveyors:	**281**
Medical surveyors	78
Technical surveyors	162
Management surveyors	41

2009/10 Committee Report

From the
Ethics Committee

The mandate of the Ethics Committee is the formulation of contemporary policies and guidelines which are based on universal ethical principles as well as the *Code of Ethics* published by the Canadian Medical Association. The drafted or revised policies of the Ethics Committee are reviewed by the College's Quality Assurance Committee prior to discussion and final presentation to the Board. Once adopted, they are posted on the College website and/or appear in the *College Quarterly*.

Considering the legal and sociological changes in Canadian society, it has been necessary to revise existing guidelines and to craft new policies. All policies are created respecting our duty under the *Health Professions Act* to act in the public interest. In the past year, this committee has revised College policies regarding Advertising and Communication with the Public, Conflict of Interest, Walk-In Clinics – Standard of Care, Withdrawal of Services, Planned Home Births, and Ending the Patient-Physician Relationship. New policies have been drafted for Primary Care Multi-physician Clinics, Third Party Requests for Information, and Professionalism in the Era of Online Social Networking. The latter is rapidly developing and changing communication landscape.

The Ethics Committee meets five times per year.

Arthur Dodek, MD, FRCPSC
Chair, Ethics Committee

For more information regarding this report, please contact:
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2009/10 Committee Report

From the
Finance and Audit Committee

2009/10 was an excellent financial year for the College of Physicians and Surgeons of British Columbia. The College will finish the year with approximately a $2 million operating surplus. This leaves the College in excellent financial position heading into 2010/11. As part of the Board's 2010/11 strategic planning process, the College allocated an additional $300,000 to enhance quality assurance programs and $660,000 for year one expenditures to develop a multi-year College IT plan, including the potential for implementing an electronic document and records management system (EDRMS).

College Investments
The College more than recovered financial losses from 2008 with over $2.5 million in realized and unrealized gains on investments in 2009. After interviewing five potential firms to manage the College's $6 million Canadian equity portfolio, the Finance and Audit Committee selected MD Private Investment Counsel. The Finance and Audit Committee modified the College's asset mix target from 90/10 to 85/15 (ratio of fixed to equity investments) with a maximum of 20 per cent equity content. The College's fixed investments continue to be managed by Phillips, Hager & North (PH&N).

Building Purchase
The College continues to actively search for a building to own and occupy. This process has turned out to be more complex than originally envisioned. The search team has now looked at over 20 potential buildings and sites but has not yet been able to secure a suitable new location. The search for a new building continues to be a high priority for 2010/11.

Fees
The College's annual licence renewal fee for registrants increased to $1,200 for 2010. Despite this increase, BC physicians still pay the second lowest annual fee of all the provinces. This increase will offset costs associated with the new Health Professions Review Board (HPRB), which is adding significantly to the College's registration, complaints management and legal expenses. The introduction of the Harmonized Sales Tax (HST) in July will also add significantly to the College's expenditures. College bills for rent, professional fees, etc. will

all increase seven per cent effective July 1, 2010. This will cost the College almost $1 million per year annualized.

Online Licence Renewal
2010 marked the first year of mandatory online licence renewal for College registrants. Throughout the renewal process (January-March), 20 per cent of registrants utilized the College helpdesk for assistance in completing the new online form. There were some technical hurdles, yet, over 98 per cent of College registrants renewed online by the March 1, 2010 deadline. In the end, 188 physicians were fined for late registration—the lowest number of late fines issued in College history. Despite the prize offered for using pre-authorized payment or internet banking, 79 per cent of registrants renewed using their credit card. Consequently, College credit card fees increased from $120,000 in 2008/09 to $240,000 in 2009/10. Renewing fees via credit card costs the College approximately $23 per registrant.

Additional Revenues
Additional revenues were secured in 2009/10 through an enhanced Methadone Maintenance Program contract and one-time government funding for developing a regulatory framework for physician assistants beginning in 2010.

Expenditures
College Board and committee costs were significantly lower in 2009/10 due to one less week of meetings during the winter Olympics. The Board and committees are returning to their normal meeting schedule in 2010/11. Legal fees were also much lower in 2009/10.

I would like to thank my fellow committee members and College staff for their diligence in making good use of College financial resources and look forward to a productive 2010/11.

Mr. Walter Creed, FCA
Chair, Finance and Audit Committee

For more information regarding this report, please contact:
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2009/10 Committee Report

From the

Inquiry Committee

The proclamation of the *Health Professions Act* (*HPA*) mandated many changes to the way in which the College investigates complaints received from the public and concerns regarding the conduct and competence of registrants. The former Medical Practitioners Act (*MPA*) established committees to separately consider clinical performance; professional ethics and conduct; and sexual misconduct and other serious matters. Under the *HPA*, panels of the Inquiry Committee manage all of these.

The initial task of Inquiry Committee investigations is to determine whether complaints are sustained by documentary and other evidence and whether, if they are, remedial (the vast majority) or disciplinary action is indicated.

In ideal circumstances, self-regulating professionals will respond to valid complaints thoughtfully and proactively by formulating appropriate remedial plans voluntarily. These typically include acknowledging that errors were made; apologizing to those affected; amending practices; and pursuing relevant continuing professional development (CPD) activities. Many physicians do just that. Others require more direction.

Prior to June 1, 2009, under the *MPA*, when the College determined that a matter before it was concluded, it generally was. Dissatisfied complainants could and did sometimes bring their concerns to the Office of the Provincial Ombudsperson. At that level, a generic review was done to ensure that the College had adequately investigated and concluded the complaint in accordance with the statute and its own policies and procedures.

The *HPA* established a new agency: the Health Professions Review Board (HPRB). Within thirty days of receipt of the letter notifying them of an Inquiry Committee decision, complainants may apply to the HPRB for review of the adequacy of the investigation and the reasonableness of that decision. The *HPA* anticipates procedures that are "transparent, objective, impartial and fair." The HPRB was created in that spirit.

The *HPA* requires significantly more of the College than the *MPA* did. There are mandated timelines, with letters to complainants. Transparency means more patient requests for

documents at every step of the process, in turn prompting more correspondence to sort out identified rebuttal issues. Many complainants are choosing to exercise their right to go to the HPRB, triggering significant activity fulfilling our obligations to that process. The College will incur more staff and other costs in order to do these things, ultimately funded by the dues of its registrants. The cost will be substantial.

While the *HPA* has amalgamated complaints management activities, the College continues to find it instructive and useful to categorize these concerns as conduct, clinical performance, and boundary violation matters. Numbers of complaint files opened are tabulated below. The past year was consistent with recent experience, with just less than one thousand new complaints in total, mostly divided about evenly between clinical and conduct issues, with a much smaller number of boundary concerns.

Conduct and Ethical Standards
Nearly 50% of complaints from the public concern breaches of ethical standards and/or professional conduct by registrants. The vast majority of these complaints arise from poor communication or miscommunication between registrants and patients.

During this past year, common complaint themes relate to rude or insensitive physician comments; failure to respond in a timely manner to third party requests for medical reports; complaints regarding failure to transfer patient medical record information with patient consent to other physicians; allegations of discrimination; allegations of abandonment of patient care; conflict of interest breaches, especially in the realm of cosmetic medicine; and a few but worrisome breaches of patient confidentiality.

Many conduct complaints need not occur if physicians reflect upon and always consider first and foremost their patients' needs and wellbeing in addition to their professional obligation to always treat patients with dignity and respect. The physician-patient relationship is a sacred trust. It is incumbent on physicians to always protect the privacy and confidentiality of patients' personal and health information. Legislation defines specific circumstances in which physicians must breach patient confidentiality; the College's Physician Resource Manual document entitled *Duty to Report* summarizes the specific exceptions to a physician's ethical responsibility to maintain patient confidentiality at all times. Otherwise, disclosure of a patient's personal health information requires patient consent.

The College continues to receive a few complaints from physicians concerning the actions of their colleagues. Most of these complaints could be avoided entirely by being mindful of the need to treat colleagues with dignity and respect. It is particularly disconcerting when one physician criticizes or ridicules the conduct or competence of a colleague in the presence of a patient or publicly in front of other colleagues.

Advertising breaches continue to consume significant resources. The College Board recently approved the revised policy document entitled *Advertising and Communication with the Public*. Of note, testimonials are not permitted in any form of physician advertisements. In addition, no physician can claim their services to be superior to those of their colleagues, utilize exaggerations in their advertisements or offer gifts, discount coupons, prizes or any other form of inducement. In response to advertising breaches, the College will continue to

firmly enforce its advertising guidelines and Part 7 of the College Bylaws, pursuant to the *Health Professions Act*.

At present, of those complaints determined by the Inquiry Committee to be sustained, the majority are resolved through prescribed education and remediation action plans for the physicians who are the subject of these complaints.

Clinical Performance

Complaints citing allegations of deficient performance on the part of older doctors continue to be a major part of the work of the College. According to Statistics Canada, the median retirement age in the general population is 60.6 years. There is a great deal of variation amongst physicians, but the comparable number is probably about age 70. Ideally, a professional in a safety sensitive occupation will be fully competent on his or her last day on the job. For the vast majority of physicians this is demonstrably true; however, a small number of older colleagues are struggling, usually without insight.

Where concerns are identified, practice reviews are ordered. It is very sad when, in the twilight of a productive career of service to many people, an older physician will not withdraw without enduring the painful exercise of having his declining performance documented. Registrants are urged to give thoughtful reflection with the well being of patients in mind to their own retirement plans. Physicians observing age-related declining performance in colleagues are urged to take appropriate action.

Another recurring theme is patient dissatisfaction with poor surgical outcomes. No surgeon can guarantee a good result in every instance. No procedure is risk free. However, even decades after the requirements for informed consent were set out by the courts, some surgeons are not adequately counselling their patients preoperatively. And too often, even when the surgeon has done a good job of communicating these difficult messages, the discussion is not documented. Patients enduring chronic pain after a procedure meant to relieve it often have no memory of what they were told. Proceduralists must keep records that will be of assistance to them when, inevitably, complications arise.

When health concerns affect fitness to practise

The clinical performance of physicians, ranging from communication and conduct to clinical care decisions, can be affected by physicians' personal health and wellbeing. Of particular concern are diseases which affect cognition, insight and judgment.

When the College becomes aware that a physician has such a disease that has the potential to impact patient care, it immediately takes the necessary steps to ensure public safety. This if often accomplished by seeking an undertaking from the physician to withdraw from practice until such time as an appropriate assessment is completed, necessary treatment is undertaken, and reports are obtained that confirm ongoing fitness to practise. The processes regarding fitness for health reasons are under the supervision of the Inquiry Committee. If it is determined that physician health issues are a concern to public safety and if the physician will not undertake in writing to withdraw from practice, a formal process with the potential for disciplinary action will be immediately commenced. It has been the experience over a number of years that physicians are very willing to refrain from practice

and to obtain the necessary treatment, so the disciplinary process rarely has to be involved for health purposes. Following return to practice after such withdrawals, the College receives regular reports from professional caregivers to confirm ongoing fitness. The proactive measures by the College are an important part of public protection and the Inquiry Committee takes such matters very serious.

Aggregate

Complaints Received	**984**
Clinical	483
Conduct	467
Boundary	34
Disciplinary Actions Taken	4

Darlene M.S. Hammell, MD, CCFP, FCFP
Chair, Inquiry Committee

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2009/10 Committee Report

From the

Library Committee

Over the past year, the College library staff and committee members have worked hard to address the information needs of College registrants. New resources have been acquired to meet registrants' current and future knowledge demands, and traditional services of reference, article copying and teaching are in high demand.

Increased e-Resources

Over the past years, the library has been thoughtfully transitioning from collecting print material, particularly journals, to enhanced online access. The process accelerated in 2009 after the library did a detailed review of the journal collection, reducing print subscriptions and re-investing in high impact electronic journals. More BMJ Press and Elsevier titles were acquired with the highlight being online access for College registrants to 18 Clinics of North America titles. Over 2500 e-journals are now available through the library's website.

Physicians have asked for reliable, current, evidence-based resources and the library has responded. Another online decision support tool, BMJ Point of Care, was acquired in 2009 and provides many of the components that have a direct positive impact on practice such as patient-focused diagnosis and therapy information integrated with a detailed drug database from Epocrates, as well as a drug interaction checker.

Ensuring access to multiple formats is important to meet library users' differing learning preferences. Accordingly, College registrants may now view a new online multimedia product, Procedures Consult, which demonstrates important emergency medicine and anesthesia procedures through streaming video with sound, text and pictures,. This resource supplements the NCME online videos and Audio-Digest MP3 audio lectures already offered on the Library's website.

Reaching College Registrants

Over the last 2 years, approximately 45 per cent of College registrants have turned to the library for assistance, and College librarians responded to almost 3000 in-depth reference questions. Within just the last year, over 45,000 articles were either sent out by library staff or were downloaded by registrants. This use demonstrates the intensity with which College

registrants seek information to support their efforts to provide high quality clinical care and the important role of the library in assisting them.

Active Teaching Program
Not surprisingly, the same enthusiasm for current, relevant information is expressed in attendance at library workshops. The library, either on its own or in partnership with UBC Division of Continuing Professional Development, presented 34 workshops on finding medical evidence online, in which 246 College registrants participated.

A Smaller Footprint
The re-evaluation of the library's print collection was timely as it coincided with an expansion of College offices. The physical space of the library is now smaller but the quality of the collection remains strong.

Andrew Sear, MB, BS
Chair, Library Committee

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2009/10 Committee Report

From the

Medical Practice Assessment Committee

With the transition to the *Health Professions Act* (HPA) in June 2009, the 21-year-old Committee on Office Medical Practice Assessment (COMPA) became the Medical Practice Assessment Committee (MPAC). For all practical purposes the responsibilities of the committee remained unaltered except for the fact that the committee now reports to the Quality Assurance Committee rather than the Board. The committee continues to promote physician peer assessment *for* physicians rather than *of* physicians. With the exception of very rare egregious circumstances, the peer assessment reports are maintained in confidence and the data provided to the Quality Assurance Committee remains anonymous and synoptic.

Having performed over 2,400 practice assessments, the committee has made several observations of interest which serve to give future direction. These findings include:

- Over 85% of practices assessed met the expected standard of record keeping.
- 90% of those physicians who needed reassessment complied with the peer reviewer's suggestions.
- Unsatisfactory practice assessments were found more prevalent in physicians who were in solo practice, older and without hospital privileges. While random peer reviews are useful, more efficient use of resources would be made by acting on the above data.

The committee notes that the transitioning of medical records to an electronic format poses unique challenges to reviewers. Whereas to date, a lack of recorded care is not an infrequent finding, increasingly with Electronic Medical Records (EMRs) especially with "auto fill" features, erroneously recorded care has the potential of becoming a much greater problem.

The committee is also looking at assessing multi-physician primary care clinics as a group instead of individual physicians only, using updated college guidelines for multi-physician clinics and walk-in clinics.

The committee notes that a number of physicians who now perform locums only obviate the standard medical practice assessment format intended for physicians with established practices. In order to review locum physicians, the committee decided to ask the locum's hiring physician a number of relevant questions and in addition, to supply samples of recorded care.

Lastly, the committee's peer-assessor pool has decreased substantially over the years and is in need of new recruitments. The committee appreciates that a large number of physicians expressed interest in helping with peer assessments. The committee has chosen to invite a number of these physicians, particularly if they have undergone a successful medical practice assessment in the last ten years, to participate in a peer-assessor training workshop.

The chair is grateful to all peer-assessor physicians as well as for the positive responses received from those physicians who have undergone a peer review assessment.

John W. Barclay, MD, CCFP
Chair, Medical Practice Assessment Committee

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2009/10 Committee Report

From the

Methadone Maintenance Committee

One of the responsibilities of the College of Physicians and Surgeons of British Columbia is the administration of the Methadone Program. This includes making recommendations to the federal minister of health on behalf of registrants who wish to prescribe methadone for either pain or the treatment of opioid dependency. The College also maintains a register of patients receiving methadone for the treatment of opioid dependency. The work of the College is enhanced and facilitated by the expert advice provided by the Methadone Maintenance Committee (MMC).

In order to receive authorization to prescribe methadone for maintenance, a physician must complete a one-day workshop and two half-days of a preceptorship. During the past calendar year, two full-day introductory workshops (101) were held in February and November 2009 at St. Paul's Hospital in Vancouver. The focus of the 101 workshop is on the fundamentals of methadone maintenance therapy as well as a review of the guidelines and standards of care for methadone maintenance therapy. The focus of the 201 workshop is on the management of opioid dependence complicated by chronic pain, co-occurring mental health problems, HIV infection and pregnancy.

Audits, or peer reviews, are an integral part of the program and are essential in maintaining standards of care. All newly authorized physicians with opioid dependency treatment exemptions are peer reviewed within the first year of practice and as necessary thereafter. During 2009, 26 peer reviews were undertaken. Of these, 20 were satisfactory and 6 physicians received recommendations to improve their practice prior to a repeat review.

The Methadone Maintenance Committee reviews coroners' reports that have been submitted to the College involving deaths where methadone may have been a contributing cause. Follow-up recommendations are made when necessary.

As of December 31, 2009, 11, 033 patients were registered with the program. Three hundred and ninety physicians are methadone maintenance exempted, and 218 of these have patients registered with them. Twenty eight physicians were granted methadone maintenance exemptions in 2009.

Methadone Maintenance Committee

The revised and updated *Methadone Maintenance Handbook* was published in December 2009 and distributed to all maintenance authorized physicians.

Jeffrey E. Dian, MB BCh
Chair, Methadone Maintenance Committee

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2009/10 Committee Report

From the

Non-hospital Medical and Surgical Facilities Program – Committee

Overview
2009/10 has been a year of continued development in the Non-hospital Medical and Surgical Facilities Program (NHMSFP) with expansion and improvements being made to the website, accreditation processes and guideline revisions in keeping with current evidence, standards and consensual best practices.

Highlights for the past year include:

Revenues
To ensure program costs are contained within the Non-hospital Medical and Surgical Facilities Program, the committee restructured annual fees for facilities into five distinct classes as well as increased the annual fees. The committee also continued to analyze and review the costing of accreditation fees to ensure that the accreditation processes are maintained as a cost-recovery basis.

Accreditation Process
One of the responsibilities of this committee is to establish accreditation and performance standards, procedures, policies and guidelines for the non-hospital program to ensure the delivery of high quality and safe services for the public using these facilities. Currently there are 66 accredited non-hospital facilities in BC.

The committee is working towards streamlining, yet enhancing the accreditation processes for both the facilities and for the accreditation teams performing the accreditations.

Reprocessing of Medical Devices
College staff and accreditation teams are continuing to work with facilities to meet acceptable reprocessing and sterilization practices through renovation improvements, practice improvements and education opportunities for personnel. Recently, all ophthalmology and dental facilities have begun or completed upgrades to meet present

best practices as set by the Ministry of Health Services and Canadian Standards Association (CSA).

Surgical Procedures
The introduction of a laparoscopic adjustable gastric banding surgery program (LAGB) has been approved by the NHMSFP Committee. Strict College policy has been established with the development of the *LAGB Program Guideline* in collaboration with facility stakeholders and health care personnel considered experts in the field.

Heating Ventilation and Air Conditioning (HVAC)
As a move forward, it is the expectation of the committee that all non-hospital facility operating rooms meet the requirements for HVAC systems and in particular air movement and air quality in accordance with the Canadian Standards Association. The College has elicited assistance from a registered professional engineer who is considered a leading expert in the design, construction and maintenance of health care facilities and who is a member of the CSA Technical Committee for Health Care Facility Engineering and Physical Plant.

Steven G. Holland, MD, FRCPC
Chair, Non-hospital Medical and Surgical Facilities Committee

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Elliot Phillips, MD, FRCSC
Deputy Registrar

2009/10 Committee Report

From the
Patient Relations Committee

The Patient Relations Committee establishes and maintains procedures for dealing with complaints of sexual misconduct of registrants as well as programs to prevent professional misconduct of a sexual nature. This year it has provided oversight to a number of activities untaken by the College. The College provided education to medical students and practising physicians. It held an intensive two-day workshop on boundaries, ethics and professionalism for physicians and plans to continue to do so annually.

Remediation has been a significant aspect in the disposition of allegations of sexual misconduct. The College of Physicians and Surgeons of BC has taken an active role in collaborating with the Colleges of other health professions in the province to promote common goals and initiatives to prevent sexual misconduct. These initiatives have included a joint education endeavor and a commitment to work together collaboratively in the future.

Current guidelines and complaint procedures have been reviewed with a focus on continuous quality improvement. Because this College views any conduct of a sexualized nature between physician and patient to be unacceptable, the Patient Relations Committee will continue to work actively to promote activities that will address the prevention of such conduct.

Darlene M.S. Hammell, MD, CCFP, FCFP
Chair, Patient Relations Committee

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2009/10 Committee Report

From the

Prescription Review Committee

The Prescription Review Program, overseen by the Prescription Review Committee, is a quality assurance activity of the College, established to provide collegial assistance to practitioners in the challenging task of utilizing opioid analgesics, benzodiazepines, and other controlled substances safely and effectively, for the benefit of their patients. Physicians consistently rate the treatment of chronic noncancer pain (CNCP) among the most difficult areas of practice. In that uncertain interface between pain and addiction, for example, modern notions of *patient centredness* and *collaborative decision making* may not come easily.

In the last two decades, the research literature and lay media alike have documented a dramatic increase in *per capita* prescribing of opioids, with an associated increase in patient death and injury, as well as criminal diversion. There are many compelling stories. At the same time, clinicians and the public remain concerned about instances where pain is inadequately treated. This resulting tension has been characterized as a "perfect storm of controversy"[1] bearing down on prescribers.

The Prescription Review Committee includes experienced practising physicians with backgrounds in pain management, family medicine, psychiatry, addictions, teaching, and research. The committee provides practice advice to physicians, sponsors courses, and has contributed to the work of the National Opioid Use Guidelines Group (NOUGG) and the development of *The Canadian Guidelines for the Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*.

As a quality assurance initiative, the committee cannot compel practitioners to take its advice; however, physicians are obliged to engage in the process by answering correspondence and attending interviews. The vast majority of physicians we work with tell us the process has been helpful to them.

[1] Fishman, Scott M. ***Responsible Opioid Prescribing***. Federation of State Medical Boards.

Prescription Review Program staff members are available to advise practitioners by telephone every working day. The following useful resources and events are recommended by the committee:

- *The Canadian Guidelines for the Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* developed by NOUGG are posted at: http://nationalpaincentre.mcmaster.ca/opioid/
- An introductory summary was published in the CMAJ online on May 3, 2010.

- *The Prescribing Program*, jointly developed by the Colleges of BC, Alberta, Saskatchewan, and Manitoba is held twice yearly in various locations.

- *The Foundation for Medical Excellence Chronic Pain Symposium* held each March in Vancouver, sponsored by the College of Physicians and Surgeons of BC.

Lorna Sent, MBChB, CCFP
Chair, Prescription Review Committee

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2009/10 Committee Report

From the

Quality Assurance Committee

The Quality Assurance Committee is a new statutory committee of the College of Physicians and Surgeons of British Columbia established under the *Health Professions Act*. Formerly, quality assurance programs reported directly to the Council or the Executive Committee. The committee now reports directly to the Board.

The committee is composed of two elected physician members and one appointed public member of the Board.

The responsibilities of the committee are:

(a) To review standards of practice, to enhance the quality of practice, and to reduce incompetent, impaired or unethical practice by registrants;

(b) To administer the quality assurance programs of the College to promote high standards of practice among registrants;

(c) To assess the professional performance of registrants; and

(d) To recommend to the board mandatory continuing professional development requirements and any other requirements for revalidation of licensure.

Committees that report to the Quality Assurance Committee are:

- Ethics Committee
- Blood Borne Communicable Diseases Committee
- Medical Practice Assessment Committee
- Methadone Maintenance Committee
- Prescription Review Committee

The Quality Assurance Committee, or any of the above referenced committees, may recommend remedial steps that a registrant can employ to address any deficiencies or

concerns identified. Serious concerns regarding non-compliance or lack of competence can be referred by the committee to the Inquiry Committee for investigation. Information obtained as part of quality assurance activities are held in confidence and may not be used by the Inquiry Committee so as not to influence any subsequent investigation.

The committee is currently in the early planning stages to develop a means of assessing the professional competence and performance of registrants. The recently mandated continuing professional development enrollment with the national colleges is a first step in ensuring compliance with the *Health Professions Act* and Bylaws. The College is collaborating through the Federation of Medical Regulatory Authorities of Canada to ensure that its continuing competency requirements are robust and similar to those in other Canadian jurisdictions so as not to impair physician mobility within Canada.

Lorna Sent, MBChB, CCFP
Chair, Quality Assurance Committee

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2009/10 Committee Report

From the
Registration Committee

The Registration Committee has had an extremely full and productive year.

During 2009, there were 10, 339 registered physicians practising in the province, a total of 529 new registrants in the full licensure class and 175 new provisional class International Medical Graduates (IMGs). Sixty-four Canadian-trained physicians were licensed from other Canadian jurisdictions for locum purposes. Of note, out of the large number of new requests for licensure in the last 10 months, only 11 applications were denied, usually for reasons of inadequate training, and 3 deferred, usually as further information was required from the applicant.

In the last five months of 2009, the College received 44 applications from Canadian physicians outside of British Columbia seeking licensure under the Agreement on Internal Trade (AIT). These are physicians who obtained a full licence in another province but may not have fully completed or successfully completed all of their Canadian examinations. Despite many discussions with government, the College has been unable to create any exceptions to the *Labour Mobility Act* for medicine, and these physicians will be offered a licence to practise in BC. Under the AIT the College is precluded from requiring any additional training, experience, examination or assessments of these physicians prior to licensure. It is noted that most other provinces have had few or no applications under AIT and that BC would appear to be the destination of choice.

The Registration Committee has been working hard to develop and define classes of licensure under the new *Health Professions Act* (HPA) and most recently has been working on a restricted licence class that may be used for American trained physicians who have completed three years of postgraduate training in general pediatrics, emergency medicine, internal medicine or clinical pathology. This training is not equivalent to Canadian specialty training but may in the future have some restricted areas of employability, such as hospitalists.

Under the HPA the College moved to acceptance of American Board Examinations and USMLEs, and after a period of supervised practice in BC, these physicians may be eligible for

full licensure. Similarly, the College of Family Physicians of Canada has reviewed training in the USA and Australia and will now award its certification to those physicians who have completed training and examinations in those jurisdictions. The committee has also been working to review the postgraduate training in the UK and will now accept a Certificate of Completion of Training (CCT) as an indicator of completion of adequate and acceptable training. The committee has gained significant expertise in reviewing South African training. From this year forward, all internationally educated physicians who wish to move to Canada must complete the Evaluating Examination of the Medical Council of Canada (MCCEE) prior to any form of licensure.

The changes of the last year have presented the Registration Committee with some philosophical challenges: the College is now charged with ensuring that physicians applying for a licence in BC have the training and experience necessary to protect the public; however, under the AIT it now legally has to license some whom it previously would have denied. In other cases, where an application is denied for reasons of deficiencies in training, these physicians may now appeal to the Health Professions Review Board (HPRB) which has the right to overturn a College decision.

The committee recognizes and supports the need to move to national standards for licensure and this process is moving slowly forward through the Federation of Medical Regulatory Authorities of Canada (FMRAC), which will likely lead to a national registry of credentials of physicians practising in Canada. It also recognizes the need to have a mechanism in place to review the clinical competency and training adequacy of the many IMGs who wish to come to Canada but do not have recognized postgraduate training. Assessment and additional training programs are certainly desirable, but would require significant funding and organization which lies outside the manpower, financial capabilities and mandate of the College.

Recognizing the increasing complexity of the practice of family medicine and many sub-specialties, it is now required that a physician be "current" in their chosen area of practice. For example, a surgeon who has been practicing as a surgeon for 20 years may not just suddenly decide to become a family physician. Likewise, a family physician who has had an administrative position for many years, may not just decide to return to clinical practice. Absence from an area of expertise for more than three years or less than eight weeks of practice in each of the preceding three years will require a review of skill, knowledge and competency before a return to practice and may require specific retraining if recommended by the registrar. All physicians are required to comply with continuing professional development/continuing medical education requirements of the national colleges for revalidation of licensure.

The registration department is frequently in communication with the University of British Columbia and is responsible for reviewing applications for educational licences and fellowships. More recently, the College has been discussing possible expansion of academic appointments.

This report touches only on the highlights of some of the committee's work in the last year.

Registration Committee

The impact of changes under the *HPA*, issues arising from AIT, and a larger volume of requests for licensure have greatly increased the work of the registration department. This year has seen the need to hire three new staff members to the department. The work involved in developing a new online screening application, and implementing a mandatory online licence renewal has been substantial, but the end result in terms of future efficiencies will be well worth the effort.

The Registration Committee is composed of two elected board members, two appointed public members, one physician from the rural community and one physician from the University of British Columbia. The broad perspective and depth of knowledge that the committee members bring makes the work possible.

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