

Committee reports

Diagnostic Accreditation Program Committee

The scope of the Diagnostic Accreditation Program Committee is set out in section 5-21 of the Bylaws made under the *Health Professions Act, RSBC 1996, c.183*.

The Diagnostic Accreditation Program (DAP) has a mandate to assess the quality of diagnostic services in the province of British Columbia through accreditation activities. As a program of the College of Physicians and Surgeons of British Columbia, the mandate and authority of the DAP is derived from section B of the Bylaws of the College made under the *Health Professions Act*.

The DAP is committed to promoting excellence in diagnostic health care through the following activities:

- establishing performance standards that are consistent with professional knowledge to ensure the delivery of safe, high-quality diagnostic service
- evaluating a diagnostic service's level of actual performance to achieving the performance standards
- monitoring the performance of organizations through the establishment of external proficiency testing programs and other robust quality indicators of performance

The DAP currently has 24 accreditation programs covering the following diagnostic services:

Diagnostic imaging

- diagnostic radiology
- diagnostic mammography
- diagnostic ultrasound
- diagnostic echocardiography
- diagnostic computed tomography
- diagnostic magnetic resonance imaging
- diagnostic nuclear medicine
- diagnostic bone densitometry

Laboratory medicine

- sample collection, transport, accessioning and storage
- hematology
- chemistry
- transfusion medicine
- microbiology
- anatomic pathology
- point of care testing
- cytology
- cytogenetics
- molecular genetics

Neurodiagnostic services

- electroencephalography
- evoked potentials
- electromyography and nerve conduction studies

Pulmonary function

- hospital-based services
- community-based services

Polysomnography

- adult and pediatric polysomnography

HIGHLIGHTS IN 2015/16

The DAP provides accreditation services to 677 diagnostic facilities of which 284 are private and 393 are public.

	Public	Private	Total
Laboratory Medicine	155	154	309
Sample Collection Sites	42	132	174
Laboratories	113	22	135
Diagnostic Imaging	136	64	200
Pulmonary Function	69	23	92
Neurodiagnostics	26	38	64
Polysomnography	7	5	12

NUMBER OF FACILITIES SURVEYED MARCH 1, 2015 TO FEBRUARY 29, 2016

Laboratory Medicine	58 on-site surveys that assessed 145 services
Diagnostic Imaging	38 on-site surveys that assessed 98 services
Pulmonary Function	10 on-site surveys that assessed 10 services
Neurodiagnostics	9 on-site surveys that assessed 20 services
Polysomnography	7 on-site surveys that assessed 7 services
Total	122 on-site surveys with 319 services

**INITIAL ASSESSMENTS FOR NEW FACILITIES PERFORMED
MARCH 1, 2015 TO FEBRUARY 29, 2016**

Diagnostic Imaging	8 that assessed 8 services
Laboratory Medicine	11 that assessed 18 services
Neurodiagnostics	1 that assessed 3 services
Polysomnography	3 that assessed 3 services
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Total	23 services

PROFICIENCY TESTING AND QUALITY SYSTEMS**Laboratory medicine**

The DAP monitors the proficiency testing (PT) results of all 137 laboratories in the province and follows up with laboratories on performance issues. The disciplines monitored are transfusion medicine, microbiology, chemistry, hematology, immunohistochemistry and cytogenetics.

Pulmonary function

The DAP monitors the technical performance of all 27 pulmonary function laboratories through the DAP Pulmonary Function Quality Control Program, and follow up as required.

Spirometry

The DAP continues to monitor the technical and medical interpretation performance of the 53 community based Spirometry sites.

Regional assessment process

In 2015 the DAP laboratory medicine program introduced a regional assessment methodology using the new 2015 Laboratory Medicine Accreditation Standards.

The goal of utilizing a regional assessment methodology is to:

- reduce duplication by assessing regional processes and systems and applying to the facility accreditation assessment when appropriate
- reduce the amount of time facility staff spend in completing an on-site facility assessment
- improve the quality of the accreditation process by assessing the accreditation standards with the appropriate regional staff, at the appropriate location
- improve DAP stakeholder satisfaction with the program.
- continuously improve the methods and outcomes in DAP accreditation processes
- work in collaboration with stakeholders

The DAP looks forward to receiving stakeholder feedback regarding utilization of a regional assessment methodology and to continue to work with DAP stakeholders to design efficient and effective accreditation processes.

STRATEGIC PLAN 2015–2018

The DAP was pleased to launch the DAP three-year strategic plan, which is linked to the College's Strategic Plan for each of the DAP's strategic goals. The three-year strategic plan was developed by the DAP Committee with input and feedback from DAP stakeholders and their ideas are reflected in this plan.

The DAP strategic plan has four key strategic directions which are as follows:

1. Enhanced communication and engagement with DAP stakeholders
2. Enhancing quality in the DAP services by developing an ISO-compliant quality management system
3. Ensure the DAP continues to be relevant and sustainable to the BC diagnostic community to deliver patient centered services
4. Seek engagement and collaboration with the Ministry of Health, health authority CEOs and other provincial Colleges of Physicians and Surgeons in performance management evaluation of regional diagnostic health systems

INTERNATIONAL ACCREDITATION

The DAP is pleased to announce that in 2015 it attained accreditation by the International Society for Quality in Health Care (ISQua). The DAP first underwent ISQua organizational accreditation in 2010 and again in 2011.

The ISQua organization survey and international accreditation process is a mechanism for health-care external evaluation organizations (e.g. DAP) to assure themselves that their organization meets the highest international organizational management and client service requirements. The process is voluntary and is entered by application. Evaluation services are provided on a voluntary basis by international surveyors.

The survey process is similar to the stages used by accreditation and other external evaluation bodies in several countries and is a proven and robust method of organizational development and independent evaluation. It includes:

- self-assessment
- peer review evaluation
- written report with recommendations
- award
- continuous assessment

*J.C. Heathcote, MD, FRCPC
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INFORMATION

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Committee reports

Finance and Audit Committee

The scope of the Finance and Audit Committee is set out in section 1-14 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

The Finance and Audit Committee helps the Board fulfill its mandate by developing the College's budget, regularly reviewing operational and capital expenditures, governing the annual external audit and regularly reviewing the College's systems of financial control.

PROPERTY

The College owns a total of 62,495 square feet at 669 Howe Street and currently leases out 17,743 square feet on two floors through August 2016. Upon expiry of these leases, the intention is to repurpose approximately 20 per cent of this space for College use and continue to lease out the remaining space for another four to five-year term.

COLLEGE INVESTMENTS

The College's investments are maintained within two types of accounts as follows:

Short-term investment accounts

The primary goal of the short-term account portfolio is to preserve cash or cash equivalents to meet the annual financial obligations for operational expenses of the College, while optimizing investment returns. The allocation of operational funds is currently 100% fixed investments (short-term bonds, cash and/or term deposits). The balance of cash and short-term investments in the operating accounts at February 29, 2016 was \$23,781,000 (\$23,516,000 in 2015).

Long-term investment accounts

The primary goal of the long-term investment portfolio is to preserve capital. The secondary goal is to provide reasonable growth while minimizing risk to meet the long-term financial obligations of the College.

The target allocation for long-term investments is 40% fixed (bonds and cash), 45% Canadian equities and 15% global equities. The balance of cash and investments in the long-term accounts at February 29, 2016 was \$11,810,000 (\$6,495,000 in 2015).

Investment income

- Investment income for the 2015/16 fiscal year before any gains, losses, or investment management fees was \$654,000 (\$989,000 in 2014/15)
- Unrealized losses in 2015/16 were \$374,000 (\$39,000 unrealized losses in 2014/15)
- Investment management fees in 2015/16 were \$77,000 (\$78,000 in 2014/15)

Investment management firm

At the request of the Finance and Audit Committee, the College issued a request for proposal (RFP) in July 2015 for investment management firms to advise the College on its investment strategy. Twelve respondents submitted proposals and, after a thorough evaluation and interview process, a new investment advisor was chosen.

Realized loss on investments

Based upon the recommendations of the new investment advisor, the College diversified its investment portfolio in fiscal year 2016. As a result of this diversification, the College converted significant unrealized losses to realized losses.

- Realized losses on investments in 2015/16 were \$1,094,000 (\$172,000 realized gains in 2014/15).

COLLEGE SYSTEM AND PROCESS RENEWAL PROJECT (CASPER)

CaSPeR is a three-year business process/technology renewal project approved by the Board in 2013, which encompasses a new database (iMIS), enhanced online functionality, eAccreditation software, significant updates to the College website and the various systems working together to improve the way the College conducts its day-to-day operations. The Board approved that \$1.8 million be set aside for Phase 3 of the CaSPeR project in fiscal year 2016/17.

Phase 3 of the project includes, but is not limited to the following:

- iMIS implementation for the Methadone Maintenance Program, Prescription Review Program, and Physician Practice Enhancement Program
- installing advanced reporting for iMIS
- enhancing the College's intranet portal for automation of business processes and to improve internal communications
- scope and approach evaluation for an electronic documents and records management system (EDRMS)

WATER DAMAGE

On September 30, 2015, the College sustained significant water damage caused by vandalism. An individual gained access to the emergency exit stairwell in the residential tower above the College at 669 Howe Street and turned on two of the standpipes designed for fire hoses. As a result of this unfortunate incident, the College premises incurred more than \$940,000 in damages. Fortunately, the insurance deductible charged to the College for this event was only \$2,500 and additional security measures have since been implemented.

*P.D. Rowe, MD, CCFP(EM), FCFP
Chair, Finance and Audit Committee*

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Committee reports

Inquiry Committee

The scope of the Inquiry Committee is set out in section 1-16 of the Bylaws made under the *Health Professions Act*, RSBBC 1996, c.183.

The committee performs three regulatory functions central to the mandate of the College:

1. investigation of complaints and reports concerning College registrants
2. practice investigations initiated by the Inquiry Committee on its own motion
3. oversight when a physical or mental health disorder may impair the ability of the physician to practise safely and effectively; in such circumstances, if the physician is appropriately engaged and compliant with treatment to the satisfaction of the monitoring department, the Inquiry Committee is usually not required to take further action

Twenty-six Inquiry Committee members (16 physicians and 10 public members) are appointed for five specialized panels. The total number of complaints and reports received is remarkably constant, in the range of 900 to 1,000 annually. Adding files opened for own-motion, practice investigations, the Inquiry Committee concluded 959 matters in 2015/16.

Concerns brought to the attention of the College are initially triaged and categorized as primarily matters of clinical performance, physician conduct, boundary violations (which may include sexual misconduct or a variety of other breaches such as inappropriate self-disclosure or dual relationships), and fitness to practice issues. Statistics for 2015/16 are tabulated in this report.

The committee is specifically charged by the *Health Professions Act (HPA)* with establishing review procedures that are “transparent, objective, impartial, and fair.” Following a thorough investigation, the committee must determine whether the available evidence forms an adequate basis for criticism of the registrant. Given that most complainants are not medically trained, sometimes the investigation identifies unacceptable conduct or deficient clinical performance that the complainant was unaware of or unable to articulate. When the committee concludes a review with criticism, the *HPA* provides three options for resolution, depending on the seriousness of the concern:

- informal resolution through correspondence, interviews, and/or educational activities

- formal consequences, short of discipline, including reprimands and practice limitations entered into voluntarily
- referral to the registrar with direction to issue a citation and commence disciplinary proceedings

In 2015/16, disciplinary citations were authorized against four physicians.

The majority of complaints prompting the issuance of a citation are ultimately resolved through consent orders pursuant to section 37.1 of the *HPA*. If a consent resolution is not possible, the matter proceeds to a hearing before a panel of the Discipline Committee. There were no Discipline Committee hearings held in 2015/6.

CONDUCT, ETHICS AND PROFESSIONALISM

Complaints of failure to provide third party reports and/or patient records in a timely fashion continue to comprise a significant portion of the Inquiry Committee workload. Patients rely on reports to access the financial resources they require for the necessities of life. There was a time when paperwork was performed by physicians for little or no compensation, but remuneration has improved significantly in recent years. The committee holds physicians to the letter of the relevant College standard, *Medical Certificates and Other Third Party Reports*. Repeat offenders face disciplinary action for this entirely avoidable misconduct. Recent fines have been of the order of \$5,000 per tardy report.

The committee concluded two complaints concerning the inappropriate provision of medical care by physician parents to their children, with criticism of the physicians involved. These are typically brought to the College by former spouses with shared custody, or by physician colleagues. The College standard, *Treating Self, Family Members and Those with Whom You Have a Non-professional Relationship*, prohibiting care of family members applies and is enforced.

Every year the Inquiry Committee receives complaints from patients who have suffered adverse outcomes because their physicians’ offices filed abnormal test results without taking appropriate action, causing delays in diagnosis and treatment. In most instances these have been signed off by the physician, either on paper or electronically. Invariably, the physicians feel very badly, apologize for their errors, and can offer no explanation for the error, beyond the sheer volume of reports requiring review. A combination of vigilance and fail-safe office procedures is expected. It is unacceptable to apply the historic approach of “no news being good news.”

CLINICAL PERFORMANCE

Some themes reported last year (preoperative consent and marijuana for medical purposes) again figured prominently in 2015/16. Telemedicine and adverse outcomes arising as a result of over-prescribing of opioids and benzodiazepines were other recurring themes.

The quality of the preoperative consent discussion and whether it was adequately documented is frequently a central issue when the Inquiry Committee investigates complaints of adverse outcomes following surgery. Cataract surgeons are disproportionately represented in part because of the extent to which their work involves a combination of insured services (removal of the cloudy lens and replacement with a prosthetic one) and optional refractive correction. The latter is regarded as a convenience by provincial insurance plans, intended to address refractive errors easily managed with glasses, and therefore uninsured. Eye surgeons are obliged to provide patients with the information they need to make informed choices, but the challenge is acknowledged.

These issues were recently reviewed in the *Canadian Medical Association Journal (CMAJ)* article “Noninsured services provided with insured cataract surgery in Canada: ensuring transparent and fair treatment for patients.” Legal requirements for informed consent are well established in the Canadian Medical Protective Association (CMPA) handbook, *Consent: A guide for Canadian physicians*. The Inquiry Committee is critical of surgeons in all disciplines when the specifics of the discussion are not adequately documented. General reference in the record to having discussed risks, benefits and alternatives with nothing specified is inadequate. An adequately documented consent discussion describes a conversation.

The committee again reviewed a number of cases of practices established for the sole purpose of assessing patients seeking to access marijuana for medical purposes. In some instances physicians who had been working for years to discourage patients from demonstrably harmful excessive marijuana use (family physicians, psychiatrists, and addictions physicians) notified the College when physicians in marijuana practices endorsed its use on the basis of a single visit.

To date there is little scientific evidence supporting the safety and efficacy of therapeutic cannabinoids. Accordingly they should, for the time being, be reserved for moderate to severe symptoms associated with serious afflictions. Prescribing must be based on comprehensive assessment. Substance use disorders are clinical diagnoses that require observation over time. Based on these experiences, the College Board adopted and later updated a standard on *Marijuana for Medical Purposes* in 2015, which now forms the basis of reviews of such practices. An assessment based entirely on a patient’s desire to possess marijuana because it makes them feel better in unspecified ways is considered inadequate.

The Inquiry Committee continues to receive complaints of

substandard care provided using telemedicine. These invariably arise from telemedicine utilized essentially as a “virtual walk-in clinic,” where physicians with no knowledge of or longitudinal responsibility for the care of patients provide one-off, virtual services and make clinical decisions that exceed their own capacity and that of the technology. Telemedicine is a boon when used as an adjunct to an integrated service supporting primary or specialized care.

The College standard *Telemedicine* is posted on the website and advice regarding the safe and appropriate use of the technology has been provided in the *College Connector* (volume 2, issue 3). A recent article “Incorporating a New Technology While Doing No Harm, Virtually” in *The Journal of American Medical Association (JAMA)* offers a list of the higher level competences required of doctors providing care via telemedicine. A particular concern has been the recruitment of physicians with limited current involvement in clinical practice, including some who are semi-retired, to work virtual walk-in shifts. The College warns that this emerging field of clinical practice requires superior clinical skill and judgment.

With the best of intentions, supported by the advice of experts in the then-emerging field of pain medicine, beginning about 20 years ago our profession embraced a liberal approach to the use of long-term opioids for the treatment of chronic non-cancer pain. This was founded on a now-discredited interpretation of information available at the time that taught that long-term opioids were both safe and effective for large numbers of patients. As it turned out, only a minority of the most severely afflicted benefitted and many have suffered significant adverse consequences including addiction, injury, loss of employment, functional impairment, and even death. The current epidemic of overdoses of prescription opioids, heroin, and illicit fentanyl has its roots in over-prescribing. The medical profession has a collective responsibility to help address the consequences of the serious errors we have made in this regard.

The College’s current expectations of registrants are set out in a document titled *Prescribing Principles* posted on the website.

The Inquiry Committee concluded more than 50 investigations this past year with criticism of registrants for: unacceptable practices such as prescribing opioids in circumstances where they were not indicated; combining opioids with other sedatives; renewing without checking PharmaNet; and renewing at all for patients they do not know.

Physicians are encouraged to include the College Prescribers’ Course, the annual Foundation for Medical Excellence Chronic Pain Management Conference and/or the pain management modules offered by the Practice Support Program through local Divisions of Family Practice, and are welcome to call the College to speak with a deputy registrar or medical consultant about their prescribing challenges.

BOUNDARY VIOLATIONS AND DISCIPLINARY MATTERS

Boundary violations are comprised primarily of sexual misconduct and prohibited dual relationships, including taking financial advantage of patients. The number of complaints alleging intimate relationships between physicians and current or former patients has declined in recent years. Most complaints alleging sexual misconduct are found to involve misperception of sensitive examinations. Some complainants appropriately reference the College guideline *Sensitive Examinations* in formulating their submissions. Common points of criticism include inappropriate and unwelcome attempts at humor in the course of sensitive examinations; inadequate communication (failure to describe the examination and explain why it is necessary) and inadequate draping. In 2015/16 complaints of this nature were concluded with remedial education and commitments from physicians to amend their practices.

Four matters were concluded with discipline in 2015/16 and are summarized in press releases posted on the College website: <https://www.cpsbc.ca/disciplinary-actions>. The misconduct was varied, including: providing diagnostic services without a licence; photographing a vulnerable patient without his consent; prescribing psychotropic medications to family members; and violations of College Bylaws concerning disclosure and responsiveness.

SIGNIFICANT EVENTS IN 2015/16

Following direction from the Health Professions Review Board, the process for documenting Inquiry Committee review and endorsement of complaint decisions made by the registrar pursuant to section 32(3) of the *HPA* was amended.

With the assistance of an evolving IT solution and amendments to our processes, our priority continues to be improvements in the timeliness of our investigations and decisions.

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Committee reports

Library Committee

The aim of the College library is to be a prime source of clinical information for practising registrants by supporting physicians' efforts to remain competent throughout their careers. In order to build on the impact of the library on clinicians' practice, feedback from key knowledge leaders was sought in 2015. Key knowledge leaders were identified by registrants in a 2013 survey using the Hiss¹ criteria: having strong communication skills; knowledge expertise; and a high level of humanistic concern. A survey of the key knowledge leaders was launched in October, 2015 and 19% of 1,171 key knowledge leaders responded. Survey responses were reviewed using a strengths/weaknesses/opportunities/threats analysis. With the inclusion of staff suggestions, over 65 enhancements to the library website, services, promotion and *Cites & Bytes* were identified, prioritized, and formed the basis of future library planning.

Ongoing efforts to encourage registrant use of high quality medical evidence were supplemented in 2015 with a communication plan to maximize use of two new information resources: ClinicalKey and PsychiatryOnline. As a result, 7,739 ClinicalKey ebook chapters were viewed in 2015 – 66% greater than its predecessor, MD Consult. A total of 9,881 ClinicalKey articles were downloaded, which was 48% greater than MD Consult. PsychiatryOnline had the highest per title usage of all e-journal and ebook collections to which the library subscribes: 99 articles downloaded per journal title and 47 chapter views per ebook. Overall, usage of online resources displayed an upward trend: ebook chapters from various collections on the library's website were viewed 14,533 times (7% increase from 2014) and 43,300 articles were downloaded (31% increase from 2014). In keeping with this data, feedback from key knowledge leaders who use the library indicated that the library's e-journal collection is particularly appreciated – 86% stated that the library's e-journals were relevant to their practice. Mobile and online access to College library e-journals was facilitated through integration with Read by QxMD.

Other aspects of library service that key knowledge leaders highlighted as particularly valuable for practice, research, and continuing professional development are in-depth literature searching by librarians, rapid delivery of requested articles, the *Cites & Bytes* newsletter, and workshops on finding medical evidence. Notable College library statistics from last year are listed below:

- 1,403 reference questions were answered in 2015
- an average of 1,730 articles per monthly issue of *Cites &*

Bytes were delivered by staff or downloaded by self-service

- 203 registrants interacted with College librarians in 17 outreach situations including workshops and one-on-one instruction

Considering direct contacts by registrants for any library service, 2,471 individual registrants contacted the library 12,329 times, which is a 7% decline from 2014, but similar to the average contacts over the last four years (12, 492). This excludes self-service on the library website. Lastly, in the past three years, 4,442 individual registrants used the library over 38,000 times.

Dr. G. Parhar, MD
Chair, Library Committee

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1. Hiss RG, MacDonald R, David WR. Identification of physician educational influentials in small community hospitals. *Res Med Educ* 1978; 17:283-288.

Committee reports

Methadone Panel

The scope of the Methadone Panel of the Quality Assurance Committee is set out in section 9-2 of the Bylaws made under the *Health Professions Act, RSBC 1996, c.183*.

To prescribe methadone, physicians must hold an authorization (in the form of an exemption under section 56 of the *Controlled Drugs and Substances Act* with respect to methadone) from the federal Ministry of Health.

Under the *Health Professions Act* and in accordance with Health Canada's Drug Strategy and Controlled Substances Program, the College of Physicians and Surgeons of British Columbia administers the Methadone Maintenance Program with the clinical guidance of the Methadone Panel. Authorizations (or exemptions) to prescribe methadone may be for the treatment of opioid dependence, for analgesia, or for the provision of work as a hospitalist. Authorizations may be either full (up to five years) or temporary (up to 60 days).

The Methadone Panel meets four times a year to assist physicians in prescribing methadone safely and effectively by developing guidelines, providing education and assessing methadone practice.

Guidelines for prescribing methadone can be found on the College website under the Methadone Maintenance Program – the *Methadone Maintenance Program: Clinical Practice Guideline* (previously called the *Methadone Maintenance Handbook*) and *Recommendations for the Use of Methadone for Pain*. The *Methadone Maintenance Program: Clinical Practice Guideline* was published to the College website in February 2014. Both are being reviewed and updated in 2016.

To become a methadone prescriber for opioid dependence, physicians need to attend a methadone workshop. Two courses were held this past year in Vancouver and one in Vernon. The focus going forward is to hold rotating annual rural workshops (in-person and via videoconference). Exemptions to prescribe for analgesia simply involve required readings and a telephone interview with a member of College staff.

The panel reviews a new prescriber's practice after the first year and every five years thereafter. Twenty-six peer practice assessments were performed last year: 19 in-office assessments and seven "documentary" assessments by chart review for prescribers with less than 15 patients receiving methadone. The lack of prescribers in rural British Columbia concerns the panel and the Ministry of Health. New prescribers from rural areas are therefore particularly encouraged to apply for an exemption. To remove a barrier to methadone prescribing, the College no longer

requires registration of methadone patients.

When Suboxone (buprenorphine/naloxone) became an insured benefit under PharmaCare, many physicians and patients became interested in this new therapy. In order to prescribe Suboxone, physicians need to notify the College, complete the online Suboxone CME module and manage the patient's substance use disorder as per safe opioid prescribing guidelines. As with opioid, sedative/hypnotic and stimulant prescriptions, usage will be reviewed via PharmaNet.

The panel also reviewed 48 reports from the BC Coroner's Office where the coroner had identified methadone as a potential contributor to a death, to look for potential lessons in safer methadone prescribing. The large number of overdoses and deaths due to prescription opioids, along with synthetic fentanyl, has been front page news this past year. The panel encourages appropriate use of these powerful medications to ensure individual and community safety.

A list of BC methadone clinics accepting new patients can be found on the College website. This list is updated quarterly.

HIGHLIGHTS IN 2015/16

Number of methadone patients registered with the Methadone Maintenance Program	16,527
Number of new physicians with opioid dependence exemptions	43
Number of new physicians with analgesic exemptions	52
Number of new physicians with temporary exemptions	228
Number of new physicians with hospitalist exemptions	14

WORKSHOPS IN 2015/16

Vernon – May 1, 2015	11 attendees
Vancouver – May 9, 2015	82 attendees
Vancouver – October 3, 2015	75 attendees

D.J. Etches, MD, MCISc, CCFP, FCFP
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Committee reports

Non-Hospital Medical and Surgical Facilities Program Committee

The scope of the Non-Hospital Medical and Surgical Facilities Program Committee is set out in section 5-1 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

As legislated by the Ministry of Health, the Non-Hospital Medical and Surgical Facilities Program (NHMSFP) accredits 64 private surgical facilities within BC. The program's accreditation and certification is recognized as a standard that demonstrates a facility's commitment to delivering safe, quality health care.

PUBLIC TRUST

The NHMSFP overriding interest is in the protection and safety of the public through ensuring quality and safe patient care delivery in the non-hospital sector. The NHMSFP is committed to promoting excellence in medical and surgical services through establishing accreditation standards, evaluating performance and monitoring outcomes in non-hospital medical/surgical facilities.

As part of the College's overarching objectives, the NHMSFP created a three-year strategic plan. Three key strategic directions were identified:

1. Strengthen the role of the medical director

The medical directors have a responsibility for the overall quality of care provided in their facilities. The actions within this strategy include the development of standards for medical directors, and education on specific functions in patient safety incident reviews and credentialing and privileging. Adopting the provincial credentialing and privileging dictionaries will ensure all physicians are qualified to perform their roles in the facilities.

2. Strengthen the role of the committee

The committee will have an enhanced role in the review of patient safety incidents and approving privileges on the recommendation of medical directors. The committee will join the medical directors in the educational sessions.

3. Strengthen the role of the program

The program will strengthen its oversight of the NHMSFP and will focus on its role in accreditation. It will undertake a communications strategy to improve engagement with facilities. The program will look to technology to improve

efficiency and better manage information.

HIGHLIGHTS IN 2015/16

- 12 new private medical/surgical facility applications in process
- 64 private medical/surgical facilities operate in BC
- 14 private medical/surgical facilities were accredited as part of their four-year accreditation cycle or focused visit
 - 10 received four-year terms
 - 4 received one-year terms
- 59,874 procedures were performed in private medical/surgical facilities across BC
- 41% of procedures (excluding laser refractive eye surgeries) were publically funded cases (e.g. MSP or health authority)
- 7% of procedures (excluding laser refractive eye surgeries) were contracted by a third party (e.g. WorkSafeBC, ICBC)
- 696 physicians are authorized by the College to provide medical services in one or more private medical/surgical facilities

*A.I. Clarke, MD, FRCPC
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Facilities Program Committee*

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Committee reports

Patient Relations, Professional Standards and Ethics Committee

The scope of the Patient Relations, Professional Standards and Ethics Committee is set out in section 1-18 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

The Patient Relations, Professional Standards and Ethics (PRPSE) Committee administers a patient relations program to prevent professional misconduct of a sexual nature, and to serve as a resource to the Board in matters pertaining to standards of professional ethics in medical practice. The committee identifies opportunities to consult with stakeholders as draft standards and guidelines are being developed. The PRPSE Committee reports directly to the Board.

LANDMARK CASE LEADS TO LEGALIZATION OF MEDICAL ASSISTANCE IN DYING

On February 6, 2015, the Supreme Court of Canada (SCC) in *Carter v. Canada* struck down the provisions in the Criminal Code prohibiting medical assistance in dying (MAiD). In January 2016, the SCC extended its original twelve-month suspension for an additional four months from February 6, 2016 to June 6, 2016. The SCC also granted an exemption to the suspension, permitting individuals seeking MAiD in accordance with the criteria established by the SCC to apply to the Supreme Court of British Columbia for approval relief during the four-month extension.

Like other medical regulatory authorities across the province, the College, with guidance from the PRPSE Committee, consulted with registrants and collaborated extensively with other agencies, including provincial medical regulatory authorities, the Ministry of Health, the Chief Coroner's Office, health authorities, the College of Registered Nurses of BC, and the College of Pharmacists of BC to develop interim guidance for the medical profession.

The interim guidance, which outlined a practical process for physicians to follow until legislation is enacted, was supported by a comprehensive questions and answers document.

Through its discussions, the College made it clear that it is not the role of the regulator to take a stand for or against this divisive societal issue; rather its role is to ensure that physicians are aware of and practising within the confines of the law. The College's interim guidance struck an appropriate balance

between a patient's right to access a legal medical service, and a physician's right to choose not to provide the service based on an objection of conscience.

Developing the interim guidance was singularly the most important work undertaken by the PRPSE Committee in 2015.

L.C. Jewett, MD, FRCSC
Chair, Patient Relations, Professional Standards and Ethics Committee

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Committee reports

Physician Practice Enhancement Panel

The scope of the Physician Practice Enhancement Panel of the Quality Assurance Committee is set out in section 9-1 of the Bylaws made under the *Health Professions Act, RSBC 1996, c.183*.

The Physician Practice Enhancement Panel gives oversight to the Physician Practice Enhancement Program (PPEP). Under the College Bylaws, its main responsibilities include:

- establishing, developing and administering an ongoing program of peer assessment of the practice of registrants
- assisting registrants in maintaining proper standards of practice in the care of patients and the keeping of records

The PPEP is a collegial program that proactively assesses and educates physicians to ensure they meet high standards of practice throughout their professional lives. The goal of the program is to promote quality improvement in community-based physicians' medical practice by highlighting areas of excellence and identifying opportunities for professional development. Following a PPEP assessment, a physician may be required to participate in remedial or educational activities to enhance their practice.

Each PPEP assessment is comprised of three distinct assessment components:

- peer practice assessment of recorded care
- multi-source feedback assessment
- office assessment

The program continues to actively assess physicians, prioritizing the assessment of physicians aged 70 and above who are practising in solo and unsupported environments. It is the intent of the program that all community-based physicians have a periodic assessment, with physicians aged 70 and above or those requiring ongoing remediation assessed on a more frequent basis. The PPEP continues to assess physicians practising in a multi-physician clinic as a unit to provide valuable feedback to medical directors.

STRATEGIC PLANNING

The panel held a strategic planning session in December 2015 for the purposes of developing a three-year plan that reflects the vision of the PPEP and supports the vision and mission of the College, as outlined in the College Strategic Plan. The panel articulated strategies for its four program objectives:

- shift the program focus to an explicit quality-improvement

orientation

- encourage and support physicians to take a more proactive role in their own quality improvement
- incorporate program enhancements that will lead to measurable improvements in the quality of reviews conducted
- scale up the program's capacity to assess additional medical specialists

PEER PRACTICE ASSESSMENTS

In 2015, the panel provided guidance on over 600 PPEP assessments with the most common opportunity for improvement being record keeping. The panel refers to the requirements for medical records outlined in the *Health Professions Act* and in the College's professional standard titled *Medical Records*. Physician records need to document an intellectual footprint to allow for continuity of care by other health professionals such as locums. This requirement forms part of the panel's mandate to ensure patient safety.

The majority of PPEP assessments completed were conducted in multi-physician clinics, including walk-in clinics. Although physicians working in walk-in clinics often defined their medical practice as to the provision of transient care, the College does not recognize "transient care" as a scope of practice. In 2014, the panel directed several clinics, medical directors, and clinic physicians to assume appropriate longitudinal and proactive patient care responsibility for those patients without an identified family physician or who attended the clinic repeatedly. This includes having a system in place to capture detailed recorded care, a cumulative patient profile, and an identified most responsible physician (MRP).

OFFICE ASSESSMENTS

By assessing multi-physician clinics as a unit, the panel has collated valuable information on systemic concerns that may impact physician performance. The office assessment component has been improved with a stronger emphasis on reprocessing of instruments, infection prevention and control, and office policies and procedures, and expects to implement the revised component in the spring of 2016. The program hired an assessment officer to lead this initiative.

Pursuant to the Board's strategic priority to expand our quality improvement activities, pediatricians and psychiatrists are being assessed regularly as well.

HIGHLIGHTS IN 2015/16

Number of multi-physician clinics assessed	713
Registrants agreeing/strongly agreeing that assessment was worthwhile experience	59%
Registrants agreeing/strongly agreeing that their practice changed as a result of the assessment	61%

*D.J. Etches, MD, MCISc, CCFP, FCFP
Chair, Physician Practice Enhancement Panel*

INFORMATION

For more information regarding this report, please contact:

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Deputy Registrar

J.D. Agnew, PhD
Interim Director, Physician Practice Enhancement Program

Committee reports

Prescription Review Panel

The scope of the Prescription Review Panel of the Quality Assurance Committee is set out in section 9-3 of the Bylaws made under the *Health Professions Act, RSBC 1996, c.183*.

The Prescription Review Panel gives oversight to the Prescription Review Program. Under the College Bylaws, its main responsibilities include:

- reviewing the prescribing of drugs on controlled prescriptions and selected other drugs, like benzodiazepines, sedatives/hypnotics, and stimulants, with addictive potential
- providing guidance to registrants on the use of these drugs by:
 - corresponding with physicians
 - reviewing submitted patient records and providing advice
 - directing that physicians attend for interview
 - assigning readings
 - providing relevant courses

Physicians participating in this practice improvement intervention are protected by provisions in the *Health Professions Act* giving privileged status to documents generated in the course of quality assurance activities.

The College approach to prescribing issues is collegial and educational. The program is informed by the PharmaNet database. When the College contacts physicians whose prescribing appears to be suboptimal, it is an offer to be helpful, not punitive. Most are unhappy with the status quo and grateful for the intervention. These educational activities qualify for Mainpro-M1 credits in the practice audit category.

The panel is motivated by the public health crisis associated with the dramatic increase in long-term opioid prescribing in the past decade. Prescription opioid misuse now accounts for more unintended deaths in British Columbia than drinking and driving. Accordingly, the panel gives emphasis to promoting:

- careful patient selection—a history of addiction and/or mental illness is a strong relative contraindication to long-term opioid prescribing
- an approach that includes firmly declining to prescribe combinations of opioids with benzodiazepines and/or sedative hypnotics—physicians should feel free to simply

advise patients that they cannot have both

HIGHLIGHTS IN 2015/16

- 175 files opened
- 185 files closed
- Foundation for Medical Excellence Chronic Pain and Suffering Symposium – February 19 to 20, 2016
- Continued implementation and ongoing review of a new case management system based on adult learning methods

PRESCRIBER'S COURSE IN 2015/16

May 14, 2015	16 attendees
May 15, 2015	24 attendees
November 25, 2015	35 attendees

Most of the day was spent in practice interviews with standardized patients.

B.A. Fleming, MD
Chair, Prescription Review Panel

INFORMATION

For more information regarding this report, please contact:

A.M. McNestry, MB, CCFP
Deputy Registrar

F.J. Bhimji, BSP
Manager, Drug Programs

Committee reports

Registration Committee

The scope of the Registration Committee is set out in section 1-15 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

PROVINCIAL

The College Bylaws recognize general/family practice international medical graduates (IMGs) who have not completed jurisdictionally approved and accredited postgraduate training, as recognized by the College of Family Physicians of Canada (currently only those IMGs from the United States of America, United Kingdom, Ireland and Australia are so reciprocally recognized), as eligible for provisional registration if they have undergone an assessment of competency (practice ready assessment or PRA) in a Canadian jurisdiction acceptable to the Registration Committee.

BC currently is in the second year of the Practice Ready Assessment – British Columbia (PRA-BC) program which is governed by a steering committee made up of representatives from the Physician Services Strategic Advisory Committee, the University of British Columbia, the College of Physicians and Surgeons of British Columbia, the BC Ministry of Health and its health authorities, the Doctors of BC and Health Match BC. The PRA - BC program was developed between 2012 to 2014 to create an acceptable entry-to-practice competency assessment program for general practitioners wanting to practise in British Columbia. The program consists of four components: a screening and selection process; point-in-time orientation and examination phase; a clinical field assessment; and an application for provisional registration and licensure from the College for successful program candidates. The clinical field assessment is 12 weeks in duration in a group general/family practice setting in BC. The first iteration of the PRA-BC program commenced in April 2015. Fourteen of the 15 candidates passed the competency-based assessment in late July 2015 and are now engaged in the independent practice of medicine as family practitioners under sponsorship and supervision. In the next year, there will be 60 candidates that go through the PRA-BC program.

Work continues on updating and developing policies that support the implementation of College Bylaws made pursuant to the *Health Professions Act*. Policy development and implementation has focused on defining parameters around current registration and licensure requirements for the various classes of registration and reviewing and updating the current registration assessment program.

Under the College Bylaws, certain registrants must meet criteria stipulated by the Registration Committee within a given time period (these are defined at the commencement of their practice in British Columbia). As part of this process, summative assessments are completed for those general/family practice registrants who were first registered under the provisions of the former *Medical Practitioners Act* (i.e. those registered prior to June 1, 2009) and who elect to undergo a summative practice assessment in lieu of obtaining their CCFP examinations. These are also completed for specialists trained in the United States of America who have registered under either the *Medical Practitioners Act* or the *Health Professions Act* and who have completed postgraduate training accredited by the Accreditation Council for Graduate Medical Education (ACGME) and who hold their American board specialty examinations. Those registrants with successful summative assessments are eligible to be granted registration and licensure in the full class in their primary specialty in lieu of obtaining Royal College of Physicians and Surgeons of Canada (RCPSC) certification if the practice eligibility route (PER) component 3 (Route B) examination is not available to them following two years of continuous practice in BC in the provisional – specialty class of registration.

The College developed and implemented an online application process for educational registrations with implementation in May 2015. This process has streamlined application and registration processes and improved the speed and efficiency of the College's work processes. Some improvements to the online application process for educational registrations will be made.

ONLINE ORIENTATION

The College has developed an online orientation for applicants applying for independent practice that was implemented in May 2015. The online orientation has reduced the number of applicants for independent practice that need to attend the College in-person for registration and licensure.

EXECUTIVE DIRECTOR, REGISTRATION

In January 2016, the College and the Committee welcomed Ms. Corinne de Bruin in the position of executive director, registration. Ms. de Bruin graduated with a Bachelor of Laws degree from the University of British Columbia and is certified with the Canadian Society of Association Executives. Prior to joining the College as director, registration in 2012, she held management positions in strategic planning, policy and program development at the Ministry of Finance, Workers' Compensation Board and Legal Services Society.

NATIONALLY

On the national level, work continues on developing national registration standards for the full class of registration for all provinces and territories. Together with the Medical Council of Canada (MCC), the Federation of Medical Regulatory Authorities of Canada (FMRAC) and its member colleges began developing the web-based electronic application process for physicians wanting to obtain full or provisional registration in any province or territory of Canada. The Medical Council of Canada launched a new system and candidate portal on May 23, 2013: the Application for Medical Registration in Canada (AMRC) at physiciansapply.ca. Pilots of the web-based electronic application began in 2013 in a few other Canadian provinces. The College will be coming on board with the AMRC process in 2016, with implementation anticipated by September 2016.

HIGHLIGHTS IN 2015/16

- 293 IMGs applied for registration in BC
- 78 Practice Ready Assessment program-related applications for eligibility were reviewed by the committee
- 136 new IMG applicants were granted provisional registration (provisional registrants must complete their Canadian qualifications by either examination or the PER within a defined time period)
- 111 new IMG applicants were granted full registration
- 116 IMGs previously on the provisional register were advanced to the full register

M. Corfield, DM
Chair, Registration Committee

INFORMATION

For more information regarding this report, please contact:

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Executive Director, Registration