College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

The College Connector

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In this issue:

The *College Connector* is sent to every current registrant of the College. Decisions of the College on matters of standards and guidelines are contained in this publication. Questions or comments about this publication should be directed to communications@cpsbc.ca.

Registrar's message

Pick up the phone and bring a human touch to the communication process

Every day the medical profession is confronted with a myriad of difficulties. It comes as no surprise that wait times for diagnostic imaging, specialist appointments and surgical procedures continue to be highlighted as an ongoing area of concern within the health-care system. Wait times, despite many good intentions and efforts, are an everyday reality. As physicians, it is our responsibility to work collaboratively with colleagues to find patient-centred solutions to system issues.

A recent report tabled by the Health Quality Council of Alberta (HQCA) entitled Continuity of Patient Care Study (December 19, 2013) highlights a system issue that contributed in the premature death of a young man with testicular cancer. The patient's family agreed to participate in the study and share details of his medical records "to rightly keep him, and other patients like him, in the centre of the issue of continuity of care." The report notes: "In these situations patient care is critically dependent on (1) reliable, accurate information being exchanged between providers and between providers and the patient; (2) maintaining continuity among providers in the management of a patient's condition(s); (3) providers understanding and agreeing on their individual responsibilities for the aspects of a patient's care; and (4) patients' awareness of who to contact for assistance with their healthcare needs, especially for emergencies or unexpected complications." To read the full report visit: https://d10k7k7mywg42z.cloudfront.net/assets/53275975f002ff4d14000011/Dec19_ContinuityofPatientCareStudy.pdf

Occasionally, the College hears from specialists who are concerned about the lack of information they receive about a patient from referring primary care physicians. Likewise, primary care physicians report that they do not receive confirmation from the specialist as to wait times for appointments. The HQCA report contained ten recommendations to ensure that patients are successfully transitioned through consultation, testing and treatment. The relationship between the primary care physician, specialist and institution is an important component. Physicians can ensure effective interactions between primary care physicians and consultants through clear communication. The College provides guidance on the matter in *Expectations of the Relationship between the Primary Care / Consulting Physician and Consultant Physician*.

The College's guideline clearly states that a primary care physician is required to provide enough information to the receiving consultant to triage the request. The same applies to requests for diagnostic tests. If the situation is obviously urgent, verbal communication between the consultant and the primary care physician is expected, to expedite the care. Simply put, pick up the phone and bring a human touch to the communication process—this ultimately equates to quality of care. The primary

care physician must remain vigilant to any change in the patient's status, and if the signs are ominous, this information must be conveyed to the consultant or facility where the patient is on a waiting list.

To complete the circle, the consultant must provide a prompt response to the referring physician acknowledging the referral and anticipated appointment date. The consultant and the primary care physician should discuss and mutually agree as to who will take responsibility for scheduling the appointment directly with the patient. Providing this information to the patient is the responsibility of both the primary care physician and consultant, and is an important step in the communication process.

The vast majority of BC physicians are working to achieve patient-centred care. Collaborative, two-way communication has the power to ensure that patients like the young man noted in the HQCA's report receive coordinated care and a seamless journey through the BC health-care system.

H.M. Oetter, MD
Registrar

We hope registrants and other readers enjoy this new method of receiving College news. We welcome your feedback.

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Creating a vision towards an excellent health-care system

A health-care system purpose built for all patients—elusive pipe dream or emerging reality?
Friday, September 26, 2014

Save the date for the much-anticipated College Education Day, held again this year at the Vancouver Convention Centre. This year's theme: building a quality health-care system that meets the needs of our province's diverse population. There will be sessions that focus on the challenges and obstacles, and compelling reasons for driving change. Other sessions will highlight current examples of physicians engaged in evidence-based initiatives that are improving care delivery for patients and practitioners.

For more information about the plenary and workshop topics and presenters, see the complete program.

Download the registration form now.

CME/CPD credits:

- Up to 5.75 Maintenance of Certification Section 1 credits
- Up to 5.75 Mainpro-M1 credits

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College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

New website login process for registrants—action is required

To ensure uninterrupted service following the transition to the new system, please take note of the following:

1. You must have a unique email address to log in to the website

    - To maximize privacy, all registrants will be required to have a unique email address associated with their own online profile. To avoid login issues during the annual licence renewal in January 2015, if you are currently sharing an email address with another registrant (e.g. spouse, partner, clinic) you are required to update your account with a unique email address by **August 29, 2014**. Email addresses can be updated by logging in to the College website.

    - **Note: Failure to provide a unique email address prior to the go-live date will prevent login to the College website.**

2. You will need to reset your password at first login

    - Registrants' passwords on the current legacy system are encrypted and cannot be transferred to the new system. Upon logging in to the College website for the first time following the go-live date, you will need to use the "reset password" feature to set up a new encrypted password. Attempts to login with your current password will result in a failure message.

3. You are limited to one home and two business addresses on your registrant profile

    - The new system has capacity to store a maximum of three addresses in total for each registrant—one home address and up to two business addresses. If you currently have more than two business addresses or more than one home address associated with your profile, you will be required to log in and delete addresses, and reset your preferred addresses. You must also indicate which address you would like to use as your primary address for College-related matters. Addresses will appear in the online physician directory in the order they are entered. Please be advised that if you do not self-select the preferred addresses you would like the College to retain by the go-live date, the new system will randomly and automatically force a selection.

    - **Note: Your home address will not appear in the online physician directory unless it is the only address you have provided to the College.**

4. Enabling security questions is always a good idea

- If you have not already done so, please activate security questions for your online profile for enhanced protection of privacy. The option to enable security questions is listed as a task under My Tasks on your profile page.

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Reporting a child in need of protection—what you need to know

The following is a fictitious story, which serves to illustrate the importance of early detection and action by health-care providers when child abuse is suspected. This story was provided to the College by Dr. Jean Hlady, FRCPC, Clinical Professor, Department of Pediatrics, UBC and Ms. Barbara Willson, RN, Nursing Practice Consultant, College of Registered Nurses of British Columbia.

Reporting a child in need of protection

A young mother brings her two-month-old infant to a child health clinic for his first checkup and immunizations. The infant's mother reports to the public health nurse that he is fussy, spits up frequently and is difficult to feed. She mentions that she has tried a different formula without success. The nurse notes that while the infant's weight gain is adequate and his development appropriate, the mother is concerned. The nurse suggests that the mother take her infant to their family physician. She also discusses strategies for managing fussiness and proceeds with the immunizations. The nurse arranges to follow up with the mother in two weeks.

A follow-up visit

At the next visit, the nurse notes that the infant has a dime-sized bruise on his left cheek. The mother says the infant's three-year-old brother hit him with a toy. She also says that she and the infant's father find the infant's crying stressful. She admits that yesterday the children's father became quite angry and pushed her. When the nurse questions her further, the mother states that the father does get angry but has never threatened or hurt her or the children. The nurse is concerned and gives the mother a domestic violence resource card. They talk about having a safe place to go. While the infant looks well, the nurse advises the mother to more closely watch the infant in the presence of the three-year-old. She discusses strategies for managing a crying infant and arranges a home visit in two weeks.

When the nurse arrives for the scheduled visit, no one is home. The nurse leaves her card with a note for the mother to call. She also calls the mother's cell phone and leaves a message.

An emergency department visit

Three weeks later the child presents to a nearby emergency department with bleeding from the mouth and is found to have a torn upper frenulum. The mother explains that the infant accidentally bumped heads with his father during feeding. The physician says this should heal with no problem. The infant looks well—his bruise has disappeared and the mother does not mention it. It is late on a Friday night and a social worker is not available. The infant is discharged.

Note to physicians: Bruising or oral injury in pre-cruising infants should be taken very seriously as they are commonly seen in abused infants and exceedingly rare in well infants.

Back in emergency

At age four months, the infant returns to the emergency department by ambulance. His mother claims she found him unresponsive and seizing earlier that morning. His condition is serious. He has severe abusive head trauma, including bilateral subdural hematomas, retinal hemorrhages and four old rib fractures of two different ages.

The infant survives but is left with permanent neurological damage.

Questions to consider?

- What red flags should have alerted health professionals to the potential for abuse?
- What other questions should the health professionals have asked the infant's mother?
- What else could have been done to prevent this tragic outcome?

Your legal obligation—early detection and reporting is critical

All health professionals have a legal obligation to report a child in need of protection to a local child protection social worker with the Ministry of Children and Family Development (Helpline for Children 310-1234—no area code is required). If in doubt, consult with someone who has experience in this area.

There are five specialty teams across the province that offer additional support and guidance. **Note:** *Contacting them does not replace the obligation to report concerns to a child protection social worker.*

- Child Protection Service Unit, BC Children's Hospital 604-875-3270
- Northern Health SCAN Clinic, Prince George 250-565-2120
- Health Evaluation, Assessment and Liaison (HEAL) Team, Surrey Memorial Hospital 604-585-5634
- Vancouver Island Suspected Child Abuse and Neglect Team, Nanaimo 250-755-7945
- Kamloops Suspected Child Abuse and Neglect Clinic, Royal Inland Hospital 250-314-2775

What does "reason to believe" mean?

In British Columbia, anyone with *reason to believe* that a child has been or is likely to be abused or neglected—and the child's parent is unwilling or unable to protect them—has a legal duty to report that concern to a child protection social worker. Reason to believe simply means that, based on what you have seen or information you have received, you believe a child has been or is likely to be at risk. You do not need to be certain. It is the child protection social worker's job to determine whether abuse or neglect has occurred or is likely to occur.

Resources

British Columbia, Ministry of Children and Family Development. The B.C. handbook for action on child abuse and neglect: for service providers [Internet]. [Victoria, BC: Ministry of Children and Family Development; 2007]. [cited 2014 Aug 6]. 64 p.

Sheets LK, Leach ME, Koszewski IJ, Lessmeier AM, Nugent M, Simpson P. Sentinel injuries in infants evaluated for child physical abuse. *Pediatrics*. 2013 Apr;131(4):701-7.

Professional Standards and Guidelines

Physicians should be aware of their reporting obligations as described in the new standard *Reporting a Child in Need of Protection*.

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New or updated professional standards and guidelines

The College develops *Professional Standards and Guidelines* to assist physicians in meeting high standards of medical practice and conduct. The topics addressed focus on specific issues that are relevant to the practice of medicine. Physicians are encouraged to become familiar with the College's *Professional Standards and Guidelines*. The *Professional Standards and Guidelines* are reviewed regularly and may be updated over time.

New

- Reporting a Child in Need of Protection

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Updates from the Physician Practice Enhancement Program

Transient care is not a scope of practice

Walk-in clinics provide a valuable service to patients in providing care to those who are unable to see their own family physicians and whose medical care concerns do not need to be addressed in an emergency department. The provision of transient care is appropriate as long as there is effective continuity of care and follow-up. However, concerns arise when patients who do not have a family physician are told to find a family physician for their follow-up care. Despite the work by divisions of family medicine and others in improving patient access to family physicians, the reality is that a large number of patients are still unable to find a family physician and therefore have chosen a walk-in clinic as their "medical home."

Physicians working in walk-in clinics sometimes define their medical practice as confined to the provision of transient care. The College does not recognize "transient care" as a scope of practice. The College does appreciate the difficulty imposed on physicians obliged to take on the role of most responsible physician for patients who have no family physician, particularly if they themselves work only episodically in a walk-in clinic. In situations such as this, a reasonable solution is for walk-in clinic physicians to provide longitudinal care to those patients who have no family physician and have chosen to use the clinic for all their health-care needs by a shared-care model.

All clinic physicians thereby assume appropriate longitudinal and proactive patient care responsibility. In order to enable such a model, clinic physicians must have a system in place that provides detailed recorded care along with a cumulative patient profile. Ideally, all physicians should use an electronic medical record that identifies a most responsible physician (MRP) for the patient.

While it is hoped that all patients will eventually have access to their own family physician, the College is pleased to note that in the interim a number of community walk-in clinic physicians have agreed to participate in the longitudinal care of patients who have adopted the walk-in clinic as their medical home.

Through its Physician Practice Enhancement Program, the College will support responsible proactive activities such as this and persuade others to do so.

The Physician Practice Enhancement Program 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.

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Updates from the Prescription Review Program

Expanded focus on the national drug strategy

The harms associated with controlled psychoactive prescription drugs such as opioid analgesics, sedative-hypnotics and stimulants represent a significant public health concern. A recent study from Ontario published in the journal *Addiction* found that opioid deaths, for example, increased 242% in the 10 years from 1991 to 2010.

In response to this growing problem, the federal government has committed $44.9 million over the next five years to expand the focus of the national anti-drug strategy to include activities to address prescription drug abuse. This includes working closely with regulatory authorities such as the various provincial colleges of physicians and surgeons.

In British Columbia, the College has in place a number of mechanisms to support practitioners' prescribing practices for controlled substances. For example, the Prescription Review Program—one of the College's quality assurance activities—assists physicians with the challenging task of prescribing potentially addictive medications with appropriate caution. The work of the program is informed by the PharmaNet database.

In addition, the College offers an annual Prescribers Course, where participants learn techniques for talking to patients in realistic terms about the risks and benefits that attend the use of opioids, benzodiazepines and other potentially habituating medications—situations that challenge even the most seasoned practitioners. Participants in this intensive course learn new approaches, primarily though interview simulations in small groups, supported by sympathetic, experienced and clinical teachers.

Given growing demand for the Prescribers Course, the College will offer for the first time two sessions on November 27 and 28, 2014. Registrants interested in attending should contact the Prescription Review Program at 604-733-7758 extension 2629.

Protecting patients from unauthorized access to PharmaNet and other electronic systems

The *Vancouver Sun* recently reported a breach of prescription records in the PharmaNet system that affected 1,600 people. By accessing a physician's PharmaNet account without consent, an unauthorized individual was able to see personal patient information including names, dates of birth, addresses, telephone numbers, and medication histories. Although the breach did not result in fraudulent prescriptions, enough information was accessed to be used for identify theft.

For physicians using electronic health information systems—including electronic medical records and PharmaNet—ensuring the privacy and security of data is both a professional and legal obligation. The

College expects registrants to be aware of and comply with their obligations, and to ensure that patient information under the custody and control of physicians' private practice offices is handled in a secure manner from the time the patient records are created to the time patient information is disposed.

Physicians' private practice offices are subject to the *Personal Information Protection Act*, SBC 2003, c.63, which requires physicians to make reasonable security arrangements to protect personal information, including patient medical records, from unauthorized access, use, disclosure and disposal, and sets out consequences for non-compliance.

Registrants have at their disposal a number of resources to assist them in meeting their professional and legal obligations in this area:

1. The Canadian Medical Association describes the ethical obligations of physicians regarding privacy and confidentiality in its *Code of Ethics*.
2. The College, the Doctors of BC (formerly the British Columbia Medical Association) and the Office of the Information and Privacy Commissioner of British Columbia (OIPC) have jointly issued two documents. The first document entitled *Physicians & Security of Personal Information* discusses safeguards for protecting patient records, and the second, *BC Physician Privacy Toolkit*, includes a section outlining key steps for physicians when responding to a privacy breach.
3. The College has a number of professional standards and guidelines related to medical records. All are available on the College's website under For Physicians > Standards and Guidelines.

Registrants who have specific inquiries about patient confidentiality and privacy are encouraged to seek the guidance of legal counsel or the Canadian Medical Protective Association (CMPA) or may contact the College's registrar staff to discuss expectations.

The Prescription Review Program (PRP) is a practice quality assurance activity established to assist physicians in the challenging task of utilizing opioids, benzodiazepines, and other potentially addictive medications with appropriate caution for the benefit of their patients. The work of the PRP is informed by the PharmaNet database.

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Updates from the Non-Hospital Medical and Surgical Facilities Program

All medical staff—including surgical assists—must be authorized by the NHMSFP Committee

Medical directors are reminded that, in accordance with section 5-5 of the Bylaws made under the *Health Professions Act*, an initial application for appointment of all medical staff to the facility must be submitted to the Non-Hospital Medical and Surgical Facilities Program Committee for approval, including surgical assists. In addition, medical directors are responsible for ensuring that members of their medical staff perform only those procedures which they are individually authorized by the committee to perform.

Continuous quality improvement

Non-Hospital Medical and Surgical Facility Program accreditation involves preparing for an accreditation visit; and, even more importantly, it requires facility commitment to continuous self-assessment and evaluation of the quality and safety of patient care delivery. Between accreditation visits non-hospital facilities, through their own quality improvement (QI) programs, are expected to continually evaluate their performance to identify their strengths, risks and opportunities for improvement—and to take action to correct deficiencies.

During the 2014-15 accreditation cycle, in addition to conducting a comprehensive patient and facility tracer, the accreditation team will focus on the following QI initiatives:

- medication management, e.g. patient-specific orders, preparation, storage
- allergy management
- surgical safety checklist compliance
- post-anesthesia discharge scoring system
- anesthesia equipment reprocessing
- obstructive sleep apnea screening and post-anesthesia care
- hand hygiene education and compliance auditing

The Non-Hospital Medical and Surgical Facilities Program requires private facilities to maintain high standards of practice equal to or exceeding public hospitals. The program establishes accreditation and performance standards, procedures and guidelines to ensure the delivery of high quality health services. The 700 physicians who work in private facilities across the province must be granted privileges by the College.

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CME events: mark your calendars

Methadone 101/Hospitalist Workshop
Saturday, September 13, 2014
https://www.cpsbc.ca/for-physicians/professional-development/methadone-101-hospitalist-2014-09

A health-care system purpose-built for all patients—elusive pipe dream or emerging reality? – 2014 Education Day
Friday, September 26, 2014 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/education-day-agm-2014

Finding medical evidence: supporting patient care – using the Internet to your advantage
Saturday, September 27, 2014 – Vancouver
http://www.ubccpd.ca/course/fme-vancouver-2014

Spirometry for Health-care Providers
Saturday, September 27, 2014 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/spirometry-2014-09

Professional Boundaries in the Physician-Patient Relationship
Friday, November 14, 2014 – Edmonton, AB
https://www.cpsbc.ca/content/professional-boundaries-physician-patient-relationship

Prescribers Course
Thursday, November 27, 2014 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/prescribers-course-2014-11-27

Prescribers Course
Friday, November 28, 2014 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/prescribers-course-2014-11-28

Medical Record Keeping for Physicians
Wednesday, February 4, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/medical-record-keeping-2015-02

Pain and Suffering Symposium
Friday, March 6, 2015 to Saturday, March 7, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/pain-suffering-symposium-2015
http://tfme.org/component/content/article/15--pain-management-conference/174-assessment-a-management-of-patients-with-complex-chronic-pain-2015

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