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

Guard against the risk of creating an impression that you are facilitating the unauthorized practice of medicine

On March 19, 2015, the BC Supreme Court granted an Order prohibiting Ms. Anita Fofie of Dermix Institute of Aesthetic Medicine located in downtown Vancouver from injecting medication including, abobotulinumtoxin A (Dysport®) and Restylane® (containing hyaluronic acid), which as an unlicensed practitioner she is not authorized to inject. Under BC law, the injection of such medication is a medical service that only physicians, dental surgeons, naturopaths who have been granted certification in esthetic procedures – cosmetic Botox®, and registered nurses and licensed practical nurses under the order of a physician are allowed to perform. Fortunately, in this instance, no public health or infection control concerns were identified.

While this was the first time the College has gone to court to obtain an injunction against an individual posing as a physician for the purpose of injecting medication for cosmetic enhancement, it may not be the last as injectable product becomes increasingly available, and stories of botched procedures continue to make headlines.

Registrants may have heard of another recent seizure in Vancouver by Health Canada of a product being injected for cosmetic purposes that was not labelled, inspected, nor deemed safe for human beings; or the shocking incident in Toronto where an unlicensed practitioner was found guilty of criminal negligence causing bodily harm after a woman was hospitalized following injections of industrial silicone in her buttocks.

In hearing these stories it might be tempting to conclude that it is solely the unlicensed practitioners who put patients at risk by misrepresenting themselves, and injecting medication and other products into innocent patients looking for low-cost cosmetic enhancements.

Unfortunately, the College has encountered a number of cases of late where registrants are either directly or indirectly involved in unauthorized practice. In some instances, during the course of investigating allegations of unauthorized practice by non-registrants, the College has found that registrants have knowingly allowed themselves to be identified as the “medical director” of a spa or other personal service establishment (PSE) offering Botox® or dermal filler treatments. To make matters worse, these medical directors may be physically absent from the premises, and may never have met with the patients/clients of the PSE, even though they were fully aware that an unregulated individual was providing an injectable treatment.

Registrants who are involved in the injection of medication for cosmetic purposes should be aware that the following circumstances or arrangements are not acceptable and may be deemed unprofessional conduct:

1. Registrants must not sign documentation agreeing to be the "medical director" of a spa or PSE, where that agreement includes providing oversight to unauthorized practitioners who inject medication.
2. Registrants must not allow unauthorized practitioners to purchase injectable prescription medication using their name and CPSID number.
3. Registrants must not train unauthorized individuals to inject medication, and must not issue "certificates" which could be used by those individuals to mislead patients.
4. Registrants should not establish a business association with individuals who may misrepresent that association to the public (e.g. use the registrant's name and status as a physician to legitimize their business and the treatments they provide). Registrants must take extreme measures to guard against the risk of creating an impression that they are facilitating the unauthorized practice of medicine.

The College will continue to do whatever it can to stop unauthorized practitioners from putting the public at risk. In collaboration with British Columbia's 26 regulated health professionals, the College is also actively involved in a public awareness campaign, which focuses on the importance of seeing a regulated health professional and verifying credentials before agreeing to any treatment.

Registrants also have an important role to play in educating patients and ensuring that their business associations don't inadvertently put patients at risk. Situations as described above may be investigated by the Inquiry Committee, and may result in findings of unprofessional conduct.

Registrants should familiarize themselves with the professional standard: *Injection of Botulinum Toxin, Dermal Fillers and Venous Sclerotherapy*

H.M. Oetter, MD
Registrar

We welcome your feedback on any article contained in the College Connector.

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New deputy registrar joins the College to lead QA and accreditation programs

The College is very pleased to announce the appointment of Michael J. Murray, MD, CCFP(EM), MHSc, CHE to the position of deputy registrar, providing strategic leadership for the Physician Practice Enhancement Program, the Non-Hospital Medical and Surgical Facilities Program and the Diagnostic Accreditation Program.

Dr. Murray most recently held the position of executive medical director for quality improvement and chief medical information officer for the Interior Health Authority. Prior to this he was the senior medical director for tertiary acute services for the Interior Health Authority. He brings with him five years of health leadership and administration experience in BC, and over a decade of health administration experience from Ontario in his roles of VP medicine and chief medical executive, and chief of staff at a regional acute care hospital. Dr. Murray has held the position of president of the Canadian Association of Emergency Physicians and president of the International Federation for Emergency Medicine.

He has been a member of various provincial committees including the Physician Services Strategic Advisory Committee (PSSAC), Physician Quality Assurance Steering Committee (PQASC), and the IMIT Executive Committee (IMITEC).

Dr. Murray obtained his medical degree from the University of Western Ontario in 1983. He holds certification in family medicine and emergency medicine from the University of Ottawa. In 2008 he obtained a master's degree in health administration from the University of Toronto, and received the distinguished Robert Woods Johnson award that same year. He is designated as a certified health-care executive from the Canadian College of Health Leaders, and is a clinical lecturer in the department of family practice at UBC. Previously, he was clinical associate professor in the department of family medicine at McMaster University.

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Announcing the launch of the province's first-ever practice ready assessment for internationally trained family physicians

British Columbia's first Practice Ready Assessment Program for family physicians, PRA-BC, will launch its inaugural pilot in April 2015 with a second pilot scheduled for fall 2015. The first cohort of 20 candidates is scheduled to complete a three-week orientation and examination process in Vancouver this month. These candidates include jurisdictionally recognized family physicians from South Africa, Iraq, Nigeria, Egypt, Pakistan, India, China and Poland.

Unlike applicants who completed their training in the United States, United Kingdom, Ireland and Australia, and who are eligible for registration and licensure through reciprocal recognition by the College of Family Physicians of Canada, candidates in the PRA-BC program must complete a rigorous and comprehensive 12-week clinical field assessment following their success on a number of examinations conducted as part of the orientation process. During 2015, the PRA-BC program will enable up to 30 additional family physicians, who would not otherwise be eligible to practise in BC, an opportunity to be registered and licensed for independent practice.

PRA-BC is aligned with the National Assessment Collaboration (NAC) Practice Ready Assessment (PRA) program's standards and pan-Canadian processes which have been developed with the assistance of a number of Canadian organizations including Health Canada, the Medical Council of Canada (MCC), the Federation of Medical Regulatory Authorities of Canada (FMRAC), the Association of Faculties of Medicine of Canada (AFMC), the Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC), regional IMG assessment programs, provincial and territorial government representatives, and provincial and territorial medical regulatory authorities.

The PRA-BC program is an intense, comprehensive and rigorous competency-based assessment to determine if a candidate is ready to safely enter family practice in the provisional class of registration under sponsorship and supervision. The program consists of an initial screening and selection process, consistent with the NAC PRA family medicine standards, an orientation and examination component, a 12-week clinical field assessment in a health authority designated community, and a three year return of service in a community clinic chosen by the sponsoring health authority. The initial screening process requires candidates to demonstrate that they have completed a minimum of two years of family medicine training in their foreign jurisdiction, including rotations in internal medicine, general surgery, obstetrics and gynecology, pediatrics, emergency medicine, psychiatry, and family medicine, and that they practise as family physicians in that jurisdiction.

All candidates must successfully pass the Medical Council of Canada Evaluating Examination (MCCEE) and demonstrate English language proficiency to the standards required by the College. Candidates must also meet the College's currency for practice requirements and must have their identification, academic credentials and postgraduate training verified by the Medical Council of Canada's Physician Credentials Registry of Canada (PCRC). Successful program candidates will then be required to provide

the College with certificates of professional conduct to confirm that they are of good character and fit to practise family medicine.

Learn more about the assessment process and curriculum

Interested IMG family physicians should contact Health Match BC to discuss whether or not they are eligible to apply for entry into the PRA-BC program, and to learn more about the program's screening and selection processes.

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After-hours coverage is a professional and legal obligation

The January/February issue of the *College Connector* included a reminder from the Physician Practice Enhancement Program (PPEP) that office practice assessors too often find that after-hours coverage is deficient. Some physicians have indicated to the College that the advice was unclear. In the meantime, there have been media reports of disputes in this regard between physicians and medical regulators in other provinces:

Manitoba
Doctors not on board with on-call order – *Winnipeg Free Press*

Alberta
Alberta doctors neglect after hours care – *Edmonton Journal*

There is no ambiguity in British Columbia: the provision of after-hours coverage is a professional and legal imperative for all physicians. It is both a professional standard of the College Board titled *After-Hours Coverage* and a part of the common law duty of care (see CMPA's *Medico-legal handbook*, under Duty of Care).

Among other things the professional standard states that:

- The provision of ongoing medical care is not only the responsibility of the family physician, but also of specialists and other focused-practice physicians who are involved in the treatment of patients.
- Physicians may assign on-call coverage to groups of physicians or to local emergency departments if all parties have agreed to this arrangement in advance. It is not appropriate to leave a message for patients telling them to go to an emergency department for after-hours, non-urgent care if this has not been arranged with and agreed to by the physicians in the emergency department.
- Physicians must also ensure that their patients are aware of the on-call or after-hours coverage that is available to them.

The CMPA's *Medico-legal handbook* states: "Referral or coverage arrangements must be made when the physician will not be available to continue to treat the patient."

Recorded voice messages should provide callers with contact information for a physician who has agreed to provide coverage. Family physicians and specialists in groups should normally ensure that someone is designated to field phone calls, usually as part of an on-call rota. Given the reality that patients do not call as often as they once did, some physicians advise that they fulfill this obligation by providing their personal cell phone numbers and cover the practice themselves. Where group call is not feasible, such as the situation of solo subspecialists in small communities, physicians must make explicit

arrangements with other physicians to ensure that the practice is covered when they are not available. It is also acceptable to have calls managed initially by a first-tier responder (such as an advanced practice nurse or even a lay answering service), but only as part of an established protocol; a physician must be immediately available to the first responder.

Registrants should be aware that recorded messages with general direction to attend at an ER or walk-in or call the BC NurseLine are not acceptable.

In the event of a civil action or a College complaint where availability after hours is an issue, these are the standards by which physicians will be judged.

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Don't practise without a formal written agreement

The College receives numerous distress calls from physicians in the midst of crumbling practice arrangements. There are many variations. Sometimes it is long-term associates seeking to leave. It may be a clinic medical director or group feeling abandoned and abused by the conduct of a departing colleague. Increasingly, it is physicians in novel arrangements with other organizations such as university student health services, hospitals, a provincial health services provider, or non-physician owners of a primary care clinic. As the crisis unfolds, the College too often becomes unproductively embroiled in the dispute. The College has neither the authority nor the capacity to provide legal or mediation services.

Physicians in these difficult circumstances appropriately cite their obligation to ensure that patients are protected. The College's first question to them is whether they took proactive steps to address these legal, professional, and ethical issues by insisting they were comprehensively covered in a written agreement or contract before seeing their first patient. In most cases, there is no agreement and nothing exists in writing. This type of situation is unacceptable and may even be characterized as unprofessional.

The College's professional standard on *Medical Records* includes these statements:

- Physicians have an ethical, professional and legal obligation to ensure that *before they create a medical record* they comprehensively address the issues of ownership, custody, confidentiality and enduring access for themselves and their patients.
- The College cannot arbitrate ownership of medical records retrospectively.

Every time a physician provides a medical service to a patient, s/he takes on a bundle of obligations such as ensuring continuity of care, follow-up of reports and management of records. Physicians must ensure in advance that everyone involved in the practice arrangement (colleagues, clinic owners, EMR vendors, other professionals, administrators) is engaged in a manner that will allow physicians to fulfill their obligations to patients.

Some of these obligations are set out in the College's *Professional Standards and Guidelines*, including, *Medical Records*, *Primary Care Multi-physician Clinics*, *After-Hours Coverage*, *Conflict of Interest*, *Telemedicine*, and *Ending the Patient-Physician Relationship*. Some derive from the common law duty of care. Both the College and the CMPA are available to discuss these issues, but neither has a mandate to assist with individual contracts.

For review:
Medico-legal issues to consider with individual contracts
CMPA assistance with general contracts

Physicians dealing with private business matters should seek the assistance of their personal lawyers. Although physicians may be concerned with legal costs, the consequences of failing to obtain timely legal advice may be even more expensive in the long run, as well as personally stressful. Some physicians advise that the clinical activity where the problem arose was too small to justify legal advice or a contract—a few shifts in a walk-in clinic, for example. Based on the multitude of sad stories brought to the College's attention, it would be wise to question whether minor commitments are worth the risk. The lesson may be that a professional association too small to warrant a formal contract should be declined.

The bottom line is that every professional working relationship will end eventually, usually leaving one or more physicians significantly inconvenienced. Under section 16 of the *Health Professions Act*, the sole duty and object of the College is public protection. The College has a very limited role in assisting physicians in their business affairs or protecting them from each other. The College's job is to ensure that patients are not harmed by the business decisions their physicians make.
The College urges all physicians currently practising in a setting without a contract or equivalent written agreement to take immediate steps to ensure that they have one.

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Cultural competency—Canada's history and today's physician

Cultural competence (CC) means that "as physicians, we must make multiple communication adjustments each day when interacting with our patients to provide care that is responsive to the diverse cultural backgrounds of patients in our highly multicultural nation" (Caron, 2006, p.20). Indigenous cultural competency (ICC) is being able to recognize and respect the unique history of indigenous peoples in order to provide appropriate care in a respectful and safe way. One may say culturally competent care is "targeted" or "personalized" medicine based on the individual's culture, history, and personal sociocultural background.

The *Transformative Change Accord: First Nations Health Plan, 2005* was created to direct the improvement of the health of First Nations peoples and close the gap compared to the general population by 2015. This agreement saw the development of ICC curriculum and the commencement of training for health authorities' staff in 2008-2009.
The San'yas Indigenous Cultural Safety program[1] is an accredited[2] online training program designed to "increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Aboriginal people" (PHSA, 2015). San'yas is a valuable learning opportunity for any individual interested in closely examining the broader issues affecting indigenous peoples attempting to access health-care services.

Why is it relevant?

Creating a culturally safe space in a practice empowers patients to participate more effectively in the patient-physician relationship where the desired outcome is that patients access care sooner, and adhere to treatment plans that are specifically designed to improve their health (NCCAH, 2013). With a focus on patient-centred care it makes sense to establish a culturally competent manner of communication, and care plans that address individual needs, backgrounds and expectations.

Increasingly, BC physicians and trainees are engaging in this San'yas curriculum. Emergency medicine physicians in Prince George committed to completing this training by 2015/16; perhaps not surprising as the Northern Health Authority has the highest participation rate of the geographic health authorities, according to Leslie Varley (personal communication, March 30, 2015). Fraser Health Authority independently committed to training its workforce in ICC by 2015 (PHSA, 2014). Interest has also been shown by BC's international medical graduate workforce, and the entire 2014/15 first year UBC medical school class enrolled in the ICC training program in parallel to their general medical school curriculum.[3]

In 2005, then National Chief Phil Fontaine stated that in order to bridge the gap between First Nations patients and their health-care professionals it was important "'to know our history—our true history,

not what they teach in school.'… [and that an] understanding of this history should *not* be optional" (Caron, 2006, p.23).

By 2014, thousands of health-care professionals had completed the ICC program, and the PHSA continues to consult with other provinces that aim to develop this training for their health care professionals.[4]

College supports ICC courses

With the new First Nations Health Authority requesting this ICC training and accompanying health care services for its people, the College of Physicians and Surgeons of BC has agreed to add a mandatory question to the 2016 Annual Licence Renewal Form inquiring whether registrants have completed ICC training.[5] The resulting data will be linked to patient satisfaction and health-care evaluations in follow-up analysis. The College supports the utility of ICC courses, such as those offered through the San'yas program, to maintain standards of excellence in BC.

For many at the hub of this movement, it has been a long road. The assertion that "cultural competency is a necessary currency in managing medical conditions today," (Caron, 2006, p.23) was not questioned in 2006, yet we continue to accept mere "competence" as a goal. Where else in the medical profession is "adequate" a driving goal and ambition? When do we drop competence for a loftier expectation? When nothing less is accepted, as a profession we should expect more.
More information on the Indigenous Cultural Competency Training Program can be found here.

References

Caron NR. Caring for Aboriginal patients: the culturally competent physician. Royal College Outlook [Internet]. 2006 [cited 2015 Apr 7];3(2):19-23. Available from:http://www.med.uottawa.ca/sim/data/Images/Aboriginal_care_Caron_e.pdf

British Columbia; First Nations Summit; BC Assembly of First Nations; Union of British Columbia Indian Chiefs. Transformative change accord: First Nations health plan - supporting the health and wellness of First Nations in British Columbia [Internet]. [Victoria, BC: Province of British Columbia, 2006] [cited 2015 Apr 7]. 20 p. Available from: http://www.nccah-ccnsa.ca/docs/social%20determinates/FirstNationsHealthImplementationPlan_Combo_LowRes.pdf

National Collaborating Centre for Aboriginal Health [Internet]. Prince George, BC: National Collaborating Centre for Aboriginal Health; 2013. Cultural safety in health care [cited 2015 Apr 7]; [about 2 screens]. Available from:http://www.nccah-ccnsa.ca/368/Cultural_Safety_in_Healthcare.nccah

Jayatilaka D. Dancing in both worlds: a review of the aboriginal patient liaison/navigation program in British Columbia [Internet]. Victoria: Provincial Health Services Authority; 2014 [cited 2015 Apr 7]. 88 p. Available from:http://www.phsa.ca/Documents/DancinginBothWorldsFINALJuly2015.pdf

Indigenous cultural competency training program [Internet]. Victoria: Provincial Health Services Authority; 2015 [cited 2015 Apr 7]. Available from: http://www.culturalcompetency.ca

Footnotes

1. Leslie Varley, Director, Aboriginal Health Program of the Provincial Health Services Authority (personal communication, March 28, 2015) communicated that the PHSA changed the name of the Indigenous Cultural Competency training program to San'yas Indigenous Cultural Safety program as of March 2015.

2. The ICC training program/San'yas Indigenous Cultural Safety program has accreditation with the College of Family Physicians of Canada and the Canadian Counseling and Psychotherapy Association. It is currently seeking accreditation with the Royal College of Physicians and Surgeons of Canada.
3. PHSA offered the ICC training to UBC Faculty of Medicine as a pilot project without additional cost to the students or to UBC. At the time of this article, the project underwent an evaluation process and the results are forthcoming.
4. BC PHSA website: http://www.culturalcompetency.ca/training/ontario
5. There are Indigenous cultural competency training programs available in and across Canada.

About the authors

Nadine Caron, MD, MPH, FRCSC is a general and endocrine surgeon in Prince George, British Columbia. She is an advocate for aboriginal health and was the first female aboriginal student to graduate from the University of British Columbia (UBC) medical school. Dr. Caron is co-director of UBC's Centre for Excellence in Indigenous Health.

Jennifer Mackie, MSc, is the administrative manager for UBC's Centre for Excellence in Indigenous Health and a researcher in indigenous community health.

Leslie Varley is director of the Aboriginal Health Program at the Provincial Health Services Authority.
Cheryl Ward is the provincial lead for the Indigenous Cultural Competency curriculum in the Aboriginal Health Program at the Provincial Health Services Authority.

Evan Adams, MD, MPH is chief medical officer for the First Nations Health Authority and the former deputy provincial health officer.

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Update from the drug programs

DRUG PROGRAMS Update

Be aware of the dangers of prescribing tricyclic antidepressants for methadone patients

As many as half of all patients in methadone maintenance therapy may also suffer from depression. While physicians often understand the challenges of treating patients suffering from both addiction and depression, not all may be aware of the dangers of prescribing tricyclic antidepressants (TCAs) such as amitriptyline and desipramine for patients on methadone. Understanding these risks can help physicians to select appropriate therapies and reduce the chance of adverse drug events.

Tricyclic antidepressants, often known as "first generation" antidepressants, are less commonly prescribed than newer antidepressants such as SSRIs, which have fewer side effects. However, TCAs are still considered effective and are used for treatment-resistant depression, which may be one reason why methadone prescribers may consider using them.

Although evidence suggests that the concurrent use of most opioids and tricyclics is uneventful, methadone prescribers should be aware that serum levels of tricyclic antidepressants have been shown to increase when co-administered with methadone. This may be significant since both methadone and tricyclic antidepressants can prolong the QT interval and perhaps increase the risk of arrhythmias. Indeed, such risks are more than theoretical. In a 2006 study of coroner's cases in New York City, Chan et al. found that the odds of an accidental overdose death were more than double among methadone patients testing positive for a TCA than for those on methadone alone.[1]

Physicians treating patients on methadone maintenance therapy can take a number of steps to reduce the risk of adverse events associated with concomitant use of TCAs:

1. Consider alternative antidepressant therapies first. TCAs should never be used as first-line treatment for depression in methadone patients.
2. Check PharmaNet. PharmaNet review is mandatory in methadone clinics in British Columbia. When reviewing a methadone patient's PharmaNet profile, physicians should check for the prescribing of TCAs.
3. Consider random urine drug testing for TCAs. Some MMT patients abuse TCAs for their sedative effects. If obtained illicitly, these drugs will not appear on the patient's PharmaNet profile, and patients may not admit to their use.
4. Chan GM, Stajic M, Marker EK, Hoffman RS, Nelson LS. Testing positive for methadone and either a tricyclic antidepressant or a benzodiazepine is associated with an accidental overdose death: analysis of medical examiner data. Acad Emerg Med. 2006 May;13(5):543-7.

Add fentanyl testing to random urine drug screens as part of pharmacovigilance strategy

The College recently reviewed a case of a physician whose PharmaNet profile suggested a high number of patients abusing prescription opioids. The physician in question had been performing random urine drug screens as part of his pharmacovigilance strategy but had not discovered anything out of the ordinary. Nonetheless, suspicions remained, and after discussing the issue with one of the College's medical consultants, the physician added fentanyl testing to the urine drug screens. The results showed that all of the patients in questions were using fentanyl illicitly.

Fentanyl is a synthetic opioid that is 50 to100 times more potent than morphine.[1] Its use with a transdermal delivery system ("the patch") makes it unique among opioids, and it has become an increasingly common choice for the management of chronic pain[2]. However, as with other powerful opioids, fentanyl has been associated with a risk of overdose, misuse, and diversion. Multiple jurisdictions in North America, Europe, and Australia have reported a spike in illicit fentanyl use and a corresponding increase in fentanyl-related deaths in the past several years.

In October 2014, Vancouver police issued a warning about fentanyl being sold as heroin, leading to more than 30 overdoses and at least two deaths since then.

Since fentanyl is not reactive in immunoassay screening tests for opioids, negative screens for morphine and other such drugs are not indicative of fentanyl non-use. In cases of suspected opioid misuse but negative screening for morphine and the like, physicians should specifically request testing for fentanyl.[3]

References

1. Mercado-Crespo MC, Sumner SA, Spelke MB, Sugerman DE, Stanley C. Notes from the field: increase in fentanyl-related overdose deaths - Rhode Island, November 2013-March 2014. MMWR Morb Mortal Wkly Rep. 2014 Jun 20;63(24):531.
2. Krinsky CS, Lathrop SL, Crossey M, Baker G, Zumwalt R. A toxicology-based review of fentanyl-related deaths in New Mexico (1986-2007). Am J Forensic Med Pathol. 2011 Dec;32(4):347-51.
3. Berens AI, Voets AJ, Demedts P. Illicit fentanyl in Europe. Lancet. 1996 May 11;347(9011):1334-5.

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College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

Updates from the Non-Hospital Medical and Surgical Facilities Program

NHMSFP Update

Bilateral simultaneous cataract surgery not allowed in a non-hospital setting

As peer-reviewed literature on the safety of bilateral simultaneous cataract surgery (also known as immediately sequential or same-day cataract surgery) remains limited, medical directors are reminded that bilateral simultaneous cataract surgery may not be performed in a non-hospital setting.
For further information, please refer to the Canadian Ophthalmological Society evidence-based clinical practice guidelines for cataract surgery in the adult eye.

Abdominoplasty complication rate benchmarks

The NHMSFP Committee is pleased to report that BC non-hospital complication rates of abdominoplasty +/- combined procedures fall within acceptable levels as per the tracking operations and outcomes of plastic surgeons (TOPS) database, which collates data from many sources including the American Society of Plastic Surgeons and the American Society of Aesthetic Plastic Surgery.

The TOPS data is collected using a similar model to the self-reporting of non-hospital facilities and therefore is considered an acceptable benchmark to compare current complication rates of abdominoplasties performed in the non-hospital setting.

Incident reporting and review is one of the many ways facility medical directors and the NHMSFP Committee demonstrates their commitment to patient safety and quality care.

TOPS Benchmarks for Abdominoplasty

	Total Complication Rate (%)	Infection rate Abdominoplasty Site (%)	Total Rate of all Infections (%)	Rate of venous thrombosis/ pulmonary embolism (%)	Rate of Abdominal hematomas (%)
NHMSFP **Abdominoplasties +/- combined with other procedures**	4.6	0.6	1.0	0.001	1.3
TOPS (2009 data) **(abdominoplasty only)**	4.7	3.5	-	0.02	0.6-3.0

New infection prevention and control advisor joins program team

Ms. Sandra Daniels, BTech Emergency and Intensive Care Nursing, MScN (c), RN has joined the College as an infection prevention and control (ICP) advisor in the Non-Hospital Medical and Surgical Facilities Program. Ms. Daniels previously worked in Fraser Health as an ICP managing consultant. Her background includes front-line care delivery in critical care departments of tertiary and community hospitals in Vancouver Coastal Health, as well as writing policy documents for the BC Ministry of Health. In this new role, Ms. Daniels will focus on developing policies, procedures and training for the program's accreditation teams and supporting facilities in meeting provincial ICP requirements.

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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Serving the public through excellence and professionalism in medical practice

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 across the province. 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.

Updated

- Telemedicine
- Marijuana for Medical Purposes

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CME events: mark your calendars

Finding medical evidence: supporting patient care – using the Internet to your advantage
Saturday, April 11, 2015 – Vancouver
http://ubccpd.ca/course/FME-Vancouver-2015

Methadone Hospitalist Workshop
Friday, May 1, 2015 – Vernon
https://www.cpsbc.ca/for-physicians/professional-development/methadone-hospitalist-2015-05-01

Methadone 101/Hospitalist Workshop
Saturday, May 9, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/methadone-101-hospitalist-2015-05-09

Prescribers Course
Thursday, May 14, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/prescribers-course-2015-05-14

Prescribers Course
Friday, May 15, 2015
https://www.cpsbc.ca/for-physicians/professional-development/prescribers-course-2015-05-14

Finding medical evidence: supporting patient care – using the Internet to your advantage
Saturday, June 6, 2015 – Kelowna
http://ubccpd.ca/course/FME-Kelowna-2015

Annual General Meeting and Education Day
Friday, September 25, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/education-day-agm-2015

Finding medical evidence: supporting patient care – using the Internet to your advantage
Saturday, September 26, 2015 – Vancouver
http://ubccpd.ca/course/FME-Vancouver-Sep-2015

Professional Boundaries in the Physician-Patient Relationship
Friday, October 16, 2015
https://www.cpsbc.ca/for-physicians/professional-development/professional-boundaries-2015-10

Medical Record Keeping for Physicians
Wednesday, November 25, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/medical-record-keeping-2015-11

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College of Physicians and Surgeons of British Columbia

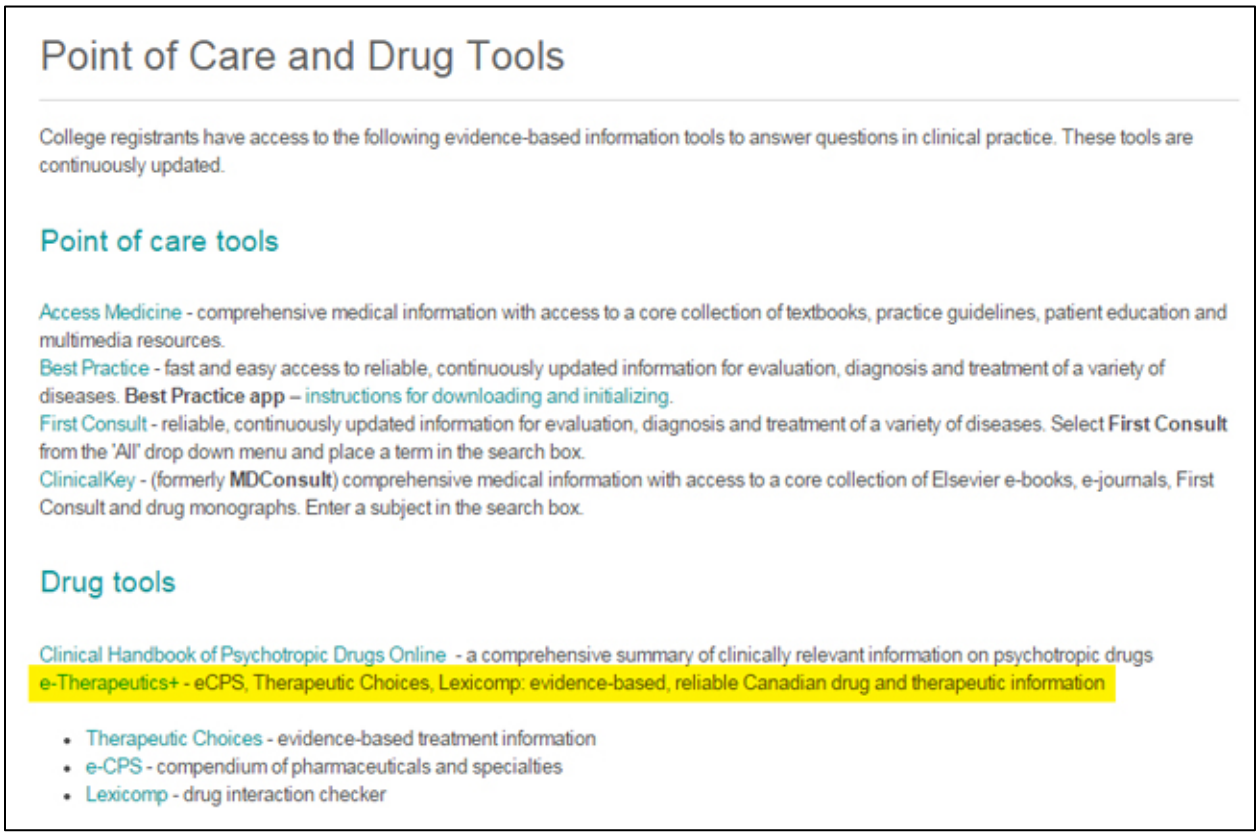
Serving the public through excellence and professionalism in medical practice

A word from the College library

College LIBRARY

Drug interaction checker

Adverse drug events are frequent, experienced by approximately 3% of hospitalized patients in Canada.[1] A large proportion is preventable as they are due to inappropriate prescribing and drug-drug interactions.[2] On-demand drug interaction checker software can support physicians' efforts to optimize prescribing and avoid "alert fatigue" arising from computer-triggered alerts.[3] The College library now provides online access to a drug-drug interaction checker, Lexi-Interact, which is part of a larger online information resource called e-Therapeutics+. e-Therapeutics+ includes the CPS (compendium of pharmaceuticals and specialties), Therapeutic Choices, Lexi-Interact, and patient information. Library users can access Lexi-Interact through e-Therapeutics+ on the College library's point of care and drug tools page.



Point of Care and Drug Tools

College registrants have access to the following evidence-based information tools to answer questions in clinical practice. These tools are continuously updated.

Point of care tools

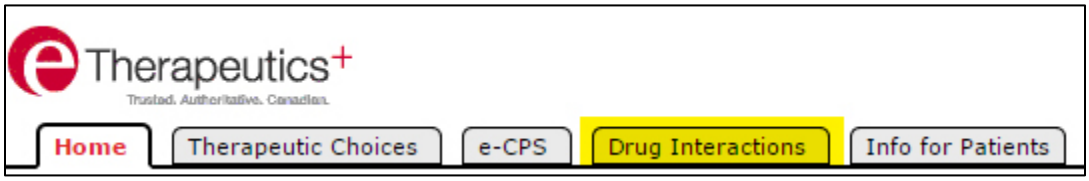
Access Medicine - comprehensive medical information with access to a core collection of textbooks, practice guidelines, patient education and multimedia resources.
Best Practice - fast and easy access to reliable, continuously updated information for evaluation, diagnosis and treatment of a variety of diseases. **Best Practice app** – instructions for downloading and initializing.
First Consult - reliable, continuously updated information for evaluation, diagnosis and treatment of a variety of diseases. Select **First Consult** from the 'All' drop down menu and place a term in the search box.
ClinicalKey - (formerly **MDConsult**) comprehensive medical information with access to a core collection of Elsevier e-books, e-journals, First Consult and drug monographs. Enter a subject in the search box.

Drug tools

Clinical Handbook of Psychotropic Drugs Online - a comprehensive summary of clinically relevant information on psychotropic drugs
e-Therapeutics+ - eCPS, Therapeutic Choices, Lexicomp: evidence-based, reliable Canadian drug and therapeutic information

- Therapeutic Choices - evidence-based treatment information
- e-CPS - compendium of pharmaceuticals and specialties
- Lexicomp - drug interaction checker

On the e-Therapeutics+ home page, select the Drug Interactions tab to open Lexi-Interact as shown below:



Lexi-Interact identifies drug-drug interactions with good sensitivity and specificity.[4] A risk rating is provided for each interaction and, importantly, a summary of the nature of the interaction and recommendations for patient management are offered, providing background and context for decision making. Lexi-Interact can both analyze a specific drug combination for potential interactions or display all interactions for a selected medication. The discussion of each drug-drug interaction is relatively detailed and citations to supporting evidence is provided. Lexi-Interact, through e-Therapeutics+, is web-based. An app is not yet available. The College library subscribes to e-Therapeutics+, through eHLbc, a provincial library consortium.

For further information, please contact library staff at medlib@cpsbc.ca or 604-733-6671.

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Regulatory actions

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