College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

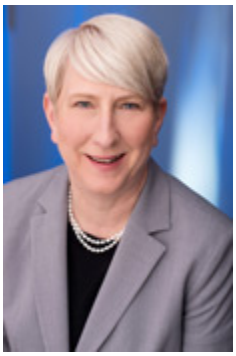
College Connector

Volume 4 | No. 2 (March/April 2016)

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 – new CDC opioid guidelines a game-changer



As the Centers for Disease Control and Prevention (CDC) points out, there were more than 28,947 opioid-related deaths in the US in 2014, which is a 14 per cent climb from the year before. British Columbians are not immune from this epidemic. Prescription drug abuse kills as many here in this province as drinking and driving.

Seeing those numbers – even with the knowledge that many of those deaths were from drugs purchased off the street – it is clear that physicians play a critical role in managing this serious problem.

The 12 recommendations from the CDC are well-researched, well-reasoned and clear. They address how primary care physicians can determine when to initiate or continue opioids for chronic pain; how they might select opioids; the dosage, duration, follow-up and discontinuation; and the assessment of risk and addressing harm.

Much of what is contained in the CDC guideline is outlined in the College's own Prescription Review Panel Prescribing Principles for Chronic Non-Cancer Pain. Specifically, the CDC encourages physicians to avoid prescribing opioid pain medication and benzodiazepines concurrently; to monitor patients routinely through urine drug testing; and to prescribe the lowest effective dosage when opioids are started, among other parallel recommendations.

The CDC further recommends that physicians review a patient's history using state prescription drug monitoring program data, which in BC would be equivalent to PharmaNet. This underlines the College's position that physicians should be checking PharmaNet each time a patient is prescribed medications. British Columbia is fortunate to be one of the few provinces in Canada where physicians have access to such a database for the benefit of their patients.

At its recent meeting, the Board endorsed the CDC guideline and directed that the College review and update its prescribing principles to reflect the 12 recommendations contained in the document. In the interim, registrants are strongly encouraged to review the CDC guideline and apply the recommendations in their practice.

The *CDC Guideline for Prescribing Opioids for Chronic Pain – United States 2016* can be found here. Additional tools to guide physicians who wish to implement the recommendations can be found here.

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Registrar

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

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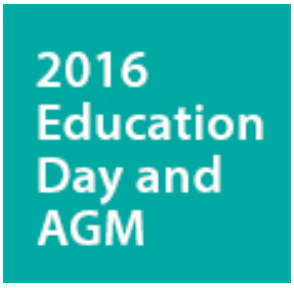
When duty calls: legal and professional obligations in medical practice



The College receives many calls from physicians seeking advice about their legal and professional obligations in specific circumstances. Failure to act according to the law can have a serious negative impact on patients and their families and put physicians in legal and regulatory jeopardy. This year's program will focus on operationalizing physicians' statutory and other ethical duties to care for and protect at-risk children, seniors, impaired health professionals, the gravely ill, and other vulnerable groups.

For more information, click here.

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The sign says, one issue only per visit. But is that OK?

A member of the public recently contacted the College asking whether it was acceptable for physicians to have a practice policy limiting patients to one issue only per appointment. Following is the College's response.

Physicians have a professional, ethical and legal obligation to provide **appropriate** medical care to each and every patient irrespective of the setting in which they work, and regardless of the amount of time that may take. Patients are not medically trained. It is not realistic or acceptable from a clinical practice perspective to expect patients to be able to identify the one problem deserving of priority management. Eliciting a list of presenting complaints and triaging accordingly is foundational to all of medicine. It is how all patient encounters must begin.

It is a reality that patients with long problem lists who make recurrent requests for discussions of multiple and seemingly unrelated health issues can make patient scheduling in a busy practice difficult. The College is sympathetic in these circumstances to patients, to physicians and to medical office assistants who are responsible for running an efficient practice. Rather than posting a sign outlining a practice rule of "one issue only," the College always recommends that physicians have open discussions with their patients to understand the scope of their concerns, to make clinical judgements about related or unrelated health issues, and to manage patient expectations. In some situations it would not be unreasonable for a physician to decide which problems need to be addressed immediately, and which problems can be addressed at a subsequent appointment. The College encourages physicians to advise patients when more time is required to "do justice" to a more complex concern.

While the College has limited authority to direct how physicians manage their office practices, including time management, it would not accept a "one issue only" policy as a defence in the event of a complaint alleging deficient care.

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Surgical safety checklist: maintaining success, sharing experiences

There have been two patient safety incidents recently reported to the College where the implant was not reviewed as part of the surgical safety checklist (SSCL) briefing resulting in the wrong implant being implanted during surgery.

Contributing factors to these patient safety incidents included relying on the OR slate order rather than using two patient-specific identifiers (e.g. name, date of birth) to identify the implant, and lack of adherence to the SSCL to ensure that key patient care information is communicated.

In light of these incidents, medical directors are encouraged to discuss with their surgical team the ongoing importance of the surgical safety checklist and the significant impact it can have on patient safety and improved outcomes.

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New facility construction or existing facility renovation (2012)

Physicians who are considering building a new non-hospital facility and/or renovating an existing non-hospital facility, are strongly encouraged to contact the non-hospital program in the planning stage prior to procuring space for a new facility and/or embarking on a renovation of an existing facility.

The design and construction/renovation of a non-hospital is complex. Program staff members are knowledgeable in the required standards for physical design and can answer some initial questions, provide a list of the applicable Canadian Standards Association (CSA) standards, and highlight some important design requirements from the standards such as CSA Z8000 *Canadian Health Care Facilities – Planning, Design and Construction* and the Ministry of Health *Best Practice Guidelines for the Cleaning, Disinfection and Sterilization of Critical and Semi-Critical Medical Devices*.

In addition, having all of the required individuals (e.g. architect, engineers, infection prevention and control consultant) experienced in health-care facility design at the table from the pre-design phase right through to construction completion and operation is essential in ensuring the facility meets standards for accreditation.

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Medical director standard now on the College website

The NHMSFP Committee is pleased to announce the posting of the medical director standard for private medical/surgical facilities in British Columbia. In 2015, the committee recognized that medical directors would benefit from tools and resources to carry out the duties required of them, as set out in the Bylaws; in particular a medical director's responsibilities for privileging and credentialing of medical staff and for reporting and reviewing patient safety incidents.

This standard was developed to support and ultimately strengthen the role of the medical director. To view the standard, click here.

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Currency of practice

The British Columbia Medical Quality Initiative (BC MQI) is the governance framework established in response to issues raised in the Cochrane reports (2011) *Investigation into Medical Imaging and Credentialing and Credentialing and Quality Assurance* and the BC Auditor General Report (2014) on the *Oversight of Physician Services.*

Under the BC MQI, new processes for credentialing and privileging physicians were established including the introduction of 62 privileging dictionaries. These dictionaries provide consistent benchmarks for medical directors to use with their medical staff during initial and renewal privileging processes regarding current experience in the various procedures and practices they wish to perform at a non-hospital facility.

Medical staff without current demonstrated competence and sufficient experience, as outlined in the BC MQI privileging dictionaries, may not provide services in a non-hospital facility until return-to-practice requirements have been met.

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Disposable devices are the safest and most convenient option for medical offices

Semi-critical medical devices are items that come in contact with intact mucous membranes or non-intact skin such as vaginal specula, nasal specula, vaginal/anal ultrasound probes, gastrointestinal/nasopharyngeal endoscopes, and laryngoscopes.

Two methods of reprocessing of semi-critical medical devices are sterilization and high-level disinfection. Depending on the item, the manufacturer may have strict instructions to only sterilize or only high-level disinfect (HLD). If the manufacturer states both options, choose sterilization.

The following points describe the requirements and limitations of HLD:

1. Manufacturer's instructions for the medical device must be followed to identify acceptable method of reprocessing.

2. Manufacturer's instructions for each medical device must be followed to identify compatible and validated disinfectant agents that can be used on the item.

3. Adequate cleaning is imperative prior to HLD.

4. Medical devices must be thoroughly dried, as any trace of moisture promotes microbial overgrowth and materials deterioration.

5. Chemicals used for HLD must be labelled, stored and handled. Personnel must be properly trained to handle these toxic chemicals. Education must include the correct selection and use of personal protective equipment such as gloves, gowns, and eye protection.

6. MSDS sheets must be accessible to staff at all times on all chemicals used in the facility.

7. Most HLD products require a spill kit that must be stored near where the product is used and stored.

Physicians should remember that HLD only kills some organisms and not spores. Best practice states that sterilization is the gold standard and should be selected if possible. As both sterilization and HLD require additional processes and different reprocessing equipment, using disposable devices represents the safest and most convenient option for physician offices.

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But I know my patient!

When the College speaks to physicians who have challenges related to safe prescribing and who have not practised the precautions that are referred to as "pharmacovigilance," one of the most common responses is: "But I know my patient!"

What is almost always evident in these conversations is that these physicians highly value the therapeutic relationship they have with their patients. Unfortunately, what is also frequently evident is that they don't know their patients as well as they think they do.

For example, physicians may not know:

- if their patient has ever been diagnosed with, or is at risk of having, a substance use disorder
- that patients with an active substance use disorder will and must often be dishonest in order to obtain drugs
- that substance use disorder is often misdiagnosed as chronic pain or anxiety
- if there is a family history of substance use disorder
- if their patient smokes (or had trouble quitting)
- if their patient drinks alcohol (frequently the response is "only socially" but they don't know how much or how often)
- if their patient drives, including public transit or a school bus
- what their patient does for a living or what their job entails (e.g. operating machinery)
- if the patient is a caregiver for small children or the elderly

Sometimes physicians claim that the reason they haven't found out more about their patient's work or lifestyle in general is because they're too busy dealing with high patient volumes. Other times physicians are uncomfortable asking pertinent questions or setting treatment boundaries because they worry they may be perceived by their patient as "intrusive."

The College reminds physicians that providing safe medical care, and specifically safe prescribing, will always involve some difficult conversations. Keeping patients and the public at large safe from the consequences of one's prescribing requires physicians to put in place a treatment framework that is respectful, non-judgmental and focused on first doing no harm.

Pharmacovigilance includes:

- a substance use disorder screen documented in the medical record
- an agreement for long-term opioid treatment
- having access to and regularly checking PharmaNet
- providing regular, small dispense volumes
- including a schedule of random urine drug testing and/or random pill counts for any patient receiving regular dispenses of medications with the potential for diversion

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Injectable naloxone soon to be available in most pharmacies

Currently, the BC Centre for Disease Control's Toward the Heart program provides take-home naloxone kits, and firefighters are now also allowed to carry the kits. The College of Pharmacists of BC, together with the College of Physicians and Surgeons of BC, have been active proponents of making naloxone more widely available without prescription, and the federal ruling now allows the colleges to move forward with changes to provincial drug scheduling.

As with any legislative change, some time is needed for implementation. Fortunately, because the College of Pharmacists of BC has been working on this for some time already, this College anticipates that naloxone will soon be available in most pharmacies. Currently in Canada, only the injectable form of naloxone is available. Due to the delivery system, it will be classified as a Schedule II drug under the Drug Scheduling Regulations for now. Similar to Tylenol No.1, it may be purchased without a prescription but will be kept behind the counter to allow opportunity for proper patient counselling.

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CME events: mark your calendars

NHMSFP Medical Directors Education Session
Monday, April 11, 2016 – Vancouver
Learn more

NHMSFP Medical Directors Education Session
Friday, April 15, 2016 – Vancouver
Learn more

Finding Medical Evidence: Support Patient Care – Using Online Resources to Your Advantage
Saturday, April 23, 2016 – Victoria
Learn more

Finding Medical Evidence: Support Patient Care – Using Online Resources to Your Advantage
Sunday, April 24, 2016 – Ladysmith
Learn more

Methadone 101/Hospitalist Workshop
Saturday, April 30, 2016 – Vancouver
Learn more

Prescribers Course
Friday, May 13, 2016 – Vancouver
Learn more

Medical Record Keeping for Physicians
Wednesday, August 24, 2016 – Vancouver
Learn more

Education Day and Annual General Meeting 2016
Friday, September 30, 2016 – Vancouver
Learn more

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Apps for ClinicalKey and BMJ Best Practice

College LIBRARY

Clinically relevant apps constitute a small fraction of available medical apps. Using emergency medicine apps as a test, Wiechmann et al (2016)[1] estimate that clinically relevant apps represent only about 7% of the medical section of the App Store and 0.1% of all apps in the App Store. The College library helps registrants cut through the questionable value of some apps by curating a collection that is worthy of consideration for clinical decision-making. See the Apps and Audiovisual page of the College's website.

The ClinicalKey app is the most recent addition to the College library's app collection. Like the online version of ClinicalKey, the app searches a broad range of publication formats including current summaries of disease management, recent editions of about 180 ebooks, articles from over 150 e-journals, drug monographs, patient handouts, and practice guidelines from Canadian and international professional and governmental organizations.

The Procedures Consult portion of ClinicalKey displays videos, images and detailed text on care and techniques before, during, and after procedures. The app is available for iOS and Android devices. The College library subscribes to seven ClinicalKey modules that comprise the specialties of the most intensive library users: emergency medicine, obstetrics and gynecology, pediatrics, orthopedics, internal medicine, psychiatry, and family medicine.

BMJ Best Practice app makes an interesting comparison to ClinicalKey. Best Practice is a point of care tool that summarizes evidence and opinion on major aspects of clinical management of diseases and symptoms. It links to relevant guidelines and published evidence within disease monographs and offers patient leaflets. Best Practice's intuitive navigation allows for rapid identification of information relevant to specific patient groups. By comparison, a search in ClinicalKey leads to a list of content (e.g. monographs in a point of care tool, First Consult) as well as chapters, articles, guidelines, drug monographs and so on.

Generally speaking, BMJ Best Practice organizes material into consistently formatted monographs which link out to relevant material. ClinicalKey delivers a broad range of resources as a list in response to a search. Depending on the clinical query, navigating ClinicalKey search results may be more laboured but the range of information may be broader. BMJ Best Practice and ClinicalKey provide sound and clinically meaningful information in well-designed interfaces – try both, explore and compare.

1. Wiechmann W, Kwan D, Bokarius A, Toohey SL. There's an App for That? Highlighting the Difficulty in Finding Clinically Relevant Smartphone Applications. West J Emerg Med. 2016 Mar;17(2):191-4

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