College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

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—insights from our international colleagues

I recently returned from the biannual meeting of the International Association of Medical Regulatory Authorities (IAMRA), which was held in Melbourne, Australia. As many of you will know, IAMRA exists as a global collaboration of medical regulators who share a common mandate to protect the public by ensuring high standards of ethical and professional medical practice. The conference is a thought-provoking forum where medical regulators, policy makers and academics share ideas, engage in dialogue about emerging issues, and learn from each other across nations.

This year's theme, *Medical regulation—making a difference*, challenged participants to think beyond organizational performance measures such as cost and timeframes associated with regulatory processes, and focus rather on impact. To ask ourselves instead: are we as regulators delivering the right results through the work that we do? And, are we targeting our regulatory efforts to address the greatest risks?

It was interesting to hear multiple and diverse perspectives being shared by people who described systemic issues that simply cannot be addressed through regulation, but still affect the quality of care being provided to patients. These issues include fragmented care, a focus on hospital care over community care, misdistribution of human resources, and difficulties accessing and navigating care. Across the world, health systems are struggling with demographic changes, a shift in diseases burden from acute care to chronic disease management, and increasing patient expectations driven by enhancements in technology, and greater demand for transparency and accountability.

As a regulator of the medical profession, we must be aware of these issues and ensure we have the right legal tools to do our work. Based on comparisons with other international regulators, our governing legislation, the *Health Professions Act*, provides a wide range of tools to ensure physicians are practising to high standards, including requirements for continuing competency, and quality assurance activities, such as the Physician Practice Enhancement Program, that set us ahead of many of our peers.

Every regulatory conference includes presentations on high-profile cases of extraordinary patient harm caused by an individual physician. Usually, these are not attributed to poor educational institutions or registration failures. The underlying issue is one of gross incompetence that has seeped in over time, or character pathology that emerges when no one is watching. These physicians pose the greatest risk to patient well-being that as regulators we have to address swiftly.

While often patients act as the eyes and ears of the regulator through the complaints process, physicians must also play this role. Patients should rely on all of us to do a better job of holding each other accountable. Collectively we have a responsibility to create a culture that allows all members of the healthcare team to speak up if they have concerns about the care a patient is receiving.

One of the important takeaway messages from the IAMRA conference was the need for regulators to build greater public trust and confidence in regulatory systems. The public may not know or understand how regulation works, and may believe it acts on behalf of the profession. The common perspective is often—don't tell us to trust you, tell us why we should trust you. This means we must continue to find ways to be more transparent, and make more information available to the public about the work that we do as regulators. This is a commitment that the College Board has fully endorsed.

Heidi M. Oetter, MD
Registrar and CEO

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

This year's program focused on operationalizing physicians' statutory, professional and ethical duties to care for and protect at-risk children, seniors, impaired health professionals, the gravely ill, and other vulnerable groups.

Presentations are provided based on availability and can be found here.

All of the resolutions for the 2016 AGM were adopted. Audited financial statements for the 2015/16 fiscal year are available here.

Mark your calendars: next year's Education Day will take place on Friday, September 29, 2017.

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Can a physician turn a prospective patient away?

It is a challenging time to practise medicine in North America, particularly where opioid analgesics and other potentially addictive prescription drugs are concerned. Many physicians in British Columbia have or will encounter prospective patients already using opioids who are seeking primary care.

While treating these patients may be more complex, physicians cannot refuse to accept them, as outlined in the College standard *Access to Medical Care*. Physicians who choose to conduct a "meet and greet" session can only do so to learn more about a new patient's health concerns and history, not for the purpose of screening out these patients, which may be seen as discriminatory.

Rather than dismissing prospective patients summarily because they are taking long-term opioids and/or benzodiazepines or z-drugs for chronic pain, they should be told in clear and simple terms at the outset that the College's standard for prescribing these drugs has evolved based on emerging scientific evidence. Patients should be advised that they will be prescribed medications cautiously, in accordance with the standard, which means that combinations of opioid analgesics ("strong pain medications") and sedatives (usually "sleeping medications") are not allowed. Patients who are currently on combinations should have one or the other tapered, starting immediately. The patient may have some input into which is more important to him/her.

Based on this conversation, if a patient is unwilling to accept these terms then the physician may choose not to take the patient into his/her practice.

The College offers two highly-rated educational events to assist physicians in this always-challenging task:

1. A limited-enrollment Prescribers Course, which makes use of standardized patients to assist physicians with the communications challenge
2. A plenary course provided by the Foundation for Medical Excellence of Portland, OR, with the support of the College

View the College's professional standard: *Safe Prescribing of Drugs with Potential for Misuse/Diversion*

View questions and answers about the standard: FAQs

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Useful resources to strengthen quality outcomes

Non-hospital medical and surgical facilities are encouraged to access patient safety and quality improvement networks (e.g. BC Patient Safety and Quality Council, Canadian Patient Safety Institute), as these organizations have a variety of tools and resources, including educational webinars, which may assist in strengthening quality outcomes such as: improved clinical outcomes; improved efficiency of managerial and clinical processes; and improved communication. Many networks make it easy to receive safety alerts, advisories and invitations to patient safety webinars. By simply signing up for their service, facilities can receive information automatically via email.

The Canadian Patient Safety Institute recently announced its SHIFT to Safety website. Medical directors may find this website and its resources useful in establishing a quality improvement program at their non-hospital facility.

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If a fire breaks out at your facility, would you know how to respond?

NHMSFP Update

Fire in a health-care facility poses a serious threat for patients, visitors and staff. Patients in the ambulatory surgery setting may be especially vulnerable in a fire emergency; therefore, non-hospital facilities must be physically prepared and staff ready to respond.

Being prepared includes, but is not limited to:

- having written policies and procedures for emergencies including fire, flood and gas leaks
- training staff on patient evacuation priorities, fire alarms and extinguishers, exit routes, location of utility shut-offs
- conducting periodic emergency drills

Once the danger to patients and staff has been eliminated, emergencies, such as fire, flood, hazardous spills, and gas leaks are to be immediately reported to the College. Depending on the extent of the damage, the non-hospital facility may be required to suspend its operations until otherwise directed by the College.

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Surgical site infections: what you are required to do

NHMSFP Update

Surgical site infection (SSI) prevention and surveillance is an important and ongoing patient safety initiative. Surgical site infections are defined as any infection, from superficial incisional, to organ and/or space infection that occurs within 30 days after surgery.

The majority of SSIs become apparent within 30 days of an operative procedure and most often between the fifth and tenth post-operative days. Without a SSI surveillance protocol in place, infection rates will invariably be an underestimation of the actual rates as the sensitivity of SSI reporting is low.

Therefore, non-hospital facilities are required to have a surgical site infection prevention and surveillance program in place, which includes tracking infections in patients up to 30 days post-operatively, and the regular sharing of SSI data with facility leadership and frontline staff.

Medical directors may find the Canadian Patient Safety Institute *Surgical Site Infection (SSI): Getting Started Kit* useful when reviewing and updating their non-hospital facility SSI prevention and surveillance program and associated protocols.

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Common medical device reprocessing deficiencies in physicians' offices

PPEP Update

The office assessment is one of the three components of a Physician Practice Enhancement Program (PPEP) peer assessment, and often brings to light important opportunities for improvement in community-based practice related to operating a clinical office. Following are some examples of recurrent issues noticed by clinicians working with PPEP particularly around the topic of medical device reprocessing (MDR):

The clinic does not have manufacturer's instructions for use (MIFU) for its medical devices. The MIFU dictates specific instructions on how a particular medical device must be reprocessed. Without referring to the MIFU for each medical device, physicians and their staff may be improperly reprocessing equipment, which increases the risk of damage to the device and compromises patient safety. Note: only the MIFU can confirm whether a medical device requires disposal, disinfection, sterilization or other treatment. The MIFU also indicates the appropriate cleaning solution or detergent that can be used.

Dual-purpose areas for both patient care and medical device reprocessing are not used appropriately. Physical space in community-based offices is often limited. Where clinical offices use a common space for patient care and the reprocessing of reusable medical devices, parameters and rules must be in place to ensure each activity is done safely. For example, if the sterilizer is in the exam room used to see patients, reprocessing must only take place when the room is not used for patient care (such as early morning, or after hours).

Biological monitoring is not being performed. When it comes to the sterilization of reusable medical devices and the use of a sterilizer, there are three quality assurance parameters that must be met: biological, chemical and physical monitoring. These parameters are based on the BC Ministry of Heath's best practice document (see link below). Of the three quality assurance monitoring of a sterilizer, the single most common deficiency seen in practices is the absence of biological monitoring.

Chemical monitoring and physical monitoring are required, but are not sufficient to assure sterilization, as they are not a substitute for biological monitoring. Biological monitoring equipment must include the test strips and the incubator.

Sterilization monitoring parameters are not documented. Documentation of all quality assurance parameters (biological, chemical and physical indicators) must be documented in a log book.

Additional details are available in the BC Ministry of Health's *Best Practice Guidelines For Cleaning, Disinfection and Sterilization of Critical and Semi-critical Medical Devices (2011)*.

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CME events: mark your calendars

Prescribers Course

Friday, November 25, 2016 – Vancouver
Learn more

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Cites & Bytes featured specialties

College LIBRARY

Cites & Bytes has traditionally highlighted updates in the literature from family practice and internal medicine as well as content from other specialties of general interest, e.g. psychiatry, obstetrics and gynecology, dermatology, and emergency medicine. A new "featured specialties" section now features clinical developments from two selected specialties each month. The intention is two-fold: to inform specialists of updates in their field; and to highlight issues of significance in various specialties relevant to all practitioners. This feature came out of feedback received from a 2015 library survey of key knowledge leaders for improving library services and resources.

To date, featured specialties have been:

- March - Ophthalmology and Urology/Nephrology
- April - Oncology and Pediatrics
- May - Cardiology / Cardiovascular Surgery and Emergency Medicine
- June - General Surgery and Obstetrics/Gynecology
- July - Critical Care / Hospital Medicine and Plastic Surgery
- August - Pathology and Radiology/Nuclear Medicine
- September - Gastroenterology and Geriatrics

The library will continue to highlight content from specialties until March 2017, at which time an evaluation will determine its utility to library users. Feedback about the feature is welcome. Suggestions for improving *Cites & Bytes* or any other library service can be sent to the library at medlib@cpsbc.ca, 604-733-6671.

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