College of Physicians and Surgeons of British Columbia

Serving the public by regulating physicians and surgeons

College Connector

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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.

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Registrar's message—New reality, same standards: what practising medicine means in the #MeToo era

These days, few could be blamed for finding that a visit to an online news source or a scroll through their social media feeds is more difficult than ever. They are inundated with heartbreaking stories of sexual impropriety in both professional and non-professional settings, and the repercussions that follow: years of shame, mental and emotional scarring, and stymied careers. The much needed #MeToo and #TimesUp movements are significant, breaking a code of silence that has forced many people to confront this issue, triggering deep reflection and uncomfortable soul-searching.

No amount of unplugging from social media will change the new reality: the world is much different than it was six months ago. Of course, the practice of medicine does not exist in a vacuum. Far from it.

Stories from the profession and patients have emerged as a result of the discussion. The prevailing theme is familiar: the unwanted sexual advances come from someone who is in a position of power, leaving the survivor with the difficult decision to either acquiesce, or face sizable consequences.

In medicine, it is well accepted that a power imbalance exists between a patient and physician. Patients are considered to be vulnerable especially if they are very ill, experiencing pain, afraid or worried, do not speak the same language, or are undressed or exposed. They are also often required to disclose the most personal details of their lives and consent to sensitive exams. The Canadian Medical Protective Association offers this advice:

Courts have long recognized that the doctor-patient relationship is built on trust; this relationship of trust is recognized as fiduciary duty. Physicians must act in good faith and demonstrate loyalty toward the patient, never placing their personal interest ahead of the patient's.

If that trust is betrayed, there is the potential to cause serious harm to the patient. Negative psychological effects can carry into other areas of a patient’s life, and may even prevent them from seeking medical care in the future.

It is the physician’s responsibility to ensure that appropriate professional boundaries are maintained, even if the patient seems willing to cross those boundaries. Now more than ever, at a time when there is greater scrutiny on the actions on those in positions of responsibility, it is important for physicians to equip themselves with the right tools to prevent harm to patients.

Registrants seeking guidance on recognizing and maintaining professional boundaries are strongly encouraged to enroll in the Professionalism in Medical Practice course, which takes place in November. Registrants should also be aware of these applicable practice standards *Boundary Violations in the*

Patient-Physician Relationship and *Physical Examinations and Procedures* to ensure the protection of patients, and themselves.

Heidi M. Oetter, MD
Registrar and CEO

Comments on this or any other article published in the *College Connector* can be submitted to the Communications and Public Affairs Department at communications@cpsbc.ca.

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Update on two consultations with the profession

Professional Standards & Guidelines

The College is finalizing revisions to one standard and one guideline that were both circulated to the profession for input in 2017.

During the consultation process, the standard *Safe Prescribing of Drugs with Potential for Misuse/Diversion* received extensive feedback from physicians, representatives from patient support groups, members of the public through an online engagement platform, the Canadian Medical Protective Association and other key health partners, members of the College's Prescription Review Panel, and the Board. The revised standard will be re-circulated for final consultation in May with a detailed explanation of the changes.

The guideline *Expectations of the Relationship between the Primary Care/Consulting Physician and Consultant Physician* also received valuable feedback from the profession and others during consultation. To ensure the revisions addressed the many concerns about gaps in the referral process expressed by primary care physicians and specialists, the College established an advisory group of GPs and specialists to work with members of the Patient Relations, Professional Standards and Ethics Committee on redrafting the document. Once the revised guideline has been considered by the Board, it will be circulated for final consultation.

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Federal exemption to prescribe methadone no longer required as of May 19

Health Canada has announced that effective May 19, 2018, prescribers will no longer require a federal exemption to prescribe methadone. This announcement results after an extensive national consultation on subsection 56(1) of the Controlled Drugs and Substances Act. What remains to be determined over the next two months is what will happen at a provincial level. As set out in section 2-3(3) of the College Bylaws, physicians are required to practise medicine within their scope of practice and should, therefore, acquire the relevant knowledge, training and experience before initiating patients on methadone. To access applicable training on prescribing methadone for opioid use disorder, physicians should contact the BC Centre on Substance Use. Questions related to prescribing methadone for analgesia should be directed to the College.

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New policy enables physicians to act as attestors for MSP and BC Services Card applications

When enrolling or renewing enrolment in MSP, most adults need to attend an ICBC driver licensing office in person for identity proofing and to obtain their photo BC Services Card.

In instances where individuals are not able to attend in person due to a medical condition, a health-care professional can complete an Attestation Form on their behalf (forms are available by calling Health Insurance BC).

Health-care professionals in this context include:

- Physician
- registered psychologist
- nurse practitioner
- registered nurse
- medical social worker

By signing the Attestation Form, a health-care professional attests that the individual has a health-related issue that prevents them from attending a driver licensing office to complete in-person identity proofing. Once the form is submitted and enrolment or renewal of enrolment in MSP is successful, a non-photo BC Services Card will be mailed to the individual

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Enhanced road assessment to strengthen road safety

DriveABLE assessments are no longer being used by RoadSafetyBC to make licensing decisions. RoadSafetyBC has stopped referring drivers to DriveABLE, and will not pay for any DriveABLE assessment that was completed as of March 1, 2018.

Key points for physicians:

- DriveABLE will be replaced by a new enhanced road assessment (ERA) administered by ICBC.
- The ERA will also replace Class 5 ICBC road test re-examinations.
- The ERA is an on-road assessment, which does not have or use an in-office computer-based screening component.
- The ERA will be used by RoadSafetyBC to evaluate drivers of any age with a cognitive, motor, or visual deficit that may impair their ability to safely drive.
- The results of the ERA will be reviewed by RoadSafetyBC along with all other information related to the driver's medical fitness to drive, to make a licensing decision.
- There is no change to the age 80 Driver Medical Examination Report process.
- The Report of a Condition Affecting Fitness and Ability to Drive form has been updated to remove DriveABLE from the recommendation section. Physicians should recommend an ERA conducted by ICBC if they wish to refer a patient for a driving assessment.

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#RealityCheckup: addressing confounding societal issues that undermine people's health and the care they receive

Save the date for the much-anticipated College Education Day, held again this year at the Vancouver Convention Centre on Friday, September 14, 2018.

With guidance and insight from experienced, engaging experts, this year's theme aims to address a selection of complex topics, from the importance of cultural humility to combating anti-science myths. Join colleagues to explore these and other confounding issues facing physicians today.

The program includes plenary sessions, case studies and interactive workshops for an all-encompassing educational experience and an opportunity for deep reflection on these ongoing challenges.

Plenary sessions:

The College is very pleased to welcome back the ever popular Timothy Caulfield, BSc, LLB, LLM, professor, presenter, and author of *The Vaccination Picture*, *Is Gwyneth Paltrow Wrong About Everything?: When Celebrity Culture and Science Clash*, and *The Cure for Everything: Untangling the Twisted Messages about Health, Fitness and Happiness*. This year, Tim will focus on the art and science of communicating evidence-based medical concepts to skeptical patients.

The College is also pleased to welcome Joe Gallagher, chief executive officer, and Dr. Evan Adams, chief medical officer, of the First Nations Health Authority. Given the current landscape in Canada around reconciliation, there is an opportunity to begin a cultural safety and humility journey together through a First Nations approach to transform the present through the learnings of the past, for a better future. This presentation will examine how physicians and health organizations can innovate, develop cultural humility and foster an environment of cultural safety.

More information will be available soon on the CPD events page.

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A case study—prescribing methadone for pain

DRUG PROGRAMS Update

The following case study sends an important message to physicians about the benefits of prescribing methadone for chronic pain.

"Lilian" is 76 years old and has successfully been treated for colon cancer with surgery and adjuvant chemotherapy. The chemotherapy exacerbated her mild peripheral neuropathy from type 2 diabetes. She now has severe burning pain in her feet and hands. In the morning, she experiences intermittent electric shock-like pains when she first puts weight on her feet. Tricyclic medication causes postural hypotension and weight gain, and therapeutic doses of gabapentin cause unsteadiness. She does not tolerate codeine, morphine or oxycodone because of nausea and constipation despite laxatives, and hydromorphone is ineffective for her pain. She is not able to become sufficiently opioid-tolerant to start on a fentanyl patch. Lilian is becoming depressed and socially isolated.

When Lilian attends the local cancer centre's pain and symptom management clinic she is started on methadone 0.5mg every eight hours. Within two days she reports a substantial 50% reduction in her pain and is now able to go outside in proper shoes rather than slippers. She increases the dose as instructed after three days to 1 mg every eight hours, and the next week, when contacted by the clinic nurse, she reports further improvement: the pain is now 90% gone and she is driving again.

Three weeks later, she attends the clinic again and no further changes are needed. The clinic provides a letter to her family practice clinic requesting that they take over prescribing methadone (including detailed instructions on how to do it), but Lilian is told that none of the physicians there have an authorization to prescribe methadone for analgesia. Her own physician is about to retire and has declined to take this on. Lilian is told that the practice does not support patients who take opioids for non-cancer pain. She approaches a number of family physicians' offices and walk-in clinics and is told at each one that they do not "do methadone" and she "needs to go to a methadone clinic for this."

Lilian returns to the cancer clinic three months later, having stopped the methadone on her own, and is now tearful, depressed, and in severe pain. Within two days of resuming methadone 1 mg every eight hours her pain is under control. The cancer centre pain and symptom management clinic now has a four-week wait for new consults because of inability to discharge Lilian and many patients like her, and the need to see them all every three months.

Lilian's case is a very real and ever growing problem. Methadone is frequently used in management of chronic and palliative pain situations. When patients are started and stabilized in the hospital setting, they are discharged with a request for ongoing monitoring and prescribing by their family physician. Some physicians may be reluctant to accept this responsibility, but if patients are refused such care, patients are destabilized causing significant, unnecessary, and prolonged pain and suffering. Physicians have an obligation to provide timely and appropriate care to patients, and must not discriminate against

them or refuse treatment based on patients' diagnoses or care needs. The College encourages physicians to consider prescribing methadone for this group of patients in their time of need.

The College has made significant changes in the past two years to make the analgesia authorization process easier. Physicians can quickly and easily get temporary exemptions for methadone for a patient by filling out a one-page form on the College website. Temporary exemptions are granted for up to 120 days, and physicians can use this time to meet requirements for full authorization if they wish. The specialist clinic or the original prescriber can usually provide ongoing guidance and support for physicians new to prescribing methadone. Similarly, physicians are encouraged to contact the College's drug programs for information or assistance.

Note: Health Canada has announced that effective May 19, 2018, prescribers will no longer require a federal exemption to prescribe methadone.

Note: All details that could identify the patient or physicians involved in this case have been removed to protect privacy and confidentiality.

Registrants interested in sharing a case for publication in a future edition of the College Connector can contact the Prescription Review Program at prp@cpsbc.ca or 604-733-7758 extension 2629. Identifiable information should not be included. All confidentiality will be maintained.

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Surgeries over six hours need to be reported

Starting April 15, 2018, in accordance with the College Bylaws, medical directors will be required to notify the Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) Committee within 24 hours of becoming aware of any surgery with an overall duration of greater than six hours, as well as complete and submit a Reportable Incident Form within 14 days.

Following a literature review about the effects of length of surgery on the incidence of adverse events, the NHMSFAP Committee directed that the overall duration of surgery, defined as skin-to-skin time, in the non-hospital setting be limited to six hours. The committee further directed that any surgery with an overall duration of greater than six hours be considered a patient safety incident requiring mandatory reporting. The Reportable Incident Form can be found here.

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Medical directors are responsible for chart audits and sharing results with staff

NHMSFAP Update

A patient's medical record is a single comprehensive file containing all information and documentation related to the patient's surgical encounter including medical history, physical exam and a surgeon's consultation outlining the indication(s) for surgery.

To ensure that the medical record provides an accurate and comprehensive account of the care provided to each patient, medical directors are required to have a chart auditing process in place. In addition, medical directors are responsible for ensuring chart auditing results are shared with their staff and any required actions are implemented and maintained.

To access the Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) accreditation standard *Medical Records and Documentation* and other NHMSFAP accreditation standards, click here.

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Low body mass index and anesthetic-surgical risks

NHMSFAP Update

The Non-Hospital Medical and Surgical Facilities Accreditation Program Patient Safety Incident Review Panel recently reviewed two incidents involving underweight patients.

While elevated body mass index (BMI) is now well known to increase surgical and anesthetic risks such as surgical site infection and difficult intubation, patients with low BMI (<20.5) may not be appreciated as having increased perioperative risk.

The BMI-surgical risk curve is U-shaped, and recent studies have shown increased 30-day mortality and malnutrition with those who have low BMI. Intraoperative hypothermia is also more difficult to manage in those with low BMI. The conditions associated with low BMI include old age, cancer, malnutrition, and eating disorders. These comorbidities are also associated with additional anesthetic considerations including hypoglycemia, hypoalbuminemia, intraoperative hypothermia, and possible sensitivity to neuromuscular blocking drugs due to low muscle mass.

Patients with low BMI scheduled for surgery should be seen in anesthetic consultation prior to the day of surgery to ensure appropriate work-up and assessment is completed and to confirm the patient is appropriate for surgery in the non-hospital setting.

The following information and recommendations are being shared with all facilities in the spirit of learning and improving patient safety. Medical directors are encouraged to discuss these articles with their clinical teams.

1. Tangvik RJ, Tell GS, Guttormsen AB, et al. Nutritional risk profile in a university hospital population. Clin Nutr. 2015 Aug;34(4):705-11.

2. Yi J, Lei Y, Xu S, et al. Intraoperative hypothermia and its clinical outcomes in patients undergoing general anesthesia: National study in China. PLoS One. 2017;12(6):e0177221.

3. Cereda E, Klersy C, Hiesmayr M, et al. Body mass index, age and in-hospital mortality: The NutritionDay multinational survey. Clin Nutr. 2017 Jun;36(3):839-47.

4. Leandro-Merhi VA, de Aquino JL. Determinants of malnutrition and post-operative complications in hospitalized surgical patients. J Health Popul Nutr. 2014 Sep;32(3):400-10.

5. Cho M, Kang J, Kim IK, et al. Underweight body mass index as a predictive factor for surgical site infections after laparoscopic appendectomy. Yonsei Med J. 2014 Nov;55(6):1611-6.

6. Hirose K, Hirose M, Tanaka K, et al. Perioperative management of severe anorexia nervosa. Br J Anaesth. 2014 Feb;112(2):246-54.

7. Poulida S, Hadzilia S, Stamatakis E, et al. Ambulatory anesthesia in a patient with anorexia nervosa: 2AP1-11. Eur J Anaesthesiol. 2012;29 Suppl.(50):33.

8. Kulshrestha A, Bajwa SJ. Nutritional and eating disorders: Clinical impact and considerations during anesthesia procedures. J Med Nutr Nutraceut 2012;1(2):77-82.

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The two Cochranes—what's the difference between Archie and Douglas?

College LIBRARY

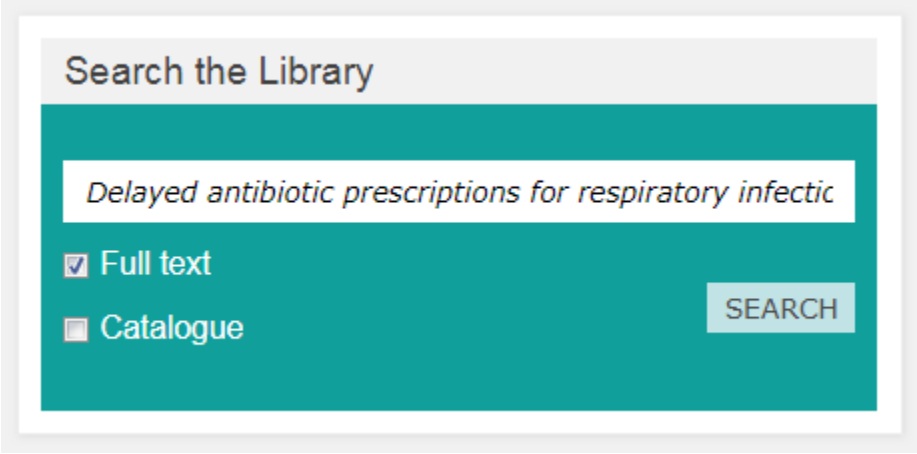
Recently, confusion has arisen about "Cochrane" in the context of quality of health care. The Cochrane Collaboration and the Cochrane Report both address health-care quality but do so in very different ways.

Dr. Archie Cochrane was a Scottish physician and epidemiologist. His slim 1972 collection of lectures, Effectiveness and Efficiency: Random Reflections on Health Services, was a founding text of evidence-based medicine. His name graces the Cochrane Collaboration, an international, non-profit, non-governmental organization that produces authoritative systematic reviews in health care and policy. Cochrane reviews are well-regarded for their validity and relevance to practice and BC physicians have free access through the College library in the Cochrane Database of Systematic Reviews.

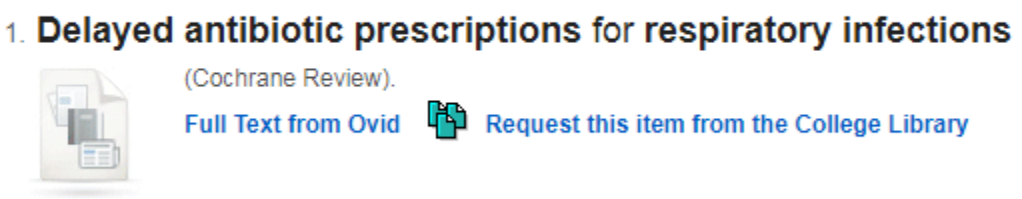
Find the Cochrane Database of Systematic Reviews in the library's e-journals collection or in this list of databases and search for reviews on a specific topic.

Do you know of a specific Cochrane review?

1. Enter the title in the library search box and click **Search**.



2. You will get a link to the full-text review.



The other Cochrane, the Cochrane Report by Dr. Douglas Cochrane, has been highly influential in identifying quality concerns in medical imaging and credentialing in BC and recommending improvements. Dr. Cochrane, chair and provincial patient safety and quality officer, BC Patient Safety & Quality Council, authored the two-part report, *Investigation into Medical Imaging Credentialing and Quality Assurance* in 2011 (Phase 1 Report, Phase 2 Report), and also, in 2016, delivered the *Review of the Functioning of IHealth: Nanaimo Regional General Hospital, Oceanside Health Centre and Dufferin Place*.

Registrants are welcome to contact the College library for Cochrane systematic reviews or other information needs including personalized literature reviews, delivery of articles and books, and access to an excellent collection of online clinical information.

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CPD events: mark your calendars

Prescribers Course
May 11, 2018 – Vancouver
Learn more

Medical Record Keeping For Physicians
August 22, 2018 – Vancouver
Learn more

Education Day and Annual General Meeting 2018
September 14, 2018 – Vancouver
Learn more

Medical Record Keeping for Physicians
Wednesday, October 10, 2018 – Vancouver
Learn more

Professionalism in Medical Practice: Avoiding the Pitfalls
November 2, 2018 to November 3, 2018 – Vancouver
Learn more

Medical Record Keeping for Physicians
Wednesday, November 21, 2018 – Vancouver
Learn more

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Regulatory actions

- Killick, Lyn Melvina – February 26, 2018
- College granted permanent injunction for unlawful practice of medicine – March 15, 2018

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