College of Physicians and Surgeons of British Columbia

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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—new video highlights best practices for conducting physical examinations and procedures: a refresher for some; new expectations for others

Conducting physical examinations that require patients to disrobe is one of the most common aspects of medical practice that physicians may take for granted in their busy daily routine. However, it is also an experience that can leave patients feeling vulnerable, exposed and uncomfortable, and has been the source of many patient complaints over the years.

I have written before about the inherent power imbalance that exists between patients and physicians. Physicians must maintain their patients' trust by conducting physical examinations and procedures professionally and respectfully. But what does that look like in practice?

The College has released a new video to help registrants better understand what is expected of them when conducting physical exams on patients. The video, which complements the College practice standard *Physical Examinations and Procedures*, illustrates the importance of continuous two-way communication, appropriate exposure, and the provision of privacy.

Watch here and provide feedback on the video here.

The principles outlined in the video include offering the use of a chaperone; obtaining consent to perform the exam; providing the patient with both a gown and drape; leaving the room while the patient changes and giving them enough time to change; knocking on the door before entering the exam room; explaining what you are doing at each step of the exam and why; and exposing parts of the body only when necessary.

Many of these principles may be common sense to some, while others may find them new. Either way, I hope that the video and a review of the practice standard will encourage all registrants to reflect on how these principles can be applied in practice. Registrants are encouraged to treat the practice standard as a checklist of sorts, to ensure nothing is overlooked, thereby ensuring patients feel comfortable, safe and respected in their care.

Another new resource: Doctors of BC and the College—who does what?

Registrants may also be interested in a new resource that describes the primary difference between the role and mandate of the College and Doctors of BC. This useful chart, Who Does What?, is available on the College website.

H.M. Oetter, MD
Registrar

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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Registered care advisors—an essential medical resource for advancing the care and recovery of patients injured in vehicular accidents

On November 9, 2018, the provincial government announced new Insurance (Vehicle) Regulations for the treatment of motor vehicle accident injuries that allow for the creation of a list of medical care consultants called registered care advisors. Through the upcoming annual licence renewal process, the College will verify that registrants interested in becoming registered care advisors are qualified and otherwise eligible.

The role of the registered care advisor is to support the treating physician when an injured patient has not reached their expected recovery goals. They provide expedited medical consultations to family physicians treating patients of motor vehicle crashes, and are available for a second opinion on diagnosis and treatment plans when the initial care and recovery plan is not working. The role of the registered care advisor is consultative in nature with the intention of advising on best practice and appropriate treatment pathways.

The treating physician initiates a consultation with a registered care advisor when a second opinion on the diagnosis and/or treatment plan is required. The treating physician and registered care advisor should communicate to ensure the patient is provided with the most appropriate care. In order to maintain independence from the process, ICBC is not involved in these conversations. While the registered care advisor's role is to provide recommendations based on best practice guidelines, the treating physician remains the primary care provider for the patient.

A registered care advisor must be a qualified and independent assessor, not hired by the defendant insurer or plaintiff lawyer, and not have a financial interest in the treatment plan. To ensure fairness, the family physician and patient—not the lawyers or insurance companies—will choose a registered care advisor.

Registered care advisors are College registrants who self-select in one or more of three areas of competency:

- musculoskeletal injuries
- acute and chronic pain
- mental health issues and other psychosocial issues

Registrants who are interested in becoming a registered care advisor will apply through the College and specify their area(s) of expertise when they renew their licence in January. The College's role is to verify that the registrant is in the full class of registration in a relevant discipline, and is not otherwise limited in providing assessments due to limits, conditions, undertakings, etc. Registrants in the provisional class or disciplined class of registration are not eligible to apply.

The information collected through the annual licence renewal process will be provided by the College to the Ministry of the Attorney General who will establish the list of registered care advisors. The list will be published on ICBC's Business Partners page. Physicians treating injured patients will be able to access the list to select the most appropriate registered care advisor.

Registered care advisor consultations will be paid by ICBC according to the Insurance (Vehicle) Regulations.

Instructions for preparing and submitting invoices to ICBC will be available on ICBC's Business Partners page in January.

See Government of BC Regulations – Part 3 – Registered Care Advisors

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2019 annual licence renewal begins January 1

Annual licence renewal begins January 1, 2019. Here's what registrants need to know.

Important dates to note

January 1, 2019: start of annual licence renewal

February 1, 2019: deadline to complete the Annual Licence Renewal Form and payment of fees

March 1, 2019: penalties applied for late licence renewal or late payment of fees

April 1, 2019: suspension for non-renewal of licensure or non-payment of fees

Note: due to scheduled maintenance on the College website, the Annual Licence Renewal Form will not be available on February 9 and 10.

Getting started

Use a computer—the form cannot be completed on a tablet or mobile device

The licence renewal process is best experienced using a PC or Mac. Mobile devices or smart phones, including tablets and iPads, are not supported.

Update web browser

It is best practice to have the most recent version of a web browser installed on your computer. Optimum browsers include Internet Explorer 9, Safari 5, Mozilla Firefox 14, Google Chrome 46 or better. Optimum operating systems include Windows 7 or OSX 9 or better. Lower versions, other operating systems or browsers may cause viewing or loading issues.

Gather documents

- BC driver's licence
- Method of payment (credit or debit card)
- CPD cycle date
- Health authority letter of reappointment (for verifying hospital privileges)

Update contact information

Log in to the College website to update your primary business address and email before January—this will save you some time during the renewal process.

1. **Log in**

   You will need your CPSID and password to log in and complete the renewal questionnaire. **Did you forget your password?** Follow these instructions to reset your password.

2. **Set a primary business address/publishable address**

   Registrants are required by statute to provide their current contact information to the College, including their professional mailing address(es), and telephone/fax number(s). Provide one publishable business address to be displayed to the public in the physician directory. This is for contact and publication purposes.

   Note: if you have only provided one address and that address is your home address, it will be published on the physician directory. Ensure you have made the necessary updates by adding a publishable business address as your primary address—this could be a PO box address.

3. **Email address**

   For completion of the annual licence renewal process, you must also provide your current email address. Add the College to the safe senders list to ensure that important notifications do not end up in the spam or junk email folder.

   Your email address is not shared with third-party agencies and is not visible in the online physician directory. For more information, please refer to the College's corporate policy regarding Distribution of Information/Material On Behalf of Third Parties via Broadcast Email or Other Communication Channel.

To renew

Complete all the sections of the renewal process

It should not take more than 20 minutes.

Most questions remain the same on the 2019 Annual Licence Renewal Form, with the addition of new or updated questions regarding the following topics:

- Practice setting and scope of practice
- ICBC registered care advisors
- Aboriginal health professionals

Save responses

If you started your renewal form partway but need more time to complete later, save your answers by completing all the questions in that section. Click Continue at the end of the section to save your entered data.

For security reasons, the form is set to **timeout after 1 hour of inactivity**. You will need to log in again and re-enter your unsaved answers.

Attestation

At the end of the questions and prior to submitting the online form, you will be asked to certify that the information provided is truthful, accurate and complete. The College expects you to complete your own Annual Licence Renewal Form. It is not acceptable for registrants to ask a medical office assistant, spouse or partner to complete the form on their behalf.

Pay the amount owing

Your 2019 renewal fee of $1,700 can be paid in one of three ways online:

- By credit card
- By debit credit card

- By Interac® Online

Note: online banking is not a payment option.

Confirmation email and receipts

Once your form has been submitted, you will receive a confirmation email from the College. Receipts are ready within two (2) to five (5) business days after completion of the entire licence renewal process. To access the receipts, log in, click the Financial tab under My Account.

More details on annual licence renewal can be found here.

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Prescribing methadone—consultation results point to an effective standard

Practice Standard

A total of 179 registrants participated in the recent consultation on the College's *Prescribing Methadone* practice standard, which ran from August 28 to September 28, 2018.

Results:

- 62% indicated that they had past experience prescribing methadone to their patients, and that they did so most commonly to treat opioid use disorder
- 80% indicated that the standard is clear and easy to understand, that it aligns well with other standards and guidelines related to prescribing methadone, and that it helps promote patient safety
- 55% agreed that the *Prescribing Methadone* standard helps prescribers feel more confident; 20% were neutral

One area of concern raised about the current standard is the requirement of a physician to complete a comprehensive, biopsychosocial examination of a patient before prescribing methadone. Consultation feedback showed that the wording in the standard is not conducive to team-based care as it specifically states that the physician must be responsible for conducting the assessment. The wording for this requirement has now been revised to enable other health-care professionals to conduct the patient assessment before methadone is prescribed, thus promoting the primary care network model. The physician continues to hold responsibility for ensuring that all aspects of the assessment have been completed.

Further feedback from the survey indicated that the standard could provide more clarity regarding best practices for hospital-based physicians when the need arises to prescribe methadone in the emergency department. This concern, along with a few other feedback points, have been passed along to the BC Centre on Substance Use to be addressed in clinical guidelines.

The revised *Prescribing Methadone* practice standard was approved by the Executive Committee, and published to the College website.

The College thanks all those who participated in the consultation.

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Reducing risk to patients through effective compliance monitoring

As part of its public protection mandate, the College monitors all registrants who have conditions on their practice. At the core of this function is the need to mitigate the risk of non-compliance. The expectation is that registrants remain 100 per cent compliant, and the College has zero tolerance for non-compliance. Without exception, alleged breaches are referred to the Inquiry Committee.

Practice conditions arise from numerous sources, including discipline and complaints dispositions, voluntary undertakings provided by registrants, and as part of the return to work process, to name a few.

Over the past two years, the College's investigations team has developed a robust program to ensure effective compliance monitoring, and has adopted an approach which is based on focused, file-specific assessments of all relevant factors, including risk, to determine the best monitoring approach, and the timing and frequency of monitoring inspections of registrants' practices.

The investigations team regularly conducts unannounced office inspections of registrants subject to conditions, pursuant to section 28 of the *Health Professions Act*. These inspections usually include interviews with registrants and office staff, random patient chart reviews, and ensuring that appropriate signage is conspicuously displayed, if required.

In cases where registrants are required to use chaperones for sensitive exams as a condition of practice, monitoring includes chaperone vetting and approval to determine the suitability of individuals to act as chaperones. Monitoring may also include receiving and reviewing weekly reports from chaperones.

Other ways that the College monitors compliance with conditions include reviews of billings and prescription profiles. If registrants are required to have monitors as a condition of practice, the College ensures that only suitable physicians are approved. Practice monitors are required to provide regular reports to the College and have an obligation to report irregularities or concerns.

The primary objective of the compliance monitoring program is to be proactive in ensuring compliance, versus reacting once a breach has occurred and is reported to the College.

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Medical complaint reviewer—applications now being accepted

Registrants with broad clinical experience are invited to apply to the College for the part-time position (up to 20 hours per week) as medical complaint reviewer.

Under the direction of the deputy registrar, medical complaint reviewers carry out the mandate of the complaints department: to deliver transparent and impartial case reviews in compliance with College policies and procedures, and in accordance with the *Health Professions Act* (*HPA*) and Bylaws.

Working in a collaborative team environment, medical complaint reviewers function as experts in the review and assessment of both clinical and conduct complaint files.

Candidates must

- possess exceptional writing skills, including the ability to present technical concepts in lay terms and formulate clear and logical reasons in a style that expresses both empathy and a commitment to fairness;
- thrive in a high-volume, fast-paced environment while maintaining quality and timeliness standards;
- work collegially and interact effectively with College staff; and
- complete complaint reviews and attend meetings at the College office in Vancouver.

Send a letter of application, with resume, to the attention of the director, complaints and practice investigations by January 18, 2019.

Confidential facsimile: 604-733-3503

All correspondence will be held in strict confidence.

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Considerations for difficult extubation in non-hospital facilities

NHMSFAP Update

The unanticipated difficult airway is a very stressful event. When it goes well, everyone involved should be thanked, and in the best of medical worlds, there would be a debrief and discussion as to what went well and what could be done better next time. What perhaps is not paid enough attention to is the extubation plan, following either an anticipated or unanticipated difficult airway. This is despite the mounting evidence that the peri-extubation period is a high-risk time that requires planning with appropriate monitoring, good communication and skilled staff.

A recent case reviewed by the Non-Hospital Medical and Surgical Facilities Accreditation Program Patient Safety Incident Review Panel highlighted the need to have extubation protocols at non-hospital facilities.

Extubation is an elective procedure, and following an unanticipated difficult intubation there are several factors one must consider prior to extubating the patient, other than ensuring a patient can protect their airway and has reasonable ventilation parameters. Questions to consider: Did airway trauma occur during the intubation attempts? Was the surgical procedure long and associated with significant fluid shifts? Is there facial edema following use of prone or steep Trendelenberg position? Was bag-mask ventilation challenging? Is the patient at high risk for oxygenation challenges?

An extubation plan should include at a minimum:

1. An assessment of the internal airway (e.g. laryngeal area)—supraglottic edema is a risk factor for post-extubation respiratory distress. This can be done with a videolaryngoscope (VL) prior to awakening the patient; the VLs such as the Glidescope and C-Max have a large field of view providing visual assessment of potential airway trauma. The presence of an endotracheal cuff leak is not a guarantee of a successful extubation, as edema is typically supraglottic in these scenarios (known tracheal stenosis/small trachea suspected being the exceptions).
2. Having a fully awake and cooperative patient—this may take time, and one has to consider the process for supported ventilation outside of the OR in the facility—transfer to a hospital may be required. Good communication with the surgeon and facility staff is a priority.
3. Consideration of the use of
    a. an extubation catheter—these are purpose built and well tolerated in the awake patient; providing the security of an ‘easy’ reintubation, or
    b. extubating to a supraglottic device if that was a successful oxygenation strategy during the difficult intubation and the concern is not airway edema.
4. Have available a temporizing medication such as nebulized racemic epinephrine, as it may be sufficient to manage supraglottic airway edema that is symptomatic but not severe or worsening.

The presence of risk factors such that extubation may well fail is best managed by keeping the patient intubated and sedated, with transfer emergently to a hospital.

A set of extubation algorithms is freely available online from the Difficult Airway Society.

References:

1. Quinn A, Woodall N. Chapter 8, The end of anaesthesia and recovery. In: Cook T, Woodall N, Frerk C, editors.4th national audit project of the Royal College of Anaesthetists and the Difficult Airway Society: major complications of airway management in the United Kingdom: report and findings [Internet]. London: Royal College of Anaesthetists and the Difficult Airway Society; 2011. [cited 2018 Dec 5]; p. 62-71. Available from: https://www.rcoa.ac.uk/system/files/CSQ-NAP4-Full.pdf
2. Kluger MT, Bullock MRM. Recovery room incidents: a review of 419 reports from the Anaesthetic Incident Monitoring Study (AIMS). Anaesthesia 2002;57:1060-1066.

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Medical staff must be current for emergency training to practise in non-hospital facilities

NHMSFAP Update

The Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) has an accreditation standard Human Resources, which states that regulated health-care professionals must have *current* basic life support (BLS), advanced cardiac life support (ACLS), pediatric advanced life support (PALS) and airway management courses appropriate to the clinical setting where they work.

The NHMSFAP Committee has directed that *current* be defined as:

- BLS courses must include an in-person/hands-on component and be renewed every two years. BLS courses must be designed for health-care professionals (health-care provider or equivalent level).
- ACLS/PALS courses must include an in-person/hands-on component and be renewed every two years.
- A difficult airway management course is required for anesthesiologists who have not regularly practised in a hospital setting for three years. Difficult airway management courses must be renewed every three years.

Many course providers offer portions of courses online, which is acceptable. Courses entirely online are not acceptable. Courses must include an in-person/hands-on component to demonstrate the importance of effective team interaction and communication and participation in simulations and scenarios.

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Use of ultrasound gel for external ultrasound probes

External ultrasound probes are those which only come into contact with intact skin during a procedure. These probes are considered non-critical devices and require cleaning and low-level disinfection after each use.

Although external probes are intended for use on intact skin, they can still contribute to the transmission of infectious agents either by contaminated hands of a health-care professional, contamination on the probe itself, or, even from the gel/gel bottle used during procedures.

While reusable multi-use non-sterile gel bottles may be used for low-risk general examinations on intact skin, they are not considered best practice. These reusable multi-use non-sterile gel bottles can be easily contaminated and have been involved in the transmission of infectious agents associated with outbreaks of infection.

The following practices must be adhered to when using reusable multi-use non-sterile gel containers/bottles:

- Dispense gel from the original gel manufacturer's container and use a clean dispensing device
- Never "top up" gel bottles that are partially full
- Refill the bottle only after it has been emptied, cleaned (using a medical grade detergent, rinsed and dried) and then disinfected with a medical grade low-level disinfectant
- Label a newly opened or newly refilled gel bottle with the date
- Discard any unused gel left in bottle after 28 days
- Unused gel is discarded if at any time the cleanliness of the bottle or contents is questioned or compromised, or if the bottle is not marked with the fill date
- After each patient use, wipe the outside of the gel bottle with a medical grade low-level disinfectant and ensure lid is closed
- Never heat gel bottles for use

If an external ultrasound probe is used for a procedure that involves a sterile field, such as for needle guidance, both the gel and the probe cover must be sterile.

Always follow the manufacturer's instructions for the ultrasound probe. Other basic infection prevention and control measures, including hand hygiene and environmental cleaning and disinfection, are also essential to prevent the transmission of pathogens in medical ultrasound.

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Prescribing apps—the challenge of choice

College LIBRARY

As software and hardware develops, functionality is expanding from simple educational text to video, animation, and audio guidance, recording and display of symptom trends, artificial intelligence for auditory or text conversations (chatbots), and augmented reality.

Some apps have evidence for their value in physical and mental health care as shown in this sample of systematic reviews on patient care apps from a PubMed search*; however, for the most part, more rigorous trials and systematic reviews are needed for final verdicts. Ultimately, apps will offer meaningful value when their content is evidence-based and privacy and security are assured, at a minimum.

Before recommending an app for patients' self-care, registrants may want to apply a grading system to assess its quality. One such system is the practical App Evaluation Model from the American Psychiatric Association. It is a five-step assessment starting with background aspects (business model, advertising conflicts of interest), and moving on to privacy and security, evidence base for effectiveness, ease of use, and interoperability.

Registrants looking for other examples of app grading systems can contact the library for a literature search on this fast-changing topic at medlib@cpsbc.ca, 604-733-6671, or through the library request form.

*Note: if the document does not open in the browser, download it to a computer and open in Adobe Reader.

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CPD events: mark your calendars

Medical Record Keeping for Physicians
February 13, 2019 – Vancouver
Learn more

Chronic Pain Management Conference
March 1, 2019 to March 2, 2019 – Vancouver
Learn more

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Regulatory actions

- Sander, Donald Albert – November 29, 2018

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