College of Physicians and Surgeons of British Columbia

Serving the public by regulating physicians and surgeons

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: Telemedicine and licence portability—the future of medical regulation in Canada

The College of Physicians and Surgeons of British Columbia, in partnership with its sister medical regulatory authorities (MRAs) across Canada, has been discussing the future of registration and licensure in Canada. Currently, the delivery of health care is a constitutional responsibility of each province and territory, and physicians must obtain licensure in the jurisdiction (or jurisdictions) in which they wish to practise. With the increased provision of medical services through digital health options, physicians may seek to work in more than a single provincial/territorial jurisdiction.

The provision of telemedicine services is not standardized across Canada:

- Some jurisdictions require physicians to have registration in the province in which the patient is located, regardless of location and licence status.
- Some jurisdictions require out-of-province physicians to obtain a specific telemedicine licence.
- Some jurisdictions simply require the physician to hold an acceptable licence in the Canadian jurisdiction in which they reside (the "home" jurisdiction) in order to be able to provide telemedicine services in that jurisdiction.

In some Canadian jurisdictions, the provision of telemedicine services may not be an insured service and physicians may be billing the patient directly. In others, the provincial or territorial health plan may consider this to be an insured service. Some jurisdictions are reconsidering requirements for telemedicine services, given the proliferation of entrepreneurial, stand-alone companies for the provision of episodic care.

In an effort to reduce fragmentation of care, some jurisdictions want to ensure that providers of telemedicine services have a clear and verifiable connection with the patient's jurisdiction of residence and, through that, an ongoing connection with the patient.

In response, the Federation of Medical Regulatory Authorities of Canada (FMRAC) is embarking upon a review of the licensure of physicians.

There are three projects:

a. Telemedicine: FMRAC is exploring the possibility of creating a single licence to support telemedicine across all jurisdictions in Canada. If possible and approved by the provincial/territorial ministries of health, the MRA in the host jurisdiction in which the physician is licensed would assume responsibility for the investigation and adjudication of concerns regarding competence or conduct by the physician in any other Canadian jurisdiction where the physician is providing services through telemedicine.

b. Fast-track licences: FMRAC is examining the opportunity to expedite the issuance of licensure for physicians who hold full registration in another province/territory through the traditional route (MD, LMCC, certification with either the CFPC or RCPSC) and have a "clean" certificate of professional conduct.

c. Licence for portability: Finally, FMRAC is considering a licence portability agreement to enable physicians to work for a short time (locum tenens) in another jurisdiction based solely on licensure in the "home" jurisdiction. Interestingly, this aligns with a similar process for members of the legal profession across Canada used by the Federation of Law Societies of Canada.

As medical regulators are bound by statute, the first key stakeholder consultation will occur with all of the ministries of health. I hope to have more information on our consultations in a future edition of the College Connector.

H.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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Non nocere: useful ideas and initiatives in the cause of patient safety

The 1999 publication of *To Err is Human: Building a Safer Health System* prompted the advent of "patient safety" as a scholarly and practical discipline and movement. Two decades on, many physicians describe a mixed experience: a whirlwind of changes with patient safety as the stated goal, but also a weary sense that, at the level of patient-physician relationships, it often doesn't seem as productive as it could be.

This year's Education Day will focus on ideas, initiatives and practical tools that are effectively addressing a shared commitment to avoid harm at the bedside. The day will feature the perspective of a well-informed patient navigating the system and expert insights for physicians on how to thrive despite the seemingly overwhelming demands of present-day practice. Join colleagues for plenary sessions, case studies and interactive workshops to explore these and other compelling topics on how physicians can contribute to the cause of safety in the course of their daily work with patients.

Find information about the program and speakers here.

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Why does the College hold so many consultations? Insight into the policy review cycle

For some, the idea of a policy brings to mind an image of a paper document, stamped and signed, gathering dust on a shelf in a big red binder.

The notion of a policy being inflexible and unchanging is far from the reality of the College's dynamic review process, designed to facilitate the implementation of adaptable practice requirements.

Practice standards and guidelines are reviewed on a regular basis to ensure they fulfill the College's statutory mandate to govern the medical profession in the interest of the public, address critical and emerging issues, and reflect stakeholder values. As part of the regular review cycle, or when a major change to a standard or guideline is deemed necessary, a consultation is held with physicians to gather insight into how the standard or guideline is utilized in practice. This provides physicians with a platform to articulate their views and offer insight into the pragmatic consequences of any proposed new draft and/or subsequent revisions.

The College acknowledges that physicians have busy schedules, and may find it unattainable to participate in all of the consultations. Registrants are reminded that they may pick and choose which consultations they respond to, based on the relevancy to their specific practice setting, and that responding to a consultation is never mandatory. While some may find satisfaction in providing the College with their experiences and feedback, it is recognized that this type of engagement may not suit everyone.

Input received from those who do choose to participate is thoroughly reviewed. Even when there are hundreds of respondents, each and every comment submitted is considered, and themes are identified. Insightful responses and key themes are presented to the registrar and the College's Patient Relations, Professionals Standards and Ethics (PRPSE) Committee, which is tasked with utilizing the consultation results to consolidate new revisions.

The College extends a sincere thank you to all those who participate in consultations on practice standards and guidelines.

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Update on consultation results: (1) *Emailing Patient Information*, (2) *Walk-in, Urgent Care and Multi-physician Clinics*

Practice Standards & Professional Guidelines

The College recently held two consultations, seeking feedback from registrants on one professional guideline and one practice standard.

A total of 380 physicians provided their feedback on the *Emailing Patient Information* professional guideline in a consultation which ran from February 15 to March 5, 2019. Multiple choice data indicated the majority of physicians currently "rarely" or "never" utilize email in their current practice. The vast majority either strongly or somewhat agreed that the guideline is clear in outlining what is expected of physicians and effective in promoting patient confidentiality, while roughly half of the participants indicated that the guideline is operable in practice.

The most common themes from the qualitative data were:

- Email encryption is not practical.
- Patients who are educated on the benefits and risks should have the choice between ease of access versus security of information.
- Texting guidance should be provided.
- Differences in electronic communication requirements for physician to patient and physician to physician (or allied health-care provider) should be clearly distinguished.

The consultation on the *Walk-in, Urgent Care and Multi-physician Clinics* practice standard, held March 6 to March 27, 2019, drew feedback from 426 physicians. Of these respondents, 58 per cent reported that they currently work in a walk-in, urgent care or multi-physician clinic. Multiple choice data showed that the vast majority either strongly or somewhat agree that the standard is clear and effective in protecting patient safety. Just over half indicated that the standard is supportive of team-based care and further insight into the governance of nurse practitioners was requested.

When asked if there is anything in the standard physicians would like to see added, removed, or revised, the following themes emerged:

- The settings described are all very different, and should be governed by unique standards.
- The requirement for providing after-hours care is not appropriate in some circumstances.
- Responsibilities for ordering tests and monitoring results are not clear.
- Online provision of primary care is not addressed.

The College thanks all those who participated in the recent consultations. Feedback gathered will be shared with the Patient Relations, Professional Standards and Ethics Committee to help guide further revisions.

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Minor updates made to MAiD forms

ArticleThe Ministry of Health has made minor updates to the provincial forms for Medical Assistance in Dying (MAiD) in response to feedback from practitioners and pharmacists. Physicians must use an up-to-date version of the forms, which are available for download from the Ministry of Health's website here. Physicians should familiarize themselves with the following form changes:

1633 Assessment Record (Assessor) Form and 1634 Assessment Record (Prescriber) Form

Minor changes to clarify the meaning of specific questions, including

- any consultations with the patient prior to their request for MAiD,
- the assessment of the patient and if they are in an advanced state of irreversible decline, and
- the conclusion regarding the patient's eligibility for MAiD.

A few additions to better reflect federal legislation, including

- a definition of the 10 clear days, noting that 10 clear days begins on the day on which the request was signed by the patient (day zero) and the day on which MAiD was provided (day 11 or later), and
- an affirmation of the agreement between the assessor and prescriber if MAiD has proceeded within less than 10 clear days.

Prescription

The British Columbia Pharmacy Protocols guidance document and Prescription for Medical Assistance in Dying have been updated to include bupivacaine as an optional add-on medication for the intravenous drug protocol. Bupivacaine may be ordered at the discretion of the prescriber if there is risk of delayed cardiac arrest.

Note:

- When ordered for the **intravenous drug protocol**, bupivacaine is an **optional** add-on medication for the primary intravenous kit only, **not** the second back-up kit.
- When the **oral drug protocol** is ordered, bupivacaine is an **optional** add-on medication for the back-up intravenous kit.

The updated British Columbia Pharmacy Protocols guidance document (version 4) and Prescription for Medical Assistance in Dying are available to physicians through each health authority and through the College of Physicians and Surgeons of British Columbia and the College of Pharmacists of British Columbia.

For questions related to provincial forms:

BC Ministry of Health – Medical Assistance in Dying Oversight Unit
hlth.maidoversight@gov.bc.ca
778-698-7497

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Obtaining patient consent for reports submitted to ICBC

Significant improvements have been made to ICBC accident benefits which improve access to care for anyone injured in a crash.

To support these changes, ICBC worked with Doctors of BC to revise assessment report templates. ICBC will use the information in the report for the following:

- Ensuring the correct claims representative or recovery specialist is assigned to the claim
- Authorizing necessary equipment and treatment purchase and process payment in a timely manner
- Proactively addressing potential barriers at an early stage to ensure optimal recovery outcomes

Questions physicians may have

1. **Why is the process for managing consent changing?**

   The new report templates include a specific checkbox to prompt physicians to obtain consent from a patient who has been injured in a motor vehicle accident. The purpose is to help streamline the new workflow process by proactively sending information to ICBC on all motor vehicle accidents.

2. **What changes do physicians need to make in managing ICBC patients?**

   During an assessment, the patient should be informed that a report on the diagnosis and care plan may be shared with ICBC. Physicians should ask for the patient's consent to do so consistent with all consent and information sharing guidelines. If the patient provides consent, physicians should send the report.

   If the patient does not provide consent, physicians should not send the report and instead document the information in the patient's record.

3. **What if a patient refuses to consent to the sharing of information with ICBC?**

   ICBC has legal authority to collect personal information from patients who have an open claim.

   If physicians do not have consent to send a report, ICBC will send the patient's physician a formal request to obtain relevant information on their injuries.

   If physicians receive this request from ICBC they are obliged under section 28.1 of *the Insurance (Vehicle) Act* to provide this information in the report provided. ICBC encourages physicians to contact ICBC in cases where consent has not been obtained.

4. **How do physicians invoice if they do not receive consent to share information with ICBC?**

   In such cases, physicians should invoice a standard office visit through MSP. Physicians should not invoice the new ICBC fees for physicians if they do not have consent from the patient.

5. **How do physicians bill if they do not receive consent to share information with ICBC?**

   In such cases, physicians should invoice the standard assessment fee ($120) or extended assessment fee ($325).

   Physicians should not invoice an office visit in addition to these fees. The report will serve as the invoice for the appropriate assessment and report fee.

6. **How do physicians contact ICBC?**

   A feedback form is available on ICBC's Health Services Business Partners site for any questions physicians may have.

As of April 1, 2019, the Health Care Inquiry Unit (HCIU) will be active and their contact number will be posted on ICBC's Health Services Business Partners site.

For more information regarding fees and reports, visit ICBC's Health Services Business Partners site.

An illustration of the change in process, using simplified patient and report journeys, is available here.

Note: This article was submitted to the College by ICBC.

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Large dispenses of psychoactive medication risk harm to both patients and the public

Medication used for non-medical purposes can originate from physician prescriptions. Large dispenses have been identified by public health and law enforcement authorities as a major source of diverted medications (mainly sedatives and opioids). Once dispensed, these medications are stored in a home presenting a public safety issue to an experimenting teen or visitor. Police report vulnerable patients (e.g. seniors) observed filling their prescriptions and then being robbed, or persuaded to sell medications with street currency.

Providing large dispenses makes it very hard to monitor individual patients' use. It increases the risk of medication error by patients as they may be less mindful of the amount taken, or become more prone to overuse, when hundreds of tablets are in their possession. Such misuse can go unchecked for long periods of time if they do not have frequent follow-up appointments.

The self-reporting of drug use is often unreliable, and the detection of illicit drugs is important in the early intervention of addiction. Patients with current or past history of substance misuse will often experience increased loss of control if provided large dispenses. Physicians should consider medication and treatment agreements for all patients on long-term psychoactive medications, including provision for random urine drug screening, random pill counts and blister packaging as indicated. The agreement should also include provision for referral to addiction services or a pain specialist if required for continued safe prescribing.

Pharmacovigilance dictates that prescription sizes should be modest. The College recommends that dispenses should not exceed a three-month supply or 250 tablets, whichever is less. However, logic and prudence suggest that dispenses of psychoactive medications should be in modest amounts, usually 50 to 100 units, for anyone facing the risks noted above. There are options for writing prescriptions that allow flexibility and avoid large dispenses, such as more frequent dispenses of smaller quantities from the pharmacy.

Misuse and diversion of prescription medication is at epidemic proportions. Physicians have an obligation to play their part in addressing this through careful prescribing.

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Quality improvement does not equate to "pass or fail"

The Physician Practice Enhancement Program (PPEP) is educational and its mandate is to encourage ongoing quality improvement in multiple aspects of physicians' practices. Everyone has room for at least some improvement, which is what PPEP is designed to uncover and encourage.

From the first mail-out to the office assessment and physician interview to the resulting report, there are many opportunities for physicians to review their clinical practices and record-keeping. While most physicians report it is initially stressful, it should be considered a reflective, and ultimately, an educational process.

Physicians may want to ask these key questions in advance:

- How can I improve on what I may have been doing since medical school and residency? Do I recognize what medical knowledge and standards of care have changed or know where to look to apply these changes into my practice?
- My medical records show the clinical care I provide. Do my encounter notes clearly detail why a patient was seen, what was found, and what was done?
- As I complete these notes, do I reflect on what assumptions I may have made, and what I may have missed?
- If another physician came into my office, could he or she efficiently and effectively assume the care of my patients?
- Is there enough information in the patient's cumulative patient profile (CPP) for another physician to understand the patient's past, familial, and social history? Is there enough information in the CPP to trigger me to ask about necessary longitudinal care/health maintenance, or to remind me of factors to consider in my management?

While all physicians want to do well in the eyes of their peers, no one will get 100 per cent on their assessment. The program is not about passing or failing. Rather, PPEP enables every physician to further enhance the care they provide for their patients, to continue to adapt, and to continue to learn. It is an ongoing process of professional development, reflection on practice, and self-improvement. Many assessed physicians have stated openly that they valued the process and have made positive changes to their practices.

This is the desired outcome for all BC physicians.

Find more information about the program, assessment standards, and available resources here.

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Access Medicine—an internal medicine clinical resource for College registrants

College LIBRARY

Access Medicine is a collection of current, online texts for background knowledge and quick answers at the point of care. As a resource, it contains numerous ebooks such as the continuously updated *Harrison's Principles of Internal Medicine*, *Current Medical Diagnosis & Treatment 2019*, *Schwartz's Principles of Surgery*, *Tintinalli's Emergency Medicine*, *Hurst's The Heart*, and *Williams Gynecology*; a drug database; patient handouts; multimedia; and self-assessment questions for exam and board review. The desktop and app versions contain quick reference tools such as *Quick Medical Diagnosis and Treatment 2019* and *Diagnosaurus* for browsing differential diagnoses by symptom, disease, or organ.

Access Medicine has information on emerging topics such as point-of-care ultrasound examinations, which are being implemented in numerous specialties such as general practice, emergency medicine, cardiology, and anesthesia.

The 2019 ebook *Pocket Guide to POCUS: Point-of-Care Tips for Point-of-Care Ultrasound* offers concise summaries in areas such as peripheral intravenous access, focused assessment for free fluid, paracentesis and thoracentesis, lung sliding, cardiac assessment, internal jugular central venous catheterization, renal and bladder ultrasound, assessment of abscess and cellulitis, and ocular ultrasound. Each section has brief videos and images with bulleted text on acquisition tips, interpretation, and examples of pathology.

Registrants are welcome to use Access Medicine either through the library's webpage or as an app.

Contact the library for other online resources and queries.

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CPD events: mark your calendars

Prescribers Course
May 10, 2019 – Vancouver
Learn more

Medical Record Keeping For Physicians (Psychiatry)
June 3, 2019 – Vancouver
Learn more

Medical Record Keeping For Physicians
August 21, 2019 – Vancouver
Learn more

Education Day and Annual General Meeting 2019
September 20, 2019 – Vancouver
Learn more

Medical Record Keeping For Physicians
October 16, 2019 – Vancouver
Learn more

Professionalism in Medical Practice: Avoiding the Pitfalls
November 1, 2019 to November 2, 2019 – Vancouver
Learn more

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Regulatory actions

- Nguyen, Viem Chung – April 1, 2019

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