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COLLEGE OF PHYSICIANS & SURGEONS INCORPORATED 1886
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BRITISH COLUMBIA

**Serving the public through excellence and professionalism in medical practice**

# College Quarterly

COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

In this issue:



Enclosed with this issue of the *College Quarterly*:
- The College library's *Cites & Bytes*

**www.cpsbc.ca**

*The* College Quarterly *is sent to every current registrant of the College. Decisions of the College on matters of standards and guidelines are contained in this publication. The College therefore assumes that each registrant is aware of these matters.*

# Message from the Registrar

## Medical marijuana – the physician as gatekeeper

On December 16, 2012, Health Canada published proposed changes to its *Marihuana for Medical Purposes Regulations* and invited comment from key stakeholder groups. Both the Canadian Medical Association (CMA) and the Federation of Medical Regulatory Authorities of Canada (FMRAC) made submissions strongly opposing the proposed changes, which would shift the responsibility of "gatekeeping" access to marijuana from Health Canada to physicians. Both the CMA and FMRAC agree that physicians should not be asked to prescribe or dispense substances or treatments for which there is little or no evidence of clinical efficacy or safety.

The medical community has acknowledged that marijuana for medicinal purposes may provide some relief to those suffering from a terminal illness or chronic pain when conventional therapies cease to have an effect. However, in the absence of scientific evidence, many physicians have been reluctant to authorize its use as a medical therapy, particularly for younger patients.

The proposed regulations place physicians in a very difficult position by giving them the authority to sell, dispense or administer dried marijuana when it hasn't undergone the same scientific and clinical assessments requisite for all other prescription drugs, making it impossible to standardize dosage, therapeutic blood concentration, health benefit, and route of administration. The lack of evidence to support the use of marijuana for medical purposes signifies that it is not a medical intervention. If and when appropriate research is conducted, physicians may eventually have accurate information in the form of a clinical practice guideline on the use of marijuana and can "prescribe" it in the same manner as all other prescription drugs. Further, Canadian physicians do not dispense the drugs they prescribe. If marijuana was a drug like other drugs it would be dispensed in a pharmacy with all of the appropriate safeguards in place.

Canadians are well aware of the adverse impacts associated with the supply and distribution of illicit marijuana on individuals and communities. A more tightly regulated system for supplying and distributing marijuana to those who wish to use it for medical purposes may help to mitigate the negative outcomes. Alternatively, Canada could follow the lead of those jurisdictions in the United States that have recently decriminalized the use of marijuana, recognizing that trying to regulate it for medical purposes simply isn't feasible. There are many who would support an amendment to the Criminal Code.

Either way, physicians should not be forced to address the social implications of the new access regulations, and make decisions that are contrary to their ethical obligations and clinical judgement. It is irresponsible of Health Canada to download the risks, legal and otherwise, to physicians as gatekeepers to marijuana. This change will have significant impact on medical regulators who will be charged with providing oversight and forced to use resources which would be much better spent on ensuring patient safety through excellence in medical practice.

Tell us what you think. If you have further thoughts, ideas or concerns about Health Canada's proposed regulations, please send them to us at communications@cpsbc.ca.

Heidi M. Oetter, MD
*Registrar and CEO*

The proposed regulations can be accessed through this URL:
http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2012/2012-193-eng.php

# Communication
## Sound Bites

## The College Quarterly

### A glance back

Keeping registrants informed about the work and activities of the College has always been a top priority for the Board. According to historical records, the College first began communicating with registrants by submitting articles to the *Vancouver Medical Association Bulletin*, which started publication in 1924 and morphed into the *BC Medical Journal* in 1959. In 1950, the College began production of its own CPSBC Newsletter to bring registrants "up to date in College affairs." The first issue of the current *College Quarterly* was published in 1993.

### New beginnings

To keep up in this fast-paced era of information exchange, the College decided to pilot-test an electronic newsletter concept last fall with a random sample of registrants. The feedback was very interesting. While a few respondents indicated a preference for "all things paper" (rather than electronic), the vast majority was very supportive of ending the paper production and evolving the *College Quarterly* into an online publication. At its meeting in December, the Board endorsed the recommendation to transition it to an electronic format by June 2013. This seventy-ninth issue will be the very last printed *College Quarterly* registrants will receive. Stay tuned for the new dynamic online publication coming via electronic mail in early summer.

What survey respondents said about the electronic *College Quarterly*

**"I would prefer to receive the newsletter in this form. Good to have it readily accessible on computer and iphone."**

**"I was surprised to find that I actually read the online *College Quarterly* as soon as I received it and more thoroughly than I usually read the hard copy. I would not have predicted that I liked reading it this way, but I did!"**

**"I really enjoyed it—it was quicker to read."**

## ALR update

The 2013 annual licence renewal cycle has come to an end. With that, the College thanks all registrants who completed the process. The College continues to enhance its website to ensure an efficient online experience for registrants when they renew their licence. More information about specific enhancements to the login process will be forwarded to registrants in June.

## Retiring from practice

Registrants who plan to retire from practice should inform the College by completing the *Retirement / Resignation from the College* form available on the College website at Physicians' Area>Registration>Retirement/Resignation. This important step saves the College from administering fines to registrants for failing to renew their licence or cancelling their registration when their intention is to retire from practice.

## Lasers in clinical practice

Physicians using medical class 3B or class 4 lasers in an office or a non-hospital facility setting are reminded that the laser(s) must be registered with the College. The *Laser Registration* form can be found on the College website under About the College>Accreditation Programs>Non-Hospital Medical and Surgical Facilities Program>Facility Resources.

## Phone before you dig

Physicians working in private medical offices are reminded to contact the College if they are unsure a procedure is appropriate to be performed in an office setting. With countless new advances in medical technology, vendors often present medical devices and procedures as "office-based procedure(s)" and physicians may be unaware of the College's applicable bylaws, requirements and restrictions. Physicians who are uncertain or are enticed by new technologies targeted for office treatments or procedures are advised to contact the College for guidance prior to purchasing specialized equipment.

## New bugs and drugs antimicrobial reference guide – available now

College registrants are eligible to receive a complimentary copy of the updated *Bugs & Drugs Antimicrobial Reference Guide* as either an iPhone application or as a hard copy. Copies of the guide can be ordered directly online at http://fluidsurveys.com/s/BugsandDrugs. Funding for this initiative is provided by the BC Ministry of Health, Pharmaceutical Services Division.

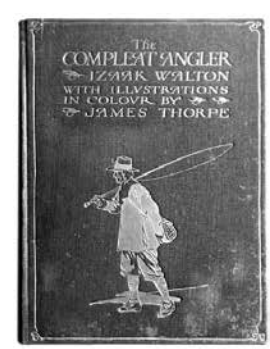
# Announcements and Events

## Courses and workshops – *mark your calendars*

*Information about College-sponsored educational initiatives are published on the website at www.cpsbc.ca>Physicians' Area>Physician Education.*

## Save the date for this year's Education Day: Friday, September 20, 2013

### The Complete Physician: Anachronism or Imperative




Friday, September 20, 2013 is the date for the much-anticipated College Education Day, held again this year at the Vancouver Convention Centre.

Excellent physicians require in-depth biomedical skill and knowledge, but optimal patient outcomes depend on the acquisition and application of other critical attributes too. In this era of rapid information exchange, greater patient expectations and advanced technologies, excellent physicians are also effective communicators, collaborators, managers, health advocates and scholars.

Join colleagues at the 2013 Education Day to explore these and other attributes of the complete physician in the twenty-first century. The program includes plenary sessions, case studies and interactive workshops for an all-encompassing educational experience.

*Confirmed presenters and proposed session topics*

**Morning plenary**

**Practising physicians and health care system reform**

André Picard
Public Health Reporter
*The Globe and Mail*

**Afternoon plenary 1**

**The cure for everything: myths about health and fitness and where they come from**

Tim Caulfield, BSc, LLB, LLM
Author and Professor, Faculty of Law and School of Public Health
University of Alberta

**Afternoon plenary 2**

**Medical marijuana – future options for regulating or decriminalizing**

Geoff Plant, QC
Partner at Heenan Blaikie LLP,
Former Attorney General of British Columbia

**Workshops**

1. **Educating the complete physician**
   Dave Snadden, MB ChB, MCISc, MD, FRCGP, FRCP, CCFP
   Executive Associate Dean, Education, Faculty of Medicine
   UBC
2. **Group medical visits: why and how to lead them**
   John Pawlovich, MD, CCFP, FCFP
   Clinical Associate Professor
   Department of Family Practice
3. **Relationships and healing: what we know cures; who we are heals**
   David Kuhl, MD, MHSc, PhD
   Founding Director, Centre for Practitioner Renewal
   Providence Health

*More information about program content, session presenters and registration will be available in the coming weeks on the College website.*

### Prescribers Course—*Vancouver*

Family physicians consistently rate prescribing for chronic pain amongst the most difficult areas of their professional lives. In a discipline where communication is the core skill set, talking to patients in realistic terms about the risks and benefits that attend the use of opioids, benzodiazepines and other potentially habituating medications challenges even the most seasoned practitioners. Participants in this intensive course will learn new approaches, primarily though interview simulations in small groups, supported by sympathetic, experienced, clinical teachers.

| | |
|---|---|
| **Date:** | April 19, 2013 |
| **Location:** | Four Seasons Hotel<br>791 West Georgia Street |
| **Time:** | 8 a.m. to 5 p.m. |
| **Registration Fee:** | $682.50 ($650 +$32.50 GST) |

For more information and to register, please call 604-733-7758 extension 2255.

*Previous workshops have been accredited for up to 8.0 Mainpro-M1 credits.*

### Medical record keeping workshop—*Vancouver*

This course is primarily directed at general/family practitioners and other physicians providing primary care. It is an interactive program using real case examples and simulated patient encounters to demonstrate the practice of effective clinical record keeping. Six to eight weeks after the course, attendees are asked to submit files to the instructor for review to ensure that the newly learned techniques are being incorporated into daily practice.

| | |
|---|---|
| **Date:** | May 22, 2013 |
| **Location:** | 300-669 Howe Street, Vancouver, BC |
| **Time:** | 8 a.m. to 5 p.m. |
| **Registration Fees:** | $481.60 ($430 + $51.60 HST) for registrants<br>$593.60 ($530 + $63.60 HST) for non-registrants |

A registration form is available on the College website. For more information, please call 604-733-7758 extension 2234.

*This program meets the accreditation criteria of the College of Family Physicians of Canada and has been awarded 6 Mainpro-M1 credits. Those completing the post-course feedback exercise qualify for 8 Mainpro-C credits.*

# Quality Assurance

## Ethics

### Standards and guidelines

*Registrants are asked to familiarize themselves with the documents contained in the* Professional Standards and Guidelines *section of the College website. Any questions regarding the content in these documents should be directed to one of the College's deputy registrars.*

### NEW STANDARD: *Treating Self, Family Members and Those with Whom You Have a Non-professional Relationship*

*This standard addresses the issue of physicians treating those with whom they have a personal or non-professional relationship and reminds them of their duty to exercise sound professional judgement. It also directs physicians that they must not prescribe narcotic or psychoactive medications to themselves or family members.*

### UPDATED STANDARD: *Advertising and Communication with the Public*

*The Board recently revised this standard by removing the paragraph on patient testimonials. While testimonials may be deemed unprofessional in some instances, the College would prefer to focus on the broader issues of accuracy and truthfulness and felt that explicit mention of testimonials was not required.*

# Quality Assurance *continued*

### The use of portable oximetry in the diagnosis of obstructive sleep apnea

The College has received concerns from physicians and continuous positive airway pressure (CPAP) providers regarding the use of portable oximetry data to establish the diagnosis of obstructive sleep apnea syndrome (OSAS).

The concerns are as follows:

*People who sell CPAP machines note that:*

- The wait-list for level 1 sleep studies in BC's eleven accredited sleep laboratories is very long.
- The use of portable monitoring home oximetry data in patients with a high pre-test probability of OSAS can expedite diagnosis and treatment.

*Physicians who diagnose and treat OSAS:*

- Portable monitoring overnight oximetry performed by CPAP providers is sometimes performed in incorrect clinical situations, resulting in inappropriate or delayed treatment due to a wrong diagnosis (e.g. Cheyne-Stokes breathing, narcotic-induced hypopnea).
- There is sometimes a lack of appropriate physician and allied health professional expertise or backup availability of polysomnography.
- Physicians may not know that CPAP providers are not accredited by the Diagnostic Accreditation Program (DAP) and physicians using such services must be aware of the quality of the data reported.

While the College has no data to substantiate these concerns, the College notes the Canadian Sleep Society / Canadian Thoracic Society's position on the use of portable monitoring for the diagnosis of OSAS is as follows:

- Portable monitoring studies can be used to confirm the diagnosis of OSAS in patients with moderate to high pre-test probability of this disorder based on clinical evaluation when integrated into a package of care that includes a comprehensive sleep evaluation by a qualified sleep physician and the backup availability of polysomnography.
- A portable monitoring device should not be used for screening of asymptomatic patients, for the evaluation of individuals with co-morbid medical conditions (e.g. pulmonary disease, neuromuscular disease or congestive heart failure) or those suspected of having other sleep disorders (e.g. insomnia, periodic limb movement disorder or central sleep apnea).
- Any individual or group performing portable monitoring should do so in a partnership with, or under the supervision of an accredited community or hospital level 1 facility, and a sleep medicine physician or a specialist physician with recognized training in sleep medicine.
- A physician prescription is required to order portable monitoring for OSAS.
- The testing and analysis should be performed under general supervision of a qualified physician with training in sleep medicine.

In summary, the limitations of overnight oximetry to distinguish between different types of sleep disorder breathing must be fully appreciated before it is used to make diagnostic and therapeutic decisions.

## Prescription Review Program

*The College's Prescription Review Program (PRP) is a practice quality assurance activity established to assist physicians in the challenging task of utilizing opioids, benzodiazepines, and other potentially addictive medications with appropriate caution for the benefit of their patients. The work of the PRP is informed by the PharmaNet database.*

### Save lives: don't combine opioids with benzodiazepines or sedative hypnotics

Prescription drug misuse now causes as many unintended deaths in British Columbia as drinking and driving.[1] Recently the medical health officers in the Interior Health Region reviewed coroners' reports for opioid related deaths over a five-year period in an attempt to create a profile of patients at greatest risk.[2] One of their most striking findings confirmed many years of experience of the College drug programs: almost all of the patients who died (93%) were combining opioids with other central nervous system (CNS) depressants. Seventy percent were receiving two or more other sedating drugs.

The *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* recommends that benzodiazepines be tapered and stopped if possible if long-term opioid therapy is contemplated. The experts on the Prescription Review Committee believe that benzodiazepines have no role in the treatment of chronic pain since:

- they are not co-analgesic
- they increase risk without conferring benefit

- sedative hypnotics are for short-term use only
- if pain interferes with sleep, the solution is usually not to add a sedative

Conversations about safe prescribing can be difficult. Following is a suggestion: make it an evidence-based rule of your professional life that you will rarely prescribe combinations of opioids with benzodiazepines and/or sedative hypnotics. Patients should not take both. Together, the patient and physician should choose. (Slowly taper patients already on these drugs: 10% every two weeks to 1/3 of the original dose, then 5% every two weeks.) Patients should also be reminded not to drink alcohol.

In the normal course of business, staff in the College drug programs hears from grieving family members of patients who have died as a result of these combinations, and from the shaken physicians who treated them. Both are severely affected. To avoid that fate, the College recommends a practice quality initiative. Identify every patient receiving both an opioid and one or more sedatives and, where possible, systematically taper and stop one class of drug or the other. In appropriate circumstances, physicians shouldn't hesitate to characterize this as a standard rule of practice.

The College has no authority to direct prescribing to individual patients. The Prescription Review Program Committee acknowledges that this is a controversial area of medical practice where experts may disagree. The *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* identifies situations where benzodiazepines may be appropriate. The collegial advice being offered is to be very selective.


1. British Columbia Coroners Service. Motor vehicle incident deaths 2002-2011 [Internet]. Burnaby, BC: Ministry of Justice (BC); 2012 Jun 15 [cited 2013 Feb 19]. 6 p. Available from: http://www.pssg.gov.bc.ca/coroners/publications/docs/stats-motor-vehicle.pdf
2. Barss P., Corneil T., Larder A., Parker R., Pollock S. Prescription opioid overdose deaths of persons with chronic pain in the Interior Health region. MHO Update [Internet]. 2012 Oct 9 [cited 2013 Feb 18]; 125. Available from: http://www.interiorhealth.ca/AboutUs/MediaCentre/PublicationsNewsletters/Documents/MHO%20Update%20October%209,%202012.pdf


## Non-Hospital Medical and Surgical Facilities Program

*The College's Non-Hospital Medical and Surgical Facilities Program (NHMSFP) has the legislated mandate to establish, monitor and ensure standards of practice in private medical and surgical facilities in BC. There are currently 63 accredited facilities providing a range of minor to more complex surgical procedures, which are approved by the NHMSFP Committee.*

### Incident Reporting Responsibilities

Medical directors are reminded that, in accordance with section 5-6(1) of the Bylaws, the following must be reported in writing to the College:

a. all incidents that may result in unintended consequences of a significant risk or hazard to the patient, whether or not the risk or hazard was averted

b. any (patient) stay at the facility more than 24 hours following a procedure

c. any death which has occurred during or within 28 days after a procedure in the facility

### CPR and ACLS

All surgeons and nurses who work in non-hospital facilities are required to maintain CPR health care professional level certification. In addition, facility surgeons and nurses may also require advanced cardiac life support (ACLS) and pediatric advanced life support (PALS), or a pediatric critical intervention course acceptable to the College as applicable to the setting. The NHMSFP Committee has directed that online certification and re-certification courses are not acceptable. The College notes that the Canadian Red Cross and St. John's Ambulance agree that a hands-on component to demonstrate chest compression technique is essential.

### Equipment Maintenance

The NHMSFP Committee reminds medical directors that all facility equipment must be in good working order and that aging equipment must not present any additional risk to patients. Facilities should be aware of equipment that may no longer be supported by the manufacturer and have contingency plans in place for the replacement of aging equipment, which would include anesthesia machines and monitors. In addition, regular equipment maintenance must be completed by a licensed biomedical technician annually or more frequently as specified, and in accordance with the manufacturer's instructions. Documentation of regular maintenance and repairs must be kept on file and will be reviewed at the time of accreditation.

# Committee Cases and Recommendations

## Inquiry Committees

**Avoid complaints: strive to make a positive first impression**

At a typical Inquiry Committee meeting, members may review up to 20 new matters. Like clinical practice, patterns inevitably begin to emerge, and one might reasonably ask why equally competent and dedicated physicians doing seemingly similar work can have vastly different complaints histories. Of particular interest are the physicians who become the subject of multiple, relatively low-level complaints, which on their own, are usually concluded without criticism.

Frequently, the problem is failure to establish a productive relationship with a patient at the outset—a serious flaw if the sole purpose of the intervention is to be helpful to the patient. Complainants often refer to these physicians as "dismissive," and add comments like "it was obvious s/he didn't care at all about me or my problem." Sadly, the medical record and response to the complaint often reveal quite the opposite, leaving the physician sincerely wondering what went wrong.

The solution lies in the truism about the importance of making a first impression—you only get to do it once. A friendly greeting that specifically acknowledges the presenting problem in a manner that communicates genuine concern has been shown to work very well.

# A Word from the College Library

## The library: your partner in CPD

Learning that arises from individually planned and conducted initiatives by physicians is the most effective approach to improving clinical practice. The College library supports physicians' self-directed learning with services and material that satisfy Royal College of Physicians and Surgeons of Canada (RCPSC) and College of Family Physicians of Canada (CFPC) criteria for continuing professional development (CPD) activity. The use of library services and resources fits particularly well with RCPSC Personal Learning Projects described in section 2: Self-directed Learning, and CFPC Pearls™ and Linking Learning to Practice.

The resources and references which support these planned learning experiences include literature searches performed by College librarians, or by registrants searching library databases through the College website. The RCPSC MAINPORT portal makes recording CPD particularly easy: literature search citations can be saved electronically and directly uploaded into the portal. There is no limit to the number of literature search requests that registrants can pose to the library. Registrants can expect carefully selected, detailed results with evidence-based filters applied as needed for capturing higher quality publications.

Many physicians are interested in doing their own searches but recognize a need for refreshing their skills. The library, in partnership with UBC's Continuing Professional Development division (UBC CPD), offers CFPC- and RCPSC-accredited workshops on finding evidence-based information on the internet. Contact the library for more information (medlib@cpsbc.ca or 604-733-6671) or see upcoming workshops listed on the UBC CPD website.

Other resources for self-directed learning include scanning journals, podcasts, audiotapes, and videotapes, and internet searching. The library offers access to all of these formats. For example, 2,500 online journals are available for free to registrants and, through interlibrary loans, practically any article can be obtained. MP3 audio files of recordings of medical lectures from Audio-Digest are available for downloading to mobile devices or desktop computers and cover a variety of specialties, which are also avaiable on CD.

Appraising material from general internet searching is challenging. Alternatively, credible, evidence-based current clinical information is readily available through the library's website in such tools as *Best Practice* from BMJ Press. Registrants can create their own portfolios to track their use of information, and export as documentation of self-directed learning.

The library can assist with finding resources to suit individual learning needs.

# Disciplinary Actions

**Dr. William Ewart Martin, Victoria, BC**

Dr. Martin, a specialist in internal medicine and neurology, has been the subject of the following formal action by the College:

Dr. Martin was the subject of an investigation into whether, as a registrant of the College of Physicians and Surgeons of British Columbia, he had and was applying adequate skill and knowledge to practise medicine. An investigation was conducted by the College pursuant to s. 25.2 and s. 39(2) of the *Health Professions Act*. The investigation concluded that Dr. Martin lacked the skills to function effectively in an acute care hospital setting but possessed the skill and knowledge to practise medicine confined to a private office or clinic. Dr. Martin accepted the outcome of the investigation and consented to the following direction of the Board.

Dr. Martin's registration is subject to the following limits and conditions:

1. Dr. Martin absented himself from practice effective April 2011, and remains absent from practice. He will not return to practice until he has:
   a. attended and successfully completed assessments approved by the College with a report to the College, which must confirm his fitness to practise; and
   b. attended an interview at the College to discuss the assessment and his proposed plans for returning to practice, to review Dr. Martin's fitness to resume practising, and to determine the limits and conditions of his registration.
2. Upon return to independent practice Dr. Martin will:
   a. restrict his practice as a neurologist to a private outpatient office or clinic setting approved by the College;
   b. not apply to alter his scope of practice without prior approval from the College;
   c. attend counselling with reports acceptable to the College;
   d. participate in ongoing continuing medical education and professional development as directed by the College; and
   e. comply with monitoring by the College.

(L TO R) FRONT ROW: Dr. D.M.S. Hammell, Dr. L.C. Jewett *(vice president)*, Dr. M.A. Docherty *(president)*, Mr. W.M. Creed, FCA *(treasurer)*, Ms. L. Charvat
SECOND ROW: Dr. A.I. Sear, Dr. S.M.A. Kelleher, Dr. M. Corfield, DM, Dr. H.M. Oetter *(registrar)*, Dr. J.R. Stogryn, Dr. J.G. Wilson
THIRD ROW: Dr. D.J. Etches, Dr. W.R. Vroom, Ms. E. Peaston, Dr. A.J. Burak, Dr. N.D. James, Dr. P.T. Gropper
FOURTH ROW: Dr. D.A. Price, Dr. G.A. Vaughan, Ms. V. Jenkinson, Mr. M. Epp ABSENT: Dr. A.M. McNestry, Mr. S.S. Gill

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The *College Quarterly* is produced four times a year by College staff. It contains information relevant to the profession including new standards and guidelines, and disciplinary actions. Medical content contained in the *College Quarterly* is reviewed by the publication's Advisory Panel consisting of practising physicians who are not employed by the College. The *College Quarterly* is sent to every current registrant of the College. Questions or comments about this publication should be directed to the editor at **communications@cpsbc.ca.**