Committee Reports

Diagnostic Accreditation Program Committee

The scope of the Diagnostic Accreditation Program Committee is set out in section 5-21(1)–(6) of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183.

The Diagnostic Accreditation Program (DAP) has a mandate to assess the quality of diagnostic services in the province of British Columbia through accreditation activities. It establishes, evaluates and monitors performance standards, provides education and consultation in diagnostic health care, and administers 23 accreditation programs covering the five diagnostic services: diagnostic imaging, laboratory medicine, neurodiagnostics, pulmonary function and polysmnography.

The program currently assesses 299 private and 382 public diagnostic facilities. In 2011 the Diagnostic Accreditation Program completed 29 surveys involving 40 modalities and disciplines. There were also 22 initial assessments performed for new facilities.

In September 2011 the program completed an accreditation review by the International Society for Quality in Health Care (ISQua) and achieved ISQua organizational accreditation as a health care external evaluation organization.

J.C. Heathcote, MD, FRCPC
Chair, Diagnostic Accreditation Program Committee

For more information on this report, please contact:
W.R. Vroom, MD, CM, CCFP (EM)
Senior Deputy Registrar
604-733-7758

H. Healey, RN
Senior Director
604-733-7758

Committee Reports

Ethics Committee

The scope of the Ethics Committee is set out in section 1-18(1)–(4) of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183.

The mandate of the Ethics Committee is the formulation of standards and guidelines of medical practice. The guiding principles are based on the Canadian Medical Association's *Code of Ethics*. Existing College standards and guidelines need to be constantly reviewed and updated as the practice of medicine and communication change over the years. The committee does not deal with complaints as it is separated by an administrative firewall from the College complaint process.

In 2011, the committee reviewed its Terms of Reference, including its method of engagement with other College committees while maintaining its independence. The committee made recommendations to the Board regarding the review and maintenance of the *Physician Resource Manual* (now named *Professional Standards and Guidelines*) on the College website.

In 2011, the following standards and guidelines were developed or updated:

New

- Physician Prescribing of Performance Enhancing Drugs in Sport
- Infection Prevention and Control (IPAC) in Physicians' Offices

Updated

- Advertising and Communication with the Public
- Marijuana for Medical Purposes
- Duty to Report

The Ethics Committee is comprised of a professional bioethicist, a medical anthropologist, a family physician, a psychiatrist, one public board member and two physician board members.

The committee reviews ethical standards widely when establishing its recommendations.

A.I. Sear, MBBS, CCFP
Chair, Ethics Committee

For more information on this report, please contact:
A.M. McNestry, MBBCh, BAO
Deputy Registrar
604-733-7758

Committee Reports

Finance and Audit Committee

The scope of the Finance and Audit Committee is set out in section 1-14(1)–(4) of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183.

The Finance and Audit Committee helps the Board fulfill its mandate by developing the College's budget, regularly reviewing operational and capital expenditures, governing the annual external audit and reviewing the College's systems of financial control.

669 Howe Street

One year after signing the purchase agreement for seven floors of the Offices at Hotel Georgia, the College settled into its new building on October 14, 2011. This was a very significant move both in terms of providing the College room for growth, as well as securing the College's long-term financial health. The Board's direction was to purchase a building that cost no more than an additional $500,000 per year to operate. We are pleased to report that, in the first year, we anticipate the new building will cost approximately $200,000 less per year to operate than the previously leased premises. This has enabled the Board to allocate additional resources to important College programs like quality assurance, peer accreditations and legal services. In April 2012, the Diagnostic Accreditation Program (DAP) was relocated to 669 Howe Street as well. Bringing the DAP offices and employees into the College will help to capitalize on organizational efficiencies and improve communication throughout the College. The College has secured a lease for two of the purchased floors (17,431 of the total 59,295 sq. ft.) for a five-year period. These floors will allow for future growth of the College while maintaining a greater than five per cent rate of return for these leased assets. The Board also decided to sell two paintings by E.J. Hughes to help finance the building purchase. These paintings were auctioned by Heffel Galleries and netted roughly $1.4 million for the College.

College Investments

The Finance and Audit Committee reviews the College's investment policy annually. The College's current investment allocation is 85 per cent fixed investments (combination of bonds and term deposits) and 15 per cent Canadian equities. Investment income for the 2011/12 fiscal year was $518,637. Realized losses on investments were $89,537 and unrealized gains were $76,353. In February, the Finance Committee shifted a portion of the investment portfolio into a term deposit to reduce risk and preserve operating capital for 2012/13.

Fees/Online Renewal

The College's annual licence renewal fee increased to $1,400 effective January 1, 2012. Despite this increase, and operating in one of the most expensive cities in Canada, the College continues to have the third lowest annual licence fee of all Canadian provinces. Credit card fees continue to be a significant cost to the College. Approximately 95 per cent of physicians renew their licence via credit card, costing the College approximately $26 per renewal fee processed. The College encourages physicians to renew their licence by either internet banking or *Interac Online*®. These payment options significantly reduce the cost of the licence renewal process and help to improve College programs while keeping registrant fees among the lowest in Canada.

W.M. Creed, FCA
Chair, Finance and Audit Committee

For more information on this report, please contact:
M. Epp, MBA
Chief Operating Officer
604-733-7758

J. Pesklevits
Director (Finance and Office Services)
604-733-7758

Committee Reports

Inquiry Committee

The scope of the Inquiry Committee is set out in section 1-16(1)–(2) of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183.

The Inquiry Committee performs three regulatory functions central to the mandate of the College:

1. To investigate complaints received at the College.
2. Where concerns about the conduct or competence of a registrant come to the attention of the College, to review the practice of the registrant, on its own motion.
3. To investigate when a physical or mental health concern may impair the ability of the physician to practice safely and effectively.

Twenty-three committee members (15 physicians and eight public members) contribute to the work of the committee by participating in one of four specialized panels. The total number of complaints received is remarkably constant, in the range of 800 to 900 annually.

Concerns brought to the attention of the College are initially triaged and categorized as matters of clinical performance, physician conduct, boundary violations (which may include sexual misconduct or a variety of other breaches such as inappropriate self-disclosure or dual relationships), or fitness to practice issues.

The committee is specifically charged by the *HPA* with establishing review procedures that are transparent, objective, impartial, and fair. Following a thorough investigation, the committee must determine whether some or all of the allegations presented to it have been proven. Given that most complainants are not medically trained, sometimes the investigation identifies unacceptable conduct or deficient clinical performance that the complainant was unaware of or unable to articulate. When the committee is critical of a registrant on the basis of its review, the *HPA* provides three options for resolution, depending on the seriousness of the concern:

- informal resolution through correspondence, interviews, and/or educational activities;
- formal consequences, short of discipline, including reprimands, and practice limitations; and
- referral to the registrar with direction to issue a citation and commence disciplinary proceedings.

In 2011, disciplinary citations were authorized against 15 physicians:

- two for competence concerns
- four for allegations of unprofessional conduct
- six for boundary issues
- three for deficient clinical performance

Conduct and Ethical Standards

Year-by-year, communication failures account for about one-half of the physician conduct complaints brought to the College. At the root of many of these is the failure to set aside sufficient time to provide explanations to patients and their families in terms they can understand and to adequately answer their questions. Other recurring themes include comments perceived by patients to reflect rudeness or insensitivity.

Another major conduct category is failure to provide copies of medical records or complete third-party medical reports in a timely fashion or at all. Physicians have a professional obligation to provide patients with the documentation they need to substantiate claims for benefits to which they are entitled. When, for example, a patient is unable to work as a consequence of a medical condition, delay in provision of reports may have serious consequences including the loss of housing and other property. Physicians must deliberately build time into their busy professional lives to ensure that this easily neglected area of responsibility is adequately attended to.

Clinical Performance

The efforts of patient-safety researchers and advocates in recent years have given appropriate emphasis to the reality that many preventable adverse outcomes result primarily from system failures. Even when physician error is a factor, the solution may lie in addressing deficiencies in the practice environment. The College applauds and supports efforts to establish a clinical culture of patient safety where critical incidents are reviewed constructively and openly without the counterproductive application of shame and blame.

When an Inquiry Committee investigation concludes with a finding of significantly deficient physician performance, the underlying problem is often inadequate patient assessment leading to an incorrect diagnosis. Dr. Stephen Barron of the Clinical Competence Program at UBC observes that continuing professional development for physicians is almost exclusively focused on the management of medical conditions and not their diagnosis. As the years go by, some physicians rely more and more on pattern recognition and less on analytical problem solving founded on careful assessment of the specific circumstances of the patient at hand. This tendency shows up in complaint investigations where clinical records fail to document an adequate history or appropriate physical examination.

Another prominent clinical performance theme is patient dissatisfaction with poor surgical outcomes. Dissatisfied patients include those who have had total joint replacements, spinal surgery, and cataract extraction with lens implantation. It is acknowledged that many such patients were provided with appropriate information preoperatively but simply do not remember when significant complications arise subsequently. Preoperative discussions must be well documented.

When Health Concerns Affect Fitness to Practice

While the *HPA* authorizes the committee, following due process, to suspend physicians whose deficient performance is the result of illness or injury, health matters are virtually always addressed with voluntary withdrawal from practice, followed by monitored recovery and assessment prior to any consideration of return to practice.

Boundary Violations

Of 34 such boundary complaints concluded in 2011, one-third related to touching that was perceived by the patient to be sexualized. The number of these cases has declined over time. In 1994, for example, there were 74 complaints alleging inappropriate comments and/or touching. In 2011 there were 15. During that period the College has regularly reminded physicians of the importance of giving adequate time to explaining the purpose of examinations, careful attention to draping, consistently offering a chaperone, and taking great care with what is said in the course of intimate examinations. These things describe the standard of care to which the College expects all physicians to adhere.

Under the *HPA*, responsibility for programs aimed at preventing sexual misconduct rests with the Patient Relations Committee. Through the work of this committee, the College will continue to give priority to interventions that protect patients by reducing the risk of boundary transgressions by physicians.

The Health Professions Review Board

The *Health Professions Act* came into effect for the medical profession on June 1, 2009, succeeding the *Medical Practitioners Act*, which was originally proclaimed in 1886. The *HPA* established a new agency, the Health Professions Review Board (HPRB). Complainants who are dissatisfied with the adequacy of the Inquiry Committee investigation or the reasonableness of its decision have 30 days from the receipt of the Inquiry Committee's decision letter to apply for a review. About 12 per cent of complainants currently exercise that right. In decisions issued to date (accessible on the HPRB website), most College investigations and decisions have been upheld by the HPRB, which has complimented the College specifically on the clear, plain-English explanations it provide to complainants. The reality that every one of roughly 800 decisions issued annually may be subject to close scrutiny by an expert review panel has caused the Inquiry Committee to make significant additional investments in its complaint review processes. The work of complaint and practice review is inevitably held to a higher standard under the *HPA*.

Some HPRB decisions have prompted changes in College processes and the acquisition of new resources. For example, remedial education assignments to physicians whose performance has been found deficient have traditionally been quite informal. Physicians, typically, would attend for an interview and give an account of activities such as presenting at rounds, attending courses, and pursuing relevant independent studies. An HPRB decision directed that the circumstances of one particularly compelling case called for greater adherence to adult education principles in order to meet acceptable standards of accountability. Specifically, the Inquiry Committee must formulate an education plan, explicitly based on a needs assessment informed by the review, and document achievement of pre-set competencies through the administration of a terminal assessment. The decision was clearly precedent setting. To meet

that standard going forward the College would need adult educational expertise. Accordingly, it hired an educator to give direction to this aspect of complaints resolution.

Conclusion

We live in an era where the public expects deliberate pursuit of continuous quality improvement in regulation. With Inquiry Committee oversight, the complaints resolution and practice review aspects of the work of the College saw significant investment in this regard in 2011.

M.A. Docherty, MBChB, CCFP, FCFP
Chair, Inquiry Committee

For more information on this report, please contact:
J.G. Wilson, MD, MSc, FCFP
Deputy Registrar
604-733-7758

HPRB decisions can be found at:
http://www.hprb.gov.bc.ca/decisions/final_decisions_complaint.stm

Committee Reports

Library Committee

The library supports College registrants' research and clinical work by providing them with the best evidence. This, in turn, contributes to the quality assurance focus of the College. Registrants connect with the library frequently and in a variety of ways: person-to-person, in teaching events, and online.

Person-to-Person

Over the last three years, 40 per cent of registrants contacted the library and did so 12,000 times in 2011, similar to 2010. Most contacts are to request copies of articles, borrow books, or request literature searches. The library staff delivered almost 23,000 articles electronically or in print and loaned about 4,100 books. Extended literature searches reached a historic high number of 1,508. The nature of the questions continues to grow in complexity, reflecting the real-life situations of practising physicians and the need for patient-specific evidence.

Teaching and Presentations

Workshops and conference presentations by College librarians assisted physicians in becoming more proficient at locating credible, relevant medical information. Teaching initiatives have increased steadily over the past five years, reaching a current high of 27 events attended by 376 registrants. In particular, the four-hour workshop titled Finding Medical Evidence – Supporting Patient Care, presented in partnership with UBC's Division of Continuing Professional Development, is well attended and feedback indicates that the learning experience is useful.

Online

Registrants access information independently through the College's website. The library offers over 2,000 electronic journals from which over 30,000 articles were downloaded in 2011. While the library has shifted almost entirely from print to electronic journals, both print and electronic books are collected in response to users' interest in using both formats. The selection of electronic books has increased from about 30 titles in 2010 to over 100 in 2011 and mobile access to library resources is now possible. For example, MD Consult, Procedures Consult, and Access Medicine are smartphone-enabled and First Consult, a point of care tool, is available as a smartphone application.

Some things are very different at the library this year such as more electronic information and a new building with a bright, spacious reading room. At the same time, our core commitment to offering exceptional library service tailored to the individual needs of registrants remains unchanged.

N.D. James, MD
Chair, Library Committee

For more information about this report, please contact:
K. MacDonell, PhD
J. Neill
Librarians/Co-Managers
604-733-6671

Committee Reports

Medical Practice Assessment Committee

The scope of the Medical Practice Assessment Committee is set out in section 1-22(1)–(7) of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183.

The Medical Practice Assessment Committee (MPAC) is responsible for the development and administration of the College's proactive peer assessment of physicians' medical practices. The committee's mandate is to ensure appropriate standards are maintained in the care of patients and medical records. The committee is comprised of five family physicians and two specialist physicians.

Peer assessments are educational in focus and the committee works collaboratively with physicians to identify areas for potential improvement.

Information obtained through peer assessments is protected in accordance with the *Health Professions Act* and cannot be used for any purpose other than to assist physicians maintain proper standards in patient care and record keeping. As a College quality assurance program, the committee reports to the Quality Assurance Committee.

Enhanced Peer Assessment Program

The committee held its second annual peer assessor training course for general practice in 2011 increasing the number of available peer assessors to 48. New assessors will be trained and available for assessments in 2012. In 2011, the program successfully completed 130 peer assessments for general practice and will continue this momentum into 2012.

Psychiatry
The committee approved the implementation of a peer assessment program for psychiatry. Psychiatrists working in the community, including mental health teams, will be reviewed under the quality assurance mandate. Assessor training for this new program will begin in 2012. Similar to our general practice program, information collected through peer assessment is confidential.

Diagnostic radiology
Under the purview of the Diagnostic Imaging Quality Assurance Committee, an ad-hoc committee under the Medical Practice Assessment Committee, the review of community-based radiologists not affiliated with a health authority will begin in 2012.

Multi-source feedback module
In 2010, the College approved a hybrid peer assessment program that captures communication and patient-centered practice principles to become part of its peer assessment program. The College will work with consultants to help develop an effective and cost efficient program for 2012.

Clinic assessments
Whereas in the past the committee assessed individual physicians chosen randomly, the committee felt that it was more efficient to assess all physicians at a randomly chosen clinic simultaneously. The committee determined that physician performance was at times hampered by clinic policy or inefficiencies and has added a report to the clinic medical director with recommendations to address these issues.

Medical Record Keeping for Physicians

The committee offers a Medical Record Keeping for Physicians workshop three to four times a year. This interactive course addresses both paper and electronic medical records, and offers both Mainpro-M1 and Mainpro-C continuing medical education credits.

Highlights

- Over 100 general practice peer assessments completed in 2011
- An additional 15 new peer assessors for general practice were trained
- The committee welcomed two new committee members: Dr. Mellisa Fahy (psychiatry) and Dr. Elizabeth Payne (general practice)

J.W. Barclay, MD, CCFP
Chair, Medical Practice Assessment Committee

For more information on this report, please contact:
W.R. Vroom, MD, CM, CCFP (EM)
Senior Deputy Registrar
604-733-7758

N. Castro
Director
604-733-7758

Committee Reports

Methadone Maintenance Committee

The scope of the Methadone Maintenance Committee is set out in section 1-23(1)–(10) of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183.

Methadone is an oral long-acting synthetic opioid which is effective in treating opioid dependency. It is a banned substance and in order to prescribe methadone for opioid dependency or for pain management, an authorization in the form of an exemption is required from the federal minister of health.

Under the *Health Professions Act*, and in accordance with Health Canada's Drug Strategy and Controlled Substances Program, the College of Physicians and Surgeons of British Columbia administers the BC Methadone Program through the Methadone Maintenance Committee (MMC). Authorization to prescribe methadone for opioid dependency involves attending a basic workshop, an interview with the registrar staff and a preceptorship. The College then applies to the federal minister of health for an exemption on behalf of the physician.

The members of the MMC include registrants who have expertise in methadone prescribing, addiction medicine, pain management and psychiatry, and a member of the Board of the College. The MMC is assisted by the deputy registrar and Methadone Maintenance Program staff.

The Methadone Maintenance Program serves to assist physicians in prescribing methadone safely and effectively. It develops guidelines and provides education for safe prescribing of methadone for opioid dependency, and reviews coroner's cases when methadone has been identified in toxicology.

Guidelines for safe prescribing of methadone can be found in two handbooks available on the College's website under the BC Methadone Program—the *Methadone Maintenance Handbook* and *Recommendations for the Use of Methadone for Pain*. Both of these were extensively reviewed and revised in 2009 and were published in December 2009 and January 2010, respectively. Another review of the handbooks will take place in 2012 to ensure they remain current and relevant.

Educational workshops are held at least twice per year. The Methadone 101 workshop is a basic course on the fundamentals of methadone maintenance therapy, guidelines and expected standard of care. A separate workshop has been developed for hospitalist physicians managing methadone maintenance patients during hospital admission, and is a half-day option at the 101 course. In 2011, two Methadone 101 workshops were held in May and November, with 58 and 55 registrants respectively. The Methadone 201 workshop deals with methadone management in more complicated medical scenarios. Due to the lack of enrolments, the 201 workshop was not provided in 2011. As part of continuing quality assurance, the MMC has been reviewing and updating these workshop presentations. There are two 101 workshops scheduled for 2012; one in the spring (May) which will include the hospitalist portion, and the second 101 workshop in

the fall (October) will include the 201 workshop. The fall courses are planned for a Friday and Saturday respectively, and will be the first two-day event.

The methadone maintenance physician peer review process is being reviewed, standardized and enhanced in conjunction with all the other College quality assurance programs. Until now, practice reviews were done within the year after registration in the program and subsequently only when concerns were expressed with regard to standard of care. Practice assessments of all methadone prescribing physicians will in the future be done cyclically, as in other programs, so the number of reviews per year will be substantially increased. Only 21 peer practice reviews were done in 2011. Recruitment for peer assessors is on-going and a peer reviewer training workshop is being planned.

The BC Coroners Service refers cases to the MMC where methadone may be implicated as a cause or a contributory cause of death. All physicians involved in the care of that patient are contacted for information about the patient's care, then the case is referred to the committee to review care provided and what can be learned from the events leading to death. In 2011 the MMC reviewed 25 coroner's cases. In most cases no fault can be attributed to the standard of care; however, in many cases recommendations were made to improve future outcomes.

The committee focuses on remediation of deficiencies found in all of these reviews and follow-up assessments are made at various intervals. Severe deficiencies and unsuccessful remediation are reasons to refer these physicians to the Inquiry Committee for independent investigation. Fortunately these are not common.

Visit the BC Methadone Program section on the College website for further information. A list of BC methadone clinics accepting new patients can also be found there.

Methadone Statistics

Number of methadone patients registered with the Methadone Maintenance Program*	13,046
Number of physicians with opioid dependency exemptions*	422
Number of physicians with opioid dependency exemptions with patients registered*	225
Number of new physicians with opioid dependency exemptions+	33
Number of peer practice reviews+	21

*Figures calculated as of December 19, 2011

+Figures calculated from January 1 to December 31, 2011

J.R. Stogryn, MD, CCFP
Chair, Methadone Maintenance Committee

For more information about this report, please contact:
A.M. McNestry, MBBCh, BAO
Deputy Registrar
604-733-7758

Committee Reports

Non-Hospital Medical and Surgical Facilities Program Committee

The scope of the Non-Hospital Medical and Surgical Facilities Program (NHMSFP) Committee is set out in section 5-1(1)–(5) of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183.

The NHMSFP Committee completed its 24th year of operation in 2011. Over the past year the 66 private surgical facilities performed over 62,000 surgeries, of which approximately 27 per cent were contracted cases from health authorities and 10 per cent were cases from third-party contractors such as WorkSafeBC and ICBC. These facilities provide a range of services which include orthopedics, otolaryngology, urology, plastics, ophthalmology, general, vascular, gastroenterology, dermatology, gynecology, neurosurgery and dentistry.

Program staff and committee members have worked diligently in developing new accreditation standards and responsibilities include compliance monitoring of these standards. As well, program staff offer direction to existing, new and renovating facilities, including the evolving Canadian Standards Association standards for heating, ventilation, air conditioning (HVAC), medical gas piping systems, medical device reprocessing and fire safety.

Currently 782 physicians provide services in one or more private non-hospital facilities. The NHMSFP Committee verifies the credentials and privileges of all medical practitioners working in these facilities. In addition, the Complication Review Subcommittee of the NHMSFP oversees the management and quality monitoring of patient complications.

In order to share and learn from other Canadian provinces, the NHMSFP staff attended the inaugural national non-hospital-round table working group meeting on November 15, 2011 in Winnipeg. This meeting provided valuable insight into the services provided by other non-hospital programs across Canada and how efficiencies may be possible through collaboration in standard setting.

In light of the recent recommendations from Dr. Douglas Cochrane's report regarding credentialing, privileging and performance monitoring, the College Board commissioned an external review to see if the NHMSFP is properly resourced and staffed to enable it to meet its responsibilities. Many recommendations arose from this report which included the need to improve IT systems, document management, quality monitoring processes and, in particular, the need for increased staffing. It is for this reason that facilities saw a substantial increase in annual fees this year.

Lastly, in the move to the College's new location, the Diagnostic Accreditation Program and the NHMSFP will be sharing space and hopefully achieving many efficiencies through collaboration in accreditation activities.

The NHMSFP Committee is pleased to report that non-hospital facilities in British Columbia continue to deliver excellent patient care as the public has come to expect.

L.C. Jewett, MD, FRCSC
Chair, Non-Hospital Medical and Surgical Facilities Program Committee

For more information on this report, please contact:
W.R. Vroom, MD, CM, CCFP (EM)
Senior Deputy Registrar
604-733-7758

P. Fawcus, RN
Director
604-733-7758

Committee Reports

Prescription Review Committee

The scope of the Prescription Review Committee is set out in section 1-24(1)–(7) of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183. The Prescription Review Committee gives oversight to the Prescription Review Program (PRP).

The main responsibilities of this committee are:

- To review the prescribing of drugs on controlled prescriptions and selected other drugs, like benzodiazepines, sedative hypnotics, and stimulants, with addictive potential.
- To provide guidance to registrants on the use of these drugs, the committee:
    - corresponds with physicians,
    - reviews submitted patient records and provides advice,
    - directs that physicians attend for interview,
    - assigns readings, and
    - provides relevant courses.
      (These educational activities qualify for Mainpro-M1 credits in the practice audit category.)

The BC Coroners Service reports that between 150 and 200 British Columbians die each year as a result of prescription drug misuse—numbers higher than the toll taken by drinking and driving. The task of the committee is to address the harms associated with inappropriate prescribing while not depriving the important minority of chronic non-cancer pain patients who might benefit from opioid therapy of appropriate treatment.

The PRP is supported in its quality assurance task by a committee of physicians engaged in the management of chronic pain from a variety of perspectives including community family medicine, pain clinic consultation, addictions, palliative care, workplace injuries, and clinical pharmacology. The program utilizes the PharmaNet database to identify concerning prescribing patterns. Physicians provide us with brief narrative accounts of their prescribing rationale, together with copies of relevant records. The committee reviews the responses and updated PharmaNet profiles and offers remediation and support as listed above.

At the conclusion of the process physicians usually express gratitude for the intervention. They tell us they have learned a great deal. On average the program is working with about 200 physicians at any given time.

Highlights

- Inaugural limited enrollment Prescribers Course, November 30
  - 23 registrants—16 from BC, 5 from Alberta and 2 from Saskatchewan
  - most of the day given over to practice interviewing, with standardized patients
- Foundation for Medical Excellence Chronic Pain and Suffering Symposium, March 11–12
  - 24th annual event
  - 148 attendees
- Injectable meperidine review, concluded November 21 (standard drug references and authoritative clinical practice guidelines all now say that meperidine has no place in the management of chronic pain)
- New drugs added to the list reviewed by the PRP
  - BuTrans (transdermal buprenorphine)
  - zolpidem
  - OxyNEO (sustained release oxycodone)

D.J. Etches, MD, CCFP
Chair, Prescription Review Committee

For more information on this report, please contact:
J.G. Wilson, MD, MSc, FCFP
Deputy Registrar
604-733-7758

Committee Reports

Quality Assurance Committee

The scope of the Quality Assurance Committee is set out in section 1-20(1)–(3) of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183.

The Quality Assurance Committee was established to oversee the quality assurance programs of the College under the *Heath Professionals Act* (*HPA*). It is the responsibility of the Quality Assurance Committee to: review standards of practice; enhance the quality of practice; reduce incompetent, impaired and unethical conduct of registrants; assess professional performance of registrants; and recommend requirements for revalidation of licensure.

The following College committees report to the Quality Assurance Committee:

- Ethics Committee
- Blood Borne Communicable Diseases Committee (BBCDC)
- Medical Practice Assessment Committee (MPAC)
- Methadone Maintenance Committee (MMC)
- Prescription Review Committee (PRC)

The function of the methadone program, prescription review program, and medical practice assessment program is to review the delivery of appropriate care by assessing individual physicians' management of opioid dependent patients, prescription of controlled substances and medical records. When deficiencies are found the programs offer collegial, remedial and educational advice.

The programs also develop education workshops and practice guidelines.

Highlights

- Prescribers Course
  Family physicians consistently rate prescribing for chronic pain amongst the most difficult areas of their professional lives. This course provided alternative approaches for registrants through small interactive focus groups. This course was first held in 2011 with 23 attendees.
- Methadone 101
  This course provides physicians with the fundamentals of methadone maintenance therapy, guidelines and expected standard of care. In 2011 two courses were held with 58 and 55 attendees.
- Medical Record Keeping for Physicians
  This comprehensive course provides physician with the fundamentals of practice guidelines and charting requirements. This course was held three times in 2011 with 40 physicians attending the course.

Quality Assurance Committee Report

The current peer assessment program through the MPAC completed 130 general practice peer assessments in 2011 and recruited an additional 15 peer assessors. In 2012, the program will expand further to include a multi-source feedback module and implement specialty practice assessments for non-hospital based psychiatry and diagnostic imaging. Peer assessments facilitated through the MMC will be standardized and enhanced in conjunction with the other quality assurance programs of the College. Peer assessor training for both programs will continue in 2012.

The Ethics Committee is responsible for developing standards and guidelines relevant to medical practice and standards of care. College polices and guidelines are reviewed by the committee and updated as required by the profession.

The Quality Assurance Committee is comprised of three physicians, one appointed board member, and a public representative. Activities of the committee and its subcommittees are separated by an administrative firewall from the College's other regulatory functions. Information obtained by the committee cannot be used for any purpose other than for education and remediation of maintaining an appropriate standard of care. Matters outside the scope of the committee function are referred to the College's Inquiry Committee for independent action.

D.M.S. Hammell, MD, CCFP, FCFP
Chair, Quality Assurance Committee

For more information on this report, please contact:
W.R. Vroom, MD, CM, CCFP (EM)
Senior Deputy Registrar
604-733-7758

Committee Reports

Registration Committee

The scope of the Registration Committee is set out in section 1-15(1)–(4) of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183.

The work of the Registration Committee has become increasingly complex as the standards for licensure at provincial and national levels are harmonized. In addition, the College's Registration Committee and the College Board have directed that a thorough reassessment and updating of the registration department's systems be undertaken. This will include reviewing the processes utilized to assess qualifications of applicants, follow-up of requirements for necessary examinations and ongoing continuing medical education, and strengthening communication with health authorities to ensure appropriate credentialing of physicians. The roles and expectations of sponsors and supervisors for provisional licensees have been further defined and enhanced. Supervising physicians now have access to training information through webinars and faculty workshops conducted through the BC Physician Integration Program.

On the national level, the colleges of all the provinces and territories continue to work toward establishing uniform Canadian national registration standards for both specialty and family practice since physicians now have full mobility across Canada under the *Labour Mobility Act* and the Agreement on Internal Trade (AIT).

There have also been significant changes at the national level with the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC). The RCPSC now offers a Practice Eligibility Route (PER) to certification, which is intended for physicians who completed their specialty training in another country and have been in independent practice for at least five years, two of which must be in Canada. These physicians must commit to a program of mentored study, practice observation, and competency assessment, which the Royal College considers to be substantially equivalent in rigour to the traditional RCPSC certification examination. This process recognizes that physicians who are in the mid-stages of their medical careers may have entirely acceptable training, experience and competency, but may have difficultly passing the certification examinations. In the initial roll out of the PER, only a few core specialties have been offered this option; initially there is no PER for sub-specialties although it is hoped that these will be included in the future.

In a similarly progressive vein, the CFPC has assessed family practice training programs in the United States, the United Kingdom, Australia and Ireland and has determined that they are sufficiently equivalent to Canadian postgraduate training in competency standards, content and duration, including accreditation. Physicians who have completed postgraduate training and certification in those countries can apply for certification without examination with the CFPC when they move to Canada. Additional changes to family practice certification will occur in 2013 when the Medical Council of Canada Qualifying Examination Part II and CCFP examinations become harmonized with a single qualifying examination for family physicians, leading to the awards of both the LMCC and CCFP.

Registration Committee Report

During the dialogue on national registration standards, it has become clear that all Canadian colleges need better tools to adequately assess international medical graduates from countries whose training is not considered equivalent or has not been assessed and accredited. Under present legislation, as of January 1, 2012, general and family physicians from countries other than those listed above will now be required to have an assessment of competence prior to being granted provisional licensure in BC. Some provinces have established such entry-to-practice assessment programs. For example, Alberta has a three-month assessment program for internationally trained family physicians. The Registration Committee continues to advocate for a practice-ready assessment program and has entered into preliminary discussions with the Ministry of Health.

Work on other potential classes of registration continued in 2011 with the proposed restricted class of licence. Further amendments to the College Bylaws will be pursued through collaborative discussion with the provincial government over the next several months.

The committee assessed 288 applications from international medical graduates (IMGs) last year. Of those, 112 physicians completed their application requirements and were granted provisional registration. Provisional licensure does not grant a permanent licence; provisional registrants must complete their Canadian qualifications by either examination or the PER within a defined time span. Eighty new IMG applicants were granted full registration, and 10 physicians who were previously on the provisional register were advanced to the full register.

J.R. Stogryn, MD, CCFP
Chair, Registration Committee

For more information on this report, please contact:
A.J. Burak, MD, CCFP
Deputy Registrar
604-733-7758

C. de Bruin
Director
604-733-7758