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 made under the *Health Professions Act*, RSBC 1996, c.183.

The Diagnostic Accreditation Program Committee provides oversight to the College's Diagnostic Accreditation Program (DAP). The 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 polysomnography.

The DAP currently assesses 290 private and 384 public diagnostic facilities. During the past year, the DAP completed 133 surveys. There were also 35 initial assessments performed for new facilities.

Employees and all operations of the DAP moved to the new College premises on April 13, 2012 at 669 Howe Street, Vancouver, BC.

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

INFORMATION

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Committee Reports

Ethics Committee

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

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

The proposed new Terms of Reference of the Ethics Committee was reviewed and approved by the Board in January 2012. The broad responsibilities of the Ethics Committee as identified in the Bylaws include advising and providing recommendations to the Board on ethical issues, and to review ethical standards and guidelines. The committee reviews a wide spectrum of related documents and standards from other organizations when establishing its recommendations.

The Ethics Committee has a dual reporting role to the Board through the Quality Assurance Committee.

During 2012, the committee made recommendations to the Board regarding the review and maintenance of those documents in the *Professional Standards and Guidelines* on the College website, which were considered to have an ethical focus.

NEW

- Access to Medical Care
- Treating Self, Family Members and Those with Whom You Have a Non-professional Relationship

UPDATED

- Advertising and Communication with the Public
- Duty to Report
- Medical Records – Maintenance and Security
- Withdrawal of Physician Services

L. Charvat, JD, LLM
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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 made 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 regularly reviewing the College's systems of financial control.

OCCUPANCY COST SAVINGS

Now that all of the College departments and programs are located at 669 Howe Street, a comparative analysis of occupancy costs shows savings in excess of $790,000 per year (approximately $70 per registrant) between the College's owned space at 669 Howe Street and its former leased properties at 777 West Broadway and 858 Beatty Street in Vancouver. These savings are based on rates at the time the former leases expired. A comparison at current lease rates would increase the differential savings to the College.

COLLEGE INVESTMENTS

In 2012/13, the Finance and Audit Committee revised the College's investment policy statement (IPS) to better reflect the goals set by the Board. Investments of the College are maintained within two types of accounts as follows:

Operating Accounts

The purpose of the operating accounts is to provide sufficient cash to meet the annual obligations for operational expenditures of the College. The investment objectives of the operating accounts are to preserve capital and maintain liquidity, while optimizing investment returns. The allocation of operational funds of the College is currently 100 percent fixed investments (short-term bonds, cash and/or term deposits). According to the IPS, the College may invest up to ten percent of operational funds in Canadian equities.

Capital Accounts

The purpose of the capital accounts is to provide reasonable growth while maintaining sufficient fixed investments to meet the long-term financial obligations of the College. The investment objectives of the capital accounts are long-term capital appreciation and optimization of investment returns. The capital investments of the College are currently allocated 50 percent in fixed investments (bonds and cash) and 50 percent in equities.

Investment income for the 2012/13 fiscal year was $486,597. Realized gains on investments were $13,028 and unrealized gains were $272,776.

CONTINGENCY RESERVE CONTRIBUTIONS

The Board has mandated that the College establish reserves sufficient to allow it to operate in the event of significant legislative change, a natural disaster, economic disaster, pandemic, or other unfortunate event. The Board's policy is that this reserve should be adequate to cover operational costs for a twelve-month period. Any general surplus in each year is added to the College's capital investments until the target of twelve months' operational expenditures is met.

The Board budgets for an annual contribution equal to five percent of operational expenditures until the required levels of funds are reached. As at February 28, 2013, the balance in capital investments was $9,394,048. Once the contingency reserve is fully funded, any surplus from future operational years can be used to offset future annual fees to registrants.

Reserve balances as at February 28, 2013

College	$6,109,074
Diagnostic Accreditation Program	3,009,684
Non-Hospital Medical and Surgical Facilities Program	275,290
Total reserve balances	$9,394,048

ASSESSMENTS, ACCREDITATIONS AND REVIEWS

Quality assurance activities include the following College departments and programs:

- Diagnostic Accreditation Program
- Non-Hospital Medical and Surgical Facilities Program
- Drug Programs (Methadone Maintenance and Prescription Review)
- Quality Assurance and Practice Assessments

While all of these programs increased activity in 2012/13, the number of quality assurance assessments and peer reviews increased by 280 percent. Consequently, the expenditures for assessments, accreditations and reviews increased to approximately $1,265,000 from the prior year's figure of $443,000. The Board has a goal to conduct 500 physician peer reviews for 2013/14.

CREDIT CARD FEES

Transactions processed by credit card continue to be a significant cost to the College. Credit card fees totalled more than $378,000 in fiscal year 2012/13 at a rate of approximately $30 per renewal fee versus $0.90 per transaction using internet banking or *Interac Online®*. In 2012/13, there was a slight increase in the number of registrants renewing their licence using an alternative method of payment. However, approximately 95 percent of physicians still renew their licence using a credit card. Registrants are encouraged to consider using either internet banking or *Interac Online®* during the licence renewal process to help keep fees among the lowest in Canada.

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

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Committee Reports

Inquiry Committee

The scope of the Inquiry Committee is set out in section 1-16(1)–(2) of the Bylaws made 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 practise safely and effectively.

Twenty-four members (16 physicians and eight public members) contribute to the work of the Inquiry Committee by participating in one of four specialized panels. The total number of complaints received remains constant, in the range of 900 to 1,000 annually.

Concerns brought to the attention of the College are initially triaged and categorized as primarily 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), and fitness to practise issues.

The committee is specifically charged by the *Health Professions Act* (*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:

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

In 2013, disciplinary citations were authorized against 16 physicians:

- 2 for competence concerns
- 11 for allegations of unprofessional conduct
- 2 for boundary issues
- 1 for deficient clinical performance

It should be noted that the majority of the complaints resulting in the issuance of a citation are ultimately resolved through Consent Agreements pursuant to section 37.1 of the *HPA*. A small number result in a hearing of the Discipline Committee. There were no Discipline Committee hearings held in 2012.

CONDUCT, ETHICS AND PROFESSIONALISM

Complaints in this category continue to reflect patients' concerns around physicians' poor communication skills and apparent lack of empathy. In these situations, the Inquiry Committee relies heavily on the evidence of the medical record. Careful documentation not only indicates that specific issues were addressed, it also shows that an appropriate level of care was provided.

The College received an increased number of complaints reflecting public concerns around private billing for medical services. The College is not critical of physicians who appropriately bill patients privately for services that are not

covered by the Medical Services Plan. However, the Canadian Medical Association's *Code of Ethics* highlights physicians' responsibility to consider whether or not a patient is able to pay professional fees. Physicians are advised to consider these issues before assigning all discussions of private fees to office staff. Failure to offer patients an opportunity to discuss the fees with their physician directly may result in criticism.

Other complaints, both from the public and physicians themselves, reflect concerns that private billing may create a barrier to accessing medical care. While the broader social discussion lies outside the mandate of the College, the Inquiry Committee has been clear that private fees must not prevent patients from accessing insured medical care.

CLINICAL PERFORMANCE

Surgical complications have the potential to trigger complaints to the College. Every operation carries the accepted risk of recognized complications, which must be explained to the patient at the time of a well-documented preoperative consent discussion. Patients suffering significant, life-altering complications and the grieving families of patients who die following surgery will often not recall what was said even if the consent discussion was comprehensive and expertly delivered. The Inquiry Committee panel investigating such complaints too-often finds that the account of the consent discussion provides no assistance to the surgeon in defending the quality of care.

Missed diagnoses account for a major portion of clinical complaints. Commonly missed conditions include fractures, ectopic pregnancies, thromboembolic events, and early peritonitis. These and other conditions are recognized as inherently difficult to diagnose at first presentation. The deficient aspect of care is frequently the follow-up advice given to the patient at the time of discharge. All such patients need clear, well-documented direction to return for reassessment if their condition deteriorates.

Addiction, injury, and death due to psychotropic medication misuse, especially prescription opioids, is a growing problem. It is believed that more British Columbians now die unintentionally as a result of their use of opioids, benzodiazepines and other central nervous system depressants than drinking and driving. It is also believed that half of those who die used pills prescribed to someone else. The Inquiry Committee investigated a number of third-party complaints alleging reckless prescribing by physicians who ought to have known that their patient was addicted to or diverting drugs. Informants in these cases include family members, pharmacists, and the Office of the Chief Coroner.

BOUNDARY VIOLATIONS

The number of cases alleging boundary violations has declined over time. In 1994, for example, there were 74 complaints alleging inappropriate comments and/or touching. In 2012, 37 were received. During that period the College has regularly reminded physicians of the importance of carefully explaining the purpose of examinations, ensuring that adequate consent has been given, paying 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 expected of all physicians by the College.

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 minimizing the risk of boundary transgressions by physicians.

WHEN HEALTH CONCERNS AFFECT FITNESS TO PRACTISE

The College is authorized by law to suspend physicians whose deficient performance is the result of illness or injury. Health matters are virtually always addressed with a physician voluntarily withdrawing from practice, followed by a closely monitored recovery, and an assessment by the College prior to any consideration of return to practice.

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 ten percent of complainants currently exercise that right. In decisions issued to date, most College investigations and decisions have been upheld by the HPRB, which has complimented the College specifically on the clear, plain-language explanations provided to complainants.

The reality that every one of roughly 900 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. The complaint review team now includes two part-time medical reviewers, one registered nurse, and two decision writers.

Additionally, remedial education assignments to physicians whose performance had been found deficient were traditionally quite informal. Typically, physicians 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. It is now common practice in such circumstances to formulate a formal individualized educational plan, which may include a requirement for direct observation and instruction of the physician in clinical settings.

All HPRB rulings can be viewed here:
http://www.hprb.gov.bc.ca/decisions/final_decisions_complaint.stm

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 continued significant investments in support of meeting those legitimate expectations in 2012/13.

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

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Committee Reports

Library Committee

The library was very active in 2012, supporting a wide range of clinical queries from physicians across the province and beyond.

LIBRARY USERS

Registrants reached out to the library 12,112 times. The level of contact between the library and patrons has been consistent over the last five years, ranging from 11,769 to 12,379 interactions. A large portion of the College registrants use the library; over the last three years, more than 40 percent of registrants requested assistance. The geographic distribution of library users approximates the distribution of physicians in British Columbia. All specialties are represented among library users, from anatomical pathologists to urologists. Registrants in general medicine/family practice, psychiatry and internal medicine contact the library most frequently.

CORE SERVICES AND MATERIALS

The importance to registrants of in-depth research by College librarians is clear. Librarians responded to 1585 queries; a five percent increase over 2011 and a fourth year of continuous growth. The searches were complex and broad, and reflected registrants' need for high-quality, evidence-based information to support clinical decisions.

The print and electronic collections continue to be carefully cultivated to reflect the broad range of medical specialties represented by library users. Registrants have access to a diverse list of approximately 2,500 electronic journals. In 2012, 32,000 individual articles were downloaded by registrants and library staff, a more than six percent increase over the previous year. Technology is shaping the nature of libraries, which is reflected in the College's growing electronic book collection, now at 150 titles including an important Canadian drug information resource, the *Clinical Handbook of Psychotropic Drugs Online*. In 2012, physicians used these e-books approximately 5,500 times through the College website. *Primal Pictures Plus*, an interactive anatomy teaching and learning tool, was acquired in a purchase negotiated through the provincial health libraries consortium, Electronic Health Libraries of BC (eHL*bc*), of which the College is a founding member.

TEACHING INITIATIVES

Recognizing that mental health issues form a significant portion of the clinical work of family practitioners and that psychiatrists actively use library services and materials, the library developed and presented, in partnership with UBC CPD, a new continuing professional development workshop on locating high-quality evidence to support mental health care; Finding Medical Evidence: Mental Health. In addition, librarians helped registrants hone their literature searching skills in a variety of teaching situations, from one-on-one sessions to hands-on, computer-based workshops to conference presentations. Twenty-three teaching events reached 208 registrants.

Employees in the library are dedicated to providing College registrants with the highest quality of service and the best evidence for clinical decision making.

N. James, MD
Chair, Library Committee

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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 made under the *Health Professions Act*, RSBC 1996, c.183.

The Medical Practice Assessment Committee (MPAC) provides oversight to the Physician Practice Enhancement Program (PPEP) (formerly the Medical Practice Assessment Program).

In keeping with the Board's strategic priority that the College increase its engagement in programs that assess and enhance the medical practice of physicians, MPAC has increased the annual number of practice assessments, added new assessment tools and streamlined a number of processes, both to achieve relevance to registrants, and to look at efficiencies.

The underpinnings of the medical practice assessment program have always been to collegially and proactively assess, educate and possibly remediate physicians to meet the standard of care. The committee works under the privacy provisions of section 26.2 of the *Health Professions Act*, thereby ensuring that assessment information is known only to MPAC members and is shielded from other College programs. In the rare event of egregious clinical conduct or repeated non-compliance with MPAC recommendations, the committee is able to refer to the Inquiry Committee, for a possible re-investigation and appropriate action.

Currently, PPEP is limited to community-based family physicians and psychiatrists, with plans to expand to other community-based specialties in the future.

During the past year, 334 peer practice assessments were completed. An additional 13 assessors were recruited to help manage the increased volume, bringing the total number of trained assessors up to 70.

It is the intent of the College that all community-based physicians have a periodic assessment at least every ten years. While the assessed physician is chosen at random, the committee has prioritized assessments of physicians with a higher likelihood of practice deficiencies, such as those over age 60, or those practising in an isolated, unsupported environment.

Integral to the success of the program is the cadre of 70 dedicated family physicians and psychiatrists participating as peer assessors by travelling extensively throughout the province.

Formerly, peer assessments focused on individual physicians. A change in philosophy to assessing all physicians in a clinic has resulted in a marked improvement in cost efficiency and has also allowed the committee to identify systemic clinic concerns which may hinder physician performance.

As a further improvement in medical practice assessment activities, MPAC noted that while the current process of assessing a physician's clinical records may provide a reasonable window of judging physician competence, clinical performance is not always reflected by recorded care. To that end, the Board approved an add-on component to the medical practice assessment program by way of a multi-source feedback assessment, which includes feedback from patients, medical office staff and colleagues. The enhanced program, which includes peer assessment of recorded care, a multi-source feedback assessment and an office assessment was renamed the Physician Practice Enhancement Program in 2012.

The 2013 assessment goal of performing 500 peer reviews and issuing timely reports has resulted in upgraded IT support to the program. Assessors will soon be able to use iPad technology during the assessment process. The

committee always welcomes comments and suggestions for improvement, and is grateful for the co-operation and support of all participants. The excellent feedback that the College has received about the program is a tribute to the design and management of the program by physicians for physicians.

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

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Committee Reports

Methadone Maintenance Committee

The scope of the Methadone Maintenance Committee is set out in section 1-23 (1)–(5) of the Bylaws made 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 controlled substance and in order to prescribe it, physicians must hold an authorization (in the form of an exemption under section 56 of the *Controlled Drugs and Substances Act*) 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 administers the Methadone Maintenance Program (MMP) with oversight from the Methadone Maintenance Committee (MMC). Authorizations (or exemptions) to prescribe methadone may be for the treatment of opioid dependency, for analgesia or for the provision of work as a hospitalist. Authorizations may be either full (for up to three years) or temporary (for up to 60 days.) The requirements for each type of authorization are outlined on application forms found on the College website.

The MMC includes physicians who have expertise in prescribing methadone for the treatment of opioid dependency and pain management, as well as physicians who work in addiction medicine and in correctional facilities.

The Methadone Maintenance Committee assists physicians in prescribing methadone safely and effectively for the treatment of opioid dependency. It develops guidelines, provides education for physicians and other health-care providers, and reviews coroner's cases when methadone has been identified in toxicology.

In addition, the MMC provides advice to those physicians prescribing methadone for analgesia—in the treatment of chronic non-cancer pain and for palliative care conditions. Hospitalist physicians provide care to patients who are in public hospitals in both opioid dependency and analgesia categories.

Guidelines for prescribing methadone can be found in two handbooks available on the College website under the Methadone Maintenance 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. To ensure they remain current and relevant, another review of the handbooks began late in 2012 and will continue into 2013.

Educational workshops are held at least three times per year. The Methadone 101 workshop is a basic course on the fundamentals of methadone maintenance therapy, guidelines and expected standards of care. A separate course has been developed for hospitalists managing methadone maintenance or analgesia patients during hospital admission, and can be provided as a "stand-alone" program or as a half-day option at the 101 course. In the past year, two Methadone 101 courses were held, in May 2012 and in November 2012, with 45 and 54 registrants respectively. A hospitalist-only workshop in Victoria in November 2012 had 20 registrants. The Methadone 201 course deals with methadone management in more complicated medical situations and this course was presented in November 2012, with 27 registrants.

As part of continuing quality assurance, the MMC has been reviewing and updating these workshop presentations. There are two 101 courses scheduled for 2013: one in May 2013, which will include the hospitalist portion; and a second 101 workshop in October 2013 will be combined with a 201 workshop.

The MMP physician peer practice assessment process (PPA) is being reviewed, standardized and enhanced in conjunction with all the other College quality assurance (QA) programs. Until now, peer practice assessments (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 be conducted cyclically in the future, as in other QA programs. Although 10 assessments were done in the 2012/2013 year, it is anticipated this number will increase substantially in the future. A training workshop for assessors was held on May 17, 2012, with 20 attendees, 10 of whom are new assessors.

The MMC focuses on remediation of any deficiencies found in peer practice assessments, however if severe deficiencies are noted the matter may be referred to the College's Inquiry Committee for investigation. Minor deficiencies may result in the physician being scheduled for a follow-up assessment within a 12 or 24-month period.

The Office of the Chief Coroner refers cases to the MMC where methadone may be implicated as a cause or a contributory cause to death. Relevant physicians involved in the care of that patient are contacted for information about the patient's care. The case is then referred to the committee for review, and possible remediable issues identified. In 2012/2013 the MMC reviewed 36 coroner's cases. In most cases no remediable issues were identified, but in some cases recommendations could be made to provide education and address gaps in medical care.

A list of BC methadone clinics accepting new patients can be found on the College website. This list is updated quarterly.

PROGRAM STATISTICS

Number of methadone patients registered with the Methadone Maintenance Program	14,572
Number of new physicians with opioid dependency exemptions	27
Number of new physicians with analgesic exemptions	39
Number of new physicians with both opioid dependency and analgesic exemptions	3
Number of new physicians with hospitalist exemptions	15
Number of peer practice assessments	10
Number of coroner's cases reviewed	36
Number of educational workshops held	4
Number of attendees at each workshop	45 (May 26) 20 (Nov 9) 27 (Nov 23) 54 (Nov 24)

P.W. Sobey, MD
Chair, Methadone Maintenance Committee

INFORMATION

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Committee Reports

Non-Hospital Medical and Surgical Facilities Program Committee

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

The Non-Hospital Medical and Surgical Facilities Program (NHMSFP) focuses on quality assurance and public protection.

More than ever before, increasing public need requires surgical procedures to be performed in non-hospital medical surgical and medical facilities. During 2012, 65 facilities performed over 62,000 procedures, of which 32% were contracted cases from BC health authorities and 7% were third party contractors, WorkSafeBC and ICBC.

The program is overseen by the College's NHSMFP Committee, chaired by a physician member appointed by the Board. Ten physician members bring relevant specialty expertise to the program in addition to one public member of the Board, and one registrant of the College of Registered Nurses of British Columbia.

Given the College's role as the governing body for physicians and surgeons and its obligation to act in the public interest, the committee inspects private facilities to ensure high standards of practice that are equal to or exceeding public hospitals. In the interest of patient safety, the committee is tasked with establishing accreditation and performance standards, procedures and guidelines to ensure the delivery of high quality services and to ensure compliance.

The committee is also responsible for the privileging and credentialing of over 700 physicians who work in private facilities, and for reviewing all adverse events reported to the College to monitor quality improvements within facilities.

Only qualified and highly competent physicians, nurses and medical reprocessing technicians are appointed to perform accreditation inspections. Regardless of the scope of services provided, all facilities must undergo a rigorous and comprehensive review prior to being awarded a term of accreditation. In ensuring public protection, if any facility does not meet program standards, and depending on the risk to patient safety, it may be required to close until such time as the deficiencies are corrected. Examples that may result in closure or require immediate action be taken include: inappropriate staffing levels and qualifications; medical devices reprocessing issues; inadequate physical space; infection prevention and control issues; and emergency cart supplies and medication management concerns. All reports, mandatory requirements and facility responses are thoroughly reviewed by the committee prior to awarding a final accreditation term.

Numerous program initiatives are currently in progress to facilitate public protection and include:

- improved adverse event reporting
- collaboration with the Ministry of Health's medical device reprocessing working group and with health authorities relating to enhancing infection prevention and control improvements
- reviewing standards and recognizing the need for additional standards and facility involvement
- development of a new transparent fee structure
- development of a robust physician peer-review model

- development of electronic accreditation processes to expedite reporting to facilities

D.A. Price, MBBS, FRCSC, FACOG
Chair, Non-Hospital Medical and
Surgical Facilities Program Committee

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Committee Reports

Prescription Review Committee

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

The Prescription Review Committee provides oversight to the College's Prescription Review Program.

Under the College Bylaws, the committee's main responsibilities include:

- Reviewing the prescribing of selected drugs requiring the use of controlled prescriptions, as well as other drugs which are potentially addictive such as benzodiazepines, sedative hypnotics, and stimulants

- Providing guidance to registrants on the use of these drugs by:
  - corresponding with physicians
  - reviewing submitted patient records and providing advice
  - directing that physicians attend the College for an interview
  - assigning readings
  - providing relevant courses

Physicians participating in this practice improvement intervention are protected by provisions in the *Health Professions Act* giving privileged status to documents generated in the course of quality assurance activities. The College approach to prescribing issues is collegial and educational. The program is informed by the PharmaNet database. When the College contacts physicians whose prescribing appears to be suboptimal, it is an offer to be helpful, not punitive. Most physicians are generally unhappy with the status quo and grateful for the intervention.

These educational activities qualify for Mainpro-M1 credits in the practice audit category.

This past year the program opened 99 files and closed 29. At the close of the year, the committee was corresponding with 240 College registrants regarding their prescribing practices.

The committee is motivated by the public health crisis associated with the dramatic increase in long-term opioid prescribing in the past decade. Prescription opioid misuse is said to account for more unintended deaths in British Columbia than drinking and driving. In 2012, the medical health officers in Interior Health Authority completed a five-year review of coroner files to create a profile of patients at risk. They found that while the majority had chronic pain, most were also able to work. About half suffered from a mental health disorder. Almost all (93%) were taking other central nervous system depressants.

Accordingly, the committee gives emphasis to promoting:

- careful patient selection. A history of addiction and/or mental illness is a strong relative contraindication to long-term opioid prescribing.

- an approach that includes firmly declining to prescribe combinations of opioids with benzodiazepines and/or sedative hypnotics—physicians should feel free to simply advise patients that they cannot have both.

HIGHLIGHTS OF THE PAST YEAR

1. Limited enrollment *Prescribers' Course*, November 30, 2012
   - 19 registrants
   - Most of the day spent in practice interviews with standardized patients

2. Foundation for Medical Excellence *Chronic Pain and Suffering Symposium*, March 2-3, 2013
   - 25th annual conference
   - 160 attendees; 127 from BC, 56 of them currently enrolled in the Prescription Review Program

3. Summer student project (July 2012) to do preliminary work to assist in the development of a database to support the work of the program

4. Participation in the planning of chronic pain modules with both the practice support program of the BC Medical Association and the provincial academic detailing program

5. Presentations at major CME events including the Society of Rural Physicians of Canada Rural and Remote Conference, the Annual Review of Family Medicine, and the College Annual Education Day

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

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Committee Reports

Quality Assurance Committee

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

The Quality Assurance Committee was established to oversee the quality assurance programs of the College. 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 committee is composed of three physicians, one appointed board member and a public representative. Activities of the committee and its sub-committees 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 education and remediation of maintaining an appropriate standard of care. Matters outside the scope of the committee function are referred to the Inquiry Committee for independent action.

The following committees report to the Quality Assurance Committee:

- Ethics Committee
- Blood Borne Communicable Diseases Committee
- Medical Practice Assessment Committee
- Methadone Maintenance Committee
- Prescription Review Committee

The function of the Methadone Maintenance Program, Prescription Review Program, and Medical Practice Assessment Program is, respectively, to review the delivery of appropriate care by assessing individual physicians' management of opioid dependent patients, prescription of controlled substances and recorded care. When deficiencies are found, the programs offer collegial, remedial and educational advice. These programs also provide educational workshops and practice guidelines which include:

- Prescriber's Course
- Methadone 101
- Medical Record Keeping for Physicians
- Medical practice assessment workshops

In addition to reviewing the above committee reports, the committee also reviews:

- interrelationship and participation of College activities with the Cochrane Phase II report recommendations
- continuing competency requirements of physicians
- scope of physician practice changes or re-entry to practice
- links with academic or educational institutions for CPD or practice enhancement
- review and approval of medical practice assessment tools
- case management reviews arising from the Non-Hospital Medical and Surgical Facilities program

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

INFORMATION

For more information regarding this report, please contact:

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Committee Reports

Registration Committee

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

On the national level, work continues on developing national registration standards for the full class of registration for all provinces and territories. Together with the Medical Council of Canada, the Federation of Medical Regulatory Authorities of Canada (FMRAC) and its member colleges began developing the web-based electronic application for physicians wanting to obtain full or provisional registration in any province of Canada at physiciansapply.ca. Pilots of the web-based electronic application will begin in 2013. The College expects to be on board in 2015 once its new database has been developed and fully implemented.

Additionally, the colleges of all the provinces and territories continue to work toward establishing uniform Canadian national registration standards for both specialty and family practice in the provisional class of registration.

As of October 2011, FMRAC developed consensus on the Canadian Standard for English Language proficiency (ELP) testing scores, which resulted in changes to BC's English language requirements including changes in the acceptable scores on the TOEFL-iBT, the application of ELP requirements in all classes of registration and licensure, and the requirement for test results to be received by the College directly from the testing agency (TOEFL or IELTS) to ensure authentic documentation.

As mentioned last year, the College of Family Physicians of Canada now recognizes postgraduate family medicine training completed in Australia, the United Kingdom, Ireland and the United States as substantially equivalent to Canadian training, and grants certification without examination to individuals of those countries. Under the new bylaws, graduates from other countries must undergo an assessment of competency prior to being granted a provisional licence. In 2012, a BC international medical graduate (IMG) practice-ready assessment steering committee made up of representatives from the Physician Services Strategic Advisory Committee, the University of British Columbia, the College of Physicians and Surgeons of British Columbia, Ministry of Health, and BC-IMG Assessment Program was created to develop an acceptable entry-to-practice competency assessment program for general/family practitioners in British Columbia. The assessment will consist of three components: a pre-screening assessment filter, a point-in-time assessment and an observed (supervised) clinical in-practice assessment or "field assessment." The program is aligned with the National Assessment Collaboration framework, led by the Medical Council of Canada, and is expected to launch in 2015.

The provincial Ministry of Health in cooperation with Health Canada is proposing an integrated assessment service for internationally educated health professionals focusing on eight "in-scope" priority health professions, which also includes registered nurses, licensed practical nurses, pharmacists, occupational therapists, physiotherapists, medical laboratory technologists, and medical radiation technologists. This program would include competency improvement and assessment, navigation services to help IMGs get information about job opportunities, and data collection and analysis.

The committee reviewed 292 applications from international medical graduates last year.

HIGHLIGHTS FOR THE YEAR

- 217 IMG applicants were granted provisional registration (provisional registrants must complete their Canadian qualifications by either examination or the practice eligibility route (PER) within a defined time period)

- 95 IMG applicants were granted full registration
- 63 IMGs previously on the provisional register were advanced to the full register

Updating of the registration department's systems continues as it prepares to implement a new technology management and IT system that will streamline all of its business processes and improve the speed and efficiency of its work.

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

INFORMATION

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