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 (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.

NUMBER OF ACCREDITED FACILITIES

	Public	Private	Total
Laboratory Medicine	158	11	169
Sample Collection Sites	38	136	174
Diagnostic Imaging	142	67	209
Pulmonary Function	62	25	87
Neurodiagnostics	26	34	60
Polysomnography	8	3	11

NUMBER OF FACILITIES SURVEYED JANUARY 1, 2013 TO FEBRUARY 28, 2014

Laboratory Medicine	47
Diagnostic Imaging	78
Pulmonary Function	18
Neurodiagnostics	4
Polysomnography	0
Total	**147**

INITIAL ASSESSMENTS FOR NEW FACILITIES PERFORMED JANUARY 1, 2013 TO FEBRUARY 28, 2014

Diagnostic Imaging	10
Laboratory Medicine	7
Neurodiagnostics	2
Pulmonary Function	0
Polysomnography	0

PROFICIENCY TESTING LABORATORY MEDICINE

The DAP monitors 137 laboratories, both hospital and private, on an ongoing basis for the accuracy of their proficiency testing results. The disciplines covered are chemistry, hematology, microbiology, transfusion medicine, cytogenetics and immunohistochemistry.

PULMONARY FUNCTION QUALITY CONTROL

The DAP monitors 27 level 3 pulmonary function laboratories by administering a DAP monthly quality control program.

A new pulmonary function spirometry quality control program was started in 2013 for the 57 facilities, both hospital and private offices, that perform level 1 and 2 spirometry.

NEURODIAGNOSTICS

New 2014 accreditation standards for neurodiagnostics were published this year.

WESTERN CANADIAN DIAGNOSTIC ACCREDITATION ALLIANCE

The DAP is part of an alliance with the four western provinces of Canada that are collaborating to produce a common set of laboratory accreditation standards, that would recognize the uniqueness of each province.

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

INFORMATION

For more information regarding this report, please contact:

W.R. Vroom, MD, CM, CCFP (EM)
Senior Deputy Registrar

H. Healey, RN
Senior Director, Diagnostic Accreditation Program

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 serves to further the College's quality assurance and accountability mandate through the review and development of ethics-related standards and guidelines. The committee reports to the Board through the Quality Assurance Committee. Comprised of physicians and non-physicians, the Ethics Committee provides thoughtful and diverse insight into ethical dilemmas that arise in medical practice – insights which manifest as standards and guidelines to assist physicians in navigating these complexities. The committee ensures that emerging ethical topics are addressed and that the standards and guidelines remain current and relevant to today's medical practice.

To respond to the needs of new, younger registrants, this year the Ethics Committee invited a representative from the Professional Association of Residents of British Columbia (PARBC) to join its membership. The committee also expanded its outreach to stakeholders, inviting members of academia, the BC Ministry of Health, fellow medical regulators across Canada, and Doctors of BC to comment on some of its proposed new standards and guidelines. The committee has plans to expand this stakeholder consultation to the general public over the next year.

Each year, the Ethics Committee reviews and updates existing standards and guidelines and provides direction for the development of new standards and guidelines. Below is a summary of the Ethics Committee's work this past year:

UPDATED

- After-Hours Coverage

NEW

- Medical Certificates and Other Third Party Reports

L. Charvat, JD, LLM
Chair, Ethics Committee

INFORMATION

For more information regarding this report, please contact:

A.M. McNestry, MB, CCFP
Deputy Registrar

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.

PROPERTY PURCHASE AND RENTAL

In December 2013, the College purchased an additional 3,200 square feet (including improvements) on the fifth floor of its current location at 669 Howe to allow for future expansion. Of this space, 2,312 square feet has now been rented, along with 17,743 square feet on two other floors. The College owns a total of 62,495 square feet at 669 Howe Street.

ASSESSMENTS, ACCREDITATIONS AND REVIEWS

The Board has significantly increased funding for physician assessments, facility accreditations and peer reviews in the past few years. Quality assurance activities of the College include the following:

- Diagnostic Accreditation Program (DAP)
- Non-Hospital Medical and Surgical Facilities Program (NHMSFP)
- Physician Performance Enhancement Program (PPEP)
- Drug Programs (Methadone Maintenance and Prescription Review)

Due to significant increased activity in all of these programs, expenditures for assessments, accreditations and reviews increased by 53% in 2013/14 to $1,932,000 from the prior year's figure of $1,265,000. This is the largest single expenditure increase for 2013/14. The Board has a goal to conduct 700 physician peer reviews for 2014/15.

PENSION PLAN

During 2013/14, the College was advised that the defined benefit pension plan administered by the Canadian Medical Association (CMA) in which the College participates had a significant deficit that would add considerable expense to the College for years to come. In 2013, the CMA Board approved substantive increases to employer and employee contribution rates, as well as imposed solvency deficiency payments on plan participants. Consequently, the College explored alternative options and the Board ultimately recommended that the College join the British Columbia Public Service Pension Plan (BCPSPP) for the following reasons:

- the BCPSPP is fully funded
- participation in a pension plan with a sound governance structure and significantly lower administrative and investment costs
- lower employer contribution rates
- most of the College's future obligation for deficiency payments to the CMA Pension Plan is eliminated
- greater certainty and less variability of future pension costs
- the College's supplementary defined contribution pension plan and its corresponding liability can be terminated*
- participation in the BCPSPP is expected to improve employee recruitment and retention

* The supplementary defined benefit pension plan for existing and deferred pensioners will continue to be administered by the College.

In December 2013, the BCPSPP Board of Trustees approved the College's application for enrolment in the BCPSPP. On January 1, 2014, the College enrolled its employees in the BCPSPP and withdrew from the CMA Pension Plan effective December 31, 2013. The CMA has requested the consent of the Financial Services Commission of Ontario (FSCO) for the transfer of the College's pension assets from the CMA Pension Plan to the BCPSPP. The decision by the FSCO is still pending

as of the date of this report.

NEW DATABASE AND ELECTRONIC DOCUMENT AND RECORDS MANAGEMENT SYSTEM (EDRMS)

The College began implementing its new database system, iMIS, in October 2013, and plans a significant deployment of functionality in June 2014. As at February 28, 2014, the College had invested $2,183,000 into this project and set aside an additional $1,250,000 for fiscal year 2014/15. Part of these additional funds will be used to start the implementation of an electronic document and records management system (EDRMS) for the College. These new systems are at the heart of enhanced business processes enabled by improved technology, which will better support the College's mandate of public protection through effective regulation.

COLLEGE INVESTMENTS

As part of its annual review of the College's investment policy statement (IPS), the Finance and Audit Committee revised the asset allocation of its capital accounts on the advice of its financial advisors to better reflect current market conditions and the goals set by the committee. The purpose and asset allocations of the College investment accounts are as follows:

Capital accounts

The purpose of the capital accounts is to provide reasonable growth while minimizing risk 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 target allocation for capital investments of the College is 40% fixed investments (bonds and cash) and 60% Canadian equities. The balance in the capital accounts at February 28, 2014 was $10,841,000 ($9,394,000 in 2013).

Operating accounts

The purpose of the operating accounts is to provide sufficient cash to meet the annual obligations for operational expenditures of the College and to fund capital expenditures expected to be paid within the current year. 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% fixed investments (short-term bonds, cash and/or term deposits). The balance of cash and short-term investments in the operating accounts at February 28, 2014 was $15,146,000 ($16,276,000 in 2013).

Investment income for the 2013/14 fiscal year was $748,000 ($487,000 in 2012/13). Realized losses on investments for 2013/14 were $182,000 ($13,000 realized gains in 2012/13) and unrealized gains in 2013/14 were $151,000 ($273,000 unrealized gains in 2012/13).

CONTINGENCY RESERVE CONTRIBUTIONS

Subsequent to the fiscal year ended February 28, 2014, the Board reduced the target reserve balance from 12 months to a period of nine months' operating expenses. The reserves may be used to cover costs during a significant unfortunate event, or for one-time, non-recurring expenses that will build long-term capacity. Any general surplus in each year is added to the College's reserve balance until the current target of nine months' operational expenditures is met. Annual contributions equal to 5% of operational expenditures are added to the reserve balance until the required levels of funds are reached.

As at February 28, 2014, the contingency reserve balance (included in the capital investments) was $6,791,000. Once the contingency reserve is fully funded, any surplus from future operational years can be used to offset future annual fee increases.

Reserve balances as at February 28, 2014

College	$2,403,000
Diagnostic Accreditation Program	4,014,000
Non-Hospital Medical and Surgical Facilities Program	374,000
Total reserve balances	**† $6,791,000**

† A portion of these reserves will be used to fund the potential shortfall of past service pension credits from the CMA Pension Plan to the BCPSPP, as well as to further fund the new database and EDRMS as mentioned in the notes to the audited financial statements.

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

INFORMATION

For more information regarding this report, please contact:

M. Epp, MBA
Chief Operating Officer

J. Pesklevits, CMA
Director, Finance and Office Services

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 committee performs three regulatory functions central to the mandate of the College:

1. investigation of complaints
2. where concerns about the conduct or competence of a registrant come to the attention of the College, investigation of the practice of the registrant, on its own motion
3. oversight when a physical or mental health disorder may impair the ability of the physician to practise safely and effectively; in such circumstances, if the physician is appropriately engaged and compliant with treatment to the satisfaction of the monitoring department, the Inquiry Committee is usually not required to take further action

Twenty-six Inquiry Committee members (18 physicians and eight public members) are appointed amongst five specialized panels. The total number of complaints received remains constant, in the range of 900 to 1,000 annually. Adding files opened for practice investigations and duty-to-report concerns, the Inquiry Committee gave oversight to 1,024 matters in 2013.

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. Statistics for 2013 are tabulated below.

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:

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

In 2013, disciplinary citations were authorized against four physicians.

The majority of complaints prompting the issuance of a citation are ultimately resolved through consent orders pursuant to section 37.1 of the *HPA*. If a consent resolution is not possible, the matter proceeds to a hearing before a panel of the Discipline Committee. There were no Discipline Committee hearings held in 2013.

CONDUCT, ETHICS AND PROFESSIONALISM

Failure of communication and/or the perception that physicians lack empathy are at the heart of most of these. As most of the interactions will have taken place in the privacy of clinical settings, the Inquiry Committee is often left to rely on the clinical record. Careful documentation is not only evidence that specific issues were addressed but also more generally indicative of whether the expected standard of care was provided.

Private billing for medical services may prompt complaints. The Canadian Medical Association *Code of Ethics*, to which College registrants are obliged to adhere, speaks clearly in article 16 to an expectation that physicians will both consider the ability of patients to pay and be prepared to discuss fees openly with them. When responding to complaints of this

nature, physicians are expected to have documented how the fee was arrived at and how it was determined that the patient could afford to pay it.

Other issues of conduct, ethics and professionalism commonly brought to the Inquiry Committee are reviewed in the College standard *Access to Medical Care*, available on the College website: https://www.cpsbc.ca/files/pdf/PSG-Access-to-Medical-Care.pdf.

CLINICAL PERFORMANCE

The Inquiry Committee continues to be critical of physicians for inadequately conducted and/or documented preoperative consent discussions. 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. It is not enough for physicians to declare that they have advised every patient of a significant risk if the patient who has suffered an adverse outcome later claims no recollection of the discussion, and no record exists.

As in the past, the committee investigated a number of complaints alleging deficient performance by older physicians. Many of these triggered separate practice investigations. The literature on occupational performance teaches that older professionals do best when they stick to familiar tasks and settings. The common pre-retirement scenario of leaving a familiar practice population and doing walk-in clinic shifts and locums may be associated with errors these physicians would not have made treating patients they knew well. The committee reminds physicians of their professional obligation to retire before the decline in performance that attends normal aging places patients at potential risk. Ideally every physician will perform optimally on his or her last day of practice.

WHEN HEALTH CONCERNS AFFECT FITNESS TO PRACTISE

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

The 31 complaints concerning personal boundary violations accounted for 3% of investigations concluded in 2013. Just one of those concerned an intimate relationship between a physician and a patient. Several more were about unwelcome communication. The majority were prompted by examinations that were perceived by patients as insensitive and/or disrespectful. The committee again reminds physicians of the importance of carefully explaining the purpose of examinations, ensuring that adequate consent has been given, careful attention to draping, consistently offering a chaperone, and taking great care with what is said in the course of intimate examinations. A rushed examination will rarely impress a patient. These things describe the standard of care expected of all physicians by the College.

SIGNIFICANT EVENTS IN 2013

BC Supreme Court decision concerning the Health Professions Review Board

The *Health Professions Act* came into effect for the medical profession on June 1, 2009, succeeding the *Medical Practitioner 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 College decision letter to apply for a review. About 10% of complainants currently exercise that right. In decisions issued to date (accessible at the website of the HPRB: http://www.hprb.gov.bc.ca/decisions/final_decisions_complaint.stm), most College investigations and decisions continue to be upheld.

College registrants who take issue with decisions of the College or the HPRB have recourse to the courts. In 2013, the BC Supreme Court heard the petition of a physician concerning an HPRB decision. The original complaint was from a patient alleging that the physician's decision to try a series of other drugs in place of Lyrica® was inappropriate and unacceptable. The College review concluded with no criticism of the physician, essentially finding that the approach

taken was standard medical practice. The HPRB found that the College investigation had been inadequate and sent the matter back to the Inquiry Committee with direction.

The registrant applied for judicial review, arguing, in part, that the HPRB owed deference to the College registrar in matters such as this. The Supreme Court decision, found at http://www.courts.gov.bc.ca/jdb-txt/SC/13/20/2013BCSC2081.htm, upheld the original College decision and had the potential to clarify important aspects of the jurisdiction of the registrar. The HPRB has filed a Notice of Appeal.

Electronically supported practice investigations

When the Inquiry Committee directs an on-site investigation of the practice of a physician, the stakes are high both for the physician and the public protection mandate of the College. It is therefore crucial that these investigations are consistently conducted in a standardized fashion. The College is in the final stages of implementing a tablet-based assessment system with those ends in mind.

Acquisition and implementation of a new database to streamline complaints review

The complaints review process is stressful for complainants and registrants alike. Both parties contact the College to express their frustration with delays and bottlenecks. The College is committed to a comprehensive process of identifying and addressing those things. A crucial part of that is automating investigative and review activities with a new database, set to go live in 2014. A great deal of effort was invested in 2013 in preparatory work.

CONCLUSION

In the wake of highly publicized regulatory failures in recent years in the United States and Canada, from public utilities and food safety to private corporations and financial institutions, the Inquiry Committee is keenly aware of the public expectation that the investigation of complaints and the conduct and competence of BC physicians will meet high standards and be subject to deliberate, continuous quality improvement. The committee has worked diligently in 2013 with those legitimate expectations in mind.

L.C. Jewett, MD, FRCSC
Chair, Inquiry Committee

INFORMATION

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Deputy Registrar

B. Fishbook, MPH
Director, Complaints

Committee reports

Library Committee

The library supports the quality assurance activity of the College and aims to be a prime source of information for registrants. Finding high quality information efficiently is a challenge in this era of high rates of scholarly output. Registrants relied on the expertise of College librarians to provide in-depth, quality-filtered literature searches 1,555 times in 2013, second to the historic high of 1,585 requests made in 2012. This upward trajectory is the opposite of declining numbers of literature search requests in academic libraries. Inquiries were from a wide range of specialties and their nature ranged from precise patient-focused questions to broader systems-related topics. Librarians also provided evidence to support decision making by College staff.

While registrants call on librarians for literature searching, many seek assistance from the library for instruction on performing their own searches or using electronic resources more effectively. Librarians interacted with 259 registrants at conferences, small group presentations, computer lab-based workshops, or in-person or online one-on-one sessions in 2013. These sessions include the four-hour, accredited Finding Medical Evidence workshop delivered in Surrey and Vancouver, and online to Dawson Creek and Victoria.

The monthly newsletter, *Cites & Bytes*, is designed to help registrants keep current on a variety of aspects of clinical care by providing a selected list of recent narrative and systematic reviews, controlled trials or guidelines publications from major journals, and new books and audio material. Over 1,600 registrants requested copies of articles cited in *Cites & Bytes* with the most represented specialties being family practice, psychiatry, internal medicine and dermatology. This past year was the first year that *Cites & Bytes* was distributed monthly to all registrants, not just those who requested a subscription, and during this first year of broad distribution approximately 10 to 20 registrants each month requested material from *Cites & Bytes* for the first time.

Library users access journal articles either directly from the College's website or by requesting copies from library staff. In 2013, 34,120 articles were downloaded, which is 7% more than the previous year and marks a continuance of an upward trajectory of use of College library electronic journals. Seventy-five per cent of articles were downloaded by staff on behalf of registrants. The cost of all the library's services and resources is recouped simply in access to journal articles; on average, a registrant would need to acquire only three articles a year from the library to cover their portion of the expense of the entire library.

In contrast to the almost complete switch from print journals to electronic, print books remain an important albeit diminishing item circulated by the library. In 2013, 2,434 print books were loaned. On the other hand, electronic books and similar online material such as BMJ Best Practice and First Consult point-of-care tools are increasingly used by library patrons; these resources were accessed 10,834 times in 2013, representing another year of steady increase in usage since the library started collecting these formats. Technologies for viewing online material are changing with handheld devices and tablets becoming important clinical tools. As of 2013, the library offered access for all registrants to the BMJ Best Practice app in addition to the First Consult and Audio-Digest apps.

College registrants contacted the library a total of 12,843 times in 2013, the most contacts yet recorded. These library patrons are demographically very similar to the average registrant in terms of age, geographic distribution, urban/rural distribution, and gender. A deeper understanding of the characteristics and information needs of these users would help shape the future direction of the library. A specific group of registrants is of particular interest as key knowledge leaders, i.e. those physicians who other physicians reach out to, and pattern their own practice after. A project was launched in 2013 to identify this group among College registrants, determine the extent that the library supports their practice, and gather their ideas about optimizing library services. The project is expected to be complete in 2014.

P.D. Rowe, MD, CCFP(EM), FCFP
Chair, Library Committee

INFORMATION

For more information regarding this report, please contact:

J.G. Wilson, MD, MSc, FCFP
Deputy Registrar

K. MacDonell, PhD
Director, Library Services

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) is comprised of six general practice physicians and two specialist physicians, and provides oversight to the Physician Practice Enhancement Program (PPEP). The committee works under the privacy provisions of section 26.2 of the *Health Professions Act*, thereby ensuring that information garnered during an assessment is only known to MPAC members and used for remedial education. Assessment information is shielded from other College programs, and only in the event of egregious clinical conduct or repeated non-compliance with MPAC recommendations, can the committee refer to the Inquiry Committee.

The Physician Practice Enhancement Program (PPEP) is a collegial program that proactively assesses and educates physicians to ensure they meet high standards of practice throughout their professional lives. The goal of the program is to promote quality improvement in community-based physicians' medical practice by highlighting areas of excellence and identifying opportunities for professional development.

Pursuant to the strategic priorities provided by the Board, the program continues to actively assess physicians, prioritizing the assessment of physicians over the age of 70 practising in solo and unsupported environments. It is the intent of the program that all community-based physicians have a periodic assessment on an eight-year cycle, with physicians over 75 years or those requiring ongoing remediation assessed on a more frequent basis. The PPEP will continue to assess physicians practising in a multi-physician clinic as a unit to provide valuable feedback to medical directors on systemic concerns that may impact physician performance. Current assessment of office premises and processes are conducted in conjunction with on-site peer assessments; however, office assessments will transition to focus on reprocessing of instruments, occupational health and safety, and patient safety issues.

In 2013, the program launched a multi-source feedback (MSF) assessment as a complement to peer assessments. The addition of the MSF provided physicians with a more comprehensive and balanced review of a physician's practice with the focus to provide meaningful feedback for improvements. Two physician consultants were recruited to the program to expedite the review of assessments and offer remedial guidance and support to registrants.

The role of appropriate and relevant feedback is critical to the success of the program. The program will collaborate with University of British Columbia researchers to explore the role of feedback within the framework of practice improvements and better understand contextual factors that may influence the feedback provided.

While the PPEP continues to increase the number of physician assessments completed, the following program enhancements are in development:

- program expansion to include specialists practising in the community (e.g. ENT, orthopedics)—PPEP will begin recruiting specialty assessors in 2014
- transition to an e-assessment platform for more objective and efficient assessments
- evaluation of program data with the focus of program improvement
- creation of a collaborative assessor community; annual assessor conference is held in the fall of each year

PROGRAM STATISTICS FOR 2013:

Number of multi-physician clinics assessed	129
Number of peer practice assessments assigned	754
Number of peer practice assessments completed	606
Number of multi-source feedback assigned	751
Number of multi-source feedback completed	477
Number registrants participating in remedial education	113
Number of physicians referred to consultants	41

PPEP is in transition to track statistical information from a calendar year to a fiscal year. The above information represents data from January 1, 2013 to February 28, 2014.

R.A. Baker, MD
Chair, Medical Practice Assessment Committee

INFORMATION

For more information regarding this report, please contact:

W.R. Vroom, MD, CM, CCFP (EM)
Senior Deputy Registrar

N. Castro, MHA
Director, Quality Assurance and Practice Assessments

Committee reports

Methadone Maintenance Committee

The scope of the Methadone Maintenance Committee is set out in section 1-23 (1)–(10) 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 dependence. It is a controlled substance. To prescribe methadone physicians must hold an authorization (in the form of an exemption under section 56 of the *Controlled Drugs and Substances Act* with respect to methadone) from the federal minister of health.

Under the *Health Professions Act* and in accordance with Health Canada's Drug Strategy and Controlled Substances Programme, the College of Physicians and Surgeons of British Columbia administers the Methadone Maintenance Program (MMP) with the clinical guidance of the Methadone Maintenance Committee (MMC). Authorizations (or exemptions) to prescribe methadone may be for the treatment of opioid dependence, for analgesia, or for the provision of work as a hospitalist. Authorizations may be either full (for up to five years) or temporary (for up to 60 days.)

The Methadone Maintenance Committee assists physicians in prescribing methadone safely and effectively for the treatment of opioid dependence. It develops guidelines, provides education and reviews cases.

In 2013, Dr. Paul Sobey, Dr. Patricia Mark and Dr. Jennifer Melamed retired from the MMC. All three had provided much time and expertise to many areas of the MMP. New members include Mr. Kenneth Tupper from the Ministry of Health, and clinical expert Dr. Alex Chan. Dr. Anne Clarke is committee chair and a new member of the College Board.

The MMC includes physicians who have expertise in prescribing methadone for the treatment of opioid dependence and pain management, as well as physicians who work in addiction medicine. The committee recognizes that it is important to have a cross-section of expertise from the methadone prescribing community.

Guidelines for prescribing methadone can be found on the College's website under the Methadone Maintenance Program – the *Methadone Maintenance Program: Clinical Practice Guideline* (previously called the *Methadone Maintenance Handbook*) and *Recommendations for the Use of Methadone for Pain*. The *Methadone Maintenance Handbook* was extensively reviewed and revised over the course of 2013, renamed, and published to the College website in February 2014.

In 2013, in preparation for a change in methadone formulation in British Columbia (from 1 mg/ml to 10 mg/ml), the MMC collaborated with the College of Pharmacists of British Columbia and the Ministry of Health to provide education and support to stakeholders including physicians, pharmacists, clients (patients) and other health-care facilitators. In addition, a new methadone maintenance controlled prescription form was instituted. As of February 1, 2014 all prescriptions for Methadose™ for opioid dependence must be written on the new pad.

Educational workshops are held at least three times per year. The Methadone 101/Hospitalist workshop is a basic course on the fundamentals of methadone maintenance therapy, guidelines and expected standards of care. A separate component of this workshop has been developed for hospitalist physicians managing methadone maintenance or analgesia patients during hospital admission. Two Methadone 101/Hospitalist workshops were held in May 2013 and in October 2013, with 34 and 62 registrants respectively. The Methadone 201 course was presented in October 2013 with 20 registrants.

The MMP physician peer practice assessment (PPA) process is being reviewed, standardized and enhanced in conjunction with all the other College quality assurance programs. Going forward, practice assessments of all methadone prescribing physicians will be done cyclically, as in other quality assurance programs. Thirty-three PPAs (21 in-office assessments and 12 documentary assessments) were done in the 2013/14 year, and it is anticipated that this number will increase substantially in the future.

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. In 2013/14 the MMC reviewed 31 coroner's cases.

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

PROGRAM STATISTICS FROM APRIL 1, 2013 TO MARCH 31, 2014

Number of methadone patients registered with the Methadone Maintenance Program	14,662
Number of new physicians with opioid dependence exemptions	37
Number of new physicians with analgesic exemptions	45
Number of new physicians with both opioid dependence and analgesic exemptions	18
Number of new physicians with Hospitalist exemptions	14
Number of peer practice assessments (21 in-office assessments and 12 documentary assessments)	33
Number of coroner's cases reviewed	31
Number of educational workshops held	3
Number of attendees at each workshop	25 (May 25) 20 (Oct 18) 62 (Oct 19)

A.I. Clarke, MD, FRCPC
Chair, Methadone Maintenance Committee

INFORMATION

For more information regarding this report, please contact:

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Deputy Registrar

Jonathan D. Agnew, PhD
Director, Monitoring and Drug Programs

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.

As legislated by the BC Ministry of Health, the Non-Hospital Medical and Surgical Facilities Program (NHMSFP) accredits 64 private surgical facilities within BC. Program accreditation and certification is recognized as a standard that demonstrates a facility's commitment to delivering safe, high quality health care.

PUBLIC TRUST

The NHSMFP has been entrusted to serve the public by improving care through standard setting, measuring performance and monitoring outcomes in a transparent program. Patients should expect a standard of care that equals or exceeds the care delivered in our public hospitals.

The NHMSFP serves to engage and inform the public, as active participants in their own care. The committee is dedicated to developing mechanisms to improve transparency and accountability to patients who receive care in any private health-care facility in BC.

COMMITTEE

Committee members play a critical role in serving the public. Membership includes both physician experts from surgery and anesthesia, and nursing. In addition, public members bring leadership experience in business, accounting and education to the committee. To best serve the interests of patients, the committee continuously strives to improve quality and safety. This year, the committee will be assessing both the effectiveness of the programs and stakeholder engagement by involving an external consultant to review the College's internal accreditation processes. From time to time, the committee may also direct subcommittees and workings groups, and commission other activities as necessary in response to emerging safety and quality issues.

ACCREDITATION PROCESS

In collaboration with stakeholders, the NHMSFP evaluates facilities and encourages them to excel in providing the high quality of care. The NHMSFP promotes safe patient care by monitoring performance through peer-based accreditation processes, education, research and consultation. A facility accredited by the NHMSFP assures the public that the facility meets national performance and quality standards. Facilities must undergo an on-site survey by an accreditation team at least every four years. Only after meeting all mandatory requirements does the facility earn accreditation certification. If a facility does not meet the requirements for accreditation, its certificate is withdrawn and it must stop providing patient care. After the facility demonstrates that all safety deficiencies have been addressed, service delivery can safely resume.

FEES

The NHMSFP is a full cost-recovery program. Facilities are required to support the program and committee through annual and accreditation fees.

ANNUAL HIGHLIGHTS

- 64 private medical/surgical facilities in BC
- In 2013, 33 facilities were accredited as part of their four-year accreditation cycle
- 3 new facilities opened
- 63,890 procedures were performed in a non-hospital medical and surgical facilities across the province
- 34% of procedures performed were contracted from health authority and/or third party (WorkSafeBC and ICBC)
- 673 physicians are authorized by the College to provide medical services in one or more private/medical surgical facility

A.I. Clarke, MD, FRCPC
Chair, Non-Hospital Medical and Surgical
Facilities Program Committee

INFORMATION

For more information regarding this report, please contact:

W.R. Vroom, MD, CM, CCFP (EM)
Senior Deputy Registrar

P. Fawcus, RN
Director, Non-Hospital Medical and Surgical Facilities Program

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 gives oversight to the Prescription Review Program. Under the College Bylaws, its main responsibilities include:

- reviewing the prescribing of drugs on controlled prescriptions and selected other drugs, like benzodiazepines, sedative hypnotics, and stimulants, with addictive potential
- 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 for 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 are 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 137 and closed 62 files.

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 now accounts for more unintended deaths in British Columbia than drinking and driving. In 2012, the medical health officers in the 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 have chronic pain, most are also able to work. About half also suffer from a mental health disorders. Almost all (93%) were taking other CNS 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 held on April 19, 2013 and November 29, 2013
    - 19 registrants – April 19, 2013
    - 21 registrants – November 29, 2013
    - most of the day spent in practice interviews with standardized patients
2. Foundation for Medical Excellence Chronic Pain and Suffering Symposium – March 8–9, 2013
    - 26th annual conference
    - 204 total attendees
        - 157 physician attendees from BC
        - 40 physician attendees currently enrolled in the Prescription Review Program
3. Participation in the planning of chronic pain modules with both the Practice Support Program of the Doctors of BC and the Provincial Academic Detailing Program

G. Parhar, MD
Chair, Prescription Review Committee

INFORMATION

For more information regarding this report, please contact:

A.M. McNestry, MB, CCFP
Deputy Registrar

Jonathan D. Agnew, PhD
Director, Monitoring and Drug Programs

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
- and recommend requirements for revalidation of licensure.

The committee is composed of two 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 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:

- Blood Borne Communicable Diseases Committee
- Ethics 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:

- Prescribers 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

M.A. Docherty, MBChB, CCFP, FCFP
Chair, Quality Assurance Committee

INFORMATION

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Senior Deputy Registrar

N. Castro, MHA
Director, Quality Assurance and Practice Assessments

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.

PROVINCIALLY

The College Bylaws recognize general/family practice international medical graduates (IMGs) who have not completed jurisdictionally approved and accredited postgraduate training, as recognized by the College of Family Physicians of Canada (currently only those IMGs from the United States of America, United Kingdom, Ireland and Australia are so recognized), as eligible for provisional registration if they have undergone an assessment of competency (Practice Ready Assessment or PRA) in a Canadian jurisdiction acceptable to the Registration Committee.

The BC IMG PRA Steering Committee is 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, the BC Ministry of Health, the Doctors of BC and Health Match BC. The BC IMG PRA program is being developed to create an acceptable entry-to-practice competency assessment program for general practitioners wanting to practise in British Columbia. The assessment will consist of three components: a screening assessment; a candidate selection process and point-in-time orientation phase; and an observed (supervised) clinical in-practice assessment or "field assessment." The clinical in-practice assessment is 12 weeks in duration in a group general/family practice setting in BC. It is anticipated that the first iteration of the BC IMG PRA program will occur in the late fall of 2014 or early spring of 2015. Selected candidates who pass the competency-based assessment will be eligible to apply for the provisional class of registration and licensure for general/family practitioners.

Work continues on updating and developing policies that support the implementation of College Bylaws made pursuant to the *Health Professions Act*. Policy development and implementation has focused on defining parameters around the provisional, conditional – practice setting, and administrative classes of registration and licensure. This includes the development of a memorandum of understanding and policy to enable the University of British Columbia (UBC) faculty of medicine to employ suitable former registrants of the College or former registrants of another Canadian medical regulatory authority to teach medical students at the bedside, or with simulated and/or volunteer patients at its distributive sites. The committee is also working with the UBC faculty of medicine postgraduate dean's office to clarify time limits and stated purposes of clinical fellows registered in the educational – postgraduate (fellow) class of registration and licensure.

Under the College Bylaws, certain registrants must meet criteria stipulated by the Registration Committee within a given time period (these are defined at the commencement of their practice in British Columbia). As part of this process, summative assessments are completed for those general/family practice registrants who were first registered under the provisions of the former *Medical Practitioners Act* (i.e. those registered prior to June 1, 2009). These are also completed for specialists trained in the United States of America who have registered under either the *Medical Practitioners Act* or the *Health Professions Act* who have completed Accreditation Council for Graduate Medical Education (ACGME) accredited training and who hold their American board specialty examinations. Those registrants with successful summative assessments are eligible to be granted registration and licensure in the full class.

A new College information technology system is under development with the goal of streamlining application and registration processes and improving the speed and efficiency of the College's work processes.

NATIONALLY

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 (MCC), Federation of Medical Regulatory Authorities of

Canada (FMRAC) and its member colleges began developing the web-based electronic application process for physicians wanting to obtain full or provisional registration in any province or territory of Canada. The Medical Council of Canada is launched a new system and candidate portal on May 23, 2013: the Application for Medical Registration in Canada (AMRC) at physiciansapply.ca. Pilots of the web-based electronic application began in 2013 in a few other Canadian provinces. The College will be coming on board with the AMRC process in 2015, once its new technology system has been developed and fully implemented.

HIGHLIGHTS OF THE YEAR

- 196 applications for eligibility were reviewed by the committee
- 170 new 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
- 87 new IMG applicants were granted full registration
- 164 IMGs previously on the provisional register were advanced to the full register

M. Corfield, DM
Chair, Registration Committee

INFORMATION

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