College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

The College Connector

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In this issue:

The *College Connector* is sent to every current registrant of the College. Decisions of the College on matters of standards and guidelines are contained in this publication. Questions or comments about this publication should be directed to communications@cpsbc.ca.

Registrar's message

Child abuse is one of the most serious problems facing society. Each year, the Ministry of Children and Family Development reportedly receives approximately 30,000 calls from concerned citizens that a child or youth might be in need of protection. Under BC law, all citizens have a moral and ethical duty to report any concerns if they have reason to believe that a child has been, or is likely to be, abused or neglected.

In my message in last month's *College Connector*, I wrote about the challenges in accessing mental health services for children and youth. This month my focus is on children who live with domestic and family violence. These are children who are experiencing trauma, including trauma which is ongoing and long-lasting. Domestic and family violence disrupts attachment to the primary caregiver, and it severely disrupts, even prevents, the ability of the primary caregiver to administer care.

This may cause diminished mental health and exhaustion for both the caregiver and the child, and triggers numerous emotional, behavioural, cognitive and physical issues for those trapped in the cycle. Children may be forced to have an ongoing relationship with someone they fear. Alternatively they may be coerced to join in with verbal abuse and contempt, or risk being victimized for supporting the caregiver.

On June 1, 2014, the domestic violence amendments to the *Child, Family and Community Service Act* came into force and the Ministry of Children and Family Development amended its handbook, *Responding to Child Welfare Concerns: Your Role in Knowing When and What to Report*. The handbook can be accessed online at http://www.mcf.gov.bc.ca/child_protection/pdf/child_welfare_your_role.pdf. Significantly, the handbook clarifies reporting requirements of domestic violence when witnessed by children, citing that the likelihood of physical and emotional harm to a child increases when the child is living in a situation where there is domestic violence by or towards a person with whom a child resides. This handbook is available in five different languages including Chinese, French, Punjabi, Spanish and Vietnamese at http://www.mcf.gov.bc.ca/child_protection/translated.htm.

Physicians play a significant role when identifying child abuse or neglect. It is our collective responsibility to report any such concerns, and there may be a requirement to remain involved in cases where the child is removed from current care followed by court actions and decisions. In this situation, physicians will be expected to cooperate with the Ministry for Children and Family Development and/or the local Delegated Aboriginal Child and Family Services Agency, while maintaining their ethical responsibility to their patient, the child, and to the child's parents or legal guardians. Physicians are encouraged to take a collaborative approach where possible, acquiring consent from parents or guardians to share a child's relevant information and medical records, unless this interaction jeopardizes a situation where a child requires protection.

Currently there are five child protection teams in BC:

- Child Protection Service Unit, BC Children's Hospital, 604-875-3270
- Northern Health SCAN Clinic, Prince George, 250-565-2120
- Health Evaluation, Assessment and Liaison (HEAL) Team, Surrey Memorial Hospital, 694-585-5634
- Vancouver Island Suspected Child Abuse and Neglect Team, Nanaimo, 250-755-7945
- Kamloops Suspected Child Abuse and Neglect Clinic, Royal Inland Hospital, 250-314-2775

Other sources of support are available after hours at the Helpline for Children at 310-1234. I quote Franklin D. Roosevelt, “We may not be able to prepare the future for our children, but we can at least prepare our children for the future.” Children are our future, and how we protect them and provide for them will in essence shape the next generation of leaders, thinkers and physicians. We cannot afford to let them down.

H.M. Oetter, MD
Registrar

We welcome your feedback on any article contained in the College Connector.

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Creating a vision towards an excellent health-care system in BC

A health-care system purpose built for all patients—elusive pipe dream or emerging reality? – 2014 Education Day
Friday, September 26, 2014

Save the date for the much-anticipated College Education Day, held again this year at the Vancouver Convention Centre. This year's theme: building a quality health-care system that meets the care needs of our province's diverse population. There will be sessions which focus on the challenges and obstacles, and compelling reasons for driving change. Other sessions will highlight current examples of physicians engaged in evidence-based initiatives that are improving care delivery for patients and practitioners.

For more information about the plenary and workshop topics and presenters, see the complete program.

Download the registration form now.

Application has been made for CME/CPD credits:

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- Mainpro-M1 – to be advised

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Changes being implemented to OSMV's urgent licence cancellation process

The Office of the Superintendent of Motor Vehicles (OSMV) is making a number of changes to how they review unsolicited driver medical fitness reports from medical practitioners, police and the public and how they make subsequent driver medical fitness decisions, including urgent licence cancellations. The changes include strengthening the evidentiary requirements under which OSMV makes an urgent licence cancellation decision. In cases where this threshold is not met, OSMV will use a "Notice to Cancel" approach, which notifies the driver that OSMV is considering a licence cancellation and provides the driver with the opportunity to respond to the concerns raised. Registrants are encouraged to read the full letter from the deputy superintendent here:
http://www.pssg.gov.bc.ca/osmv/shareddocs/UrgentCancellationProcessDriver.pdf

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Telemedicine—an adjunct to comprehensive care; not an end in itself

For more than a century the telephone has been an integral part of medical practice. Used appropriately, it has the potential to make physicians more efficient and patients safer. But, even after 100 years, making good decisions on the telephone requires superior clinical judgment.

Telemedicine has the potential to reduce the risk of error by providing physicians with considerably more information. However, a decision to rely on a virtual visit to conclude a medical assessment for an acute concern will always be a high stakes one, which requires thoughtful consideration and superior clinical judgment.

Telemedicine is here to stay. Like the telephone, physicians must learn to use these new technologies safely. The College urges registrants to review two articles:

1. The College's professional standard *Telemedicine* at https://www.cpsbc.ca/files/pdf/PSG-Telemedicine.pdf

2. An editorial in the *BCMJ* by Deputy Registrar Dr. W.R. Vroom, titled *Does telemedicine need stricter rules for engagement?* at http://www.bcmj.org/editorials/does-telemedicine-need-stricter-rules-engagement

The College regulates medical practice, not communications technology. Standards for patient assessment and documentation are the same, whether the interaction is face-to-face or virtual. Failure to perform an adequate physical examination is one of the most common deficiencies identified when patients suffer adverse outcomes and bring complaints to the College.

Physicians are accountable every time they decide that a physical examination is not required. In his *BCMJ* editorial, Dr. Vroom comments that "Telemedicine has tremendous potential value in enhancing comprehensive longitudinal care and should not result in greater fragmentation." The College's depth and breadth of experience reviewing physician practices and investigating complaints indicates that telemedicine will add value for patients and providers if it forms part of an integrated whole, such as a full-service primary care clinic, a provincial or regional specialty service, or a robust outreach program for people living in remote locations. Significant risk is anticipated if physicians attempt to use telemedicine to provide episodic services in isolation to patients they are not familiar with. Telemedicine holds great promise as an adjunct to well-organized systems of care. Without the support of such systems, it is expected that telemedicine will be neither efficient nor safe.

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The "abandonment" of palliative care patients

Palliative care is an emotionally charged area in which to practise medicine. Families and loved ones are often overwhelmed by their situation and may be as in need of a physician's patience, empathy and attention as the patient.

The College sometimes receives calls from family physicians and physicians working with palliative care teams with questions about their joint involvement with a patient's care. Two of the most common questions are:

1. Should the involvement of a palliative care team mean that the family physician withdraws his/her care of the patient and family?

2. Should the family physician continue to prescribe narcotics to a patient who has moved into a hospice or palliative care ward or is now under the care of a palliative care team?

Palliative care teams may provide care to many patients across several facilities or at home. This may mean that the palliative care physician is not able to assume the role of the family physician. However, the role and scope of the palliative care team or palliative care physician may differ depending on the location.

The family physician may have provided care to the patient over a period of time and be aware of his/her other medical conditions, as well as have a rapport with the family. On an emotional level, the patient and his/her family may feel abandoned if the family physician automatically or abruptly withdraws from involvement in the care. This can add to the stress of an already difficult situation.

Transfer of patient care to a palliative care physician or team may be appropriate and should be done, as with all transfers of patient care, in a professional, collegial manner and always after direct communication between the physicians involved. This should be followed by clear communication with the family as to where the medical responsibility for the patient's care now rests.

Different palliative care programs have different policies and resources. Some have the capacity to assume primary care and some do not. It is expected that referring physicians be mindful, where applicable, of the specifics of the program (if any) in which the palliative care physician is working.

Prescribing narcotic medications to a palliative care patient may also be the responsibility of the family physician or the palliative care physician, depending on the circumstances. The patient and the family should never become the victims of the failure of physicians to communicate about prescribing responsibilities.

Citing jurisdictional issues or the guidelines of the College's Prescription Review Program (which speaks primarily to prescribing for chronic non-cancer pain and not acute or palliative care pain) is not helpful or professional in such situations, and may cause unnecessary distress, and even pain, to palliative care patients and their families.

Reference to generic guidelines on expected standards for referring physicians and consultants can be found at: https://www.cpsbc.ca/files/pdf/PSG-Expectations-of-the-Relationship-Between-Physicians.pdf

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Updates from the Prescription Review Program

Your prescription; your responsibility

The Prescription Review Committee recently learned of a patient who received a single dispense of narcotics and sedative medications with a combined street value of over $17,000. Aside from the potential of accidental harm to the patient involved and to those with whom s/he lives, the situation presents a significant public safety risk—particularly when such large amounts of money are at stake.

Physicians can avoid putting their patients and the community at risk by practising pharmacovigilance. Pharmacovigilance means doing more than ensuring that the prescription one writes is therapeutically appropriate at the time it is given. It also means conducting the appropriate screening of the patient to minimize the kinds of problems that can emerge when at-risk patients are prescribed psychoactive or controlled medications.

Physicians can practise pharmacovigilance by taking a several important precautions:

1. Remember that your prescription is your unique responsibility. The advice you receive from other physicians, even specialists, simply provides the context for your decision to prescribe.
2. Do not prescribe potentially addictive medications to patients whom you have not screened for addictions or whose PharmaNet prescription profiles you have not reviewed. Even a brief screening can significantly reduce the risk of inappropriate prescribing.
3. Learn whether the patients for whom you prescribe psychoactive medications drink, drive or perform safety-sensitive work, including caring for children.
4. Pay close attention to the size and frequency of the dispenses authorized by your prescription. Unusually large or frequent authorizations can turn a safe prescription into a potentially hazardous one.
5. Help to reduce the risk of medications being diverted by using treatment agreements, random pill counts, and urine drug testing where appropriate, for example, with patients on long-term opioid therapy.

The Prescription Review Committee provides additional information in its prescribing guidelines. Reviewing the guidelines while practising the five precautions above will help to protect patients and the community.

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

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Updates from the Non-Hospital Medical and Surgical Facilities Program

Sterilizing gauze

The practice of sterilizing gauze in instrument packs has been observed at several non-hospital facilities. Although this practice was reintroduced in the local health authorities as a temporary measure following a Health Canada recall, the recall advisory ended several months ago. Therefore, non-hospital facilities are advised that the practice of sterilizing gauze is no longer permitted.

Emergency cart – pediatric supplies

It has come to the attention of the NHMSFP Committee that pediatric non-rebreather oxygen masks are becoming difficult to procure. Therefore, non-hospital facilities providing pediatric services are advised that the *Emergency Cart Medication and Equipment: Class 1 Facility* standard has been revised to include the Jackson-Rees T-piece as an alternative to the pediatric non-rebreather oxygen mask. Facilities are required to have either Jackson-Rees T-piece or the pediatric non-rebreather oxygen masks; they are not required to have both.

The Non-Hospital Medical and Surgical Facilities Program requires private facilities to maintain high standards of practice equal to or exceeding public hospitals. The program establishes accreditation and performance standards, procedures and guidelines to ensure the delivery of high quality health services. The 700 physicians who work in private facilities across the province must be granted privileges by the College.

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New or updated professional standards and guidelines

The College develops *Professional Standards and Guidelines* to assist physicians in meeting high standards of medical practice and conduct. The topics addressed focus on specific issues that are relevant to the practice of medicine. Physicians are encouraged to become familiar with the College's *Professional Standards and Guidelines*. The *Professional Standards and Guidelines* are reviewed regularly and may be updated over time.

- Disclosure of Adverse or Harmful Events
- Job Shadowing/Observing
- Promotion and Sale of Products

College of Physicians and Surgeons of British Columbia

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Recipients of the 2014 Award of Excellence in Medical Practice

Every year the College Board, through a peer nominations process, recognizes outstanding physicians who have made an exceptional contribution to the practice of medicine in teaching, research, clinical practice, administration or health advocacy. The recipients are presented with an Award of Excellence in Medical Practice at the annual president's dinner.

Recipients

- Oscar G. Casiro, MD, FRCPC – Victoria, BC
- Noel Donnelly, MD, FRCSC – Williams Lake, BC
- L. Jean Hlady, MD, FRCPC – Vancouver, BC
- Robin R.R. Love, MD, FCFP – Nanaimo, BC

L to R: Dr. Robin R.R. Love, Dr. Lawrence C. Jewett (President), Dr. Noel Donnelly, Dr. Oscar G. Casiro; Absent: Dr. L. Jean Hlady

The full media release is available here.

A word from the College library

Learning visually

Procedures are often more effectively learned by visual methods rather than through reading text.[1] On the College library's Audiovisual page, a variety of audiovisual materials are offered to learn new clinical techniques, refresh one's knowledge, or to share with patients to further their understanding of procedures, normal anatomy or injuries. The following are a sample of available resources:

- **Access Medicine** contains a multimedia collection of more than 250 examination and procedural videos, audio files, and animations from the online version of *Harrison's Principles of Internal Medicine*.
- **ACP Clinical Skills Collection** features physicians performing clinical skills on live models, while highlighting key facts on such topics as arthrocentesis and joint injection, sports medicine musculoskeletal examination, counselling for behaviour change, prevention of diabetic foot ulcers, and skin biopsy in the office.
- **Procedures Consult** provides audiovisuals, illustrations and text to prepare for, perform, and follow up on about 100 common procedures in emergency medicine and anesthesiology. Instances when patient informed consent is required are highlighted, as are essential guidance and clinical pearls. Procedures consult is available as an Android and iOS application. Contact the library for a personal username and password to log onto the app.
- **Primal Pictures Interactive Anatomy** is an interactive online learning tool for both patient and physician education. The 3D anatomical structures are detailed and can be displayed in layers to provide a clear understanding of anatomical relationships. Text, clinical slides, dissections, and therapy animations are also included.
- While not online yet, the 18 DVDs of **Bates' visual guide to physical examination** are available for loan. The videos cover head-to-toe and systems-based physical examination techniques which complement the *Bates' Guide to Physical Examination and History Taking* text edited by Lynn Bickley. The library plans to stream the videos from the College website later in 2014.

Library patrons are welcome to use these and more of the audiovisual materials listed on the Audiovisual page. For assistance, please contact the library at 604-733-6671 or medlib@mls.cpsbc.ca.

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[1] Flores, P. Demoss, C. Klene, R. Havlik and S. Tholpady. Digital animation versus textbook in teaching plastic surgery techniques to novice learners. Plast Reconstr Surg 2013 Jul;132(1):101e-9e.

CME events: mark your calendars

Finding medical evidence: supporting patient care – using the Internet to your advantage

June 14, 2014 – Victoria
http://www.ubccpd.ca/course/fme-victoria-2014

June 19, 2014 – Kamloops
http://www.ubccpd.ca/course/fme-kamloops-2014

September 27, 2014 – Vancouver
http://www.ubccpd.ca/course/fme-vancouver-2014

These workshops are accredited for 3.5 Mainpro-M1 credits from the College of Family Physicians of Canada and an Accredited Group Learning Activity (MOC Section 1) as defined by the Royal College of Physicians and Surgeons of Canada.

A health-care system purpose-built for all patients—elusive pipe dream or emerging reality? – 2014 Education Day

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Medical record keeping workshop

Wednesday, November 5, 2014

This course is primarily directed at family/general practitioners and other physicians providing primary care. The course is delivered in an interactive format using real case examples and simulated patient encounters to demonstrate the practice of effective clinical record keeping.

- More information on the program
- Register now

Pain and Suffering Symposium

Friday, March 6–Saturday, March 7, 2015

The 28th annual Pain and Suffering Symposium is presented by the Foundation for Medical Excellence in cooperation with the College of Physicians and Surgeons of British Columbia. This course is designed to assist clinicians in managing the most challenging of pain patient—patients with complex chronic pain. This program will benefit physicians, health professionals, administrators, and others interested in the management of pain.

For more information, visit The Foundation for Medical Excellence.

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