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

Debunking misperceptions about the updated standard regarding walk-in clinics

Misperception 1: The standard is new

To ensure quality of care in all practice settings in British Columbia, this past June the Executive Committee approved an amended professional standard entitled *Walk-in, Urgent Care and Multi-physician Clinics*. Contrary to what has recently been reported in the media, this standard is not new. The revised document merges and modestly revises two earlier, separate standards developed in 2008, and reiterates one basic principle that every physician must abide by: that the medical care of a patient, and not the setting of a medical practice, must guide the ethical, professional and clinical decisions around the provision of appropriate medical care.

This means that a patient is owed the same standard of care from a family physician whether treatment is being sought at a solo practice or a multi-physician clinic. While walk-in clinics may typically treat less severe medical episodes, patients who do not have a dedicated family physician and who are in need of longitudinal medical care should not be made to feel like they are on an assembly line for hurried and potentially compromised treatment.

Misperception 2: The standard has a "one visit" rule

All patients *do not* automatically become permanent patients of the clinic at the time of their first visit. Patients who do not identify a family physician and who *regularly attend* the same walk-in, urgent care or multi-physician clinic must be assumed to be receiving their primary health care from that clinic. The physicians and medical director are responsible for ensuring these patients are offered longitudinal medical care, including the provision of appropriate periodic health examinations and follow-up.

As in the past, a patient attending repeatedly at one clinic, essentially receiving all of his/her care there, is undeniably already accessing longitudinal primary care from that group of physicians. Providing such a patient with episodic care exclusively is inadequate.

Misperception 3: The standard says that patients get to choose a primary care physician at the clinic

The updated standard does not require that the ongoing care at a walk-in clinic be provided by only one physician, but rather all of the physicians and medical director collectively. The clinic must ensure there is a unified patient record that is accessed by all physicians at every visit. No individual physician working in a walk-in clinic is obliged to take a patient exclusively, nor can a patient demand that a particular physician working at a walk-in clinic become their dedicated family physician.

Overall, the updated standard outlines and strengthens the language on the expectations of physicians and the medical director. It also retains the requirement that clinics must have on-site access to PharmaNet and document appropriate review in the patient's medical record. Accessing PharmaNet will help prevent situations like the one reported by CBC's Go Public recently: Regulators' investigation into prescription fraud identifies 150 health professionals. The College encourages registrants to review the revised standard: *Walk-in, Urgent Care and Multi-physician Clinics*.

While resolving health resourcing issues falls primarily with the provincial government, the College and physicians across the province have a role to play in ensuring that British Columbians are receiving the highest quality medical care possible—whatever the practice setting.

H.M. Oetter, MD
Registrar

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

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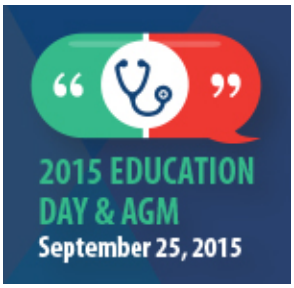
Notification of the 2015 Education Day and Annual General Meeting



Getting the script right: communications challenges in medical practice

Date: Friday, September 25, 2015
Location: Vancouver Convention Centre, 1055 Canada Place, Vancouver
Event registration: Register now

For more information about CME credits, click here.

Plenary topics and presenters

Timothy Caulfield, BSc, LLB, LLM
Celebrity spin: what's driving (and how to deal with) health myths and pseudoscience?
Mr. Caulfield is a Canada research chair in health law and policy and a professor in the Faculty of Law and the School of Public Health at the University of Alberta. He writes frequently on a range of health and science policy issues and is the author of *The Cure for Everything: Untangling the Twisted Messages about Health, Fitness and Happiness (Penguin 2012)* and *Is Gwyneth Paltrow Wrong About Everything?: When Celebrity Culture and Science Clash (Penguin 2015).*

Angelo Volandes, MD, MPH
The Conversation: A Revolutionary Plan for End-of-Life Care
Dr. Volandes is a physician, writer and patients' rights advocate. He practises internal medicine at Massachusetts General Hospital in Boston, and is on faculty at Harvard Medical School. He is co-founder and president of Advance Care Planning Decisions, a non-profit foundation implementing systems and technologies to improve the quality of care delivered to patients in the health-care system. Dr. Volandes will present on his new book *The Conversation: A Revolutionary Plan for End-of-Life Care*, about how people can empower themselves to get the right medical care at the right time and on their terms.

Workshop topics and presenters

Janet Nuth, MD, CCFP(EM)
Effective advocacy—how to negotiate on behalf of patients professionally and effectively
Dr. Nuth has been recognized as an accomplished educator by a wide spectrum of learners from medical students, residents, medical faculty, and allied health personnel. She currently serves as the physician risk manager, safe medical care at the Canadian Medical Protective Association and continues to practise part-time in the department of emergency medicine at the Ottawa Hospital where she has worked for more than 20 years.

Andrew Clarke, MD, DOHS
How to engage other physicians when you have concerns about their health
Dr. Clarke has been the executive director of the Physician Health Program of BC since 2008. Prior to that he practised occupational medicine for more than 20 years in Toronto, where his research interests focused on the social psychology of the workplace. He is a graduate of UBC's Faculty of Medicine, and is currently completing a master of arts in education at Simon Fraser University focusing his thesis on physicians' understanding and practice of empathy.

Heather Buckley, MD, CCFP
Difficult office conversations? Pushed for time? Strategies and tips
Dr. Buckley has been a leader in the development of communication skills for medical practice for more than 10 years. She has been the faculty development coordinator in the Vancouver Fraser Medical Program at UBC since 2012. In this capacity, she enjoys working with faculty members to further their teaching and assessment abilities.

Sharon Salloum, MD, MEd, CCFP, FCFP
Difficult office conversations? Pushed for time? Strategies and tips
BC physicians who experience difficulties in communication with patients regularly turn to Dr. Salloum for advice and guidance. From 2000 to 2006, she was the course director for Clinical Skills Year 1 in the UBC MD Undergraduate Program and worked to develop a communication skills program for year 1 students. She and her colleagues also worked to include communication skills training across the four years of the MDUP curriculum.

Ailve M. McNestry, MB, CCFP
Respectful refusal when patients demand opioids and/or sedatives
Dr. McNestry has been a deputy registrar at the College of Physicians and Surgeons of BC since 2011. Prior to that, she practised as a family physician and worked as a medical advisor for WorkSafeBC. At the College, she is responsible for the BC Methadone and Prescription Review Programs, and monitoring.

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Use of specialist titles by naturopathic physicians

The College of Physicians and Surgeons of BC has received several expressions of concerns from registrants regarding the use of specialist titles by naturopathic physicians, such a "naturopathic oncologist" or "naturopathic physician specializing in oncology." Discussions with the College of Naturopathic Physicians of BC have confirmed that naturopathic physicians may not hold themselves out to the public as specialists.

As health professionals regulated under the *Health Professions Act*, registrants of the College of Naturopathic Physicians are subject to the same legal requirements as physicians and surgeons, and similar processes exist to review concerns regarding a naturopathic physician's practice or conduct.

Registrants who become aware of any naturopathic physician identifying him/herself as a specialist, or advertising that s/he is a "naturopathic oncologist" may contact the College of Naturopathic Physicians of BC at 604-688-8236 or visit their website at www.cnpbc.bc.ca to learn more about filing a complaint.

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Hospital specialists should normally follow the patients they see in consultation

General internists are often the unsung heroes in a hospital setting. When patients suffer medical complications or exacerbations of pre-existing conditions, it is the medical consultants that other specialists rely on to diagnose and manage complex, potentially life-threatening events, often in challenging circumstances.

The College is concerned by the recent emergence of a pattern of practice in a number of hospitals that puts patients at risk—the apparent inclination of some internists and other specialists (in hospitals with subspecialty departments) to attempt to limit their involvement in the care of in-patients to a single consultative visit. Surgeons, family physicians, ER physicians, GP hospitalists, medical staff leaders and even other internists have contacted the College with disappointing accounts of evolving serious medical conditions and internists declining to cover beyond the day they were on call, directing callers (generally a nurse, primary care physician or surgeon) to check the schedule and summon the specialist designated for that day.

Last year the Inquiry Committee was highly critical of an internist for instructing a nurse to call the surgeon after-hours to assess an evolving coronary syndrome in a post-operative patient that the internist had earlier seen in consultation for the same problem.

More recently a worried surgeon wrote:

> "I think it inappropriate that I am asked to provide primary care for internal medicine problems. I would ask that my colleagues follow internal medicine problems for which they have been consulted until the problem is resolved, or the patient is discharged. I do not think that I should have to find a new consultant for the same problem daily to secure appropriate follow-up for my patient."

The College agrees. The surgeon is paraphrasing article 19 of the CMA *Code of Ethics*:

> "Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship."

The College does not have a professional standard that addresses this issue directly as it is a relatively new problem. Nor does the College have authority to be prescriptive for the unique context of each BC

hospital. Some employ GP hospitalists and/or clinical associates who are expected to function much like internists for many conditions. Some are extensively subspecialized, while others depend on a small group of general internists. Some have surgical special care units, while others rely on a general ward, minimally staffed. In some communities, family physicians provide primary in-patient care.

The historical roots of this problem also vary between medical communities. Combinations of inadequate support from other disciplines, perceived lack of respect, unrealistic expectations for teaching and administrative contributions, flaws in the payment system and, occasionally, deficient performance on the part of another member of the team may have strained collegial relationships.

Whatever its origins, fragmented care is suboptimal care. Patients requiring medical consultations will frequently require a series of reassessments and may need to be seen urgently if they deteriorate. If the original internist expects to be temporarily unavailable, s/he must arrange coverage and document it in the patient's chart. If medical consultants work shifts, a formal system of handover may be required.

This issue won't be solved by individual physicians or departments. It requires collaboration by internists, surgeons, primary care providers and the medical staff leadership to formulate an approach that is effective in their hospital. At this stage, the role of the College is to flag the issue in the expectation that hospital-based physicians will find a solution.

Physicians are individually accountable to their medical staff organization, the College and the civil courts for their conduct and clinical performance. Consultants who see patients once, then decline to follow-up and/or return when asked may anticipate criticism in the event of a College complaint. The College encourages physicians with questions in this regard to consult the CMPA or call the College. While physicians' autonomy is respected, it is limited by ethical, professional, and legal obligations to contribute to a system of care that gives priority to the safety and well-being of patients.

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Refusing to treat a WorkSafeBC patient may be discrimination

Recently, WorkSafeBC has had a number of reports from injured workers, their employers and case management teams that some physicians and clinics are refusing to see injured workers as patients. While there may be some legitimate occasions when a patient presents that are inappropriate for a specific practice setting, almost all of the reports WorkSafeBC follows up on reveal clinics or physicians refusing to see patients on the basis of their status as a WorkSafeBC claimant.

The College's professional standard titled *Access to Medical Care* reminds physicians that refusal to treat patients belonging in less-defined categories than those detailed in the BC Human Rights Code or the CMA's *Code of Ethics* may lead to allegations of discrimination, and may result in complaints to the College, and to the BC Human Rights Tribunal.

Physicians who are having challenges dealing with an injured worker patient should contact one of WorkSafeBC's physician medical advisors toll free at 1-855-476-3049.

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Methadone prescribers must pay attention to patients at risk for methadone toxicity and QT prolongation

DRUG PROGRAMS Update

The College's *Methadone Maintenance Program: Clinical Practice Guideline* notes that physicians prescribing methadone must pay careful attention to patients at risk for methadone toxicity and QT prolongation. There have been reports of torsades de pointes cardiac arrhythmia in patients taking high-dose methadone. While there has been controversy related to screening recommendations for all patients considered for methadone treatment, it is reasonable for patients with risk factors for QT prolongation to be considered for electrocardiogram (ECG):

- Patients who have cardiac disease, who are taking medications that prolong the QT interval or have metabolic concerns known to cause QT prolongation should have an ECG reviewed prior to starting methadone. The ECG should be repeated as clinically indicated.
- In patients with no other risk factors for cardiac arrhythmia, an ECG should be done if the dose of methadone exceeds 150 mg (some guidelines recommend > 120 mg) and repeated when the patients' clinical status changes.
- Using low starting doses, titrating slowly, and careful follow-up are all prudent measures for the methadone prescriber to take.

QT intervals greater than 450 msecs should prompt review of methadone doses for other potential causes including medications that may prolong QT intervals. Physicians should discuss the clinical implications with their patient and consider dose reduction and/or cardiology consultation. Drugs associated with QT prolongation fall across many therapeutic classes, and include anesthetics, antidepressants, antihistamines, antipsychotics, and migraine agents, to name several. The College provides a list of specific medications which physicians should review.

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Problematic prescribing may trigger a review

DRUG PROGRAMS Update

The Prescription Review Program (PRP) manages hundreds of files each year as part of the College's quality assurance activities. As the media and academic community have drawn attention to the severity of the opioid crisis in North America, some registrants have expressed interest in enhancing their understanding of how the College identifies potentially problematic prescribing that might trigger a review.

British Columbia is fortunate to have PharmaNet, a province-wide prescription drug database that allows the College to have a comprehensive view of physicians' prescribing practices. All cases in the PRP begin with a review of a physician's PharmaNet profile. During this initial first step, a medical consultant at the College would consider several factors based on the College's *Prescribing Principles*:

- large dispenses, e.g. dispense sizes of more than 200 pills
- concurrent prescribing of opioids with drugs that have sedative side effects and/or hypnotics
- illogical prescribing of multiple drugs with psychotropic effects
- concurrent prescribing of multiple opioids
- single or multiple prescriptions that indicate high morphine equivalent daily doses
- injectable opioids (when prescribed for chronic, non-cancer pain)
- out-of-date drugs such as meperidine and butalbital

Given the varied nature of physicians' patient populations, practice settings, and other contextual factors, the decision to open a PRP file is always made by a physician and is never based on a single datum. After the initial PharmaNet review, the PRP requests information from the physician to clarify whether the profile reflects circumstances that justify such prescribing (e.g. a number of palliative care patients, in which case the program does not review appropriateness of care except to advise against large, single dispenses of medications) or rather provides an opportunity for learning. In all cases, the PRP is reviewing both the appropriateness of the prescribing to individual patients and also the application of pharamcovigilance principles to protect the public.

For more information about this quality assurance process, contact the Prescription Review Program at 604-733-7758 extension 2629.

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Working towards the provincial goal of 100% hand hygiene compliance

NHMSFP Update

Based upon accreditation findings over the last few years, non-hospital facilities are encouraged to review the following as they continue to work towards the provincial goal of 100% hand hygiene compliance:

- Hand hygiene practices: ensure all staff perform hand hygiene at essential moments, e.g. before initial contact with a patient or items in their environment, before putting on gloves, immediately after removing gloves.
- Hand hygiene products: ensure all hand hygiene sinks are equipped with a liquid soap dispenser and a hands-free paper towel dispenser. Single-use products, e.g. soap, alcohol-based hand rub dispensers are preferred and should be discarded when empty. Refilling hand hygiene products is not permitted.
- Hand hygiene education: ensure all health-care providers receive hand hygiene education training and periodic retraining. Various hand hygiene education modules are available including an online provincial training course, Provincial Hand Hygiene Basics. In addition, hand hygiene posters with instructions regarding when and how to perform hand hygiene are to be posted at each hand hygiene sink including staff, patient and visitor washrooms.

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Understanding an incident analysis in a non-hospital facility

NHMSFP Update

The primary objective of incident analysis and management is to learn from the situation and ensure safer outcomes for future patients. An incident analysis includes a detailed description of the incident, analysis of underlying systems through a series of "how," "why" and "what influenced this" questions in order to determine contributing factors, to formalize recommended actions related to improvements in processes or systems, and to document the findings and recommended actions and follow-through to identify and share learning.

Incident Analysis Collaborating Parties. Canadian incident analysis framework [Internet]. Edmonton: Canadian Patient Safety Institute; 2012. Figure 3.1, Incident analysis as part of the incident management continuum; [cited 2015 Jul 21]; p. 26. Available from: http://www.patientsafetyinstitute.ca/English/toolsResources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework.PDF

After recognizing that an incident has occurred and attending to the safety and well-being of the patient(s) and the provider(s) involved, the next step generally includes reporting so that further steps can be taken to manage the incident. Reporting assists in understanding the next steps, and is also the trigger for a chain of both internal and external notifications.

Effective and timely incident notification results in increased trust of all stakeholders, including the public. Internal notifications include the medical director as well as other individuals such as the attending physician, nurse manager and facility staff. External notification includes the College, as per the Bylaws, as well as other organizations as required by law.

The quality of incident analysis is extremely important for all involved. Medical directors play an integral role in ensuring that an incident analysis is conducted and in closing the loop by submitting a complete Reportable Incident Form to the Non-Hospital Medical and Surgical Facilities Program Committee.

Medical directors may find the Canadian Patient Safety Institute's Incident Analysis Framework to be a useful resource in strengthening their incident analysis and reporting process.

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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.

Updated

- *Ending the Patient-Physician Relationship*
- *Photographic, Video and Audio Recording of Patients*
- *Walk-in, Urgent Care and Multi-physician Clinics*

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CME events: mark your calendars

Annual General Meeting and Education Day
Friday, September 25, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/education-day-agm-2015

Finding medical evidence: supporting patient care – using the Internet to your advantage
Saturday, September 26, 2015 – Vancouver
http://ubccpd.ca/course/FME-Vancouver-Sep-2015

Methadone 101/Hospitalist Workshop
Saturday, October 3, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/methadone-101-hospitalist-2015-10-03

Medical Record Keeping for Physicians
Wednesday, October 7, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/medical-record-keeping-2015-10

Professional Boundaries in the Physician-Patient Relationship
Friday, October 16, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/professional-boundaries-2015-10

Prescribers Course
Friday, November 20, 2015 – Vancouver
https://www.cpsbc.ca/for-physicians/professional-development/prescribers-course-2015-11-20

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A word from the College library

College LIBRARY

Diagnostic information resources: reducing uncertainty

Making timely and accurate diagnoses requires access to relevant and valid information resources. BMJ Best Practice is an online evidence-based resource that summarizes current diagnostic and therapeutic evidence. Organized by condition, each monograph has a "Diagnosis" section with history and examination, tests, differential diagnosis, step-by-step, criteria, diagnostic guidelines, and a case history subsection. Typically, content is briefly introduced with options for drilling deeper into the text as you choose. Another approach to locating diagnostic information in BMJ Best Practice is to select “Show Conditions” and browse over 125 evaluations. These assessments guide clinicians through the evaluation of a symptom or a lab result finding. The differential diagnoses provided are categorized as common or uncommon and alerts are highlighted for urgent considerations. Load the app and have easy access on the go to about 1,000 topics.

The number and complexity of diagnostic laboratory tests is rapidly expanding, e.g. Life Labs currently provides at least 1,000 laboratory tests according to its listing at http://tests.lifelabs.com/. The College library offers online support for accurately and efficiently interpreting diagnostic tests. For example, the following atlases, physical diagnosis guides, and clinical chemistry ebooks can be viewed online in the ClinicalKey collection:

- *Atlas of Pediatric Physical Diagnosis*
- *Churchill's Pocketbook of Differential Diagnosis*
- *Clinical Dermatology: A Color Guide to Diagnosis and Therapy*
- *Clinical Diagnosis in Ophthalmology*
- *Diagnostic Atlas of Gastroesophageal Reflux Disease*
- *Diagnostic Atlas of Melanocytic Pathology*
- *Diagnostic Atlas of Renal Pathology*
- *Differential Diagnosis of Common Complaints*
- *Evidence-based Physical Diagnosis*
- *Ferri's Best Test: A Practical Guide to Laboratory Medicine and Diagnostic Imaging*
- *Ferri's Differential Diagnosis*
- *Henry's Clinical Diagnosis and Management by Laboratory Methods*
- *Laboratory Tests and Diagnostic Procedures*
- *Making the Diagnosis*
- *Physical Diagnosis of Pain*
- *Physical Diagnosis Secrets*
- *Textbook of Physical Diagnosis*
- *Tietz Textbook of Clinical Chemistry and Molecular Diagnostics*

ClinicalKey offers over 1,000 ebooks, including the above, and is a starting point for a deeper search of Medline and the journal literature. It also includes the point-of-care resource, First Consult, which can be viewed online within ClinicalKey and is also an app (downloading instructions here).

These are just a few of the clinical decision support tools provided to registrants through the College library and quick access to laboratory consultations. For more, browse the library's website or contact staff at 604-733-6671 or medlib@cpsbc.ca.

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Regulatory actions

- Regulators' investigation into prescription fraud identifies 150 health professionals
- Kinahan, John Francis Joseph David – July 22, 2015

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