



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice



## In this issue:

Registrar's message—safe prescribing: where are we now? .....	3
Twenty-first century challenges: informing medical practice in an era of increasing complexity and rising expectations.....	5
Important change in prescription drug coverage coming for FNHA clients—new PharmaCare program .....	6
A “palliative pause”—end-of-life crises deserve priority in the ER or clinic .....	7
Updated expectations of supervisors of registrants in the provisional class.....	9
A snapshot of the Prescription Review Program.....	10
The program is seeking a part-time consultant medical advisor .....	12
Common examples of reprocessing practices that do not meet acceptable standards.....	13
New updated guidelines.....	15
Safety incident: sharing learning.....	16
iStent—a micro-invasive treatment for open-angle glaucoma .....	17
New DAP section published on the College website.....	18
Laboratory medicine—regional assessments: from an idea to reality .....	19
Guidelines: summarized evidence, optimized practice.....	20
CPD events: mark your calendars.....	21
Regulatory actions.....	22

---

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](mailto:communications@cpsbc.ca).

---



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## Registrar's message—safe prescribing: where are we now?



*Safe Prescribing of Drugs with Potential for Misuse/Diversion* was a reframing of its predecessor—then a professional guidance document called Prescribing Principles, which was developed in 2012 based on the expert advice of members of the Prescription Review Committee. It outlined precautions specifically related to prescribing opiates.

The publication of the revised standard was timely as BC and other jurisdictions in Canada were in the midst of dealing with an escalating public health crisis related to prescription drug misuse, and the criminal importation of illicitly manufactured opioids such as fentanyl and carfentanyl. It was elevated to a standard at that time to emphasize the profession's collective responsibility to prescribe safely and be aware of abuse risk.

### ***One year later – what has changed?***

In response to the crisis of overdose deaths, Canada's minister of health, the Honourable Jane Philpott, together with the provinces, territories and other partners, initiated the [Joint Statement of Action to Address the Opioid Crisis](#), which outlines specific commitments from 30 partners to act on this crisis, including the College of Physicians and Surgeons of BC and other regulators.

In a letter to the provincial ministers of health, Minister Philpott specifically called on the provincial and territorial medical regulators to consider endorsing the updated [2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain](#) and to develop enforceable standards for physicians to support appropriate prescribing. This College was pleased to report that it had already adopted a standards-based approach to safe prescribing.

There has been a lot of broad public commentary about why North Americans, who have the highest standards of living and greatest access to health care in the world, have become the highest consumers of prescription opioids. There has also been discussion about the role of pharmaceutical company marketing in the making of this epidemic, and physicians in Canada and the US are appropriately examining these relationships.

Physicians who are engaged in the College's Prescription Review Program gain a better understanding of why there is a need to continue to remediate prescribing. Physicians continue to call the College for advice, often realizing that that they need support and guidance. The Prescription Review Program staff and medical consultants hired by the program spend a lot of time speaking to individual physicians about the difficulties of treating legacy patients (those who were started on prescriptions of long-term opioids often at very high doses, and various sedatives many years ago and are reluctant to stop).

The College continues to stress that the practice standard is about safe prescribing. There are and will be patients who benefit from opioid therapy for chronic pain. The abrupt discontinuation of long-term

opioids and benzodiazepines is both inappropriate and potentially dangerous. Patients need to know of the potential harms related to prescription opioids, and take-home doses of Naloxone should be considered for patients receiving opioid therapy. Patients who are addicted need to be directed to substitute opioid therapy such as methadone or buprenorphine.

The College is looking forward to meeting and working with the new minister of health and the minister of mental health and addiction to address the current opioid overdose problem, and will be seeking their support to develop and implement a provincial prescription monitoring program to maximize the reporting potential of the existing PharmaNet database, and support regulatory follow-up related to prescribing. Evidence from the United States supports that better regulation of prescribing reduces drug overdose deaths.<sup>1</sup> Future regulatory activities will eventually include the requirement for all physicians in primary care to have PharmaNet access in their medical offices and not just in walk-in clinics and methadone clinics, which is the current requirement. To operationalize this, the College will also encourage improvements to the existing PharmaNet platform to make point-of-care access easier and more functional for busy clinicians.

H.M. Oetter, MD  
Registrar and CEO

1. [Centers for Disease Control and Prevention – State Successes](#)

[Back to table of contents »](#)



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## Twenty-first century challenges: informing medical practice in an era of increasing complexity and rising expectations

2017 **SEPT 29**  
Education  
Day + AGM

#InforMed2017

Register now for the much-anticipated College Education Day, held again this year at the Vancouver Convention Centre. With guidance and insight from experienced, engaging experts, this year's program will provide an opportunity for deep reflection on some major challenges, which are often brought to the College.

### ***Avoiding diagnostic error by understanding how physicians think***

The College is pleased to welcome Dr. Patrick Croskerry from Dalhousie University as its morning plenary presenter to address his work in understanding how physicians think in order to avoid diagnostic errors.

### ***The story of life, end of life and dignity – medical assistance in dying, a Quebec perspective***

The first afternoon plenary presenter is Dr. Alain Naud from Université Laval, who will discuss his experiences in medical assistance in dying from a Quebec perspective.

### ***The opioid crisis – a deeper understanding between exam rooms and ivory towers***

The final afternoon plenary presenter is Dr. Hakique Virani from the University of Alberta who will address the opioid crisis from public health and clinical perspectives.

To learn more about the plenary and workshop topics and presenters, click [here](#).

To view the event program, click [here](#).

To download the registration form, click [here](#).

### **CPD CREDITS**

Up to 5.0 Section 1 credits (Maintenance of Certification)  
Royal College of Physicians and Surgeons of Canada

Up to 5.0 Mainpro+ credits  
College of Family Physicians of Canada

[Back to table of contents »](#)



## College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

### Important change in prescription drug coverage coming for FNHA clients—new PharmaCare program



First Nations Health Authority (FNHA) and BC PharmaCare are working together to ensure the smoothest possible transition to the new PharmaCare plan from Health Canada's current Non-Insurance Health Benefits (NIHB) program.

The vast majority of FNHA clients will be enrolled in PharmaCare "Plan W" prior to the transition. Special authorities for clients with existing treatments will be in place prior to the transition, which also includes clients taking drugs on the reference drug program.

Although most FNHA clients will continue to be eligible for the medications they need, a small percentage of clients will have to adjust drug therapies as they switch to the PharmaCare formulary. Information about which drugs are affected is posted at [FNHA.ca/benefits](http://FNHA.ca/benefits).

With this change, physicians should be aware of the following considerations for FNHA clients:

1. Select over-the-counter drugs, and medical supplies and equipment are currently provided through NIHB, and will continue until further notice.
2. PharmaCare cannot pay for prescriptions outside of the province. FNHA clients are strongly encouraged to plan ahead if travelling out of province beyond October 1, 2017, and to fill prescriptions at a pharmacy in BC in advance.

Detailed information on these changes and how they affect physicians and their patients will be communicated closer to the October 1, 2017 transition date and posted on the FNHA website at [FNHA.ca/benefits](http://FNHA.ca/benefits).

Questions can be directed to FNHA at 1-855-550-5454 or via email at [HealthBenefits@fnha.ca](mailto:HealthBenefits@fnha.ca).

[Back to table of contents »](#)



## College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

### A “palliative pause”—end-of-life crises deserve priority in the ER or clinic

#### Inquiry Committee CASES

A The Inquiry Committee recently concluded an investigation of a profoundly sad complaint alleging over-treatment of a terminally ill young adult, contrary to her expressed wishes, in the emergency department and palliative care ward of a major BC hospital. With the dedication of her parents and expertise of community and BC Cancer Agency palliative care teams, the patient had received exemplary care at home, focused on aggressive symptom management and informed by constant consultation with patient and family. Unfortunately, near the very end of her life, the patient suffered a significant fall. A fractured femur was suspected and an ambulance was called.

In their complaint submissions, the bereaved parents poignantly described a jarring cultural shift at the emergency room door. At home, every intervention was carefully considered and administered only with the explicit consent of the patient. At the hospital, assessments felt algorithmic and rushed, and tests and interventions (blood work, ECG, catheterization and IV resuscitation) were administered seemingly without adequately considering the wishes of the patient, who died on the second day in hospital.

The physicians responded to the complaint by describing the palliative intent of their interventions and impressions formed at the time that the care was accepted and appreciated. There was reportedly no overt objection or resistance from patient or family and, from a medical perspective, the care was considered supportive.

With the benefit of hindsight, it would have been better for all concerned if the otherwise-superb community palliative care in this instance had included a well-documented crisis plan, with advance direction from the patient, and telephone availability of a nurse or physician familiar with the circumstances. However, advance planning can never anticipate every eventuality. Patients at the end of their lives and their families are owed a supportive, unhurried consent process at every stage, even in a crisis.

Based on its careful review, the Inquiry Committee concluded that the actions of the physicians were reasonable, given the limited supports available to them at the time. At that point, the committee considered observations offered by a member of the Health Professions Review Board (HPRB) in her review of this case. Noting that “the complainants’ determination to affect change and the deep disappointment that their daughter’s request for end of life care was not realized,” she suggested that College standards for all physicians for palliative care patients could prevent events like these.

The committee was doubtful that a standard was the best tool. Rather, if surgical and baby pauses improve patient safety, a similar approach could be applied when palliative crises present to ERs, GPs’ offices or walk-in clinics to improve the quality of communication, consent, and care for vulnerable

patients and their families. The Inquiry Committee recommended that ER, primary care and palliative care providers consider collaborating on the development of protocols and checklists to operationalize a “palliative pause” or “code palliative,” where routines are set aside and a designated team member sits down with the patient and family to make sure everyone involved in the care of that patient knows exactly what is wanted. Standard documentation, including facilitated contact with community caregivers would be part of the process. It need not tie up a lot of resources. It would simply mean that, like hemorrhagic shock, chest pain, and respiratory distress, a system is in place to ensure that such patients receive prompt and consistent attention.

The College does not have the authority to direct or be prescriptive about improvements to the system of care. It does have an obligation to be supportive. Physicians who have a leadership role in emergency, primary, or palliative care are invited to contact the College to discuss this issue with a member of the registrar staff.

[\*Back to table of contents »\*](#)



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## Updated expectations of supervisors of registrants in the provisional class



The College has updated the [Expectations of Supervisors for Registrants in the Provisional Class](#) document to ensure greater support is provided to provisional registrants in meeting their mandated registration and licensure requirements. Key changes include the following:

- The supervisor must provide quarterly feedback (written or verbal) to the provisional registrant on performance and allow an opportunity for a response.
- In collaboration with the sponsor, the supervisor is expected to assist the provisional registrant in meeting continuing registration and licensure requirements.
- The supervisor and sponsor will be provided a copy of the registration and licensure requirements of the provisional registrant.
- The supervisor must inform the sponsor and the College when they cease to supervise a provisional registrant, prior to the conclusion of the supervision.
- The College reserves the right to share the supervisor report with the provisional registrant and the sponsor.
- The inclusion of supervisor eligibility guidelines – note these guidelines have not changed, but have been included in the Expectations of Supervisors for Registrants in the Provisional Class document for clarity.

These changes will be in effect for new registrants to the provisional class only; they will not be applied retrospectively.

Sections 2-14 to 2-17 of the [College Bylaws](#) detail the registration and licensure requirements for provisional registration.

[Back to table of contents »](#)



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## A snapshot of the Prescription Review Program

### DRUG PROGRAMS Update

Referrals come to the Prescription Review Program (PRP) from a variety of sources: public, patients, other health-care professionals, other College departments, or other organizations. When a referral is received, program staff reviews prescribing patterns over the previous three months. The intention is to confirm that prescribing is safe and in alignment with current national guidelines and the College's standard. Particular attention is paid to instances of co-prescribing opioids and benzodiazepines – especially multiple opioids and multiple sedatives, and of large dispenses (>250 units).

Consideration is made for scope of practice, notably palliative medicine and addiction medicine. PharmaNet profiles cannot provide clinical context.

A current snapshot of activity in the PRP:

- There are roughly 12,000 professionally active physicians in BC.
- In 2017, the program has received 236 referrals. Of those referrals, only 90 were accepted for enrolment. Of the 146 that were not accepted, only four received a message from the College advising of instances that did not align with safe prescribing.
- There are 287 files open in PRP (there are usually 250 to 300 files open at any given time), with 194 in early stages.

The [PRP process](#) was revamped in 2017 to provide enrolled physicians more opportunity in the early stages to provide clinical context, and time to institute changes that reflect safer prescribing practices. It is expected that the new process will allow the PRP to open fewer files, and to close files more quickly.

### More resources from the Prescription Review Program

Registrants looking for tools to manage their patients on controlled medications are encouraged to visit the [Prescription Review Program](#) section of the College website.

One of the features is a selection of clinical papers, the [Recommended Resources from the Drug Programs](#). This list is updated quarterly and registrants can contact the College library to receive any of these articles, free of charge.

Last year, the program added a section for patient information on the College website, which answers questions most commonly asked by patients and provides them with resources. This year, a Safe Prescribing Tool Kit, a checklist of things to consider when prescribing opioids, sedative/hypnotics, and stimulants, and tapering tools were added.

Feedback and suggestions can be provided at [drugprograms@cpsbc.ca](mailto:drugprograms@cpsbc.ca).

[\*Back to table of contents »\*](#)



## College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

### The program is seeking a part-time consultant medical advisor

PPEP  
Update

Under the direction of the deputy registrar, quality programs, the medical advisor carries out the mandate of the Physician Practice Enhancement Program, to provide external evaluation and promote quality improvement in community-based physicians' medical practice in accordance with the *Health Professions Act* and Bylaws.

Working in a collaborative team environment, the medical advisor functions as an expert in the review of program files to highlight areas of excellence and identify opportunities to guide professional development and lifelong learning.

Exceptional interpersonal and oral communication skills are required. Previous experience in evaluating clinical performance and developing continuous improvement plans would be advantageous. The College is seeking efficient, responsive physicians who thrive in a high-volume environment, while maintaining demanding quality and timeliness standards. The candidate must work collegially and interact effectively with College staff.

All applications for this position must be submitted [online](#) by the close of business on September 29, 2017.

All correspondence will be held in strict confidence.

[Back to table of contents »](#)



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## Common examples of reprocessing practices that do not meet acceptable standards

### POMDRA Update

The following are some common examples of reprocessing practices, which do not meet provincial and national standards, or the manufacturer's instructions.

1. **Gauze and other woven fabrics are being sterilized by steam in a tabletop steam sterilizer (autoclave).**

A common practice amongst physicians is to purchase bulk unsterile gauze packages and include one or two as part of the wrapped procedure kit, which is then steam sterilized in its entirety. Gauze is not validated by the manufacturer for steam sterilization and cannot be successfully sterilized in a tabletop steam sterilizer.

Appropriate practice: Physician offices must obtain individually packaged sterile gauze that has been sterilized by the manufacturer. **Note:** Manufacturer uses radiation or gas sterilization, not steam, to render the gauze sterile.

2. **Reusable metal ear syringes are being reprocessed by soaking in a chemical solution.**

Metal ear syringes are commonly used in the community-based physician office. Instances have been identified where physician offices are reprocessing their reusable metal ear syringes in a chemical soaking solution.

Appropriate practice: All reusable semi-critical medical devices such as metal ear syringes that are validated for steam sterilization must be steam sterilized. Metal ear syringes cannot be reprocessed in a chemical soaking solution and therefore must be steam sterilized. Disposable ear syringe systems are also available as an alternative.

3. **Reusable nail clippers are not being sterilized between patient uses.**

Reusable nail clippers have the potential to penetrate skin when used on a patient and therefore are considered critical reusable medical devices. Best practice, including direction from the Provincial Infection Control Network of British Columbia (PICNet) document entitled *Reprocessing of Equipment and Instruments Used in the Provision of Foot Care* (March

2015), directs that foot care equipment such as reusable nail clippers and other nail care devices remain sterile until point of use.

Appropriate practice: Nail clippers and other nail care devices must be packaged appropriately for steam sterilization and remain in their package, intact, until time of use.

[Back to table of contents »](#)



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## New updated guidelines

NHMSFP  
Update

The NHMSFP Committee is pleased to announce the updated Obesity guideline and a new ASA Physical Status Classification guideline.

A guideline reflects a recommended course of action established based on the values, principles and duties of the medical profession. Physicians may exercise reasonable discretion in their decision-making based on the guidance provided.

Guidelines and other NHMSFP accreditation standards are available [here](#).

[Back to table of contents »](#)



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## Safety incident: sharing learning

### NHMSFP Update

The Non-Hospital Medical and Surgical Facilities Program Patient Safety Incident Review Panel recently reviewed an incident of pneumothorax following fine wire localized partial mastectomy and sentinel lymph node biopsy. In the post-anesthesia care unit, the patient had persistent issues with low oxygen saturations and ongoing chest pain.

Contributing factors to this incident included not documenting a respiratory exam, which raises concerns that: one was not performed and that the persistence of chest pain and decreased oxygen saturation did not trigger further assessment and follow-up investigation; and that it was assumed the pain was incisional without considering alternative causes.

Following its review of this patient safety incident, the panel recommended that:

- pneumothorax should be considered as a differential diagnosis when the post-operative stay, following use of fine wire guidance in the chest area, is complicated by chest pain and oxygen desaturation
- education should be provided to staff regarding this possible complication with a reminder of the importance of continuous assessment and examination with proper documentation

This information and recommendations are being shared with all facilities in the spirit of learning and improving patient safety. Medical directors are encouraged to discuss this article with their clinical teams.

[Back to table of contents »](#)



## College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

### iStent—a micro-invasive treatment for open-angle glaucoma

#### NHMSFP Update

In recent years the NHMSFP Committee has received physician requests for approval to use the iStent device for the surgical treatment of open-angle glaucoma.

After review of the literature regarding the efficacy and safety related to the use of the iStent device, and recognizing its use within hospitals in health authorities, the NHMSFP Committee has approved the use of iStent in the non-hospital setting with several provisos including:

- iStent may only be performed as an add-on procedure with cataract surgery
- iStent as a stand-alone procedure is not approved
- iStent is the only minimally invasive glaucoma surgery (MIGS) device approved for the non-hospital setting
- Other MIGS devices, including second generation iStent Inject, are not approved for the non-hospital setting

Registrants wanting non-hospital privileges to perform implantation of iStent should contact the NHMSFP for guidance with the application process.

[Back to table of contents »](#)



## College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

### New DAP section published on the College website



DAP  
Update

The DAP's now former website ([www.dap.org](http://www.dap.org)) has been disabled and all relevant content has been migrated to the College website. The transition also includes an improved navigation and a refresh of DAP documents to enhance user experience.

Find information about the DAP and access DAP web accounts (if applicable) by visiting [www.cpsbc.ca/programs/dap](http://www.cpsbc.ca/programs/dap).

[Back to table of contents »](#)



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## Laboratory medicine—regional assessments: from an idea to reality

DAP  
Update

### Why conduct regional assessments?

What are regional assessments? Traditionally, the Diagnostic Accreditation Program has assessed facilities individually. However, many individual facilities form part of a larger group (e.g. laboratories in the same health authority) where certain processes, policies, and procedures are managed at a regional level. Rather than assess each facility individually, a regional assessment assesses them once at the regional level. There are many reasons

to conduct regional assessments:

- reduce duplication that comes from having every facility in a group completing the same DAP documentation
- reduce the amount of time facility staff spends in completing an on-site facility assessment
- improve the quality of the accreditation by assessing all the laboratory medicine 2015 accreditation standards with the appropriate organization's staff and at the appropriate place
- improve DAP stakeholder satisfaction with the program—stakeholders asked the DAP to review the assessment process to find areas where it could be improved; the DAP agreed, and moving to regional assessments is one way to make its processes better

### How have regional assessments been rolled out?

The regional assessment project began in 2015. The DAP started by using the laboratory medicine 2015 standards to determine which standards would apply to regional systems in health authorities and private laboratories. This was followed by the development of the regional evidence document, communication to stakeholders, and beta testing of the regional assessment process.

### What's next?

As the DAP rolls out the regional assessment model, it will continue to work with stakeholders to design a well-functioning process. Stakeholders can provide feedback to the DAP at [laboratorymedicine@cpsbc.ca](mailto:laboratorymedicine@cpsbc.ca).

[Back to table of contents »](#)



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## Guidelines: summarized evidence, optimized practice

### College LIBRARY

Clinical practice guidelines endeavour to synthesize the highest quality evidence available to recommend best practices that will achieve optimal patient outcomes. Locating guidelines differs from finding typical journal articles because guidelines are not always published in journals, thus they are not necessarily indexed in databases such as Medline. Instead they may form part of the “grey literature” – non-indexed materials stored on websites or printed as ad hoc documents. Guideline databases are time savers because they pull together guidelines from disparate grey literature sources.

The following are excellent sources of guidelines and are listed on the [practice guidelines page](#) on the College website:

- Local sources: [BC Guidelines](#), [BC Cancer Agency Cancer Management Guidelines](#)
- Canadian guidelines: [CMA CPG Infobase](#). These guidelines are created by Canadian associations, societies, government bodies, etc. (not individual people). Each is created or revised in the last five years.
- American and international guidelines: [National Guideline Clearinghouse](#). An inclusion criteria set provides a minimum quality standard for listed guidelines.

High-quality guidelines provide explicit statements on levels of evidence that support guideline recommendations. Readers should note whether the strength of recommendations accounts for the validity of evidence (i.e. low quality anecdotal reports or high quality systematic reviews, randomized controlled trials or cohort studies). Other factors influence the direction and strength of recommendations such as balance of harm and benefit, feasibility, and value to stakeholders, including patients. As a quality indicator, look for statements where internationally recognized tools such as [Grading of Recommendations Assessment, Development and Evaluation \(GRADE\)](#) were used in developing guidelines’ recommendations.

[Back to table of contents »](#)



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## CPD events: mark your calendars



### **Finding Medical Evidence – Computer Workshop**

Friday, September 22, 2017 – Comox

[Learn more](#)

### **Education Day and Annual General Meeting 2017**

Friday, September 29, 2017 – Vancouver

[Learn more](#)

### **Finding Medical Evidence – Computer Workshop**

Friday, September 30, 2017 – Vancouver

[Learn more](#)

### **Professionalism in Medical Practice: Avoiding the Pitfalls**

Friday, November 3, 2017 to Saturday, November 4, 2017 – Vancouver

[Learn more](#)

[Back to table of contents »](#)



# College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

## Regulatory actions

- [Milne, Stephen Michael – July 25, 2017](#)
- [Fuller, John Arnold – July 26, 2017](#)

[Back to table of contents »](#)