College of Physicians and Surgeons of British Columbia

Serving the public through excellence and professionalism in medical practice

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—registrants who are not current for clinical practice may not bill, refer or prescribe

As of November 1, 2017, registrants who indicate that they have undertaken fewer than eight weeks (320 hours) of clinical practice per year or 960 hours in the preceding three years will be flagged as ***not current for clinical practice*** in the College's registration database, pursuant to section 2-8 of the Bylaws made under the *Health Professions Act*. Physicians considered to have currency issues that warrant this flag will receive prior written notification via standard mail. The letter will inform relevant registrants that once the flag is added, they will be unable to prescribe medications or bill the Medical Services Plan (MSP).

This internal flag is one of a number of improvements being implemented by the College to ensure that registrants are qualified, competent and fit to practise medicine within their scope, and according to legislated requirements. While this information will not be displayed to the public via the online physician directory, it will be shared with relevant government agencies, including PharmaNet and MSP. It may also be indicated on certificates of professional conduct issued by the College to provide other organizations, including medical regulatory authorities and health authorities, with more accurate information on former or current registrants.

Registrants identified by the College as not current for clinical practice may be able to regain currency through an individualized plan, which may require the completion of a period of formal assessment of skill, knowledge, and competency as determined by the registrar.

FAQs on clinical currency can be found on the College website here.

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2017 Education Day and Annual General Meeting

Thank you to all who attended this year's Education Day. Please be sure to complete the online evaluation form to share your thoughts and help us plan for next year.

Presentations are provided based on availability and can be found here. This year, the College is pleased to offer a video recording of all three plenary sessions.

- Avoiding diagnostic error by understanding how physicians think Dr. Patrick Croskerry
- The story of life, end of life and dignity – medical assistance in dying (MAiD), a Quebec perspective Dr. Alain Naud
- The opioid crisis – a deeper understanding between exam rooms and ivory towers Dr. Hakique Virani

Agenda and resolutions for the 2017 AGM

Audited financial statements for the 2016/17 fiscal year

Mark your calendars: next year's Education Day will take place on Friday, September 14, 2018.

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Consultation results on the guideline: Expectations of the Relationship between the Primary Care/Consulting Physician and Consultant Physician

Professional Standards & Guidelines

Following is an overview of the feedback received from the profession:

- 944 submissions were received in response to the consultation: 512 from general practitioners and 432 from specialists

- 98% of respondents (both GPs and specialists) agreed that the expectations of the referring physician and the duties of the consultant are clearly stated in the current guideline; however, both GPs and specialists felt that these expectations and duties are not being followed consistently by their colleagues in practice

Common themes from the open-ended survey comments:

- **Referral letter/request completion/written reports following consultation:** Referral letters should contain relevant information about the patient's condition with explicit detail about why the patient is being referred, and similarly, the written report to the referring physician should be clear in terms of diagnostic/therapeutic interventions, and proposed next steps

- **Repeat/retrospective referral:** If a consultant arranges a follow-up appointment with a patient, a re-referral for the same patient and problem should not be necessary

- **"Shot-gun" referrals:** Referral requests are sometimes sent to multiple physicians in the hopes of avoiding wait-times; respondents agreed that this practice is counterproductive and should be avoided.

- **Refusal of referrals:** Respondents felt there should be clarity on when it is appropriate to reject a referral request (e.g. referral should have been sent to another specialist with a defined scope of practice or expertise).

- **Process for urgent consultation:** Verbal communication should be required and accommodated in urgent situations rather than a written referral.

- **Acknowledgement of referral:** Good practice suggests that consultants should acknowledge receipt of a referral.

- **Communication re: wait times:** Consultants should provide estimated wait times to the referring physician in order for the referring physicians to assess whether or not to refer to another specialist.

- **Responsibilities re: continuity of care:** Referring physicians, consultants and the patient must be clear on who is responsible for the provision of ongoing care to the patient following a consultant visit.

Many comments were provided regarding systemic issues, such as long wait times, and hospital admission practices. These issues are outside of the College's scope and regulatory mandate, and will not be included in the revised guideline.

During this first round of consultation, the College also sought input from patients who are directly involved in and affected by the referral process. Through the Patient Relations, Professional Standards and Ethics Committee, the College will develop a revised draft of the guideline, which will be circulated to the profession for review and discussion in the New Year. Thank you to all physicians who participated in this process.

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Physicians must not delay or impede access to medical assistance in dying

At the request of the provincial health authorities' medical assistance in dying (MAiD) care coordination services, the College is reminding registrants that while they have the right to decide whether or not to perform or be involved in MAiD in any capacity, patients have the right to make decisions about their autonomy, and to have access to unbiased, timely and accurate information about relevant and available treatment and services.

Registrants who choose not to be involved in MAiD should direct patients to health authority care coordinators who can arrange for assessments from other registrants with experience. Similarly, completed patient request forms must be transferred in a timely manner to the appropriate care coordinator. Physicians must not delay or impede access to patients seeking additional information about MAiD, or to care coordinators attempting to assist patients. Intentional delays in responding to or releasing information about a patient to care coordinators may be deemed unprofessional in the event of a complaint.

Health authority MAiD care coordination services support patients and physicians:

Fraser Health – MAiD information site
mccc@fraserhealth.ca
1-604-587-7878

Interior Health – MAiD information site
Online form
1-877-442-2001

Island Health – MAiD information site
maid@viha.ca
1-877-370-8699

Northern Health – MAiD information site
maid@northernhealth.ca
1-250-645-6417

Provincial Health Services Authority – MAiD information site
1-888-875-3256

Vancouver Coastal Health – MAiD information site
assisteddying@vch.ca
1-844-550-555

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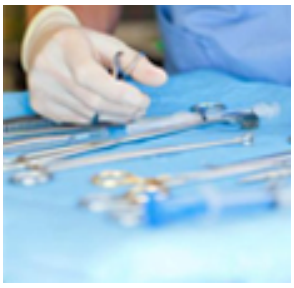
Preventing transmission of blood-borne infections



The The College recognizes that the treatment for blood-borne agents has undergone a revolution as a result of modern antivirals and vaccination for HBV.

For example:

- HIV replication can be completely controlled, leading to undetectable viral loads, and this has been shown to prevent blood-borne HIV transmission as well as sexual transmission.
- Similarly, for HBV, antiviral therapy can control HBV replication and thereby prevent HBV transmission from blood and body fluids. In addition, the general population is now increasingly being vaccinated against HBV, and therefore protected from becoming chronically infected even if exposed.
- For HCV, antiviral treatments can now cure >95% of those infected. Once cured, unless there are ongoing reinfection risk factors, the person will no longer be able to transmit this blood-borne infection.

Transmission of blood-borne infections from physicians is rare and largely occurs during exposure prone procedures (EPPs) where the infected physician has sustained an injury that exposes the patient to their blood.

Reference: SHEA guidelines Table 2, Category III

Prior to 2016, the College required all registrants to disclose if they had been infected with a blood-borne pathogen. Now the College only requires registrants to disclose if they perform or assist in performing EPPs.

Undergraduate medical trainees are considered to be performing EPPs during their undergraduate training. They are also considered to be performing EPPs in their first postgraduate year and throughout residency depending on their specialty.

The current standard, *Blood-borne Pathogens in Registrants*, mandates that all registrants (including trainees) who perform or assist in performing EPPs and who do not have a blood-borne infection must be tested for BBPs at three year intervals.

Registrants who are shown to be infected with one of more of the agents will be allowed to continue performing EPPs if their viral loads are either undetectable (HIV), cured of HCV or have HBV viral loads that are sufficiently low as to pose a negligible risk during EPPs. Registrants' health information is de-identified prior to being reviewed by the Blood Borne Communicable Diseases Committee expert panel.

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Still asking patients for the old CareCard/GoldCard?

Since February 2013, British Columbia has been replacing current CareCards with the BC Services Card. CareCards and GoldCards can still be used to access health services until March 2018, at which point the old CareCard will be officially retired, and it will no longer be recognized by the provincial government as valid identification. The Medical Services Plan website has uploaded a small BC Services Card sign that physicians can download and post in their lobby or reception areas reminding patients to present a BC Services Card (instead of the old CareCard).

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Protect prescription pads—they're valuable!

Whether prescription pads are used or unused, registrants are advised to store pads in a secure (preferably locked) location away from public access. When travelling with a prescription pad, registrants should keep the pad on their person at all times, and never in a vehicle. **Note:** The blue carbon copy of the prescription contains sensitive patient information and must be retained separately as part of the patient record for 16 years. Registrants with electronic medical records should consider scanning and attaching the image of the prescription to the electronic medical record, then shredding the original paper version. Registrants who are using paper charts should attach the physical blue copy to the paper chart.

More information on lost, stolen or forged prescription pads can be found on the College website here.

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Recognizing and addressing "red-flag" behaviour

DRUG PROGRAMS Update

MH is a 49-year-old male with complex regional pain syndrome, moderate hypertension, and family history of atrial fibrillation. Current daily medications include: 27 mg hydromorphone immediate-release (IR) (135 mg morphine equivalent), 900 mg gabapentin and 5 mg bisoprolol. A treatment agreement between MH and his physician was signed at the start of their professional relationship.

In January, MH falls and presents to the ER where his urine drug test (UDT) is positive for cocaine. MH admits to peer-pressured drinking. By February he states that he is clean and sober. On five separate occasions throughout the year, MH requests early medication refills through the pharmacy, citing various reasons: vacation supply; his partner left and stole them; the cat knocked them (narcotics only) down the sink.

Despite a report from another health professional that MH smells of alcohol, the physician allows the refills without any reference to the treatment agreement. In April, MH's UDT tests positive for benzodiazepines, which he admits to borrowing from a friend. In August, he presents with nasal lesions, which should have triggered suspicion of continued stimulant misuse. In September, MH's physician suggests methadone to treat his pain, but MH refuses, citing stigma. The physician does not bring it up again.

Red flags and possible strategies:

- Check PharmaNet at every visit. Employ random pill counts to see if quantity and dispense dates align. Address the pattern of early refills and reasons given. Question if only certain medications are requested. Normalizing the situation by noting "it's only a few days early," or not addressing the issue immediately, inadvertently gives the patient permission to continue the behaviour.

- Holding patients accountable for their choice to break the treatment agreement helps them understand the consequences. Question and document the reasons given—could they indicate confusion, an acute pain event, or addiction? Re-obtain a patient's commitment to honour the agreement and remind him/her that continuing to break it may result in ending the physician-patient relationship. Send a copy of the agreement to the pharmacy they usually use.

- Document discussions about "borrowing" other people's medications, avoidance of alcohol, risks of combining opioids and sedatives and stimulants, risks of falls and potential for overdose. Advise patients of side effects from illicit drug use, especially given personal and family history.

- If the first UDT is abnormal, discuss with the patient and be clear that further inappropriate test results will lead to changes in treatment plans, including tighter dispensing restrictions, no early

refills, addictions referral and medication tapering or discontinuation. If two UDT are abnormal, increase frequency of random UDT.

- Remind patients that their health and safety is your primary concern. If prescribing is to continue, perform periodic clinical reassessment of the patient's conditions, and risks versus benefits of psychoactive medications. Make patients aware of all possible non-pharmacologic and pharmacologic options. Assess the patient for substance use disorder, alcohol use disorder, and mental health disorders regularly, as life situations may trigger changes in status. Engage addiction services and treatment where necessary.

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Useful guidance on medical device reprocessing in community-based practice

POMDRA Update

The following are common questions from physicians with guidance on addressing the concerns.

How do community-based physicians know if the tabletop steam sterilizer they are currently using, or are considering purchasing, is both approved for use in Canada, and appropriate for use in an office-based setting?

Physicians should be aware that there are three key requirements that the sterilizer must have:

1. Health Canada approval and classification: Any sterilizer sold in Canada **must** be approved and classified by Health Canada otherwise it cannot be used in Canada. To be sure,
    - ask the medical supplier to verify that the sterilizer is validated by Health Canada, or
    - if the sterilizer is used and/or purchased online, enter the sterilizer make and model in the Government of Canada's Medical Devices Active Licence Listing.
2. Canadian Standard Association (CSA) electrical safety inspection sticker: Any sterilizer sold in Canada must pass the CSA electrical safety requirements.
    - Look for CSA or Underwriters' Laboratories (UL) electrical safety inspection sticker on the sterilizer.
3. Manufacturer's instructions indicate that sterilizer can reprocess packaged and lumened/cannulated medical devices. The sterilizer **must** be able to sterilize packaged medical devices. A reusable medical device that is sterilized in sterilization packaging enables sterility to be maintained until point of use.
    - Verify the manufacturer's instructions for use (MIFU) of the sterilizer to confirm that it can sterilize packaged and lumened/cannulated devices.

Physicians should be wary of purchasing a sterilizer online or second-hand as the same requirements described above would apply. One example of a sterilizer that does not meet all three requirements described above is a sterilizer called the Prestige Classic 210006. Upon review, the Prestige Classic 210006 does have a valid Health Canada licence; however, based on its MIFU, this sterilizer is unable to sterilize packaged devices. Packaging materials represent a challenge for some smaller sterilizers as the steam from these sterilizers does not always penetrate sterilization packaging. The MIFU clearly states that the Prestige is "designed to sterilize solid (non-lumened) unwrapped instruments." This type of

sterilizer may be used in settings such as tattoo facilities, however, it is not appropriate for medical settings such as physician clinical offices.

Physicians considering purchasing a tabletop steam sterilizer should review the College's Checklist for Purchasing a Tabletop Steam Sterilizer.

Are all disposable medical devices equal?

The POMDRA team is often asked where to purchase disposable/single-use medical devices, such as suture removal kits, for community-based clinics. Although there may be cost implications when purchasing supplies from a reputable medical supply company versus an online supplier, physicians must be confident that their products are approved for use in Canada and safe for use on patients. All disposable medical devices must be purchased from a company that has an active medical devices establishment licence (MDEL) from Health Canada. This confirms that the company is approved to sell medical devices in Canada.

Verify that a company has an active MDEL here.

For additional information on medical device reprocessing, visit the POMDRA section on the College website.

References

1. Canadian Standards Association. User handbook for medical device reprocessing in community health care settings. Mississauga: Canadian Standards Association; 2014. 102 p. CSA Standard No.: SPE 1112-14.

2. British Columbia Ministry of Health. Best practice guidelines for cleaning, disinfection and sterilization of critical and semi-critical medical devices in BC health authorities [Internet]. Victoria: British Columbia Ministry of Health; 2007 [revision 2011 Dec; cited 2017 Oct 4]. 136 p. Available from: http://www.health.gov.bc.ca/library/publications/year/2011/Best-practice-guidelines-cleaning.pdf

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Early warning systems

The Canadian Patient Safety Institute (CPSI) cites research indicating that virtually all critical adverse events are preceded by early warning signs. Therefore, ensuring appropriate system supports and resources are in place to recognize clinical deterioration early, and effectively managing timely and appropriate response to patient deterioration are essential for patient safety.

Medical directors may find the following resources useful in implementing an early warning system and when reviewing and updating their non-hospital facility emergency protocols:

1. The Canadian Patient Safety Institute: Recognizing Deteriorating Patient Condition in a General Care Setting

2. The Institute for Healthcare Improvement: Early Warning Systems: Scorecards That Save Lives

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Transfer via emergency health services (EHS)

NHMSFP Update

Medical directors are advised that the policy and procedures must include the following:

- patients must be transferred via emergency health services (EHS)
- the most responsible physician (MRP) determines whether a regulated health-care professional needs to accompany the patient during transfer
- if transfer is arranged via the EHS Patient Transfer Network and the patient deteriorates at the non-hospital facility while awaiting transfer to the hospital, 911 is to be called to advise EHS of the increased urgency of transfer
- the MRP ensures that essential medical information is sent with the patient (e.g. pre-op history, ECG strips, OR record, anesthesia record, consultation note); however, this information should not delay transfer
- if not accompanying the patient, the MRP must contact the receiving physician immediately by phone or in person to ensure continuity of care
- a patient safety incident report must be submitted to the College

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Proctorship in non-hospital facilities

NHMSFP Update

In addition to ensuring appropriate requirements for proctorship, both the physician proctor and the physician trainee must be granted privileges at the non-hospital facility where the medical/surgical procedure training is occurring prior to the training taking place. This is to ensure that a physician proctor, qualified in the medical/surgical procedure, is present to provide oversight of the patient during the training.

The College has provisions in place for temporary (educational) privileges to allow registrants an opportunity to maintain or enhance their clinical skills.

Note: This does not apply to medical students or residents who may receive training at the non-hospital facility where the physician preceptor of the medical student or resident has been granted privileges at the non-hospital facility.

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Glucometer practices

NHMSFP Update

All non-hospital medical and surgical facilities are required to have a glucometer, and they are encouraged to review their glucometer practices to ensure they are in accordance with the program's *Point-of-Care Testing* standard.

Fingerstick devices

Only single-use auto-disabling finger stick devices, also known as "safety lancets," are to be used in the non-hospital setting. Fingerstick devices are designed to be used only once, after which the blade retracts, is capped or is otherwise made unusable.

Reusable fingerstick devices are not to be used in the non-hospital setting. Reusable fingerstick devices resemble a pen and lancet (endcap). The lancet is removed and replaced after each patient use. These devices are no longer permitted because of their link to blood-borne virus transmission and because they cannot be adequately cleaned.

The Centers for Disease Control and Prevention website provides useful images and descriptions of appropriate single-use fingerstick devices and reusable fingerstick devices.

Glucometers

Glucometers are to be cleaned and low-level disinfected (e.g. wiped down with a CaviCide™ wipe) after every use.

To ensure that the glucometer provides accurate blood glucose testing results, quality control testing needs to be performed in accordance with the glucometer's manufacturer's instructions for use. Glucometers are to be calibrated using testing reagents, which can be obtained from a pharmacy or the medical supplier/distributor of the device. Both the testing reagents and the glucometer testing strips also need to be checked to ensure they are within their labeled expiry date.

For further information, refer to the program's *Point-of-Care Testing* standard.

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Newly established DAP advisory committees

DAP Update

Following are answers to questions about the Diagnostic Accreditation Program (DAP) advisory committees:

How are the advisory committees formed?

The DAP relies on its facilities to nominate experts within their respective organizations as members of the committees. Nomination requests are sent to regional administrative and medical leaders within health authorities and community-based diagnostic facilities. DAP staff collate the nominations and send them to the DAP Committee for approval. Once approved, the membership of each committee is posted to the DAP section of the College website.

The advisory committee term is four years.

What do the advisory committees do?

In addition to reviewing and revising the DAP accreditation standards, the advisory committees report to the DAP Committee. By providing advice and guidance on medical, technical and management issues the DAP Committee can make the best possible decisions regarding diagnostic service accreditation.

Is it possible to participate in the standards review and not be on an advisory committee?

The DAP is founded on the principles of quality improvement and as such relies on the expertise of individuals working within its facilities to identify areas of improvement. Facility staff are encouraged to provide feedback on the accreditation standards through the post on-site assessment questionnaire. In addition, proposed revisions to the DAP standards are distributed for community review prior to being submitted to the DAP Committee for approval. Community review provides facilities affected by the standard revisions an opportunity to review and comment on the changes. Feedback received during this process is reviewed by the DAP staff and advisory committees.

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New accreditation and development officer, laboratory medicine joins the DAP

DAP Update

Susanna Darnel comes to the College with over twenty years' experience in laboratory medicine. She is the current chair of the Canadian Society of Transfusion Medicine Standards Committee and sits as a member of the Technical Committee of the Canadian Standards Association (CSA)-Z902 Blood and Blood Components.

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What are Cochrane reviews and where can they be found?

College LIBRARY

Registrants with library privileges have free access to all Cochrane reviews through the College library. Since the Cochrane Database of Systematic Reviews can be classified as either a database or a journal, it may be accessed through several library webpages:

- Databases – click Cochrane Database of Systematic Reviews or Evidence Based Medicine (EBM) Reviews (a collection of evidence-based databases including Cochrane reviews and the research appraised to develop the Cochrane reviews)
- Books and Journals – click eJournals and search for "Cochrane Database of Systematic Reviews"

What is Cochrane and why are its reviews important in evidence-based practice? The Cochrane Collaboration is a non-profit global network of researchers who create systematic reviews and meta-analyses on important questions in health care. The rigor of the Cochrane review methodology has set the standard for creating systematic reviews and meta-analyses. Cochrane does not accept commercial or conflicted funding, adding unbiased reliability to their research. Locating a Cochrane review on a topic of interest ensures the user that they have found authoritative research that is worthy of consideration to change or confirm a practice.

Free access to Cochrane reviews is possible for registrants through the College's membership in the Electronic Health Library of British Columbia, a consortium of health libraries dedicated to ensuring a level playing field for high-quality health information access for BC researchers, students, and health professionals.

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CPD events: mark your calendars

Professionalism in Medical Practice: Avoiding the Pitfalls
Friday, November 3, 2017 to Saturday, November 4, 2017 – Vancouver
Learn more

Chronic Pain Management Conference
Friday, March 2, 2018 to Saturday, March 3, 2018 – Vancouver
Learn more

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