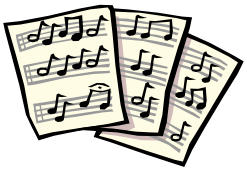

College Notes

The College of Physicians and Surgeons of Prince Edward Island

Fall 2018

Dear Colleagues:

The College office staff is pleased to issue the Fall edition of our C*ollege Notes* as a means of communication with our members. This Newsletter provides a brief summary on some topics that we feel are important.

New Policies

New and revised Policies and other documents are continually added to the website once approved by Council. Please regularly check our website (www.cpspei.ca). Since our last newsletter we have added/revised the following policies:

1). Standard on Prescribing Buprenorphine for Opioid Dependency (Revised June, 2018)
2). Certificates of Professional Conduct (Revised June, 2018)
3). Standard for Prescribing Methadone (Revised June, 2018)
4). Supervision-Qualifications, Roles and Responsibilities (Revised June, 2018)
5.) Retention, Access and Transfer of Medical Records (April 2018)

News

1). Federal MAID Legislation

New federal reporting requirements for MAID became effective November 1, 2018. This means that any **written** request for MAID received on or after November 1, 2018, may trigger reporting requirements under the new regulations. For this requirement, the patient's written request may take any form including a text message or an email. The request does not have to be in the format required under the Criminal Code as a safeguard when MAID is provided (i.e. duly signed, dated and witnessed) to require reporting. The regulations require written requests to be reported in certain situations. Reports are to be sent to the Federal Minister of Health, through the Canadian MAID Data Collection Portal developed jointly by Health Canada and Statistics Canada. Pharmacists also have a requirement to report. Practitioners and Pharmacists are required under section 241.31 of the Criminal Code to file the information required in the regulations within specific timeframes. Those who knowingly fail to comply with this requirement could face a maximum term of imprisonment of two years.

Scenarios where a written request is received and MAID is provided:

Scenario 1: You provided MAID by administering a substance to a patient- you must report within **30days** after the day the patient dies,

Scenario 2: You provided MAID by prescribing or providing a substance for self-administration by the patient-you must report within 120 days after the day of prescribing or providing; you can report earlier if you know the patient has died. In all other cases, you must wait 90 days before reporting.

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Scenarios where a written request is received and MAID is not provided:

Scenario 3: You referred a patient to another practitioner or a care coordination service or transferred their care as a result of the request- you must report within 30 days after the day of referral/transfer,

Scenario 4: You found a patient to be ineligible for MAID- you must report within 30 days after the day ineligibility is determined,

Scenario 5: You became aware that the patient withdrew the request for MAID- you must report within 30 days after the day you became aware of the withdrawal,

Scenario 6: You became aware of the death of the patient from a cause other than MAID- you must report within 30 days after the day you became aware of the patient's death.

The reporting requirement ceases after 90 days where MAID is not provided.

There is a list of information that must be reported in all cases including:

*Date you received the written request
*From whom you received the written request
*The patient's date of birth, sex, HIN and province of issuance, postal code
*Your name, province or territory of practice, licensing or registration number, mailing address and email
* For physicians, your area of specialty
*Whether the patient consulted you for another reason before you received the request for MAID.

In addition there is other information required when patient eligibility has been assessed, and information to be reported depending on the scenarios 1-6 above.
There is a detailed guidance document for practitioners and pharmacists on the webpage, links to the Canadian MAID Data Collection Portal and to the designated recipients' processes for reporting, and a checklist outlining the information required in each of the scenarios listed above.
For more information on these new reporting requirements see: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/reporting-requirements.html

Our MAID Policy (2017) will be updated shortly to reflect these new changes and will be posted to the website.

Health Canada will begin producing Annual Reports on MAID in 2019. Until then, interim reports every six months have and will be produced. The first report was issued on April 26, 2017 and is found at https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-dec-2016.html . The second report was issued on Oct 6, 2017 and is found at https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assitance-dying-interim-report-sep-2017.html . The latest (3rd) interim report was issued on June 21, 2018 and is found at https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-june-2018.html

2). Federal Cannabis Legislation

The Cannabis Act received royal assent June 21, 2018. It is found at https://laws-lois.justice.gc.ca/eng/acts/C-24.5. The Federal Government legalized cannabis October 17, 2018 for recreational use. A person has to be 19 years old to buy, possess or grow recreational cannabis. It is illegal to share cannabis with minors. An individual can carry up to 30 gms of dried cannabis (or its equivalent) in public. It is illegal to use cannabis in public spaces. There are no limits on how much dried cannabis a person can have in their home. There is a maximum of four plants per household at one time.
Cannabis for medical purposes will continue to exist to provide access to individuals who have an authorization to use cannabis for medical purposes. There will continue to be patients who seek Cannabis for medical purposes and our help to access it.
Practicing medicine while impaired by any substance, including cannabis, is not acceptable and puts patients at risk. Using cannabis with any amount of THC will cause some degree of impairment and should be avoided. Evidence shows that residual effects of cannabis can influence psychomotor and cognitive functioning, causing conditions such as confusion, sleepiness, impaired memory, anxiety and diminished reflexes.[1] These effects can persist for hours, sometimes days, after consumption. The Occupational and Environmental Medical Association of Canada recently announced that until definitive evidence is available, it is not advisable to operate motor vehicles or equipment, or engage in other safety-sensitive tasks for 24 hours following cannabis consumption, or for longer if impairment persists.[2]
The CMA Code of Ethics section 5 states: "Practice the art and science of medicine competently, with integrity and without impairment".
It would be considered unprofessional conduct to provide patient care while impaired by cannabis.

3). AGM

The CPSPEI AGM was held on November 1, 2018. The Honorable Mr. Robert Mitchell, Minister of Health and Dr. Kim Critchley, Deputy Minister of Health were in attendance. Mr. Mitchell addressed the audience with opening remarks and was open and responsive to questions during the meeting. As a result of his attendance, there is an upcoming meeting with legal counsel for the

DOH and the CPSPEI staff in December to start writing the regulations concerning physicians for the Regulated Health Professions Act, under which physicians will soon be regulated.
The guest speaker for the evening was Dr. Steven Bellemare, MD, FRCP from the CMPA, who presented the topic "Helping Build Alliances with Patients". Dr. Bellemare cited that poor communication was the main factor in physicians getting sued or receiving a College complaint and not a patient safety issue or negligent care. Communication really matters and better communication can likely reduce the risk of a medical-legal challenge.
He also spoke of Balancing Difference, Diversity & the Standard of Care. He reviewed the dimensions of culture in relation to patient care. Actively listening, a pleasant & inviting attitude, being empathetic, showing interest, good eye contact, facilitating, and providing reassurance-these are all important to the patient. If you treat the patient the way they want to be treated, you likely will not get a College complaint or medical-legal challenge. The Golden Rule of "treating others as you would wish to be treated" is the maxim to follow. Building a strong relationship early on with your patient strengthens the relationship in the end.
Dr. Belllemare recommended two books to read regarding communication, written by a fellow Canadian physician: "How to Break Bad News-A Guide for Health Care Professionals" by Robert Buckman, MD, with contributions by Yvonne Kason, MD, and "I Don't Know What To Say-How to Help and Support Someone Who is Dying" by Robert Buckman, MD.

4). OPIOIDS

A new national clinical practice guideline on the management of opioid use disorders was published in the CMAJ March 5, 2018. This guideline strongly recommends opioid agonist treatment with buprenorphine-naloxone as the preferred first-line treatment when possible, because of buprenorphine's multiple advantages, which include a superior safety profile in terms of overdose risk. Withdrawal management alone is not recommended. The guideline supports using a stepped and integrated care approach, in which treatment intensity is continually adjusted to accommodate individual patient needs and circumstances over time, and recognizes that many individuals may benefit from the ability to move between treatments.
The full guideline is available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.170958/-/DC1

The Centre for Addiction and Mental Health is embarking on creating a new Canadian Opioid Use Disorder Guideline. Each MRA will contribute to this project by providing personnel to review and provide feedback on the draft document. The content of the draft guideline will be prepared by the CAMH. CPSPEI has provided funding support and Dr. Geraldine Johnston has been appointed to represent the CPSPEI.

Machealth, in collaboration with Ontario's six medical schools, has launched a new online learning program, The Opioids Clinical Primer, designed to help Canadian health professionals better understand their role in the management of the ongoing opioid crisis. The program addresses common challenges in the management of chronic pain, with a specific focus on risk reduction when prescribing opioids, as well as a focused look at preventing opioid use disorder and overdoses. The online program was developed with the goal of reducing opioid-related harms by helping clinicians develop strategies for safer opioid prescribing, increasing awareness of opioid use disorder and the availability of evidence-based treatment, facilitating access to naloxone, and educating regarding harm reduction. The program is entirely free and will include six courses, the first two courses which have launched to date. Every course will be certified for both Mainpro+ and RCPS MOC credits for continued professional development.
The link to this new online program is https://machealth.ca/programs/opioids_clinical_primer/
The CPSPEI would appreciate feedback from physicians who decide to participate in this program.

5). CMA Physician Health Survey 2017

The results of the CMA Physician Health Survey 2017 were made available October, 2018. Nearly 3000 CMA members participated in the survey. In summary, 87% of respondents said their emotional well-being was high, 81% said their psychological well-being was high and 65% said their social well-being was high. However, one in four Canadian physicians report burnout. Rates of burnout, depression and suicidal ideation were reported higher among residents than physicians, and among women more than men. Physicians with five or fewer years in practice were more likely to experience burnout and have low resilience than all other physicians. Physicians whose main practice setting was a hospital had increased odds of lower emotional well-being and lower psychological well-being, compared with those working in other settings. More than 80% of respondents said they were aware of physician health programs available to them, while 15% reported having accessed one. Poor physician health affects physicians themselves and also affects the delivery of high-quality care to their patients.
The results of the survey can be found at http://www.cma.ca/Assets/assets-library/document/en/advocacy/nph-survey-e.pdf

6). Physician Burnout

There have been a lot of publications in the past few years regarding physician burnout. Burnout is a psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment, which can occur among individuals who work with other people in some capacity (Maslach & Jackson, 1981,1984a,1986).[3] Physicians are at high risk for burnout . Physicians with burnout usually feel overworked and underpaid, with increased patient loads and long hours. Burnout is associated with medical errors, decreased work engagement and productivity, adverse personal health and early departure from practice.[4] Burnout is described by some as an adjustment disorder, while others feel it is on the depression spectrum. It is not listed in the

DSM-V and it does not have clear treatment guidelines. Also of concern, it should be noted that physicians have the highest rate of suicide of all the professions and more than twice that of the general population.[5]
Physicians need to promote strategies that support their well-being. Physicians at risk and those suffering burnout need to address it with prevention, self-care management, and when necessary, by seeking professional help. With the new Physician Health Program (PHP) through the MSPEI, physicians can now access confidential professional help for stress, burnout, emotional disorders, substance abuse disorders, etc. The College would like to remind physicians that this program is separate from the College and the only way the College would be made aware of an issue is if there was a competency or patient safety issue, which the Medical Act mandates a treating physician to report. The College wants to encourage the membership to seek help with any health problems and to use this valuable program when needed. The MSPEI Physician Health Program is truly a welcomed program for physicians in our province.

Professional Issues / Education

1). CMPA Publications

Important articles in the CMPA Perspective publications for all to read include:

June, 2018: How physician leaders can nurture teams that provide highly reliable healthcare
Medical assistance in dying: Where do we stand two years later?
Responding to a patient without a health card
Providing access to independent medical examinations
Medical scribes: An increasing reality

September, 2018: Accepting new patients: The key to effective practice management
Creating a culture of accountability promotes safe medical care
The medical legal risks of opioid therapy: Questions from members
The unanticipated complicated airway: Are you ready?

December, 2018: Collaborating and innovating to promote safe care
Managing stress when transitioning to new electronic record systems
Avoiding pitfalls in the emergency department: Recognizing and managing risks of diagnostic error
The CMPA Member Support Program: A year of positive change
Limited health-care resources: The difficult balancing act
Safe prescribing: Risks for older patients

2). Health Product Infowatch

Health Product Infowatch is a monthly Health Canada publication designed to raise awareness and to provide clinically relevant information to healthcare professionals concerning health products and their safety. Each publication includes a recap of health product advisories and summary safety reviews, as well as new health product safety information. The Health Canada Infowatch replaced HC's quarterly Canadian Adverse Reaction Newsletter (CARN) in 2015.
The Health Product Infowatch Publications can be found at: http://www.hc-sc.gc.ca/dhp-mps/medeff/bulletin/index-eng.php
Recent information in the Health Product Infowatch publications since our last newsletter:

- Summary Safety Review articles: June, 2018-Enterra Therapy System, Gadolinium-based contrast agents, Isoniazid, Pradaxa; July,2018-Clozapine, Imatinib mesylate (Gleevec and generics): August,2018-Imbruvica (ibrutinib), Remicade (infliximab), SGLT2 inhibitors; September, 2018-Methadose, Metadol-D (methadone hydrochloride), Prednisone and prednisolone; October, 2018- Beta-Lactam Antibiotics, Fibristal (ulipristal acetate)

- Information Update: July, 2018-Dolutegravir-containg medicines (Tivicay, Triumeq and Juluca), Fentanyl-detection test strips, Sunscreens; August, 2018-EpiPen and EpiPen Jr (epinephrine), Valsartan-containing drugs; September, 2018-Azithromycin, Epinephrine auto-injectors, Valsartan-containing drugs, Valsartan-containing drugs (estimates of health risks), Valsartan-containing-drugs (second impurity); October, 2018- Hydroquinone, Multiple unauthorized health products, Valsartan-containing drugs (estimates of health risks), Valsartan- containing drugs (second impurity)

- Recent Monograph Updates: June, 2018-Proscar and Propecia; July, 2018-Imbruvica (ibrutinib); August, 2018-Avapro (irbesartan) and Avalide (irbesartan and hydrochlorthiazide), Tactupump and Tactupump Forte (adapalene and benzoyl peroxide); September, 2018-Flarex (fluorometholone acetate ophthalmic suspension), Orgalutran (ganirelix acetate injection); October, 2018- Lenvima (lenvatinib)

- Health Professional Risk Communication: June, 2018-Barbed suture, GlaxoSmithKline Inc. vaccines; July, 2018-Blincyto (blinatumomab), Dolutegravir-containing medicines (Tivicay, Triumeq and Juluca), Jamp-Glucose 50 and Jamp-Glucose 75; August, 2018- Tromboject (sodium tetradecyl sulfate); September, 2018- Epinephrine auto-injectors; October, 2018- Tecentriq (atezolizumab), Tromboject (sodium tetradecyl sulfate)

- Drug Recall: June, 2018-Erfa-Tranexamic 100mg/ml (5ml); August, 2018-Pro Doc Valsartan, Sandoz Valsartan, Sanis Valsartan, Sivem Valsartan, Teva Valsartan

- Notice of Compliance with Conditions: June, 2018-Lynparza (olaparib) tablet formulation; August, 2018-Alunbrig (brigatinib)

- Advisory: July, 2018-Demulen 30 birth control pills; August, 2018- Valsartan-containing drugs; September, 2018-Jian Pai Natural Skin Care Cream; October, 2018- "Dr.King's" homeopathic products, EpiPen and EpiPen Jr (epinephrine), Health products containing 2,4-dinitrophenol, Marvelon 28

- Biannual Vaccine Safety Summary (July, 2018)

- Dose Prescribing Error Alert: October, 2018- Ocaliva (obeticholic acid)

Extended Relationships

1). Federation of Medical Regulatory Authorities of Canada (FMRAC)

The FMRAC AGM was held June 9-11, 2018 at the Delta Hotel in Charlottetown. This AGM celebrated the 50th anniversary of FMRAC! The theme of this year's meeting was "Advancing Public Protection Through Risk-Based Regulation".

There were 3 education sessions during this meeting: Session I-Integrated Risk Management, Session II-FMRAC's Integrated Risk Management System (FIRMS), Session III- Physician Factors.

FMRAC's top organizational priorities for 2018/2019 are:

1) Telemedicine-FMRAC is reviewing it's policy on Telemedicine. There is a new draft FMRAC framework on Telemedicine, which was presented at the AGM in June, 2018. MRAs can only regulate physicians in their own jurisdiction. FMRAC is further considering telemedicine done for profit versus publicly funded telemedicine. There will be more to come once the new policy has been adopted.
2) Opioids- A Working Group is developing a FMRAC Framework on Prescription Opioids that will propose minimal regulatory standards of practice on: acute and chronic pain management, managing patients with substance use disorders and other related issues such as opioid agonist therapy. In addition FMRAC is also working with the Canadian Pain Forum and the Pan-Canadian Collaborative on Opioid Prescribing.
3) Physician Competence-The Working Group on Physician Competence is looking at mandatory participation in Physician Practice Improvement (PPI).
4) Pan-Canadian Registration- There is a Working Group on Pan-Canadian Registration that is trying to define the issue more clearly, to learn government's interest in Pan-Canadian Registration and to map out a process for MRAs across the country. The working group will look at physicians moving from one jurisdiction to another, short term licenses, and the concept of the "trusted traveler" -where if a physician is registered in a Canadian province/territory with full qualifications, an unblemished record and in good standing, this physician could be registered/licensed in another jurisdiction.

Other concerns and ongoing activities of FMRAC include: Model Standards for Medical Registration in Canada, the use of MINC (Medical Identification Number for Canada)which is jointly owned by FMRAC and MCC, and Pan–Canadian Physician Factors (both risk factors and supportive factors).

The newly elected President of FMRAC for the next 2 years is Dr. Linda Inkpen of Newfoundland.

2). Medical Council of Canada (MCC)

The Medical Council of Canada 106th AGM was recently held in Ottawa Sept 23-25, 2018. The theme of this year's meeting was "Shifting the Landscape: Medicine 2033" which was planned with the intent to take a forward look at the MCC's strategic directions to help inform the 2019-2023 Strategic Plan.

Five themes driving the evolution of the MCC were examined:

1) Responding to the changing role of the future physician
2) Assessing core competencies of all physicians prior to specialty training and certification
3) Assessing in-practice physician competency
4) Providing information collection, management and dissemination
5) Forming strategic alliances

Guest speaker Mr. Larry Sylvestre, Client Executive, IBM Watson Health, spoke on the role of Artificial Intelligence in Healthcare. Guest speaker Ms. Rachael Bryson, Senior Research Associate, National Security and Public Safety presented an introduction to strategic foresight.

As a result of the Assessment Evolution project, changes to the MCC exams occurred in 2018. The final session for the MCCEE was held in November, 2018. The new enhanced MCCQE Part I, based on the new blueprint, was launched in March, 2018. Beginning in 2019, the MCCQE Part I will be used for evaluating both Canadian trained and internationally trained candidates, and will be delivered in Canada and internationally in over 80 countries up to 5 times per year. The new enhanced MCCQE Part II, based on the new blueprint, was launched in September, 2018. The MCCQE Part II will be delivered in Canada up to 4 times per year.
In April, 2018 a new Webinar was launched –"The New MCCQE Part II: What's in it for me?" In January, 2018 the new MCCQE Part I Multiple Choice Questions (MCQ) Practice Test was launched. As well, a new MCCQE Part I Clinical Decision Making (CDM) Practice Test was launched in September, 2018. The NAC (OSCE) exam eligibility criteria changed in the past year. Candidates for the NAC (OSCE) exam are now able to retake the NAC (OSCE) exam if they have a pass (or fail) result, for up to three attempts in all. The candidate's latest result will be the only valid result and will not expire. The new enhanced NAC (OSCE) exam, based on the new blueprint, will launch in the spring of 2019. Starting in 2019, all international candidates wanting to enter a residency position in Canada will need to pass both the MCCQE Part I exam and the NAC (OSCE). The NAC PRA (Practice Ready Assessment) is for IMGs wanting to enter practice in Canada under provisional licensure and is regionally delivered.
The MCC 360, a new physician assessment tool, has been developed and is being piloted in Alberta with 500 Family Physicians. The cost of this tool is approximately $330 per physician.
The Application for Medical Registration is currently being used by nine MRAs, with Nunavut, Ontario (IMG Fellows) and New Brunswick currently in the on-Boarding process.
In the fall of 2018, Dr. Ian Bowmer, Executive Director and CEO of the MCC retired from his post and Dr. Maureen Topps has taken over his position. We all wish Dr. Bowmer well in his retirement and welcome Dr. Topps to the MCC.

References:

1. Health Canada [Internet]. Health effects of cannabis. Ottawa: Health Canada; 2018 Mar 6. https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/health-effects/effects.html.
2. Occupational and Environmental Medical Association of Canada [Internet]. Position statement on the implications of cannabis use for safety-sensitive work. Winnipeg: Occupational and Environmental Medical association of Canada; 2018 Sep 24. https://oemac.org/wp-content/uploads/2018/09/Position-Statement-on-the-Implications-of-cannabis-use.pdf.
3. Burnout: A Multidimensional Perspective, Christina Maslach, University of California, Berkley. Published in Schaufeli, W.B., Maslach, C., & Marek, T. (Eds), (1993). Professional burnout: Recent developments in theory and research. Washington, DC: Taylor and Francis.
4. CMAJ Physician burnout a major concern Roger Collier, CMAJ, October 2, 2017
5. CMAJ News. Has suicide become an occupational hazard of practicing medicine? Lauren Vogel, CMAJ, May 29, 2018

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Please look after your own health & well-being.

Healthy & happy physicians look after their patients competently and with compassion.

The College office will be closed December 24, 2018 – January 1, 2019
There is a mail slot at the front door of our building for those who wish to drop off anything when the office is closed over the holidays.
The Council and the College office staff want to wish everyone a Happy Holiday!
And best wishes for the coming year 2019!