DocTalk 2022 - Volume 9 Issue 4 March 2022

TABLE OF CONTENTS

PHYSICIAN HEALTH

SENIOR LIFE DESIGNATION

The Council and the College of Physicians & Surgeons of Saskatchewan respectfully acknowledge that the land on which we live and work is Treaty 6 Territory, the traditional territory & home of the Cree, Dakota, Saulteaux and Métis Nations. We would like to affirm our relationship with one another now and for the future, and our role in guiding the profession to achieve the highest standards of care to benefit all people in this territory equally.

DocTalk Volume 9, Issue 1

EDITOR
Caro Gareau

REVISION
Caro Gareau
Dr. Werner Oberholzer
Sheila Torrance
Dr. Jurgen Maslany
Joanna Alexander
Alyssa Van Der Woude
Sue Waddington

PHOTO CREDITS
Stock photo, As indicated, CPSS photos or public domain.

Do you have an idea for the next issue? Email us!

Message from the President of Council

March 2022

By: Dr. Olawale Franklin Igbekoyi, CPSS Council President

The Confident, Caring Physician

A favourite personal pastime of mine is watching animal documentaries. I am always amazed in particular to observe the confidence of lion prides as they hunt. It is quite remarkable to see how they use teamwork and team confidence to achieve their common goals: collaborating to feed the pride and teach the young. During the hunt, the lead lion starts the process, and the rest of the team follows, each team member having learned their role and the calculated manoeuvres required to carry out that common goal.

Similar to the pride, physicians work together as a team for an ultimate goal, although conversely, theirs is to ensure quality healthcare delivery to patients in our communities. But like the lion, physicians should tap into their individual and group confidence to deliver that quality and thereby instill confidence in their patients as well.

The Merriam-Webster dictionary defines confidence as feeling that you can do something well or succeed at something.

Self-confidence is defined as the state of being clear-headed either that a hypothesis or prediction is correct or that a chosen course of action is the best or most effective. “Confidence” comes from the Latin word “*fidere*,” which means "to trust"; therefore, having self-confidence is having trust in oneself[1].

Patients want their physicians to be self-confident; any perception of loss of confidence rapidly erodes trust in the physician. The implication of loss of physician confidence is far-reaching and detrimental to patient safety and public confidence in the profession.

Unfortunately, situations do sometimes happen that could affect physician self-confidence.

There is evidence in literature of the prevalence of loss of self-confidence among physicians. Early in their career, many medical students graduate with a significant loss of confidence because of some unique experiences in their medical school. Trainers must support the positive self-esteem and promotion of self-confidence among our trainees. Physician learners who graduate with poor self-confidence are future physicians who may be critical of others, have low self-esteem, and cannot lead and effectively coordinate the team. Ultimately, this leads to poor performance, reduced patient confidence in the physician and public confidence in the profession.

Impostor Syndrome (IS) is another kind of insecurity among physicians and physicians in training. While this is not directly a loss of confidence, it is similar. In a study of family medicine residents and the impostor phenomenon in Wisconsin by Kathy Oriel et al., 41 % of women and 24% of men scored as impostors using the Clance Impostor Scale. This study concluded that about one-third of family medicine residents believe they are less intelligent and less competent than others perceive them to be[2].

In another review of impostor syndrome among physicians and physicians in training, a meta-analysis of existing literature on impostor syndrome among physicians and physicians in training, most studies utilized the Clance Impostor Phenomenon Scale and cited rates of IS ranging from 22% to 60%. Studies found that gender, low self-esteem and institutional culture were associated with higher IS rates. In contrast, social support, validation of success, positive affirmation, and personal and shared reflections were protective. Overall, IS was also associated with higher rates of burnout[3].

Yet, loss of self-confidence can happen to any physician, regardless of their place along their career path and/or regardless of their unique specialty. From the intensive care unit and operating theatre, where there is the required command of high medical knowledge, to the generalist world, whether urban or rural, loss of self-confidence is possible and does happen. In addition to experiences during medical school, it may happen over the course of a physician's career, when sometimes things do not go as expected. Physicians have been known to miss diagnoses that resulted in patient harm. Sometimes, even if you did your very best, things still did not turn out as expected. Take for example the ICU physician managing a COVID patient only to have that patient succumb to their illness. Or, you may have performed that surgery to your best abilities, yet complications still arose. Situations such as harm to a patient, disciplinary proceedings from regulatory bodies, and litigation from a patient could all have an impact on the self-confidence of practitioners.

While some data from a January 2021 survey reveals that 41 % of Americans lost confidence in their health care systems, Canadians have placed the highest level of trust and confidence in their health care providers[4].

To maintain that public confidence in the profession, individual physicians must possess sound self-confidence balanced with adequate humility and convey that to those they care for.

High workplace confidence has also been associated with high patient satisfaction ratings. A study by Katie Owen on exploring workforce confidence and patient experiences discovered that higher workforce confidence in the patient experience resulted in higher patient ratings[5]. Physician

leaders must therefore be confident in their ability to provide quality and cost-effective health care to our communities. Leaders must promote team and workplace confidence. They must effectively deal with every obstacle that undermines their skills and confidence in health system administration. They must also foster confidence in health system administration and consciously promote physician team confidence and psychological safety in their workplace. Physician executives can elevate our health care systems to a domain of excellence resulting in public safety and excellent patient satisfaction. Many physician chief executives successfully manage many high-performing organizations, including healthcare systems in North America.

Medical school trainers and supervisors of internationally trained physicians should appreciate the value of building the self-confidence of their trainees and be sensitive to promoting the confidence of their trainees during the process of training and/or supervision. Let us focus on constructive criticism of poor performance and appreciate and reward good performance. We must balance healthy criticism with coaching to help skill acquisition and improvement. Mentors should focus on building the self-confidence of their mentees and not destroy their self-esteem in the process of mentoring.

When situations go awry, individual physicians should not lose their self-confidence, but rather learn from their failures. With humility, reflect on your weakness and grow that area of weakness and skills to improve future performance. *Winners do not quit, and quitters do not win.* Restore your self-confidence – do not throw it away! - and move on.

While it may on occasion be necessary to impose corrective measures, physician leaders must do this with room for restoration. Physician leaders who are health care administrators must be supportive and give opportunities for growth, personal self-improvement and repair of self-confidence of the physician experiencing struggle. Physician leaders must be proactive and put programs in place to boost the self-confidence of their team. Given the complexity surrounding our profession, physician leaders must understand that any physician, whether great or struggling today, is at the risk of losing self-confidence and as such, should create a culture of support to restore self-confidence. When things go wrong, we must all be humble to learn, be supportive and create an atmosphere of restoration. Praising good performance, a warm thank you message, and creating an atmosphere of trust and self-reflection will promote self-confidence.

When it happens to the leader of a medical team, loss of physician self-confidence affects the team confidence and leads to poor performance of the group. The ripple effect of loss of physician confidence is significant, therefore leaders and physician colleagues must work hard to promote and support the self-confidence of our physician providers. The tendency of destroying others' self-confidence to boost personal ego is counterproductive and contrary to healthy team confidence. Physicians and physician leaders must support one another to maintain professional self-confidence. Always treat your physician colleagues with respect and always do your best to boost their morale. This support will improve the future of medical practice, improve public safety, enhance team confidence and promote public confidence in the profession.

Do not lose your confidence. It is one of the most important tools in your doctor's kit. With it, you can be a great administrator of our health care system.

[1] Wikipedia

[2] Kathy Oriel 1, Mary Beth Plane, Marlon Mundt, **Family medicine residents and the impostor phenomenon.** Fam Med . 2004 Apr;36(4):248-52.

[3] Michael Gottlieb, Arlene Chung, Nicole Battaglioli, Stefanie S. Sebok-Syer, Annahieta Kalantari, **Impostor syndrome among physicians and physicians in training: A scoping review.** MEDICAL EDUCATION IN REVIEW**.** February 2020 February 54(2): 116-24

[4] https://narrativeresearch.ca/canadians-place-the-highest-level-of-trust-and-confidence-in-healthcare-professionals-including-doctors-and-nurses-followed-by-a-high-degree-of-trust-in-school-teachers-and-police-services-confiden/

[5] Katie M. Owens, Stephanie Keller, *Exploring workforce confidence and patient experiences: A quantitative analysis.* Patient Experience Journal 2018 5(1): 97-105

Dr. Olawale Franklin Igbekoyi is President (2021-present) of the Council of the College of Physicians and Surgeons of Saskatchewan and a Family Physician practicing in Rosetown.

By: Dr. Karen Shaw, CPSS Registrar & CEO

Reaffirming the Value of Physician Leadership

High-functioning healthcare systems have physician leadership at the helm[1][2]. Physician leaders in Saskatchewan have been instrumental in improving our healthcare system. There should be no doubt of the value of physician leaders in our system.

The expertise of physicians and other healthcare providers has taken us through the pandemic. The predictions and planning from our physician pandemic leaders helped us avoid a more disastrous outcome. The recent struggle to contain the pandemic has been partially influenced by the rapidly changing variants being more contagious. However, the other challenge that medical pandemic planners and healthcare providers have faced is the tension between politics and science.

While the hospitals are burdened with those affected with COVID-19, the health needs of the non-COVID patients are not being addressed. While Omicron, the latest COVID-19 variant, has not led to as much requirement for intensive care as other variants, record numbers of hospital beds are being utilized, surgical waiting lists have swelled, and medical and cancer treatments continue to be delayed, yet those with decision-making authority ignore the medical advice that has worked to date to keep us safe. We now have a healthcare workforce that is tired, frustrated, feels unsupported, and is generally demoralized. I fear the unknown long-term health consequences of pandemic-related stresses on our healthcare workers and our pandemic leaders. Some healthcare workers have chosen to leave their profession or contemplate early retirement rather than face another day at work.

I learned this week that one of our physician leaders is leaving the province. Dr. Kevin Wasko has been an asset to us throughout this pandemic and prior to the pandemic with his involvement in LEAN and the development and implementation of a single health authority. His leadership was a blend of administrative and clinical talent. His patients and his colleagues in rural Saskatchewan will miss him dearly. When physicians choose to leave their Saskatchewan "*roots*" to practice elsewhere, this can only be viewed as a system failure. Other healthcare leaders have also stepped down over the past few months. How much of this is due to politics trumping medical science and public health measures?

The decision made recently to open the province up when we are still struggling to manage large numbers of hospitalized patients was a decision that did not heed the

medical profession's advice. These decisions place an undue burden on an already exhausted workforce.

I started this article by saying high functioning healthcare systems worldwide have physician leaders at the helm. I hope this will be considered when the search is conducted for the CEO of the Saskatchewan Health Authority. While it is essential to have administrative skills to perform well in these positions, it is imperative that a clinical lens be applied. Let's not reinvent the wheel, or worse, go backwards; the literature reports the proof. We should be continuing to build a high-functioning healthcare system that listens to and welcomes physician leaders.

Thank you for providing care during the pandemic and for your flexibility and perseverance to meet the needs of your patients, especially when you are tired. Thanks to those who work as pandemic leaders helping to identify the best ways to manage the situation, literally on the fly, due to the ever-changing information. We have witnessed multiple examples of excellent physician leadership during these trying times.

There are challenges other than COVID that we need to address in our healthcare system. Racism is an important issue that negatively affects all aspects of care for the patient and the providers. If we are to achieve the necessary culture change, it will require our collective efforts.

I hope that you will continue to serve in healthcare leadership, whether it is helping the College in our role in regulating the profession, tackling systemic racism in healthcare, serving in roles within the SHA or shaping health policy. I encourage physicians to apply for the recently vacated CEO position at the Saskatchewan Health Authority.

I hope that some of you have escaped the cold and have felt the warmth of the sun and sand this winter. For those of us who have not, I look forward to the sunshine and warm breezes of the spring and summer months that will bring a welcome reprieve from COVID-19 and our cold winter. Take the time to refresh and refocus. Hopefully, after that renewal you'll be ready to accept new leadership challenges. More than ever, our Saskatchewan healthcare system needs you as a physician leader.

---

[1] Angood, Peter, MD, FRCS(C), FACS, FCCM, and Birk, Susan "*The Value of Physician Leadership*" PEJ, May-June, 2014.

[2] "*Exploring the Dynamics of Physician Engagement and Leadership for Health System Improvement. Prospects for Canadian Healthcare Systems*" – Final Report – April 4, 2013. Denis, Jean-Louis, Baker, G. Ross, Black, Charlyn, etc.

March 2022
By: Dr. Karen Shaw, CPSS Registrar & CEO

We're really not that scary!

While many members of the College are comfortable contacting the College for information or advice it has come to our attention that there are others who appear not to be.

I was contacted by a senior staff person at the Saskatchewan Medical Association (SMA) for some clarification on two of our policies. He was receiving calls and concerns from a few physicians about several policies and wanted to make sure he understood the policies. When I suggested we would be happy to speak to the physicians if they contacted us directly, I was told that "*some don't feel comfortable*." This was a disappointing message to receive.

Over the twenty years I have worked at the College, senior staff have been accessible to answer questions and concerns from the profession and the public. Who better to ask than those involved in the details of the development and implementation of these policies? We pride ourselves on being a small College that continues to be responsive to our registrants and the public by phone or in-person. Many physicians do reach out for advice. However, it is apparent that some still have reservations about calling.

In this particular case, some physicians had misunderstood the policy and appeared unaware that it was a policy that had been approved and circulated previously. It was also a policy that had benefited from the input of the SMA. We reminded physicians that they needed to ensure their phone message systems provide clear direction on how patients could access after-hours care, with the distribution of a sample infographic.

The frustration and angst experienced by these physicians could have been avoided. We think physicians have enough stress in their lives. Don't ruminate! Please reach out when you have a question or need advice. If you don't want to identify yourself, we are okay with that. We will answer your questions to the best of our ability, or suggest to you where you can get the information if it is outside our expertise. If we think the matter needs additional consideration by you or us, we will advise you.

Please take an opportunity to meet us. Drop in, consider attending the next SMA Representative Assembly where College Staff are present or the open portion of Council meetings which occur 5 five times per year. Remember, most of our work is spent trying

to keep physicians out of trouble. *We are not that scary!* We want to improve our interactions with you. We hope to meet more of you in the future.

Respectfully submitted,

Karen Shaw

Dr. Karen Shaw has served as Registrar and CEO of the College of Physicians and Surgeons of Saskatchewan since 2011.

Council last met on the 28th & 29th of January 2022. The next Council meeting is scheduled for the 18th & 19th of March 2022. Agendas and Executive Summaries with information about the content of the open portion of Council meetings are available here and on the College website.

Highlights from the last Council Meeting

- Council approved several appointments to College Committees.
- Council established a *Registrar's Search Committee* with the mandate to advertise for and find a successor for the current Registrar, who plans to retire in mid-2023.
- Council appointed a committee to review the injection of bioactive substances by registered nurses.
- Council approved a new guideline, End of Life Care. Mr. Bryan Salte, Senior Legal Counsel, elaborates on the provision of care at the end of life in this article.
- Council approved a new policy addressing Responsibility for medical practice. Ms. Sheila Torrance, Legal Counsel, explains the changes in more detail in this article .
- The Council directed the Registrar's office to liaise with the government on the matter of non-physicians controlling physician clinics.

Executive Committee Elections

Please see below the list of successful candidates who have been newly elected/re-elected to serve on Council's Executive Committee for the year 2022.

President	Dr. Olawale Franklin Igbekoyi
Vice President	Dr. Alan Beggs
Member-at-Large	Dr. Sarah Mueller
Member-at-Large	Dr. Oladapo (Dapo) Mabadeje
Public Member-at-Large	Mr. Burton O'Soup

Dr. Brian Brownbridge will continue to serve on Council as **Past President**.

March 2022
By Sheila Torrance, Legal Counsel, CPSS

Council Approves New Policy - Responsibility for a Medical Practice

The College Council recently approved a new policy "Responsibility for a Medical Practice". This followed a second round of stakeholder consultation, as described in the previous issue of DocTalk. The policy applies broadly to *all Saskatchewan physicians* who provide patient care in any practice environment *except* those providing care in facilities owned or operated by the Saskatchewan Health Authority, and facilities designated under *The Facility Designation Regulations*.

As set out on the CPSS website, policies "contain requirements set by the Council of the College to supplement the Act and Bylaws. Policies are formal positions of the College in relation to defined areas of practice *with which members must comply*."

This new policy confirms that physicians are accountable for their own medical practice, including the patient care provided and billing for insured services. In addition, it establishes expectations for physicians in multi-physician clinics (as defined in the policy):

- Each multi-physician clinic must have a physician designated as the "primary contact" for the purposes of communication with the College.
- That primary contact must be able to either answer questions directly or direct the CPSS to another individual within the clinic who can provide the requested information.
- Each clinic can decide on the allocation of responsibilities set out in section 4.4, including:
    - Oversight of staff
    - Billings for uninsured services

    - Advertising and promotion of services
    - Quality assurance, quality improvements, and infection prevention and control
    - Custody or control of health information
    - Providing notification to the College at least 30 days prior to changes in the physical location of the practice or to the services/procedures offered if those require approval by the College pursuant to bylaws
    - Ensuring proper identification of all care providers in the clinic.
- Unless another physician in the practice has designated responsibility for the items listed in 4.4, each physician remains individually responsible to ensure these obligations are met.
- Even if another physician in the clinic has designated responsibility for these expectations, physicians retain an individual responsibility to speak up if they are aware of concerns in the function of the clinic/practice environment. If reasonable steps taken by the physician do not result in the appropriate change in the practice environment, physicians must seek guidance from the clinic owner. If the issue remains unresolved, the physician must seek guidance from the Registrar's Office.
- In some cases, the Registrar's Office may be able to mediate the situation with the clinic owner by explaining the expectations and encouraging compliance. However, the College has no authority over non-physician owners. In some cases, the College's advice may be that unless the physician is able to provide proper care to patients in that environment, the physician may need to consider leaving the practice.

The College received more than 135 responses to its second round of consultation, many of which raised legitimate concerns about the proposed requirement (in the previous version of the policy) that all multi-physician clinics must have a physician designated as the medical director. Many respondents expressed that the expectations would place a significant burden on the medical director. Another theme that arose was a concern that a physician designated as the medical director in a clinic owned by non-physicians may result in that physician having the responsibility without the authority to make changes.

All of this feedback was considered by the Council in deciding to remove the requirement for a medical director and instead requiring a "primary contact" for the purposes of communication with the College.

If physicians have questions about the application of this new policy, please contact the Registrar's Office for assistance.

Sheila Torrance is Legal Counsel at the College of Physicians and Surgeons of Saskatchewan.

March 2022

By Bryan Salte, Associate Registrar and Senior Legal Counsel, CPSS

End of Life Care

At its January meeting the Council approved the guideline on end of life care. This was the culmination of a long period of development by a number of individuals and consultation with stakeholders.

Providing appropriate care in end of life situations can be a very significant challenge for physicians. Among other benefits of the guideline, it assists physicians when they are deciding whether to withhold or withdraw life-sustaining treatment on the basis that the treatment is futile. It provides information to assist physicians to consider how to make those decisions.

The foundational principles that formed the basis for the guideline state:

1. *Treatment can only be provided to a patient with the consent of the patient, or, if the patient lacks capacity, according to previously expressed written wishes in an advanced care directive, or, in the absence of that, with the consent of the substitute decision-maker.*

2. *A physician who provides treatment contrary to the direction of a competent patient, or who provides treatment to an incompetent patient contrary to the directions set out in an advance care directive, may be found to have committed a battery on the patient.*

3. *Shared decision making between a physician and the patient or the patient's substitute decision-maker (SDM) is the expected standard of care in addressing all care, including end-of-life care.*

4. *Communication with the patient and/or the patient's family or substitute healthcare decision-maker is critical. Pursuant to The Health Information Protection Act, a physician can only disclose personal health information to a patient's family with the consent of the patient or in circumstances in which that information can be provided without patient consent.*

5. *Neither the patient, nor the patient's SDM, has a right to insist or require that a physician provide or continue life sustaining treatment if, in the treating physician's opinion, that treatment is futile.*

6. *A physician is not required to provide or continue life-sustaining treatment which the physician concludes is futile.*

7. *Physicians who provide care to patients in end-of-life situations should inform the patient or the patient's substitute decision-maker at the earliest opportunity if the physician will not be providing or continuing certain forms of life-sustaining treatment.*

8. *The College recognizes that irreversible cessation of cardiorespiratory function or the irreversible cessation of all brain function constitutes death.*

The guideline also establishes expectations for physicians who provide longitudinal care: *It is expected that physicians who provide ongoing longitudinal care to patients whose medical condition makes it a reasonable possibility that end-of-life decisions will have to be made in the foreseeable future will:*

a. discuss those issues with the patient;

b. encourage their patient to discuss those issues with their SDM and family;

c. be willing to discuss those issues with the patient's SDM or family if requested by the patient; and

d. document those discussions.

The College encourages all physicians to review the guideline on its website and to act consistently with the expectations in the guideline.

Bryan Salte is Associate Registrar and Senior Legal Counsel at the College of Physicians and Surgeons of Saskatchewan.

March 2022

By Sheila Torrance, Legal Counsel, CPSS and Dr. Werner Oberholzer, Deputy Registrar, CPSS

Medical Practice Coverage Policy - FAQ

The Medical Practice Coverage policy has now been in force for nearly one year. At the March 2022 meeting the College Council will consider whether to institute any form of proactive enforcement to ensure physicians/clinics have implemented the expectations in the policy. While the Registrar's Office will inform physicians of the details if the Council

directs this, one option the Council will consider will be after-hours phone calls to physicians/clinics to ensure the appropriate arrangements have been made and the necessary information communicated to callers.

To date, the College has provided the following education regarding the application of the policy:

- An article published in the May 2021 issue of DocTalk, "Increased clarity on expectations for Medical Practice Coverage"
- An article published in the December 2021 issue of DocTalk, "Medical Practice Coverage – What should physicians implement?"
- An email blast to the profession on December 16, 2021 providing further education on compliance and attaching an infographic "Setting Messages on a Physician Office Answering Machine"

Over the past months, the Registrar's Office has received a number of inquiries from physicians and clinics as to the requirements of the policy. We thought it might be helpful to share some Frequently Asked Questions with physicians who are considering their own compliance with the policy.

FAQ 1: How will this policy be applied to sole practitioners in small towns who cannot find any coverage?

Answer: The College does not expect coverage provision that is not sustainable. The policy will be applied reasonably, and cases will be assessed in the context of what is available. In some of these cases, the Saskatchewan Health Authority (SHA) may be able to assist. Rural and remote physicians can also consider whether they might be eligible for the SMA Rural Relief Program during planned absences.

Many small-town physicians have a telephone message for patients to call the ER after-hours, where the physician(s) themselves provide services. The Nursing staff work collaboratively with the physicians to assess and triage complaints, to reduce the burden of callouts.

On occasion, some small centres will be unable to provide coverage for short periods of time, despite efforts by the physician, SHA and SMA. When this happens, patients are directed to visit nearby towns where ER services are available. Such absences must be clearly communicated to the population served by the ER – in social media, newspapers, on answering machines, etc., and coordinated with EMS services

FAQ 2: How will this policy be applied to physicians who provide services intermittently in communities not otherwise served by

physicians? Are those physicians expected to provide 24/7 coverage in communities where they may attend only one day per month?

Answer: Physicians who provide intermittent services in remote communities cannot reasonably be expected to provide 24/7 coverage in those communities. Many of those communities will have a health centre or clinic staffed by allied healthcare providers, such as Registered Nurses or Nurse Practitioners, who provide services. The expectation would be that the clinic/facility clearly communicate and document who will be responsible for any after-hours follow-up

FAQ 3: The policy states that physicians can make "mutually acceptable agreement" with the SHA for their patients to attend at an emergency department and/or physician emergency clinics if they have needs that arise after-hours. What is required to establish this "agreement"?

Answer: The Registrar's Office suggests that any such arrangement be formalized with the Area Chief of Staff (ACOS) or the area lead/head of the emergency department. The key is to ensure this is not a unilateral offload of patient care to other facilities. This will also provide clarity to the ER staff when they, for example, receive a call about a critical result for a patient of the practice which needs to be managed.

FAQ 4: Can physicians suggest that patients use the 811 Healthline before deciding whether they need to speak to a physician?

Answer: Yes, as long as the intent is that 811 will review the patient complaint and make recommendations, and not be the only or primary management option. The 811 service does not have access to patient records or results (for example, though the eHR Viewer), so is unable to address specific questions about conditions requiring access to those.

FAQ 5: Is it expected that there is always a physician available to speak with a patient?

Answer: While this would be ideal, the College recognizes that this is not always feasible. Many physician groups have a designated on-call physician who carries a cell phone to field after-hours patient calls. This implies that the physician can provide advice, triage, and direct patients (for example, proceed to the ER now; wait until tomorrow; proceed to the extended hours clinic, etc.). Even when there is not a designated on-call physician, there should be arrangements in place for patients to obtain care if required after-hours, and those arrangements should be clearly described in the office telephone message. As noted above, any arrangements should be

formalized with the physician/group who will take call and/or provide after-hours coverage.

FAQ 6: Are specialists expected to arrange for a coverage schedule over and above the call schedule existing through the SHA/hospital?

Answer: No. All specialist groups have an on-call roster via the Saskatchewan Health Authority (SHA), whereby a member of the group can be contacted through SFCC or switchboard. The expectation is that 24-hour coverage is available through the existing call schedule. This meets the policy requirements.

FAQ 7: What is the expectation with respect to urgent results from laboratory or diagnostic imaging?

Answer: All physicians must have a system in place whereby emergent results can be relayed to a physician or designate, who must be able to manage the concern on an emergent basis.

One last piece of advice: CLARITY is key.

Patients who phone a physician's office must be provided with clear directions on how to obtain care. It is *not* sufficient to simply state "the office is closed, please call back tomorrow", or "go to the ER."

Sheila Torrance is Legal Counsel at the College of Physicians and Surgeons of Saskatchewan.

Dr. Werner Oberholzer is Deputy Registrar at the College of Physicians and Surgeons of Saskatchewan and specializes in Family Medicine, Emergency Medicine, and Care of the Elderly.

The Council would like to hear from you!

The Council of the College has approved in principle changes to the Guideline on Patient Physician Relationships. The Council has split the existing guideline into two policies and one guideline as follows: "Guideline – Establishing the Patient Physician Relationship", "Policy – Ending the Patient Physician Relationship" & "Policy – Physicians Surgeons Leaving Practice."
Click here for details

Changes to Regulatory Bylaws

March 2022

The College's Regulatory Bylaws establish expectations for physicians and for the College. They establish practice standards, establish a Code of Ethics and Code of Conduct, define certain forms of conduct as unprofessional and establish requirements for licensure.

There were **six (6)** changes to College regulatory bylaws since the last edition of the Newsletter.

Regulatory bylaw 19.1 – replace the word "addiction" with "opioid use disorder"

The word "addiction" carries a stigma and is not the term used in DSM-5. "Opioid use disorder" is the term most commonly used.

Regulatory bylaw 19.1 – Standard for prescribing of methadone or buprenorphine was amended by substituting the term "opioid use disorder".

Regulatory bylaw 2.6 – removing supervision requirement for physicians who achieve certification

Regulatory bylaw 2.6 is the bylaw which establishes the conditions that apply to physicians who have received a provisional licence. Some physicians have attained certification with the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada but have not yet met the requirements for a regular licence.

The bylaw was amended to remove the requirement that physicians who have attained certification but remain on a provisional licence must practise under supervision.

Regulatory bylaws 2.5 and 2.6 – licensure of physicians with SEAP attestation

SEAP attestation is provided by the Royal College of Physicians and Surgeons of Canada to some physicians who have international sub-specialty credentials. Among other criteria, the physician must have practised in Canada and must pass the Royal College examination in the sub-specialty.

Bylaws 2.5 and 2.6 were amended to grant a provisional licence to a physician who has attained the SEAP attestation and who meets the other licensure requirements. The physician will practise under supervision until they complete a summative assessment. A physician who successfully completes a summative assessment will be granted a regular licence, limiting that physician to practise in the sub-specialty.

Regulatory bylaw 18.1 amendment to allow verbal prescriptions for PRP medication

Physicians who provided virtual care during the pandemic sometimes had difficulty meeting the bylaw requirements to prescribe prescription review medications. Canadian legislation was amended to temporarily remove the requirement that controlled medications could only be prescribed by a written prescription.

The bylaw amendment permits physicians to issue verbal prescriptions for prescription review medications if the physician concludes that it isn't reasonably possible to provide a written prescription or an electronic prescription. The physician must include the same information in a verbal prescription as is required in a written prescription.

Regulatory bylaw 3.1 amendment to change the questions asked on licence renewal

Physicians are required to respond to a series of questions when applying for a licence or when renewing a licence. There was inconsistency between what was asked on an initial application and what was asked on renewal.

The amendments change the health-related questions asked on renewal to be consistent with the health-related questions asked on an initial application. The amendment also limits the question about a physician's blood borne virus status to only those physicians who perform or may perform exposure-prone procedures.

Regulatory bylaw 2.4 – licensure of physicians who achieve Royal College certification through the practice eligible route (PER)

The practice eligible route (PER) of the Royal College of Physicians and Surgeons allows physicians with international specialty certification to apply to challenge the Royal College examinations in their specialty. Physicians who have passed the Royal College examinations and who meet the other requirements for licensure can obtain a provisional licence. Physicians will only receive Royal College certification after passing the Royal College examinations and after the Royal College assesses their practice in Canada and concludes that they have practised appropriately. That assessment will only be done after the physician has been in practice in Canada for at least two years.

The bylaw was amended to allow physicians who have achieved Royal College certification through the PER route and who have met the other requirements for licensure to obtain a

regular licence without additional requirements. They will not be required to achieve the LMCC or MCCQE1 plus 5 years of successful practice.

** Bylaw changes come into effect once they are approved by the Government of Saskatchewan and published in the Saskatchewan Gazette.*

Policy, Standard and Guideline Updates

March 2022

Council regularly reviews the policies, guidelines and standards which are then made available on the College's website.

Since the last edition of DocTalk, Council has adopted **one** *new policy and* **one** *new guideline.*

*Click on each title below to view the complete version of the policy, standard or guideline.

NEW GUIDELINE – End of Life Care

See also the article, *End of Life Care*, in this edition of DocTalk, which provides additional information about this Guideline.

In general terms, the primary focus of the Guideline is to assist physicians who have to consider whether to refuse to provide or withdraw life-sustaining treatments because the treatments would be futile.

NEW POLICY - Responsibility for a Medical Practice

After two rounds of stakeholder consultation, Council approved a new policy, Responsibility for a Medical Practice . The policy sets out the underlying obligations that exist for all physicians, regardless of their practice environment (with certain limited exceptions). Physicians are responsible for their own medical practice including patient care provided, taking reasonable care to ensure billings for insured services are appropriate, and ensuring they are familiar and compliant with applicable laws, bylaws, policies and standards. The policy identifies a number of other obligations that fall on each physician unless another designated physician in the clinic has accepted responsibility. Even in that circumstance, physicians remain responsible to ensure steps are taken to address any concerns.

The policy also requires all multi-physician clinics (as defined in the policy) to have a "primary contact" who is available to respond to inquiries from the College. While that individual does not necessarily need to be in a position to answer all questions posed, they must be able to direct the College to a person who will be able to answer.

See also the article, *Council Approves New Policy - Responsibility for a Medical Practice*, in this edition of DocTalk, which provides additional information about this Policy.

College Disciplinary Actions

The College reports discipline matters in the next issue of the Newsletter after the disciplinary action is complete. The College website also contains information on discipline matters that are completed and matters where charges have been laid but have not yet been completed.

The website contains additional details about all disciplinary actions taken by the College since 1999. That includes information about the charges, a copy of the discipline hearing committee decision if there was a hearing, and the Council decision imposing penalty. If a discipline matter was resolved through alternative dispute resolution, the information will include a copy of the undertaking signed by the physician or a summary of the terms to be completed.

There were **four (4)** discipline matters completed since the last Newsletter report.

Dr. Robert Colistro

Dr. Colistro was found guilty of unprofessional conduct after a hearing before the discipline hearing committee. The more significant finding related to inappropriate billings submitted to Medical Services Branch in relation to billing codes 20W and 50W. The discipline hearing committee concluded that Dr. Colistro failed to exercise due diligence to ensure billings were submitted accurately and appropriately. The committee also found Dr. Colistro guilty of a portion of a second charge that he failed to have a policy in place for inspection of ultrasound equipment.

Council imposed a penalty of a two-month suspension, a requirement to take a course in ethics and professionalism and a requirement to take the Medical Services Branch online billing course. Council also imposed a fine of $15,000 and required Dr. Colistro to pay costs in the amount of $70,559.17.

Dr. Colistro has appealed the Discipline Hearing Committee decision and the Council's penalty decision to the Court of Queen's Bench. With the exception of the two courses, the penalty has been stayed pending the determination of the appeal.

Dr. Naveen Tandon

Dr. Tandon admitted five charges of unprofessional conduct which stated he failed to provide appropriate oversight over individuals who were providing cosmetic services and failed to have an appropriate process in place to address possible emergent complications.

Council imposed a penalty of a reprimand, a one-month suspension, a requirement to take a course in cosmetic procedures, a requirement to sign an undertaking to comply with College bylaws and a requirement to pay costs in the amount of $29,133.20.

Dr. Laura Tanyi-Remarck

Dr. Tanyi-Remarck admitted a charge of unprofessional conduct related to the billings submitted to Medical Services Branch for pregnancy testing and urinalysis.

Council imposed a penalty of a reprimand, a two-month suspension, a requirement to take an ethics course and a requirement to pay costs of $30,693.06.

Dr. Jan Van Der Merwe

Dr. Van Der. Merwe admitted unprofessional conduct for removing Atropine and Glycopyrrolate from a hospital.

The matter was resolved through post-charge alternative dispute resolution when Dr. Van Der Merwe signed an undertaking to provide an apology, take an ethics course and pay the costs associated with the investigation.

March 2022
By Werner Oberholzer, Deputy Registrar

Do you use the PIP and/or eHR viewer, and do you have an active login?

A reminder to Saskatchewan physicians that, pursuant to the CPSS policy Prescribing: Access to the Pharmaceutical Information Program (PIP) or electronic Health Record (eHR) Viewer, all physicians licensed in Saskatchewan who prescribe and/or order medications:

- must have active login capability with either the PIP and/or the eHR Viewer.
- In circumstances where the physician is unable to obtain active login capability with either the PIP and/or the eHR Viewer, or where that login capability is suspended or rescinded by eHealth, the physician must report this to the College.

When access is available, the College recommends that physicians view a patient's medication profile in the PIP or the eHR Viewer prior to prescribing. This is highly recommended when prescribing opioids or other psychoactive medications to a patient and, most particularly, when the physician does not look after the patient on a regular basis.

The Pharmaceutical Information Program (PIP) has been developed with the primary purpose of improving patient care in Saskatchewan.

The PIP program provides authorized health care providers access through a secure computer network to information about drugs dispensed to Saskatchewan patients by community pharmacies in Saskatchewan, and by select out of province pharmacies. The PIP

also permits authorized providers to enter allergy/intolerance information and to ePrescribe.

The electronic Health Record (eHR) Viewer is a secure website that authorized health care providers can use to access clinical information on Saskatchewan residents. It includes information such as:

- medication information,
- laboratory results,
- transcribed clinical documents,
- chronic disease information,
- medical imaging reports, and
- records of hospital visits.

The eHR Viewer includes medication information from the PIP, including medications dispensed by any community pharmacy in Saskatchewan, and select out of province pharmacies, to Saskatchewan residents with a valid Health Services Number (HSN) for the past 25 months.

Access to information within the PIP and eHR Viewer assists physicians in providing the best possible quality of medical care to their patients.

The Saskatchewan Medical Association (SMA) has advisors who can assist with PIP/eHR Viewer set-up, including integration of these programs into your EMR.

SMA Toll Free in Saskatchewan: 1-800-667-3781

Register for a PIP Account

Register for an eHR Viewer Account

Training Resources for PIP

Training Resources for eHR Viewer

Dr. Werner Oberholzer is Deputy Registrar with the College of Physicians and Surgeons of Saskatchewan and specializes in Family Medicine, Emergency Medicine, and Care of the Elderly.

Physician obligation to disclose their vaccination status to patients

This expectation is in force until the State of Emergency has been lifted, which at the time of publishing this article, still applies:

> OC 1/2022 - Renewal of Declaration of a State of Emergency Throughout the Province of Saskatchewan to Address the COVID-19 Public Health Emergency (President of the Executive Council)
>
> *Title: Renewal of Declaration of a State of Emergency Throughout the Province of Saskatchewan to Address the COVID-19 Public Health Emergency*
>
> *Minister: President of the Executive Council*
>
> *Summary: Orders that effective January 17, 2022, the declaration of a state of emergency made pursuant to Order in Council 465/2021, dated September 13, 2021, and most recently renewed pursuant to Order in Council 626/2021, dated December 16, 2021, is further renewed and continued throughout the province of Saskatchewan to address the COVID-19 public health emergency.*
>
> *See: The Emergency Planning Act, section 17*
>
> *Date Signed: January 12, 2022*

Physicians should remain up-to-date with current public health orders, which can be found on the Government of Saskatchewan website.

Physicians among Professional Persons Designated in The Victims of Interpersonal Violence Act

Physicians should be aware of recent legislative amendments that include provisions for victims of sexual violence/interpersonal violence to end a fixed term tenancy agreement without penalty. The amendments, laid out in The Residential Tenancies Amendment Act, 2021 and The Residential Tenancies Amendment Regulations, 2021, allow victims of sexual violence to apply for a **Certificate Confirming Safety Risk** and thereby end a fixed-term tenancy by providing the Certificate Confirming Safety Risk and 28-days' notice to their landlord.

Section 12.4 (4) (c) of *The Victims of Interpersonal Violence Act*, designates duly qualified **medical practitioners as Professional Persons who can provide a written statement** indicating that a person is subject to interpersonal violence or sexual violence. The written statement is provided to the Victims Services Branch of the Ministry of Justice and Attorney General in the form of a "Professional Person Statement". Receipt of a signed Professional Person statement authorizes Victims Services to provide a Certificate Confirming Safety Risk to the person experiencing interpersonal or sexual violence.

Click here for more information and for the revised forms:
Professional Person Statement Form and ***Court Order Submission Form***.
Please destroy any copies you may have of the old forms.

Tramadol Schedule & Reporting Requirements Update

Physicians should be aware of the recent Amendment to the Controlled Drugs and Substances Act and the Narcotic Control Regulations concerning tramadol and the record-keeping requirements required following this change. The changes are set to be in effect starting **March 31, 2022**.

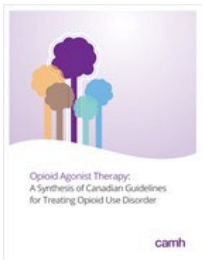
Source: Health Canada - Office of Controlled Substances.

Survey: Accommodating Students with Reading Disabilities in K-12 Education

The Saskatchewan Human Rights Commission is studying how children with reading disabilities, including dyslexia, experience and receive accommodations in Kindergarten to Grade 12 classrooms.

Physicians & individuals: If you have professional experience helping students with reading disabilities, please participate in our survey.

The survey will remain open until March 21, 2022.



Source: Nicole Bootsman, OATP Program

Canadian Opioid Use Disorder Guideline

The Canadian Opioid Use Disorder Guideline, Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder is available on the CPSS website.
Great collaborative work was done on this project to ensure safe standards of practice across the country! We are especially proud of the support provided by our own CPSS Opioid Agonist Therapy Program staff.

See the CAMH website for more details on the project.

Information courtesy of LINK

LINK Telephone Consultations - New Services Available

Saskatchewan primary care providers can call LINK to consult with a specialist regarding complex but non-urgent patient care. New specialties included! FIND OUT MORE

Information courtesy of CCENDU

Stay updated on drug news in Saskatchewan and across Canada

Be sure to like the "CCENDU Saskatchewan" Facebook page.

The Canadian Community Epidemiology Network on Drug Use (CCENDU), is a nation-wide network of community partners that informs Canadians about emerging drug use trends and associated issues

Information courtesy of RSFS

Health Accompagnateur Interpretation Services

Saskatchewan primary care providers and patients can call the *Réseau Santé en français de la Saskatchewan Health Accompagnateur Program* to obtain assistance for French-speaking patients!

Trained Health Accompagnateurs act as the patient's guide to the health system and as an interpreter during consultations with various health providers: doctors, pharmacists, lab technicians, nurses, therapists, etc.

Infection Prevention and Control - Link Letter

See the latest IPAC-SPIC Link Newsletter for the latest updates on Infection Prevention.

Information courtesy of Dr. Katelyn Halpape

The MAC for Medication Assessment

The MAC is a pharmacist-led clinic at the University of Saskatchewan that offers general medication assessments and cognitive behavioural therapy for insomnia (CBTi).

The MAC for Chronic Pain

The MAC iOPS (soon to be renamed the USask Chronic Pain Clinic) provides patients the opportunity to receive care from a pharmacist, physical therapist, medical social worker, and physician with expertise in chronic pain in a team-based approach.
Details

2022 Renewal Summary

Thank you for completing your **2022 renewals**! CPSS would like to give a special shout out to those of you who agreed to be early-bird testers, to help us make sure our online systems were in working order for the October launch windows. This year, we had:

- **80%** of physicians submit their Licence Renewal form by the **November 1 deadline**.
- **77%** of physicians submit their corporate permit renewal form by the **November 15 deadline.**

Approximately 815 physicians also took the time to complete the brief feedback survey. We thank you as this survey provides us with important feedback to help drive continued improvements each year.

The table below shows our survey results over the last two years. We are happy to see things are starting to move in the right direction!

Indicator	Physician Licensure		Medical Corporation Permit	
	2022 (n=558)	**2021**	**2022 (n=227)**	**2021**
Time to Complete	73% report 15 min or less	62.75% report 15 min or less	57.5% report 15 min or less	57.5% report 15 min or less
Ease of Use	76% report Very Easy	59.58% Report Very Easy	47% reported Very Easy	47% reported Very Easy
Overall Experience	83.5% report Very Satisfied	60.37% report Very Satisfied	54.29% report Very Satisfied	54.29% report Very Satisfied

Based on your feedback, we have identified the following improvements to target for 2023:

- Continue to provide advanced notice of what is needed to be prepared for renewal season.
- Streamline and simplify the renewal guides for increased usability.
- Enhance explanations or use examples for questions that continue to cause confusion.
- Make it easier to find the renewal log in and log out buttons.

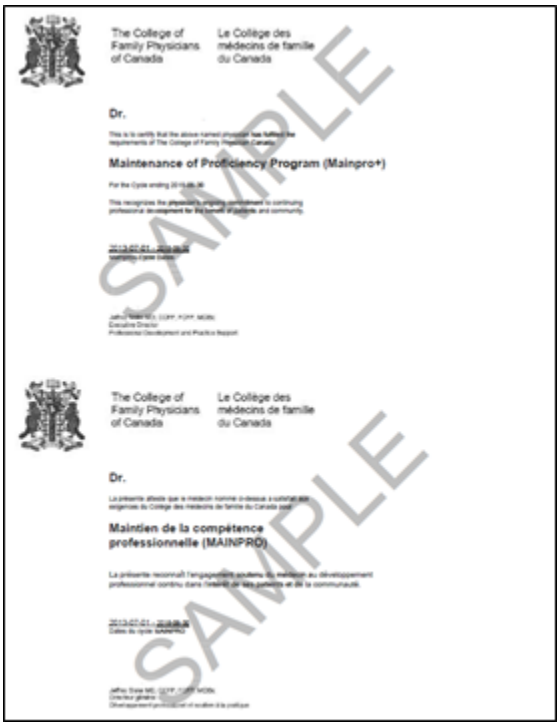
We will also be addressing the specific technical issues that some users experienced while completing the Corporate Permit Renewal and we will be introducing a new set of health-related questions within the physician licensure renewal form this year. Look for further information on those questions in the next issue of DocTalk.

Continuing Medical Education

If you completed your CME learning cycle on December 31, 2021 for the Royal College of Physicians and Surgeons of Canada (RCPSC) or June 31, 2022 for the College of Family Physicians of Canada (CFPC), you will be required to upload your Completion Certificates in order to be able to renew your licence this fall.

Many of you are scheduled to end your cycle this year, so please ensure to make note of your cycle dates and make sure to obtain your required documents prior to this year's renewal.

Below is a sample image of each document required for the CFPC (MainPro) and the RCPSC (MOC), respectively, to help you know which certificate you are looking for. You can download your Completion Certificates from your respective learning portals.



GET CHATTING!

The CFPC and Mainpro+ have made it even easier
to discuss and obtain advice about your CME choices!
Click here for a peek at what the new chat box
on your Mainpro+ Dashboard is all about!

Interested in building your Supervision Experience?

We are always looking for and in need of physicians who would be willing to act as a practice supervisor.

Serving as a Supervisor helps to build our provincial capacity to provide safe, high quality health care services to our patients. If you have been practising with a regular licence for a period of three years or more, you may meet our requirements to serve as a supervisor.

Who would you supervise? Supervision is a requirement for all physicians who have been issued a provisional licence. This includes new graduates who have not yet achieved all their examinations, and International Medical Graduates who have either

completed the Saskatchewan International Physician Practice Assessment (SIPPA) Program or an equivalent pre-licensure assessment and have been granted a provisional licence. Your supervision will allow these physicians to engage in independent medical practice while they prepare to write their examinations or strive to complete their Summative Assessment, with the ultimate goal of achieving regular licensure.

Want to know more?

Please see the CPSS Supervision Infographic for a quick overview

Please refer to the CPSS Supervisor Handout for additional information.

Or, feel free to email cpssreg-assess@cps.sk.ca if you have questions or are interested to learn more.

Update on the LMCC Service

On January 20, 2022, the Medical Council of Canada (MCC) announced the launch of its new Licentiate of Medical Council of Canada (LMCC) service. This signals that the MCC is ready to process LMCC requests for candidates who meet the established criteria.

If you meet the criteria, you can request and pay the LMCC Application fee through your physiciansapply.ca account. Through this portal, the MCC will issue the LMCC.

For more information on the new LMCC service, please see the MCC Website and FAQs.

While the CPSS will have access to verify that you have been awarded the LMCC through physiciansapply.ca, we will not receive notice from either the MCC or from physiciansapply.ca. As such, we ask that you please email cpssreg-assess@cps.sk.ca to inform us if you have been awarded your LMCC, as this may have a positive impact on your current licensure status.

Due to the high volume of requests made, there may be a delay in responding and reviewing your file to determine if this credential has an impact on your current licensure status. We thank you in advance for your patience.

CONTACT INFO CHECK

Have you moved recently?

Whether it's your personal residence or your clinic practice, please remember to reach out to the College to keep your correspondence and office address contact information up to date. This helps to ensure you do not miss any critical communications sent out by the College and to ensure information remains accurate for patients, partners and funders through the use of the Physician Directory that the College maintains!

Update contact information

By Brenda Senger, Physician Health Program Director, Saskatchewan Medical Association

12 Steps for Medical Professionals

Throughout my years in this career, I have come across many documents which I squirrel away. Given the pressures that physicians have endured over the last 2 years, I remembered this hand-out and thought that it could be helpful to reframe how we define ourselves and provide permission for self-care and support.

THE 12 STEPS FOR MEDICAL PROFESSIONALS (as taught in medical training)

1. We learned that we could handle anything perfectly as Medical Professionals, that we had total control.

2. We came to believe that there is no greater calling than to be a Medical Professional, that we ARE what we DO.

3. We made a firm decision to live our lives as consummate Medical Professionals, resisting the need for self-care and the influence of anything outside of our careers.

ANOTHER 12 STEPS FOR MEDICAL PROFESSIONALS (who seek re-humanizing)*

1. We admitted difficulty living as a medical professional only, that our problems arise from this single focus in life.

2. We came to believe that accepting help and support from everything life has to offer could restore our physical, mental, social and spiritual health.

3. We made a decision to turn our will and our lives over to the care of our fellows who have learned these lessons and a Higher Power as we understand one.

4. We made a searching and thorough inventory of all medical knowledge, committing it to memory for all time.	4. We made a searching and fearless personal inventory of our problems, strengths, goals and dreams.
5. We recognized that our discomforts are the fault of people, places and things outside of us, that professional failing and weakness of character are inappropriate for a Medical Professional.	5. We shared our list with trusted others, acknowledging our character weaknesses, virtues and humanity.
6. We were entirely ready to deny our own negative feelings, doubts and misgivings.	6. We were entirely ready to accept the help available to address our basic human needs.
7. We never let our mistakes, fear or feelings of inadequacy show.	7. With humility and an open mind we sought to correct the shortcomings in our lives.
8. We made a list of all people and institutions which upset us and harboured resentments towards them all.	8. We made a list of all persons and institutions we resented and became willing to address these issues.
9. We refused to take action to resolve these tensions, but tried to get even whenever we could.	9. We made direct amends where necessary and took any action required to relieve these tensions, except when doing so would harm others.
10. We continued to act as though everything was fine, always maintaining the correct appearance of a Medical Professional.	10. We continued to monitor internal feelings and needs promptly admitting when we had a problem.
11. We diligently refused to accept new ideas, seeking only to live life on our own terms, as we feel entitled to.	11. We remained open and responsive to help, guidance and love we can receive from others who care about us.
12.Having rigidly clung to our original attitudes and practices, we continue to recommend them to other Medical Professionals, joining together in our misery for the rest of our practising lives.	12. Having achieved personal revitalization as a result of these steps, we try to carry this message to the others in our lives, and to practise these principles in all our affairs.

Source of handout:
http://www.mainemphp.org/uploads/2/7/3/9/27399337/12_steps_for_professionls.pdf

Stress is inevitable. Struggling is optional.

If you are a physician struggling with mental health concerns, please know there is a safe, confidential place for you to contact.

Call the Physician Health Program at the Saskatchewan Medical Association.

Brenda Senger
Director
306-657-4553
brenda.senger@sma.sk.ca

Jessica Richardson
Clinical Coordinator (Regina/South)
306-359-2750
jessica.richardson@sma.sk.ca

Senior Life Designation Award

CELEBRATING 40 YEARS OF PRACTICE?

Have you been licensed on a form of postgraduate licensure in Saskatchewan for 40 years or more?

Think you may be eligible to be a recipient in 2022?

CONTACT
OfficeOfTheRegistrar@cps.sk.ca
or call **306-244-7355**