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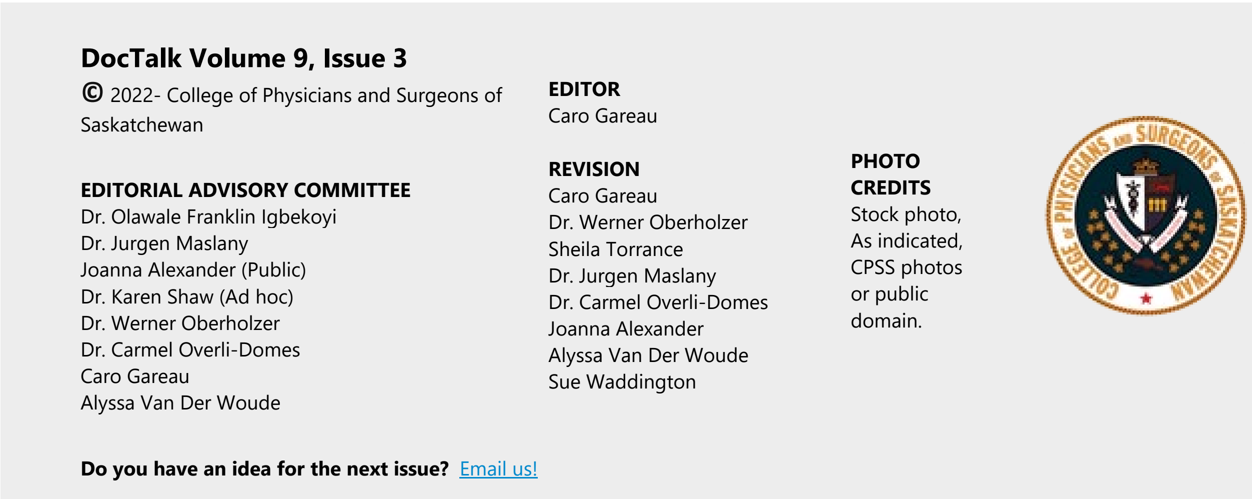
The Council and the College of Physicians & Surgeons of Saskatchewan respectfully acknowledge that the land on which we live and work is Treaty 6 Territory, the traditional territory & home of the Cree, Dakota, Saulteaux and Métis Nations. We would like to affirm our relationship with one another now 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.



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

Message from the President of Council

By: Dr. Olawale Franklin Igbekoyi, President of Council

Missed Diagnosis and Patient Safety

Introduction

A physician makes many decisions every day while carrying out their professional responsibility. When patients come into the office or hospital setting, they expect that physicians will articulate their concerns, use their professional skills to arrive at a diagnosis and solve the problems. Physicians are well-trained to make reasonable sense of what brings patients to their attention. Training through medical school, continuous professional development, and experience provides most physicians with the skills to make a correct and timely diagnosis and resolve patient concerns. Our healthcare systems are also equipped with powerful diagnostic resources with proven high accuracy to reduce the incidence of missed diagnoses.

Despite all these factors, physicians do occasionally miss diagnoses with a negative implication for quality care and patient safety.

Missed diagnosis is defined as the incorrect diagnosis of a morbid condition.[1]

The National Academies of Sciences, Engineering, and Medicine defined diagnostic error as the failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or

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[1] https://medical-dictionary.thefreedictionary.com/misdiagnosis

(b) communicate that explanation to the patient. Simply put, these are diagnoses that are delayed, wrong, or missed altogether.

These categories overlap, but examples help illustrate some differences:

- A **delayed diagnosis** is a case where the diagnosis should have been made earlier. Delayed diagnosis of cancer is by far the leading entity in this category. A significant problem in this regard is that there are very few good guidelines for making a timely diagnosis, and many illnesses aren't suspected until symptoms persist or worsen.
- A **wrong diagnosis** occurs, for example, if a patient truly having a heart attack is told their pain is from acid indigestion. The original diagnosis is incorrect because the actual cause is discovered later.
- A **missed diagnosis** refers to a patient whose medical complaints are never explained. Many patients with chronic fatigue or chronic pain fall into this category, as well as patients with more specific complaints that are never accurately diagnosed.[2]

Recent research suggests that family physicians and specialists are experiencing overwhelming circumstances in their practices. Many are stretched to the limit and experience a form of burnout. Many patients stayed home during the initial wave of the pandemic and are now more confident to visit their family physicians and specialists. As a result, clinics are experiencing a surge in patient visits, and specialists are dealing with backlogs in their waitlists. Surgeons have an impressive operative list that might take years to perform. In addition, a few physicians and health care professionals are leaving for other provinces or choosing to leave practice entirely. To add to the stress of the situation, supportive healthcare professionals such as nurses, licensed practical nurses and medical office assistants are also experiencing shortages in the workforce, creating a gap. Our emergency rooms are overwhelmed. Seeing that wait times in our urban emergency rooms are skyrocketing is disheartening. Under these very pressing and demanding situations, the risk of misdiagnosis, missed diagnosis, delayed diagnosis, and medical errors is high.

According to the Patient Safety Institute, misdiagnoses, falls, infections and mistakes during treatment are the most common types of patient safety incidents. Those who have experienced a patient safety incident commonly cite distracted or overlooked health care practitioners (HCPs) as the most significant contributing factors that led to the incident.[3]

While we may not know the exact data, some surveys estimate that about 7.5 percent of Canadian patients experience missed diagnoses in their lifetime. [4]

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[2] https://www.improvediagnosis.org/what-is-diagnostic-error/

[3] https://www.patientsafetyinstitute.ca/en/toolsResources/Documents/Patient%20Harm%20Awareness%20-%20Ipsos/CPSI%20-%20Patient%20Safety%20in%20Canada%20Baseline%20Report.pdf

[4] https://www.willdavidson.ca/practice-areas/personal-injury/medical-malpractice-lawyers-toronto/misdiagnosis/

In a study of Interval cancers after colonoscopy: the importance of training, John Inadomi discovered the rate of 7.9% of missed diagnosis of colorectal cancers after colonoscopy. Evidence in the study supported missed diagnoses from colonoscopy quality rather than tumour biology.[5]

Another study by Harminder Singh, Zoann Nugent, Alain A Demers, Charles N Bernstein, *Rate and predictors of early/missed colorectal cancers after colonoscopy in Manitoba: a population-based study* presents a 3-year analysis of missed cancer after colonoscopy, where 1 in 13 colorectal cancers are missed diagnoses. Factors responsible are either tumour biology, bowel preparation or procedural difficulty. [6]

In a study of **Determinants of appendicitis outcomes in Canadian children** by Li Hsia Alicia Cheong and Sherif Emil , a higher rate of misdiagnosis was associated with lower age, female gender, non-children's hospitals, and western Canada. [7]

A review of interval breast cancers diagnosed among participants of the Nova Scotia Breast Screening Program discovered that the rate of missed cancers per 1000 women screened was one-half of the true interval rate among women screened annually (for ages 40-49 years, 0.45 vs 0.93; for ages 50-69 years, 1.08 vs 2.22)[8]

Missed diagnosis occurs in the clinical and hospital setting in Canada and is a significant cause of patient safety incidents. Various factors are responsible for the prevalence of missed diagnoses. In an overwhelming work environment, the risk of missed diagnosis or misdiagnosis is high. Physicians, health care providers and patients should work together to reduce its incidence to the minimum to prevent patient harm.

Poor handoffs, lack of feedback, limited support, and a complex diagnostic process contribute to the thousands of misdiagnosis-related hospital deaths yearly. [9]

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[5] John Inadomi, **Editorial: Interval cancers after colonoscopy: the importance of training** Am J Gastroenterol 2010 Dec;105(12):2597-8.
doi: 10.1038/ajg.2010.385.

[6] Singh H, Nugent Z, Demers AA, Bernstein CN. Rate and predictors of early/missed colorectal cancers after colonoscopy in Manitoba: a population-based study.
Am J Gastroenterol. 2010 Dec;105(12):2588-96. doi: 10.1038/ajg.2010.390. Epub 2010 Sep 28.

[7] Li Hsia Alicia Cheong, Sherif Emil **Determinants of appendicitis outcomes in Canadian children** Pediatr Surg 2014 May;49(5):777-81.
doi: 10.1016/j.jpedsurg.2014.02.074. Epub 2014 Feb 22.

[8] Jennifer I Payne, Judy S Caines, Julie Gallant, Theresa J Foley, **A review of interval breast cancers diagnosed among participants of the Nova Scotia Breast Screening Program** Radiology 2013 Jan;266(1):96-103. doi: 10.1148/radiol.12102348. Epub 2012 Nov 20.

[9] https://www.healthleadersmedia.com/clinical-care/6-factors-enable-diagnostic-errors

Graber et al. divided diagnostic errors into three categories:

- No-fault errors, which result from factors outside the control of the physician or the healthcare system;
- System-related errors, which include technological or organisational barriers;
- Cognitive errors, which include inadequate knowledge, poor critical thinking skills, a lack of competency, problems in data gathering, and failure to synthesize information.[10]

The Implication to Patient Safety

A 70-year-old male known hypertensive diabetic presented to the ER with spontaneous onset severe back pain of one-day duration. After history and focused physical examination, a tentative diagnosis of musculoskeletal pain was made. The patient was given Tylenol 3 for pain management and a muscle relaxant. He presented a day later to the ER with a ruptured aortic abdominal aneurysm.

A 65-year-old female known case of diabetes mellitus, rheumatoid arthritis wheelchair-bound called the family physician because of increased numbness at the extremities and inability to perform her usual activities of daily living. She requested an increased dose of muscle relaxant because of worsening extremity spasms. Family physicians approved an increased dose of muscle relaxant by telephone. They did not arrange any visit for a physical examination. Two days later, the patient presented to the ER with quadriparesis secondary to cervical spine erosive disease from rheumatoid arthritis.

A 60-year-old female presented to her family physician's office for periodic medical evaluation. Her urinalysis revealed greater than 5 red blood cells. The family physician was late in reviewing her laboratory reports. After three months of assuming everything is normal, she called the family doctor, who then reviewed the labs with her. An urgent ultrasound confirmed the diagnosis of renal cell cancer with metastasis to the lungs.

A twenty-five-year-old First Nations female presented to her family physician in a solo, busy family practice clinic at around closing hours. She is known to the family medicine clinic to be a frequent clinic attendant with dysmenorrhea and STI concerns. After a short encounter, she was sent home with Naproxen for abdominal pain. She ended up in the ER two days later with ruptured ectopic pregnancy.

A 56-year-old First Nations male presents with chest discomfort, diaphoresis and anxiety. He is known in the local ER as an individual with a history of substance use disorder. The attending physician assumed he was experiencing typical panic attacks and drug withdrawal symptoms. He sent him home without any investigation with a week's course of diazepam and advised him to follow up with his family doctor. Two days later, he was transferred to a tertiary center for acute ST-elevation myocardial infarction.

[10] Graber ML, Franklin N, Gordon R. Diagnostic error in internal medicine. Arch Intern Med. 2005;165(13):1493-1499.

While these case scenarios are not actual cases, they are very similar to patient situations that can result in diagnostic errors and the severe consequences that could result from such errors. We cannot over-emphasize the safety implication of diagnostic errors; physician leaders, administrators, educators and physicians must shine their eyes to prevent this situation. This is even more important in our present circumstance, where resources are stretched, and healthcare providers are overwhelmed.

According to the Society to Improve Diagnosis in Medicine, diagnostic error is one of the most important safety problems in health care today and inflicts the most harm. Significant diagnostic errors are found as the cause of death in 10% to 20% of autopsies, suggesting that 40,000 to 80,000 patients die annually in the U.S. from diagnostic errors. Patient surveys confirm that at least one person in three has firsthand experience with a diagnostic error, and researchers have found that diagnostic errors—not surgical mistakes or medication overdoses—account for the most considerable fraction of malpractice claims, the most severe patient harm, and the highest total of damages/settlement payouts. It is likely that most of us will experience at least one diagnostic error in our lifetimes, sometimes with devastating consequences.[11]

COVID has taken its toll on the health of our communities; allowing diagnostic error to inflict its negative consequences upon our patients' safety is truly adding insult upon injury. I call on my physician colleagues, physician leaders, health care administrators, and allied health care providers to pay attention to patient care and the health care delivery system and actively implement strategies to avoid diagnostic errors to prevent further patient harm.

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

Message from the Registrar

By: Dr. Karen Shaw, CPSS Registrar & CEO

[11] https://www.improvediagnosis.org/what-is-diagnostic-error/

Equity, Diversity and Inclusivity

Equity, diversity, and inclusivity do not exist for all.

The College is working to improve its understanding of these issues by learning about equity, diversity, and inclusivity (EDI) and by critical self reflection of our processes. Our governing Council is comprised of elected physician members and has the addition of five government appointed public members. While we can encourage diversity and inclusivity, our system does not allow for specific selection of physician Councilors. Despite this we are fortunate that our Councilors (physician and public) are diverse in age, gender, and ethnicity. We benefit from this diversity.

Anti-Indigenous Racism

Council and College staff have been learning about anti-Indigenous racism through the excellent resources from the Office of the Treaty Commissioner. Mr. Burton O'Soup is an appointed public member of the Council, and he is the Chair of the CPSS Truth and Reconciliation Committee. Mr. O'Soup is also a member of The Key First Nation.

We have adopted as foundational documents the Truth and Reconciliation: Calls to Action, the United Nations Declaration on the Rights of Indigenous Peoples, and Joyce's Principle. A land acknowledgement is part of Council and committee meetings and we have developed a commitment statement that has been approved to send out for feedback from our Indigenous partners.

The College is aware of the work completed in British Columbia with the *In Plain Sight* report that casts a critical eye on the state of anti-Indigenous racism in Healthcare in British Columbia. We do not think the experiences of Indigenous people is any different in Saskatchewan. Systemic racism exists here as it does elsewhere in Canada, and physicians are part of this system. We are exploring what we, as a regulator, can do to support the changes that are needed.

We have set the course to look at our processes to examine how they may discriminate so that we may make improvements to counter this. There are criticisms of a racist healthcare system, yet we do not often receive formal complaints from Indigenous persons. Anecdotally, we know they are not happy with their healthcare. Why do they not inform us of their concerns? Is it because of the requirement to register a written complaint? Is it because they do not know where to register a concern? Is it because they feel we will do nothing with their concern? We are taking a critical look at the barriers that may be faced by an Indigenous person in registering a concern/complaint with the College. We are also building relationships so that Indigenous knowledge from the knowledge keepers and the Elders can help guide us in transforming our processes to be more culturally aware and welcoming. You will find another excellent article from Elder Willie Ermine in this issue of Doctalk.

Anti-Black Racism

Discrimination and racism are widespread. We know discrimination and racism affects Indigenous people, but Black physicians in Saskatchewan have raised their concerns as well. In response to these concerns, Council has constituted the Diversity and Bias Committee. Dr. Oladapo Mabadeje, a physician Councilor, chairs this group. We are also working with the SMA's EDI committee to develop a survey that will hopefully lead to a clearer understanding of the specifics of the racism that exists, so the actions taken to combat racism can be specific and appropriately directed. As a protector of the public, we are aware of the reports of racism against patients. However, we know our providers are subject to racist and discriminatory behaviour as well. We hope we might have the survey completed and distributed late this year. When it becomes available, please take the time to inform us with your answers, as it will assist in directing our efforts to combat racism and/or discriminatory practices.

We hope that, as we gain knowledge in anti-Indigenous and anti-Black racism, we can use the lessons learned to address other forms of racism or discrimination that patients and providers might experience. We recommend that physicians learn as much as possible about anti-Indigenous racism and anti-Black racism, starting with understanding your own biases. There are many excellent resources to help you in your journey of understanding. The Harvard reference for Implicit Bias is a good start to understanding your inherent or unconscious biases.

Resources

There are excellent courses offered through the U of S College of Medicine CME Department and the College of Nursing on anti-Indigenous racism specific to the Saskatchewan Indigenous population. The following foundational documents, Truth and Reconciliation Commission of Canada: Calls to Action, United Nations Declaration of Indigenous Rights (UNDRIP), Joyce's Principle and the *In Plain Sight* report are all helpful to gaining knowledge and perspective in understanding the challenges. The Office of the Treaty Commissioner also has highly informative videos.

Resources to assist your understanding of anti-Black racism can be accessed at Black Health Alliance. A reading list issued by the University of Toronto Scarborough (UTSC) library for its students provides basic anti-Black racism reading.

Act with a Trauma-informed Approach

Self reflect and take the initiative to challenge the current state. Stop and think about your words, your body language, and your actions. Remember inaction is an action.

Taking a trauma-informed approach to care ensures the patient's physical and emotional safety. Do not ask "What is wrong with the patient;" rather ask, "What has happened to this patient?" This trauma-informed approach will keep the patient emotionally and physically safe and it will also decrease the risk of the provider unknowingly re-traumatizing the patient.

The Saskatchewan Health Authority has been offering trauma-informed training to its staff and to physicians. We applaud their efforts and encourage physicians to seek additional resources on trauma-informed care at the Institute on Trauma and Trauma-Informed Care.

Rebranding

We are aware that elements of our current College seal that serves as a logo on our letterhead and other documents are of historic significance, but several of the elements of the seal are constant reminders of colonialism, which is offensive to many. Part of the College's work over the past few months has been to engage with a graphic designer to rebrand the CPSS and modernize the College logo. We have partnered with the designer to develop something that will identify the College as a medical regulator in Saskatchewan. We look forward to sharing this fresh look with you soon.

What we have accomplished so far feel like small steps – however we hope that they are steps towards a better future of equity, diversity, and inclusivity for all of us. If you would like to assist with these efforts, please do not hesitate to contact the College by emailing us at OfficeoftheRegistrar@cps.sk.ca.

Respectfully submitted,

Karen Shaw

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

DocTalk

Council last met on the 17th & 18th of June and on September 30th-October 1st, 2022. The next Council meeting is scheduled for the 25th & 26th of November 2022. Agendas and Executive Summaries with information about the content of the open portion of Council meetings are available here on the College website.

Highlights from the Last Council Meetings

JUNE 17-18, 2022

- Council agreed to sign a draft statement of commitment in the spirit of Truth and Reconciliation. The Registrar and the Truth and Reconciliation committee will ensure partner outreach and a signing ceremony at an appropriate date.
- Council approved the following policies, standards and guidelines:
    a. Guideline - *Patient-Physician Relationships*
    b. Policy - *Ending the Patient-Physician Relationship*
    c. Policy - Physicians-Surgeons Leaving Practice
    d. Standards & Guidelines: *Opioid Agonist Therapy (OAT)* and 6 *Prescribing OAT* Policies
    e. Policy - Sale of Products by Physicians
    f. Policy - Informed consent
    g. Council also rescinded the Unplanned Pregnancy Policy.

- Council provided advice to the Registrar that cancelling the emergency declaration effective July 15 is appropriate.
- A Code of Conduct for the Discipline Committee was approved.
- An educational session for physicians will be held in connection with the AGM in November.

SEPTEMBER 30-OCTOBER 1, 2022

- Council approved several bylaw amendments after considering stakeholder feedback, and also approved several bylaw amendments in principle for the purpose of stakeholder

consultation. Amended bylaws will be reported in a future issue of DocTalk once they have been approved by the Minister of Health and published in the *Saskatchewan Gazette*.

- Council approved the following policies, standards and guidelines:
  - Policy *Disclosure of Adverse Incidents*
  - Guideline *Physicians and Public Health Emergencies*.
  - Policy *Role of Council, Executive Committee and Legal Counsel in Disciplinary Investigations and Court Matters*
- Council also approved the guidance document on *Ketamine Administration in Community-Based Settings* and the application document on Ketamine administration in community-based settings. More details will be made available in the December issue of DocTalk.
- An increase in annual fees for physician licensure renewal was approved, from $1880 to $1950. The change was effective immediately.
- An educational compliance monitoring process to determine if physicians are available to be contacted both during office hours and after office hours (as required by the Medical Practice Coverage policy) has been approved for implementation following notification of physicians.
- Council endorsed the FMRAC *Statement on Indigenous-Specific Rac*ism.
- Senior Life Designation Recipients for the years 2020 to 2022 will be invited to a joint celebration in November 2022.
- Funding was approved for the following programs:
  - The College of Medicine's *Wellness Leadership Role,* for 2022 and 2023. The 2023 year will be a pilot project with a review to determine whether there should be more permanent funding after 2023.
  - Council approved $150,000 funding for the Practice Enhancement Program (PEP) for 2023.
- Council adopted the Budget for 2023.

It's Election Time, Saskatoon!

The Saskatoon Area is going to ballot in Council elections this month, with candidates **Dr. Nathan David Ginther** and **Dr. Sarah Mueller** running for a seat on Council. Ballots were sent out to eligible voters in mid-October.

Saskatoon Area Members: Please remember to participate by sending in your ballots by the **November 29, 2022** deadline!

Good luck to the candidates!

Meet the Newest Council Members!

Council wishes to thank past Council Members for their contribution during their term: Dr. Amos Akinbiyi, Dr. Aqeel Ghori, Mr. William (Bill) Hannah (Public Member, August 2017-May 2022), and Mr. Ken Smith (Public Member, January 2015 - May 2022).

Since the last issue of the newsletter, Council also welcomed three new Councillors to the table:

Ms. Carolyn Hlady
Public Member

Carolyn Hlady is a retired Police Officer with 34 years experience split between the RCMP and the Saskatoon Police Service. She is married with two adult children. She first became involved with the CPSS conducting Preliminary Inquiry Committees and is now looking forward to participating on Council. Her hobbies include travel, cycling, and needlework.

Mr. Jeff Howlett
Public Member

Jeff Howlett is an Architect with Capital & Project Management in the Saskatchewan Health Authority. He lives in Saskatoon with his wife, two daughters and dog. He has previously served on Council with the Saskatchewan Association of Architects and was a Public Representative with the Saskatchewan Association of Optometrists.

Dr. Lenny Pillay
Saskatoon Area (elected)

Dr. Lenny Pillay is an Otorhinolaryngologist (ENT) Specialist who has been in practice in Regina SK for 21 years. His hope is to advocate for the continued delivery of appropriate and excellent health care to Saskatchewan patients by our dedicated, respected and valued Saskatchewan Physicians.

Find out more about the Council & the CPSS in the 2021 CPSS Annual Report

It is with pleasure that the Council and the College of Physicians and Surgeons of Saskatchewan recently published the **2021 Annual Report** of the College of Physicians and Surgeons of Saskatchewan. An annual report is the fruit of much collaboration and many hours of work, and we have strived to provide the most accurate and relevant information possible.

The year covered by this report was one of adaptation, adjustment and accommodation, and of determination to do what was needed to carry out our regulatory activities and keep our staff and Council safe.

We hope that you will enjoy learning about the College's activities in the past year, and how Council and staff worked diligently to rise to the challenge of continuous improvement in fulfilling its mission to serve the public by regulating the practice of medicine and guiding the profession to achieve the highest standards of care.

Click on the link below
to view the full animated report:

2021 Annual Report

Downloadable PDF

Transition to process established in policy "Blood-borne Viruses: Screening, Reporting and Monitoring of Physicians/Medical Students"

By Sheila Torrance, Legal Counsel, CPSS

As the College previously reported in Doc Talk [see DocTalk 2021, Volume 8, Issue 2: "A Shift in Approach to Screening, Reporting and Monitoring Blood-borne Viruses"] and in Dr. Shaw's letters to all physicians sent in April and May of 2021, the policy "Blood-borne Viruses: Screening, Reporting and Monitoring of Physicians/Medical Students" ("BBV policy") was amended effective March 2021. While the policy expectations came into force at that time, there were a number of steps required prior to moving the monitoring process from the Registrar's office to the Physician Health Program (PHP) of the Saskatchewan Medical Association (SMA). This included the amendment of the health-related renewal questions [see article in DocTalk 2022, Volume 8, Issue 2: "Recent Amendments to the Health-related Renewal Questions"].

The College is currently in the process of transitioning to the new monitoring processes established in the BBV policy. Physicians who perform or assist in performing, or who may perform or may assist in performing, exposure-prone procedures (EPPs) and who are seropositive for a blood-borne virus (BBV) [specifically hepatitis B virus (HBV), hepatitis C virus (HCV) or human immunodeficiency virus (HIV)], must report such seropositivity to the Deputy Registrar, Dr. Werner Oberholzer. After gathering some initial information, Dr. Oberholzer will refer the reporting physician to the PHP committee for management and monitoring. As set

out in the BBV policy, the PHP committee is supported in this work by the College's Expert Advisory Committee on Blood-borne Communicable Diseases (EAC).

To date, the policy page on the CPSS website has included a notice that the College was still in transition to the new processes established in the policy. As of October 31, that notice will have been removed and the policy will be fully in force. While physicians have received several communications drawing their attention to the expectations of the policy, our recent experience in the annual renewal process has highlighted that a number of physicians are still unclear on their obligations. While physicians are encouraged to read the policy in its entirety to ensure they are compliant, the primary differences with the revised policy can be summarized as follows:

1. **Monitoring -** This will be performed on an arm's length basis by the Physician Health Program (PHP), rather than through the Registrar's office;
2. **Testing schedule -** Instead of the general responsibility that physicians/medical students who perform or assist in performing EPPs know their status, a specific testing schedule has been included: annually for HBV (unless confirmed to be immune), q3 yearly for HCV and HIV;
3. **Reporting -** Reporting of seropositive status is only required for physicians/medical students who perform or may perform / assist or may assist in performing EPPs.

Some physicians have also had questions about whether or not their practice includes (or may include) EPPs. At its most basic, if there is a potential for your blood or body fluid to contaminate a patient's tissue during an invasive procedure, then it is an EPP. Can you adequately visualize your hands and fingers throughout the entire procedure, with no risk of injury? If so, then it is likely not an EPP. If you cannot, or if there is a potential that you will not be able to, then it is likely an EPP.

The College will continue to work with physicians who have questions about the implementation of the BBV policy, and how it may impact their individual situation. If you have questions, please contact the Deputy Registrar, Dr. Werner Oberholzer.

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

CPSS Council approves compliance monitoring process related to Medical Practice Coverage policy – is your office ready?

By Sheila Torrance, Legal Counsel, CPSS

It has now been over a year since the Medical Practice Coverage policy was amended. Since that time, the College has taken several opportunities to ensure physicians are aware of their obligations pursuant to 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"
- A "FAQ" document published in the March 2002 issue of DocTalk, "Medical Practice Coverage Policy – FAQ"

At its September 2022 meeting, the CPSS Council directed the Registrar's office to proceed with a compliance monitoring process that will gather data as to the percentage of physician offices that are compliant with the policy. Details of the process follow:

WHO does this impact: ALL physicians in Saskatchewan who are involved in direct patient care. As defined in the policy, this includes primary care physicians (including those working at urgent care/walk-in/episodic care clinics/virtual care services), and specialists/consultants providing care as part of a sustained physician/patient relationship.

WHAT: A compliance monitoring process to determine whether Saskatchewan physician offices are compliant with the Medical Practice Coverage policy

HOW: Physicians will be randomly selected from within general areas of practice; College staff will call those physicians' offices a) during the daytime to ensure calls are answered in a timely fashion and/or appropriate messaging is in place, and b) after-hours to ensure appropriate messaging is in place. As set out in section 3.1 of the policy, messaging must provide clear, accurate and current information on:

a) practice office hours;
b) any office closures;
c) any relevant coverage information (i.e. how the patient can access after-hours, non-emergent care); and

d) instructions on how to access emergency care (i.e. to call 9-1-1).

In addition, messaging must confirm a mechanism is in place to communicate urgent lab or imaging results to the on-call physician or designate, as well as a mechanism for colleagues or associated health professionals to speak to the physician or designate if required.

WHEN: It is anticipated that this process will start in early 2023.

WHY: The College continues to receive complaints and concerns from patients and other physicians that they are unable to reach their physician's office, either due to no one answering the phone during the day, inadequate direction on the voicemail message, or a lack of instructions for after-hours care. The amended policy clarified the Council's expectations of physicians; Council now wants to determine whether physicians are compliant, in order to ensure safe and appropriate patient care. This is an opportunity for physicians to ensure they have appropriate processes and messaging in place.

Council was clear that this will be an **educational** process at this time. If physicians are non-compliant, they can expect to receive a telephone call from the Registrar's staff followed by a letter clarifying expectations that were not met and providing advice on changes to be made to ensure compliance.

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

Are you a trustee? Your obligations

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

The Health Information Protection Act (HIPA) assigns significant responsibilities to individuals and organizations that are defined as a trustee under that legislation.

A physician can be a trustee of personal health information if that physician has custody or control of personal health information.

The Information and Privacy Commissioner, who is responsible for enforcing HIPA, has defined custody or control as follows:

Custody is the physical possession of a record by a trustee, who has a measure of control. Control connotes authority.

A record is under the control of a trustee when the trustee has the authority to manage the record, including restricting, regulating and administering its use, disclosure or disposition. Custody is not a requirement.

That means that a physician who has neither custody nor control of personal health information is not a trustee as defined in HIPA. A physician who is not a trustee has legal and ethical obligations to protect the confidentiality of personal health information. However, only the trustee of that information is required to meet the requirements in HIPA.

A trustee's obligations are summarized at page 3 of the College Guideline: *Confidentiality of Patient Information*. Those obligations include:

- Informing patients about the anticipated use and disclosure of their personal health information.
- Establishing policies and procedures to protect the integrity, accuracy and confidentiality of patient health information.
- Establishing policies and procedures to limit employee access to only the personal health information that is necessary to carry out the employee's responsibilities.

The Information and Privacy Commissioner has addressed some circumstances in which physicians have custody or control of personal health information and are trustees:

- If a corporation has custody or control of personal health information, the physicians who are directors of the corporation are trustees.
- If a non-profit corporation or other entity controls the EMR and enters into a relationship with physicians in which the physicians are unable to transfer patients' information without patient consent, the physicians are not trustees.

Additionally, if a physician is an employee of a trustee (such as the Saskatchewan Health Authority), only the SHA is a trustee of that information. The physician is not a trustee.

Both the Information and Privacy Commissioner and the College of Physicians and Surgeons strongly encourage physicians to ensure that they have an agreement with any clinic in which they practise stating who are the trustees of personal health information held by the clinic. If physicians are only trustees for specific patients, the agreement should make that clear. In a 2022 investigation report the Information and Privacy Commissioner concluded the following:

In the course of this investigation, my office recommended that these agreements specify precisely that the trustee has custody or control over the personal health information of their respective patients, and not simply that they are the trustees of the personal health information. These agreements should specify who is the trustee with custody or control …

A 2020 report states:

I view written agreements between health professionals that describe the trusteeship of personal health information as a fundamental safeguard that all trustees should have in place.

My office has said in previous reports … that is not enough for a trustee to adopt the policies of another organization. It must ensure policies and procedures are tailored to meet the unique and

specific needs of the trustee. My office encourages trustees to alter any templates available to them and tailor them to the unique circumstance of their practice.

The College and the SMA worked together to develop the privacy resources that are on the SMA website. Those resources include sample agreements, including a template for an agreement *Clinic-Information Sharing Agreement (Shared Practice*) which can provide a basis to develop an agreement specifying each physician's responsibility for medical records within the practice.

As always, we at the College are available to provide advice to physicians on issues of confidentiality of patient information and a physician's obligations under HIPA.

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

Disclosure of Adverse Incidents – New Policy

By Rochelle Wempe, Legal Counsel, CPSS

At its last meeting, the CPSS Council approved a new policy, "Disclosure of Adverse Incidents". The policy replaces the former policy, "Disclosure of Adverse Events", and differs significantly from the previous policy. The policy was circulated for stakeholder consultation and many of the suggestions were incorporated into the new policy.

As set out on the CPSS website, policies "contain requirements set by the Council 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*."

The new policy confirms that all adverse incidents, including those that cause harm, have the potential for future harm, and some near misses must be disclosed to patients. Physicians have a legal duty to disclose errors made in the course of medical treatment.

A full and sincere apology may contribute to a successful disclosure discussion and, in Saskatchewan, legislation states that an apology does not constitute an express or implied admission of fault or liability and must not be taken into account in any determination of fault or liability.

The policy defines incidents which must be disclosed as follows:

> **Harmful incident:** an incident that has resulted in harm to the patient (also known as an "adverse event").
>
> **No-harm incident:** an incident with the potential for harm that reached the patient, but no discernible or clinically apparent harm has resulted.
>
> **Near miss incident:** an incident with the potential for harm that did not reach the patient due to timely intervention or good fortune (also known as a "close call").

Physicians must ensure that both harmful and no-harm incidents are always disclosed. Physicians must consider whether to disclose near miss incidents, taking into account whether:

a. the patient is aware of the incident and an explanation will reduce concern and promote trust;
b. the patient should be educated to monitor for future similar incidents; and
c. a reasonable person in the patient's position would want to know about the incident.

The policy contains further guidance regarding to whom to disclose, when to disclose, what to disclose, who must disclose, post-graduate trainees, documentation, and subsequent physicians. The policy also contains examples of harmful incidents, no-harm incidents, and near misses and includes links to a number of educational resources for physicians.

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

Rochelle Wempe is Legal Counsel for the CPSS.

Changes to Regulatory Bylaws

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 have been **no** changes to College regulatory bylaws since the last edition of the Newsletter.

Policy, Standard and Guideline Updates

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 updated **9** policies/guidelines/standards.*

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

UPDATED POLICY – Ending Patient-Physician Relationship

At its June meeting Council approved an updated policy "Ending a Patient-Physician Relationship." The updated policy includes a preamble, sets out the College's expectations when a patient-physician relationship is ended, and outlines circumstances in which a physician must not discharge a patient. The CPSS recognizes that there may be exceptional circumstances and encourages physicians to contact the Registrar's office for advice in those situations. The policy was assigned a five-year sunset review date.

UPDATED Guideline – Establishing the Patient-Physician Relationship

Also at the June meeting, Council approved an updated guideline "Establishing a Patient-Physician Relationship." The updated guideline includes a preamble and sets out the College's position with respect to communication during a patient encounter, the initial family physician office visit, emergencies, and also addresses the guideline's relevance to specialists. The guideline was assigned a five-year sunset review date.

UPDATED Policy – Physicians Leaving Practice

The updated policy has been renamed from the former "Physicians/Surgeons Leaving Practice," and sets out the mandatory requirements for all physicians leaving practice. It covers expectations relating to notification of patients and organizations, ensuring continuity of care and appropriate arrangements for medical records. In addition, the policy addresses expectations in the event of an emergency practice closure, or the sudden death or illness of a physician. The policy contains a link to the CPSS Guidance document "Leaving Practice: A Guide for Physicians and Surgeons" which contains valuable and practical resources to assist physicians with the transition to leaving practice. The policy was assigned a five-year sunset review date.

UPDATED Policy - Informed Consent and Determining Capacity to Consent

Council accepted amendments to this policy which had reached its sunset review date. The amendments included the addition of a preamble, an expansion of the definition of 'capacity' and inclusion of a definition of 'consent', and added criteria for consent and circumstances in which a physician may delegate the responsibility for obtaining informed consent. The document also included a redrafted section on translation and

interpretation resources. The amended policy was assigned a five-year sunset review date.

UPDATED Policies - Opioid Agonist Therapy (OATP) Prescribing

At the June meeting, the Council accepted amendments to the six policies addressing the process to approve physicians to prescribe opioid agonist therapy (OAT). The amendments were intended to make the language gender neutral, to ensure consistency with the amendments made to the body of the Standards and Guidelines at the March 2022 meeting. These policies were assigned a five-year sunset review date.

UPDATED Standards and Guidelines - Opioid Agonist Therapy Standards and Guidelines for the Treatment of Opioid Use Disorder

At the June meeting, the Council accepted amendments to Appendix D of the Opioid Agonist Therapy Program Standards and Guidelines for the Treatment of Opioid Use Disorder in order to make the language gender neutral. Again, this was to ensure consistency with the amendments made to the body of the Standards and Guidelines at the March 2022 meeting.

UPDATED Policy - Sale of Products by Physicians

At the June meeting, the Council approved minor amendments to the "Sale of Products by Physicians" policy which had reached its sunset review date. The amendments included a clarification that while physicians may sell medically necessary or medically optional products (as defined in the policy), they must avoid selling products that do not fit within those definitions. The other primary amendment was to add hyperlinks to all referenced CPSS documents. The Council assigned a three-year sunset review date.

UPDATED Policy - Disclosure of Adverse Incidents

At the September 2022 meeting, the Council approved an updated comprehensive policy "Disclosure of Adverse Incidents." The policy addresses disclosure obligations for physicians for harmful incidents, no-harm incidents, and near misses and includes examples for guidance. This policy is described more fully in the article "Disclosure of Adverse Incidents – New Policy". The policy was assigned a three-year sunset review date.

UPDATED Guideline – Physicians and Public Health Emergencies

This guideline had reached its sunset review date. At the September 2022 meeting, the Council approved amendments to the guideline after considering feedback from physicians and other stakeholders who had responded to the request for consultation on the guideline that had been approved in principle at the June meeting. The amendments included a definition of and reference to "public" health emergencies, and the addition of the College's strong encouragement of physicians who are limited from providing direct medical care to people in need during a public health emergency (such as due to personal health or the health of close family members) to engage in indirect activities that support the response during public health emergencies. The guideline was assigned a five-year sunset review date.

UPDATED Policy – Role of Council, Committees and Legal Counsel in Disciplinary Investigations and Court Matters

This policy had reached its sunset review date. At the September meeting, the Council approved an updated policy that more clearly established the roles of the Registrar's Office, the Council, the Executive Committee, CPSS legal counsel, and independent legal counsel retained on behalf of the Council or Executive Committee in the discipline processes of the College and court matters. The amendments included a section detailing the expectations of independent legal counsel. The policy was assigned a five-year sunset review date.

College Disciplinary Actions

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 post-charge 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. Iffat Muhammad

Dr. Muhammad admitted three charges of unprofessional conduct. The charges stated that she altered copies of patient records to provide to the Joint Medical Professional Review Committee (JMPRC), was untruthful to the JMPRC when asked about the alterations, and billed for counselling services when she had not recorded the time spent, which was a requirement to bill those fee codes. The penalty order included a written reprimand, a two-month suspension, a requirement to take an ethics course and complete the Medical Services Branch billing modules, a fine of $2,500.00 and payment of the costs of and incidental to the investigation and hearing in the amount of $3,643.23.

Dr. Gregory Dalshaug

Dr. Dalshaug admitted one charge of unprofessional conduct. The charge stated that he altered electronic records which resulted in him receiving payment for medical services provided by other physicians. The penalty order included a written reprimand, a six-month suspension, a

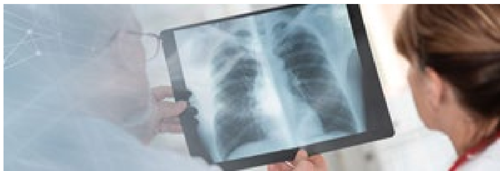
requirement to take an ethics course, a fine of $15,000 and payment of the costs of and incidental to the investigation and hearing in the amount of $1,710.

Dr. Ali Cadili

Dr. Cadili admitted three charges of unprofessional conduct for his involvement as the medical consultant at the Clear Health Inn. The charges stated that he caused or permitted inaccurate and/or misleading advertising on behalf of the Clear Health Inn, caused or permitted the Clear Health Inn to utilize remedies, treatments or devices which were not generally accepted by the medical community as having therapeutic value, and as a result of the advertising and conversations with Dr. Cadili, a person believed they were receiving alternative treatment for pancreatic cancer at the Clear Health Inn. The penalty order included a four-month suspension (retroactive to November 2019), a written reprimand, completion of an ethics course and payment of the costs of and incidental to the investigation and hearing in the amount of $85,377.87.

Dr. Svitlana Ziarko

Dr. Ziarko admitted three charges of unprofessional conduct. The charges stated that she failed to send a tissue sample for examination by histology, she failed to take reasonable care to ensure that her billings to Medical Services Branch for testing were consistent with the payment schedule, and she failed to take reasonable care to ensure that her billings for virtual visits were consistent with the payment schedule. The penalty order included an in-person reprimand, a six-month suspension, a fine of $7,500 and the payment of costs of and incidental to the investigation and hearing in the amount of $6,400.



Radiology Reports and Accountability – A Case Study

By Dr. Werner Oberholzer, Deputy Registrar

The College of Physicians and Surgeons of Saskatchewan was recently made aware of a case where an interpreting radiologist had included potentially serious incidental findings in the body of the imaging report, but not in the summary, nor in the conclusion. The referring physician had not read the report in its entirety, relying only on the conclusion, and therefore missed the clinical finding, leading to an unfavorable patient outcome.

Following the principles of Just Culture - a system of shared accountability in which organizations are responsible for the systems they have designed and for responding to the behaviors of their employees in a fair and just manner – the College wants to take this opportunity to appeal to physicians to work collaboratively in creating a patient-centred, safe, and responsive system for the preparation and management of imaging reports.

Physician ordering the diagnostic imaging

The ordering physician is responsible to review and follow-up the results:

- The physician who requested the imaging is responsible for the follow up and appropriate management of the result, in keeping with the College's standards of practice, the Code of Ethics and the Code of Conduct.
- The College's Policy "Standards for Primary Care" is clear that the CPSS expects that:

"physicians will … provide the medical follow-up required by a patient's condition after undertaking an examination, investigation or treatment of a patient unless the physician has ensured that another physician, another professional or another authorized person has agreed to do so."

- The College's Guideline "Referral – Consultation Process" also states that "the ordering physician is responsible for the follow-up of diagnostic testing" unless otherwise mutually agreed between the referring physician and consulting physician.

This brings us to factors that may have impacted on appropriate review of the radiology report in the scenario outlined above.

A CMPA article, Creating a culture of accountability highlights three types of human behaviour recognized as affecting the ability of providers to fulfill their duties in support of their organization's mission:

- human error,
- at-risk behaviour, and
- reckless behaviour.

In this case study, it is possible that human error or at-risk behaviour contributed to the inadequate review of the diagnostic imaging result.

In the Saegis Just Culture in Healthcare Workshop, it was highlighted that at-risk behavior includes "Behavioral drift." This is described as "*an unconscious choice to deviate from training, stemming from a lack of perception of risk or a mistaken belief that the risk is justifiable. As providers become more comfortable with their tasks, drift is further reinforced by the fact that any resulting harm is relatively rare, thus obscuring the link between drift and potential harm.*

Within a culture of accountability, it is generally recognized that behavioral drift is the single greatest threat to patient safety, owing to its unconscious nature and to its pervasiveness in everyday practice."

Looking back to our case study, we recognize that as physicians try to cope with the ever-increasing demands of daily life and clinical practice - similar to when we review scientific literature and articles - we tend to skip over the body of the document and read only the summary or recommendation. This unfortunately may cause us to potentially miss important clinical findings. The radiology report, like all consultations, is a conversation. The "quality" of the conversation can be defined by the indication and pretest probability and the clarity of the response to the question. Even if the situation is not clear as to the right course of action, the conversation provides a benefit to the medical decision process.

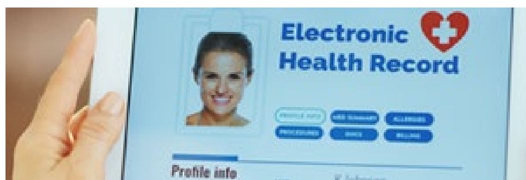
It is a reminder to all of us that when we request any imaging, we must review the report in detail and put the information in appropriate context. The requesting physician is responsible for patient management based on the report, unless the physician has made arrangements for another physician, another professional or another authorized person to do so.

Radiologist preparing the diagnostic imaging report

From the perspective of the radiologist reporting on the imaging, the 2000 article Language of the Radiology Report contains information that is still very relevant today. The CAR Standard for Communication of Diagnostic Imaging Findings defines the principles of practice for the purpose of communicating findings. By clearly communicating relevant findings (including incidental findings) in their reports, radiologists can significantly contribute to patient safety. If a significant abnormality is identified, radiologists should make efforts to contact the requesting physician directly.

When communicating with Dr. Sheldon Wiebe, the Provincial Head of Medical Imaging in Saskatchewan, in relation to this case study, he stated "*I think we are talking about professional accountability of the referring/requesting physician as well as the radiologists in the dialogue that occurs through the request-report mechanism of communication*." The delivery of high quality, patient-centred health care is a team endeavour; all team members, on the reporting and receiving end, have equally important roles and rely on each other to fulfil those roles.

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



EMR Template Use – Timesaver or Potential Pitfall?

By Dr. Werner Oberholzer, Deputy Registrar

Prepopulated templates are often suggested as a potential time-saver when entering clinical data into the Emergency Medical Record (EMR). It is important to recognize that these may pose a risk to accuracy and integrity of clinical data.

The CPSS Bylaw 23.1 sets out the expectations for Medical Records. While the prepopulated templates may make the record look more complete and adherent to the requirements of the College's bylaw or for billing purposes, there is an inherent danger that, when not carefully reviewed, it may reflect inaccurate or unreliable information.

This applies to prepopulated templates, copy-and-paste (cloned) notes, acronym expansions, and auto-populate functions in the EMR.

For example, a patient attends for a sore throat, and the prepopulated template contains elements such as "Vitals stable", "No pallor or jaundice", or "Neurovascularly intact"; these are unlikely to be assessed at such a visit. If not assessed during the visit but still contained in the EMR note, this can be viewed as misleading or erroneous charting. From a medicolegal perspective, such chart notes can potentially lead to action by the College.

Some templates may not be suitable to the reason for which the patient is being seen, potentially failing to accurately reflect the clinical status or contain only certain elements which are inadequate to describe the complexity of the patient's condition.

There are templates that are suggested for use specific to the patient's complaint (e.g., backache template, full physical template, sore throat etc.) that may limit the provider to record additional information by the design of the specific template.

Sometimes it may seem like a good option to copy and paste the previous visit note to avoid the need to enter some clinical information. This may lead to errors in perpetuating incorrect or outdated information. It also may lead to unnecessary redundancy, in which the essential information may get lost.

If an audit is performed on the notes, for example by the Practice Enhancement Program (PEP) or by the JMPRC, and every note looks the same, it will raise a red flag about whether the care was actually provided as described. Common documentation risks with copy-and-paste or cloning include features such as vital signs that never change from one visit to the next, pronouns used incorrectly such as "he" instead of "she", a statement that the patient is not anemic when the lab results indicate the contrary, etc.

In some templates there may be multiple checkboxes and dropdown menus to facilitate completeness, and this may lead to the so called "Alert Fatigue Syndrome", similar to what is described as "Alarm fatigue" (frequent alarms, many of which are avoidable, can lead to inadequate responses, impacting patient safety). It is described as "data overload" and "template noise" in some articles.

There is a difference between prepopulated and care-facilitating templates. A well designed template (for example the Chronic Disease Management or CDM QIP flowsheets, and the Saskatchewan Prenatal Record, both of which are incorporated in the EMR) may facilitate quality of care – and both of these are templates that import relevant previous data, rather than prepopulating the clinical findings for the current visit.

Ensure the integrity of the patient record when using prepopulated templates, to make sure that only the relevant clinical information is accurately reflected, and that incorrect auto-generated entries are deleted or amended.

The CMPA has a short document on tips to improve electronic records, and point (4) speaks to template use.

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

Indigenous-Western Healing – Possibilities for positive change in the health care landscape for Aboriginal people

Source: Mr. Willie Ermine, M. Ed, Assistant Professor, First Nations University. A member of the Sturgeon Lake First Nation in the north-central part of Saskatchewan, he has worked extensively with Elders, promotes ethical practices of research involving Indigenous Peoples and is particularly interested in the conceptual development of the 'ethical space'–a theoretical space between cultures and worldviews.

This paper will examine some of the benefits of traditional healing and medicines with tentative possibilities entertained. It will also briefly look at the nature of traditional medicines and healing traditions, examine the reflective space in which a dialogue can ensue, and provide a surface discussion of a few possibilities with respect to the calls by the Truth and Reconciliation Commission of 2015.

"We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients" **(TRC, 2015)**

The above Call to Action by the Truth and Reconciliation Commission (2015) presents intriguing possibilities for positive change in the healthcare landscape for Aboriginal people. The possibility presented is that Indigenous and Western knowledge systems can co-exist and harmonize treatment resources, and that this pluralism expands opportunities for effective

mediation of sickness and disease and related traumas. This idea also offers an opportunity for the exchange of critical knowledge that can lead to opportunities of innovation, informed policy, and to advocate for greater recognition for the role of traditional medicines, where and when they fit best alongside western medical practices, and vice versa. Such collaboration would enable the visionary elements of a harmonized health care system that can start to create parity in health care for Aboriginal users. We will examine herein some of the benefits of traditional healing and medicines and the tentative possibilities of health that protracted cooperation between knowledge systems can create. With this in mind, we will also briefly look at the nature of traditional medicines, examine the reflective space in which a dialogue can ensue, and provide a surface discussion of harmonization possibilities as called for by the Truth and Reconciliation Commission of 2015.

Background

In 2009, an international collaborative research proposal was submitted to the three health funding councils of Canada, Australia, and New Zealand. The "International Collaborative Indigenous Health Research Partnership Grant" proposed research towards reducing the burden of disease and inequalities for Indigenous peoples through collaborative efforts between Indigenous healing and Western medical practices. The funding for such a project was tethered to the approval of the respective proposals in all three countries. The unwelcome news is that unanimous approval in all three countries did not happen, and the ambitious research projects never saw the light of day. The good news, however, is that the Canadian research team's proposal was approved by the Canadian Institutes of Health Research, indicating a general measure of willingness for innovation in the Canadian healthcare system.

The general intent of the Canadian research proposal was to identify where and when traditional medicines and practices fit best alongside Western medical practices in the management of sickness and disease for Indigenous peoples. The idea was to bring Indigenous healers and Western medical practitioners to meet and exchange critical knowledge for the greater recognition of the role traditional medicine and practices can play in contributing to the well-being of Indigenous populations. The visionary appeal of the Canadian proposal was to identify innovation and cooperation in health care, which could lead to the development of a framework for harmonizing traditional medicines and practices with the established organisation of the Western medical system. The Canadian research proposal was built on the assumption that Indigenous and Western knowledge systems of health already co-existed, and that greater recognition of this medical pluralism could expand opportunities for effective disease management and prevention, particularly in Indigenous populations.

Traditional Medicine

The World Health Organization defines traditional medicines as, '**the sum total of knowledge, skills and practices based on the theories, belief and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illness**.' Despite the oppression and suppression that Indigenous peoples experienced through the past, and claims that such healing practices were no longer in use, substantial evidence exists of the knowledge and continued practices of healing with the benefits of associated Indigenous pharmacopeia. Indigenous healing and its cultural

foundations are part of recognized Aboriginal Rights in this country and, as such, need to be defined solely by the Indigenous knowledge base composed of its epistemology, philosophy, and spiritual worldview. The protocols of Indigenous healing and associated knowledge have always guided the work of Indigenous healers and pharmacopeia specialists through many generations. Implicit with these rights and practices is the requirement for self-determination and the protection of that autonomy in cross-cultural contexts. Indeed, traditional medicine practices have continued despite policies, and are used in contemporary contexts in assisting individuals and communities to address the legacy of historical trauma as well as the emergence of sickness and disease.

In Canada, there has not been an overarching policy on traditional medicine. That no national policy exists results in a patchwork of existing practices, with some provinces and territories remaining silent or endorsing the use of traditional medicines and role of Aboriginal healers. For example, Ontario has some provisions for traditional healers[12] and midwives[13] to continue practice without fear of prosecution. In Manitoba, a provincial government report expressed the importance of traditional Aboriginal healers and has indeed implemented a functioning and effective traditional health system through the Winnipeg Regional Health Authority.[14] Alternatively, where no such guidance exists, there are promotional claims that existing health services have models of care that are 'patient-centered.' As affirming as these statements might be for expansive and focused care, culture has always been notably absent in the services afforded to Aboriginal patients. The Indigenous worldview is said to be "holistic," by encompassing all aspects of life: the physical, mental, emotional and spiritual.[15] The holistic perspective informs Indigenous values and ways of being, including a conscious and harmonious relationship with the natural and spiritual environments articulated and expressed through culture. This holistic theory continues to be the foundation of Indigenous healing. Within Western paradigms of healthcare, the concept of patient activation from an Indigenous or cross-cultural perspective, where patients can take a measure of ownership of their continued health is not fully addressed. Embedded in local traditions, traditional healing/medicine practices offer culturally consistent and appropriate care, thereby increasing acceptability and service responsiveness.

Ethical Space

Ethical Space[16] is a theory that has been proposed to frame the respective encounters between knowledge systems and proponents alike. Collaboration between Indigenous healing systems and Western medical processes will require a place of reflection and dialogue that is safe and inclusive while invigorating honest exchange and partnership. The framework provided by the theory of ethical space is seen through the analogy of a space between two entities, such as the space between the individuals and in the time-lagged void between Indigenous and Western knowledge worlds. The space is initially conceptualized by acknowledging diversity between human communities and unwavering constructs of difference between peoples' worldviews as

[12] Ontario. Regulated Health Professions Act. 1991. 2022
[13] Ontario. Midwifery Act. 1991. 2022
[14] Manitoba. Health Choices: What Manitobans Said: Final Report. 2002. 2022
[15] Benton-Benai E. 1988. The Mishomis Book. Hayward, Wisconsin: Indian country Communications Inc.
[16] Ermine W. Ermine, W. (2007). The Ethical Space of Engagement. In Indigenous Law Journal. Vol. 6:1. Pp193-

highlighted by distinct histories, knowledge traditions, philosophies, and social, political and economic realities. Western medical practice, with its flagship enterprise of Western science, has been variously described as reductionist, linear, objective, hierarchal, empirical, static, temporal, singular, specialized, and written.[17] By contrast, the Indigenous worldview as stated above, encompasses so much more.

Recognizing that the Indigenous-Western encounter is about thought worlds reminds us that frameworks or paradigms are required to reconcile these solitudes in the interest of mutual understanding. The proposed framework builds on the assumption that Indigenous and western knowledge systems exist simultaneously, and that the affirmation of this knowledge pluralism expands opportunities to develop effective strategies for health care and its maintenance. The creation of the ethical space paradigm in health delivery is one whose time has come. In the words of Naisbitt (1982), "those who are willing to handle the ambiguity of this in between period and to anticipate the new era will be a quantum leap ahead of those who hold on to the past."[18] It is anticipated that a new alignment built on partnership will create new currents of thought that flow in different directions and overrun the old ways of thinking.

Relationships

Ethical space reminds us of the unseen but influential nature of the forces we bring to our encounters with each other. The human-to-human interface of our encounters are composed of decision points and actions that summarily create our human experience, particularly in cross-cultural contexts. From Indigenous perspectives, health and relationships are thought of in ways that go beyond the physical encounter to include the other dimensions of our being such as our sensibilities, mind, and spirit. This holistic way of looking at healthiness and interaction is acknowledged in the practices of traditional healers. There are relatively few processes in the Western biomedical model that take care of spiritual wounds for example or how matters of the mind such as stress could affect the condition of the heart.[19] The healer's art is to simultaneously entertain the inner spiritual world, emotions, mental states, along with the physical condition of a person.

Dialogue and cooperation between knowledge systems need to be grounded to human experience in the sense that the participants must speak from the heart or as autonomous actors in the universe with unscripted thoughts and feelings. Harwood and Creighton (2009) suggest in their report *The Organization-First Approach* to "promote the practices that enable citizens to act together effectively – that is, to engage one another rather than just be engaged by institutions." [20] This is to recognize that the inertia of health institutionalisation has appropriated our human freedom to intend the future of our healthcare and to speak to each other from our real selves about our dreams of healthiness. Not all health knowledge necessarily resides in Western institutions or systems. Empowering Western health systems with inclusivity

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[17] Smylie J. Martin C.M. Kaplan-Myrth N. Steele L. Tait C. Hogg W. 2003. Knowledge translation and indigenous knowledge. Circumpolar Health. Nuuk.
[18] Denzin N. Lincoln Y. Handbook of Qualitative Research. 2000. Thousand Oakes: Sage
[19] Robertson P. Collaborative Organizing: an "ideal type" for a new paradigm. In Research in Organizational Change and Development. 1999. Greenwich, Conn.: JAI Press.
[20] Harwood, R. C., & Creighton, J. A. (2009). The organization-first approach: how programs crowd out communities. Bethesda, MD: The Harwood Institute for Public Innovation.

involves protracted efforts of dialogue and sensitivity to the holistic dimensions of Indigenous health practice.

This often involves taking risks with new and innovative programming that is relevant to the Indigenous community but may cause anxieties for mainstream agencies. These resourceful programs that are created "outside the box" have often become models. Indeed, it is through this process of risk taking that the creation of new health delivery models becomes possible.

Indigenous Art of Healing

Indigenous traditional medicine practitioners have been variously identified as spiritualists, herbalists, diagnostic specialists, medicine men/women, healers, and midwives.[21] These are the specialists in field of Indigenous healing and traditional medicines with each performing their service independently. Traditional healers are herbalists or medicine persons who "know medicine well," or "ones who use medicine for healing purposes." These Indigenous practitioners not only have knowledge of plants and their properties as well as the methods of preparing and administering them to patients, but are also gifted in their own right with sensibilities to work as healers. The art of the healer includes healing methods such as the use of herbal medicines and other spiritual observances including cleansing of mind spirit and body and often with the use of the sweat lodge or other ceremonial practices. Indeed, the healer's work is supported by the ceremonial traditions where, depending on the diagnosis, treatments can range from the application of roots and herbs to spiritual intervention, community-wide ritual, and ceremony. This tradition of the healer has never been abandoned. Significantly, the healer's art includes encouraging and enabling patients to take ownership and a degree of control of their own health and remedy with active participation. This involves patients to "story" their condition and the Healer's counsel on the personal ritual that must accompany the herbal treatment. The healer's art enables wellness to become a spiritual journey, for patients to enter into newness – new understandings, new awareness, and new ways of being through traditional teachings of wholeness and healthiness.

Innovation in Health Care Delivery

One feature of health care delivery in the Indigenous community is the emergence of the *traditional health clinic,* where patients have access to traditional healers and other alternative therapies. It is a forum where patients can sit in consultation with traditional healers, and therapies, most often in the form of traditional medicines, are prescribed by practitioners. Helpers and apprentices assemble the prescribed medicines taken from the Indigenous pharmacopeia, or the "medicine room." This community practice has been an innovative creation in the Manitoba experience of traditional and western collaboration. In this instance, there are traditional health clinics with the use of traditional medicines conducted by a traditional healer in the Winnipeg General Hospital (K. Bird, 2022, personal communications). In the Manitoba model, space is provided for the healer along with a "medicine room" where the healer keeps the array of Indigenous pharmacopeia for use during the clinics. The space also lends itself to procedures requiring medical smudging of patients for conditions such as mental

[21] Martin Hill, Dawn. 2003. Traditional Medicine in Contemporary Contexts: Protecting and Respecting Indigenous Knowledge and Medicine. National Aboriginal Health Organization. March, 2003.

anguish, emotional distress, or the spiritual cleansing that goes with traditional health practice. Contracting of the healers through the Health Authority covers the costs of apprentices and medicinal harvesting besides all the administrative and logistical exigencies that go with the services within the hospital.

The Manitoba experience and model of inclusive healthcare, as a feature of traditional and Western health collaboration, reminds us that there are possibilities of affirmed healthcare and harmonization of practices where none have existed before. The road to harmonization takes into consideration a referral system, for example, that goes both ways. With the model of harmonization adopted by the Winnipeg Regional Health Authority, there is a system of continuing referrals between Western doctors and Indigenous healers for the holistic care of patients. The organized practice encourages referrals at the critical decision points about the health status of patients. Mutual respect for one another's practice is one of the guiding principles of such collaboration and balance is achieved by not discouraging patients from consulting any one system for their medical needs. Mutual respect for each other's knowledge and methods is a requirement under this system. Indigenous healers understand that traditional medicines can be directed to work in harmony with Western medications and that the two prescriptions should not be subjected to competition. Indeed, Indigenous healers working from a spiritual grounding can also recognize the spirit of Western medicine. Reciprocally, in the Manitoba experience, doctors working with addicted patients have made referrals to Indigenous healers for patients to go on traditional liver cleansers as part of their treatment to extricate residual toxins from the body.

Healthcare is a concept with practices that respond to the debilitating nature of sickness and disease and associated trauma. It is at the point of urgent need by a patient, at their most vulnerable, that medical treatment should be at the ready and at its finest. For Aboriginal patients, as others, these points of urgent need are usually experienced in the intensive care units of hospitals, and at times in lonely anguish without family and other supports. Without the recognition of unique Aboriginal needs nor Aboriginal healing resources, many patients may be denied very crucial service involving traditional medicines at these critical stages when, indeed, all possible resources should be made available. A harmonized system of care involving traditional health practices and Western medical resources would enable continuing care at all levels and stages patients are experiencing.

Another possibility of collaboration between Western and Indigenous health approaches is within the area of *diagnostics*. For Indigenous healers, the range of interaction required with patients is an important consideration because of the expansive nature of diagnosis at the emotional, physical, mental, and spiritual levels. This feature of the healer's method is significantly different than the Western physician's practice, but one that ensures that the practice of traditional medicine acknowledges the ongoing healing journey of an individual to acquire restoration and balance.

The cooperative roads might also lead directly to Indigenous communities where the Western medical practitioners can be variously engaged to *support community health traditions* in the treatment of sickness and disease for Aboriginal people. Physicians and other specialists have indeed taken part in community sweat lodge ceremonies, and many are aware of the availability of indigenous healing resources. Whether in hospital settings or community contexts, one of the

recent and promising recognitions is the role of an *Aboriginal liaison/navigator* to help steer the cooperative spirit between the West and the Indigenous. An aboriginal liaison or navigator is a competent mediator of cross-cultural interaction with a sensibility to the ways of ethical engagement between contrasting cultures or worldviews. In Cree society, this navigator, or servant of the people is better known as the "*Oskapiwis*." Workers that can navigate the contours of Indigenous knowledge and have the skill set to work with Elders and knowledge keepers, while possessing the capacity to operate in the Western world, have significant roles to play in the creation of new and relevant health programming for Aboriginal users.

The cooperation between the traditional and bio-medical models of health is captured in the Cree First Nations term *mâmawôhkamâtowin,* that talks about putting energies together and doing things together for a common cause. There are various dimensions to the idea of *mâmawôhkamâtowin*. For example, consensus is the agreement of the collective, or a shared consciousness about the need to do things that really matter to people. The collective effort is to recognize that individuals or mono cultural systems have limitations in what they can accomplish and that the pooled energy of working together takes them beyond individual constraints and thresholds. Such collaboration would enable the visionary elements of a harmonized health care system that starts to create parity in health care for Aboriginal users.

Thus, in examining some of the benefits of traditional healing and medicines as well as the reflective space in which dialogue can ensue, and by providing further discussion of some of the possibilities with respect to the calls by the Truth and Reconciliation Commission of 2015, this paper surmises that it would be conceivable to develop a model for a harmonized, collective system that would encompass the different styles of medicine in a complementary and collaborative fashion.

Cancer Centre Medications Appearing on PIP

Source: Provincial Medication Reconciliation Steering Committee (MedRec)

Medications dispensed from the Saskatchewan Cancer Agency (SCA) on or after August 29, 2022 will start appearing on the Pharmaceutical Information Program (PIP) and downstream applications such as MySask Health Record and eHealth eHR Viewer.

This addition will improve patient care by providing a more complete patient medication profile on which to base treatment decisions.

Healthcare providers with medication management and reconciliation responsibilities can review a short video and update resource about SCA medication integration in PIP on the Medication Reconciliation intranet page.

SHA Update Notification: Cancer Medications Appearing on PIP

Education to Physicians about Scripts

Source: Nicole Bootsman, Prescription Review Program

The recent amendment to bylaw 18.1 permits part-fills for some PRP medications (baclofen, chloral hydrate, gabapentin, oxybutynin, pregabalin, lemborexant and zopiclone) without the federal written requirements of opioids, benzodiazepines, stimulants and anabolic steroids. See the examples linked below illustrating the amendment, whereby the total quantity, amount to be dispensed each time, and time interval between fills relating to part-fills are no longer required for baclofen, chloral hydrate, gabapentin, oxybutynin, pregabalin, lemborexant and zopiclone.

Sample scripts PDF

The College of Registered Nurses of Saskatchewan has moved!

The CRNS (formerly the Saskatchewan Registered Nurses Association, SRNA) has moved to new spaces!

As of September 20, 2022, the new address is:
1-3710 Eastgate Drive
Regina, SK S4Z 1A5

The following numbers remain the same:
Phone: 306-359-4200
Toll free 1-800-667-9945
Fax number: 306-359-0257
Email address: info@crns.ca

Practice Tools

UnScripted: NEW PRP/OATP Newsletter

Have you subscribed to UnScripted yet? Are you prescribing opioids and/or other PRP medications? Stay current with the latest news from the Prescription Review Program and the Opioid Agonist Therapy Program.

Find links to the most recent issue here.

New Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis and Treatment

Source: Saskatchewan Prevention Institute

The World Health Organization (WHO) published new *Consolidated guidelines on HIV, viral hepatitis, and STI prevention, diagnosis, treatment, and care for key populations* on July 29, 2022. There are 5 key populations identified: 1) men who have sex with men; 2) trans and gender diverse people; 3) sex workers; 4) people who inject drugs; and 5) people in prisons and other closed settings. This document presents and discusses new recommendations as well as consolidates a range of existing recommendations and guidance from current WHO guidelines. A *Policy Brief* was also released to summarize the new consolidated guidelines.

Official news release and additional information

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

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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

Changes to Supervision for physicians graduating from the SIPPA Program

In the spring of 2022, the Saskatchewan International Physician Practice Assessment (SIPPA) program obtained funding from the Ministry of Health to expand its responsibility to oversee the completion of the Clinical Field Assessment (CFA) through to completion of the Supervised Practice Period. The SIPPA program will officially assume its newly expanded role as of January 2023.

CPSS and SIPPA have been working closely throughout the fall to ensure there is a seamless transition for those who will newly participate in the supervised practice period under the guidance and support of SIPPA.

To read more about the transition, please click here.

Quick note about Renewal Season

Thank you for completing our Renewal Survey! With your consent, we have been reaching out to learn more about your experience, based on comments you have left within the survey. We are very appreciative of the additional insight we are gaining through these follow up emails as this helps us to better understand the types of things that are leading to unnecessary confusion or frustration. Your feedback is helping us to plan for a more positive renewal experience.

Thank you and please keep your feedback coming!

Thinking about taking some time away from practice?

Everyone needs time away from the day-to-day grind of work to restore their energy. This is even more so for those who work in helping professions. You may also be thinking about taking time away from practice to study and prepare for examinations.

If you are currently licensed on a ***Provisional with Restrictions Licence***, we would like to remind you to please notify the CPSS if you are planning to take some time away from your clinical practice. A condition of your provisional with restrictions licence is that you are practising at all times under supervision (Bylaw 2.6 (ww)).

You can make a request to the Registrar to temporarily suspend this condition, if the Registrar feels it is appropriate to do so. If you do not request permission for time away from practice while working on a Provisional with Restrictions licence, you could be at risk of having your licence suspended.

You can submit your request for time away by emailing cpssreg-assess@cps.sk.ca.

Residents planning to moonlight during the academic year

Just a quick reminder that Residents can obtain an endorsement for their Educational Licence to provide moonlighting coverage during the following periods throughout the academic year:

- May 1 to October 31
- November 1 to April 30

Residents must obtain permission from their Program Director with the Post Graduate Medical Education (PGME) Office. To request an application form please email sam.curnew@usask.ca at the PGME office.

Please also note that your Moonlighting endorsement is time-limited and will be ended by the timeframes noted above or earlier if deemed required by the Program Director.

You can find more information about moonlighting on the CPSS website, found here

Or if you have any questions about moonlighting you can email cpssreg@cps.sk.ca or call the CPSS main office at (306) 244-7355

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

Attitude

By Jessica Richardson, Clinical Coordinator, Saskatchewan Medical Association

Are you a glass half-full or half-empty kind of person? Our world view has a direct impact on our personal well-being. Recent studies have shown that, on average, people have 6,000+ thoughts per day. What is the temperament of your thoughts throughout the day? Consider thoughts about yourself and others. Imagine the impact your thoughts have on your mood if they are cynical or hypercritical compared to thoughts that are supportive, kind, or curious.

I'm not suggesting there is a place for toxic optimism (that's just insensitive); rather, this is an opportunity to examine your perspective and overall attitude in life and find a healthy balance. Stress and challenges happen (especially in the field of medicine), that's as certain as the sun rising and setting each day. The way in which we choose to manage those stressors, or the attitude in which we view them, is what's in our control.

We are all solely responsible for our own personal management. Management is not "shutting off emotions" or ignoring stressors. Management is acknowledging the impact of a situation, identifying the thoughts and emotion(s) we are experiencing, and processing (or managing) your response. By heightening personal awareness, you can become more attuned to the perspective you hold throughout the day. If you're stuck in the glass-half-empty mentality this is your opportunity to consider an alternative perspective.

There is a poem by Charles Swindoll that I refer to often in which he explains, "The remarkable thing is we have a choice everyday regarding the attitude we will embrace for that day… I am convinced that life is 10% what happens to me and 90% how I react to it." Grace (for yourself and others) doesn't cost you anything. So, let me ask you again, are you a glass half-empty or half-full kind of person?

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.

Lorraine Scott
Clinical Coordinator
306-657-4585
lorraine.scott@sma.sk.ca

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

Brenda Senger
Director
306-657-4553
brenda.senger@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 or 2023?

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