

Doctalk

**SPECIAL
TOPIC**
Indigenous
Wellness

Truth and
Reconciliation Efforts

Communication and the
Indigenous Patient

The MEET & GREET Appointment

Prescribing Opioids: Challenging Scenarios

SK Bleeding Disorders Program

"The Melody of Creation"

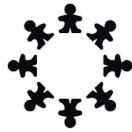
Background image: This mural by Indigenous artist Daniel Sanderson O'Shea adorns the wall of the Spiritual and Cultural Room at St. Paul's Hospital, Saskatoon. Photo courtesy of First Nations and Métis Health Services.



NEW ELECTORAL BOUNDARIES FOR COUNCIL

In this issue

Articles in this issue featuring information relating to Indigenous Wellness are marked with earthen-coloured circles.



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From the President

Governance Reform, the Opioid Epidemic and Sexual Boundary Violations 4

Council News

New Council President 5

From the Registrar

“R-E-S-P-E-C-T - Find out what it means to me” 6
Anecdotes & Comments from the *Gathering at miyo mahcihowin* 9

Special Topic - Indigenous Wellness

Communication and the Indigenous Person 12
The Role of Practitioners in Indigenous Wellness 14
Eat Well Saskatchewan - Dietition Service for First Nations Patients 15
Naloxone Nasal Spray Now FREE for First Nations and Inuit 15

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Addressing Quality of Care

<i>The Meet-and-Greet</i>	16
<i>Announcing Dr. Howard-Tripp's Retirement</i>	16



Legally Speaking

<i>Policy, Standard and Guideline Updates</i>	17
<i>Governance Policies Now Online</i>	17
<i>College Disciplinary Actions</i>	18
<i>Physician Lists</i>	18



Registration Times

<i>Are you a Resident Completing Training in 2018?</i>	19
<i>Report your CME Credits - Reminder to Family Physicians</i>	20
<i>Interested in Supervised Practice?</i>	
<i>Consider Practice Supervision/Consider Practice Assessment</i>	20
<i>Change in Registration Services Director</i>	21
<i>Thinking of Relocating during your Summative Assessment?</i>	21



CPSS Programs and Services

<i>Prescribing Opioids: Challenging Scenarios (Part 2 of 3)</i>	22
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Physician Update

<i>Dictated reports using the Provincial Transcription Service: How to further reduce errors and delays</i>	25
<i>Patient Safety Alert - Saskatchewan Cancer Agency Referrals</i>	26
<i>You've only heard half the story - Immigrant and Refugee Mental Health Project</i>	26
<i>Saskatchewan Bleeding Disorders Program</i>	27
<i>LINK - Leveraging Immediate Non-Urgent Knowledge</i>	28



Sask Leaders in Health Care

<i>Kendel Award - Call for nominations</i>	29
<i>Senior Life Designation - Have you served 40 years in SK?</i>	29

We're Working for You 31

Do you have feedback to provide or a suggestion for an article to include in the next issue of DocTalk?

Submit your ideas & articles by **August 15, 2018** to COMMUNICATIONS@cps.sk.ca



Dr. Brian Brownbridge
President, CPSS

FROM THE PRESIDENT

Governance Reform, the Opioid Epidemic, and Sexual Boundary Violations

I am much honored to have been elected as the President of the Council of the College of Physicians and Surgeons of Saskatchewan. I want to thank Dr. Alan Beggs for his wise and sound leadership of the Council and I realize that I have very large shoes to fill in following him.

Some of the issues that Council will be exploring over the next period include governance reform of Council, the opioid epidemic, and strategies to reduce sexual boundary violations by physicians.

Governance Reform

The creation of a single provincial health authority has created questions about the constitution of Council. Pursuant to the College's administrative bylaws, the province is divided into ten Medical Electoral Divisions which mirror the Regional Health Authorities as they existed in 2005. As it stands now, a Councillor can be elected from a pool of 20 physicians or from one of greater than 600, depending on the electoral division. To address these questions, Council has struck a committee to examine the present legislation and bylaws, and to consider how

the formation of one health region will affect our present elected representation.

As a related issue, I wonder whether the makeup of Council is representative of the profession as a whole. For example, with Dr. Julie Stakiw's decision not to run for a second term on Council, there are no elected female Councillors. Dr. Stakiw will be truly missed. Most medical classes now demonstrate equal female to male ratio if not a preponderance of female medical students. The issue of appropriate representation of our Indigenous population on Council must also be addressed in a manner that is acceptable to all parties.

In addition to gender and cultural representation, there is also a question of medical speciality. The issues brought to Council often require a degree of knowledge about specialized areas of care whether internal medicine, surgery, family medicine, rural medicine or pediatrics. It is very important that Council strive to have some internal expertise and representation of these different areas of care.

Instead of having all of their Councillors elected, many professional governing bodies have certain positions that are reserved to represent potential expertise needs. Law societies across Canada are studying whether their boards should be selected based on expertise, rather than being elected by their peers. A number of professional regulatory bodies have moved to an equal number of elected members and public representatives. Changing the constitution of Council would require a direct request of the Provincial Government to amend the legislation that governs the Council. I realize that this is not a short term process and welcome feedback from members on whether this issue is one that Council should be encouraged to explore.

ELECTION

new electoral
boundaries for 2018



...continued from p. 4.

The Opioid Epidemic

The College of Physicians and Surgeons of British Columbia felt a need to move early and decisively on opioid prescription and developed a guideline published on their website.

The Council has a sub-committee looking at areas of opioid prescriptions in Saskatchewan.

The College is receiving many enquiries about what to do with patients on doses of opioids outside the new Canadian recommendations. We would request that you continue to support these patients and seek advice on whether patients need to be slowly weaned to a lower dose from opioid expert physicians. I am mindful that the issue of opioid prescribing is extremely complex and will require a great deal of deliberation by Council as far as suggested approaches for Saskatchewan. We welcome feedback from members on this very complex issue.

Sexual Boundary Violations

Over the last two years, the College seems to have received an increasing number of complaints about sexual boundary transgressions.

Council is exploring putting together an educational program that will be delivered to medical students, residents and new IMG physicians entering our province with the hope that the incidence of these very significant transgressions can be reduced.



Discussion during Council meeting, March 2018



COUNCIL NEWS

New Council President

Council would like to congratulate **Dr. Brian Brownbridge**, an anaesthetist from Saskatoon, who was elected as new **President of the Council of the College of Physicians and Surgeons of Saskatchewan** in January 2018. Dr. Grant Stoneham, a radiologist from Saskatoon, was elected Vice-President.

Council would like to thank Dr. Alan Beggs, who is stepping down as President, as well as Dr. Julie Stakiw, former Vice President of Council, for their two years of service at the helm of Council. Dr. Beggs will remain on Council as Past President.

In addition, the new (and returning) members to Council's Executive Committee are:

- | | |
|-------------------------|-----------------------|
| President: | Dr. Brian Brownbridge |
| Vice-President: | Dr. Grant Stoneham |
| Member-at-large: | Dr. Mark Chapelski |
| Member-at-large: | Dr. Edward Tsoi |
| Member-at-large: | Mr. Ken Smith |



Photo (left-right): Dr. Karen Shaw, Registrar, Dr. Brian Brownbridge, President, and Dr. Grant Stoneham, Vice-President, discuss a topic during the March 2018 Council meeting.



FROM THE REGISTRAR



Dr. Karen Shaw
Registrar, CEO

R-E-S-P-E-C-T

Find out what it means to me

(Otis Redding - song writer, 1965)

In an article entitled *What does “Respect” Mean? Exploring the Moral Obligation of Health Professionals to Respect Patients*¹, the authors note that while respect is frequently considered an integral aspect of ethics and professionalism in medicine, it is often unclear what respect means in the medical setting.

These authors developed a conception of respect that imposes a distinct moral duty on physicians – respect for patients as persons. In addition, they pointed out that the respect that they promote has both a cognitive dimension (believing that patients have value) and a behavioural dimension (acting in accordance with this belief).

If we look back to the **Patient First Review Commissioner’s report (October 2009)**, respectful care was identified as:

*“patients are treated with empathy and understanding for their fears and hopes. The relationship between patient, family and provider is a balanced, mutually respectful partnership, not an imbalanced power dynamic that favours the provider.”*²

The Patient First Review also reminded us that healthcare is as much about relationships as it is about science and medicine. It heard repeatedly about the importance of the provider-patient relationship, and the qualities that make a

good relationship including: “respect, time, listening, clear communication, openness, empathy and understanding.”

Another paper *Understanding Respect: Learning from Patients*³, identified patients’ viewpoints pertaining to what it means to be respected by medical providers. The elements identified were: attention to needs, empathy, care, autonomy, recognition of individuality, information provision and dignity.

The College recently provided sponsorship for the **Gathering for miyo mahcihowin (physical, mental, emotional and spiritual wellbeing)**, a conference held on March 15 and 16, 2018 in Saskatoon. The *Gathering for miyo mahcihowin* was “a community-driven” event that focused on health issues that were identified by Saskatchewan Indigenous peoples and highlighted the successful work already happening within their communities. It was a good opportunity for the College to sponsor an event that focused on the physical, mental, emotional and spiritual wellbeing of our Indigenous people and to support the approaches for the development of a “reciprocal, respectful and authentic partnerships between the communities and the researchers.”

The Council of the College of Physicians and Surgeons of Saskatchewan has been reviewing the report *Truth and*

... continued on p. 7



¹ M. C. Beach, MD et al., *What does “Respect” Mean? Exploring the Moral Obligation of Health Professionals to Respect Patients*. J Gen Intern Med. 2007 May; 22(5): 692-695

² *Patient First Review*. <https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/saskatchewan-health-initiatives/patient-first-review>

³ N.W Dickert and N.E Kass, *Understanding Respect: Learning from Patients*. J Med Ethics. 2009 Jul; 35(7); 419-423

Reconciliation Commission of Canada: Calls to Action, to highlight what we, as a regulator, can do to improve health and wellbeing of Saskatchewan's Indigenous people. We recognize that our healthcare system has not yet eliminated the health disparities experienced by our Indigenous people.

This was an opportunity to hear from the many who attended this conference what was important from their perspectives. During the two-day conference, the College of Physicians and Surgeons of Saskatchewan provided a means for conference attendees to respond to questions posed pertaining to their health needs and care experiences.

A summary of the key points can be found below. (The questions posed and the full set of responses to those questions are reproduced in subsequent pages.)

Question 1

What can we do to improve collaboration between physicians and other healthcare service groups to better serve indigenous patients?

Responses included:

- Transparent open communication
- More education for our undergraduate students and residents
- Brainstorm with patients to find spiritual, emotional, intellectual health plans of action/resources

Question 2

What do I think about before my appointment?

Responses included:

- Will the hospital staff be nice to me, respect me?
- Scared because I'm HIV positive
- Am I going to see a new doctor *again*?
- I need to brace myself and prepare myself mentally for a few weeks because I'm afraid I won't be believed about my symptoms

Question 3

What could my doctor do to make my appointment better/easier?

- Take the time to explain my diagnosis
- Let me know what I can expect
- Give me options for a treatment plan
- Explain why you're ordering tests, consults, etc. What will it show you? How will it benefit me? What can I expect?
- Listen, don't judge
- Understand First Nations

Question 4

During my doctor's appointment - What I like...

What does my doctor do/say to make me feel more at ease?

- Good listening skills
- Washes hands with soap before she leaves
- Partnering with patients and their families to make decisions about care
- No overbooking
- Patient-centred care
- More mental health awareness

Question 5

During my doctor's appointment - what I don't like...

What does my doctor do/say that makes me feel uncomfortable?

- Doesn't include me in the treatment plan - doesn't ask me if I agree, if I can do it. Just tells me.
- Speaks over me
- Doesn't value my experience
- Not letting me tell my story, interrupting, rushing, cutting me off
- Not discussing barriers and solutions to my issue; access, finances, transportation
- Making me ashamed for my issue
- Not understanding cultural competency, cultural safety

... continued from p.7

So how can we translate this feedback to improve our day to day work?

Hopefully some of these comments will resonate with you, and you'll take some time to think how you could address some of the issues identified with your patients.

Although we at the College don't provide care to patients, it is our responsibility to regulate the practice of medicine, to improve what we can for patients and caregivers and to assist with eliminating the health disparities experienced by some of our patients; in particular, our Indigenous patients.

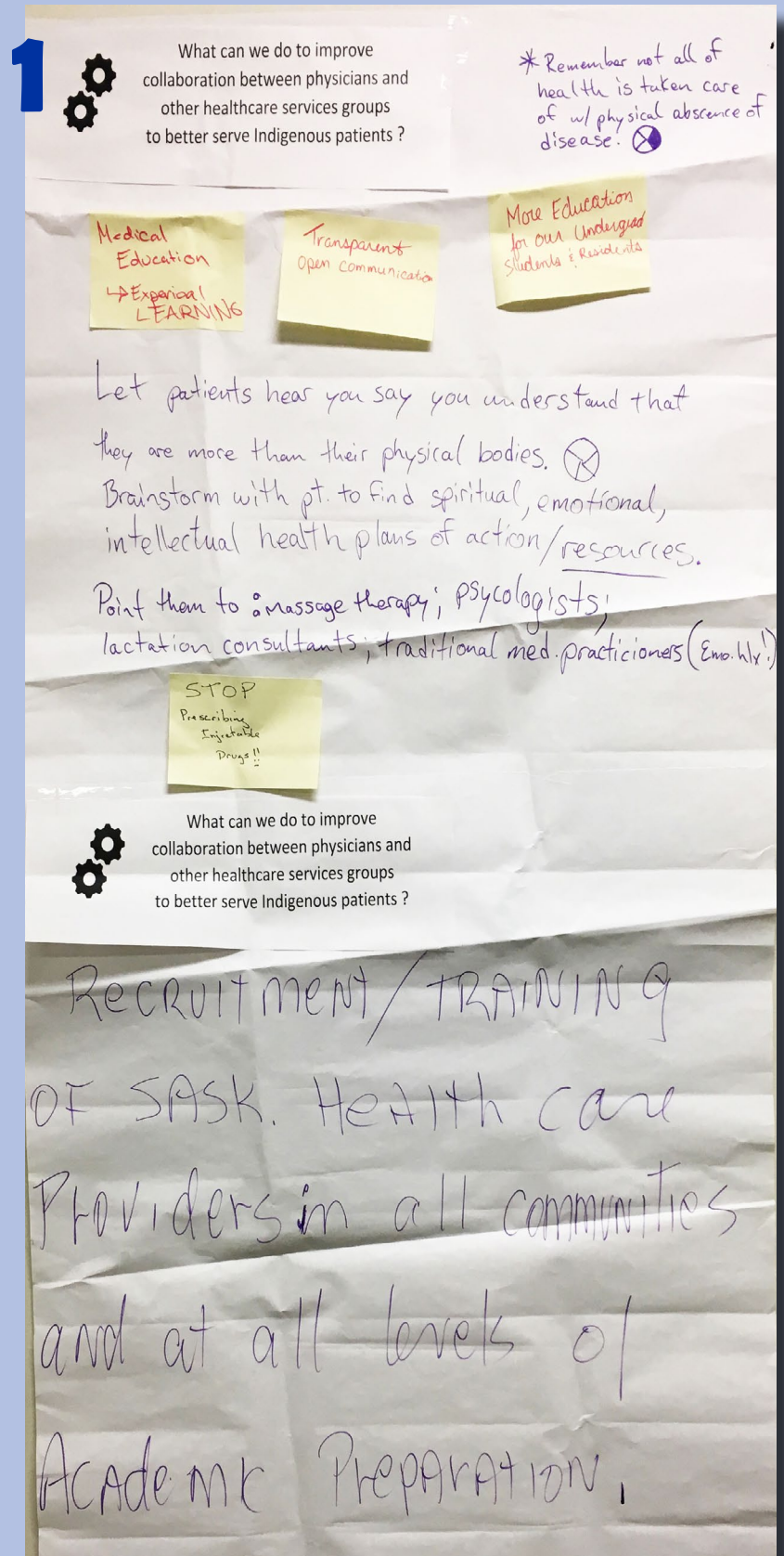
Some of the College Councillors and staff will be participating in the Continuing Medical Education course entitled *The Role of Practitioners in Indigenous Wellness*, in an effort to improve our knowledge of cultural humility. Dr. McBride, who works part time assisting us in the summative assessment work, provides his perspective on how he found the course valuable on page 11 in this edition of DocTalk. We hope that you will join us in completing this course.

As we learn more about each other, and find out what it means to each of us to feel respected, and act in accordance with the belief that each of us has value, we will be one step closer to strengthening the relationship between provider and patient that we know is imperative to achieving improved health care outcomes.



FEEDBACK FROM THE

Gathering for miyo mahcihowin



2

What do I think about before my appointment?

Will the hospital staff be nice to me, respect me?

SCARED
CAUSE
I AM
HIV POSITIVE !!

Am I going to see a new
doctor again?

I need to brace myself
and prepare myself mentally
for a few weeks because
I am afraid I won't be
believed about my symptoms

are they using my
condition to excessively bill
health canada? (Dentists giving start term solutions over and over again.)

3

What could my doctor do to make my appointment better/easier?

Have F.N. art pieces in the offices/waiting rooms....
even geometric art that looks like beadwork or birch bark bitings!!
↳ good idea!

Longer appointment times

Being on time for appointment - no full waiting rooms ✓

What I would like to see ...
- Holistic care - discussion around all
aspects of health - physical, mental,
spiritual + emotional
↳ How this impacts my current
health state
↳ How it can be included in the
treatment plan
↳ treatment plan + solutions that
I participate in, help establish,
take responsibility, feel empowered.

- Take the time to explain my diagnosis
- Let me know what I can expect.
- Explain what + why you choose a
treatment plan
- Give me options for a treatment
plan
- Explain why you are ordering tests
consults, etc. what will it show you?
How will it benefit me? What can I
expect?

↳ this will require systematic change
in terms of how doctors are paid.
We cannot provide the care we want
to in the current system.
We are ready as a profession to do
better, and I promise we will.

- LISTEN
- DON'T JUDGE
- Understand First Nations
People.

DURING MY DOCTOR'S APPOINTMENT

DURING MY DOCTOR'S APPOINTMENT

4 😊 What I Like...

5 😞 What I don't like...

What does my doctor do/say to make me feel more at ease?

What does my doctor do/say that makes me feel uncomfortable?

Good LISTENING Skills

Washes her hands & soap before she leaves.

PARTNERING WITH PATIENTS
AND THEIR FAMILIES
TO MAKE DECISIONS
ABOUT CARE.

Listen

Organized.

To be seen when scheduled -
no over booking

Patient centered care

more mental health Awareness

Doesn't include me in the treatment plan - doesn't ask if I agree, if I can do it. Just tells me

Speaks over me.

Doesn't value my

What I don't like ...
- not letting me tell my story - interrupting
- rushing, asking me off
- not discussing barriers + solutions to my issue ex. access, finances, transportation
- only allowing me to express 1 concern
- making me feel ashamed for my issue

I hate the inherent Stigmatization of Sex workers treating me like a walking risk + making suggestions to me that as a Sex-worker is impossible i.e. get ~~more~~ ^{more} addresses of all clients (partners). - bar work - non sex workers to get tested as well!

- assumptions - stigma
- judgment
- diagnosis with explanation - not taking the time to help me understand
- belittling
- being impatient
- not actually physically examining me
- not writing a prescription

Not understanding Cultural Competency Cultural safety.

My doctor goes automatically to a prescription and is sometimes inconsistent in her openness to hear me.

assumes I am heterosexual

Being physically rough w/me.

Dentists: Providing expensive, short term solutions that require extra billings to Canada; inconvenient!

Doing Anal + pop smears with doctor. Needs to be cultural appropriate + having a good relationship with the Doctor!

Control our Doctors who push the HIV/AIDS rates in SK. HIV is a money making Industry!!!!

Take the time to *Listen to My Story*

Stories heard at the CPSS booth, Gathering for miyo mahcihowin

Patient from Stony Rapids:

"I don't like to go see the doctor – I feel that it's always a different doctor and I get tired of telling my story over and over again, not knowing if I'll see that doctor again. Sometimes it's not worth it. I wish a relationship would be developed."

Female, FN, approx. 50-60 yrs:

"I like my doctor now, but it took a lot of shopping to find one I felt I could build a relationship with, who respected me as a person, a fellow human being who knew my body and my state of health. Even then, my daughter went to see him and found him abrupt and cold. I had to tell her "My girl, you have to remember he's not from the same culture as you."

A young adult male, early twenties said that his experience going to the doctor was to be prescribed a treatment with no explanation of why, nor how it would affect him, and he left confused and frustrated. *(This young man read the boards closely, and stayed and chatted with the booth rep for about 15 minutes, and came back a few times. He questioned if the information was actually going to be used/read, by whom, and when. He said he wanted to write things down but felt uneasy, not sure how to explain himself, not sure if he could trust the process, and ultimately left without leaving his story).*

Female attendee:

A nurse I know was working at a street assistance bus program. An Indigenous patient came in who had tried injecting [drugs] in the jugular but missed and had severe swelling, which was impeding breathing. The patient refused to go to hospital for fear of "not being treated well". They were right beside the hospital in one of the street help buses.

Story as told by female attendee:

I know an RN who helped a man with addiction issues who had a herniated abscess in the spine. He refused to go to see doctor/hospital – he accepted to go only once a trusted RN/friend who was familiar with the system – and was very surprised to be told at one point during the process "You matter" – when all the rest of the time he'd had a negative experience. He assumed it was because of the (white, female) RN who accompanied him.

Written follow-up submitted afterwards by the same attendee: [I was] Informed by a RN how she had to accompany a very ill man to the hospital. Many aboriginal men or women will not go to the hospital, because they are treated less than human. Apparently, many men and women have been treated badly by staff at [this hospital]. Is it because they have addictions, are HIV+, gang members? This individual male had an [abscess] on his spine and face - RN was surprised that he was even walking; she felt the need to accompany him. If he stayed is unknown, but the RN stayed with him until he was admitted, she witnessed some of the abuse [doctors] and nurses had toward the male. Apparently, this is common practice [at the hospital in question].



Communication and the Indigenous Person



Written by the staff at the First Nations and Métis Health Services, Saskatchewan Health Authority

The ability to communicate effectively takes years of practice. It is not merely about exchanging information but how you convey it, how people interpret it and the message they receive.

- (Brown, 2015)

There are many things to take into consideration when trying to learn the best way to communicate especially when dealing with different cultures and ethnic groups. Your ability to communicate just became that much more complicated by throwing these into the mix. The best way to effectively communicate cross-culturally, is to take whatever resources you can and actively learn to expand your horizons by exploring your “unknowingness” about the richness and vitality of other cultures and differences.



The “Tree of Life”

Canada has a tainted history with the Indigenous people of this land which continues to resonate with many survivors, families and communities. This history, known as the **Residential School Era**, was a time that many children, now adults, would sooner forget. This act of attempting to “civilize” Indigenous people, has left unimaginable scars leading to numerous emotional, mental, physical and spiritual harms.

The effects of colonialism continue to deeply impact survivors to a point that many of them will avoid medical care all together.

- (Allan, B., & Smylie, J., 2015)

It is often only when this need is overwhelming that they find themselves in a doctor’s office or in an emergency room, the very places they were trying to avoid. These places of vulnerability bring raw emotion and memories to the surface, causing walls and barriers to be built where they are reluctant to let anyone in. A good place to start to break down these barriers is through acceptance, understanding and seeing through the eyes of the patient.

We all have the right to receive quality healthcare that leaves one in a good frame of mind, knowing that there are caregivers out there that have compassion and sincerity and want to make a difference in their chosen field.

The hospital environment can be quite a daunting place when you are feeling vulnerable, especially if it brings up triggers and memories from the past. Acknowledging and understanding the historical background of the Indigenous

people of Canada by being more informed, can better equip the caregiver when working with Indigenous patients to be more empathetic. Being mindful of the history and differences we all carry while working from a place of humility and compassion can sometimes be quite tangible when you are on the receiving end, making the connection between caregiver and patient is more likely to be positive. One must also be cognizant of:

- body language,
- sincerity during consultations,
- non-verbal communication,
- having an understanding of Indigenous values and belief systems,
- using layman’s terms,

... continued on p. 13

... continued from p. 12

- being culturally sensitive,
- being non-judgmental
- being aware of your own perceptions, beliefs and attitudes; and
- learning to speak less and listen more.

Traditional Indigenous communication is based on balance and equal sharing (Caron, N., 2006). This idea comes from the Medicine Wheel concept that teaches that everything is balanced and interconnected. We are connected to each other through relationships, connected to the land and world around us and connected to the Creator who gives purpose and life to all. In the healthcare setting, meaningful communication and establishing rapport where both patient and caregiver are equally engaged, also provides a foundation where a trusting relationship can begin. Learning to see the patient rather than the illness is related to the holistic concept of healing and wellbeing as health does not only include the physical body, but the emotional, mental and spiritual aspects as well. Keeping this in mind will better facilitate conversation by having focus on the individual rather than the issue they are facing.

Based on Cree teachings, the three core values at the center of the tipi teachings are **obedience, respect and humility.**

-(Lee, M., 2012).

These values then extend outward to fortify the family structure giving it strength and stability as well as a firm foundation. As a result of this bond, the family plays an integral role in the progression of care for their loved one therefore keeping them involved and informed becomes a vital part of patient care. This can happen by developing and implementing a plan with revisions when needed with the input of family members. These people usually end up becoming an advocate, a support system and a lifeline for their loved one by helping them to navigate through a system that often times is foreign to them. Therefore, inclusion, clear patient understanding, respect, trust and being non-judgmental are necessary components on the care givers part to begin a process towards positive change.

Photo: Indigenous dancer Lawrence A. Roy Jr. during National Aboriginal day celebrations in June 2014, courtesy of First Nations and Métis Health Services.

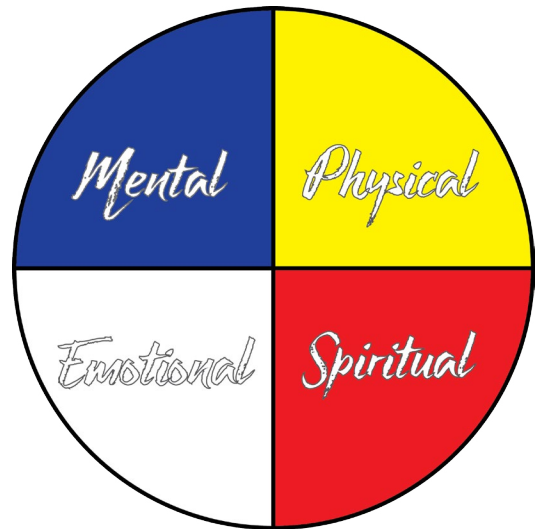
Resources

Allan, B., & Smylie, J., (2015). First Peoples, Second Class Treatment: The role of racism in the health and well-being of Indigenous peoples in Canada. Retrieved from: <http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf>

Brown, B., (2015). What Is Effective Communication? Retrieved from: <https://www.livestrong.com/article/69309-effective-communication>, Caron, N., (2006). Caring for Aboriginal patients: the culturally competent physician. Royal College Outlook, 3(2), 20-23. Retrieved from: https://www.med.uottawa.ca/sim/data/Images/Aboriginal_care_Caron_e.pdf, Lee, M., (2012). Four Directions Teachings: Aboriginal Online Teachings and Resource Center, Retrieved from: <http://www.fourdirectionsteachings.com/transcripts/cree.html>

MEDICINE WHEEL

The four Guiding Spirits of our being



Effective communication takes time and effort. It is a skill that needs to be honed and worked on with consistency and effort if we are to make a difference. The Indigenous person historically comes from a place of strength and honor and these qualities must be recognized and acknowledged by developing those relationships on which trust is built. I'm reminded of something an Elder once told me, he said...



We can never underestimate the power of listening...

Creator has gifted us with one mouth and 2 ears so we are to listen twice as much as we talk.

But we also must learn to listen with our hearts as well".

We all need to be understood, accepted and feel like we belong and can make a difference. If we learn to let our hearts guide us, how can we go wrong?

The Role of Practitioners in Indigenous Wellness

A Personal Experience

by Dr. Bert McBride, Lead Summative Assessor, CPSS

I recently completed “The Role of Practitioners in Indigenous Wellness”, an online accredited learning opportunity. described by the provider as “a collaborative project developed by the Division of Continuing Medical Education, College of Medicine, and Continuing Physical Therapy Education, University of Saskatchewan, with assistance from the Canadian Medical Protective Association. The content was created by Indigenous community members and scholars, some of whom are the on-line instructors. It is designed from an Indigenous world view, delivered through the voices and stories of leaders in Indigenous health care. Upon completion, health care practitioners will be equipped with the knowledge and insights to employ an interdisciplinary approach in understanding and supporting Indigenous patients.”

My interest in the course arose out of my role as a summative assessor of physicians completing their supervised practice in the Saskatchewan International Physician Practice Assessment program (SIPPA). SIPPA physicians receive initial orientation from representatives of the Indigenous persons but we have so far not specifically evaluated the effectiveness of that orientation.

One component of the physician assessment is a mail-in survey of patient satisfaction with the care provided. In communities with a large Indigenous population we have experienced difficulty in obtaining a sufficient number of survey returns. This led us to consider other ways of deter-

mining satisfaction with the care provided by physicians in these communities. In order to do this we knew we needed to better understand Indigenous wellness from an Indigenous perspective.

The course led me through a series of challenging online videos and readings, done at my own pace, with steps along the way for reflection based on what I learned. I learned a good deal about how past abuses have led to current struggles. It was good for me to consider ways in which my own biases may have been created and to share that with other participants. Completion of the course required submission of a final project in which I described how what I learned enabled me to create a culturally responsive plan for delivering - in my case assessing - care. Throughout I had good guidance by the moderator, Dan Mittelholtz. It was time well spent.

Has the program solved the College’s concern about how to best determine if good health care is provided to Indigenous patients and communities?

Not yet, but at least we have a much better understanding of barriers to Indigenous wellness and the need for a culturally safe and responsive methodology in assessing delivery of care. This has led to meetings with College of Physicians and Surgeons representatives and Indigenous persons active in enhancing the care of their communities. We are one step closer to our goal.



All Saskatchewan physicians and surgeons have Indigenous patients in their practice.

I highly recommend enrolling in a course such as the “The Role of Practitioners in Indigenous Wellness” as a way of strengthening the quality of care we deliver.



The Eating Well Program for First Nations Communities



Physicians: A new temporary pilot program is offering FREE dietitian services individuals in First Nations communities across Saskatchewan! Encourage your patients to try it out!

EATING WELL for your health just got easier!

EAT WELL SASKATCHEWAN IS A FREE SERVICE CONNECTING SASKATCHEWAN FIRST NATIONS COMMUNITIES TO A REGISTERED DIETITIAN

UNTIL JUNE 29, 2018, you can ask a registered dietitian questions about food, healthy eating for your family, budget-friendly meal ideas, heart health, diabetes and more—for free!



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Monday to Friday

1-833-782-7800
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 Website: www.eatwellsask.ca

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Naloxone Nasal Spray Now FREE for First Nations and Inuit



First Nations and Inuit will now have free access to **Naloxone Nasal Spray**, an antidote for opioid overdoses, in addition to the injectable form.

On April 5, 2018, Indigenous Services Canada announced the spray would be eligible for coverage under the Non-Insured Health Benefits program when prescribed or recommended by a pharmacist (or any prescriber).

Physicians are encouraged to advise those who use drugs and the people close to them to get a naloxone kit.

More information is available at <https://www.canada.ca/en/indigenous-services-canada/news/2018/04/naloxone-nasal-spray-now-available-to-first-nations-and-inuit-through-non-insured-health-benefits-program.html>



Dr. Micheal Howard-Tripp
Deputy Registrar

The Meet-and-Greet

Appropriate use of this appointment

It would appear that some practices are increasingly using the meet and greet appointment for new patients wanting to join their practice. Meet and greet appointments are only appropriate when both the physician and the patient require an introduction to each other and should; therefore, only be used to provide information about the practice, staff, hours, 'no show' policies and other uninsured charges, etc.

A meet and greet appointment is an uninsured service and is not billable to MSB and should; therefore, not be used to provide any medical service. Once a physician takes a medical history, identifies a medical problem and provides treatment for that medical problem the visit is no longer a meet and greet and a duty of care is established. Once the physician and the patient agree that a therapeutic relationship is mutually agreeable, then the patient can provide a medical history which can be reviewed to see whether there are any aspects that fall outside of the physician's scope of practice. Caution is advised with rejecting a patient after reviewing their medical history as declining to then accept the patient may be regarded as 'cherry picking' and the physician could be accused of discrimination.

If a clinic is accepting new patients, then patients attending a meet and greet should be admitted to the practice on a strictly first come first served basis. If the physician has a focused practice, it is necessary that prospective patients are advised of this in advance of a meet and greet appointment. It is important to note that advertising that a practice does not prescribe narcotic medications, despite this being within the scope and abilities of the physician, may be construed as discrimination and is not normally considered a valid reason for declining a prospective patient. Additionally, if a physician has a conscientious objection to providing certain services, it is required that the clinic communicate this clearly to prospective patients so that they can seek out a practice with no such objections. Should

there be any valid reason why a physician or a practice cannot accept a prospective patient then, wherever possible, assistance should be provided to the patient in finding an alternative provider.

Despite any practice restrictions, or decisions not to accept a patient for valid reasons, any patient presenting with an emergent medical condition must be accommodated and appropriate treatment, and/or transfer to a more suitable care provider, must be provided.

The reader is referred to the College's guideline on patient-physician relationships particularly the section on establishing a patient-physician relationship. In summary, the essential components of a meet and greet appointment are:

- Identify patients' needs and expectations,
- Disclose information about the physician's knowledge and abilities, including any restrictions as per focused practice or specialization.
- Introduction to clinic staff and clinic policies, including non-insured services, hours, patient rights and responsibilities, appointments, no-show policies and clinic policy on non-compliance with medical treatment.

Please note that this article is intended as advice only and if a physician/patient or practice has any questions they should contact the College directly.



Announcing Dr. Micheal Howard-Tripp's Retirement

Dr. Howard-Tripp has announced his retirement effective September 30th, 2018. On behalf of the College, we would like to thank Dr. Howard-Tripp for his valued service to the College. Please join us in wishing him well in his retirement.

The College will soon begin a search process to fill the Deputy Registrar's position. Any interested candidates wanting information about the position can contact Dr. Karen Shaw confidentially by writing to OfficeOfTheRegistrar@cps.sk.ca.



Bryan Salte

Associate Registrar
and Legal Counsel

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 newsletter, Council has adopted or amended four (4) of these documents. The title of the documents and a summary of their content follows:

GUIDELINE – Clinics that Provide Care to Patients Who Are Not Regular Patients of the Clinic

A new sunset date of March 2023 has been set. No other change was made.

[Click here to view full policy](#)

POLICY - College Newsletter

Council set a new sunset date of March 2023. No other change was made.

[Click here to view full policy](#)

POLICY - Patients Who Threaten Harm to Themselves or Others

Council approved an update to the link and page number for the Medical-legal handbook for physicians in Canada published by the Canadian Medical Protective Association (CMPA), and a new sunset date of March 2023. No other changes were made.

[Click here to view full policy](#)

POLICY - Professional Responsibilities in Postgraduate and Undergraduate Education

Council rescinded the previous policy, Supervision of Postgraduate Clinical Trainees, and replaced it with a new policy, Professional Responsibilities in Postgraduate and Undergraduate Education.

The purpose of this guideline is to clarify the roles and responsibilities of the most responsible physicians (MRPs), supervisors, postgraduate trainees and medical students engaged in postgraduate and undergraduate medical education programs, including the following:

1. Supervision and Training
2. Professional Relationships
3. Patient Care within the Postgraduate Educational Environment
4. Designation of Most Responsible Physician
5. Reporting Responsibilities

The College accepts the two policies, Supervision of Postgraduate Trainees and Supervision of Medical Students on Clinical Rotations, developed by the College of Medicine, University of Saskatchewan as expectations of the College regarding those roles and responsibilities.

[Click here to view full policy](#)

Website Update



Governance policies are now available on the College website at http://www.cps.sk.ca/imis/CPSS/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Governance_Policies_Table_View.aspx

The full versions of all CPSS Policies, Standards and Guidelines are available on the College Website at www.cps.sk.ca

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.

There were three discipline matters completed since the last Newsletter report.

Dr. Svitlana Cheshenchuk (now Dr. Svitlana Ziarko)

Dr. Cheshenchuk admitted two charges of unprofessional conduct. The first stated that Dr. Cheshenchuk had altered her medical record for a patient on multiple occasions between October 20, 2014 and June 22, 2015 after learning her patient had died. The second charge stated that Dr. Cheshenchuk had failed to inform the College that the records she had submitted had been altered. The second charge also stated that her office had advised the College that the record had not been altered in a substantive way and that Dr. Cheshenchuk failed to exercise due diligence to ensure that the information provided to the College was accurate.

Dr. Cheshenchuk was reprimanded, suspended for one month, required to take a course on professionalism, required to complete a course on record-keeping and ordered to pay costs of \$7,484.71.

Dr. Cheshenchuk recently notified the College that her name had been changed from Svitlana Cheshenchuk to Svitlana Ziarko.

Dr. Oluwatomi Mitchell

Dr. Mitchell admitted unprofessional conduct for failing to respond to requests for information from the College and failing to comply, to the best of her ability, fully and accurately, with requests for information.

Dr. Mitchell was ordered to pay a fine of \$1,500.

Dr. Zimran Chowdhary

Dr. Chowdhary admitted unprofessional conduct in relation to his conduct in dealing with complications of a circumcision which he performed. He admitted that he advised the parents of the child that there had been no mistake made in relation to the circumcision and admitted that he advised the parents that no further surgery would be required.

Prior to admitting the unprofessional conduct Dr. Chowdhary successfully completed a process which was overseen by the College to address concerns about his skill and knowledge in performing circumcisions.

Dr. Chowdhary was reprimanded and ordered to pay costs of \$10,051.

Physician Lists for Specific Services

The College does not keep lists of physicians providing specific services. However, general information for physicians wishing to provide and patients wishing to access certain services is available on our website:

Medical Assistance in Dying

http://www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Medical_Assistance_in_Dying.aspx

Prescribing Medical Cannabis

http://www.cps.sk.ca/imis/CPSS/CPSS/Programs_and_Services/Medical_Marijuana/Medical_Cannabis.aspx



REGISTRATION TIMES

Are you a Resident Completing Training in 2018?

Residents nearing the end of their training program (and intending to practise medicine in Saskatchewan) must apply for a licence with the College of Physicians and Surgeons of Saskatchewan.

Applicants should **apply a minimum of six weeks prior** to the date they wish to start to practice to avoid delays at the end of the academic year.

Qualifying for a Regular Licence in SK (Family Medicine or Specialty Practice)

Applicants must have:

- obtained the LMCC and have official results available*;
- satisfactorily completed his/her postgraduate training program and have access to the completion certificate;
- certification with the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada and have results available.

*Registration Services will confirm your pass results on lists that we receive from the CFPC and Royal College - timing of receiving these lists may impact your practice start date.

Qualifying for a Provisional Licence (with restrictions)

Residents who DO NOT meet the requirements for REGULAR licensure may be eligible for a PROVISIONAL LICENCE (with restrictions). Applicants must have:

- successfully completed the MCCEE or MCCQE1;
- satisfactorily completed his/her postgraduate training program and have access to the completion certificate;
- continued eligibility with the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada.

On a PROVISIONAL LICENCE (with restrictions), the physician is restricted to practising under supervision**.

Supervision includes:

- reviews of charts;
- chart stimulated discussion with the physician being supervised;
- reports to the CPSS at regular intervals on a form provided by the CPSS.

**** Physicians are responsible for the cost of the supervision and may be required to assist the College in locating a willing supervisor.**



Obtaining some of the required documentation for licensing can be time-consuming.

Please allow ample time between the date of your program completion and your practice start date.

We cannot guarantee a start date to your licence.

A licence will not be issued until:

- all of the necessary arrangements for practice supervision are complete
- AND
- all of the required documentation has been received by the CPSS Registration staff.

Either licence will require you to:

- renew annually online on or before November 1
- be enrolled in a CME program and provide us with the cycle dates of this program

For more information,
call the College's
Registration Services
at (306) 244-7355
or visit our [website](#).

REPORT YOUR CME CREDITS!

A Reminder to Family Physicians

At the end of each cycle, all Mainpro+ participants will be given a 6-week grace period. This grace period can be used to report credits for the cycle that is ending but cannot be used to earn new credits for that cycle.

For example, if your 5-year cycle runs from July 1, 2013, to June 30, 2018 (let's call this Cycle A), you will be given until August 11, 2018, to report credits for Cycle A. Any activities you enter with a completion date on or before June 30, 2018, will apply to Cycle A. During the 6-week grace period, you may also earn and report credits into your new cycle that started July 1, 2018 (let's call this Cycle B). Any activities you report with a start date of July 1, 2018, onward will count toward Cycle B.

If by August 11th you have met the 5-year credit requirements for Cycle A, you will automatically be moved into a new 5-year cycle and Cycle A will be marked as "Complete".

If by August 11th you have not met the 5-year credit requirements for Cycle A, you will automatically be placed in a **2-year remedial cycle** and Cycle A will be marked as "Incomplete." During the 2-year remedial cycle, the use of your CFPC designations (MCFP, FCFP, CCFP, and CAC) will be suspended. You will be required to earn and report 100 credits during this 2-year cycle, 50 of which must be Certified. We encourage all Mainpro+ participants to report credits on a regular basis.

Questions?

Check out the FAQ section on the CFPC website:

<http://www.cfpc.ca/ProjectAssets/Templates/FAQ.aspx?id=9307>



Interested in Supervising Practice?

Enrich your experience by helping new physicians perfect their skills



Consider Practice Supervision!

If you are approached to support the new physicians of Saskatchewan by acting as a **practice supervisor**, please consider accepting this responsibility if you have been practicing on your regular licence for a period of 3 years or more.

New graduates who have not passed all their examinations cannot practice medicine independently unless a practice supervisor is willing and able to accept this responsibility.

Practice supervision includes:

- a review of charts
- chart-stimulated discussion with the physician being supervised; and
- reports to the College at regular intervals on a form provided by the College

Consider Practice Assessment!



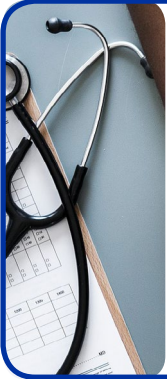
We are looking for new summative assessors to assess family physicians when they have completed their supervised practice.

If you are working full-time but believe you can commit three or four hours of time to us, or maybe you are only working part-time or are looking at retiring from practice somewhere in the near future, this may be something that would be of interest to you.

You must have practiced on a regular licence for a period of 3 years or more as a minimum requirement.

We are also looking for summative assessors for physicians who are in specialties. If you are interested in participating in assessments, we would ask that you please put your name forward so we can start a list with the specialties attached. Once we have a physician in that specialty, we will review the list for prospective assessors.

For more information, please e-mail Carol Bowkowsky at cpsreg-assess@cps.sk.ca.



Change in Registration Services Director at the College

Ms. Barb Porter retired from her position as Director of Registration Services at the College effective January 30, 2018. We thank Ms. Porter for her long service and wish her well in her future endeavours.

The College is pleased to announce Mr. Ed Pas has accepted the position of Director of Registration Services and will be starting in this position on April 30th, 2018. We welcome Mr. Pas and look forward to working with him.

Thinking of relocating during your

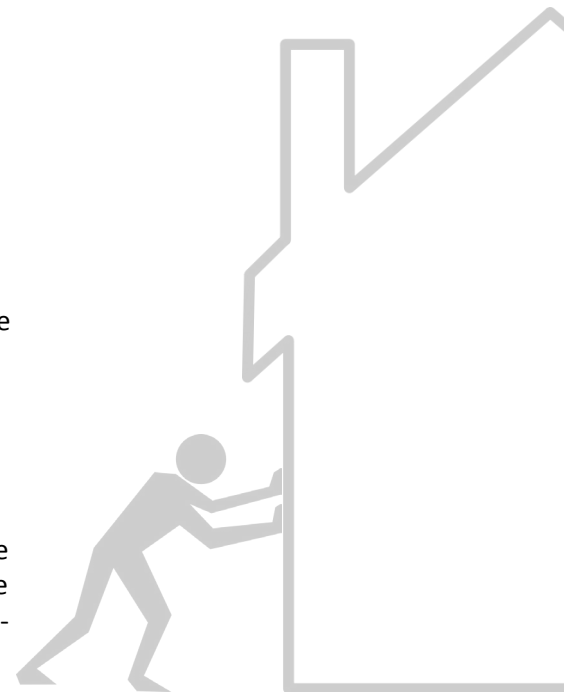
Summative Assessment?

Check with the College first...

If you have chosen or are required to undergo a summative assessment, it is in your best interest to:

1. Ensure that you have enough of a body of work for a summative assessor to review (minimum one year);
2. Help the College of Physicians and Surgeons with locating possible summative assessors; and
3. If you have plans to relocate, before putting any plans in motion, check with the College of Physicians and Surgeons to ensure that this would not require additional practice to ensure the best possible outcome.

Where such assessments are available, the Registrar's determination whether the assessment has demonstrated that the physician has appropriate skill, knowledge and suitability to enter into independent practice is **final**, subject only to the ability of the Council to review the Registrar's decision.



CCENDU RCCET

Canadian Community Epidemiological Network on Drug Use • Réseau communautaire canadien d'épidémiologie des toxicomanies

CCENDU IS ON FACEBOOK!

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.

Prescribing Opioids: Challenging Scenarios

Part 2 of a 3 part series

by Dr. Laura Lee McFadden, Senior Medical Advisor, CPSS
Julia Bareham, Pharmacist Manager, Prescription Review Program, CPSS

In the last issue of DocTalk, we reviewed the new *Canadian Guideline for Opioids for Chronic Non-cancer Pain*. Since then, we have reviewed common questions posed to the College and PRP about specific problems encountered by doctors around the province. Here are two of the most recent:

1. How do I actually get a random urine drug screen (RUDS)?
2. How do I approach a patient when the RUDS does not reflect what is prescribed?

Random Urine Drug Screens

Random urine drug screens (RUDSs) are a valuable tool for supporting the safe and effective use of medications monitored by the Prescription Review Program, such as opioids and benzodiazepines. RUDSs can help to ensure that a patient is taking a medication prescribed to them as well as to ensure no other interacting medications are being used that may place the patient at risk of harm.

The greatest challenge with a RUDS is ensuring that it is truly random. If a urine sample is collected at each scheduled appointment, the test is no longer random, but routine, and loses its clinical value.

How to collect a RUDS

The fundamental principle of RUDSs is that they should be used in all patients taking a monitored medication, not only those you suspect of non-compliance. Urine drug screens should be looked upon as no different than any other test that you would perform on a patient, such as a blood glucose test for diabetes. If routinely done, then you avoid the stigma that you are singling out any patient or accusing them of abusing their medications.

Many prescribers have found that clinical judgment alone can be inadequate and misleading. You might discover it may be the patient you least suspected who will have a substance use disorder on top of chronic pain. This will require that you alter your treatment plan to address the

two separate health issues. Substance use disorders cannot always be identified by a patient's appearance. A patient with hypertension cannot be identified by their appearance either, and that is why you regularly assess blood pressure. Treat all patients in a consistent manner to avoid possibly missing a medication-related concern.

Do not collect urine samples at all scheduled appointments. Consider having your office staff call patients at a random time and request that they present to the appropriate location (e.g. your clinic or the lab) within a specified timeframe. The refusal to provide a sample when requested may be considered as a "failed" result. If a patient argues they are not able to provide a urine sample at an appointment, consider renewing the prescription only after the urine sample is provided. Only 2 to 3 mls of urine is required in order for the lab to be able to analyze the sample. All expectations surrounding providing a RUDS should be outlined in the treatment agreement which should be discussed and signed prior to the initiation of therapy.

... continued on p. 23



How to approach an abnormal RUDS

There are two situations you will encounter that involve unexpected RUDS results:

Scenario 1: Prescribed Medication not Present

When examining a RUDS result that is absent for a chronically prescribed medication, the first step is to review the dispensing history through a reliable source such as PIP. When a medication is filled at regular intervals each month, then you would expect to see that medication present in the urine. This would be especially true if the patient often asks for early refills. Lab results always indicate the date and time the sample was collected. Crosscheck that information with dispensing data. If the medication is not present in the urine, despite regular refills, it is very possible that the patient may be diverting medications. Remember that there are a variety of patient and medication factors that may influence urinary excretion (e.g. medication half-life, medication dose, fluid intake), however a chronic medication taken regularly should appear on the result. You can always call the provincial lab as they do perform quantitative measures, but only report qualitative. They are wonderful to talk to and are very helpful when you have any questions about the results.

What to do when the prescribed medication is not present

- Call the patient in to discuss the results. Document the conversation on the patient file. Remind the patient of the terms of the treatment agreement. If there is no patient agreement in place, have the patient sign it at this encounter.
- Depending on the response you get from the patient, you may want to implement some tighter boundaries. Examples include:
 - o Reduce the amount of medication dispensed at each interval. Perhaps a weekly dispense would be appropriate
 - o Increase the frequency of RUDSs
- Consider initiating random pill counts. You can work with the community pharmacy to do this. In this scenario you call the patient in randomly to bring his or her pills in. They are counted to ensure that the appropriate amount remains based on when they were filled

and the directions for use. If you suspect diversion, the best time to do this is after a weekend as demand for drugs goes up on Fridays and Saturdays – your typical “party days”.

In terms of providing guidance in regard to continuing to prescribe or not in this scenario, this can be challenging as each situation can be very different. It would not be wrong to discontinue prescribing the medication if you were confident that there was diversion occurring. If you do, ensure you document your conversations and rationale.

Consider repeating a RUDS and compare the results. If the medication is again absent, then you have enough evidence to stop prescribing that medication. If the medication is present, then ensure you have tight boundaries in place and consider increasing the frequency of the RUDSs.

Scenario 2: Un-Prescribed or Illicit Drugs Present

The greatest concern in this situation is that the patient could be taking a non-prescribed medication that may interact with his or her prescriptions and increase the risk of harm. For example, a benzodiazepine and an opioid, or perhaps two different opioids. Many overdoses occur because of the combined effect of sedating drugs, not a toxic level of one specifically.

In this case, consider the same approach as above. Call the patient in and discuss your concerns and safety issues. Consider prescribing a naloxone kit and encourage the patient and his or her family to become familiar with its use and the signs and symptoms of overdose.

If the results continue to show dangerous combinations of medications, stop prescribing the opioid or benzodiazepine but continue to provide care for other conditions. Offer the appropriate addictions treatment and referrals. Don't forget: **document, document, document**.

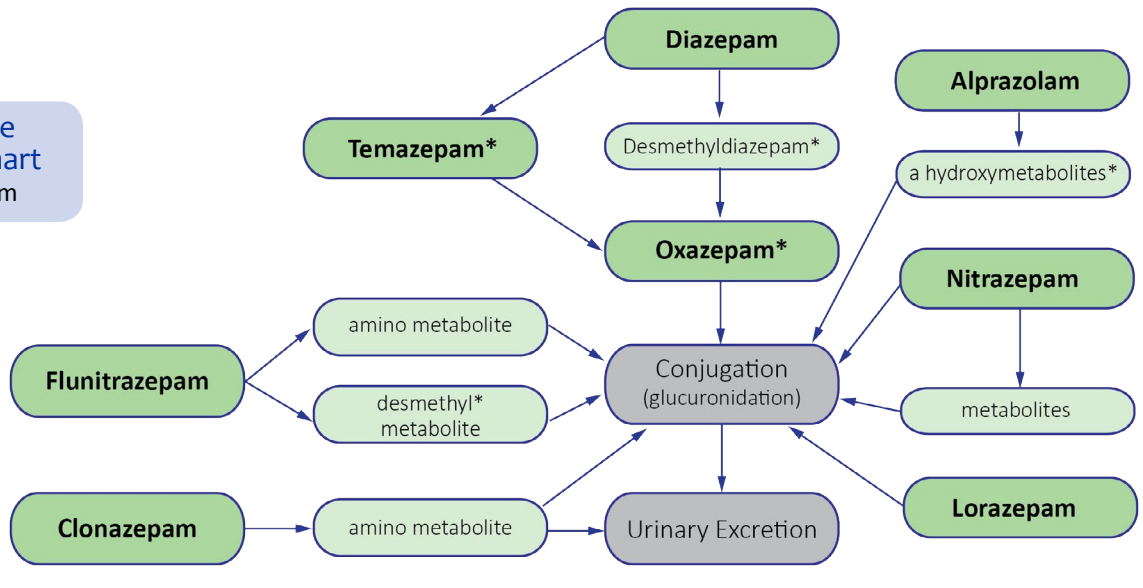
What about the presence of non-interacting illicit drugs such as cocaine or crystal meth? If these substances are present, you are clearly dealing with a patient who has a substance use disorder. Again, consider tightening up the boundaries. You may not be faced with a situation in which there is a dangerous drug interaction, however the use of the illicit substance certainly places the patient at risk. Many addictions experts would say “at least the patient is engaged in care” and would recommend that you discuss the results with the patient while offering support and treatment for the substance use disorder.

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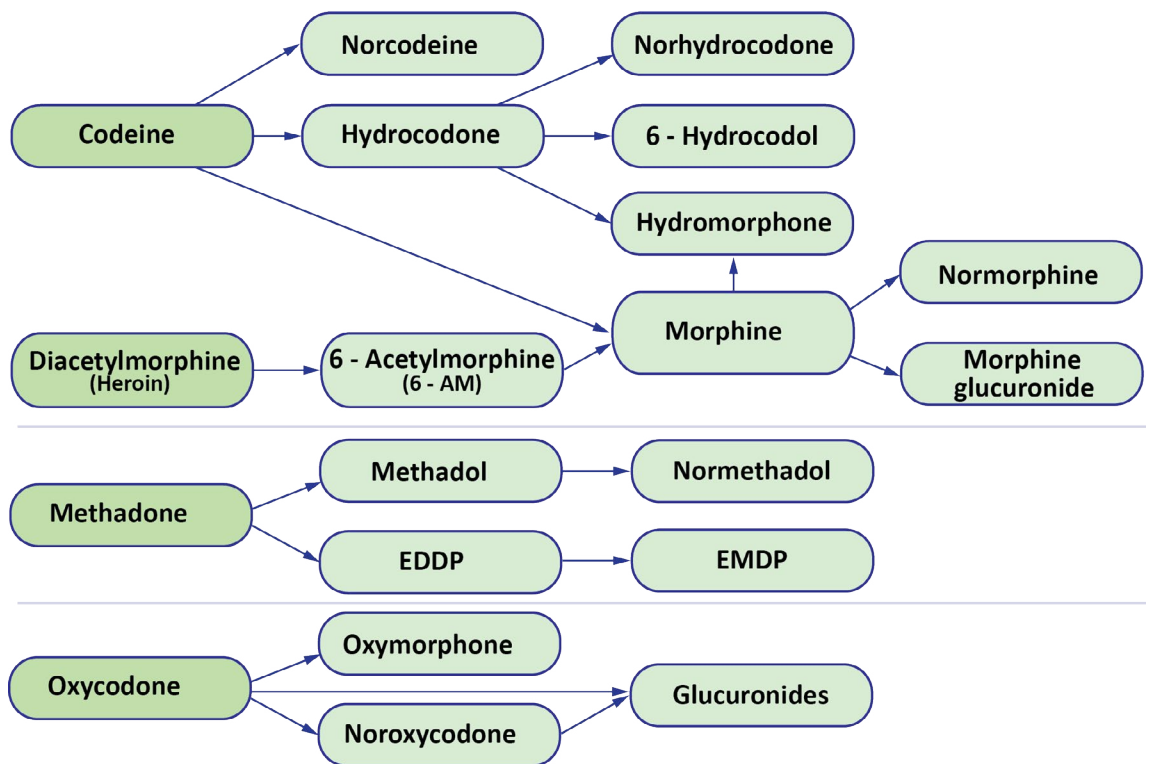
Below are the **abbreviated metabolic pathways** for commonly used benzodiazepines and opioids. Both the parent drug and the metabolite may or may not be present in the urine. For example, does your patient take temazepam on a PRN basis? Then it is possible that only oxazepam will be reported as present in the result. Does your patient take codeine regularly? Then you would expect to see both codeine and morphine in the result.

If you would like more information about interpreting UDS results, contact the PRP at prp@cps.sk.ca

Benzodiazepine Metabolism Chart
* active metabolism



Opiate Metabolism Chart



NEXT ISSUE:
 OPIOID PRESCRIBING: ADDRESSING TO DISMISS OR NOT TO DISMISS.
 THE PROS AND CONS OF ENDING THE DOCTOR PATIENT RELATIONSHIP WHEN OPIOID PATIENTS ARE NOT COMPLIANT.



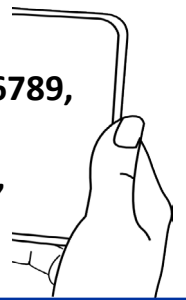
Dictated reports using the Provincial Transcription Service

How to further reduce errors and delays

We are always looking to improve. One simple step at the start of each dictation can prevent many of the current delays and errors in the distribution of dictated patient care reports.

We are asking that you start each dictation by saying:

**“Dr. John Doe dictating a care event/worktype for Jane Smith, HSN 123456789, seen on date of care event.
Copies to Dr. Tom Jones, specialty and location, and Dr. Richard Smith, specialty and location.”**



This verbal confirmation means the information needed for patient care is quickly and accurately placed into the patient’s health record, and is distributed to the correct members of the patient’s care team. Students and residents should also state the first and last name of the attending physician.

Using the Fluency Mobile app on your smartphone is another way to reduce the chance of transcription delays and errors. Find out how to get this app for use in Saskatchewan by calling eHealth at 1-888-316-7446.

We have also been creating a better version of the dictation manual used during orientation for new physicians to the province or service. Clearer directions on when to use the various worktypes, what to include for content, and how to follow best practices for your patients are included. The most significant change is that a consult worktype 2 should be used whenever that service is provided irrespective of patient location. This ensures an intuitive search by other team members is possible and the need-

ed information can more easily be found in the patient’s health record. You can download the updated document at www.3shealth.ca (located on the very top above the menu bar) or obtain a copy from your local HIMS department.

You are also able to request individual training for additional improvements to quality provided by Fluency Flex and Fluency Direct. These upgrade versions of the same voice recognition software that already knows your voice will allow you to immediately self-edit and release care reports to further reduce errors and turnaround time. To find out more, visit our FAQ or register your interest at transcription@3sHealth.ca

If you have further questions, you can call or text Dr. Joy Dobson at 1-306-209-3208 as the Senior Physician Consultant tied to this work at 3sHealth.

Patient Safety Alert

To all Saskatchewan physicians

Recently it has come to our attention that referrals to the Saskatchewan Cancer Agency (SCA) have sometimes been dictated and subsequently placed on the eHealth Viewer but have not been copied to the cancer agency for processing. These referrals are not being received by the agency.

Please be aware that the process for referral to the SCA has NOT changed with the changes to dictation services. If you require a patient to be referred to the cancer agency please fax the referral and required investigations to the applicable cancer centre.

The referral forms and required investigations are on the agency website at

<http://www.saskcancer.ca/Default.aspx?D-N=d3189b18-7716-4e26-af2f-9b730e4de1fa>

Thank you,

Dr. Monica Behl
Vice-President, Medical Services &
Senior Medical Officer
Saskatchewan Cancer Agency



You've only heard half the story

Immigrant and Refugee Mental Health Project—a free, online training with capacity-building resources for settlement, social and health service providers. Building on your existing work with immigrants and refugees, you will be able to:

- strengthen your knowledge;
- develop your skills; and
- build your networks.

Growing from the success of the Refugee Mental Health Project, which trained over 6,000 service providers across Canada, the project has expanded to give you an evidence-based learning experience with practical activities, where you can learn skills that you would use on the job.

https://irmhp-psmir.camhx.ca/?utm_source=promotion&utm_medium=email&utm_campaign=site_launch&utm_content=content



Do you speak, write or understand a language other than English?

How about sign language?

Register your language proficiencies online with the College at:

https://www.surveymonkey.com/r/cps_language_survey

Write to communications@cps.sk.ca if you are experiencing difficulty entering your information online.

Saskatchewan Bleeding Disorders Program

Who We Are

The Saskatchewan Bleeding Disorders Program (SBDP) was established as a provincial multi-disciplinary, comprehensive patient care program in 2001. From its inception, our program goal has been to improve the health of Saskatchewan patients living with congenital or acquired bleeding disorders. Primary diagnoses of our patients include von Willebrand disease, hemophilia, or platelet function defects. Our family-centred program is available to both pediatric and adult patients.

The SBDP is currently based out of Royal University Hospital in Saskatoon, under the Saskatchewan Health Authority – Chronic Disease Management umbrella. Although most our clinics are scheduled in Saskatoon, we offer several clinics in Regina and Prince Albert annually.



The Saskatchewan Bleeding Disorders Program Team 2017



Standing L to R: Doug Robertson (Quality Improvement), Glennis Killoran (Program Admin), JoAnn Nilson (Physiotherapist), Shannon Buckingham (Program Admin), O'Lynda Lovas (RN), Tara Schlosser (RN), Nancy Hodgson (RN), Jennifer King (Social Work), Dr. David Stammers (Pediatric Hematologist); **Seated L to R:** Dr. Kelsey Brose (Adult Hematologist), Dr. Robert Card (Adult Hematologist, Emeritus), Dylan Chipperfield (Program Manager)
Not pictured: Dr. Roona Sinha (Pediatric Hematologist), Dr. Oksana Prokopchuk-Gauk (Adult Hematologist)

What We Do

Our core clinical SBDP team includes both adult and pediatric hematologists, registered nurses, a physiotherapist and social worker who regularly attend the multidisciplinary clinics. All staff members are part-time, and most participate in roles outside of the SBDP.

... continued on p. 28



FactorFirst card is carried by bleeding disorders patients, containing a signed treatment prescription from the SBDP.

Remember... FactorFirst

PROMPT INFUSION will halt bleeding, minimize long-term complications and can save life. If bleeding persists, follow the guidelines for life or limb-threatening bleeds and call the:

Hemophilia Treatment Centre

Physician: _____

Nurse: _____

Day Phone: _____

Night Phone: _____

Delay in the restoration of hemostasis to the patient with hemophilia or von Willebrand disease may be life or limb-threatening.

PROMPT TRIAGE AND ASSESSMENT.

- Determine the severity of the bleed.
- Recognize that bleeding in the head, spine, abdomen or pelvis may initially be occult and potentially life-threatening.

TREAT FIRST AND INVESTIGATE LATER – “FACTOR FIRST”.

- Avoid invasive procedures such as arterial punctures unless the patient has factor replacement.
- **NO** IM injections and **NO** ASA.
- The patient or guardian may be your most important resource, so do ask about specific treatment protocols.
- Contact the patient's Hemophilia Treatment Centre where a hematologist is always on call.
- Provide clear discharge instructions and arrange a follow-up plan or admit to hospital if necessary.

Patient Information:

Name: _____

Date of Birth: _____

Diagnosis: _____

Severity: _____ Level: _____

Response to desmopressin (DDAVP): no yes to _____ %

Inhibitors: no yes

Other Medical Information: _____

Date of Recommendation: ____ / ____ / ____

Signature of Physician _____

Recommended Treatment:

Product and Dose/kg for Life or Limb-threatening Bleeds:

Product and Dose/kg for Moderate/Minor Bleeds:

Use Universal Precautions

... continued from p. 27

Each team member has a vital contribution to patient care – both in and outside the clinic setting, to ensure that not only medical needs are met. Our program members provide outpatient support, factor home infusion training, perioperative care, psychosocial counselling, physiotherapy services, and pain assessment and management.

Based on individual patient needs, we coordinate care with other specialties including Medical Genetics, Orthopedic Surgery, Obstetrics and Gynecology, Infectious Diseases, and Dentistry.

Providing education about bleeding disorders is an essential part of our program. We teach our patients about the importance of advocacy, emphasizing self-management and use of the FactorFirst card (which contains individual bleeding protocols in case of injury or procedures). We also provide education in schools, to employers, and other healthcare professionals to raise awareness and reduce stigma surrounding bleeding disorders.



New Referrals are Welcome!

We are excited to announce a new SBDP Referral Form, available online (printable template and fillable pdf for EMR upload) here: https://www.saskatoonhealthregion.ca/locations_services/Services/cdm/Pages/Home.aspx

Referrals of new patients to our program are welcome from healthcare providers located anywhere in the province. Our program staff are available Monday to Friday, 8:00 am to 4:30 pm (excluding statutory holidays).

Please contact us via our main SBDP office number at 306-655-6504 with any questions you may have!

LINK

(Leveraging Immediate Non-urgent Knowledge)

is a provincial physician-to-physician telephone consultation service that connects primary care providers to specialists to consult on pressing non-urgent patient health concerns.

To access LINK, call ACAL (1-888-831-2225 or 1-306-655-8008) or Bedline (1-866-766-6050 or 1-306-766-6050) and request a LINK call with one of the following specialties:

- Adult Psychiatry
- Palliative Care
- Nephrology

As part of the health system's commitment to improve access to specialty care, the Ministry of Health piloted LINK with adult psychiatry and palliative care specialists who reported that calls were often answered immediately (while the patient was still in the office) or returned within 15 minutes.

Visit the [LINK Brochure](#) for more information.

Should you have questions or want more information about the service, please contact Cathy Zhao, Sr. Project Manager, at LINK@health.gov.sk.ca or 1-306-787-3556.





SASK LEADERS IN HEALTH CARE

Do you have a colleague you admire?

Nominate them for the 2018 edition of this prestigious award!

The Dr. Dennis A. Kendel Distinguished Service Award is a prestigious award presented to an individual (or group of individuals) who has made outstanding contributions in Saskatchewan to physician leadership and/or to physician engagement in quality improvements in healthcare.

The award is presented during a special annual banquet organized by the Council of the College of Physicians and Surgeons of Saskatchewan each year.



Nomination packages are available by visiting the homepage of the College website, or at

<http://www.cps.sk.ca/iMIS/Documents/Dr%20Kendel%20Service%20Award%20-%20Nomination%20Package.pdf>

or by contacting Sue Waddington at OfficeOfTheRegistrar@cps.sk.ca

Have you been practicing for 40 years or more in Saskatchewan?

You may be eligible for **SENIOR LIFE DESIGNATION**

If you have practiced in Saskatchewan for 40 consecutive years or more, or if the only interruptions in your practice were for service in the armed forces or to take postgraduate training, and you have not yet received your Senior Life Designation, please let us know! Physicians with this designation are presented with an award at an official Council Banquet in November of each year.

CONTACT

Sue Waddington at OfficeOfTheRegistrar@cps.sk.ca or at **306-244-7355**





INFECTION PREVENTION

News Updates

The **IPAC Link Letter** is a monthly review of highlights and linked updates from the ever-changing world of Infection Prevention and Control to help you stay current and informed:

<https://saskpic.ipac-canada.org/picns-link-letter.php>

Réseau Santé
en français
de la Saskatchewan



HEALTH ACCOMPAGNATEUR INTERPRETATION SERVICES IN FRENCH

As health professionals, you may come across Francophone

Newcomers who are:

- Unable to navigate the Saskatchewan health system;
- Needing to consult a health professional but cannot do so because they have no or limited capacity to explain their health issues in English;
- Unable to understand your explanations in English.

You may also come across Saskatchewan Francophone Seniors and Families:

- Needing to use French in their interactions with health professionals.

This free and confidential service has been established to help you as a health professional interact more effectively with your patients.

Patients who need an interpreter are encouraged to call **1-844-437-0373**.

(Toll free)





We're Working for You



College of Physicians and Surgeons of Saskatchewan

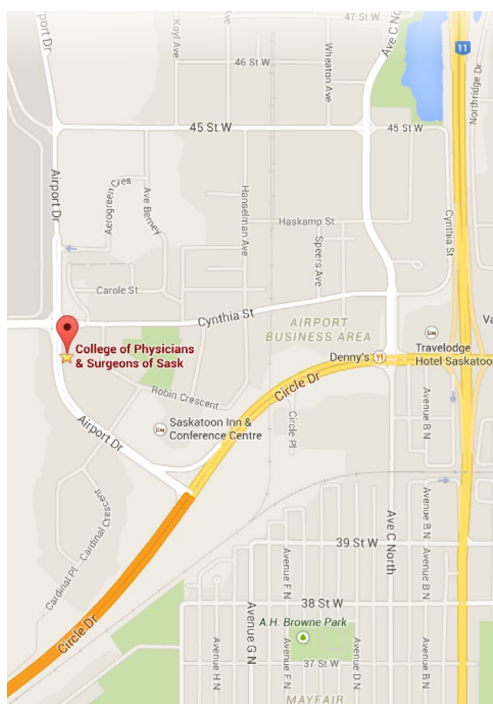
101-2174 Airport Drive
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KEEP IN TOUCH



OUR LOCATION:



Senior Staff

Dr. Karen Shaw Registrar
Dr. Micheal Howard-Tripp Deputy Registrar
Mr. Bryan Salte Associate Registrar/Legal Counsel

OUR DEPARTMENTS

Office of the Registrar

Telephone 1 (306) 244-7355
E-mail OfficeOfTheRegistrar@cps.sk.ca

HR & Finance

Telephone 1 (306) 244-7355
E-mail amy.mcdonald@cps.sk.ca

Communications

Telephone 1 (306) 667-4638
Media Inquiries communications@cps.sk.ca

Quality of Care (Complaints)

Saskatoon & area calls 1 (306) 244-7355
Toll Free 1 (800) 667-1668
Inquiries complaints@cps.sk.ca

Diagnostic Imaging & Lab Quality Assurance (Regina)

Office Address 5 Research Drive, Regina, SK S4S 0A4
Telephone 1 (306) 787-8239
E-mail cpsinfo@cps.sk.ca

Prescription Review Program (PRP) & Opioid Agonist Therapy Program (OATP)

Telephone 1 (306) 244-7355
Anonymous Tip Line 1 (800) 667-1668
E-mail prp@cps.sk.ca
oatp@cps.sk.ca

Registration Services

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