

DocTalk

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Nominations for KENDEL Award Open!

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DocTalk

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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, 2019** to COMMUNICATIONS@cps.sk.ca



Dr. Brian Brownbridge

President, CPSS

Physician Burnout/Moral Injury

Approximately 50% of physicians in the United States have at least one symptom of burnout, which is 2-3 times higher than the general public.

While statistics for Canada are not available, the incidence in other similar healthcare systems in the world is 30-40%. The Maslach Burnout Inventory (MBI) is frequently used to assess this syndrome. Physicians who are considered positive score high on at least one component of the MBI. This is a very important issue because there is growing evidence that physicians give inferior care when symptoms of burnout are present.

*The “**burnout syndrome**” has been defined as a combination of emotional exhaustion, depersonalization, and reduced personal accomplishment caused by chronic occupational stress.*

*The concept of “**moral injury**” is a new term for burnout which refers to the conflict of not being able to deliver the care one feels they should or feeling forced to deliver care they feel should not be delivered, opposite ends of the spectrum but equally upsetting to physicians.*

Just like depression, symptoms often present differently between the sexes. Female physicians tend to start with emotional exhaustion followed by depersonalization and cynicism then finally feelings of reduced accomplishment develop. Male physicians often present with depersonalization and cynicism followed by emotional exhaustion and in men, the third stage may not develop. This potentially leads to a male physician who is cynical and exhausted but does not recognize the effects on the quality of their care.

There are felt to be many causes of burnout of physicians around the world, a few factors will be highlighted below. One of the leading causes of burnout in the United States is the Electronic Medical Record. Although billions probably trillions have been invested into this technology, it remains far from physician friendly and marked improvements in the interface must occur. There are major frustrations with poor orientation, increased time to access the system and obtain data, data is required for billing and not actual patient care and difficulty in keeping algorithms up to date are just a few of the frustrations expressed by our colleagues to the south.

Patients are becoming exceedingly more complex requiring significantly more time to sort out their medical issues and concerns. Unfortunately, the system struggles to find time in busy physician's offices to deal with this increased complexity. Combined with complex patients and sometimes unrealistic expectations of what is possible for medicine to fix, this can lead to conflict if not communicated in the proper manner.

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Modern technology and new surgical techniques are virtually changing overnight which can cause stress to physicians if proper time and method of education is not used. As an example, introduction of laparoscopic techniques many years ago caused many surgeons to expedite their retirement plans. New technology has very significant benefits but can leave providers behind very easily and lead to feelings of inferiority.

Pressures to increase productivity and throughput may improve patient access but may have detrimental effects on time for teaching, research, quality initiatives and administration. Many physicians feel there is less time to savour the doctor-patient relationship that historically was a privilege of medicine.

Physician remuneration and reward certainly comes up as a cause for burnout. There is no perfect system to remunerate physicians, but the public, government and physicians must understand the positives and negatives of different systems. They can have long-term effects on burnout if not managed properly. As an example, an Alternative funding Program (AFP) arrangement can seem more like an employer/employee relationship

which may affect physician autonomy in a negative manner.

A leadership and administration system that does not recognize the inherent traits of physicians is bound to fail and precipitate feelings of burnout. A system where physicians do not feel they have control is rife with burnout.

The prevention and treatment of burnout or moral injury is not hopeless for healthcare providers, there is evidence that people can heal and that system changes can reduce the incidence of this syndrome. The combined use of personal and system changes seems most effective at preventing and healing the syndrome. Increased physical activity and mindfulness programs may reduce stress, but actual system changes need to occur to reduce the incidence of this syndrome and prevent relapse.

It is imperative that physicians recognize the symptoms of burnout in colleagues and themselves and encourage and reach out for help to their physician health program for support. Physicians must also be willing to take a more active role in “productive” leadership to improve the system.

References:

Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction, A Systematic Review and Meta-analysis. Maria Panagioti, PhD; Keith Geraghty, PhD; Judith Johnson, PhD; Anli Zhou, MD; Efharis Panagopoulou, PhD; Carolyn Chew-Graham, MD; David Peters, MD; Alexander Hodgkinson, PhD; Ruth Riley, PhD; Aneez Esmail, MD, PhD. *JAMA Intern Med.* 2018;178(10):1317-1330. doi:10.1001/jamainternmed.2018.3713. Published online September 4, 2018. Corrected on March 4, 2019.

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Physician Burnout. Shannon M. Ruzycski MD, Jane B. Lemaire MD. Cite as: CMAJ 2018 January 15;190:E53. doi: 10.1503/cmaj.170827.

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Council Activities and Plans for Improvement

By Dr. Brian Brownbridge on behalf of Council

Truth and Reconciliation

Council recognises that there are many Indigenous perspectives on key issues. We are therefore pleased to welcome Mr. Burton O'Soup as a public-appointed member on Council. Mr. O'Soup brings one of those perspectives to Council. He has already reinvigorated Council's *Truth and Reconciliation Committee* and the first recommendation of this committee was to adopt an acknowledgement statement about the original people on the land which we call Saskatchewan today. This statement will open each Council meeting in the future. (See the *Indigenous Wellness* section of this issue for more details).

Governance and Strategic Planning

One of the initiatives of Council for 2019 is to examine governance issues in more detail. Five areas of governance have been chosen to be examined by sub-committees of Council. These issues are:

1. How to develop better communication with physicians;
2. How to develop better communication with the public;
3. Developing expected competencies of Councillors and establishing a process to assist with recruitment;
4. Developing a better method for Councillor assessment;

5. Whether there should be additional standing committees and if so, what committees and how should they be constituted?

Recommendations from each of these committees will be brought back to Council as a whole for consideration.

Councillor Education

Council has decided to start each Council meeting with an education session for Councillors. Each Council member was asked to list what they felt would help them be a stronger Councillor. The choices provided included the following:

- Traditional Indigenous Health History;
- IT Security;
- Preventative Strategies that could be put in place for Sexual Boundary Violations;
- What should the College do beyond licensing, standards and discipline, reviews of *The Medical Profession Act, 1981* and Opioid Agonist Therapy?

Regulatory Topics

Council continues to be busy with penalty hearings at each meeting and policy review and development. The latest policy which has interest to many physicians is the policy on Sale of Products by Physicians (details on p. 12).

Council at work, January 2019. L-R: Dr. Y. Kasim, Dr. A. Adewumi, Dr. N. Bhatala Venkata, Dr. O. Igbekeyi, Dr. O. Mabadeje, S. Torrance (CPSS), Dr. Oberholzer (Deputy Registrar) B. Salte (CPSS), Dr. K. Shaw (Registrar), Dr. B. Brownbridge (President), Dr. G. Stoneham (Vice President), E. Pas (CPSS), S. Waddington (CPSS), B. O'Soup, B. Hannah, K. Smith, Dr. J. Fritz, Dr. A. Beggs, Dr. M. Chapelski, Dr. Y. Pillay. **Not in photo:** Dr. P. Hanekom, Dr. P. Smith (College of Medicine), L. Chabot, C. Gareau (CPSS).

* A current full list of Council Members is available on the College website. [Click here for more details.](#)





Dr. Karen Shaw
Registrar, CEO

Lessons Learned from the Recent Privacy Commissioner's Report

HIPA limitations on disclosing and accessing patient information

The Council, the Saskatchewan Medical Association, the Saskatchewan Health Authority and the College of Medicine have some important concerns about the current privacy laws.

There has been much attention given to the outcome of the Privacy Commissioner's investigation of six physicians' inappropriate access to electronic health records related to the Humboldt Broncos players involved in the fatal bus crash last April.

While many of us would have liked the Privacy Commissioner to have chosen a different word than "snooping", there is no doubt the physicians involved accessed the records inappropriately based upon Saskatchewan's current privacy legislation. The conclusions in the Privacy Commissioner's reports were recently upheld by the Court of Queen's Bench of Saskatchewan. Whether the physicians involved intended to do this or not is not the issue. The College recognizes that some Saskatchewan physicians are confused about their ability to access patient information that is not directly related to the care that they are currently providing to patients.

Saskatchewan physicians should be aware that, with few exceptions, physicians should only access patient health information if they need to access that information to provide patient care.

Unfortunately, the use of terminology such as the concept of "circle of care" has led to some of this confusion. The term should be abandoned, as it infers that once a healthcare worker is in the "circle of care" that person is entitled to access all of the patient's personal health information. This

is incorrect. The proper terminology is a "need to know" and that only extends until the care is ended. While the College agrees with the Privacy Commissioner's interpretation of the legislation, we have concerns that this interpretation of *The Health Information Protection Act* (HIPA) and regulations under the Act is not consistent with good medical practice.

The College's Executive Committee recently reviewed the two reports from the Information and Privacy Commissioner. The Executive Committee considered some of the implications of the current restrictions in HIPA and its regulations which we believe interfere with appropriate patient care and appropriate regulation of the medical profession.

HIPA and its regulations do not allow physicians to access information about the care that they have provided to patients to assess the appropriateness of care, after care has been provided. Without this access to the information, there is limited ability for physicians to understand whether the care they provided contributed to a positive outcome for the patient. We believe that physicians have a legitimate interest in knowing what the outcome was for the patients to whom they have provided care. It is important in quality improvement.

HIPA and its regulations in their current form prohibit the College from providing personal health information to other regulatory bodies in Canada.

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This is a problem in dealing with the Opioid crisis and the information that we have from the Prescription Review Program (PRP). In border towns it is particularly troublesome that physicians on one side of the border can provide prescriptions and the medications may be dispensed on the other side of the border, where they are tracked by a different program. At the present time the College's PRP program is not able to exchange personal health information across provincial borders with other Colleges. We believe the College should be able to share information about potential prescription drug abuse or potential inappropriate prescribing with other Colleges of Physicians and Surgeons within Canada where that is appropriate, and we should be able to receive information relevant to the Prescription Review Program from those other Colleges.

When physicians are licensed in more than one province, the College is prohibited by HIPA from disclosing personal health information to another College of Physicians and Surgeons in Canada, if the College does not have the patient's consent to do so. The result is that our College is unable, in some circumstances, to provide information to another College which needs that information in order to effectively regulate physicians licensed in that province. We do not believe it is in the public's interest to allow physicians to avoid professional responsibility for unprofessional conduct, because information cannot be shared between the regulatory bodies that license such physicians.

HIPA does not permit identifiable health information to be disclosed for the purpose of education. Patient health information that is being used for educational purposes should be de-identified where possible. In many cases it is not possible to de-identify information or information about the patient may be such that the individual can be identified from the educational information, even

if the person's name is redacted. We believe that our health system would benefit from a similar provision to the provision contained in Alberta privacy legislation. That legislation contains a specific provision allowing for the use of personal health information to provide education to health professionals.

The College is working with the Saskatchewan Medical Association, the Saskatchewan Health Authority and the College of Medicine to present its concerns to the Ministry with the current limitations in *The Health Information Protection Act* and its regulations. We believe that four changes to HIPA regulations are appropriate:

1. A change to allow physicians who provide care to patients to know the outcome for those patients to assist them to review the care that they provided;
2. A change to allow the College to exchange patient information with other Colleges to address concerns about potential inappropriate use or inappropriate prescribing of prescription review medications;
3. A change to allow the College to provide patient information to another College for the purpose of regulating the medical profession, without patient consent; and,
4. A change to allow personal health information to be distributed without patient consent for educational purposes, if it is not possible or practical to de-identify the patient information.

The College believes that these changes would not only be appropriate but imperative to creating a high functioning system in the public's best interest.



Dr. Val Olsen

Senior Medical Advisor

Promoting Quality in Care and Communication

Physicians are held to a high, sometimes unrealistic, standard in our society. Although we generally offer excellent medical care in our province, outcomes are not always what we and our patients hope for. We may not always communicate effectively. Sometimes we find we are overwhelmed by workload, patient behavior and unexpected changes in the condition of our patients. External stressors, as well, can influence our practice and interactions. All these factors can lead to dissatisfaction with the experience and complaints by patients and their families.

Individuals with unresolved concerns about aspects of their physician's management may file a formal complaint with the College of Physicians and Surgeons. More serious concerns are referred through the Discipline process. Most complaints are resolved through the Quality of Care process.

All complaints are acknowledged, and the process explained to the complainant. The cases are then summarized and reviewed by the Quality of Care team. Hospital records and other external documents are requested as necessary. The physician is notified, provided a copy of the complaint, and asked to respond. Sometimes supporting documents, such as office notes, are requested from the physician.

Occasionally a courtesy phone call is made to inform the physician, especially in cases where a complaint would be unexpected, or when it is the first complaint against that physician. Stress over the process, which can take several months, has been identified as the most significant concern by those doctors who completed our survey after resolution of their complaints. For this reason, the initial phone call was introduced to replace the final survey. The call is intended to reduce the shock of opening a complaint, and to inform the physician about what to expect from the process. Reassurance is provided that the process is confidential, educational and not punitive, that the

complaint is not recorded on the Certificate of Professional Conduct, and that it is not uncommon for a physician to experience being the subject of a complaint at least once during a career.

When the physician's response is received, the complainant is, in most cases, given the opportunity to review it. If the complainant accepts the explanation or apology of the doctor, the complaint is resolved at this point, and the final letters are sent to both parties. If the complaint is not resolved, it is reviewed by the Senior Medical Advisor or by the Quality of Care Advisory Committee, which meets several times a year. Allegations may be founded, unfounded, or not able to be determined. Recommendations may be made to the physician to undertake education or study in an area of practice, management, or communication, or to implement changes in the practice environment. Final letters are sent out, summarizing the complaint and findings. Occasionally a case is revisited on receipt of additional correspondence from the complainant, but is rarely reopened. The complainant may appeal a decision, but on process only. It is emphasized that the Quality of Care process does not determine liability or negligence, does not award or direct compensation, and has no authority to restrict or remove a doctor's ability to practice medicine.

Because our objective is to improve overall care

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and to support physicians as well as the public, we take great care to be as thorough and as impartial as possible. Background research, and occasionally external expert opinions, are sought as necessary.

When a pattern of problematic or uncharacteristic behavior, or of repeated concerns about care, become apparent, a call or meeting may be arranged with that physician. The goal of such an interview is to identify possible underlying factors and stressors, and to facilitate the physician in addressing them. When appropriate, we can refer or recommend resources to support the physician in making changes.

I have recently joined the College as Senior Medical Advisor, after serving on the Quality of Care Advisory Committee for several years. I will be

joined by Dr. H. Halldorson. Under the oversight of the Deputy Registrar, Dr. W. Oberholzer, and with the assistance of the extraordinary Quality of Care staff, we coordinate committee activities, review cases outside the committee, and are responsible for communication related to case reviews. The CPSS has been very welcoming!

THE QUALITY OF CARE COMMITTEE

Dr. J. Kriegler (chair)
Dr. J. Hey
Dr. J. Nel
Mrs. S. Lougheed (recently retired)
Mr. D. Ebert
Mrs. J. Beatty
Mr. B. Senger



**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/cpss_language_survey

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



Bryan Salte

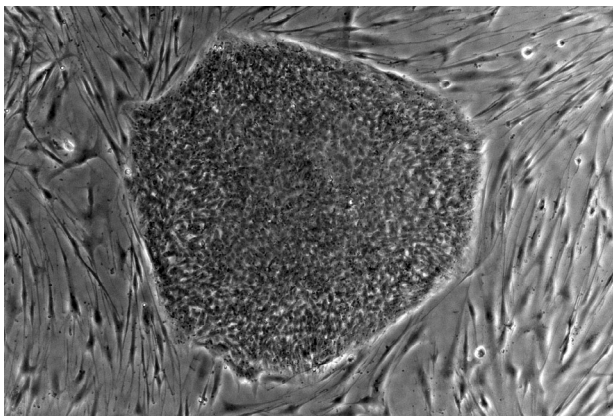
Associate Registrar and Legal Counsel

Stem Cell Therapies - Health Canada Requirements

The College has received inquiries about stem cell treatments, and whether physicians can be involved in establishing clinics that provide stem cell therapies.

We contacted the Government of Canada to clarify the legal status of stem cell treatments. We were advised that cell therapy products meet the definition of drug under the *Food and Drugs Act*. The relevant regulatory framework under the Act that applies to a particular cell therapy depends on the specific type of cells, the purpose for which they are being used, and their manufacturing processes. Each regulatory framework has its own requirements that must be met before a product can be distributed or used for treatment in Canada.

With very limited exceptions, such as the use of lympho-hematopoietic cells to reconstitute the blood system which is subject to the Safety of Human Cells, Tissues and Organs for Transplantation Regulations, using stem cells (both autologous and allogeneic) to cure or treat disease is currently at the investigational stage of development. This means that Health Canada has not yet seen sufficient evidence that they are safe and effective.



As such, these stem cell treatments are subject to the *Food and Drug Regulations* and are regulated the same as other drugs intended to treat medical conditions. In order for a physician to use a stem cell therapy to treat a medical condition, that product must have been granted market authorization by Health Canada, or Health Canada must have granted authorization to administer the investigational drug as part of a clinical trial.

A physician who provides stem cell treatments other than in the context of an authorized clinical trial commits an offense under the *Food and Drugs Act*.

Should you have any questions or would like to obtain further information about the regulatory options or additional support and resources for obtaining authorization for stem cell therapies, please contact Health Canada's Office of Regulatory Affairs, Biologics and Genetic Therapies Directorate by email at bgtd_ora@hc-sc.gc.ca.

In addition, Health Canada provides guidance information on its website related to the Preparation of Clinical Trial Applications for use of Cell Therapy Products in Humans.

<https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/applications-submissions/guidance-documents/clinical-trials/guidance-document-preparation-clinical-trial-applications-use-cell-therapy-products-humans.html>



Sheila Torrance
Legal Counsel

New Policy Applicable to Sale of Products by Physicians

Council approved a new policy addressing the sale of products by physicians. This policy can be accessed on the [College website](https://www.cps.sk.ca/iMIS/Documents/Legislation/Policies/POLICY%20-%20Sale%20of%20Products%20by%20Physicians.pdf) at the following link:

<https://www.cps.sk.ca/iMIS/Documents/Legislation/Policies/POLICY%20-%20Sale%20of%20Products%20by%20Physicians.pdf>

The policy acknowledges the potential conflict of interest that underlies the sale or promotion of products by physicians to their patients, and establishes ethical principles that must be adhered to by physicians who choose to offer products for sale.

The policy distinguishes between “medically necessary products” (those “offered for the diagnosis, cure, alleviation or prevention of disease, disorders or injuries in a patient”) and “medically optional products” (those “not considered absolutely necessary for the treatment of the patient”). Examples of medically necessary products include implanted devices such as intraocular lenses and intrauterine devices, as well as therapeutic and medical supplies. Examples of medically optional products include herbal remedies, anti-aging products and some other cosmetic products, and weight-loss and fitness products.

In selling medically necessary products, physicians are restricted to selling the products at or below the “actual price paid” (including related overhead, as defined in the policy). In selling medically optional products, physicians are able to sell at the “fair market price of that product in the community”. However, if the product is not readily available in the community, the physician must then not sell the product at a price in excess of the actual price paid (with similar definition of overhead) plus a “reasonable markup of no more than 20% of the entire cost.”

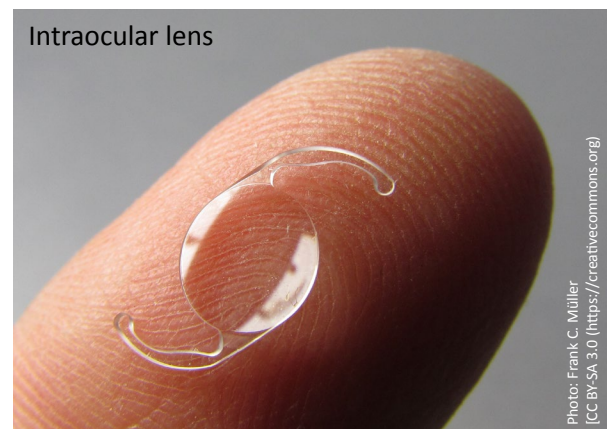
The policy identifies certain records that must be kept by physicians who choose to sell products, including the actual costs incurred, and the name of the manufacturer and supplier.

Prior to its approval by Council, feedback on this policy was sought from stakeholder organizations, as

well as from all members (through an email blast) and interested members of the public (through a survey accessible on the College website and Facebook page). More than 80 responses were received, and the majority were in favour of the implementation of a policy addressing the sale of products by physicians. Opinions varied, however, on the preferred underlying philosophy. While the majority of respondents agreed with the policy as drafted, some respondents felt strongly that physicians should not sell products to their patients in any circumstance. Others felt that free market principles should apply, more in line with the perceived situation with naturopaths, pharmacists, veterinarians and other regulated health professionals.

In approving the policy in its final form, the Council recognized that support will not be universal. However, as always the Council was guided by its primary mandate of public protection and the requirement that it act in the public interest.

Physicians are reminded that CPSS regulatory bylaw 9.1 and the CPSS guideline on conflict of interest are also relevant to a consideration of the sale of products to patients. Those documents are currently under review by Council to ensure consistency with the new policy on Sale of Products by Physicians. Any resulting changes to regulatory bylaw 9.1 and the conflict of interest guideline will be available, once approved, on the CPSS website and in a future edition of DocTalk.



Physician Advertising - Overview & FAQs

By Sheila Torrance, Legal Counsel, CPSS

One of the roles of legal counsel for the College is to respond to enquiries from members of the profession. An area of enquiry which arises fairly frequently is the permitted scope of advertising by physicians. In this article, I will provide a brief overview of the applicable rules and comments specific to several common enquiries.

Overview of Advertising Rules

Historically, professional regulatory bodies were fairly restrictive in terms of advertising, and Saskatchewan physicians were generally very cautious in what they stated on their clinic signs, business cards, etc. However, in 1990 the Supreme Court of Canada (SCC) decided a case called [Rocket v Royal College of Dental Surgeons of Ontario \[1990\] 2 SCR 232, 1990 CanLII 121](#).

In that decision, the Court held that professionals have a right to advertise pursuant to section 2 of the Canadian Charter of Rights and Freedoms. Regulatory bodies thus have only a limited ability to control advertising by preventing disclosure of patient information, prohibiting misleading advertising, etc. Since that decision, advertising by Saskatchewan physicians generally falls into one of three categories:

1. Advertising that is specifically permitted under College bylaws;
2. Advertising that is specifically prohibited under College bylaws; and
3. Advertising that is neither specifically permitted or prohibited. This encompasses the majority of advertising done by physicians.

The College's rules on advertising are set out in Part 7 of the [Regulatory Bylaws](#), available on the College website.

Frequently Asked Questions

Q1: Is it appropriate for physicians to utilize testimonials on their websites?

Physicians are prohibited from disclosing patient names in their advertising (bylaw 28.1(a)(vii)). Anonymous patient testimonials have been deemed contrary to bylaw 28.1(a)(viii), as while they may be opinions provided by former patients, they are not "statements of fact" and "cannot be proven to be accurate." Because of the emotional nature of many testimonials, there is also a risk that they may mislead the public.

Q2: If a physician is not a Royal College certified specialist but has an area of special interest or expertise, is that physician permitted to advertise as a specialist in that area?

A physician is prohibited from any advertising that misrepresents facts. As set out in bylaw 31.1, a physician can only advertise using the word "specialist" or similar term if the physician has received Royal College certification, or if the Council has provided specific permission to do so. It is, however, acceptable for a physician to advertise an area of "special interest."

Q3: Can a physician advertise the opening of a new clinic?

Yes, informational advertising that will be of assistance to members of the public is completely appropriate. This can include the names and qualifications of physicians in the practice, details about clinic hours, etc. However, the advertising cannot include any information that could be seen to compare a physician's skills or quality of service with those of other physicians.

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 [six](#) discipline matters completed since the last Newsletter report.

Dr. Tineyi Chikukwa

Dr. Chikukwa admitted to unprofessional conduct for inappropriate and excessive billing. The penalty imposed by Council included a reprimand, a four-month suspension, costs in the amount of \$1,382.36, and a fine of \$15,000.00. Dr. Chikukwa must also take an ethics course on professionalism.

Dr. Allison Christie

Dr. Christie admitted to unprofessional conduct for inappropriate prescribing of prescription review medications. Council reprimanded her and required that she successfully complete a prescribing course. She must also pay costs in the amount of \$600.00.

Dr. Patrick Duffy

Dr. Duffy admitted to unprofessional conduct for assisting a person to inappropriately engage in the practice of medicine by assisting that person in their practice of providing Botox, Belkyra and dermal filler injections. He received a reprimand and must pay costs in the amount of \$1,400.00.

Dr. Arvind Rengarajan

Dr. Arvind Rengarajan admitted to unprofessional conduct in relation to inappropriately altering a patient chart and failing to maintain appropriate professional boundaries with a patient. He has been reprimanded with respect to both charges and must complete an ethics course, a medical record-keeping course, the Saegis program on Effective Team Interactions and a boundaries course. Dr. Rengarajan must also pay costs of \$15,573.36 in relation to one charge and \$17,328.35 in relation to the other.

Ms. Lindsay Richels

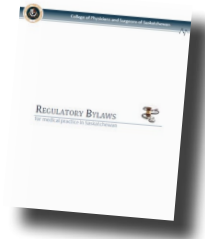
Ms. Richels admitted to unprofessional conduct for providing Botox, Belkyra and dermal filler injections, which was not authorized by her educational licence, and was reprimanded by Council.

Dr. Tshala Tshiyombo

Dr. Tshiyombo admitted to unprofessional conduct in relation to an alleged pattern of inappropriate and rude behaviour and communication with staff in her clinic and patients. She also admitted to unprofessional conduct in relation to an allegation of providing false information to the investigating committee. Her penalty consists of a reprimand, the requirement to take Saegis courses on patient communication and team interactions, and the requirement to complete the Saegis Clinical Communication program. She must also pay costs in the amount of \$15,695.75.

Changes to Regulatory Bylaws

By Bryan Salte, Senior Legal Counsel, CPSS



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

There was [one](#) change to College regulatory bylaws since the last edition of the Newsletter.

Bylaw 26.2 - Infection Control in Medical Clinics

Bylaw 26.2 was added to allow the College to investigate concerns related to inadequate infection control in locations in which physicians practise.

If the College receives information that indicates there may be a risk to patient health due to inadequate infection control measures, the Registrar can appoint one or more persons to perform an inspection. The person or persons so named are given the authority to review records, interview physicians and staff and conduct a physical examination of the premises.

The primary intention of the Council in adopting this bylaw was to allow for effective inspections and to address and resolve concerns that there may be inadequate infection control practices.

[Click here for the full text of the bylaw](#) (also available on the College website).



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 **ONE** new policy and amended **TWO** policies.

POLICIES – Opioid Agonist Therapy (OAT) Prescribing

Council approved an amendment of the previous policy to include a cover page indicating that the Registrar can waive any particular requirement set out in the policies provided the Registrar concludes that it is in the public interest to do so. That waiver can be granted subject to conditions, including conditions related to the locations in which the waiver applies and the length of time for which the waiver is in effect.

[Click here to view full policy](#)

POLICY – Physician Obligations Regarding Medical Certification of Death

Paragraph a) of the existing policy was amended by Council to ensure consistency with the applicable legislation, *The Coroner's Act, 1999*. A physician is not required to complete a Medical Certificate of Death if one of two conditions applies: 1) if the physician has reason to believe that the death occurred in one of the circumstances described in section 7 of *The Coroner's Act, 1999* (generally, a "suspicious death"), or 2) if the physician is unable to make a reasonable determination of the medical cause of death. It is not the fact of the coroner's involvement but rather the physician's conclusion that the death is one that is required to be reported to the coroner that means the physician should not complete the Medical Certificate of Death.

[Click here to view full policy](#)

NEW!

POLICY – Sale of Products by Physicians

Council has approved a policy to provide a framework on the ethics and responsibilities surrounding the sale and promotion of products by physicians to patients. The policy recognizes the potential conflict of interest that may exist, whether real or perceived, where the physician's own interests conflict with the duty to act in the best interests of the patient.

The policy, which must be read in conjunction with [CPSS Regulatory Bylaw 9.1](#) and the CPSS Guideline on [Conflict of Interest](#) (both of which are currently under review), outlines the conditions applicable to the sale of products and institutes restrictions on the sale price of these products, depending on whether the products are "medically necessary" or "medically optional" (as defined in the policy). The policy identifies certain records that must be kept by physicians who choose to sell products to their patients.

More detail on this policy is available on page 12.

[Click here to view full policy](#)

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



Mr. Ed Pas

Director, Registration Services

Renewals are Going Electronic

This year we will eliminate paper-based renewal notices and will implement electronic notification for corporation permit and physician licence renewals. This means that rather than mailing a paper renewal notification in October, we will send it by email.

We learned from last year's renewal process that many more physicians responded to the electronic notices than the ones sent in the mail. From your standpoint as a renewing physician, emailed renewal notices will eliminate mail delays which have been a challenge for many members. The notifications will arrive directly in your inbox and will be immediately actionable.

There will be little or no change in the timing of the renewal notices. As with prior years, we expect to send the notices by the second week of October.

Physician Licence Renewal

We will send to the email address we have on record for College correspondence. Over the next several months we check all physician contact information to confirm we have a valid email address for all physician members. We will follow up to obtain email addresses from those physicians who have not provided one.

Corporation Permit Renewals

We will send to the email addresses we have on file for all voting shareholders of each corporation. In cases where there is more than one voting shareholder, it will be up to the shareholders to designate which one will complete the renewal on the corporation's behalf. Note that this is a change from previous years, where we would mail the corporate renewal notice to the correspondence address which in some cases was a legal or accounting firm.

Electronic Receipts and Licences

Last year we emailed printable electronic receipts and permits for corporate renewals. We will continue this practice. This year we will also eliminate the paper-based receipt and wallet card for individual physician licence renewals, instead emailing out printable electronic versions.

Moving to email notification for physician and corporate renewal will allow us to have more consistency between the two, and should make for a clearer, more transparent process for physicians. From the College's perspective, electronic delivery will streamline the renewal process, and the move away from paper-based correspondence will significantly reduce costs.



Has any of your contact information changed? Let us know!

If any of your contact information changes—office, corporation or personal—ensure that you update it with the CPSS. You can do this by email: cpssinfo@cps.sk.ca, by fax: 306-244-0090, or by phone: 306-244-7355.

Please notify us of changes as they occur.

Physician Office Laboratories

Medical Laboratory Licences & External Quality Assurance

By Jackie Ernst, Marg Zahorski and Tracy Brown

Does your physician office need a **Medical Laboratory Licence**? Find out if this might apply to you!

The Laboratory Quality Assurance Program (LQAP) is responsible for establishing the requirements and standards of medical laboratories in Saskatchewan and to ensure their compliance with the Medical Laboratory Licensing Act and Regulations.

The College of Physicians and Surgeons of Saskatchewan (CPSS) is contracted by the Ministry of Health to operate the LQAP.

There are approximately 180 Physician Office Laboratories (POLs) in the Province of Saskatchewan.

Frequently Asked Questions

Who licenses Physician Office Laboratories?

The Ministry of Health issues licenses for POLs.

Is there a cost for a medical laboratory license?

There is no cost for a license.

What is considered a medical laboratory?

A place where a test is performed.

Why do I need a license?

Licensing is a requirement of the Ministry of Health, per the Medical Laboratory Licensing Act, 1994.

What are the requirements to maintain a medical laboratory license?

Continuous participation in External Quality Assurance (EQA).

What is EQA?

EQA is a series of proficiency testing samples, sent three times per year to the POLs for testing and results submitted for evaluation.

Where do I get EQA?

One World Accuracy is the currently mandated provider of EQA in Saskatchewan.

Is there a cost for EQA?

Yes, this cost is paid directly to the provider.

Where do the EQA results go?

Results are sent to the POL and LQAP.

What if I 'fail' my EQA?

You may receive a letter from LQAP requesting corrective action.

What if I do not participate in EQA?

LQAP notifies the Ministry of Health, and this may impact your ability to bill for this service.



(L-R) Dr. Morris Markentin, Dr. Alex Wong, Dr. Peter Butt, Dr. Erin Hamilton and Dr. Sarah Liskowich (moderator) answer questions from attendees during the Q&A Panel Discussion.

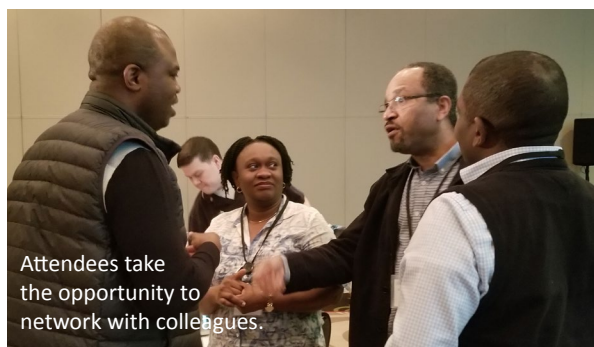
Opioid Agonist Therapy Education

The College's Opioid Agonist Therapy Program provides education to physicians on best practices for prescribing Opioid Agonist Therapies.

OATP 2019 Conference Report

The 2019 Saskatchewan Opioid Agonist Therapy (OAT) Conference was held in Regina on March 22 and 23, organised by the Opioid Advisory Committee and the Prescription Review Program staff. More than 114 physicians and healthcare workers from various sectors came from across Saskatchewan to learn more about safe prescribing practices for opioids and to gain insight on how to improve their own skills in supporting patients with opioid use disorders.

Thank you to each of the attendees for taking the time out of their busy schedule to attend. Thank you also to the Committee and Speakers for their hard work in creating a successful event!



Dr. Wilna Wildenboer speaks about ways patient care could be discontinued during her workshop, *Discontinuation: Voluntary and Involuntary Withdrawal*.

Dr. Wilna Wildenboer speaks about ways patient care could be discontinued during her workshop, *Discontinuation: Voluntary and Involuntary Withdrawal*.

Ways we lose addiction patients:

- They move away or are incarcerated.
- They choose to transfer to another physician.
- They die.
- They relapse and decide not to be on opioid maintenance therapy.
- The physician retires, changes his or her scope of practice or moves away.
- They have to be discharged from your care. This includes patient-related discharge.
- They achieve long-term recovery and were successfully weaned from maintenance therapy.

Council Responds to Calls for Action on Indigenous Health

By Caro Gareau (CPSS Communications), with contributions from Burton O'Soup (Public Member of Council and Truth and Reconciliation Committee Chair) and Dr. Karen Shaw (CPSS Registrar)

Background

The Council of the College of Physicians and Surgeons of Saskatchewan (CPSS) has been making steps to improve its knowledge and understanding of the Treaties in order to be better able to respond to the Truth and Reconciliation Report. The newly revitalized *Truth and Reconciliation Committee* of the Council has been tasked with examining the *Truth and Reconciliation Report* and making recommendations to Council on initiatives that can be undertaken to ensure that physicians understand the uniqueness of the Saskatchewan population and in particular the Indigenous population. Terms of reference are under development to help guide the committee's work.

We Acknowledge

Council members, CPSS physician members, staff and guests are encouraged to acknowledge, recognize and respect the First Peoples on whose traditional territories we live and work, in a conscious effort toward reconciliation with First Nations and Métis peoples who have lived here for many years.

To recognize the way in which many spaces, including places where medical services are dispensed, feel unsafe for Indigenous peoples and to help recognize the struggle Indigenous people face from becoming invisible, and as a start to disrupting and dismantling colonialism, Council has adopted the use of the following territorial acknowledgement preceding each Council meeting.

"The Council and the College of Physicians and Surgeons of Saskatchewan respectfully acknowledge that the land on which we gather is Treaty 6 territory, the traditional territories of the Cree, Dakota and Saulteaux First Nations and home to the Métis Nation. 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."

The CPSS Council outlines some of its initiatives in response to the Calls for Action on Indigenous health outlined in the *Truth and Reconciliation Report*.

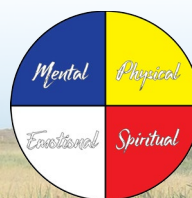
Responding to the Calls for Action

Call to Action # 22

"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."¹

The College has been reaching out to key Indigenous leaders and organizations with an interest in health care and physician services to develop partnerships for helping physicians better understand and incorporate Aboriginal healing practices into their medical practice.

Continued on p. 21...



How can you, as a physician, help provide quality care to Indigenous patients in a culturally safe and welcoming environment?

...continued from p. 20...

Thanks to funding from the First Nations and Inuit Health Branch of Saskatchewan (FNHIB-SK), projects in Kamsack and Regina have been able to increase access to Opioid Agonist Therapy and other treatments, including access to Elders.

The College's Quality of Care department has worked in the past with the Federation of Sovereign Indigenous Nations (FSIN), to assist those Indigenous persons wishing to make a complaint through the College's process and endeavours to look for ways to improve that process and accommodate complainants on a case-by-case basis.

Call to Action #23 iii.

***"Provide cultural competency training for all health-care professionals."*²**

How can Council educate new physicians and internationally trained physicians, in addition to ensuring that those physicians currently practising have an understanding of the issues faced by Indigenous people of Saskatchewan?

To be better equipped to answer this question, Council is currently exploring different ways to educate both the Board and senior leadership on cultural competency. An education session with invited speakers from the Office of the Treaty Commissioner is being planned for Council to acquire knowledge that will assist in the decision-making

processes to ensure physicians are broadly educated about Indigenous issues and to develop appropriate standards of care. A variety of existing education modules will be evaluated to eventually recommend for physicians to increase their skills in effectively treating Indigenous patients in a culturally safe and respectful way.

The Registrar, Dr. Karen Shaw and the Deputy Registrar, Dr. Werner Oberholzer, are currently taking the *Role of Practitioners in Indigenous Wellness* course offered by the College of Medicine's Continuing Medical Education program. It is hoped that our non-physician senior staff will participate in the administrator version of this course. Council members have been encouraged to consider taking the courses as well.

Looking forward, it is the College's plan to work toward reconciliation in health care by developing standards of care that will help physicians better understand and meet the needs of Indigenous patients in their care, incorporate Aboriginal healing practices as appropriate when requested, and foster better relationships between Indigenous patients and their physicians, thereby reducing gaps in care and helping to improve Indigenous Wellness as a whole.

Reference:

^{1,2}Truth and Reconciliation Commission of Canada: Calls to Action http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

TELL US!

Patient-Physician Dialogue is Important for Quality of Care to Indigenous Patients!

We encourage First Nations Health Services, healthcare providers working with First Nations, and First Nations individuals to submit their ideas, articles, or information on services, their experience with successful programs, as well as upcoming projects that encompass Indigenous Wellness and to stimulate further inquiry about Indigenous health issues.

Write to communications@cps.sk.ca for details on how you can contribute to DocTalk.

PHYSICIAN BILLING: JMPRC Review of Billing Patterns

By Dr. Karen Shaw, CPSS Registrar

What is appropriate billing? How do we, as physicians, ensure billing integrity?

The Joint Medical Professional Review Committee (JMPRC) reviews billing patterns of physicians referred by the Director of Professional Review of the Ministry of Health and in cases where they determine that monies have been paid by the Minister inappropriately, they may order recovery from the physician.

Although quality is not a mandate of the JMPRC, if questions arise about quality of the services provided during the audit, the JMPRC refers the matter to the CPSS.

The College of Physicians and Surgeons of Saskatchewan is responsible to ensure the quality of care delivered by physicians to Saskatchewan patients by ensuring physicians abide by the Code of Ethics, Bylaws, Policies, Standards and Guidelines. At times, this may include aspects of billing procedures.

In recent months, many cases have been referred to the CPSS from the JMPRC.

It is imperative that physicians know what documentation is required, appropriate billing practices, the process for new insured services, and what occurs with the payment integrity audit.

To assist physicians in understanding the JMPRC's expectations, a link to a new section on billing information, *Physician Billing Advice*, has been added to the CPSS website and can be accessed via the homepage under the Programs and Services heading (to the left):



Please take the time to review the documentation on the following pages regarding the expectations of the Medical Services Branch (MSB), the mandate of the JMPRC, its integrity audit processes, along with its billing and documentation information sheets.

The **Online Billing Course** offered by the MSB is highly recommended for physicians practicing in Saskatchewan. Additional information on this course and the other billing requirements mentioned above is available on the CPSS and MSB websites.

PHYSICIAN BILLING: What the Medical Services Branch (MSB) Expects

By Carie Dobrescu, Medical Services Branch

Where physicians are making decisions that involve the disposition of public funds, it is important that they are aware of their **professional, legal and ethical responsibility** to submit billings in an honest and forthright manner.

Physicians are essential stakeholders in publicly-funded health care expenditures and are responsible for their billing practices. Physicians who are receiving direct payment through the publicly-funded system have signed a Direct Payment Agreement with Medical Services Branch. **Direct payment agreements are considered a privilege.** This agreement stipulates the manner in which services must be submitted for payment and all physicians should be aware of their **billing obligations**.

Physicians are **personally and solely** responsible for all billings submitted to MSB under their billing number regardless of who submits the billings.

Pursuant to The *Saskatchewan Medical Care Insurance Act*, MSB has the authority to pay physicians for **medically required** services only. All services submitted for payment must also be billed in accordance with the Physician Payment Schedule

(without substitution) and must be documented in accordance with the policy outlined in the “Documentation Requirements for the Purposes of Billing” section of the Schedule.

In summary, **accountability** relies on both the physician and the Ministry of Health to **safeguard public resources**. Both parties share responsibility to ensure that health care dollars are spent in a responsible manner and that payments made to physicians are appropriate and align with the regulations and policies established in The *Saskatchewan Medical Care Insurance Act*, the Physician Payment Schedule, and the Direct Payment Agreement.

The Ministry of Health greatly appreciates physicians’ ongoing efforts and cooperation in ensuring that the services they submit to the Ministry for payment meet the requirements as outlined above.

Important billing resources can be found at this link:

<https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx>

For general billing inquiries, please contact:

Claims Analysis Unit - 306-787-3454

Policy, Governance and Audit - 306-787-0496

Billing Information Sheet

Joint Medical Professional Review Committee (JMPRC)

What is the JMPRC?

The Joint Medical Professional Review Committee (JMPRC) is a **physician peer-review** Committee that was established by section 49 of *The Saskatchewan Medical Care Insurance Act* (1988) to **review the billing patterns of Saskatchewan physicians** who are directly billing the publicly funded system for insured services.

Who are members of the JMPRC?

1. Two physician members appointed by the College of Physicians and Surgeons of Saskatchewan;
2. Two physician members appointed by the Saskatchewan Medical Association;
3. Two physicians appointed by the Ministry of Health, one of which must be an employee of the MOH (Medical Consultant).

What is the JMPRC's mandate?

The JMPRC reviews billing patterns of physicians referred by the Director of Professional Review of the Ministry of Health and in cases where they determine that monies have been paid by the Minister inappropriately, they may order recovery from the physician. The JMPRC's mandate is not to review quality of patient care.

What is the JMPRC's process?

The JMPRC initially reviews a de-identified statistical billing profile which is compiled of billings submitted to Medical Services Branch by the physician under review. The review of a physician's pattern of practice can include the number of services billed, the type of services billed and the medical record for the services that have been billed.

Matters referred to the JMPRC may be discharged without further investigation following review of the billing pattern presented. Where the JMPRC is unable to conclude its review based on the billing pattern alone, the physician is asked to provide additional information in the form of medical records. The Committee compares the billings submitted by the physician to the information documented in the medical record in order to confirm the appropriateness of the service billed.

Should the JMPRC be unable to conclude their review with the medical records provided, the JMPRC provides the physician an opportunity for an interview. The interview provides a forum that the JMPRC and physician being reviewed can discuss the issues that the Committee are reviewing.

What are the possible outcomes of the JMPRC review?

After the conclusion of the interview, the JMPRC may order recovery of monies if they determine the Minister has paid monies inappropriately. If the physician disagrees with a decision made by the Committee, he/she has 30-days after the final order has been issued to appeal the decision to the Court of Queen's Bench.

To find out more information about the JMPRC, please contact: JMPRC@health.gov.sk.ca

Billing Information Sheet

Physician Billing Obligations

Overview:

Where physicians are making decisions that involve the disposition of public funds, it is important that they are aware of their **professional, legal and ethical responsibility** to submit billings in an honest and forthright manner to a system which operates almost entirely on the honor system.

Physicians are essential stakeholders of publically-funded health care expenditures and must jointly assume accountability and responsibility. Physicians who are receiving direct payment through the publically-funded system have signed a Direct Payment Agreement with Medical Services Branch. **Direct payment agreements are considered a privilege.** This agreement stipulates the manner in which services must be submitted for payment and all physicians should be aware of their **billing obligations**.

Physicians are **personally and solely responsible** for all billings submitted to MSB under their billing number regardless of who submits the billings.

Medically Required Services:

Pursuant to The Saskatchewan Medical Care Insurance Act, MSB has the authority to pay physicians for **medically required** services only. All services submitted for payment must also be billed in accordance with the Physician Payment Schedule (without substitution) and must be documented in accordance with the policy outlined in the “Documentation Requirements for the Purposes of Billing” section of the Schedule.

In summary, **accountability** relies on both the physician and the Ministry of Health to **safeguard public resources** to ensure that health care dollars are being spent in a responsible manner and that payments made to physicians are appropriate and align with the regulations and policies established in The Saskatchewan Medical Care Insurance Act, the Physician Payment Schedule, and the Direct Payment Agreement.

The Ministry of Health greatly appreciates physicians’ ongoing efforts and cooperation in ensuring that the services they submit to the Ministry for payment meet the requirements as outlined above.

Important Resources:

- Physician Payment Schedule
- Physician’s Newsletter
- MSB Operations Bulletin
- MSB Billing Bulletin

Billing resources can be found at this link:

<https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx>

For more information:

- General billing inquiries: 306-787-3454 (Claims Analysis Unit)
- Audit inquiries: 306-787-0496 or MSBPaymentsandAudit@health.gov.sk.ca (Policy, Governance and Audit)

Billing Information Sheet

Documentation Requirements for the Purposes of Billing

Overview:

Documentation is an integral and fundamental component of a medical service. An adequate record will **enhance quality and accountability**, and **provide protection** for the physician, the patient and the Ministry. This is the only way to support that the service you provided was medically required and met the billing requirements as outlined in the Physician payment Schedule.

Physicians are required to document each patient service in accordance with accepted standards of care and guidelines for medical record-keeping, which align with the Physician Payment Schedule billing requirements.

Requirements:

The documentation requirements for each service code are clearly outlined in the “**Documentation Requirements for the Purposes of Billing**” section in the Physician Payment Schedule.

Please ensure you have read and understand these requirements. **In the case of an audit**, you will be required to produce records that support the services you have billed to the publically funded system. In some cases, if the record does not support that the documentation requirements have been met, **no payment will be made**.

Important Resources:

- Physician Payment Schedule
- Physicians’ Newsletter
- Operations Bulletin
- Billing Bulletin

Billing resources can be found at this link:

<https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx>

For more information:

- General billing inquiries: 306-787-3454 (Claims Analysis Unit)
- Audit inquiries: 306-787-0496 or MSBPaymentsandAudit@health.gov.sk.ca (Policy, Governance and Audit)

Billing Information Sheet

Payment Integrity (Audit)

Overview:

It is essential that there is a fair and effective audit process in place to ensure accountability in the expenditure of public funds. This aligns with the government's mandate to continue to implement patient first approaches in the provision of health coverage while balancing our commitment and accountability to a publicly funded and administered healthcare system.

The Saskatchewan Medical Care Insurance Act and The Saskatchewan Medical Care Insurance Beneficiary and Administration Regulations provide the legislative authority for public funding of physician services.

MSB has the legislative authority to review any accounts paid directly to a physician by MSB to ensure compliance with a physician's direct payment agreement with MSB, The Saskatchewan Medical Care Insurance Act, and the Physician Payment Schedule.

After payment, MSB may undertake further investigation of a physician's claims to identify any inappropriate or incorrect payments to:

- ✓ minimize loss and ensure government accountability to a publically funded system;
- ✓ provide education and ensure physician compliance with Ministry policy and regulations;
- ✓ deter and prevent any future inappropriate, incorrect or noncompliant billings; and
- ✓ recover any inappropriately or incorrectly paid services

Audit process:

If a claim has been recovered under a **"Routine Audit and Recovery"** explanatory code (all "R" section explanatory codes in the Physician Payment Schedule), a copy of a pertinent medical record or other appropriate documentation to support the billing is required.

Other audit methods:

- Referrals to the Joint Medical Professional Review Committee (legislated physician peer-review committee);
- Routine patient verifications; and
- Special patient verifications.

Inquiries:

- All audit inquiries can be directed to the Policy, Governance and Audit Unit at Medical Services Branch: (306) 787-0496 or MSBPaymentsandAudit@health.gov.sk.ca
- Supplementary information specific to the audit process and related audit forms can be found on our website at the following link: <https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx>

Mifegymiso

Information for the prescribing physician

Updated April 25, 2019



Health Canada approved the use of Mifegymiso for the medical termination of a developing intrauterine pregnancy with a gestational age up to nine weeks (63 days) as measured from the first day of the last menstrual period in a presumed 28-day cycle.

Health Canada considered the potential risks associated with Mifegymiso's conditions of use and the pharmaceutical company Linepharma International Limited agreed to implement the following post-authorisation commitments to ensure the safe use of this product:

- a Restrictive Distribution and Administration Program;
- a Canadian Phase IV observational study of Mifegymiso safety;
- a 24-hour support line in both English and French for patients taking Mifegymiso.

Health Canada has determined that prior to prescribing Mifegymiso physicians must:

1. ensure you have adequate knowledge of the use of these medications to prescribe Mifegymiso;
2. discuss **informed consent** with the patient and provide the patient with a printed copy of the current **Patient Medication Information** and a completed **Patient Information Card**;
3. exclude ectopic pregnancy and confirm gestational age by an appropriate method. An ultrasound is recommended when the gestational age is uncertain or an ectopic pregnancy is suspected.
4. counsel each patient on the risks and benefits of the Mifegymiso, including bleeding, infection and incomplete abortion;
5. ensure that patients have access to emergency medical care in the 14 days following administration of Mifepristone;
6. schedule follow-up 7 to 14 days after patients take the Mifepristone to confirm complete pregnancy termination.

Mifegymiso is a medication that has potential risks. The need for medical supervision is based on what Health Canada deems as "the strong evidence of good health and safety outcomes." The patient must be seen and physically examined and followed up as per the requirements.

Linepharma has developed an **educational program** for physicians to ensure safe and effective use of Mifegymiso. This program is recommended by the CPSS.

The information we have received with respect to the restricted distribution program is as follows:

1. patients can take the prescription to a pharmacist of their choice and have the drug delivered to the physician's office to take, which is consistent with the product monograph; or,
2. Mifegymiso can be dispensed directly to patients by a pharmacist or a prescribing health professional. Directions for use remain the same. Patients should take the medication as directed by their health professional, either at a health facility or at home.

Physicians and other prescribers wishing to seek additional clarification on this medication can refer to:

Health Canada Healthcare Professional Letters

April 16, 2019 update (<https://tinyurl.com/y6hkbttf>)

Nov 17, 2017 update (<https://tinyurl.com/y6bkzs6>)

May 17, 2017 (<https://tinyurl.com/yyy79ets>)

Product Monograph

https://pdf.hres.ca/dpd_pm/00050659.PDF

Saskatchewan Drug Formulary

<http://www.saskatchewan.ca/government/news-and-media/2017/august/31/mifegymiso-added-to-formulary>

Saskatchewan College of Pharmacy Professionals Dispensing Guidelines

https://scp.in1touch.org/document/3692/Mifegymiso_Dispensing_Gdlns_20170829.pdf

Study on Perspectives in Medical Assistance in Dying (MAiD) Seeking Your Input

If you are a physician or nurse practitioner who currently DOES NOT participate in MAiD and relates to one of the following statements, please consider participating in this study.

- 1) *"I don't know what I would do if I was approached by a patient for MAiD related care,"*
- 2) *"I might be interested in participating, but have not been approached by a patient,"*
- 3) *"I don't think I would participate in MAiD related care," or*
- 4) *"I would not participate if approach by a patient."*

College of Medicine, Health Sciences Program University of Saskatchewan



PARTICIPANTS NEEDED FOR RESEARCH IN MEDICAL ASSISTANCE IN DYING (MAiD)

I am looking for physicians and nurse practitioners to take part in a study to better understand the decision making factors considered by practitioners who do not participate in medical assistance in dying.

As a participant in this study you will be asked to participate in an interview and complete a short demographic questionnaire.

Your participation would involve one session, of which is approximately 60 minutes. Interviews may be in person, or via telephone/WebEx.

For more information about this study, or to participate,
please contact:
Janine Brown, College of Medicine, Health Sciences Program
Email: jma401@mail.usask.ca

(This email account is only accessed by myself and is password protected)

**This study has been reviewed by, and received approval
through, the Research Ethics Office, University of Saskatchewan on April 29,
2019 (REB #902).**



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SASKATCHEWAN

usask.ca

Stressed? We're here for you!

By Brenda Senger, SMA

A physician at the heart of the health care system and surrounded by resources, can be suffering without receiving appropriate care.

This defies belief and challenges us to explain how such a thing can occur!

- Programme d'Aide aux médecins du Québec

Traditionally physicians in need of care feel guilty about accepting help and shame for needing it. We need to challenge the culture of medicine that disallows physicians from asking for help.

But the stigma around asking for help for mental health issues is changing. When I first started in the Physician Health Program in 2003, the focus was primarily on physicians struggling with addiction issues. With the expansion of expertise on the committee, we have broadened our ability to help. In 2018, 41.3% of all calls to the PHP were for mental health concerns. Is the profession getting sicker – NO – the profession is reaching out much more proactively for help. Historically, physicians were referred by the CPSS once a mental health issue negatively impacted their work performance – in 2018 64.5% were self-referrals (only 2.8 % were referred by the CPSS). Colleagues have also begun to reach out to those struggling and encouraged them to access care.

A lot of focus has centered on enhancing personal resiliency – it is important to understand that all the resiliency in the world does not protect us from physical or mental health issues. Our level of resiliency does not make us super heroes! But our resiliency is crucial in assisting us to manage these diseases effectively when provided with appropriate care and support.

We cannot take the stress out of medicine but we can help you develop strategies for managing the impact.

The Physician Health Program of the SMA offers a confidential resource to members. The CPSS does not sit on the PHP committee. We provide assessment, treatment, on-going support, monitoring, counselling and advocacy for physicians, physicians in training and their family members who are struggling with mental health concerns.



Stress is inevitable. Struggling is optional.

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

Call Brenda Senger, Director,
Physician Health Program at 306-657-4553
Saskatchewan Medical Association





Nominate a colleague you admire for the 2019 Kendel 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.

KENDEL AWARD Nominations are open until September 30th of each year

Nomination packages for 2019

are available on the homepage
of the College website at

www.cps.sk.ca

or by writing to Sue Waddington at
OfficeOfTheRegistrar@cps.sk.ca



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

You may be eligible for

SENIOR LIFE DESIGNATION

If you have practised 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 eligible to receive 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>



A core service of the Réseau Santé en français de la Saskatchewan (Saskatchewan Francophone Health Network)



HEALTH ACCOMPAGNATEUR INTERPRETATION SERVICES IN FRENCH

French-speaking newcomers | Seniors | Families

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.

A Health Accompagnateur may be present at your patient's point-of-care and will act as an interpreter between you and your patient.

Patients who need an interpreter are encouraged to call
1-844-437-0373 (Toll free)

🌀 **This is not an emergency service** 🌀



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

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.



We're Working for You



College of Physicians and Surgeons of Saskatchewan

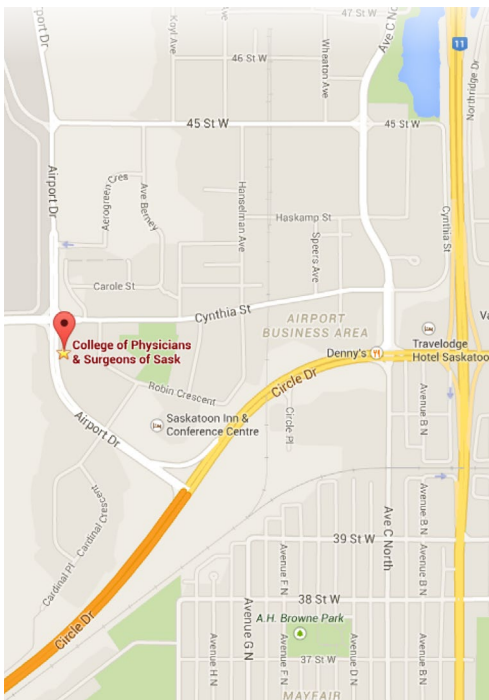
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Dr. Werner Oberholzer
Mr. Bryan Salte
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Registrar
Deputy Registrar
Associate Registrar/Legal Counsel
Director, Registration Services

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