

the Messenger

College of Physicians & Surgeons of Alberta

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College of
Physicians
& Surgeons
of Alberta

2006 Council

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Vice President - Dr. John Pasternak

Executive Member-at-large - Ms. Irene Pfeiffer

Council members are available throughout Alberta to answer questions and discuss current issues. E-mail: council@cpsa.ab.ca

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the Messenger

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Registrar's Report



For a long time I've been keenly interested in the patient safety movement, and believe that focusing on safety – as a key component of quality – would provide physicians and the health care system an opportunity and a platform to shape our culture and transform the way we work.

The *Safer Healthcare Now!* campaign, an offshoot of the *100,000 Lives Campaign* of the Institute for Healthcare Improvement in the US, is a very positive national initiative spearheaded by the Canadian Patient Safety Institute. Many Alberta hospitals and all health regions are participating in one or more of the six projects.

Already there are reported successes from use of these “bundles” of care - for example, a collaborative of hospitals in Michigan have reduced the incidence of ventilator-associated pneumonia and central line catheter sepsis to almost zero, a remarkable achievement. There is no reason we cannot replicate their success in Alberta.

Recently, I attended a meeting at which I heard an interesting presentation from an American cardiac surgeon named Paul

Uhlig. By having all team members round on each patient every day, Dr. Uhlig and his team have consistently and progressively reduced their operative mortality for open heart procedures to significantly below the expected (age and risk adjusted) mortality.

This is good not only for the patients and for Dr. Uhlig's statistics, but also translated into high staff morale and low staff turnover. Since all provider and patient questions are answered at the time of rounds, care is efficient – the need to chase

Why is it that a process that is intuitively so useful would be rejected by some of our colleagues?

after members of the team to get questions answered is greatly reduced - and patient and family satisfaction is very high.

Dr. Uhlig also incorporates a time out prior to starting any surgery. Again it's an opportunity for the team to communicate, to be on the same page, to address any specific questions or equipment needs and – just like in an airplane cockpit – to set out the rules by which the operation will proceed. In Dr. Uhlig's O.R., everyone is invited to bring a problem to his attention and to “stop the line” if safety is compromised.

There are a number of simple safety measures being instituted in Alberta which I support and which I hope all of our profession will embrace. Some examples include the elimination of unsafe abbreviations, the reporting of unsafe situations and near misses, and the use of a time out as part of a strategy to prevent wrong site surgery, one of the “never events.”

Human factors experts remind us that delivering medical care is a human activity, one that requires the coordination of many players working in complex systems. It should not surprise us, therefore, of the need for clear and consistent communication, for teamwork, for situational awareness and for shared responsibility.

It is predictable that patients will be safer when all members of the team check to ensure the consent is correct and matches with the patient's expectations, when the team has had the opportunity to discuss any unique aspects to the planned procedure (technical, equipment, positioning), when the necessary imaging studies are available for viewing and when the surgeon has marked the planned site, side or level of the procedure.

You can imagine my despair and surprise to hear, therefore, that some surgeons refuse to call or allow a time out.

Why, I ask, would someone reject a procedure that seems to me so intuitively correct, that provides such opportunity for good communication, team building and situational awareness?

Registrar's Report cont'd Pg. 12...

Do you have a question for your Registrar?

Would you like to get the College's perspective on a particular issue?

Mail your questions and comments to the College office or e-mail: ttheman@cpsa.ab.ca

Council Highlights

Council of the College of Physicians & Surgeons met on June 2, 2006 in Edmonton. Significant outcomes included:

Pharmacist Prescribing – Council raised a number of concerns regarding the new legislative change that allows for primary prescribing of certain medications by pharmacists. These concerns include:

- Patient safety - ensuring that those health professionals who are granted prescribing privileges have the necessary training and clinical expertise to make wise decisions
- Costs - who will pay for the pharmacist's role in prescribing
- Conflict of interest – an inherent conflict when the prescriber is also the dispenser
- Patient follow-up when it is the pharmacist who initiates prescribing - who will look after the complications
- Communication in collaborative care - the need for good communication between the various members of the healthcare team if there is potential for prescribing by multiple players

Council is offering its expertise to the Alberta College of Pharmacists to help them determine the necessary qualifications for pharmacist prescribing and what conditions or presentations would be appropriate for a pharmacist to treat.

Disclosure of Confidential

Information – Council approved an amendment to Section 99 of the College bylaws, which will allow for the disclosure of physician information to Alberta Health and Wellness (AHW) regarding potentially inappropriate billing practices. The investigation of such practices falls under

the jurisdiction of AHW. It was noted that Section 20 of the *Personal Information Protection Act* also allows disclosure of such information.

Methadone Program – Over the past 18 months, the CPSA had been receiving a grant from Health Canada to develop guidelines for methadone prescribing, as well as a monitoring program to ensure that such prescribing is being done. That grant funding has now run out and attempts to attract replacement government funding have failed. Council will continue to honour its responsibility to provide letters in support of physicians applying to Health Canada for methadone prescribing privileges. This activity does not incur any additional costs to physicians, but it does mean that a severe curtailment to the operation of a monitoring program. The College will continue to seek external funding for the full program. Educational activities will continue in partnership with the universities.

Health Professions Act Transitional

Policy Issues – Council was advised that the following bylaw changes would be necessary for the transition to the *Health Professions Act*:

- Transferring decision-making authority for accreditation of diagnostic and treatment facilities to the Medical Facility Assessment Committee, with Council as the appeal body
- Expanding disclosure to a regional health authority from information about “significant mishaps” to information about “the conduct of a regulated member or the quality of care provided in a non-hospital surgical facility”
- Amending the College’s Conflict of Interest regulations that currently pro-

hibit physician involvement in lease or rental arrangements that are based on a percentage of income from the medical practice

- Introducing mandatory malpractice protection for physicians

With Council’s discussion and feedback, staff were directed to begin drafting wording for such bylaws for consideration at a future Council meeting.

Council also directed that feedback from the profession be sought on the following topics:

- Physicians supervising others in the performance of restricted activities
- Physician dispensing

Future issues of the Messenger will provide physicians with the background on these topics, and pose questions for response.

Registration Information Form – Mandatory Online Completion

– Council discussed the Registration Information Form (RIF) that physicians complete as part of their annual license renewal. Council directed that:

- A.) Completion of the RIF be a mandatory pre-requisite for renewal of licenses
- B.) By **January 2009**, it will be mandatory to complete the RIF online.

Online completion represents a significant savings in staff and stationery costs, and an increase in the accuracy and timeliness of the information for the College.

Financial Statements – The Finance and Audit Committee approved the College’s audited financial statements for the year ending December 31, 2005. Copies of the complete financial statements are available through the CPSA office.

Senior Policy Advisor

Dr. Trevor Theman is pleased to announce that a new position of Senior Policy Advisor has been created at the College to develop and maintain CPSA policies and to play a key role in government and stakeholder relations. Ms. Cathy McCann, formerly the Manager of Physician Prescribing Practices, has been appointed to this position.

In this role, Ms. McCann will assist the Registrar, Council, and the Executive in issues scanning, strategic planning, Council development and governance, and policy creation.

As the title suggests, the primary duties are within the policy arena. Over the years, the College has developed a num-

ber of policies, guidelines and standards to fulfill its role to serve the public and guide the profession. However, as a great many authors have participated in the creation of these documents, a need was identified for the coordination, oversight, and editorial review of the guidance provided to the profession.

In addition to reviewing and updating existing policies and guidelines, Ms. McCann will also be responsible for working with Council and senior management to create new College documents and to ensure there is internal consistency in how those documents are interpreted and implemented.

Another major component of this new position is government/stakeholder rela-

tions. As an organization that supports the concepts of openness and transparency, the CPSA needs to make a more concerted effort to share our position on health policy and physician-related issues. By improving our relationships with regional health authorities, government departments, elected officials, universities and other key stakeholder groups, the College can play an even stronger role in discussions related to health policy and the medical profession.

As Ms. McCann becomes established in this new role, she will be actively seeking input from physicians in developing and enhancing College policy. Your comments and suggestions are welcome at cmccann@cpsa.ab.ca.

Medication Prescription Writing

The College has received complaints from pharmacists regarding the format of some prescriptions.

When prescription instructions are limited to “as directed,” pharmacists do not know how the patient has been instructed to use the medication. They are unable to provide the patient with proper advice on medication use and answer questions.

Always include specific instructions on how the medication should be used by

your patient each time you provide a prescription.

Many physicians use pre-printed prescriptions with a pre-printed signature. The federal *Food and Drug Act* requires that all prescriptions must have a hand written signature and be dated on the day they are given to the patient.

If you use pre-printed prescriptions, please ensure that you sign and date each prescription at the time you provide it to

your patient. If the prescription has a pre-printed signature, that signature must be initialed by you.

By adhering to these recommendations, you will not only ensure that your prescriptions meet legislative requirements, you can also decrease the potential for errors in the way your patients use their medications.

Dr. Kate Reed, Assistant Registrar
kreed@cpsa.ab.ca

College Introduces Community Investment Program

The main role of the College is to “serve the public and guide the profession.” In order to accomplish this, we need to have strong working relationships with individual physicians, regional health authorities, other regulatory bodies, medical schools, members of the public, elected officials, senior government personnel and many other stakeholders.

An important element of these relationships is the ability to provide support to individuals and initiatives that correspond to the CPSA mission, vision and values. To ensure we are consistent and financial-

ly responsible with this funding, we are pleased to introduce the *CPSA Community Investment Program*.

The program gives the College a way to appropriately invest in activities that help us achieve our strategic goals. It includes a sponsorship component and the creation of College logo items that can be used to promote the organization and its mandate.

As we are primarily a member-funded organization, we have a responsibility to physicians to use our resources wisely. Therefore, the CPSA will only provide sponsorship or prizes if the College is directly involved in the event/activity or

if the event/activity will provide a direct and obvious benefit to physicians, medical residents and/or medical students in the province of Alberta.

The College has long been involved in this kind of community support. This new program allows us to be more strategic in our planning and more consistent in how we handle funding/support requests.

For more information about the College’s Community Investment Program, please contact CPSA Communications Manager Kelly Eby at 780-412-2683 or via email at keby@cpsa.ab.ca.

Communications Review - High Physician Response Rate -

To find ways to improve the quality and effectiveness of College communications, the College retained Downey Norris & Associates Inc to conduct an independent communications audit earlier this year.

One component of the audit was a survey of a structured random sample of 1,000 Alberta physicians. Five hundred physicians received a mail survey and 500

physicians received an electronic survey. Response rates for both groups were high, with 26 per cent responding to the mail survey and 30 per cent responding to the electronic survey.

Detailed results of the physician survey and other information from the communications audit are now being analyzed by the College’s Communications Advisory Group, who will then recommend improvements based on the audit findings.

Their report will be presented to College Council in September 2006. A summary of the audit results and a detailed action plan will then be shared with the profession via the Messenger and the CPSA website.

Thank you to those of you who took the time to share your views through the survey process. Your comments will be used to improve College communications strategies, tools and activities.

Complaints, Discipline & the HPA

Sometime in the near future, likely in 2007, the College will move under the authority of the *Health Professions Act* (HPA), a new omnibus legislation for all health professions.

A number of changes to the College's complaint and discipline process will occur under the HPA. One significant change is that physicians and complainants will have the opportunity to work together to resolve the complaint.

Currently, when the College receives a complaint, the physician is advised of the details of the matter and is asked to respond. Aside from preparing a written response and occasionally a face-to-face meeting with College staff, physicians have no opportunity to resolve the issue directly with the complainant. The matter is essentially adjudicated by the College.

The HPA places some of the onus for resolving complaints back onto the complainant and physician, if the Complaint Director (a CPSA employee) feels it is appropriate.

There are two ways in which this can occur:

1. The Complaint Director can write the physician asking him/her to resolve the matter directly with the complainant. The physician must notify the Complaint Director of how it has been resolved and if satisfactory, the complaint will be closed.
2. The physician and complainant may be asked to participate in Alternate Complaint Resolution (ACR). In this process, which will be confidential and at arms length from the College, the two parties enter into a facilitated discussion with an independent mediator. The College will appoint a member of the profession to sit in on the process to assist the mediator and guide the parties. There will be an opportunity for the physician and complainant to share each other's perspectives and explore solutions that would meet both parties' needs. The process is confidential; only the agreed upon settlement will be shared with College staff. The agreement must be ratified by the College's Complaint Review Committee to ensure that the public's interest has been met by the mediated agreement.

If the parties are unwilling to consider the options outlined above or cannot resolve the complaint, the matter is referred back to the Complaint Director who can:

- Dismiss the complaint
- Order an investigation
- Refer the matter to a disciplinary hearing
- Attempt to resolve the complaint with the agreement of the complainant and the investigated person

In summary, the HPA (when appropriate) allows physicians and complainants to be active participants in the management of a complaint, thereby allowing both parties to maintain some control over the process and the outcome.

Watch for more information about complaints and discipline and the HPA in future issues of the Messenger.

For more information, please contact:

- Dr. Karen Mazurek, Assistant Registrar, Complaints at kmazurek@cpsa.ab.ca
- Ms. Sharon Barron, Manager, Complaints at sbarron@cpsa.ab.ca

IMGs as Physician Assistants

The College has received inquiries from physicians interested in hiring International Medical Graduate (IMG) "Physician Assistants" in their offices.

IMGs who do not qualify for an independent practice license may be eligible for Courtesy Registration as a clinical observer or trainee under a supervising physician.

Supervising physicians are advised by the College that they must **not** rely on the history or physical examination performed by a clinical observer or trainee in their medical decision-making and management of a patient. Similarly, clinical observers or trainees should not be identified as "Assistant Physician" or "Physician Assistant."

Physician Assistants in Canada are specifically trained and credentialed members of

the Canadian Armed Forces who provide paramedical service under the supervision of a physician.

As the CPSA does not regulate or license Physician Assistants, it would be inappropriate and potentially misleading to use this term.

Dr. Kate Reed, Assistant Registrar
kreed@cpsa.ab.ca

Letter to the Editor

Medical Oversight of Emergency Medical Services (EMS) in Alberta

In order for EMS practitioners to obtain licensure in Alberta, a physician licensed by the College of Physicians & Surgeons of Alberta must provide medical direction and oversight. This medical oversight defines the level of clinical care patients receive in the out-of-hospital setting. Currently, standards do not exist to address the qualifications of medical directors.

In the past, the College has made it clear that physicians must not act as a medical director “in name only.” In other words, demonstrated knowledge and active involvement in ambulance activity including protocol development and refinement, Quality Management (QM), audit, education and training are essential for EMS medical directors. Failure to demonstrate adequate level of involvement has the potential to leave the physician, the ambulance service and, most importantly, the patient at risk.

One of the roles of the Medical Advisor to the Emergency Health Services Branch of Alberta Health and Wellness is to act as a resource to medical directors throughout the province and to facilitate information sharing. All licensed ambulance services in the province have provided Emergency Health Services Branch with the names

and contact information of their medical directors. I have made contact with the majority of these physicians and continue to act as a resource when required. Medical directors of the numerous industrial EMS systems are not recorded in the Branch office and many may be providing medical direction without being fully aware of what this entails.

I encourage all physicians providing oversight to ambulance services in the province, and to whom I have not yet corresponded, to provide me with contact information. I will then be able to communicate/network more effectively with all EMS medical directors in the province in a move toward standardized medical oversight.

*Hal B. Canham MD, CCFP (EM), FCFP
Medical Advisor, Emergency Health Services
Alberta Health and Wellness
hal.canham@gov.ab.ca*

Alberta WebSMR

The Alberta WebSMR is an electronic cancer surgery data collection system that makes outcomes analysis possible, replaces the currently dictated OR report, is more efficient and generates 50 per cent more pertinent information.

This system, developed by Cancer Surgery Alberta (CSA), is comprised of

evidence-based data elements defined by Alberta surgeons for specific tumour sites. These data elements are then placed in electronic format to comprise the Alberta WebSMR.

It is currently “live” in three of the nine health regions (Calgary, Chinook and Paliser) as well as the Cross Cancer Institute in Edmonton. There are plans to implement the Alberta WebSMR in the remaining regions.

Current users of the Alberta WebSMR are now able to obtain real time outcomes data such as the use of sentinel node biopsy, breast conserving surgery and TME which reflect changes in patterns of practice.

As a result of national and international interest about the WebSMR, CSA will host a national outcomes conference June 15-17, 2006 in Banff, Alberta.

The conference will address the need for a national strategy for quality improvement in cancer surgery, including the use of synoptic reporting tools such as the WebSMR.

*Evangeline Tamano
Program Leader, Cancer Surgery Alberta
evangeli@cancerboard.ab.ca*

One Problem per Visit

The College has received feedback from many members about this issue. Thank you to everyone who provided their insights, ideas and comments about this challenging issue. The profession’s feedback can be found on our website through the online Messenger and the Complaints web pages. Click here to view responses.

College Offices to Move in 2007

In January 2007, the College of Physicians & Surgeons of Alberta (CPSA) will move from its current location in Manulife Place to Telus Plaza South in downtown Edmonton.

The move is necessary due to increasing rental costs, proposed increases to staffing levels over the next few years and the upcoming expiration of the College's current lease on the 12th floor of Manulife.

Benefits of the move include:

- The CPSA will keep its office in the

downtown core where the majority of our business partners are located. This location also benefits our employees who will have easy access to public transportation.

- The new location will meet College space requirements for the next 15 years.
- Over the long run, the new location will cost less than comparable office space in Manulife Place.

In the short term, there will be some one-time costs associated with leasehold improvements in the new space, modifica-

tions to furniture and equipment and the move itself. Council's Finance and Audit Committee is studying ways to cover these costs, and will report to Council in September.

More information will be shared with physicians through the Messenger, Regional Tours, various correspondence and the College website at www.cpsa.ab.ca.

In the interim, if you have any questions, please contact CPSA Assistant Registrar John Swiniarski at 780-970-6226 or 1-800-561-3899, extension 6226.

For Your Information

D-dimer testing and venous thromboembolism

Dr. Gwen Clarke of the College's Alberta Laboratory Quality Enhancement Program (ALQEP) has prepared advice for medical diagnostic laboratories on precautions around D-dimer testing in the diagnosis of venous thromboembolism.

Physicians with an interest in the vagaries of D-dimer testing can find this advice on the College's website in the ALQEP hematology section (www.cpsa.ab.ca/facilities-accreditation/alqep_hematology.asp) under 'Additional Information - References, Resources and Publications.'

North-South Golf Tournament

The 79th annual North-South Doctor's Golf Tournament takes place Monday, August 14 at the Red Deer Golf & Country Club.

- 6:30 a.m. - Registration and full breakfast

- 8:00 a.m. - Shotgun start (stroke play format)

\$150 per person - includes green fees, power carts, use of range and practice facility, full breakfast, and BBQ steak dinner.

Registration deadline is August 7

This event is co-sponsored by the CPSA, as a fundraiser in support of medical student bursaries.

For more information, contact the Alberta Medical Association at (780) 482-0692 or 1-800-272-9680, ext. 692

Methadone Maintenance Treatment Workshop

Differing levels of education, knowledge and competence are required in order to safely prescribe methadone to appropriate opioid-dependent individuals.

Methadone Maintenance Treatment education sessions will be offered through

the Continuing Medical Education and Professional Development Office, University of Calgary, on September 22, 2006, and Health Sciences Centre and Continuous Professional Learning, University of Alberta, in early 2007.

The workshop will provide practical information in the use of this medication and will prepare practitioners to manage methadone patients in clinical practice.

This program meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited for up to 6.25 MAINPRO-M1 credits. This event is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance Certification Program of the Royal College of Physicians and Surgeons of Canada. Information will soon be available at www.cpsa.ab.ca/collegeprograms/methadone_program.asp.

Problematic Opioid & Benzodiazepine Use

There are many risks and benefits to prescribing opioids or benzodiazepines – all of which must be considered before prescribing.

One of the major risks is that some patients receiving these medications will engage in problematic, drug-related behaviours. This is known as substance abuse - where there is significant deviation from the prescribed regimen, increasing risk of harm to the patient. The abuse generally leads to health problems with negative social and interpersonal consequences.

The three basic ways to manage problematic prescription medication are: risk assessment, use assessment and use management.

Risk assessment includes a personal and family history of substance use, psychiatric illness and present social situation. A physical examination finds evidence of intoxication, withdrawal or physical signs such as track marks on hands, legs and neck. Laboratory tests including urine toxicology testing for common drugs of abuse can also be useful. Collateral and supporting documentation available through the CPSA triplicate prescription program, pharmacist, and previous physicians may also assist in the assessment process.

Use assessment is simply ongoing risk assessment. A few simple questions, including a modified CAGE questionnaire, assist in detecting problems at their early stage, when interventions can be simple and effective.

Use Management: The primary intervention method available to clinicians dealing with substance abuse is education i.e. the

dangers associated with inappropriate drug use and realistic goals of therapy. Patient contracts, limited dispensing intervals, frequent patient contact, routine “random” urine toxicology testing, enlistment of family or outside support, and formal counseling may all play a role in allowing the patient and physician to retain therapeutic control of the prescribed medication.

Patients with significant problematic behavior usually are easy to identify. The more difficult question is whether the behavior constitutes addiction. A small segment of patients prescribed an opioid or benzodiazepine, where there is a predisposition to the disease of addiction, develop a substance dependence disorder. The diagnostic criteria are clearly defined in the DSM- IV-R Criteria for Substance Dependence. See *Standards and Guidelines for Methadone Maintenance Treatment in Alberta* at www.cpsa.ab.ca/colleg-programs/methadone_standards.asp.

The following behaviors may be suggestive of a substance dependence disorder, or addiction:

- Selling prescription drugs
- Prescription forgery
- Stealing or “borrowing” drugs from others
- Injecting oral formulations
- Obtaining drugs from multiple medical sources without informing or despite prohibition
- Concurrent abuse of alcohol or illicit drugs
- Multiple episodes of self-escalation of dose despite warnings not to do so
- Multiple episodes of prescription “loss”
- Multiple requests for “early release” of regularly scheduled dispensing

- Evidence of functional deterioration unexplained by the pain or other comorbidity
- Repeated resistance to changes in therapy despite clear evidence of adverse effects

Coordination of treatment with other care providers is recommended for patients who have been diagnosed with a substance dependence disorder. One approach is to consult with and refer to a multidisciplinary Methadone Maintenance Program where the problem is with opioid medications, or with a detoxification and addiction treatment program for both opioid and benzodiazepine dependence disorder. For the clinician with the necessary experience, willingness and time to treat addictions, carefully structured detoxification regimens may be attempted on an out-patient basis with the highly functioning, committed patient. Consultation with a clinician experienced in this area is strongly advised.

Interim measures include strictly limited dispensing of the medication to daily dispensing, if necessary, and prescribing the least amount of drug required to prevent significant withdrawal signs and symptoms. A formal patient agreement for treatment outlining parameters of care and responsibilities should be considered. For other tips on this topic please see the May 2006 issue of Messenger available on the CPSA website.

*Dr. Ian Postnikoff & Dr. Mat Rose
CPSA MMT Guidelines Development Committee*

Support for this project has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Medical Directory Amendments

Although the Medical Directory is carefully compiled and checked by College staff prior to release, errors and omissions inevitably occur. Information for the following physicians has been updated. Changes are indicated in **bold** print.

Section 1 - Alphabetical List

Name	City	Degree	Grad Place	Grad Year	Phone	Fax	Specialty	Page
Ciubotaru, Sergiu	Medicine Hat	MD	Romania	1994	(403) 526-7422	(403) 526-3349	-	15
De Freitas, Terry	Leduc	MD	U of A	1995	(780) 986-1714	(780) 986-1824	-	19
Fitzgerald, Avril A.	Calgary	MD	U of A	1976	(403) 943-3895	(403) 212-0972	IM RHEU	25
Foda, Mohamed	Leduc	MD	Egypt	1976	(780) 980-4627	(780) 980-4629	UROL	25
Jeraj, Anthony	Medicine Hat	MD	Mexico	1983	(403) 526-7422	(403) 526-3349	-	38
Laing, Ian R.	Sherwood Park	MD	U of A	1967	(780) 467-9316	(780) 467-4717	UROL	43
Marck, Paul A.	Calgary	MD	UWO	1985	(403) 802-4040	(403) 802-4020	OTO	50
McKenzie, Lynne M.	Coronation	MD	U of C	1978	(403) 578-3232	(403) 578-3235	-	52
Moriarty, Frederick	Calgary	MB, BCh	U of S	1976	(403) 228-3865	(403) 802-1181	-	55
Sprague, Jack	Leduc	MD	U of A	1962	(780) 986-1714	(780) 986-1824	IM	74
Sprague, Nancy L.	Leduc	MD	U of A	1976	(780) 986-1714	(780) 986-1824	-	74
Temple, Walley J.	Calgary	MD	Queen's	1970	(403) 521-3914	(403) 521-3744	GS	78

Section 2 - Geographical List

Community	Name	Address	Postal	Specialty	Phone	Fax	Page
Calgary	Walley J. Temple	1403 29 St NW	T2N 2T9	GS	(403) 521-3914	(403) 521-3744	128
Calgary	Paul A. Marck	1025 1 Ave NE	T2E 9C6	OTO	(403) 802-4040	(403) 802-4020	117
Calgary	Frederick Moriarty	101-1711 4 St SW	T2S 1V8	-	(403) 802-4040	(403) 802-1181	119
Calgary	Avril A. Fitzgerald	4A-188 Ambulatory Care Ctr 7007 14 St SW	T2V 1P9	IM RHEU	(403) 943-3895	(403) 212-0972	105
Coronation	Lynne M. McKenzie	PO Box 430	T0C 1C0	-	(403) 578-3232	(403) 578-3235	136
Leduc	Nancy L. Sprague	14-5201 50 St	T9E 6T4	-	(780) 986-1714	(780) 986-1824	180
Leduc	Jack Sprague	14-5201 50 St	T9E 6T4	IM	(780) 986-1714	(780) 986-1824	180
Leduc	Terry De Freitas	14-5201 50 St	T9E 6T4	-	(780) 986-1714	(780) 986-1824	179
Leduc	Mohamed Foda	4210 48 St	T9E 5Z3	UROL	(780) 980-4627	(780) 980-4629	179
Medicine Hat	Anthony Jeraj	49 8 St NW	T1A 6N9	-	(403) 526-7422	(403) 526-3349	184
Medicine Hat	Sergiu Ciubotaru	49 8 St NW	T1A 6N9	-	(403) 526-7422	(403) 526-3349	184
Sherwood Park	Ian R. Laing	76 Chippewa Rd	T8A 3Y1	UROL	(780) 467-9316	(780) 467-4717	192

cont'd...

Section 3 - Specialist List

Specialty	Name	Address	City	Postal	Phone	Fax	Page
General Surgery	Walley J. Temple	1403 29 St NW	Calgary	T2N 2T9	(403) 521-3914	(403) 521-3744	220
Internal Medicine	Jack Sprague	14-5201 50 St	Leduc	T9E 6T4	(780) 986-1714	(780) 986-1824	230
Internal Medicine	Avril A. Fitzgerald	4A-188 Ambulatory Care Ctr 7007 14 St SW	Calgary	T2V 1P9	(403) 943-3895	(403) 212-0972	224
Otolaryngology	Paul A. Marek	1025 1 Ave NE	Calgary	T2E 9C6	(403) 802-4040	(403) 802-4020	242
Rheumatology	Avril A. Fitzgerald	4A-188 Ambulatory Care Ctr 7007 14 St SW	Calgary	T2V 1P9	(403) 943-3895	(403) 212-0972	257
Urology	Ian R. Laing	76 Chippewa Rd	Sherwood Park	T8A 3Y1	(780) 467-9316	(780) 467-4717	258
Urology	Mohamed Foda	4210 48 St	Leduc	T9E 5Z3	(780) 980-4627	(780) 980-4629	258

Registrar's Report cont'd

It makes me wonder if some members of our profession haven't exposed themselves to the patient safety literature, to the practices that others have adopted with great success. And it makes me wonder if the culture under which many of us trained – which emphasized individual skill and achievement and 'named and blamed' when mistakes were made – still prevails, at least in some locations.

Team work and situational awareness and a just culture and medication reconciliation and "bundling" safe practices are not topics we learned in our training, but they're all important to improving the way we deliver care to our patients.

Physicians have been leaders in the safety movement, but the physician culture has been seen as barrier to instituting some of

these practices. Why is it that a process that is intuitively so useful would be rejected by some of our colleagues? I'd be very interested in your thoughts on this, and your solutions.

Dr. Trevor Theman, Registrar
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the Messenger

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