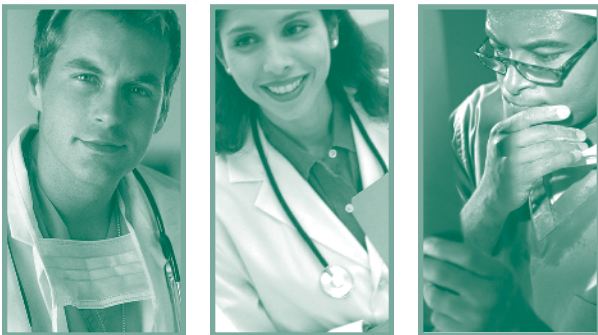


the Messenger

College of Physicians & Surgeons of Alberta

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2007 Council

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Vice President - Dr. John Pasternak

Executive Member-at-large - Ms. Linda Spencer

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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The College of Physicians & Surgeons of Alberta (CPSA) is responsible for licensing physicians, administering standards of practice and conduct and resolving physician-related complaints. We also provide leadership and direction on issues of importance to the health care system such as access to services, quality improvement, patient safety and privacy.

Registrar's Report

Physician Advocacy, Accountability and Engagement



In London in 1854, Dr. John Snow closed the Broad Street pump because he was convinced, based on 'primitive' epidemiologic data, that an outbreak of cholera was related to the water supply.

At its meeting this spring, the Representative Forum (RF) of the Alberta Medical Association passed this motion:

That the AMA express to the Federal Minister of Health that physicians as individuals need to be free to speak out for their patients and for the residents of the region in which they live, and to put Patients First.

A week ago, the Health Quality Council of Alberta (HQCA) released its report on the infection control problems at St. Joseph's General Hospital (SJGH) in Vegreville and the East Central Health Authority.

In my mind, these three events are connected by the title of this piece. They all relate in some way to the role of

physicians as advocates for the population they serve (as well as to individual patients); to the need for physicians to be engaged with the health care system where they work; and for physicians to be accountable for their various roles, including the role of advocate.

Anyone interested in healthcare safety and quality should read the Health Quality Council of Alberta's recently released report about the Infection Control Prevention and Sterilization issues at SJGH in Vegreville and the East Central Health Authority (available online at www.hqca.ca). It is comprehensive and direct. Using safety principles and the methodology of root cause analysis, the investigative team identified important system factors that contributed to the problems with the reuse of surgical instruments and with the outbreak of MRSA (methicillin resistant staphylococcus aureus) at SJGH.

I refer to it specifically because the authors identified two contributing factors that relate to the role of physicians within the healthcare system: 1) lack of a trigger process – such as morbidity and mortality rounds by the medical staff - to demonstrate the scope and seriousness of the MRSA outbreak, and 2) lack of engagement of SJGH physicians to communicate and reinforce the seriousness of the sterilization breaches and continued transmission of MRSA. Recommendations from the report include:

- Reinforce SJGH medical staff bylaws and medical staff rules to reinforce the responsibilities of physicians in quality and safety reviews; and

- Develop key performance indicators ... that demonstrate the ongoing efforts of medical staff contributions to quality and safety.

The mover of the RF resolution referenced the advocacy of Dr. John O'Connor of Fort McMurray for the health of the people of Fort Chipewyan, specifically the concerns he raised about the incidence of certain chronic diseases and cancers within that population.

Advocacy is one of the seven roles that define the competent physician in the 21st century as described by the CanMEDS 2005 Physician Competency Framework from the Royal College of Physicians & Surgeons of Canada. With the medical expert at the center, the framework identifies the various roles involved: communicator, collaborator, scholar, professional, manager and **health advocate**. It goes on to state that: *as health advocates, physicians responsibly use their expertise and influence to advance the health and well-being of individual patients, communities and populations.*

The document also says that:

Communities and societies need physicians' special expertise to identify and collaboratively address broad health issues and the determinants of health. At this level, health advocacy involves efforts to change specific practices or policies on behalf of those served.

As a health advocate, physicians are able to:

1. respond to individual patient health needs and issues as part of patient care;
2. respond to the health needs of the communities that they serve;
3. identify the determinants of health of the populations that they serve; and
4. promote the health of individual patients, communities and populations.

ARTICLE HIGHLIGHTS

- The College supports the CanMEDS competencies and has expectations that physicians will advocate responsibly for their patients, their communities and their populations.
- Greater accountability and transparency will be demanded of physicians.

Registrar's Report cont'd Pg. 10...

Why be a CPSA Council member?

This fall, the CPSA will once again elect new Council members to help the College meet its mission of serving the public and guiding the profession. Physician members of Council are elected by their medical colleagues, while public members and medical school representatives are appointed.

In anticipation of the upcoming nomination process for new physician members, the following elected College councillors shared their thoughts on the CPSA Council experience:

- Dr. Owen Heisler, VP, Medicine for the David Thompson Health Region;
- Dr. Bob Johnston, Senior VP and Advisor, Patient Experience, for the Calgary Health Region; and
- Dr. David Moores, Professor, Department of Family Medicine (UofA), and a practicing family physician at the Royal Alexandra Family Medicine Centre.

(Note: Interviews continued from August issue of the Messenger.)

Can you comment on how much time is involved in being a Councillor?

Heisler: There are regular meetings four times a year and several hours of preparation work involved. There are several different committees you may be involved with. You have to be prepared to spend some time at it. Anything worth doing is worth doing well.

Johnston: I try to read everything thoroughly, so it can be eight or more hours, depending on the depth of the material. The routine business isn't very much time; however, preparing for appeals heard at Council can be time-intensive.

Moores: Well, for an average two-day Council meeting, if there are appeals and hearings to be heard, you're probably looking at a minimum of four-six hours of prep time to read the material.

In terms of other issues that go on at Council, depending on the focus, it may be even more.

Why is it important for physicians from all locations, backgrounds and training to be involved with Council and the Council election process?

Heisler: I think the more variety you get, and the more points of view you get, the better. You need to have specialists; you need to have generalists; you need to have rural and urban. You need to have female and male. You need to have diversity. That's how you get better decisions.

Johnston: It's important to get the right representatives. They are there to represent the profession broadly, not as, say, an emergency specialist from Calgary.

A good Councillor is someone who...

Heisler: Listens well. Someone who is going to take the time to look at all sides of an issue and is interested in different perspectives at how we, as a society, provide care to a whole population.

Johnston: Is respected, willing to donate his or her time to the organization and one who brings a different perspective.

Moores: Is willing to do the work that needs to be done – and that means prep work. The likelihood of a capricious decision being made on Council is actually very, very small. That's because people do the work, are willing to listen to each other, and are willing to discuss and debate...those are the important parts of being an effective Councillor.

Summarize your experience as a Councillor:

Heisler: Being in a profession means you have both the privilege and responsibility of self-governance and that if we don't participate in being a professional, then that role will be taken on by other people and that's not what a profession is – it's a privilege and a responsibility.

Johnston: Wonderful. Great. An honour.

Moores: I guess if you ask the question, would I, having been in this role as a Councillor now for two years, consider doing it all over again? The unequivocal answer is yes. It's been an honour and a privilege to serve and I think each of us in our own ways have contributed to the College's future in how well it serves the public and how well it guides the profession.

More information on "Becoming a CPSA Councillor" is available online at www.cpsa.ab.ca/aboutus/council.asp.

(Correction: The August 2007 Messenger indicated Dr. Moores was Chair, Department of Family Medicine (UofA). Dr. Moores had been Chair 1990-2000. Dr. Rick Spooner is the current Chair.)

COUNCIL ELECTION NOMINATIONS

Election of members to the Council of the College of Physicians & Surgeons of Alberta will take place on November 16, 2007. Councillors will begin their term January 1, 2008.

Members entitled to stand for election must:

- Be in good standing.
- Have no outstanding fees.
- Have their primary business address, as recorded in the College office, within the district in which they are seeking election.

Watch your mail box for the October issue of *the Messenger* and more information.

NOW IS YOUR CHANCE TO GET INVOLVED!

Physician Health Monitoring Program

Enhanced with addition of MRO services

The College of Physicians and Surgeons of Alberta recently enhanced its Physician Health Monitoring Program (PHMP) by retaining the independent services of two Medical Review Officers (MROs).

Together with the Alberta Medical Association's Physician and Family Support Program (PFSP), the PHMP helps physicians access diagnostic assessments and treatment programs to optimize their own health and wellness. The program is tailored to serve the individualized needs of physicians. It works with the physicians, their healthcare providers, and their colleagues to develop an appropriate return-to-work plan. One of the key components of the program is the provision of continuing care, including random body-fluid screening as a universal requirement.

What is an MRO? This designation is awarded to a licensed physician, trained in reviewing toxicology testing, and who shares the responsibility with the laboratory for review of toxicology drug testing in occupational settings. The MRO also oversees the integrity of the specimen collection process, and in cases of a positive drug test, seeks for alternative explanations for such test results (e.g. the use of prescription medication, or specific dietary factors). This ensures accuracy and reliability of the process.

Physician aftercare monitoring usually involves a five-year commitment to the program; forming part of a process that ensures the impaired physician's access to support services to make a safe return to work. The program provides evidence-based, confidential and comprehensive support to those whose ability to practice

may have been impaired by any health concern, (e.g. a mental health issue or an addiction issue, or both).

The addition of MRO services adds an unprecedented level of scientific rigor to its aftercare program, and represents a first for Canada. In addition, the services add the component of independent advocacy for the accuracy and integrity of the body fluid testing process - an integral component of the program.

The MROs retained by the CPSA function as the objective gatekeepers of laboratory drug testing in the program, and work independently from the CPSA. This serves the purpose of ensuring the most accurate monitoring of physicians in recovery and subsequently the highest standards for return to work, and for maintaining public safety.

Informed Consent

From time to time, the College is contacted for advice about proper authorization or informed consent for the release of a patient's medical information, typically requested for the completion of insurance forms.

The *Health Information Act* (HIA) is law in Alberta, and Section 34(2) contains very explicit requirements for a proper informed consent for the release of health information. The Act states that a consent must specify, in writing or electronically:

- what information is to be disclosed;
- the purpose for disclosure of that information;

- to whom the information can be disclosed;
- the date the consent starts, and the end date, if any;
- that the person giving consent understands that the consent can be revoked at any time;
- that the person giving consent understands why they are being asked to consent, and what the risks and benefits of consenting or refusing to consent will be.

The obligation of physicians, both legally and ethically, is to release their patients' information only where a proper informed consent has been obtained (or unless release is otherwise allowed under

the HIA, or allowed or required under other legislation). Even in situations where release of information is allowed, physicians should still use their professional judgment to ensure that disclosure is appropriate.

And although the HIA does not apply to all health information, we recommend that physicians follow HIA rules in all cases, in order to ensure a consistent approach.

For further information, see the May/June 2007 edition of the Alberta Medical Association's *Doctors' Digest* (www.albertadoctors.org).

Golf tournament update

The North/South Doctors' Golf Tournament celebrated its 80th year in fine form July 23rd, attracting golfers from across the province and raising nearly \$12,000 for medical student bursaries.

Co-hosted by the College of Physicians & Surgeons of Alberta (CPSA) and the Alberta Medical Association (AMA) at the Alberta Springs Golf Resort near Red Deer, the tournament enjoyed wonderful weather, enthusiastic participation and incredible support from sponsors.

The CPSA sponsored a foursome of medical students and a foursome of residents from both the universities of Alberta and Calgary.

A survey of participants indicated the following:

- 94% said the tournament was worth their time and money to attend.
- 92% believed the tournament was a good way for the CPSA and the AMA to raise funds for medical student bursaries.
- 96% would recommend attending the tournament to their colleagues.

Although the majority of people surveyed praised both the tournament location and the Texas Scramble format, there were a number of players who specifically requested a return to the Red Deer Golf and Country Club and a Stroke Play format. These comments and the overall survey results will be considered as planning gets underway for next year's event.

2007 Tournament Sponsors

Thank you to the following companies for their financial contributions!

Albatross Sponsors (\$2500)



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Insurance Services Inc.



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PAR Sponsors (\$500)

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Annual re-licensure

Renewal notices for 2008 will be mailed to physicians at the end of September. Payments are due December 1, 2007 and can be made through the College's Pre-Authorized Payment (PAP) Plan, or by VISA, MasterCard, American Express or cheque.

Physicians practising in Alberta will also receive a Registration Information Form (RIF) for completion. As information contained in the RIF is required to maintain the College's physician resource database, physicians are asked to ensure all questions are answered fully and accurately.

The RIF must be completed and returned to the College by December 1, 2007 as a condition of licence renewal.

Physicians who completed their renewal online last year can access their 2008 renewal online starting October 1, 2007. A paper copy of the RIF will not be sent.

Enrolling in the College's PAP Plan simplifies the renewal process. Enrollment reduces costs (no administrative fees and automatic withdrawal of your renewal payment on the first business day in December) and eliminates the possibility of late payments and subsequent fines.

Complete the PAP enrolment form (p. 7/8) and return it, along with a VOID cheque, to the College office by Friday, November 2, 2007 in order to set up the automatic withdrawal of the 2008 renewal fee. If you are already enrolled in the PAP Plan but have since changed accounts or banks, please forward a new VOID cheque to the College by November 2, 2007.



Pre-Authorized Payment (PAP) Authorization for Business

Pre-Authorized Debit Plan

Annual Fee

I hereby authorize the College of Physicians & Surgeons of Alberta (payee) to debit my account (as identified by the attached voided cheque) for the annual College re-licensure fee. This debit shall take place during the month of December each year, for the fee applicable for the following calendar year.

I further authorize increases to this amount, as may be established by the Council of the College.

This authorization may be cancelled at any time upon written notice to the College. Any delivery of this authorization to the College constitutes delivery by me.

Name (Payor) *print or type*:

College Registration Number:

Signature(s): (see note 2)

Date:

Note:

1. A sample cheque of the account, marked **VOID**, must be enclosed with this authorization.
2. For a joint account, if more than one signature is required, all signatories must sign this authorization.
3. If this account is closed, it is the responsibility of the physician to notify the College immediately of alternative arrangements for payment of the annual fee.
4. Only Canadian bank accounts are eligible for PAP enrolment.

Authorization for Business Pre-Authorized Debit Plan

Terms & Conditions

1. In this Authorization “we”, “us” and “our” refers to the Payor indicated on the reverse hereof.
 2. We agree to participate in this Business Pre-Authorized Debit Plan and we authorize the College of Physicians & Surgeons of Alberta (the “Payee”) indicated on the reverse hereof and any successor or assign of the Payee to draw a debit in paper, electronic or other form for the purpose of making payment for goods or services related to our commercial activities (a “Business PAD”) on our account indicated on our attached void cheque (the “Account”) at the financial institution indicated on our attached void cheque (the “Financial Institution”) and we authorize the Financial Institution to honor and pay such debits. This Authorization is provided for the benefit of the Payee and our Financial Institution and is provided in consideration of our Financial Institution agreeing to process debits against our Account in accordance with the Rules of the Canadian Payments Association. We agree that any direction we may provide to draw a Business PAD, and any Business PAD drawn in accordance with this Authorization, shall be binding on us as if signed by us, and, in the case of paper debits, as if they were cheques signed by us.
 3. We may revoke this Authorization at any time by delivering a written notice of revocation to the Payee. This Authorization applies only to the method of payment and we agree that revocation of this Authorization does not terminate or otherwise have any bearing on any contract that exists between us and the Payee.
 4. We agree that our Financial Institution is not required to verify that any Business PAD has been drawn in accordance with this Authorization, including the amount, frequency and fulfillment of any purpose of any Business PAD.
 5. We agree that delivery of this Authorization to the Payee constitutes delivery by us to our Financial Institution. We agree that the Payee may deliver this Authorization to the Payee’s financial institution and agree to the disclosure of any information which may be contained in this Authorization to such financial institution.
 6. We agree to either waive the requirement of receiving written notice from the Payee of the amount to be debited and the due date(s) of debiting, or to abide by any modification to the requirement as agreed to with the Payee.
 7. We may dispute a Business PAD by providing a signed declaration to our Financial Institution under the following conditions:
 - (a) the Business PAD was not drawn in accordance with this Authorization;
 - (b) this Authorization was revoked; or
 - (c) any pre-notification required and not waived by section 6 was not received by us.
- We acknowledge that, in order to obtain reimbursement from our Financial Institution for the amount of a disputed Business PAD, we must sign a declaration to the effect that either (a), (b) or (c) above took place and present it to our Financial Institution up to and including but not later than ten (10) business days after the date on which the disputed Business PAD was posted to the Account. We acknowledge that, after this ten (10) business day period, we shall resolve any dispute regarding a Business PAD solely with the Payee, and that our Financial Institution shall have no liability to us respecting any such Business PAD.
8. We certify that all information provided with respect to the Account is accurate and we agree to inform the Payee, in writing, of any change in the Account information provided in the Authorization at least ten (10) business days prior to the next due date of a Business PAD. In the event of any such change, this Authorization shall continue in respect of any new account to be used for Business PADs.
 9. We warrant and guarantee that all persons whose signatures are required to sign on the Account have signed this Authorization on the reverse hereof.
 10. We understand and agree to the foregoing terms and conditions.
 11. We agree to comply with the Rules of the Canadian Payments Association, or any other rules or regulations which may affect the services described herein, as may be introduced in the future or are currently in effect and we agree to execute any further documentation which may be prescribed from time to time by the Canadian Payments Association in respect of the services described herein.

Please complete sections on other side of this page.

Ethics 101 scenario

You have been reading a lot about the patient safety movement and the disclosure of errors to patients and their families, and you can not stop thinking about the following incident that occurred while you were a resident.

While on call you were asked to see a woman whose labour was being induced with oxytocin or syntocinon. The fetal pH was becoming unacceptable and after consultation with your attending physician you elected to proceed with a C-Section. Once the oxytocin or syntocinon was discontinued the fetal

pH returned to normal so there was no urgency. You suggested that an epidural be used but the young anesthetist wanted to do an immediate general anesthetic. You had concerns about this and the experience level of the anesthetist but said nothing. The young anesthetist did not recognize nor know how to manage the woman's extremely small mandible and you watched both the mother and baby die. At the inquiry you were called to testify but were not asked, nor did you volunteer, information about this aspect of the tragedy. You did not speak to the anesthetist despite having seen similar

problems without consequences in the past. If you were faced with the same situation today, you are wondering what you could have done differently and why you felt compelled to remain quiet then. What could you have done then and what would you do today if faced with the same situation?

Send your comments to Dr. Janet Wright, Assistant Registrar, at jlwright@cpsa.ab.ca by October 1, 2007.

Ethics 101 responses

In the June 2007 *Messenger*, we outlined a fictional scenario where you have enjoyed practising family medicine for 10 years but have recently received an offer to join a cosmetic practice.

The hours and remuneration would be much better than you currently enjoy, but you are acutely aware of the shortage of family physicians that exists in your community. Furthermore, you know your patients will have difficulty finding a new physician.

Do you have an obligation to the community to continue providing care? Or should you accept the offer, which will allow you to work less for significantly more income?

Following are excerpts from some of the responses we received. The full text of all letters is posted on the CPSA website at www.cpsa.ab.ca - look for Ethics 101.

This society needs to decide what it values the most. If we allow cosmetic surgery to be

better remunerated than dedicated family practice, we take a collective responsibility for this. Compared to other medical disciplines, the comprehensive family doctor has not been valued as much in the past (financially nor in societal status) and we are seeing the consequences in recruitment and retention.

E. Schuster, MD

In this particular case, I think the physician has the right to change practices and I would fight hard to defend that right. Whether the doctor should choose to do so is another issue. Truth is that lots of doctors make this decision.... If the province wants doctors to stay in practice, they'd better make sure it is reasonably attractive.

Dr. G. Barr

The ethical dilemma is between exercising one's autonomous rights as a private practitioner versus the violation of social obligations by creating hardship upon one's own community of dependent patients.

Dr. N. Yee

Family practice is possibly the most undervalued area of medicine with physicians

continually dealing with higher workloads, increasing overhead, and inadequate remuneration. Continuing the status quo out of "obligation" is endorsing a system that results in unhappiness, burnout and possibly poorer patient care.

I believe the only way to have physicians (and perhaps specifically family physicians) valued appropriately is for actions to occur which force a realization of that value.

S. Kyle, MD

I believe that the hypothetical case, as presented, is a real-time dilemma presenting to most of the newer family physicians, and, unfortunately, the lures of "cosmetic medicine" and the "easier hours" and "better lifestyle" are going to win in a substantial number of situations.

...Why should a family physician feel "guilty" about crossing the line into cosmetic medicine and "feel-good medicine" when a substantial number of plastic surgeons and dermatologists and ophthalmologists have already made the journey into such lucrative pursuits?

Dr. B. Fernandes

All of these activities and attributes are consistent with the four principles of Family Medicine as presented by the College of Family Physicians of Canada (CFPC). Included in those principles are the statements:

- *Family Medicine is a community-based discipline (Family practice is based in the community and is significantly influenced by community factors); and*
- *The family physician is a resource to a defined practice population (Family physicians have the responsibility to advocate public policy that promotes their patients' health).*

In one of my examples, we see a physician being supported by his medical colleagues for his advocacy for the population he serves; in the other, we see what has been characterized as a missed opportunity by the local medical staff to have highlighted the infection control problems and to have raised the sense of urgency to address both the MRSA outbreak and infection control issues around the reuse of surgical instruments.

Advocacy, as defined in the CanMEDS framework, is not only accepted by the CPSA as an appropriate role of physi-

cians, it is expected and supported. It is my view that physicians need to be engaged with the communities they serve and in their local healthcare system (whether that is the local hospital, the local Primary Care Network, the local Regional Health Authority or simply the local medical community). The College supports the CanMEDS competencies and has expectations that physicians will advocate responsibly for their patients, their communities and their populations.

However, it is equally important to explain that advocacy does not happen in a vacuum. It is but one of the seven roles, and, as offered in the CanMEDS framework, it demands the ethical and professional principles inherent in health advocacy including altruism, social justice, autonomy, integrity and idealism. Asking questions, provocative or not, is never a problem. But physicians also need to be truthful, respectful of evidence, accepting of the right of individuals or groups to make choices, and willing to work with other individuals or agencies to understand or address the issues being advocated.

Physician advocacy must be responsible. It must be fair, and it must acknowledge and recognize evidence, the efforts of the

health system and organizations within it, limitations in resources and expertise, and the legitimate opinions of others. Because physicians are seen as acting in the best interests of their patients and the public (the core of professionalism), their views and opinions are given significant weight by the public. It is incumbent on our profession, therefore, to ensure that our members are balanced, reasonable and responsible in their advocacy.

It is very clear to me that greater accountability and transparency will be demanded of physicians. We, as physicians, need to take all of our roles seriously. We need to be engaged with communities and the healthcare system; we need to become experts in patient safety principles; we need to advocate for improvement or change when we see conditions that put patients or the population at risk; we need to collaborate with others – including regional administration and public health officials – when they raise concerns and safety issues; and we need to accept accountability for our actions.

Dr. Trevor Theman, Registrar
ttheman@cpsa.ab.ca

Informatics@CPSA

What is medical informatics, and why should the CPSA be involved?

First, consider the CPSA's main areas of focus (excluding licensing): quality of care, patient safety, and ethical/professional conduct. Then consider that medical informatics (the use of electronics in information management and communications to facilitate medical practice) includes a new set of tools and ways of

operating that offer opportunities as well as risks to physicians, their patients, and the health care system.

CPSA's Council concluded that there are most definitely issues in the informatics world with which it wanted and needed to be engaged. And so, several years ago, the Medical Informatics Committee (MIC) was created to:

1. provide advice to physicians on the use of Information Management/Information Technology (IM/IT) in their medical practices, focusing on the ethical, legal, privacy, patient safety and quality improvement aspects;
2. develop and coordinate CPSA input/leadership on IM/IT use in the healthcare system; and

HQCA recommended prescribing practices

The Health Quality Council of Alberta (HQCA) is undertaking a province-wide initiative to improve patient safety by encouraging all prescribers to change their ordering practices around the use of selected medications.

The table below identifies current unsafe practices for writing and ordering prescriptions, risks to patient safety, and recommended best practices.

The HQCA's Alberta Medication Safety Collaborative was established in 2005 to

advance the medication safety agenda for the province. For more information, visit www.hqca.ca.

HQCA'S Recommended "Do Not Use" List

STOP	CAUTION	GO
Unsafe Practice	Risk to Patient Safety	Recommended practice
IU (for International Unit)	Misread as IV (intravenous) in acute care settings	Use/write "unit"
U or u (for unit)	Misread as 0 (zero) or 4 resulting in a 10 fold overdose or greater (e.g. 4U read as "40" or 4u seen as "44")	Use/write "unit"
qd, od, QD, OD (for every day)	Misread as q.i.d., especially if the period after the "q" or the tail of the "q" misread as an "i" Misinterpreted as 'right eye' resulting in oral liquids being instilled in the eye	Use/write "daily" or "every day"
Zero after decimal (x.0)	Misread as 10x dose if the decimal point is not seen = 10-fold overdose	Never use trailing zeros for doses expressed in whole numbers (e.g. write 1 mg)
No zero before decimal dose (.x mg)	Misread as x mg (whole number dose) = 10-fold overdose	Always use zero before a decimal when the dose is less than a whole unit (e.g. write 0.1 mg)
Abbreviated drug names	Misread as an incorrect drug	Write out drug names in full

... *Informatics@CPSA cont'd*

- provide advice to CPSA staff about integrating IM/IT best practices into CPSA operations and programs.

The MIC retains the services of an external consultant, and includes observers from the Alberta Medical Association, the Office of the Information and Privacy Commissioner and iCare (a research initiative of the University of Alberta and Capital Health).

Over its short life, the MIC has produced two CPSA documents: "Transition to Electronic Medical Records" (September 2004), and "Data Stewardship Framework" (December 2006).

At present, the MIC is working on a third document, concerning the security of mobile computing devices (e.g., laptops), which will be released on October 1, 2007.

Next CPSA Council meeting - November 29 & 30 -

College Council's next meeting will take place on November 29 & 30, 2007. The open meeting is scheduled for Friday, November 30. To reserve a seat and receive a copy of the agenda, please call (780) 969-4986 or e-mail info@cpsa.ab.ca. Seating is limited and reservations are required.

Liability coverage mandatory for 2008

Effective January 1, 2008, every physician practising medicine in Alberta will be required to have professional liability coverage as a condition of licensure. At its meeting in June, Council passed the following by-law:

- 1) Every member of the College shall possess and maintain professional liability coverage that extends to all areas of the member's practice, including any vicarious liability of the member as a result of the conduct of the member's employee or agent, through either or both of:
 - a) membership in the Canadian Medical Protective Association;
 - b) a policy of professional liability insurance, issued by a company licensed to carry on business in the Province, that provides coverage of at least \$10,000,000.00.
- 2) When applying for registration with the College, an applicant must provide a declaration that the applicant will comply with subsection (1).
- 3) When applying for a renewal of a practice permit, a member must

provide a declaration that the member complies with subsection (1).

- 4) A member must keep available in the member's office, for inspection by the College, evidence that the member complies with subsection (1).
- 5) Subsection (1) does not apply to a member of the College who:
 - a) is on an Education Register of the College and who is not performing medical services outside the member's educational program;
 - b) is not providing medical services to any patient in Alberta; or
 - c) can provide written evidence from the member's employer that the member is providing medical services to other employees of the employer and not to any member of the public, and the member is covered for professional liability, direct or vicarious, through the employer.
- 6) For the purpose of subsection (5), medical services shall include the counseling, advising, diagnosing, treating or assessing of an individual

in regard to any disorder, disease or injury, whether or not the opinion of the member is based upon an examination of the individual, a review of records, or both.

New registrants after December 31, 2007 must declare their intention to comply with this requirement prior to commencing practice. Current members must declare their compliance on the Registration Information Form (RIF) at annual renewal time starting at the end of 2008. Failure to provide the required declaration without exempt status will result in suspension of licensure until the matter is resolved.

Physicians must ensure that they have coverage for all aspects of professional practice, including those for which CMPA does not provide coverage. Exemptions for special circumstances will be rare but may be requested by submission of details of practice and coverage for adjudication by the Registrar.

the Messenger

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