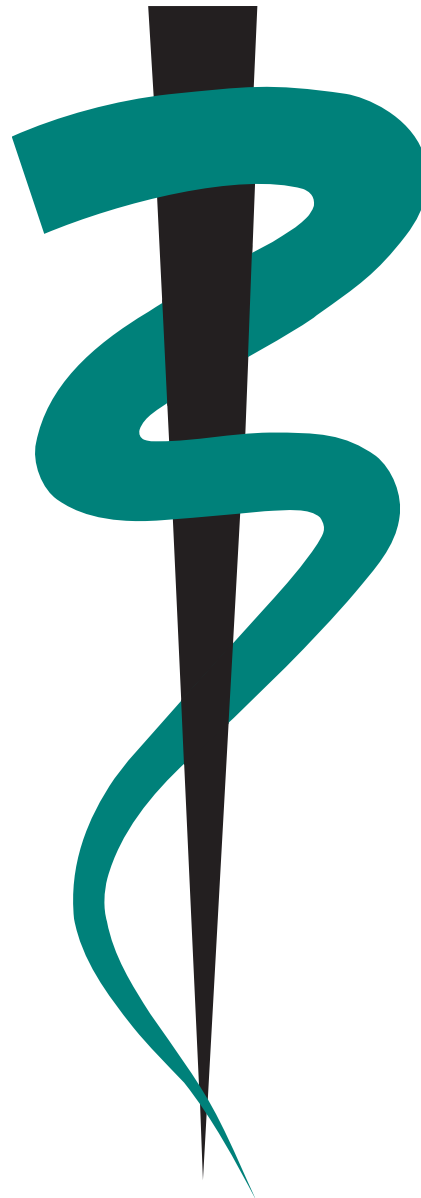


The Messenger

College of Physicians and Surgeons of Alberta

In This Issue

Registrar's Report	1
Get Your Messenger via E-mail	1
Council Highlights	2
Council Election Results	3
2003 Council Meeting Schedule	3
PIN Pilot Successful	4
Alberta Wait List Registry	4
Complaints Department How are we doing?	5
Discipline Report	6
Changes to the TPP Medication List	7
CPSA Guideline	8
• <i>Competency Assessment & Surrogate Decision Making</i>	
For Your Information	14
• <i>2003 Medical Directory: Changes & Deletions</i>	
• <i>ECG Examination</i>	



January 2003

Issue 99

2003 COUNCIL

President - Dr. Janet Wright
Vice President - Dr. Gordon Arnett
Executive Member-at-large - Dr. John McDonald

Council Members are available throughout Alberta to answer questions and discuss current issues.

DISTRICT	COUNCILLOR	PHONE	FAX
Calgary	Douglas G. Bell	(403) 220-5077	(403) 282-6170
	Robert V. Johnston	(403) 541-2737	(403) 943-0916
	Rowland T. Nichol	(403) 228-9021	(403) 228-7923
	Janet L. Wright	(403) 571-2488	(403) 571-2499
Camrose	Ross A. Purser	(780) 464-9047	(780) 417-5140
Edmonton	Gordon D. Arnett	(780) 453-6999	(780) 451-1437
	David B. Climenhaga	(780) 424-2233	(780) 426-7219
	William J. Dickout	(780) 423-4709	(780) 423-1210
	Anthony S. Russell	(780) 407-6296	(780) 407-6055
Lethbridge	R. Sebastian David	(403) 553-3351	(403) 553-4549
	Ronald N. Spice	(403) 625-8692	(403) 625-8689
Medicine Hat	Roderick I. MacKenzie	(403) 527-2281	(403) 502-8964
Northeastern	James E. Bell	(780) 459-5581	(780) 458-7515
	Harvey P. Woytiuk	(780) 645-4411	(780) 645-4566
Northwestern	Barry Norris	(780) 539-4010	(780) 538-2290
Red Deer	Owen R. Heisler	(403) 342-5155	(403) 341-3461
	Joseph F. Hopfner	(403) 346-2057	(403) 347-2989
University Representatives	D. Grant Gall, Dean	(403) 220-6842	(403) 270-1828
	Lorne Tyrrell, Dean	(780) 492-9728	(780) 492-7303
Public Members	Blair E. Maxston	(780) 426-2049	(780) 424-5864
	W. John McDonald	(780) 492-3354	(780) 492-3408
	Irene Pfeiffer	(403) 205-3640	(403) 205-4888

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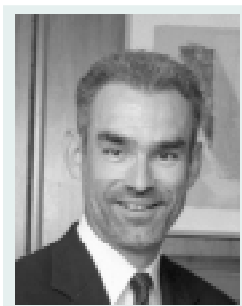
900 Manulife Place
10180-101 Street
Edmonton, Alberta
Canada T5J 4P8

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Comments or Questions regarding *The Messenger* can be directed to:
Lorie J. Webb, Communications Officer
Tel: (780) 423-4764 ext. 235
Fax: (780) 420-0651
E-mail: Lwebb@cpsa.ab.ca

General Inquiries Line: 1-800-561-3899 Complaints Line: 1-800-661-4689
Physicians Only Line: 1-800-320-8624
Web Site Address: www.cpsa.ab.ca

Registrar's Report



As I write this, I am aware that it will be read in the new year – and that events that seem so influential now may, even in that short future, have become relative non-events.

However, Commissioner Roy Romanow has delivered the product of his labours, Alberta government representatives are fretting about its intrusive elements, and we await the interim report of the Health Reform Implementation Team on its progress on the recommendations of the Mazankowski Report.

For our profession, these assessments and reports contain both reassurance – and uncertainty. We can only be reassured that the major focus is improving access – the major preoccupation of the public we serve – but uncertain about the impact on patient trust of reformed/renewed delivery initiatives. The recognition by the federal government of its obligation to improve its financial contribution is welcome – but the insistence on targeting add-on or enhanced services could worsen the existing access problems. The increased emphasis on accountability at all levels is timely – but the potential for weakening quality without well-crafted provider integration strategies demands scrutiny and leadership.

For its part, the College has a track record of activities to increase quality (PAR, the Patient Safety Institute proposal), to improve access (physician resource work, Special Register licensing), and to assess other providers' proposals for expanded/restricted activities with science and integrity. Such a tradition of leadership will enable responsible involvement and leadership in the implementation discussions to come.

On a completely separate note, may I take this opportunity to express the hope that your Christmas holiday was blessed and refreshing – and that 2003 will bring health and happiness to you and yours: Happy New Year!

*Dr. Bob Burns
Registrar*

Get your Messenger via E-mail

Since the launch of the College's new web site (www.cpsa.ab.ca), many physicians have commented on a preference to receive the newsletter by e-mail notification vs. a hard copy in the mail. The College promotes an e-version of *The Messenger* as it is more timely, cost effective and environmentally friendly.

Currently, most physicians' names appear on both the hard copy mailing list and e-mail list. If you are receiving both versions, please consider how you prefer to read the newsletter and let us know by e-mailing Lwebb@cpsa.ab.ca.

**Remove your
name from the
hard copy mailing list
or e-mail distribution
list today!**

Council Highlights

The Council of the College of Physicians and Surgeons of Alberta met November 27-29, 2002 in Edmonton. Some of the more significant items included:

Complaints Report – Drs. Chadsey and Theman made a presentation to Council highlighting how complaints are assessed and handled, desired outcomes and recent statistics. Council appreciated the review and commended the Complaints Department for their role in providing an open, fair and effective complaint process. Council also recognized the department's efforts in providing timely responses to complainants and physicians.

Council Members' Code of Conduct – Although satisfied that the *Council Members' Code of Conduct* adequately deals with conflict of interest, Council requested more information to better understand issues surrounding personal conflict of interest and disclosure. This issue will come back to Council at their February 2003 meeting.

Health IM/IT – Council received an ad-hoc committee update surrounding the College's role in health information management/information technology (IM/IT). The committee's preliminary report focused on understanding the current environment, impacts, functionality, key drivers and stakeholder feedback. Council confirmed that the IM/IT working group is on track.

Bylaw Amendments

Triplicate Prescription Program (TPP) – Council approved bylaw amendments to include the terms of reference for a new TPP Standing Committee and a list of medications to be monitored by the program. Amendments to the medication list are included in this issue of *The Messenger*.

Diagnostic Imaging – Council approved updates to bylaws, standards and guidelines surrounding retention of medical records and the operation of fluoroscopic equipment by physicians who are not radiologists. Amendments will be circulated to imaging facilities and are available on the College's web site.

Non-Hospital Surgical Facilities (NHSF) – Council approved amendments to bylaws surrounding the use of diagnostic trans-abdominal, transvaginal and intra-operative ultrasound in Non-Hospital Abortion Facilities. Amendments will be circulated to NHSF facilities and are available on the College's web site.

Research Ethics Review Committee (RERC) – Council approved amendments to bylaws adding new fees for reviews of extension studies and sub-studies.

Prescribing Privileges for Pharmacists – Mr. Greg Eberhart, Registrar of the Alberta College of Pharmacists (ACP), presented information supporting independent prescribing by pharmacists in a collaborative health team environment. The presentation outlined how he felt patients, physicians, RHAs and government could benefit. He suggested that increased quality of care, improved accessibility, time savings and cost containment would result from pharmacist prescribing. No conclusions were reached but the topic will be raised in future discussions.

College Property – Council approved the listing of College property located on 99th avenue and 108th street. Listing the property for sale follows a decision not to construct a College office building on the site. The property currently functions as a parking lot.

Council's next open meeting is scheduled for February 7, 2003. Please call Michelle at (780) 970-6227, 1-800-561-3899 ext. 227 or e-mail mgeddie@cpsa.ab.ca to reserve a seat and to receive a copy of the agenda. Seating is limited and reservations are required.

Council Election Results

Results are in from the November 25, 2002 Council election. Elected to represent their district for a three-year term were:

- District 2 (Lethbridge) - Dr. Ronald N. Spice** (elected by acclamation)
- District 3 (Red Deer) - Dr. Joseph F. Hopfner** (re-elected by acclamation)
- District 4 (Camrose) - Dr. Ross A. Purser** (re-elected by acclamation)
- District 6 (Calgary) - Dr. Janet L. Wright** (re-elected)
- District 7 (Edmonton) - Drs. Gordon D. Arnett & William J. Dickout** (re-elected)
- District 8 (Northeastern) - Dr. James E. Bell** (elected by acclamation)

Watch for new
Councillor profiles in
an upcoming issue of
The Messenger.

At its annual organizational meeting, Council elected the following:

Executive Committee

- Dr. Janet Wright** (President)
- Dr. Gordon Arnett** (Vice President)
- Dr. John McDonald** (Executive Member-at-large)

Investigation Chairman

Dr. Bill Dickout

Appointed Public Representative

Mr. Blair Maxston

The College congratulates all successful candidates and thanks Councillors for their commitment and hard work during 2002. A special thank you to those leaving Council: Dr. Harvey E. Albrecht, Dr. Colleen A. Forestier and Ms. Linda M. Hohol.

2003 Council Meeting Schedule

Council of the College of Physicians and Surgeons meets for two consecutive days, four times per year.

Day one is held in-camera with all proceedings closed to the public. On day two, members of the profession and public are invited to attend.

Agendas for open sessions are available one week prior to the meeting. Please contact Michelle Geddie at (780) 970-6227, 1-800-561-3899 ext. 227, or e-mail mgeddie@cpsa.ab.ca to reserve a seat. Reservations are required as seating is limited.

2003 Meeting Schedule

February 6 & 7
May 29 & 30
October 2 & 3
December 4 & 5

PIN Pilot Successful

The Final Report of the Pharmaceutical Information Network (PIN) Steering Committee was presented to the Information Management/Information Technology (IM/IT) Governance Council on December 2, 2002. The IM/IT Governance Council will in turn be making recommendations regarding PIN and the Electronic Health Record (EHR) project to the Deputy Minister of Health and Wellness.

The Steering Committee reported that the pilot project running in Westlock and Leduc was successful, and recommended implementing PIN province wide, as a component of the provincial EHR initiative.

Also recommended was the creation of an EHR data stewardship body, which would be responsible for health information placed into a provincial EHR system. The recommended multi-stakeholder group would ensure that EHR data is gathered, stored and shared in a secure system, with appropriate security and confidentiality provisions in place.

A total of 154 physicians, pharmacists and hospital healthcare providers in Westlock and Leduc piloted the PIN application from March through to October 31, 2002. Over 12,000 prescriptions for 3,100 patients were entered into PIN during that time.

Users stated that PIN provided value, through the provision of:

- a more complete patient medication profile,
- legible prescriptions,
- more complete prescription information (i.e. pharmacist instructions, SIG instructions, management of drug to drug interactions)
- a reduction in prescription or medication errors,
- the detection of patient medication compliance or misuse, and
- assistance in care delivery decision making (e.g. Clinical Practice Guidelines, Drug Monographs).

*Mr. John Swinarski
Assistant Registrar*

Alberta Wait List Registry

An electronic Wait List Registry for surgery and diagnostic procedures in Alberta is being developed by Alberta Health & Wellness, with representation from the CPSA. The registry is one of 44 recommendations of the Mazankowski Report.

Once on-line in the spring of 2003, the registry will provide physicians and Albertans with information on how long they may have to wait for surgical and selected diagnostic services. Data for the registry will be collected from Alberta's urban and rural hospitals, although physician participation in the registry is voluntary.

The registry incorporates best practice from British Columbia's Wait List Registry, which has been available on the B.C. Ministry of Health web site for a number of years. The B.C. experience has not indicated any significant switching of physicians.

Because the registry will not contain the names of individual patients, they will not be able to track where they place on the list. Patients in need of emergency surgery or treatment will continue to receive it without delay. A preview of the registry is available at www.health.gov.ab.ca.

Complaints Department How are we doing?

For the past two years, the College has embarked on a quality improvement initiative. In the Complaints Department, we have focused on the timeliness, fairness and effectiveness of the complaint process. A number of changes have occurred, and have been reported to the membership in *The Messenger* and at our annual meeting.

This spring we decided to ask complainants and physicians who had been complained about (“respondents”) about our process. We developed questionnaires for both groups and sent them with our final letters to all complainants and respondent physicians for a period of four months. A total of 175 questionnaires were sent to complainants and 208 were sent to physicians (some complaints are about more than one physician). While the response rate was too low to be statistically significant (18% for complainants and 30% for physicians), we believe the feedback was helpful, providing us a benchmark for further review and identifying areas for improvement.

From **complainants** we learned:

- 50% tried to resolve the issues with the physician prior to filing a complaint.
- Most found our forms and brochures understandable, our staff available and helpful, and our timelines and updates acceptable.
- The majority found our final letter easy to understand, and felt it clearly stated their issues. About half felt the process was fair, irrespective of the outcome, and about one-third didn’t understand our reasons for the action taken or the outcome of the complaint inquiry.
- While only a small number of complainants met with College staff, a significant number would have valued a meeting. About half of those who responded would have valued a meeting with the physician about whom they complained.
- Complainants generally don’t understand why the physician’s written response is not provided directly to them, perceive the College as placing greater value on the physician’s word than on theirs, and didn’t understand why we took the position (or the action) we did.

We have some challenges to make the process more acceptable to complainants. Perhaps College staff needs to have more face to face meetings with complainants. We are challenged to

explain more clearly why we took the position we did. We have a significant image problem when we are perceived as valuing the physician’s response more highly than we do the letter of complaint. We have plans to review our correspondence, including our brochure and our letter in which we acknowledge receipt of the complaint.

From **physicians** we learned:

- Most found our brochure and letters clear and helpful, our timelines acceptable, and our staff helpful.
- Most understood what issues required their response.
- Most felt our final letter accurately reflected their position.
- A small number (7 of 32) met with College staff and all but one found the meeting valuable.
- A significant fraction would have liked more contact during the inquiry. Some felt we provided inadequate time to properly respond to the complaint.
- The majority felt the process was fair, and felt that the process demonstrated our responsibility to protect the public interest.
- Some emphasized the need to provide support to physicians going through the process, or at least to direct where support is available.

Our challenges, therefore, are to provide more frequent updates to physicians, and to advise physicians where to access support (such as the Physician and Family Support Program of the AMA).

Recognizing the small numbers, we cannot draw definite conclusions, but the feedback seems ‘clinically’ correct – it is consistent with our expectations. We believe it will help us focus our quality improvement activities and it challenges us to do better when dealing with both complainants and physicians. We remain committed to our goal of resolving complaints about physicians fairly and effectively.

Your feedback on this article would be appreciated, and can be directed to our attention.

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

Ms. Sharon Barron
Manager, Complaints
sbarron@cpsa.ab.ca

Discipline Report

Dr. Scott D. Holder

On October 3, 2002 the Council of the College of Physicians and Surgeons of the Province of Alberta found Dr. Scott D. Holder guilty of unbecoming conduct in that:

Between September 1, 1998 and December 31, 1999 he did carry on an inappropriate personal relationship with his patient, which included sexual relations with his patient, between December 1, 1998 and September 30, 1999.

The Council of the College of Physicians and Surgeons of Alberta ordered that:

1. Dr. Holder's license to practise medicine in the Province of Alberta shall stand suspended for a period of three (3) months and three (3) weeks, commencing on December 1, 2002, returning to work and active licensure on March 24, 2003.
2. Dr. Holder shall consult with the Registrar of the College of Physicians and Surgeons of the Province of Alberta to determine an appropriate practice environment acceptable to the Registrar, including the designation of a physician as a monitor, the monitoring system to be followed, and the regular reporting by the monitor to the Registrar. This condition on Dr. Holder's license to practise medicine in the Province of Alberta shall remain in force for a period of three (3) years, after which time the requirement for this restriction shall be reviewed by the Registrar to determine if it should be removed or modified.
3. Dr. Holder shall not perform any examination or treatment of any female patient over the age of twelve (12) years that involves the removal of any item of clothing other than shoes, socks or head coverings unless in the presence of:
 - a) the patient's spouse;
 - b) an adult female person accompanying the patient; or
 - c) an adult female member of the staff at the practice location.
4. In any such event, the identity of the person present shall be included in the entry for the visit on the patient's chart. This condition on Dr. Holder's license to practise medicine in the Province of Alberta shall remain in force for a period of three (3) years, after which time the requirement for this restriction shall be reviewed by the Registrar to determine if it should be removed or modified.
5. Dr. Holder is permitted to provide on-call services to patients of his then current practice location, subject to the requirement of a mentor and chaperon as outlined above. Dr. Holder shall not hold a staff position in any hospital emergency department during the time period in which the monitor or chaperon requirements are in force.
6. Dr. Holder shall complete a boundaries course that is acceptable to the Registrar and this course shall be completed prior to the completion of the suspension of his license to practise medicine.

7. Dr. Holder shall remain in psychotherapy with his psychiatrist for a period of at least one year commencing from the date of this Order. Dr. Holder shall provide his consent to his psychiatrist to permit the psychiatrist to provide regular reports to the Registrar concerning Dr. Holder's progress as requested by the Registrar. If the psychiatrist is unable to continue to provide psychotherapy to Dr. Holder, the replacement psychiatrist must be acceptable to the Registrar. The termination of psychotherapy by Dr. Holder shall require the recommendation of discontinuance from the treating psychiatrist and shall require the approval of the Registrar.

Dr. Holder was assessed the costs of the investigation and hearing in the amount of \$11,411.43 with a payment schedule to be determined by the Registrar.

Changes to the TPP Medication List

Effective February 1, 2003, Council approved the following changes to the list of medications covered by the Triplicate Prescription Program (TPP) as recommended by the TPP Steering Committee.

Medications **removed** from the program:

- Anabolic Steroids (e.g. testosterone)
- Anileridine (e.g. Leritine®)
- Levorphanol Tartrate (e.g. Levo-Dromoran®)
- Normethadone (e.g. Cophylac® and Cophylac® Expectorant)
- Oxymorphone HCl (e.g. Numorphan®)

Added to the TPP medication list when Health Canada approves it for prescription use in Canada:

- Buprenorphine (trade name Subutex®)

For the complete revised list of medications please visit the TPP pages on the CPSA web site at www.cpsa.ab.ca/collegeprograms/tpp_medication_list.asp.

A more detailed explanation for the rationale for these changes is also available on the web site for your information.

*Ms. Cathy McCann, Manager
Physician Prescribing Practices
cmccan@cpsa.ab.ca*

**A revised TPP medication list is available
on the CPSA web site.
List is effective February 1, 2003.**



Competency Assessment and Surrogate Decision Making: Responsibilities and Roles of a Physician

CPSA Guideline

November 2002
Replaces: October 1995

This information is designed to aid practitioners in making decisions about appropriate care. This document does not define a standard of care nor should it be interpreted as legal advice. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

Executive Summary:

Physicians doing assessments of competency must have valid consent and understand various forms of consent, including informed consent of a patient or of a substitute decision maker. The patient being assessed is presumed to be competent until/unless evaluation determines otherwise. Physicians should also understand the legal definitions of assault and battery.

Competency is the mental ability to understand the nature and consequences of a decision in one or more areas of life under consideration, such as financial management or health care decisions.

The focus is a process standard, assessing the patient's exercise of particular decision-making abilities, not the decision's content. The determination should be time limited and reassessed periodically.

Generally one presumes competency in an adult, making an assessment only if there is reason to believe that the patient is repeatedly or continuously unable to conduct his/her personal affairs safely and properly. When there are concerns about an individual's competence, perhaps raised by the treating physician, the burden of proof is on the person/persons who raise the concern.

The physician should make task-specific assessments of risk, doing so objectively, openly and fairly. The key element is the patient's ability to make and execute choices. There may need to be collateral information from other professionals, family, or co-workers.

Any resulting conclusion should restrict the patient's autonomy as little as possible.

Physicians should be familiar with certain important legislative policies and principles:

- Dependent Adults Act (Guardianship and Trusteeship)
- Emergency Doctrine
- Mental Health Act
- Personal Directives Act
- Powers of Attorney Act
- Program appointed Benefits Administrator (informal trustee)
- Health Information Act

Assistance is available through the regional offices of the Public Guardian and Public Trustee. Advice from an Ethics Committee may be valuable as are the opinions of appropriate other health care consultants. It is important to document all communications and deliberations carefully, including the facts and the reasons for the conclusion reached concerning the patient's competency.

Preamble:

A physician undertaking assessment of competency of a patient must have a valid consent to do so. Failure to do so may expose the physician to litigation or an ethical challenge.

The prudent physician should understand the concepts of implied consent, voluntary consent, informed consent, competence to consent, and assault and battery. These are well set out in a booklet provided by the Canadian Medical Protective Association, "Consent, a Guide for Canadian Physicians", Second Edition, 1991.

Competency:

Competency can be simply defined as the mental ability to understand the nature and consequences of a decision. To make valid decisions in our everyday life, we must be competent. Some prefer the term "capacity" and restrict the words "competency" and "incompetency" to formal judicial determinations. This document will use the words interchangeably.

Competency is no longer viewed as a global state or condition (i.e., absence or presence of capacity for all tasks). Rather, the notion of restricted incapacity for specific areas has become generally accepted. In other words, we may be incompetent in one or more areas of life but remain competent in others. Examples of particular types of partial competence include, but are not restricted to, competence to manage financial affairs, to make health care decisions, to choose a place of residence, to grant Power of Attorney, to make a will, to instruct a lawyer, to drive a motor vehicle and/or to participate in a research study.

To assess capacity or competence in a specific area, physicians should use a process standard in their determination. In this, the physician focuses on assessing the patient's exercise of particular abilities in the decision-making process, and not on the specific content of the decision (which would be called an outcome standard) or on the particular characteristics of the individual (this would be called a status or category standard: if, for example, it were decided that all people with a diagnosis of Alzheimer's disease are globally incompetent).

Most feel that a determination of incapacity in a given area or areas should be time limited, requiring periodic reassessments. It must be emphasized that, even when an individual is deemed incompetent in a given area, he/she should be helped to participate as much as possible in decision-making.

Assessments of Competency or Capacity:

This section addresses the issue of a functional standard. A physician may be requested to assess the capacity of a patient. The primary goal of such an assessment is to respect the individual's autonomy as far as possible, as a determination of incompetence will deprive an individual of the right to make certain decisions for him/herself. There is a general presumption of capacity in adults. Most assessments/determinations never reach the courts. Practical considerations dictate that informal assessments of capacity occur frequently. A competency assessment, particularly a formal one, can humiliate or upset the allegedly incompetent person. Make sure the assessment (whether formal or informal) is necessary.

The trigger for an assessment of competency generally is that others believe that someone has become repeatedly or continuously incapable of conducting some aspect of his/her personal affairs without harming him/herself or others. The burden of proof is on those who raised the concern. This is so because the general presumption will be that the individual is competent, and no person willingly displays lack of competence. It is important therefore, that all available collateral evidence be made available for careful evaluation.

Several questions should be asked before starting the evaluation. Will a competency assessment solve the problem at hand? Is a voluntary solution possible? The risk for the allegedly incompetent person must be determined. For this risk assessment the following questions should be asked:

- Is the problem new or old?
- Are there actual examples of failure or is it all theoretical? Are these bad decisions likely to occur or are they only a remote possibility?
- If the person does make an unwise decision, how severe is the risk to him/her from this decision?

- Will the decisions harm others?
- It must be emphasized that a competent individual can choose to place him/herself at risk. An individual who does not have the capacity to understand the situation may require protection from him/herself. Is the patient aware of the risk?
- Is the patient able to describe the likely consequences of his/her decision?
- Can or will he/she take steps to remedy the situation?
- Will he/she accept help?

Assessments should focus on the specific tasks about which there is concern in realistic circumstances (in other words it should be task-specific):

- Try to assess individuals at their best.
- Elderly individuals should be assessed early in the day; use a quiet familiar location; and compensate for physiological or social impediments such as hearing loss or preferred language, etc.
- Look for reversible illnesses or conditions.
- Keep assessment sessions short so as to avoid fatigue.
- Make sure that all needed information is provided.
- Do not try to trick the patient and make sure that he/she understands what you are doing as far as possible.
- Point out “errors” and allow an opportunity to explain.
- Focus on abilities to make and execute choices rather than focusing on the decisions themselves. For example, in the assessment of the capacity to consent to treatment, determine whether the person has the abilities to comprehend relevant information, to deliberate about the choices in accordance with personal values and goals, and to communicate (verbally or written) his/her choice to others.

There is no “cookbook” approach that one can advocate. Assessments should be tailored to the needs of the patient and the situation. Neither performance on a standard cognitive test such as the Folstein Mini-Mental State Examination nor the presence of a particular condition such as Alzheimer’s is itself a sufficient basis on which to conclude that a person is incompetent to perform a specific task. Do not be reluctant to consult other physicians (for example psychiatrists, neurologists, geriatricians) or other health care workers (for example psychologists, occupational therapists). Try to obtain collateral information as this is normally needed to make an accurate assessment. The family or other health care workers who know the individual well can provide this information. Assessment unfortunately remains a somewhat uncertain procedure.

If, at the end of the assessment, the conclusion is that the individual has limited capacity, remember to try to restrict autonomy only as far as is absolutely necessary (the least restrictive alternative) and promote the patient’s “best interests”.

The Law and Competency:

Area	Cognition Status	
	Competent ¹	Incompetent ²
Person (including Health Care)	Personal Directive	Guardian
Estate	Enduring Power of Attorney	Trustee

¹ Advanced planning for the possibility of future incapacity; self-directed.

² Legal remedy for someone who is already incompetent; Court-appointed.

Questions may arise in the course of health care as to a patient’s capacity to make health care decisions. In Alberta, if an adult is mentally incapable of consenting to health care, the only person who has legal authority to consent on his/her behalf is a guardian appointed under the Dependent Adults Act or Agent named under the Personal Directives Act, unless the patient is detained in a psychiatric facility as a formal patient under the Mental Health Act, at which point family members can provide substitute consent.

Treatment can be given without consent if there is a true emergency:

- it is a matter of life or death, and
- the patient or guardian cannot be consulted, and
- there is no available record which clearly states the patient’s desire not to receive the proposed form of treatment.

In urgent situations where the patient is felt to be unable to provide informed consent and no guardian has been appointed, the practice in Alberta hospitals is to permit treatment if two independent physicians are willing to sign certificates stating that there is

a need for the treatment but the patient cannot consent to it by reason of mental or physical disability of understanding or consenting. Once based upon the common law Emergency Doctrine, it is now enshrined in Section 29 of the Dependent Adults Act (RSA 2000).

From a practical standpoint, physicians should consult with the family of the individual and receive their approval prior to performing the treatment under consideration. Unlike some provinces, Alberta does not have legislation expressly authorizing family members to provide substitute consent.

It is possible to pursue guardianship under the Alberta Dependent Adults Act. Guardianship is a legal process which gives an individual, called a guardian, the authority and responsibility to make decisions on personal and health matters on behalf of a dependent adult. The Court of Queen's Bench, Surrogate Division grants the guardianship order. The court can appoint a substitute decision-maker, where needed, for those Albertans 18 years of age or older who are unable to make personal decisions for themselves. The appointment must be in the best interest of the dependent adult and result in a substantial benefit to him or her.

The Dependent Adults Act requires that an application for guardianship include a medical or psychological report on a specified form (attached) as prescribed in the regulations. A physician who makes such a report for the court does not acquire any liability for making the report, if the report is made in good faith and he/she has reasonable and probable grounds to believe the report is true. These reports must be completed carefully as the court relies heavily on them in making its decisions. There is substantial cost involved and it may take in the order of 8 weeks for the application to be processed. The appointed guardian will periodically have to make reports to the court and may be called upon to explain his/her actions at any time to the court.

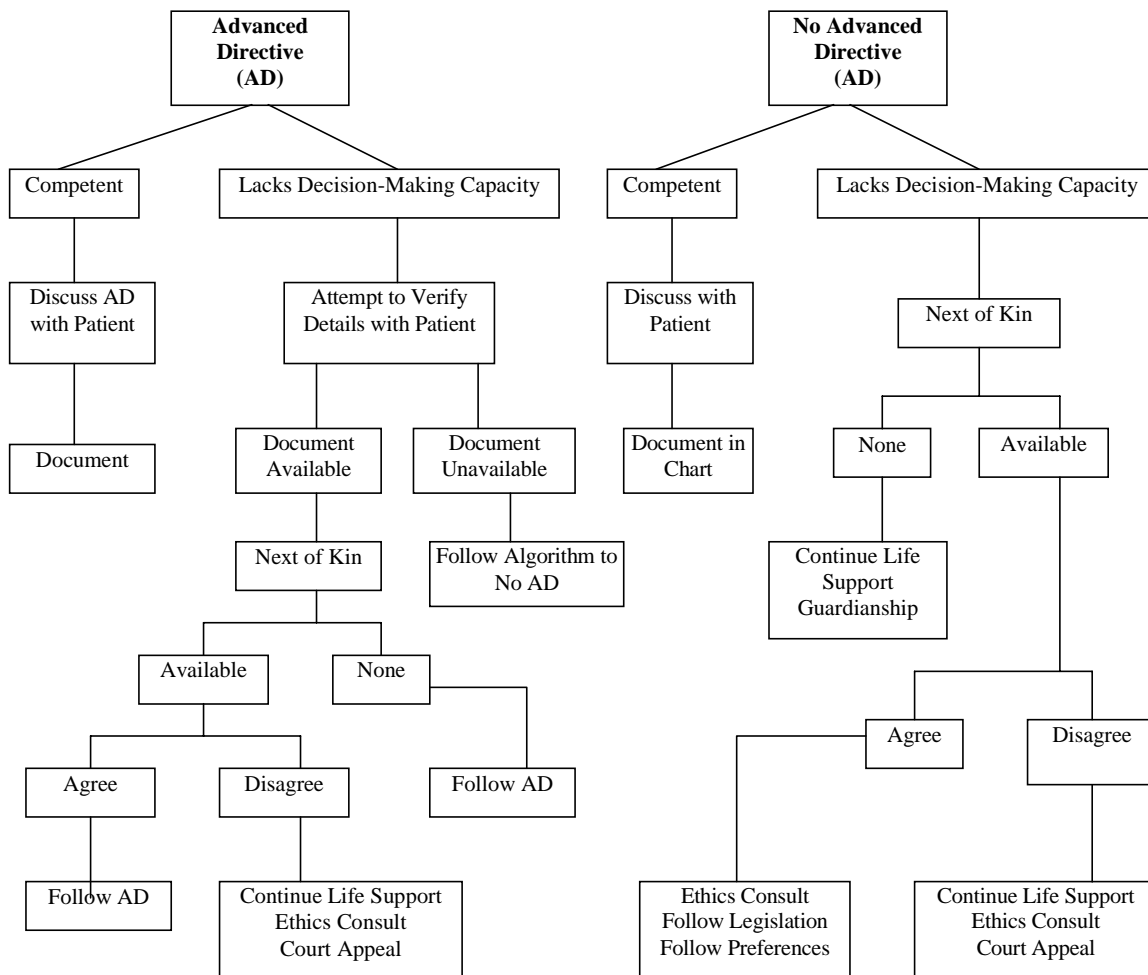
Physicians can also look for a personal directive, as provided in the Personal Directives Act, which specifies an agent to act on behalf of the individual. This agent should be someone the person knows and trusts. This agent should use a substituted judgment standard, unless otherwise specified in the personal directive, attempting to determine what that person would have chosen if able to speak for him/herself. However, if there was no clear direction from the patient or it is not possible to get a substituted judgment from someone who knows him/her well, then the standard becomes one of "best interest" as would be determined by a "reasonable person."

The Powers of Attorney Act provides that an individual who is no longer mentally competent to manage his/her affairs can have that authority exercised by the Attorney under that document. This relates only to an individual's estate and not to the care of his/her person. Establishment of such power must be prepared before the onset of a disabling condition. A medical report might be required if capacity to execute an enduring power of attorney is in question.

An informal trustee, sometimes requiring a supplementary medical report, can be appointed only to manage benefits under Old Age Security, Canada Pension Plan, Canadian Pension Commission, Veterans Affairs, Assured Income for the Severely Handicapped (AISH), and Supports for Independence (SFI). The relevant government department names an informal trustee.

Concluding Remarks:

This is a difficult area with no clear absolutes. If in doubt, remember to communicate, consult, and document. The regional offices of the Public Guardian are always available to assist. Obtain information from those who know the patient well, especially from family members. Communicate with them, letting them know the concerns and problems you are facing. Try to ensure that they agree with your approach. Consult with other physicians and other health care workers as needed. If available, you may wish to consult an Ethics Committee. Document your communications and deliberations carefully, stating the facts and outlining the reasoning. This will be your best defense against claims of malpractice.



Using advanced directives (AD) to guide decision making for a hospitalized patient.

Modified from: Clinics in Geriatric Medicine, 1998, 14:827.

Suggested Readings:

Consent, A Guide for Canadian Physicians, CMPA, 1991, 2nd edition.

Competency to make a will, AMJ Psychiatry, 1992, 149:169-174.

Financial Competence, Can J Psychiatry, 1993, 38:595-598.

Consent to Treatment, Medical Law Handbook, (T. David Marshall), International Self-Counsel Press Ltd. (1985).

Participation in Research Study, J of the Am Geriatric Soc, 1992, 40:950-7.

Driving and AD, Neurology, 1993, 43:2448-56.

Living Will, Centre for Bioethics, U. of Toronto.

Competency, When The Mind Fails, (Michael Silberfeld, Arthur Fish), U. of Toronto Press (1994).

Capacity, in Bioethics at the Bedside—A Clinician Guide, edited by Peter A. Singer, Canadian Medical Association, 1999.

Capacity to Decide, D.W. Molloy, P. Darzine, D. Strang, Newgrange Press, 1999.

A Guide for Consumers and Care-givers (Mental Health Act of Alberta), Canadian Mental Health Association.

Answers to Your Questions on the Personal Directives Act—A Guide for Physicians, G. Robertson

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Mr. Colin M. Grant, Office of the Public Guardian, Calgary

Mr. Craig Boyer, lawyer with Bryan and Co., Edmonton

Schedule

Form 1

Report of a Physician or a Psychologist

Patient's Name: _____ Birthdate: _____

Address: _____

A* is repeatedly or continuously unable to:

- (i) care for himself/herself*, and
- (ii) make reasonable judgments in respect of matters relating to himself/herself*;

B* is

- (i) unable to make reasonable judgments in respect of matters relating to all or any part of his/her* estate, and
- (ii) in need of a trustee

I have formed my opinion based on the following information, observations or symptoms:

(1) _____

(2) _____

Diagnosis: _____

Prognosis: _____

Based on this, I am of the opinion that it would be in his/her* best interests for a _____ to be appointed for him/her*.
(guardian) (trustee)*

 (physician's or psychologist's name) (physician/psychologist) *

 (signature) (address) (date)

* Delete whichever or what is not applicable (including, if appropriate, the whole of paragraph A or B.)

For Your Information

2003 Medical Directory - Changes and Deletions

The College is now collecting **new** or **amended** entries for the 2003 Medical Directory. Please complete the "Notification of Change" form located at the back of your 2002 Directory (page 247 & 249). This form is also available on the CPSA's web site (www.cpsa.ab.ca under *Physician Registration - Physician Forms & FAQs*).

The College office must receive all forms before noon on **Friday, February 7, 2003**. Updates received after the deadline will result in changes to the College's database and on-line medical directory, but no amendments to the printed directory will occur.

Remember the directory is a public document. If your home address is presently published and you wish to provide a business or alternate mailing address, please notify our office of the change prior to the February 7, 2003 deadline.

The 2003 Medical Directory will be available for distribution in the spring.

ECG Interpretation Examination

The next ECG interpretation examination is scheduled for **Tuesday, March 11, 2003**. The examination will take place from 9:00 am to 12 noon in Calgary's Health Sciences Centre. Examination fee is \$300 (GST included). For more information, please contact the Quality of Care Department at (780) 970-6248, 1-800-320-8624 ext. #248 or e-mail jhauk@cpsa.ab.ca.

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College of
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of Alberta

900 Manulife Place, 10180-101 Street
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