

the Messenger

College of Physicians & Surgeons of Alberta

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College of
Physicians
& Surgeons
of Alberta

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Registrar's Report



Change is upon us and uncertainty is ever present. For the last month, we've been focused on the Government's Health Policy Framework ("the third way") and then, in early April, we learned of the Premier's decision to tender his resignation in September. So, by the end of the year, we should have a new Premier who may or may not advance these proposals.

As the regulatory body for physicians, we want to be poised and ready for whatever changes might occur, especially for those initiatives that may impact physician behavior or the ability of physicians to provide care for their patients.

To understand better what the future may hold, and to assist us in our thinking, Council, at its annual retreat, listened to four knowledgeable people speak about population demographics, physician resource issues, the government's Health Policy Framework, and a vision of the future from one health region's perspective. From this we will identify the policy questions for Council to consider. The debate around those issues should help us position our profession for whatever changes may come.

Council heard a number of interesting and provocative facts and ideas, including:

- The population has been gradually aging for a very long time, irrespective of the "boomer generation."
- As "demography explains two-thirds of everything," our understanding of the continual aging and growth of the population should drive all decisions regarding human and other resources.
- While Alberta has been successful in its recruitment of physicians (a net gain of 400+ in the past year), we are not catching up to our physician resource needs, especially primary care physicians and medical specialists.
- With population aging, we face an increasing burden of disease. One is tempted to attribute everything to the rising incidence of obesity, but it obviously affects the incidence of diabetes, which has profound implications for many segments of the healthcare system, and osteoarthritis. While it is reasonable for health authorities and governments to focus on hip and knee arthroplasties as a priority, we could reduce the need for those surgeries by reducing the incidence of obesity in our society.
- We recognize that a significant percentage of healthcare dollars are expended in the last year of life. With an aging population, end of life issues and palliative care (among many others) become ever more important.
- As to the Health Policy Framework, we were told:
 - The first goal of the "third way" is to strengthen the public healthcare system. The "third way" is not about privatization.
 - The focus is on accountability for sound investment, fiscal management and responsive services. Sustainabil-

ity is paramount.

- The intention is on empowering individuals (giving choice) rather than entitlement.
- Flexibility in the scope of practice discussion is linked to new models of compensation.
- There is a need to ensure quality of service in the private system and avoid poaching of healthcare workforce from the public system.
- In spite of its flaws, the Alberta healthcare system is still the country's best organized. Integrated health systems (e.g. regions) offer a platform for change.
- The challenges are not public policy but how we organize and deliver care.
- As with safety, we can learn from other industries about standardizing processes and understanding human factors.
- We must stop protecting information about individual caregiver performance.
- The role of the physician must change – we must use other workers to extend what physicians are able to do.
- In spite of its potential, our system does not operate as well as it could:
 - It's not organized in the best way possible to deliver care;
 - Physicians are not an integrated part of the system;

Registrar's Report cont'd Pg. 7...

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: theman@cpsa.ab.ca

Complaint Issue

One Complaint Per Visit

Due to physician manpower shortages, the demands on individual physician's services are increasing, and it is becoming more challenging to meet patient expectations. In an attempt to manage their practices, some physicians are posting signs in their offices restricting patients to one problem per visit. Consider the following example:

A patient complained that she was discharged from her physician's practice because she often came in with more than one health problem. She wrote that she was astonished that he would do this after she trusted him with her health and that of her family for 25 years.

This physician told us that his patients often complain about the excessive waiting times in his office, which he believes is due to the complexity of his aging patient population. He has attempted to address this problem by expressing his concerns to patients individually and by creating the following sign:

*Due to a significant increase in patient waiting times, the doctors in this office will **ONLY** deal with **ONE** medical problem per office visit. If you are not in agreement with this policy, we will be pleased to transfer your medical record to another physician of your choice.*

The physician explained that he had spoken to the complainant many times about limiting her non-urgent problems, but she was not responsive to his request.

The College recognized that both parties have valid perspectives on this matter, and the complaint was closed with an explana-

tion to the complainant about the challenges of practice and the reasons behind the physician's decision to terminate her from his practice. The physician was given advice about following proper procedure when discharging patients as outlined in the College guideline, Physician/Patient Relationships, which can be found on our website at www.cpsa.ab.ca.

We are very interested in feedback from the profession on this issue. What do you think of ONE PROBLEM PER VISIT signs? Have you developed an innovative patient-centered approach to this problem that you would like to share with your colleagues?

Please forward your comments to Karen Mazurek, Assistant Registrar, Complaints, at kmazurek@cpsa.ab.ca.

We have received many complaints from the public regarding similar signs in other offices. While it is not our intention to micro-manage the practice of medicine, we feel there are better, more acceptable methods for physicians when faced with patients who present with a list of issues.

Patients are not always able to determine which symptom or concern may reflect a significant problem. Serious conditions can present with an array of symptoms but may not be recognized if the patient is limited in what (s)he can report to the physician. Therefore, instituting a rule that a patient can report only one concern may not only upset the patient, but also it may compromise patient care.

Since physicians possess more medical knowledge and skill than their patients, it is reasonable to expect physicians to make

decisions about which problems can wait and which cannot. While we are not going to set rules about the posting of "one problem, one visit" signs, we are encouraging physicians to use common sense and good communication when approaching this issue.

Although one problem per visit signs may be a recent trend, complaints from individuals who believe their medical concerns have not been satisfactorily addressed during a visit with their primary care physician or specialist are not new. Many physicians who respond to these complaints advise that it is not always possible to address every concern raised by a patient in a single visit, and their approach to these individuals is to briefly review the list of concerns and deal with the most significant issue or issues. The patient is then asked to book another visit so the proper time and attention can be focused on the concerns of lesser urgency. Some practitioners employ the assistance of their staff to educate patients and advise those presenting with multiple problems about the possibility they may be asked to schedule another appointment.

Managing patient expectations is an integral part of what physicians do every day. Being patient centered does not mean that the patient's every expectation must be met. It may not be possible or reasonable to deal with every problem a patient presents in a single visit. Being patient centered does mean that the physician should place the patient's best interests before his/her own and remain open and flexible so that serious matters are appropriately addressed in a timely fashion.

Dr. Karen Mazurek, Assistant Registrar
kmazurek@cpsa.ab.ca

Discipline Report

Dr. Austin J. Quaye

On June 2, 2005, the Council of the College of Physicians & Surgeons of the province of Alberta found Dr. Quaye guilty of demonstrating unbecoming conduct in that:

- He did breach a condition of his registration on Part 1 of the Special Register of the College of Physicians & Surgeons of Alberta (“College”), in that he did fail to make the required payments against the costs owing by him to the College as a result of previous Orders of the Council of the College.

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

1. The name of Dr. Austin Quaye be struck from the Special Register of the College of Physicians & Surgeons of Alberta effective the date of this Order.
2. Dr. Quaye be assessed the costs of the investigation, the hearing before the Investigating Committee, and the hearing before the Council, in the

amount of \$9,484.58.

3. The name of Dr. Austin J. Quaye and the circumstances surrounding this matter shall be published.

Costs were paid.

Dr. Quaye appealed the Council’s Order to the Alberta Court of Appeal. On July 20, 2005, the Alberta Court of Appeal stayed the striking of Dr. Quaye’s name from the Special Register. The appeal was heard on March 10, 2006, and dismissed. As a result, Dr. Quaye’s name was struck from the Special Register on March 10, 2006.

Dr. Quaye again came before the Council of the College of Physicians & Surgeons of Alberta on February 2, 2006. The Council found Dr. Quaye guilty of unbecoming conduct in that:

- He did fail to respond to correspondence sent to him by the College of Physicians & Surgeons of Alberta dated January 28, 2005; February 18, 2005; and March 10, 2005, relating

to an investigation under the Medical Profession Act (Alberta) concerning his prescribing practice.

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

1. The name of Dr. Austin Quaye be struck from the Special Register of the College of Physicians & Surgeons of Alberta effective the date of this Order.
2. Dr. Quaye be assessed the costs of the investigation, the hearing before the Investigating Committee, and the hearing before the Council, in the amount of \$18,380.39.
3. The name of Dr. Austin J. Quaye and the circumstances surrounding this matter shall be published.

Dr. Quaye did not appeal this decision and the costs were not paid.

As of March 10, 2006, Dr. Quaye is no longer registered with the College of Physicians & Surgeons of Alberta.

Discipline Report: Context and Commentary

The spectrum of unbecoming conduct is broad and although failure to respond and failure to pay may constitute the lower end of the spectrum, professionals have a duty to respond to their regulatory bodies.

The *Medical Profession Act* requires that the College investigate all complaints brought to our attention about physicians. Our standard practice is to correspond with physicians in writing upon receipt of a complaint. Reminders are sent at four and six week intervals. The College recognizes that physicians have significant demands on their time and we routinely accommodate those who request additional time to prepare their response. It is extremely rare and with great regret on our part that it becomes necessary to charge a physician with

unbecoming conduct for failure to respond. The action is taken only when the physician leaves us with no other option.

With respect to payment of costs, the College considers an individual’s ability to pay and every effort is made to set a reasonable payment schedule. Frequent reminders regarding outstanding payments are sent before a physician is charged with unbecoming conduct.

In a disciplinary hearing, the Investigating Committee hears submissions from the College and from the physician or his/her legal counsel. In a hearing, the physician again has the opportunity to present any and all circumstances that might have contributed to their conduct. Council’s decision is

made only after careful consideration of the evidence presented by both parties.

In determining penalty, Council considers many factors, including aggravating or mitigating conduct or circumstances and the existence of any prior disciplinary findings. Physicians have the right to appeal Council’s findings and penalty to the Alberta Court of Appeal if they believe the Council’s Order is unfair.

Disciplinary findings are published in the *Messenger* and information about previously published discipline can be found on the College’s website (www.cpsa.ab.ca) by entering the physician’s name in the “Search the site” feature on the top right hand corner of the screen.

Effective Management of Chronic Pain in the Methadone Maintenance Patient

Chronic pain may be defined as a condition in which the perception of pain is of sufficient duration — greater than six months — and of sufficient intensity to interfere significantly with daily function and general wellbeing.

As more than 60 per cent of MMT patients have chronic pain, it is important to know that chronic pain cannot be cured, but it can be treated even though treatment may be considered controversial.

It is common for patients with chronic pain to develop problems with opioids. Sometimes the use of opioids becomes so uncontrolled that the risk associated with opioid use outweighs the benefit. In this instance, MMT may be a way of reducing the risk to the patient. However, physicians should be aware that daily methadone therapy, as prescribed in an MMT program, is not a treatment for chronic pain.

It is important to consider that different circumstances and desired endpoints will require different reasons for methadone titration. For example, with an Opioid Dependence Disorder (ODD), it may be to reduce craving, improve function in chronic pain or reduce pain in palliative care.

Each situation is distinctive and every MMT patient who complains of chronic pain needs to be thoroughly assessed before receiving treatment. This is particularly crucial when the treating physician contemplates opioid analgesic therapy. For the most complex cases, consulting physicians or multidisciplinary teams experienced in

Physicians should consider the following when dealing with MMT or other high risk patients with chronic pain:

1. Take a detailed, complete history of the pain disorder,
2. Take a detailed, complete history of the substance dependence disorder(s),
3. Develop a detailed plan for dealing with the pain complaints,
4. Maximize use of adjuvant medications before an opioid trial,
5. Consider use of long acting opioids, if an opioid must be used,
6. Use highly controlled dispensing intervals such as daily dispensing,
7. Consider use of pill counts to reduce likelihood of diversion,
8. Ensure initial and regular urine toxicology testing to check for use of drugs or other non-prescribed medications,
9. Create a clearly-understood agreement, often written, with the patient

the management of dual diagnosis (pain and addiction) should be sought.

Recognizing that specialist resources are limited, physicians should consider additional training in the field of chronic pain and ODD to develop some degree of expertise in the assessment and safe management of these patients. This reduces the risk of sporadic or interrupted care for MMT patients.

In ideal circumstances, the less opioids used in treatment, the better. Once a patient is stabilized on MMT, non-opioid and other non-pharmaceutical interventions can be tried and are often effective. However, if

- that delineates expectations, roles and responsibilities of all involved parties,
10. Ensure open and timely communication amongst all treatment providers and the patient – the MMT program, the chronic pain clinic, the primary healthcare provider, and others,
 11. Monitor quality of recovery activities,
 12. Be aware that problematic opioid usage has existed, exists, or may exist again, and appropriate steps must be taken to reduce the harm associated with such usage. Optimum improvement in comfort and function is the primary objective.
 13. If suspicions are high, default to treatment of the most dangerous disease, i.e. addiction,
 14. Seek assistance from the multidisciplinary teams of the MMT program and/or the chronic pain clinic to provide the patient with the best possible care.

the use of non-opioid adjuvant therapy fails to improve functionality and/or provide adequate comfort then a trial opioid therapy should be considered.

The CPSA is currently enhancing the Guidelines for the Management of Chronic Non-cancer Pain. These guidelines will facilitate an effective approach to dealing with chronic pain, including the MMT patient.

*Dr. Ian Forster, Dr. Ian Postnikoff,
Dr. Mat Rose, and Dr. Nick Wong*

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.

Ethics 101 - A Colleague in Trouble

In the March 2006 Messenger issue, we outlined a situation where a physician notices that the behavior of one of his/her physician colleagues has changed dramatically over the past six months.

Characteristics of the colleague include being unreliable, showing up late for meetings and/or procedures, personality changes, smell of alcohol on his/her breath, he/she seems to lack judgment in a variety of everyday situations. We asked what you would do in this situation.

Following are excerpts from some of the letters we received. The full text of the letters, along with additional submissions, is posted on the College website at www.cpsa.ab.ca (look under publications/resources for the Ethics 101 section).

I would first discuss with another colleague my observations and conclusions. Hopefully we would then go together to address her/him in a friendly, candid manner if we judged we had a reasonable chance of her/his seeking appropriate help.

Dr. Cliff Nelson

This situation should be handled in the same way as any person employed in a position which would be considered a critical safety position...Since this is a physician governed by the rules of a governing board, the College should be notified. It would not be your role to treat or diagnose this situation.

Dr. Tim Leopard

The first step when encountering a case like the one described, is the recognition that there exists a great likelihood of problematic substance use, which may not be limited only to alcohol. Untreated substance use disorders in healthcare professionals may have the potential of placing the public at risk, and where a reasonable index of suspicion exists, notification of the local regulatory body is indicated. This activates a protocol for full assessment, and if indicated, the appropriate treatment...Exciting new treatment options are emerging for the treatment of addiction and comorbid mental health concerns, and the occupational, health, and social outcomes for impaired physicians are indeed optimistic....The biggest dilemma physicians face is realizing

that reporting of an impaired colleague is in the best interest of the involved physician and his patients, and in dispelling the perceived notion that staying silent "protects" our colleague. Silence only maintains the disease.

Dr. Charl Els

Ethics 101 Scenario

The year is 2007; Toronto has declared an emergency pandemic situation and all signs are that the cases in Alberta (and your community) are increasing rapidly.

You have two school age children and are responsible for aging parents. You work in a multi-doctor family clinic and take some shifts as a hospitalist every month. Your daughter has been sent home from school because she has been exposed to influenza and you are scheduled to do a shift in the hospital. You are aware the hospital is very busy, has many staff off sick and everyone is working to their maximum.

What are your responsibilities to your family, the public, and your colleagues?

Send your comments to jlwright@cpsa.ab.ca by June 23, 2006.

Registrar's Report cont'd...

- We need to change our processes and the way we get paid;
- We need to use technology better to help us and our patients;
- All healthcare workers should be trained in teams, be team-oriented and provide multidisciplinary care;
- Physicians have favoured autonomy of decision-making over scientific evidence.

Many of these statements are clearly

provocative and will stimulate further discussion.

What Council and the College will do with this information remains to be determined (another uncertainty), but the consideration of ideas like these can only help inform our positions and policies in areas such as physician resource planning, physician roles, and the integration of physicians into the healthcare system.

We need to consider what effect greater pri-

vate pay and delivery options will have on our members and their patients. Many physicians have raised concerns about possible conflict of interest and differential access based on ability to pay rather than need.

The dialogue with Council will continue up to our June meeting. Your thoughts on these ideas are always welcome.

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

Complaints, Discipline & the HPA

The medical profession will transfer under the authority of the *Health Professions Act* (HPA) – an omnibus legislation for all health professions – at some point in the near future.

When the College of Physicians & Surgeons begins to operate under the HPA, a number of changes to our complaints process will occur. Instead of an Investigation Chair – a College Council member appointed annually by the Council – the College will have a Complaints Director – a CPSA staff member who will receive and review all complaints.

Under the HPA, the complaints process is more precise and prescriptive. From the profession's perspective, major changes

include that, upon receipt of a complaint, the College may:

- Request that the physician communicate directly with the complainant and report back to the College once mutually satisfactory resolution has occurred;
- Refer the complaint to an Alternate Complaint Resolution process; or
- Dismiss the complaint if it is deemed trivial and vexatious.

Other options, not significantly different from our current process, include:

- Dismissal based on insufficient evidence;
- Expert review;
- Formal investigation; and

- Request that the physician undergo mental or physical health assessment.

Although our options in terms of resolution will change, our philosophy that complaints should be approached as problems to be solved will remain the same.

Clearly, the HPA allows a wider range of options at the initial stage of complaint resolution. How the process then plays out will be the subject of future articles.

For information about the complaint process or about the HPA, please contact:

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

Alberta Rural Health Week

The fifth annual *Alberta Rural Health Week* will be celebrated **June 18 - 24, 2006**. The goal of *Rural Health Week* is to raise awareness and to showcase the unique positive contributions and skills of rural health professionals and organizations.

This year's theme is "**Improving Access to Rural Health Services.**" For more information, please visit www.ruralhealthweek.ab.ca.

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