ALBERTA, CANADA
PAR PROGRAM RECEIVES AWARD

The Medical Council of Canada (MCC) recently honored a working group from the College of Physicians and Surgeons of Alberta (CPSA) and the University of Calgary with the MCC's prestigious Outstanding Achievement Award. With support from the University of Alberta, the working group was responsible for the initial development of the College's PAR Program — a comprehensive evaluation method providing Alberta physicians with feedback on their medical performance.

According to Dr. Dale Dauphinee, executive director of the MCC, the group developed a valuable tool to evaluate clinical competence. "Many have attempted to accomplish something of this scale, but achievements are few, and that is why they are exemplary in their field," he said.

The MCC award recognizes work done to create the assessment tool used by the PAR Program. Since its inception in 1999, more than 2,700 physicians have participated in the PAR Program and more than 65,000 patients have provided written feedback. Today, PAR is recognized both nationally and internationally as an innovative approach to quality improvement and risk management. Within the past several months, the CPSA has been approached by medical regulatory bodies in Canada, the U.S., Europe and New Zealand to discuss the possibility of implementing a similar program in those jurisdictions.

Specifically named in the award were John Swiniarski and Dr. Bryan Ward, College of Physicians and Surgeons of Alberta; Jocelyn Lockyer, Ph.D., University of Calgary; Claudio Violato, Ph.D, University of Calgary; Herta Fidler, M.Sc., University of Calgary; Dr. Raymond Lewkonia, FRCPC, University of Calgary; Dr. John Toews, FRCPC, University of Calgary.

INSURANCE ACT REGULATIONS

Challenges Created by New Insurance Regulations

By now, it is not news that the new regulations relating to sprains, strains and whiplash injuries from motor vehicle collisions are causing some frustration. On the profession's side, physicians have expressed unhappiness with:

- the fact that a diagnostic and treatment protocol is a regulation at all;
- their uncertainty about the scientific validity of the protocol;
- the amount of prior consultation with the medical profession;
- the lateness of information about the process;
- their uncertainty of the legal liability of physicians, either from compliance or non-compliance with the protocol;
- the onerous nature of required documentation; and
- the quality of the forms.

Fortunately, the protocol is a living document that will be revisited. We are assured physicians will have greater input going forward.

The CPSA, the American Medical Association and the Superintendent of Insurance are working together on the challenges to implement the new regulations. Changes have already been made and more may be necessary. The reported experiences of physicians will be used to streamline the processes further.

Questions about the added legal liability of physicians are understandable, although probably overstated. It is our view good medical practice will prevail over any other standard, and the regulations do not alter the first obligation of the physician, which is to the best interests of the patient.

The protocols do not bind the physicians to a particular diagnosis or treatment and do not substitute for individual physician judgment. Members should also know the CPSA has received complaints from patients, insurers and lawyers alleging that some physicians refuse to see these patients or to complete the prescribed forms. So, we are reminding members:

- a physician who treats injuries in the usual course of their medical practice cannot refuse to treat a patient with injuries from a motor vehicle collision; and

- a physician must provide information, upon request of the patient, that is necessary for the patient to access entitlements such as financial compensation. Therefore, a physician who provides primary care for these injuries must either complete the necessary forms or arrange for another health care provider to assess the patient and complete the forms. It is unacceptable to abandon a patient who needs the forms completed and who is unable to access those services from another provider in a timely manner.

Considering the small number of these complaints, it is clear that most physicians understand these responsibilities.

Reprinted from issue 115 of *The Messenger*, published by the College of Physicians and Surgeons of Alberta.

BRITISH COLUMBIA, CANADA
MEDICAL EXAMINATIONS FOR THIRD PARTIES

Recently, the College of Physicians and Surgeons of British Columbia (College) adjudicated a complaint and discussed the issues surrounding medical examinations for third parties. The sensitivities and the potential problems inherent in independent medical examinations (IMEs) have been addressed previously and guidelines for such examinations are included in the College's *Policy Manual* (renamed: *Physician Resource Manual*). The current concern is about the scope and extent of such examinations, specifically whether in pre-employment examinations by a physician, this should include breast, pelvic and rectal examinations.

A patient objected to the inclusion of a pelvic and breast examination as part of a pre-employment evaluation. The patient understandably questioned the need for such examination, and what such an examination had to do with her suitability for employment. Furthermore, as a result of such unanswered questions, the patient questioned the motives of the physician in conducting the examination. The physician responded he felt obligated to evaluate or exclude any medical condition or disease process, including ovarian and breast pathology, and he always included this in his physical examinations. The physician assumed the standards he set for his own patients also applied to pre-employment evaluations on behalf of a third party, in this case, the employer.

The issue here is the common one of communication or, rather, the absence of it. The requirements and scope of the pre-employment examination should be determined by the employer and the physician before the examination takes place, and the patient should be made aware of that scope. The physician should advise the patient the examination does or does not include pelvic, rectal or breast examinations. If these sensitive examinations are not required, the patient should be advised they are deliberately excluded from the evaluation and are therefore left to the patient's treating physician. Alternatively, the physician may advise the patient these examinations are not required, but if the patient wishes to have them included, for personal benefit or reassurance, they can be. In situations where these examinations are deemed to be required, the patient should be given the opportunity to object to the inclusion so that those aspects of the examination can be excluded and the patient's wishes can be documented. Through such discussions, confrontation during or after the examination, and subsequent objections after the fact, can be avoided. Based on a quick survey of current practice, most pre-employment examinations do not include pelvic, rectal and full breast examinations.

Perceptions or misperceptions are frequently created in the context of ineffective or absent communication. In the College's experience, more than half of all complaints against physicians, directly or indirectly, involve poor communication and, by adequately addressing that issue, can be avoided.

PRESCRIBING, COUNTERSIGNING PRESCRIPTIONS AND INTERNET PRESCRIBING

Earlier this year, the College published the outcome of a disciplinary action involving a physician, Satnam Singh Gandham, M.D., who, contrary to the College's well-established and published policies, authorized prescriptions issued by U.S. physicians for U.S. patients, for dispensing and purchase in Canada. Dr. Gandham admitted he had not had face-to-face contact with these patients, and further admitted his conduct was unprofessional. Subsequent to these admissions, Dr. Gandham participated in an open line radio show. During that broadcast, he made numerous comments that left a number of inaccurate impressions. First, his comments left the incorrect impression he had advised the College of his proposed prescribing. Second, his comments left the impression, again inaccurate, that his prescribing was analogous to the prescribing of physicians who may, on occasion, prescribe by telephone, on behalf of partners, or as

part of a call group after hours. Regrettably, Dr. Gandham did not refer to the College's policy that specifically addresses these situations. The College policy, which was communicated to all College members, requires the establishment of a physician-patient relationship by a face-to-face contact and examination prior to prescribing, but also addresses circumstances under which physicians may prescribe on behalf of a partner or as part of a call group:

> "In situations where the patient is known to the physician and where he or she has current knowledge of the patient's clinical status from previous encounters, a prescription may be provided on the basis of a more focused clinical evaluation. If the physician is part of a group practice or a call-group, he or she may choose to accept the previous patient evaluation by an associate, as the basis for further prescribing. However, under such circumstances, the prescribing physician would retain the professional responsibility for the prescription that he or she has written."

Dr. Gandham was subsequently interviewed by the College's Executive Committee regarding his comments. He stated it was not his intent to be critical of the College, to suggest his conduct was analogous to that of the majority of physicians, or to argue his conduct was not unprofessional and did not warrant disciplinary action. He agreed the statements made by him left an inaccurate impression and could be viewed as misleading, both by the profession and the public. Dr. Gandham offered his sincere apology to the Committee, to the College, and to the profession and accepted the Committee's invitation to publish this information.

Reprinted from Issue 47 of *College Quarterly*, published by the College of Physicians and Surgeons of British Columbia.

LONDON, ENGLAND
FAKE AND FRAUDULENT DOCTORS TARGETED BY NHS CFS AND THE GMC

As part of a more comprehensive Memorandum of Understanding, the National Health Service Counter Fraud Service (NHS CFS) and the General Medical Council (GMC) today agreed to share information relating to suspected fake and fraudulent doctors. The agreement means that the NHS CFS and the GMC will be better able to protect NHS resources from fraud and ensure that patients are properly safeguarded. Signed recently by Jim Gee, chief executive of the NHS CFS, and Finlay Scott, chief executive of the GMC, the agreement demonstrates their commitment to working more closely and opens up wider communication channels between the two organizations. Relevant information held by both parties will be disclosed, within the constraints of the Data Protection Act and Human Rights Act, and used to strengthen investigations.

"As the world expands, and it becomes easier for those entering the U.K. to obtain work, NHS systems and medical regulatory procedures must expand with it," said Gee. "Today's agreement means information relating to suspicions of fraud can be shared and the necessary action taken immediately. Both the NHS CFS and the GMC are committed to seeing NHS resources reach their intended target and patients receive quality care from qualified doctors. The NHS CFS are working on similar agreements with other regulatory bodies, including the General Dental Council."

"This agreement facilitates the exchange of information necessary to safeguard patients and to protect the NHS from fake or fraudulent doctors. We are delighted to be strengthening our already successful relationship with NHS CFS in this way," said Scott. "We are committed to working with the NHS CFS and other partners to ensure clearer standards and stronger safeguards, which together will improve patient safety and enhance the quality of health care."

Other benefits of the agreement include:

- sharing of expertise and experience in the development of effective investigative methods and
- opportunities to discuss allegations against individual doctors and policy developments at the NHS CFS and GMC.

This agreement follows the high-profile case of Barian Baluchi, an Iranian-born asylum seeker, who was sentenced to 10 years imprisonment on Wednesday, January 26, 2005, at Middlesex Guildhall Crown Court for impersonating a doctor and defrauding the taxpayer and charities of an estimated £1.2 million. The sentence followed a joint-investigation by the NHS Counter Fraud Service and the Metropolitan Police.

GMC WALES IS OFFICIALLY OPENED

The GMC has officially opened its office in Wales. The

office has been established to allow the GMC to respond to devolution more effectively and develop better relationships with our partners in Wales, including patients and the public.

Speaking at the opening, GMC President Sir Graeme Catto said: "The GMC has gone through a significant number of changes in recent years to ensure we are a regulator ready to face the challenges of modern society. Part of these challenges is effectively engaging with the devolved countries, which is why I am delighted we are opening an office in Wales."

Also speaking at the opening, Minister for Health and Social Services, Dr. Brian Gibbons, said: "I fully support the opening of the GMC office in Wales and look forward to strengthening links between the Assembly and the GMC to the benefit of both patients and doctors in Wales."

The decision to open a new office followed consultation with key stakeholders, who overwhelmingly supported the establishment of a GMC presence in Wales. This will be the fourth GMC office, supplementing those already up and running in London, Manchester and Edinburgh. The office will establish and maintain links with the National Assembly for Wales and key policy bodies. This will better enable the GMC to monitor health care issues across Great Britain and respond to the changing health agenda in Wales following devolution. It also means the GMC can further its work on patient and public involvement in Wales, ensuring that medical regulation is a partnership between patients and their doctor.

THE GMC JOINS THE MENTAL HEALTH ALLIANCE

The GMC has joined the Mental Health Alliance, a campaigning coalition for the reform of the Mental Health Act (1983), as an associate member.

The Mental Health Alliance is a coalition of more than 70 organizations working for improved mental health legislation. Members include charities, service user and care groups, professional associations and a wide range of others concerned about mental health legislation.

The GMC has an interest in the proposals in the draft Mental Health Bill as they have implications for doctors' ability to meet the standards of conduct and care expected in their relationships with a particularly vulnerable group of patients.

The GMC believes it is important to ensure people with mental health problems are able to get the treatment and care which they need, and are not subjected to compulsory assessment and treatment without appropriate safeguards of their rights and interests. The GMC would welcome reformed legislation which achieves these aims, taking account of the way that modern mental health services are provided in hospitals and the community, and reflecting modern human rights law.

"We are pleased to be part of the Mental Health Alliance and hope that the forthcoming Mental Health Bill will create a framework that respects the rights of patients with mental health problems and addresses the recommendations of the Mental Health Alliance," said Catto.

Reprinted from the General Medical Council website.

LET US HEAR FROM YOU

Would you like for information from your board to be considered for publication in the *Journal*? If so, e-mail articles and news releases to Edward Pittman at epittman@fsmb.org or send via fax to (817) 868-4098.