ALBERTA, CANADA
VERBAL PRESCRIPTION FORGERIES

The Alberta College of Pharmacists has reported a significant increase in verbal forgeries throughout the province. Individuals will call pharmacies with prescription orders, claiming to be a physician. They will often be able to provide the physician's College of Physicians and Surgeons of Alberta (College) license number, office address, and telephone number. Prevention of forgeries and fraud should be a concern for all physicians prescribing narcotics and other controlled drugs. The following are suggestions to prevent verbal forgeries of prescriptions:

- Limit the use of verbal prescriptions to exceptional cases.
- Do not use verbal prescriptions for medications prone to misuse or abuse such as benzodiazepines or acetaminophen with codeine compounds.
- Fax prescriptions to the patient's choice of pharmacy.
- Limit the quantities of prescriptions, where possible, for medications prone to abuse.
- Be accessible to pharmacists who require verification and authentication of prescriptions. It is not recommended that office staff verify prescriptions for narcotics and controlled substances.
- Protect your College registration number and only provide it when necessary for legitimate purposes.

Verbal prescription forgeries may be the most difficult forgery to detect and prevent. Using these general approaches to prescribing will assist the pharmacist in identifying a potential forgery when it is not the physician's customary practice to provide verbal prescriptions.

PHYSICIAN RESOURCE PLANNING ACTIVITIES

The Physician Resource Planning Committee (PRPC), which includes College representatives, is again working to update Alberta's physician resource plan by Dec. 31, 2005. PRPC's primary task will be to identify Alberta's optimal number, mix, skill level and distribution of physicians (working in collaboration with other health providers) to deliver appropriate care that meets the province's health care needs. The workplan will include consultation with AMA Sections, RHAs and other stakeholders with a significant interest in physician resource issues. In the long-term, PRPC will:

- provide advice about strategies and mechanisms to meet the requirements of a physician resource plan;
- develop and recommend strategies to the appropriate stakeholders to integrate physician resource planning with planning for other health human resources provincially and within regional health authorities; and
- identify and inform Regional Health Authorities and other stakeholders on opportunities to better coordinate and/or integrate medical services to create an integrated health system.

In addition to the College, PRPC members include Alberta Health and Wellness, the Alberta Medical Association, Regional Health Authorities, both Faculties of Medicine, the Professional Association of Residents of Alberta and the Medical Students' Associations. PRPC also has ex officio representatives from the Post- Graduate Medical Education Advisory Group, Alberta Physician Resource Database Working Group, Rural Physician Action Plan Coordinating Committee, and Alberta International Medical Graduate Program. PRPC provides a forum to coordinate advice and proposed initiatives including those of the member entities. In future communications, the PRPC will provide an update of progress to create a provincial physician resource plan and provide additional information about physician resource issues and upcoming activates for the committee.

THE ETHICS OF PATIENT SELECTION

The College recently received the following complaints:

One

A woman contacted a general practitioner's office to inquire whether the physician was taking new patients. The receptionist advised the physician was taking new patients but the patient was first required to answer some

questions before being granted an appointment. The receptionist inquired as to the woman's age, and upon learning that she was in her eighties, the receptionist informed the woman that the physician was not taking new patients over 65.

The physician responded he felt he was justified in refusing to see elderly patients because they require more time and he did not have the time to devote to additional members of this patient population given the current demands of his practice.

Two

A patient attended an appointment to meet a family physician taking new patients. She informed the physician her diagnoses included depression, borderline personality disorder and anxiety disorder. The physician responded that she must seek another physician. When she asked why, the patient was told that his practice was full.

The physician responded that prior to seeing the patient, he had recently made the decision to stop seeing new patients, and his staff were not fully aware of this decision. He wrote, had the patient required immediate care, he would have provided it, but because her issues were not emergent, he felt justified in refusing her care.

Three

An elderly woman made an appointment for a complete physical with a physician who advertised in the local paper that she was accepting new patients. Upon arrival for the physical, she was informed by the receptionist she would not be given a physical, instead the physician wanted to meet her first. The patient was interviewed by the physician with respect to her medical problems. At the termination of the appointment, the physician advised the patient that she would not accept her into the practice.

The physician responded that during the interview, she learned that the patient had a physician but was looking for a new physician closer to her new home in another part of the city. As such, the physician felt justified in refusing to take the patient on. All three complainants believed that they were victims of discrimination. The Canadian Medical Association (CMA) Code of Ethics states:

> "In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons."

The College appreciates that the demands of practice are great. However, the practice of screening patients based on age, medical condition and other grounds of discrimination is not acceptable, despite the fact that some groups of patients in general need more time and attention. Having said that, it is reasonable to decline to take on a patient whose needs cannot be met. For example, while it is not acceptable to screen out all patients over 65, it is acceptable to decline services to an elderly patient who attends with complex medical problems for which she has seen multiple practitioners and is not satisfied with the advice and treatment given to date, when that advice and treatment meets the standard of care. The College would not be critical of a physician who determined, after careful evaluation of the patient's history, that they had nothing to offer this patient that had not been previously offered by other providers. Physicians also have a right to limit their practices. Examples include:

- No new patients.
- Limiting new patients to family members of existing patients or referred patients only.
- Limitation of types or range of services provided. None of the three physicians listed in the above complaints intended to be discriminatory, yet their actions were clearly perceived by the prospective patients as such.

To help avoid complaints of discrimination:

- Be aware of your ethical obligations.
- A "meet and greet" appointment should not be used as a tool by physicians to screen potential patients.
- When screening potential patients on the telephone, office staff should ensure they clearly explain the physician's limitations. Appointments to meet the doctor should not be given if the patient falls outside the limitations of that physician's practice.
- When declining a new patient, the patient should be provided with the reason they were not accepted into the practice.

METHADONE MAINTENANCE STANDARDS FOR TREATMENT IN ALBERTA

In September 2004, the CPSA established an expert group

of physicians to develop consensus standards and guidelines for methadone maintenance treatment in Alberta. Their work has resulted in the development of a draft document titled *The Standards and Guidelines for Methadone Maintenance Treatment in Alberta*.

This resource will guide physicians in how best to prescribe methadone for opioid dependent patients. During the next several months, physicians will be asked to review the draft document and provide recommendations for improvement. Look for details on how you can be involved in future issues of *The Messenger*.

Other stakeholders such as pharmacists and other Colleges across Canada will also be given the opportunity to provide feedback on the draft document. Once the guidelines and standards are finalized, the document will be sent to physicians throughout Alberta to raise awareness of opioid dependency and to encourage physicians to address this issue in general practice. Although other therapies for opioid dependency have been used in locations around the globe, this document will focus on the use of methadone in addressing the issue.

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.

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BRITISH COLUMBIA, CANADA
PATIENTS ARE ENTITLED ACCESS TO MEDICAL RECORDS

A written or stamped message on a consultation report, stating "not to be released to third party," has no authority or impact if the request for medical records comes from the patient or a patient's agent, such as the patient's lawyer. This is in compliance with a ruling of the Supreme Court of Canada (*McInerney v. MacDonald*, (1992) 93 DLR (4th) 415), which states:

> "In the absence of regulatory legislation, the patient is entitled, upon request, to inspect and copy all information in the patient's medical file which the physician considered in administering advice or treatment."

These provisions are added:

> "unless there is a significant likelihood of a substantial adverse effect on the physical, mental or emotional health of the patient or harm to (an innocent) third party" and "provided the patient pays a legitimate fee for the preparation and reproduction of information."

MEDICAL MARIJUANA UPDATE

Pursuant to the Medical Marijuana Access Regulations, SOR/2001-227 ("the Regulations"), marijuana may be prescribed to patients fulfilling the criteria set out in the Regulations. The medical benefits of marijuana have been subject to much debate. To assist members in considering patient requests for medical marijuana and in making an informed decision, the College of Physicians and Surgeons of British Columbia (College) has conducted a review of the current research literature on the risks and benefits of medical marijuana. The results of this review are available to members for review in person at the College's Library or online through the College website at www.cpsbc.ca. Members may review the table of contents online and e-mail the library to request a copy of any referenced article.

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ONTARIO, CANADA
ELECTRONIC, DIGITIZED SIGNATURES NOT APPROPRIATE FOR PRESCRIPTIONS

The Physician Advisory Service of the College of Physicians and Surgeons of Ontario (College) receives frequent calls from physicians asking whether it is appropriate for them to sign prescriptions using electronic signatures. While the trend of implementing electronic medical records is advancing rapidly, neither Health Canada nor the Ontario College of Pharmacists currently recognizes electronic signatures as acceptable for signing prescriptions. The College endorses electronic record-keeping and the use of technology to assist in the practice of medicine, however, physicians should not use electronic or digitized signatures for prescriptions at this time. Recently, after inspecting 11 pharmacies that practiced distance dispensing, Health Canada issued a letter to all pharmacists reminding them of their obligations under the Food and Drug Act. The following is an excerpt from Health Canada's letter dated Nov. 16, 2004:

"During the inspections it was observed that sale of drugs was occurring pursuant to prescriptions signed using rubber stamps or electronic prescriptions signed with electronic signatures and not supported at the time of sale by a written prescription transmitted by mail or electronic means. The use of a rubber-stamp or other means of signature which is not distinct for each transaction as the basis for a prescription order is not a valid signature and does not fulfill federal requirements. The sale of Schedule F drugs in this manner is a violation of section C.01.041(1.1)(a) of the Food and Drug Regulations.

C.01.041(1.1) Subject to C.01.043 and C.01.046, no person shall sell a substance containing a Schedule F drug unless (a) the sale is made pursuant to a verbal or written prescription received by the seller;

A prescription signed by a Canadian practitioner, *then* transmitted electronically to a pharmacist by faxing or scanning, is not a violation of the *Food and Drug Regulations*."

The Ontario College of Pharmacists has instructed its members to verify all prescriptions that contain rubber stamped, electronic, or digitized signatures. This verification must occur either verbally or by a faxed request for authorization to the prescriber. The College's expectation is physicians will respond to these requests for verification professionally and courteously. Patients cannot be charged a fee for this type of verification, nor is it acceptable to encourage patients to attend pharmacies that inappropriately accept electronic signatures without subsequent verification.

The College is also aware some private software vendors have indicated to physicians their product has been endorsed or approved by this College. The College does not endorse specific products or services, so please exercise caution when presented with this type of information.

For this, and all other practice-related questions, please contact our Physician Advisory Service at (416) 967-2606 or (800) 268-7096, extension 606.

COMMITMENT TO COMPETENCE: COUNCIL SUPPORTS PRINCIPLES OF REVALIDATION

At a recent meeting, the Council demonstrated its commitment to the principles of revalidation by moving forward with a consultation of stakeholders on all aspects of the program. The proposed system of revalidation includes educational requirements and practice assessments — components that, in combination, will promote continuous improvement in practice for the benefit of patients. It will be integrated with the national educational systems and is based on the best available evidence about practice assessments and education.

"We want a process that ensures extensive feedback from the profession and other key stakeholders in the development of the methods of revalidation," said Dr. Gerry Rowland, College president.

The College foresees revalidation as a system to enhance lifelong learning opportunities for all members of the profession.

"It will be an extension of our existing peer assessment program. It is our hope that the final product will give the physician a practical and user-friendly method of evaluating his or her own continuing competence, in an integrated framework of quality improvement," said Dr. Rowland.

The system is based on the premise that all physicians will participate in effective education and are prepared to demonstrate their competence to their peers and the public at various points throughout their career.

Once the College has gathered input from the profession, the public and other stakeholders, it will then embark on a period of testing of the tools selected.

"We are working toward building a fully operational and integrated revalidation system, but we realize the profession needs to have time to understand the changes and to help us make the tools as useful as possible," Dr. Rowland said.

The proposal is that eventually all physicians registered with the College will participate in a regular cycle of revalidation, likely at the rate of every five years.

"One of the keys to the success of this program is to recognize that physicians are busy, and this program needs to be manageable for a busy physician, as well as relevant to each physician's particular practice. It also needs to be robust enough so that the public can be reassured that a system is in place to validate their trust in doctors' continuing competence,"said Dr. Rowland.

The proposed system and draft tools have been developed over the past year through a task force of representatives from the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the Medical Council of Canada, and the Ontario Medical Association.

It is proposed the profession will engage with the process of revalidation in three stages: commitment to competence, demonstration of competence and proof of competence. The latter two components should be familiar to all doctors, in that the tools used — the peer assessment program (demonstration of competence) and the PREP and SAP programs (proof of competence) — have been part of the CPSO quality assurance process for 25 years.

The Commitment to Competence stage is proposed as the first stage of revalidation — indeed, it may be the only stage of revalidation in which most physicians will be expected to participate. This level of revalidation is a purely educational component designed to help all doctors develop a practice-specific educational program.

The proposed components in this stage include:

- Demonstrating completion of a self-assessment process using questionnaires designed to help individuals understand the dimensions of their practices;
- Obtaining multisource feedback from colleagues, co-workers and patients designed to help doctors target their education in these important relationships and to make changes when necessary; and
- Demonstrating completion of a recognized system of continuing professional development from the RCPSC, the CFPC or the equivalent.

Why revalidation in a regulatory framework in Ontario?

- Doctors have a position of respect and responsibility in society based on the explicit expectations of their patients and the community-at-large.
- The public's trust in the profession is related to the leadership shown by doctors for their collective performance.
- Professional accountability is in the domain of the regulatory body.
- An individual's medical school and postgraduate training (entry to practice) does not guarantee competency and performance throughout a 25–30 year career.
- While many doctors already participate in a variety of educational and performance enhancing activities, participation is not universal, nor is there the consistency of a formal and integrated system.
- Some jurisdictions have been forced to develop systems of performance evaluation after tragic circumstances in their medical systems (e.g., UK's Bristol Inquiry related to pediatric cardiac deaths); the College prefers to lead during a time of stability, and to work proactively with the profession to identify workable solutions.
- The College's register needs to stand for more than just the name and address of a doctor; it must assure the public that each physician whose name appears in the College's register has had their competence and performance revalidated on a regular basis. Revalidation will add value to the certificate to practice medicine in Ontario.
- Ontario has been a leader in physician assessment and continues to collaborate with colleges across the country in implementing assessment and educational tools for physicians.

Principles of Revalidation

The system of revalidation will meet the following core principles:

- The component parts of revalidation must be educational, based on each physician's actual practice, and be adaptable to changing circumstances.
- Performance evaluation and education will be evidence-based and will first and foremost work towards continuous improvement of doctors' practices.
- The system of revalidation will be equitable for all physicians and a successful system will require collaboration and partnership with other organizations representing medical interests.
- In meeting these criteria, we will have a system that is accountable to the public and affordable for the profession.

From the quality improvement perspective, Component 1 represents an opportunity for physicians to assure themselves their practice achieves the objectives that are explicit in the peer assessment (Component 2). The College will maintain a random selection process for peer assessment as an important component of quality assurance and improvement.

Throughout all stages, revalidation is designed to validate performance and to help physicians to identify and implement improvement opportunities.

"The maintenance of competence is an ethical obligation of the profession," said Dr. Sandy Shulman, chair of the College's Quality Assurance Committee."It forms the basis of trust between professionals and patients, and underpins, in large part, the protected status of the profession. It is a subject that should unite doctors in assuring patients that they can continue to count on exemplary care."

ACUPUNCTURE SHOULD BE A CONTROLLED ACT

Acupuncture should no longer be exempted from the controlled act provisions of the *Regulated Health Professions Act* (RHPA) and should become a controlled act authorized to those who have the appropriate knowledge, skill and judgment to perform acupuncture, says the College Council.

In a submission to government, the Council explained the College supports the practice of acupuncture as a treatment modality for symptom control, especially for pain, practiced by health professionals trained in acupuncture techniques. However, for an act to become a controlled act under the RHPA it must be inherently dangerous if not performed by a competent health professional. And Council says there is enough risk associated with acupuncture to merit its inclusion as a controlled act.

"Although the incidents of injuries and adverse reactions associated with acupuncture may be low, the safety of acupuncture is dependent on having well trained practitioners and stringent infection control procedures. As more and more people are choosing to receive acupuncture treatments, there is an increased risk to the public," stated the submission.

Physicians are currently entitled to "perform a procedure on tissue below the dermis" and as such, acupuncture is clearly within the practice of medicine. The College recommends the government regulate persons who perform acupuncture by having the regulatory colleges whose members are legally able to perform acupuncture within their scope of practice cooperate to set standards of practice for their respective members. The CPSO, as the self-regulatory college for physicians, is the appropriate entity to set standards of practice for physicians who provide acupuncture treatments. In addition, for those regulated health professions whose members currently perform acupuncture, but would not be authorized to do so once the acupuncture exemption is removed (e.g., physiotherapists and chiropractors), they should apply to the minister for an expansion of their scope of practice, said the submission.

The submission also states that given that an increasing number of people are choosing non-traditional medicine and that there are risks inherent in Traditional Chinese Medicine (TCM), the CPSO Council believes it is in the public interest it be regulated.

"The health care interventions and treatments that comprise TCM are not insignificant health care interventions. In order to ensure that patients, as consumers, know who they are seeing, it is necessary that there be adequate standards in place for practitioners and the care offered, an accountability structure and the regulation of substances being administered. In addition, patients may be receiving TCM and traditional health care simultaneously and therefore there should be some assurance of interdisciplinary communication," stated the submission.

Recently, the College submitted responses to an Health Professions Regulatory Advisory Council questionnaire regarding the regulation of psychotherapy. The responses reflected the opinions of a consultation group comprised of physicians and CPSO staff with expertise in this area. The document was presented as a reflection of the opinions of these qualified individuals, and is not to be considered the official position of the CPSO.

The consultation group stated psychotherapy should be regulated to restrict the risk of harm to patients/clients. Currently, psychotherapy is not regulated. There are no standards for entry to practice, no standards of practice and no accountability, except for those governed by other colleges, such as the CPSO or the College of Psychologists of Ontario. The merits to having psychotherapy regulated as a controlled act under the RHPA, include enabling the development of entrance criteria and the ability to create ongoing quality assurance. However, admission to the profession should not be limited to currently recognized regulated health professionals, as this would unduly limit public access to well-qualified practitioners with other backgrounds.

The consultation group stated counseling, spiritual counseling, and crisis intervention should not be controlled acts. These services are readily distinguishable from psychotherapy in their purpose, their approach, and by those who provide these services. Counseling, spiritual counseling, and crisis intervention are important services, and the

consultation group stated that unduly restricting the scope of individuals able to provide these services would be a disservice to the Ontario public.

The consultation group made the following additional recommendations regarding the regulation of psychotherapy:

- "Psychotherapist" should be a restricted title.
- A new and separate college for psychotherapy should be created to govern those practitioners who do not have the background or training required for membership in any existing professional regulatory college (e.g., the College of Social Workers and Social Service Workers, and the colleges under the RHPA).
- Members of existing professional colleges should not be required to have concurrent membership in the new college for psychotherapists.
- Mechanisms should be established to ensure minimum standards of care are consistent among all colleges regulating psychotherapy.
- Practicing psychotherapists who do not satisfy admission criteria for either the existing professional colleges or the new regulatory college may be grandfathered into membership in the new college where competency can be established based on equivalent education, practice experience in psychotherapy, or both.

The CPSO will have an opportunity to provide its official position as consultation in this matter progresses further. The CPSO will also participate in a workshop facilitated by HPRAC.

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LONDON, ENGLAND

GMC CHANGES COMPLAINTS HANDLING PROCESS

On Oct. 17, 2005, the General Medical Council (GMC) implemented a change in the way complaints are handled. It was agreed by Council in July 2005 that the GMC should refer cases directly to local procedures for consideration where the allegations as presented, if proven, would not call into question a doctor's fitness to practice.

Since July, the GMC has been developing appropriate systems to ensure that cases referred to local procedures are returned to the GMC where there is further information calling into question a doctor's fitness to practice and that written confirmation is received that there is no such evidence where the case has been concluded locally. These systems are now in place.

The GMC is mainly limited to taking action on serious concerns which call into question the doctor's fitness to practice and suitability to retain unrestricted registration. However, most of the complaints that are received do not fall into that category; as, even if the allegations were proven, they would not be sufficiently serious to warrant action on registration. The majority would be best dealt with locally, at least initially. Since May 2004, the GMC has retained ownership of some complaints while it sought further information from the employer in relation to the doctor concerned. These were complaints that, on the information supplied (although not best practice), were not particularly serious. In the vast majority of these cases the further information received has not changed the nature of the concern and, as such, it would now seem appropriate that these are dealt with locally.

This change has been introduced as there was concern previous procedures did not ensure issues about a doctor's performance or conduct would necessarily be followed up, as the onus was placed on the complainant to pursue the matter locally. There was a danger concerns raised by the complainant would not be investigated either by the GMC or by local procedures and that any pattern of poor performance would simply not be tracked and identified.

The change will enable the GMC to continue to focus on investigating those cases where the concerns raised about a doctor's fitness to practice, by patients or employers, are sufficiently serious to require restrictions on the doctor's registration or removal from the register.

According to Paul Philip, director of Fitness to Practice: "This change will allow us to focus our resources in a much more targeted way, enabling us to deal with appropriate complaints in a timely way. This will be beneficial to both patients and doctors."

THE GMC IMPROVES INFORMATION ACCESS WITH AN ONLINE DOCTOR SEARCH

On Oct. 20, 2005, the GMC launched an enhanced web-based facility which enables patients, pharmacists and

employers to gain instant access to a doctor's registration status. The Online Doctor Search requires simply the name of the doctor in order to display whether that doctor has any restrictions on his or her registration, following either a fitness to practice hearing or an undertaking made to the GMC.

This information has been available publicly but involved either a complicated web search or a telephone call direct to the GMC contact center. Improving accessibility is part of the GMC's stated commitment to increasing the transparency of its activities in order to develop its services to the public and patients.

When there are restrictions on a doctor's registration following a fitness to practice hearing, the facility will offer a direct link to minutes of that panel hearing. This facility will be developed further next year when tiered access for employers and pharmacists will enable the GMC to give them relevant information online such as photographs or a date of birth.

President of the GMC, Professor Sir Graeme Catto, said: "The enhanced Online Doctor Search is an important step forward in terms of increasing the GMC's transparency. It will provide patients with easier access to information they are entitled to, so they can approach their discussions over treatment and referrals fully informed. Although this has been available before, it required people to have a prior understanding of the system in order to gain access to it. In the interests of patient safety, employers also need ready knowledge of any restrictions that affect a doctor's registration."

Harry Cayton, National Director for Patients and the Public, said: "I welcome the GMC's intentions to make it easier for people to find important information about doctors through their website. The additional facility to link a doctor's details to other information concerning their registration will be of particular value to the public."

The search facility will form part of the newly revamped GMC website. It has been updated to make it easier to use and more accessible to all groups, including those with disabilities. The homepage reflects the interests of doctors, pharmacists, the media and the general public, with the relevant sections clearly marked. The search facility was tested along with the new website by members of the Patient and Public Reference group, who offer the GMC an external point of view.

"It is a refreshing change that a big organization like the GMC actually welcomed patient and public involvement for their new website," said Kim Longlands, of EASE Project Manager to Endometriosis SHE Trust (UK), and a member of the PPRG. "They invested time and resources to consult with the general public and seriously took on board all comments made. I am delighted to have been involved in their project."

Reprinted from the General Medical Council website.

LET US HEAR FROM YOU

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