ALBERTA, CANADA
COUNCIL HIGHLIGHTS

The Council of the College of Physicians & Surgeons of Alberta (College) met on March 14, 15 and 16, 2007, in Edmonton. Significant outcomes included:

Assessment of foreign trained physicians

The College is discussing options with Alberta Health & Wellness that address issues of liability protection for assessors and funding for universities to develop assessment tools and protocols. Resolving these two issues is vital to having practice ready assessments available for foreign trained physicians who require them as a condition of registration.

Online Application and Tracking System

Work continues on this system that will streamline the application process and reduce the length of time it takes to complete the registration of new physicians in Alberta. The initial stages of the system will be implemented this spring.

Late Payment of Accreditation Fees

Council amended two bylaws that allow the College to recover administrative costs associated with the collection of overdue accreditation fees. The deadline for fees was March 31. Council agreed that an additional $250 charge will be applied to all fees received after this date. Furthermore, Council amended a second bylaw to state that accreditation granted by Council shall expire at 12:01 p.m. on May 1 unless the accreditation has been renewed.

Publication of Disciplinary Actions Against Physicians

Council was advised that an index of published disciplinary actions against physicians will be posted on the CPSA website. This information was previously available in individual issues of the *Messenger*. Details will now be presented in a more concise format and easily accessible location. Once the College moves from under the Medical Profession Act to the Health Professions Act (expected in late 2007), the majority of disciplinary hearings will be open to the public and information about upcoming hearings will be posted on the CPSA website.

Revalidation Working Group Progress Report

Deputy Registrar Dr. Bryan Ward provided an update to Council on the Revalidation Working Group. This group is tasked with the responsibility to develop a framework for Revalidation – a requirement until the Health Professions Act. Revalidation refers to a quality assurance process in which members of a profession regularly provide satisfactory evidence of their commitment to continued competence in their practice as a condition of remaining licensed. Scheduled to meet in April, the Revalidation Working Group will review possible components of Revalidation including mandatory CME and random practice visits. The existing elements of CanMEDS (Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional) will also be considered.

Reprinted from the College of Physicians and Surgeons of Alberta website.

BRITISH COLUMBIA, CANADA
HELP AN INTERNATIONAL MEDICAL GRADUATE

Many physicians have generously opened their offices and practices and contributed significant time and effort to upgrade, enhance and maintain clinical skills and competency to aid an IMG in preparation for the Medical Council of Canada examinations, and to familiarize him or her with the clinical and ethical requirements of the Canadian medical system.

A physician who assumes the responsibility for an IMG in a clinical traineeship program should be reminded that supervision of any clinical contact between the clinical trainee and patients is mandatory. Furthermore, any activities based on clinical judgment, i.e. procedures or activities, must be directly overseen by the supervising physician or designate.

The College of Physicians and Surgeons of British Columbia (College) has become aware that some preceptors, however, have erroneously viewed clinical trainees as

"physician assistants." The clinical traineeship is not a form of employment, nor is the IMG licensed for independent practice. The IMG in a clinical traineeship is equivalent to a medical student or junior resident in training, requiring equal and appropriate supervision. Each patient contact must include interaction with the supervising physician and cannot be limited to contact with the clinical trainee only. Physicians who are interested in providing an in-practice educational experience to an IMG should contact the College so that their names can be given to those who are seeking this important experience.

NEW COMMITTEE ON PRIVACY AND DATA STEWARDSHIP

In late 2006, Council appointed an ad hoc Committee on Privacy and Data Stewardship in response to the growing diversity of information management issues surrounding medical records.

The Committee's mandate is to explore the complex issues associated with data stewardship as it pertains to health care, and develop policy guidelines for the profession that consider the many legal, ethical and best practice considerations of managing health information electronically.

The new policy will be of considerable benefit to those physicians who use electronic technology to manage health information. More details about the guidelines will be forthcoming in the months ahead.

COMMITTEE REPORTS: STUDENTS JOB-SHADOWING M.D.S

The Committee had an inquiry from a physician who wondered whether it was appropriate for high school students on work experience programs to attend at a doctor's office and in hospitals.

Preamble: In 1998, the Ethical Standards and Conduct Review Committee drafted guidelines, which allowed limited job shadowing of physicians by high school students. While the guidelines were outlined in the *College Quarterly*, they were not included in the Committee minutes, nor were they formally endorsed by Council.

In recent years, youth work experience programs have become more prevalent. With increased inquiries from both the public and physicians, the College has recognized that job shadowing poses significant concerns about patient confidentiality and privacy since students cannot adequately be held accountable to any sort of confidentiality agreement following the observation.

The College, therefore, does not support the practice of job shadowing by students in a physician's office, clinic or a hospital setting. Students who are enrolled in a regulated health professions program can be considered for job shadowing as part of their curriculum. As in any third party observation, physicians must obtain consent from their patients prior to the shadowing.

Specifically, Council regards the following:

- A student may not be present at confidential interviews or during any examination;
- A student may not have any direct patient contact, irrespective of consent;
- A student may not be present in the operating room.

LONDON, ENGLAND

BEING BETTER PREPARED TO PRESCRIBE

There has been a good deal of recent coverage in the news media around the possible need for doctors to be better prepared to prescribe drugs when they qualify. Despite the enthusiasm with which the claims have been made, robust evidence linking education and training to errors in prescribing is fairly sparse and what does exist suggests that the problem is multi-factorial.

For example, when 41 junior doctors in a London hospital were interviewed in 2002 about prescribing errors they had made, they provided a total of 182 causes, with many occurring repeatedly. Inadequacies in training were specifically cited by 6 of the 41 doctors. Other factors included the working environment (the commonest single cause), poor communication, being asked to do something beyond their reasonable competence and, worryingly, poor health.

A guide to the relative importance of prescribing errors in the community (but not in hospitals) comes from a study in Liverpool in 2001/02 which found that among 18,820 emergency admissions, 107 or 0.6 percent, were the result of 'definitely avoidable' adverse drug reactions.

The General Medical Council (GMC) has obviously taken a strong interest in the recent claims of a link

between education, training and poor prescribing and convened a meeting to discuss the subject on Jan. 24. Those attending and presenting their views included representatives from the Audit Commission, Audit Scotland, British Pharmacological Society, medical schools, postgraduate deans, BMA junior doctors and medical students committees, as well as a medical director.

It was a very constructive and interesting meeting. While the lack of evidence was accepted by all, there were interesting themes in the anecdotes that were presented. For example, many errors by junior doctors seem pretty basic and more to do with human error than a lack of knowledge of drugs and their effects. This can happen when you think you know the dose but get it wrong or very basic arithmetical errors arise in calculating doses where these need to be adjusted, for example in patients with impaired kidneys. The lack of a single format for prescription cards throughout NHS hospitals was emphasised as an important factor. It was also noted that the level of supervision of newly qualified doctors may not be as close as was once the case.

The GMC is taking two steps specifically to address the concerns that have been raised. First, we feel it is important to get the facts, because these are singularly lacking. We are funding the initial stages of a study specifically examining the prevalence and causes of prescribing errors – not simply among junior hospital doctors but also consultants and those in general practice. This should begin in autumn 2007. Prescribing errors by doctors later in their careers would clearly be a matter that can be addressed through continuing medical education and revalidation. Second, we will facilitate a working group of all interested parties to look at practical steps that might be taken to address the anecdotal examples of human error that seem to be a factor in junior doctor prescribing. It was noted the GMC's guidance on this subject, for the undergraduate curriculum and the first Foundation year, is already quite extensive. It might be more fruitful to address behaviors and systems rather than simply knowledge, particularly by focusing on the F1 shadowing and induction periods.

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GOVERNMENT WHITE PAPER — THE GMC RESPONSE

The GMC has issued its response to the Government White Paper on health care regulation published earlier on Feb. 21, 2007. GMC President, Sir Graeme Catto, said: "This is an important day for both patients and doctors.

"We agree with the Government and with the Chief Medical Officer for England that the White Paper provides the basis for a lasting settlement in relation to professional regulation.

"We are particularly delighted that the White Paper incorporates so many of the proposals we published in November 2006. They were designed to ensure a regulatory system that commands the confidence and support of all those who receive and provide health care.

- The Secretary of State has recognized the importance of our statutory role in controlling entry to the register and the standards for entry. We are pleased that our model of interlocking functions has been endorsed. This includes our three board model for education training, which would bring together the coordination of all stages: undergraduate, postgraduate and continuing professional development.
- An extension of our role in defining and assuring standards of practice.
- We suggested in 1998 that there should be a system of 'revalidation' of doctors. We are looking forward now to being able to begin re-licensing and re-certification as soon as practicable. We will build on our existing strong relationships with the medical Royal Colleges as the custodians of specialist standards to deliver this.
- To ensure public confidence, we believe the GMC must be seen to be independent. In our package of proposals on health care professional regulation, we suggested that the composition of the council should be changed to ensure a balanced membership with equal proportions of medical and lay members. We also support clear accountability to parliament.
- We have already agreed to introduce the civil standard of proof flexibly applied and will implement this when the appropriate legislation has been passed.
- This White Paper proposes a major extension of the GMCs role in developing GMC 'affiliates.' This is a bold proposition and we will participate fully in its development. The vast majority of doctors in this country are good doctors delivering high quality health care under demanding circumstances. However, a small minority are not; and we are determined to work closely with local health care management on the early identification of problems and on appropriate remedies, to ensure patient safety is enhanced.

"The White Paper confirms the GMC will be the sole investigating authority for serious complaints against doctors. The GMC sets the standards that determine whether a doctor loses their licence. Under these proposals the GMC will now gain a right of appeal which we have long sought over cases where we consider a decision is too lenient.

"The White Paper says an independent body should carry out the adjudication of cases. This is an incremental change: We have already introduced independent panels. This goes a step further. We will now work constructively to achieve a smooth transition to the new arrangements.

"The GMC has already undertaken a very significant programme of reform. However, there is more to do. Regulation is a dynamic process — it should not stand still. It must be scrutinised, challenged and improved to take account of our changing society and the changing health care environment.

"Our priority now is to end the uncertainty for patients and doctors. We believe we can do that. We look forward to working with all those who must be placed at the heart of the regulatory system — patients and the public, doctors, the medical schools and Royal colleges, the NHS and other health care providers. In November 2006 we argued for an independent and accountable system of medical regulation that would:

- Put patient safety at its heart
- Be independent of government as the dominant health care provider and independent of dominance by any single group.
- Provide an integrated regulatory framework based on the GMC's four interlocking functions: controlling entry to the medical register; setting standards for medical education and training; determining the principles and values that underpin good medical practice; and taking firm but fair action against doctors when those standards have not been met.
- Ensure that professional regulation and workplace regulation connect in a coherent manner that reflects their distinct but complementary roles.
- Be objective, fair, accessible and transparent so as to command the confidence and support of those receiving and providing health care.
- Be suited to the local context in all four UK countries.

"The four inquiries tragically demonstrated what can go wrong when a tiny number of doctors depart from the high standards that are rightly expected of them.

"We believe that the proposals in this White Paper provide the basis for effective regulation in the future."

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 your articles and news releases to Edward Pittman at editor@journalonline.org or send via fax to (817) 868-4098.