College of Physicians & Surgeons of Alberta

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June 11, 2014

The Honorable Fred Horne
Minister of Health
208 Legislature Building
Edmonton, AB T5K 2B6

Dear Minister Horne:

Response of the College of Physicians & Surgeons of Alberta to the Health Quality Council of Alberta Continuity of Care Recommendations

I am pleased to present you with the position of the Council of the College of Physicians & Surgeons of Alberta (CPSA) with respect to the recommendations from the Health Quality Council of Alberta (HQCA) report on continuity of care, arising from its review of the circumstances surrounding the death of Greg Price, a young man with testicular cancer

I will speak directly to those recommendations that specifically task or are aimed at the CPSA. For simplicity I have paraphrased some of the recommendations.

Recommendation #2 – CPSA amends its *Standards of Practice* related to coordination and provision of services so that a request for specialist consultation, diagnostic imaging studies or invasive procedures would be tracked by both the referring physician and the service provider so that both parties – and the patient – are aware of the request, the details of the appointment and the outcome (findings). This is all about ensuring completion and documentation of critical steps in the referral and consultation process.

The CPSA is supportive of the goal of this recommendation and has no particular concerns with the recommendation, recognizing that its implementation will be greatly enhanced by an electronic referral system (as per recommendation #1).

Recommendation #3 – The Alberta Society of Radiologists (ASR) work with CPSA and AHS to develop policies and procedures to support radiologists expediting the care of patients with "time-sensitive" health conditions to directly order the next logical DI test and/or directly refer the patient to a clinical service when

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that expertise is needed. The recommendation adds that "this should be - emphasis mine - accompanied by discussion with the patient and notification to the referring physician about what actions the radiologist has taken".

The College has concerns about this recommendation, especially the part about radiologists initiating the next referral for care (as differentiated from initiating the next diagnostic imaging step) in the absence of a discussion with the primary provider. In short, the CPSA does not condone radiologists proceeding to order or initiate further treatment for a patient without consulting with the physician who ordered the diagnostic imaging consultation.

Council questioned whether radiologists are always sufficiently aware of a patient's clinical circumstances to proceed without consultation with the next appropriate diagnostic test, recognizing that there are some situations (e.g., a woman with an abnormal mammogram for whom the next test should be an US) which are obviously in the patient's best interest (low cost; low risk) and should be done. We recognize that our position places an onus on the radiologist to consult with the ordering physician that can only be realized when there is ready and easy access to the ordering physician. The CPSA will continue its discussions with the ASR, AHS and others towards the goal of a provider registry to address that solution to the problem.

The issue of defining "time-sensitive" conditions will be discussed separately.

Recommendation #5 – The CPSA amend its *Standards of Practice* to ensure that patients with "time-sensitive" health conditions know who the most responsible physician is; that the most responsible physician be available to deal with complications; that availability be defined not only for after-hours care but for weekday care; and that the transfer of responsibility be a formal process between providers.

While recognizing the need to identify the most responsible physician (MRP) within the hospital setting, we are less sure that doing so in the community setting is valuable. This is not to say that physicians and other providers should not be clear about their roles and responsibilities, and that patients should be unaware of those roles and responsibilities. The issue in the community is often that there is shared responsibility – the question is less that of who is most responsible but rather who is responsible for what. Those responsibilities should be clear to the patient and other physicians (and other providers) involved in

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the patient's care and, if it is not clear, it should be made clear between the parties. Our current standard of practice on the referral /consultation process says that is what should happen. The College, therefore, does not agree that an amendment to its standard of practice is required to address the question of most responsible physician.

The College believes that medical ethics (including explicit statements in the CMA *Code of Ethics*) and current standards of practice oblige the treating physician or his/her designate to be available to handle complications. We question whether another statement of professional responsibility is the correct mechanism by which we would ensure that physicians are available for their patients – especially for those with urgent issues, like a post-procedural complication – not only after-hours but during the working week as well. Rather, we believe that a process to ensure that physician practice is compliant with current requirements (see below) is more likely to be successful.

Recommendation #6 – That the AMA in collaboration with various organizations, including the CPSA, defines physician commitment to patients with "time-sensitive" health conditions.

The College seriously questions how realistic and successful the effort to define "time-sensitive" will be. We question how consistent such a definition would be across disciplines and medical specialties, and we question how acceptable the definition will be to patients. Is a "time-sensitive" condition the same in acute care as in long-term care? Is a "time-sensitive" condition the same for a 40 year old healthy woman and a 90 year old man with severe dementia? If this recommendation is to be pursued, we would suggest that individual specialty groups identify "time-sensitive" conditions within their own specialty area. How we address inconsistencies or disagreement is unresolved.

Recommendation #8 – That the CPSA develop a process to proactively monitor members' compliance with its after-hours care standard.

We agree that all members who provide clinical care to patients must meet this standard of practice, but our Council sees the issue of compliance as a broader question: How to ensure our members are aware of and have implemented practices to be compliant with all our standards? To this end, the Council has directed staff to include within our definition of competence the knowledge of and adherence to the CPSA *Standards of Practice*. While the mechanism by

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which this requirement will be implemented is yet to be determined, we expect it to require a formal inspection of members' practices against those standards of practice that can be directly observed or measured.

Recommendations 11, 12 & 13 – all relate to the role and functioning of the Office of the Chief Medical Examiner. As Medical Examiners are members of the CPSA, Council found it appropriate to comment on these recommendations. In short, the College supports all three recommendations.

The CPSA appreciates the work of the HQCA in investigating the tragic death of Greg Price. Its report and recommendations has had a profound influence within Alberta and nationally. While we do not agree with all the specifics contained within the HQCA recommendations, we are committed to addressing the issues of continuity of care identified within this report.

Respectfully submitted,

T.W. Theman, MD, FRCSC
Registrar

c. HQCA: Ms Patricia Pelton, Acting CEO, Dr. Tony Fields, Board Chair, Dr. Ward Flemons, Senior Medical Consultant; Dr. Verna Yiu, AHS; Dr. Lyle Mittelsteadt, AMA; Mr. David Price, Alberta Society of Radiologists; CPSA Councillors