COLLEGE OF PHYSICIANS AND SURGEONS OF NEWFOUNDLAND AND LABRADOR

CPSNL NOW

VOLUME 2, ISSUE 1 FEBRUARY 2009

Medical professionalism in the new millennium: a physician's charter

The Council of the College recently accepted the Physician's Charter as forming part of the ethical foundation of medical practice in Newfoundland and Labrador.

Developed by an international team of physicians in 2002, the Charter provides an ethical framework for the profession that applies across national and cultural borders in a time of rapid social, professional and technological change..

Following is the complete text of the Charter.

Preamble

Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession.

At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this charter in the form of three fundamental principles and as a set of definitive professional responsibilities.

Fundamental principles

Principle of primacy of patient welfare. This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

Principle of patient autonomy. Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' deci-

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sions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.

Principle of social justice. The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

A set of professional responsibilities

Commitment to professional competence. Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal.

Commitment to honesty with patients. Physicians must ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on the course of therapy. Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide the basis for appropriate prevention and improvement strategies and for appropriate compensation to injured parties.

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information. This commitment extends to discussions with persons acting on a patient's behalf when obtaining the patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever before, given the widespread use of electronic information systems for compiling patient data and an increasing availability of genetic information. Physicians recognize, however, that their commitment to patient confidentiality must occasionally yield to overriding considerations in the public interest (for example, when patients endanger others).

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purpose.

Commitment to improving quality of care. Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Physicians, both individually and through their professional associations, must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

Commitment to improving access to care. Medical professionalism demands that the objective of all health care systems be the availabil-

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ity of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.

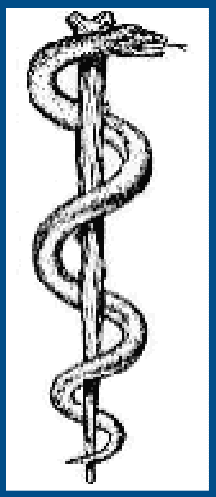
Commitment to a just distribution of finite resources. While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals, and payers to develop guidelines for cost-effective care. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one's patients to avoidable harm and expense but also diminishes the resources available for others.

Commitment to scientific knowledge. Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience.

Commitment to maintaining trust by managing conflicts of interest. Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including medical equipment manufacturers, insurance companies, and pharmaceutical firms. Physicians have an obligation to recognize, disclose to the general public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determine the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

Commitment to professional responsibilities. As members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards.

The profession should also define and organize the educational and standard-setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.



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Council Notes

Janet Gardiner

Council member honoured

Council member Janet Gardiner received the J.D. Eaton Alumni Award for service to Memorial University from the university alumni association in October.

The award recognizes exceptional leadership and outstanding service to the university.

As the alumni association citation noted:

"Janet Gardiner is no stranger to trailblazing. She is the first woman in Newfoundland to earn her chartered accountant designation and was accepted as a member of the Newfoundland and Labrador Institute of Chartered Accountants in 1956. She was awarded the Fellow of the Institute honour in 1992. She has been actively participating in the Institute's affairs for over 50 years. Janet spent most of her career working with the family firm Chester Dawe Limited and has sat on countless boards including Fishery Products International, Newfoundland & Labrador Hydro, CNLOPB, and Mutual Life of Canada. She was inducted into the Atlantic Hall of Fame for Women Entrepreneurs in 1995 for her ability to overcome barriers and for inspiring women entrepreneurs in the region.

"But Janet has done a lot more. Tirelessly supporting Memorial University, she has served for six years as the Chair of Memorial University's Board of Regents, the first woman in that position. As a generous supporter of the Faculty of Business Administration, she has answered a call for help countless times, sitting on its advisory board for almost 20 years, preparing students for case competitions, reviewing business plans and playing a key role on the Entrepreneur of the Year Award selection committee."

Council members join with the university alumni in congratulating Janet Gardiner on her exceptional leadership and outstanding service to the community.

Council Election Results

Nominations for three elected council positions closed on September 19, 2008.

Nominations were received for Dr. Barbara Grandy, Dr. William Moulton and Dr. Vinod Patel.

All were elected by acclamation.

Appointments

Council approved two appointments at its September meeting.

At the request of the **Complaints Authorization Committee (CAC),** Council approved the appointment of **Mr. John White**, a public member of council, to the CAC.

Under the *Medical Act 2005*, the CAC comprises at least three Council members, one of whom is a public member.

CAC members are:

Dr. Barbara Grandy, chair
Dr. John Collingwood
Dr. Martin Hogan
Mr. Rick Fifield
Mrs. Janet Gardiner
Mr. John White

Council also approved the appointment of **Dr. Marie Fagan-O'Dea** to the **Discipline Panel.** The panel consists of 15 members, 10 of whom are appointed by Council and five appointed by the Minister of Health and Community Services.

Three members of the panel are selected to comprise an adjudication tribunal which will hear complaints referred to the panel by the CAC.

Strategic Planning

The Council will hold a two day strategic planning session early in 2009 to lay out a long-term plan for the College.

Discussions are underway with Erik Lockhart, associate director of the Queen's University School of Business Executive Decision Centre to facilitate the session.

Quality Assurance

The College will be facilitating two professional development sessions in 2009 delivered by representatives of the College of Physicians and Surgeons of Ontario.

Physicians Prescribing Skills is a one day course designed to assist physicians in acquiring knowledge of addictive behaviours and developing new skills in the field of pain management., especially chronic non-malignant pain.

Medical Record Keeping by Physicians is a one day course aimed at office-based practitioners. It describes different methodologies for good record-keeping, clarifies the many medical and legal reasons for keeping good records and demonstrates

Council Notes

the benefits of good records for both physician and patient in the provision of quality medical care.

Further information on the course locations and costs will be distributed to members as it becomes available.

Two members of the College will be trained to deliver these courses through the College in the future. This allows the College to offer these courses locally as often as needed and at lower cost.

Task Force on Adverse Health Events

On May 26, assistant registrar Dr. Cathy Vardy and communications director Ed Hollett attended a one day workshop on adverse health events organized by the Task Force on Adverse Health Events.

The workshop brought together health professionals and administrators from across the province as part of the task Force's efforts to develop a common approach to the reporting and management of adverse health events.

The College also submitted a brief to the Task Force that discusses the College's role in and views on adverse health events.

Further information on the Task Force, including the workshop sessions can be found at http://www.gov.nl.ca/ahe/default.htm.

Orientation Guide

Work is nearing completion on a revised orientation guide and orientation process for new applicants to the College for licensure.

Developed by the College and the Professional Development and Continuing Studies Centre at the Faculty of Medicine, the new process will include a guide covering major topics related to medical practice in Newfoundland and Labrador and two self-directed, online learning modules (prescribing and communications).

The guide contains a short summary of key topics and links to further reading. It will be available as a pdf document for easy distribution via the Internet and e-mail.

The guide and new process are part of a larger effort by Physician Recruitment in the province aimed at international medical graduates.

The guide is applicable to all new applicants for licensure and can serve as a handy reference for all physicians.

New Policy on Boundary Violations and Misconduct of a Sexual Nature

Council has adopted a new policy on boundary violations and sexual misconduct.

Every physician - patient relationship is a relationship of trust, where the physician is in the position of the trusted person on whom the patient is dependent.

It is the responsibility of the physician to recognize the boundaries to a doctor - patient relationship and to avoid boundary violations.

It is the responsibility of the physician to recognize that patient participation in or purported patient consent to boundary violations does not lessen a medical practitioner's responsibility to avoid boundary violations.
The College views boundary violations as a continuum, encompassing non-sexual acts and abuse as well as acts and abuse of a sexual nature.

Some acts may be, in their context, a boundary crossing which, if an isolated incident, may be a matter that can be addressed by advice.

However, by way of this new policy, the College is stating its position that allegations of boundary violations, whether of a sexual or non-sexual nature, will be the subject of investigation by the College, and if proven may be the subject of disciplinary measures.

The College categorically states that sexual involvement between a medical practitioner and his/her patient is never acceptable.

The complete policy is available online at www.cpsnl.ca.

Dates to Remember

Feb 28
Physician Prescribing Skills Course

TBD
Medical Record Keeping

June
Annual General Meeting

Fentanyl transdermal patch and fatal adverse reactions

Marielle McMorran, BSc, BSc(Pharm)

Maria Longo, BScPharm,

The fentanyl transdermal system is indicated for the management of moderate to severe chronic pain that cannot be managed by other means such as opioid combination products or immediate-release opioids.[1] The safety of this system is contingent on its use according to the conditions recommended in the Canadian product monograph.[1] The fentanyl transdermal system has been marketed in Canada under the brandname Duragesic since 1992. In July 2006, 2 generic products were introduced: Ratio-Fentanyl and Ran-Fentanyl transdermal systems.

Health Canada continues to monitor reports of serious adverse reactions (ARs) suspected of being associated with fentanyl transdermal patches. Fatal outcomes were previously described in this newsletter involving opioid-naive adolescents and adolescents who abused this medication.[2,3] The Canadian product monograph for Duragesic was revised in 2005 to emphasize safety information following reports of death related to inappropriate use of this product. Related advisories were issued in September 2005.[4,5] Numerous publications have highlighted safety issues related to the use of fentanyl patches.[6-9]

From Jan. 1, 1992, to Dec. 31, 2007, Health Canada received 105 reports of ARs suspected of being associated with fentanyl transdermal patches wherein a fatal outcome was reported. Twenty-seven of the reports were received after the last Health Canada risk communications.[4,5] As part of the ongoing monitoring of AR reports, the data were analyzed to identify potentially preventable incidents and to increase awareness regarding the safe use of this product. In 33 of the 105 reports, the cause of death was reported to be unrelated to the fentanyl transdermal patches; in 20 cases, insufficient information was provided in the report for evaluation. The remaining 52 reports are summarized in Table 1 [Page 7].

Health care professionals are reminded to follow the directions in the product monographs for fentanyl transdermal patches.[1] Guidance on the safe use of this product is essential for patients, caregivers and their families, including the safe storage of fentanyl patches to prevent their accessibility for abuse and prevention of accidental overdose.

References

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2. Raymond B, Morawiecka I. Transdermal fentanyl (Duragesic): respiratory arrest in adolescents. *Can Advers Reaction News* 2004;14(4):1-2.

3. Raymond B. Trandermal fentanyl (Duragesic): abuse in adolescents. *Can Advers Reaction News* 2005;15(3):1.

4. *Duragesic (fentanyl transdermal system) safety information* [Dear Health Care Professional letter]. Ottawa: Health Canada; 2005 Sept 13. (accessed 2008 Jun 3).

5. *Duragesic (fentanyl transdermal system) safety information* [public advisory]. Ottawa: Health Canada; 2005 Sept 16. (accessed 2008 Jun 3).

6. Transdermal fentanyl: a misunderstood dosage form. *ISMP Canada Safety Bull 2006;6(5)*.

7. Fentanyl patch linked to another death in Canada. *ISMP Canada Safety Bull 2007;7(5)*.

8. *Ongoing, preventable fatal events with fentanyl transdermal patches are alarming!* Horsham (PA): Institute for Safe Medication Practices; 2007 June 28.

9. *Fentanyl transdermal system (marketed as Duragesic and generics) information for Healthcare Professionals*. Rockville (MD): US Food and Drug Administration; 2007 Dec 21. (accessed 2008 Jun 3)

Acknowledgement:

Health Canada acknowledges the collaboration with Sylvia Hyland, RPh, BScPhm, MHSc (Bioethics), of the Institute for Safe Medication Practices Canada (ISMP Canada) and member of the Expert Advisory Committee on the Vigilance of Health Products, in the analysis of this data and preparation of this article.

Reprinted from the *Canadian Adverse Reaction Newsletter,* volume 18, issue 3, July 2008.

Table 1: Summary of reports of 52 adverse reactions with a fatal outcome suspected of being associated with fentanyl transdermal patches submitted to Health Canada from Jan. 1, 1992, to Dec. 31, 2007*,†

Factors related to adverse reaction (AR)	No. of AR reports	Additional Information
Dose initiation and titration	6	Prescribed to opioid-naive patient (3 cases). Initiation dose high (1 case). Dose titration too quick (2 cases)
Concomitant use with other central nervous system (CNS) depressants	1	Death occurred within 24 hours after initiation of 100-µg/h fentanyl patch. Cause of death reported as probable central nervous system depression due to combination of fentanyl with other CNS depressants
Drug interaction between fentanyl and CYP3A4 inhibitor	1	Death occurred less than 4 days after initiation of lopinavirBritonavir (Kaletra), a CYP3A4 inhibitor, during fentanyl therapy
Application of patch by patient	6	Patient applied more patches than prescribed (4 cases). Patient left old patches on when applying new patch (1 case). Patient changed patch every day instead of every 3 days (1 case)
Application of patch by caregiver	3	Health care professional folded patch in half in attempt to reduce dose (1 case). Health care professional left old patches on when applying new patch (1 case). Caregiver damaged patch by pressing on it because it would not stick; fentanyl gel leaked and patient died of accidental overdose overnight (1 case)
Use of patch prescribed for another patient	1	To treat back pain, a 64-year-old man applied a 50-µg/h fentanyl patch that had been prescribed for his spouse. The patient was found unresponsive, having vomited and aspirated, and died 5 days later from pneumonia and renal failure
Accidental overdose or overdose effect	5	Patient was elderly and had lean body weight (1 case). Patient died of cardiac arrhythmia due to accidental overdose of fentanyl and elevated levels of antidepressant (1 case). Patient found dead with toxic level of fentanyl after second dose of 25-µg/h patch (1 case). Limited information provided in 2 cases
Intentional overdose or suicide	4	
Intentional drug abuse	25	Cases described abuse of fentanyl patches

*** These data cannot be used to determine the incidence of adverse reactions (ARs) because ARs are underreported and neither patient exposure nor the amount of time the drug was on the market has been taken into consideration.**

† The analysis is based on the information as reported in the cases.

"One problem per visit" not the solution

Demand for physician services continues to climb.

In an effort to manage their practices, some physicians are posting signs restricting patients to one problem per visit.

Such restrictions may cause patients to feel that their problems are not being attended to in a timely manner when they see their doctor.

Moreover, some patients who have transportation issues or other accessibility difficulties - in particular, the elderly - may "save up" their complaints for one visit.

Restricting such patients to one symptom might be construed as discrimination.

At the same time, it is widely recognized that patients who present with multiple complaints create an increased workload and patient backlogs in bustling clinical practices.

Managing a busy practice and maintaining a patient-centered approach is challenging, and is an issue that is being addressed across the country.

Recently, the Alberta College of Physicians and Surgeons issued a bulletin on the implications of limiting patients to one complaint per visit.

The Alberta College's position, endorsed by the College of Physicians and Surgeons of Newfoundland and Labrador, indicates there are more acceptable methods to use when faced with patients who present with a list of issues.

Patients are not always able to determine which symptoms or concerns may reflect a significant problem. Some patients may interpret one problem per visit to mean one symptom per visit. This may lead to inadequate diagnosis and treatment.

Therefore, instituting a rule that a patient can report only one concern may not only upset the patient, it may also compromise patient care.

The College advises that rather than posting "one problem, one visit" signs, physicians should use common sense and good communication when approaching the issue.

Physicians should determine at the outset if there are multiple concerns and then courteously explain that it may not always be possible to address every concern raised in a single visit.

The physician will then be in a position to deal with the most significant issue or issues, and ask the patient to book another visit so that the proper time and attention can be paid to concerns that are less urgent.

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 instantly. 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 always take into consideration the patient's best interests.

Physicians should remain open and flexible so that serious matters can be prioritized and appropriately addressed in a timely fashion.

Let us know...

Problem?

Concern?

Complaint?

Praise?

We'd like to hear from you.

You can contact the College at 709-726-8546, fax at 709-726-4725 or by e-mail at cpsnl@cpsnl.ca.

Our toll-free line for complaints is 1-800-563-8546.