REVIEW OF Physicians Licensure

BY THE COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

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GENERAL BACKGROUND

The provision of optimally safe, effective, and high quality health care services in the twenty-first century is reliant upon appropriate public policy, funding, facilities, technology, and a diverse array of skilled personnel.

The health care workforce in Alberta includes more than 30 different groups of regulated health professionals. All of these professionals, including physicians, are regulated under the Health Professions Act. This legislation delegates to professionally lead statutory agencies both the power and responsibility to regulate health professionals in a manner that serves the interests and needs of the public.

The Health Professions Act defines certain regulatory functions that must be sustained by each of the statutory professional regulatory agencies created under the Act. In respect to some regulatory functions, such as the investigation of complaints against a member of a regulated profession, the Health Professions Act is prescriptive in respect to how such regulatory processes will be conducted. In respect to some regulatory objectives, the professional regulatory agencies are accorded some discretion in respect to the processes they adopt to achieve those objectives.

Some professional regulatory agencies in the health sector elect to create and sustain public protection and health care quality enhancement initiatives beyond those mandated by the Health Professions Act.

The College of Physicians & Surgeons of Alberta (CPSA) is the statutory agency that regulates physicians in Alberta. The CPSA was established by the government of the Northwest Territories before the province of Alberta was established in 1905. The legislation and regulations governing the CPSA have changed considerably over this period of time. The nature and intensity of the CPSA’s regulatory work has also changed remarkably as the complexity of medical practice has evolved.

Through the first third of the twentieth century most medical practice was based upon a common foundation of knowledge and skills. With the explosion of new knowledge and new technologies, the medical profession now includes some 63 distinct specialty and sub-specialty disciplines. The task of ensuring the initial and continuing professional competence of such a diverse medical workforce is challenging.

The CPSA currently regulates 7,706 active resident physicians of whom 359 are specialist radiologists and 192 are specialist pathologists.

The subspecialties in radiology include pediatric radiology, neuro-radiology, and interventional radiology.

The subspecialties in pathology include general pathology, anatomical pathology, haematological pathology, neuropathology, and forensic pathology.

PURPOSE & SCOPE OF REVIEW

The purpose of the Alberta Assurance of Medical Quality Initiative is to confirm that practicing radiologists and pathologists in Alberta have the appropriate credentials and experience to interpret diagnostic tests. The two main components of the review are:

1) To ascertain if any radiologist or pathologist is engaged in practice activities that either the College of Physicians & Surgeons of Alberta (CPSA) or Alberta Health Services (AHS) have not authorized, and
To assess the rigor and effectiveness of the procedures followed by the CPSA and AHS (as well as other organizations that grant physicians practice privileges) to ensure that all radiologists and pathologists are practicing within their scope of competence.

**APPROACH**

My approach to the review is to follow three steps:

1) **STEP 1**: A review of policies, procedures, and data at the CPSA that are relevant to the purpose of the initiative and provision of an opinion regarding the effectiveness of the CPSA’s efforts to ensure the initial and continuing competence of radiologists and pathologists that the CPSA licenses.

2) **STEP 2**: A review of policies, procedures, and data of the AHS that are relevant to the purpose of the initiative and provision of an opinion regarding the effectiveness of the AHS’s efforts to ensure that radiologists and pathologists have the requisite competencies to match the practice privileges granted to them by the AHS initially and on an ongoing basis and that they are practicing within their current scope of competence.

3) **STEP 3**: A review of the inter-agency collaboration between the CPSA and AHS to ensure that radiologists and pathologists are always practicing within their current scope of competence and to offer recommendations for potential enhancement of the public protection effectiveness of these agencies through greater collaboration.

**BACKGROUND INFORMATION ABOUT EFFECTIVE MEDICAL REGULATION**

Under Canada’s constitution the authority and responsibility to regulate all professionals is vested in provincial and territorial (P/T) governments. The legislation enacted by the P/T legislatures to discharge this responsibility varies considerably across the country.

With respect to the regulation of physicians, there is a small national organization known as the Federation of Medical Regulatory Agencies of Canada (FMRAC) which strives to encourage common pan-Canadian medical regulatory strategies. However FMRAC has no authority to establish or enforce national medical regulatory standards.

Eligibility for medical licensure in Canada is significantly credential-based, so the credentials issued by national agencies such as the Medical Council of Canada (MCC), the College of Family Physicians of Canada (CFPC), and the Royal College of Physicians and Surgeons of Canada (RCPSC) do support pan-Canadian uniformity of medical licensure polices, particularly for physicians who complete all of their undergraduate and post graduate medical education in Canada.

The credentials issued by the MCC, CFPC, and RCPSC are not as helpful in supporting uniform medical licensure policies across Canada in respect to international medical graduates (IMGs). Until quite recently, IMG medical licensure policies and practices across Canada have varied widely. In the wake of a decision by the P/T Premiers two years ago to eliminate all inter-jurisdictional barriers to physician
mobility in Canada, FMRAC had led an initiative to foster common standards for IMG assessment and licensure. Individual medical regulatory authorities (MRAs) vary in their compliance with the “FMRAC Agreement” as complete compliance still requires statutory and regulatory amendments in many jurisdictions.

While all MRAs are statutorily obligated to determine which physician applicants are eligible for initial and continuing licensure, the range of other programs and services operated by MRAs across Canada varies enormously. Some of these programs and services yield important information about the actual performance of physicians in practice. Some also serve to continually improve the professional performance of all physicians. Such MRA programming is relevant to this review because such programs enable MRAs to make more evidence-based decisions about the continuing competency of physicians and their continuing fitness for practice.

In respect to the capacity of MRAs to initiate and sustain programming that goes beyond the minimum statutory requirements, organizational size does matter. MRAs rely almost exclusively upon annual medical licensure fees to sustain their operations. The fixed costs of sustaining statutorily mandated activity may consume almost all of the resources of the very small MRAs.

However, organizational size alone is not the only determinant of the range of programming sustained by MRAs. Much is determined by each MRA’s sense of societal obligation to protect citizens from preventable harm associated with medical care and to optimize the safety and quality of that care. Some MRAs have a much bolder vision of what they might do to make medical care safer and higher quality and they set higher annual medical licensure fees to enable them to do this work. Some also pursue innovative contracting arrangements with Ministries of Health and/or regional health authorities to operate systemic quality assurance (QA) and accreditation programs on a cost recovery basis.

One of the principles of effective medical regulation is that the intensity and rigor or regulatory effort ought to be proportional to the risk of patient harm associated with various medical practices and procedures. I will offer more focused commentary on the implications of this principle to the services provided by radiologists and pathologists.

RESPONSIBLE MITIGATION OF RISK OF HARM ASSOCIATED WITH DIAGNOSTIC IMAGING AND PATHOLOGY SERVICES

Among the spectrum of services provided by all of the regulated health professionals, those provided by physicians carry some of the greatest potential for benefit to critically ill people and the greatest potential for preventable harm. An ineffective session of massage therapy may be disappointing. An unsafe invasive medical procedure may be lethal.

Within the diverse spectrum of professional services offered by physicians, there is highly variant risk of preventable harm, especially from single physician services. A less than satisfactory visit with a family physician may certainly carry attendant risk of patient harm. However there may be options to mitigate that risk through a more satisfactory follow up visit with the same physician, consultation with another physician, consultation with another health professional, or self-directed learning about the health issue at hand via the Internet.
For many physician services, the patient gets to select the physician they will access. The nature of the service may allow patients to make a well informed judgement about the quality of the service. There may be options for patients to obtain another opinion.

With respect to the medical services provided by radiologists and pathologists, patients rarely have these options. They don’t get to choose the radiologist or pathologist who will interpret their diagnostic imaging (DI) studies or tissue/liquid specimens. They have virtually no capacity to assess the quality of the interpretation. And, apart from the most assertive and sceptical patients, the option of asking for a second opinion from another radiologist or pathologist on the same DI study or tissue slide is rare.

When patients have little or no capacity to detect risk of harm from a medical service and to mitigate that risk through their own actions, persons and agencies responsible for protecting patients from such harm have a commensurately greater obligation to ensure that such services are safe.

Optimally vigilant medical clinicians ought always to consider a report from a radiologist or pathologist in the context of a patient’s clinical presentation and should not be hesitant to review the studies with their colleague or to ask for a second opinion from another radiologist or pathologist. However, the increasing complexity of the technology in medical diagnostic services has decreased the frequency with which clinicians might review a study with a radiologist and most clinicians have little capacity to interpret what a pathologist looks at down a microscope. So, the interpretation reports issued by radiologists and pathologists are often accepted by clinicians and patients as infallible when they are not.

One of the critical success factors in making these vitally important diagnostic services safer is an acknowledgement that there can and will be reliability failures in these services. Effective public safety regulation demands that MRAs participate actively in the review of such failures and make changes in their current policies and procedures to mitigate future risk of such failures.

**REVIEW OF THE CPSA**

My review of the CPSA as Step 1 of the Alberta Assurance of Medical Quality Initiative included the following procedures:

1) Review of the following information:
   a) *The Health Professions Act* of Alberta and regulations under that Act
   b) The current CPSA Strategic Plan
   c) CPSA Registration Manual Version 12.1 (updated on February 2, 2012)
   d) Understanding International Medical Education & Speciality Certification Version 1.1 (updated on February 2, 2012)
   e) CPSA Website information about Quality of Care imaging modality review and approval process for all radiologists
   f) CPSA Website information about the CPSA QA & Accreditation programs pertaining to DI and Medical Laboratories
   g) CPSA Website information about the Physician Achievement Review (PAR)
   h) CPSA Website information about Complaints Resolution and Standards of Practice
2) Conversations with Dr. Trevor Theman (Registrar and CEO), Dr. Kate Reed (in her capacity as manager of the CPSA Physician Registration Services), and Dr. Ken Gardener (in his capacity as manager of the CPSA's Quality of Care Programs).

3) Review of both the Phase 1 and Phase 2 Reports issued by Dr. Doug Cochrane on March 9, 2011 and August 31, 2011 from an investigation into Medical Imaging Credentialing and Quality Assurance in British Columbia.

4) Review of comprehensive CPSA registration data pertaining to all of the 359 radiologists and 192 pathologists currently licensed by the CPSA to practice medicine in Alberta.

5) Review of a slide deck prepared by Dr. Doug Cochrane for an educational conference call with Alberta Health and Wellness (AHW), AHS, and CPSA staff on February 9, 2012.

6) Participation in the educational conference call with Dr. Doug Cochrane on February 9, 2012.

I was on site at the CPSA offices in Edmonton on February 7, 8, and 9, 2012, to conduct an audit of the CPSA registration procedures pertaining to all of the radiologists and pathologists currently licensed by the CPSA to practice in Alberta. During my time on site I also had ready access to Dr. Theman, Dr. Reed, and Dr. Gardener to obtain answers to any questions I had about the CPSA's Registration and Quality of Care decisions about registered radiologists and pathologists.

The CPSA has all physician registration information electronically accessible on a state-of-the-art IT system which hugely expedited my capacity to efficiently review the registration files of 551 physicians.

At my request, the CPSA prepared for me a spreadsheet that succinctly depicted key registration information for all of the 359 radiologists and 192 pathologists plus the approvals from the CPSA's Quality of Care division for the imaging modalities that each radiologist was authorized to interpret.

I was also granted access to the CPSA's DOC database which contains very detailed information about each physician’s registration.

To enable me to expeditiously review any source documents that may have played a role in the CPSA’s decision to register any of these radiologists and pathologists and to review information which supported radiologist approvals to interpret specific imaging modalities, I was also granted access to the CPSA's Quest database. The Quest database contains scanned copies of every hard copy registration document that drove CPSA registration decisions made prior to the complete transition of the CPSA to electronic data gathering and storage processes.

Throughout my time on site, the CPSA provided to me a work station with a triple monitor that enabled me to move quickly between the registration data spreadsheet, the DOC database, and the Quest database.

I must note that the CPSA's electronic physician database is the most comprehensive, functional, and pragmatic physician database that I have ever encountered during my career in medical regulation.
THE LENS THROUGH WHICH THE EFFECTIVENESS OF THE CPSA’S POLICIES AND PROCEDURES WERE ASSESSED

Where it is possible, I prefer to benchmark the performance of any organization against credible objective industry standards. It is not possible to do this in respect to medical regulatory authorities (MRAs) in Canada since no mechanism has yet emerged for defining national performance standards for these organizations. FMRAC does offer MRAs an opportunity to participate voluntarily in a pan-Canadian risk assessment process and the CPSA does participate in that process.

In the absence of national performance standards for MRAs, I based my assessment of the CPSA significantly on a quarter century of experience in the domain of medical regulation and a shorter experience in the domain of patient safety and quality improvement.

For over 25 years I served as the CEO of one of the smaller MRAs in Canada. During this interval I also had the privilege of serving in leadership roles with the FMRAC, the MCC, and the Canadian Society of Physician Executives (CSPE). I’ve served in an advisory capacity to the Canadian Patient Safety Institute (CPSI) and Accreditation Canada (AC).

I have also had valuable opportunities to learn about best practices in medical regulation through participation in meetings of the Federation of State Medical Boards (FSMB) and the International Association of Medical Regulatory Authorities (IMRA).

However I believe the lens through which I have assessed the CPSA has been focused more by a decade of service on the governing board of the Health Quality Council of Saskatchewan and my more recent service on the governing council of the Health Council of Canada. These wonderful learning opportunities have helped me to gain a better appreciation for the balance between individual professional performance and systemic factors in optimizing health system safety and quality.

OBSERVATIONS ABOUT THE CPSA PHYSICIAN REGISTRATION PRACTICES

By any metric that one might reasonably apply to MRAs in Canada, the CPSA is a high performing organization. It has a proud history of being the initiator of some of the most impressive medical QA and quality improvement programming in Canada.

A review of the CPSA’s mission, vision, values, and goals provides convincing evidence that this is an organization that is committed to optimizing the safety and quality of medical services in Alberta through both conventional regulatory means and through some very innovative means.
Statements of mission, vision and values can be just words on paper. However the CPSA has demonstrated its commitment to these values by setting the highest annual physician licensure fee in Canada ($1,900) to ensure that it has the resources to deliver on this commitment.

The CPSA has been a leader in Canada in its introduction of innovative programs such as the Physician Achievement Review program. Established in 1999, this program provides performance feedback to physicians from patients, colleagues, and co-workers with the goal of fostering continual improvement in physician performance.

The CPSA also operates impressive Quality Assurance and Accreditation Programs in Diagnostic Imaging and Laboratories, which serve to foster optimally safe high quality medical diagnostic services to all patients in Alberta.

It operates a program to monitor the prescribing of narcotic and controlled drugs with the goal of minimizing harm from inappropriate use of this special group of drugs.

All of these progressive quality assurance and quality improvement program are operated by the CPSA voluntarily and extend beyond the organization's statutory obligations under the Health Professions Act.

Given the energy and resources that the CPSA devotes to these innovative programs, one might question whether equal attention is applied to its most fundamental public protection responsibility of assuring the initial and continuing competence of all of the doctors that it authorizes to practice medicine.

If the CPSA were failing to discharge this most fundamental public protection responsibility, this failure could eclipse the benefits from its progressive programming which extends beyond its statutory obligations. So, I looked very intensely at the rigor of the CPSA’s physician registration policies and practices both in respect to initial registration and annual registration renewal.

I examined the “logic trail” in respect to the initial registration of every radiologist and pathologist currently registered with the CPSA.

The easiest files to review were those of Canadian medical graduates who moved seamlessly through their undergraduate and post graduate education in Canada and immediately after their residency acquired Royal College certification in radiology or pathology. These file reviews took relatively little time.

I then carefully checked the files of radiologists who acquired Royal College certification before 1981 to note if they had any documented evidence of subsequent formal training in the interpretations of computed tomography (CT) and ultrasound images. Similarly, I checked the files of radiologists who acquired certification prior to 1990 to look for documented evidence of subsequent formal training to interpret magnetic resonance images (MRI).

Also relatively easy to review were those registrants who completed their undergraduate education abroad but completed all of their post graduate training in Canada or the United States and promptly acquired Royal College Certification in Canada or board certification in radiology or pathology in the United States.

More challenging was the review of registration files for those radiologists and pathologists who completed most of their post graduate training in the United Kingdom, Ireland, Australia, New Zealand, or South Africa.
The most challenging were files pertaining to registrants who completed post graduate training in countries like Lebanon, Argentina, or China.

In reviewing some of the latter files I had to remain mindful of the fact that medical licensure policy is dynamic and each file needed to be assessed in the context of the licensure policy in force at the time each physician was registered.

At the conclusion of my review I was able to confirm that all of the radiologists and pathologists currently practicing in Alberta were appropriately registered in accordance with the policies that were in force when they were registered.

I then directed my attention to the rigor of the CPSA annual registration renewal policies and practices. Here I again need to provide some historical context.

In the not too distant past, the annual registration renewal process for all physicians in Canada consisted of little more than paying the requisite registration fee for the next year. Over the last decade, the CPSA has moved in concert with most MRAs to inject more rigor into the annual renewal process.

Like most MRAs in Canada, the CPSA now requires that all physicians participate in the “maintenance of competence” program of either the CFPC or the RCPSC as a condition of registration renewal. The CPSA also requires physicians to answer a series of mandatory questions as part of the annual registration renewal process.

The CPSA asks questions about health status of each physician relating to blood borne pathogens, addiction or impairment, and any conditions that may impair judgement, cognition, sensory or motor functions. Where risk of public harm is detected from evidence of untreated physician illness, prompt intervention is taken to ensure that appropriate treatment is implemented and public protection controls are in place.

The CPSA also asks registrants to disclose if they are currently having or ever have been in a sexual or inappropriate sexual relationship with a patient that has not been previously reported to the College.

At the conclusion of my file review for each radiologist and pathologist licensed by the CPSA I was able to confirm with confidence that their initial registration was appropriate and the rigor of public protection procedures applied by the CPSA at the time of annual registration renewal is comparable to that in other Canadian jurisdictions.

GUIDANCE FROM THE CPSA REGARDING SCOPE OF PRACTICE

The Quality of Care division of the CPSA reviews the training and experience of radiologists in the interpretation of images from various imaging modalities and issues approvals for individual radiologists to interpret images from ultrasound, MRI, cardiac CT, echocardiography, and nuclear medicine studies.

To my knowledge the CPSA is the only MRA in Canada that offers such scope of practice guidance in radiology outside the context of accreditation of privately owned DI facilities.

The CPSA does not provide similar guidance with respect to general radiography interpretation or interpretation of CT image other than cardiac CT.
There currently is no information linkage between the CPSA and AHS to ensure that the scope of practice of each radiologist is compliant with the CPSA's approved scope of practice.

CONCLUSIONS

1) Based upon the review described in this report, I can assure the Minister of Health that there are no radiologists or pathologists practicing in Alberta who have not been explicitly and appropriately authorized by the CPSA to practice in these two specialized domains of medicine.

2) The policies and procedures followed by the CPSA to make decisions about the licensure of radiologists and pathologists are sound and rigorous.

3) The CPSA deserves commendation for sustaining an approval process for interpretation of images by radiologists in respect to some imaging modalities.

4) The CPSA deserves commendation for creating and sustaining a state-of-the-art electronic database pertaining to its licensure of physicians.

RECOMMENDATIONS

Notwithstanding the high level of performance of the CPSA in its mitigation of risk of patient harm thorough rigorous physician licensure policies and procedures, the CPSA is encouraged to further enhance its public protection effectiveness by:

1) Including all CT imaging in its system for imaging interpretation modalities.

2) Offering AHS portal access to its physician electronic registration database with appropriate confidentiality controls.