College of Pharmacists of British Columbia

Board Meeting
April 14th & 15th, 2016
Held at the College of Pharmacists of British Columbia
200-1765 West 8th Avenue, Vancouver, BC

MINUTES

Members Present:
Blake Reynolds, Chair & District 4 Board Member *(absent for item 11)*
Anar Dossa, Vice-Chair & District 6 Board Member
Mona Kwong, District 1 Board Member
Ming Chang, District 2 Board Member *(absent for items 9, 10, and 11)*
Tara Oxford, District 3 Board Member
Frank Lucarelli, District 5 Board Member
Arden Barry, District 7 Board Member
Sorell Wellon, District 8 Board Member
Norman Embree, Public Board Member *(absent for item 15)*
Kris Gustavson, Public Board Member
Jeremy Walden, Public Board Member *(absent for item 15)*
George Walton, Public Board Member *(absent for item 15)*

Staff:
Bob Nakagawa, Registrar
Suzanne Solven, Deputy Registrar
Mary O'Callaghan, Chief Operating Officer
Ashifa Keshavji, Director of Practice Reviews and Quality Assurance
Kellie Kilpatrick, A/Director of Policy and Legislation
Doreen Leong, Director of Registration, Licensure and PharmaNet
Gillian Vrooman, Director of Communications and Engagement
Kitty Chiu, Executive Operations Manager
Lori Tanaka, Board & Legislation Coordinator
Jon Chen, Communications Project Officer

Thursday, April 14th, 2016

1. **WELCOME & CALL TO ORDER**
   Chair Reynolds called the meeting to order at 1:03pm on April 14th, 2016.

2. CONSENT AGENDA

a) Items for further discussion

No items were removed from the Consent Agenda and placed onto the regular Agenda for further discussion.

b) Approval of Consent Items (Appendix 1)

It was moved and seconded that the Board:

Approve the Consent Agenda as circulated.

CARRIED

3. CONFIRMATION OF AGENDA (Appendix 2)

It was moved and seconded that the Board:

Approve the April 14 & 15, 2016 Draft Board Meeting Agenda as circulated.

CARRIED

4. ITEMS BROUGHT FORWARD FROM CONSENT AGENDA

No items were brought forward from the Consent Agenda for further discussion.

5. LEGISLATION REVIEW COMMITTEE

Pharmacy Security Bylaws – Public Posting

Board member and Chair of the Legislation Review Committee Jeremy Walden presented information as distributed in the briefing package **(Appendix 3)**.

It was moved and seconded that the Board:

Approve the draft Pharmacy Operations and Drug Scheduling Act bylaws for public posting for a period of 90 days, as circulated.

CARRIED*

**Frank Lucarelli asked that his negative vote be recorded.*

6. GENOMICS INITIATIVE UPDATE AND PROFESSORSHIP

Associate Professor and Director of the UBC Sequencing Centre at UBC's Faculty of Pharmaceutical Sciences, and Tier 1 Canada Research Chair, Corey Nislow, presented information as distributed in the briefing package **(Appendix 4)**.

It was moved and seconded that the Board:

Grant funds to the Faculty of Pharmaceutical Sciences at UBC in the amount of $750,000 to establish a Professorship in Translational Pharmaceutical Care to be paid in five installments, as follows:

1. *April 30, 2016 - $150,000*
2. *April 30, 2017 - $150,000*
3. *April 30, 2018 - $150,000*
4. *April 30, 2019 - $150,000*
5. *April 30, 2020 - $150,000*

DEFEATED

7. TELEPHARMACY UPDATE

Director of Registration, Licensure & PharmaNet Doreen Leong presented information as distributed in the briefing package **(Appendix 5)**.

8. PHARMACY LEADERS OF TOMORROW (PLoT)

Pharmacist Aaron Sihota and Board member Ming Chang presented **(Appendix 6)**.

ADJOURN FOR THE DAY

The meeting adjourned for the day at 3:57pm.

Friday, April 15th, 2016

CALL TO ORDER
Chair Reynolds called the meeting to order at 9:01am on April 15th, 2016.

9. UPDATE FROM MINISTRY OF HEALTH

a) Reference Drug Program (RDP)
Executive Director of the Drug Intelligence & Optimization branch of the Medical Beneficiary and Pharmaceutical Services Division of the Ministry of Health, Eric Lun, presented.

b) Methadone
Assistant Deputy Minister, Medical Beneficiary and Pharmaceutical Services division of the Ministry of Health, Barb Walman, presented **(Appendix 7)**.

Chair Reynolds and Registrar Nakagawa left the meeting.
Vice-Chair Dossa assumed the Chair.

10. LEGISLATION REVIEW COMMITTEE
PPP-58 Adapting a Prescription - Amendments
Board member and Chair of the Legislation Review Committee Jeremy Walden presented information as provided in the briefing package **(Appendix 8)**.

It was moved and seconded that the Board:

*Approve Professional Practice Policy 58 - **Amendment to Orientation Guide** – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016).*

CARRIED

It was moved and seconded that the Board:

*Approve Professional Practice Policy 58 - **Orientation Guide** – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016).*

CARRIED

11. MEDICAL ASSISTANCE IN DYING (MAID)

a) Presentation
Registrar Heidi Oetter of the College of Physicians & Surgeons of BC, Partner at Lovett Westmacott, Debbie Lovett, and President of the Board of the College of Physicians and Surgeons of BC, Gerry Vaughan, presented **(Appendix 9)**.

b) Interim Guidance Document
Deputy Registrar Suzanne Solven presented information as distributed in the briefing package **(Appendix 10)**.

It was moved and seconded that the Board:

Approve the proposed Interim Guidance Document on Medical Assistance in Dying.

CARRIED

Vice-Chair Dossa returned the Chair to Chair Reynolds.

12. INQUIRY/DISCIPLINE AND ADMINISTRATIVE LAW

Partner at Lovett Westmacott, Angie Westmacott, Chair of the Inquiry Committee, John Hope, and Vice-Chair of the Inquiry Committee, Dorothy Barkley, presented **(Appendix 11)**.

IN-CAMERA

As per HPA Bylaws section 13(7)(a):

> *'financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public'*

13. SAFE DISPOSAL OF FENTANYL PATCHES

Clinical Pharmacy Specialist – Palliative Care with Lower Mainland Pharmacy Services, Bruce Kennedy, presented **(Appendix 12)**.

14. DRUGSAFEBC

a) Update

Director of Communications and Engagement Gillian Vrooman presented information as distributed in the briefing package **(Appendix 13)**.

b) Recognition

Chair Reynolds presented awards of recognition to Chief Constable Adam Palmer and Staff Sergeant Stephen Thacker of the Vancouver Police Department for their valuable contributions to the success of the DrugSafeBC program.

15. PHYSICAL ASSESSMENT PRESENTATION

Clinical Pharmacotherapeutic Specialist in Internal Medicine and the Coordinator of Clinical Services at Royal Jubilee Hospital in Victoria, Sean Spina, presented **(Appendix 14)**.

16. GOVERNANCE COMMITTEE RECOMMENDATIONS

Board member and Chair of the Governance Committee Norman Embree presented information as distributed in the briefing package **(Appendix 15)**.

It was moved and seconded that the Board:

Dissolve the following committees: Communications and Engagement Advisory, Interdisciplinary Relationships Advisory, and Technology Advisory.

CARRIED

It was moved and seconded that the Board:

Move the following committees from standing committees to ad-hoc committees: Community Pharmacy Advisory, Hospital Pharmacy Advisory, Residential Care Advisory and Ethics Advisory.

CARRIED

It was moved and seconded that the Board:

Extend committee volunteer appointments to April 30, 2017 as circulated.

CARRIED

It was moved and seconded that the Board:

Appoint new committee volunteers for terms beginning April 14, 2016 to April 30, 2017 as circulated.

CARRIED

It was moved and seconded that the Board:

Direct the Registrar to provide an update to the Board at every Board meeting of all committees except ad-hoc committees.

CARRIED

17. IN-CAMERA

As per HPA Bylaws section 13(7)(a):

'financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public'

ADJOURNMENT

Chair Reynolds adjourned the meeting at 3:35pm.

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2. Consent Agenda
b) Approval of Consent Items

DECISION REQUIRED

Recommended Board Motion:

Approve the Consent Agenda as circulated or amended.

i. Chair's Report
ii. Registrar's Update
    a. Activity Report
    b. Action Items & Business Arising
    c. Strategic Plan **[DECISION]**
iii. February 18 & 19, 2016 Draft Board Meeting Minutes **[DECISION]**
iv. March 1, 2016 Draft Board Resolution Minutes **[DECISION]**
v. March 23, 2016 Draft Board Teleconference Meeting Minutes **[DECISION]**
vi. Committee Annual Reports to the Board
vii. 125th Anniversary Working Group Update
viii. Naloxone Update
ix. Audit and Finance Committee

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.i. Chair's Report

INFORMATION ONLY

Since the February Board meeting, I have been involved in the following activities:

- March 8 – Practice Review Committee meeting
- March 9 – College of Registered Nurses of BC certified practice approval committee meeting
- March 11 – Governance Committee meeting
- March 23 – Audit and Finance Committee meeting
- March 23 – Board Teleconference meeting
- March 29 – Regular call with Anar Dossa and Bob Nakagawa

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.ii. Registrar's Update
a) Activity Report

INFORMATION ONLY

Since the last Board meeting, I have:

- Attended an advisory group to CPhA on medical marijuana, as a representative of CPRC
- Participated in the NAPRA executive committee
- Participated in the provincial data stewardship meeting
- Met with Drs Richard Bachand and Jim Hutchinson from VIHA re: pharmacy services
- Several media interviews (radio, print and TV) on marijuana sales by pharmacies
- Presented at the Hospital Pharmacy Management Seminar about the NAPRA sterile compounding guidelines
- Attended College consultation to discuss pharmacist prescribing with hospital pharmacists
- Regular teleconference calls with Barb Walman, Chair Reynolds and Vice Chair Dossa
- Meetings with McKesson to discuss some developments in their institutional area
- Met with the Chain Drug Association of BC to provide a College update
- Participated in an advisory committee to the .Pharmacy TLD
- Numerous meetings and media (print, radio and TV) on pharmacist's involvement in physician assisted death.
- Attended the Practice Review Program phase 2 workshop
- Attended Inquiry Committee meeting
- CPLT strategic planning session to follow up from the Board session.

It has been an extremely busy period of time. In addition to the Board meetings, the media requests on physician assisted death, and marijuana in pharmacies took a significant amount of time to deal with. Ongoing and significant activity on pharmacist prescribing and practice reviews also kept the office busy.

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.ii. Registrar's Update
b) Action Items & Business Arising

INFORMATION ONLY

MOTIONS/ACTION ITEMS	RELEVANT BOARD MEETING	STATUS UDPATE
Motion: Direct the Registrar to take the following actions as outlined in the MMT Action Plan: • Develop, plan and implement new undercover investigations, • Conduct priority inspection of identified MMT dispensing pharmacies, • Continue to build and maintain collaborative relationships with key stakeholders, and • Provide recommendations to the Board to strengthen legislation and licensure requirements.	Jun 2015	IN PROGRESS
Motion: Direct the Registrar to draft bylaws regarding pharmacy security measures.	Sep 2015	IN PROGRESS
Motion: Direct the Registrar to engage with stakeholders on changing the College name. The Registrar is to report back on the outcome of this stakeholder engagement process by September 2016, at which time, the Board make consider a name change.	Sep 2015	IN PROGRESS
Motion: Approve the 125th Anniversary Working Group communications plan, and host a signature gala event to celebrate the 125th anniversary of the College.	Nov 2015	IN PROGRESS

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.ii. Registrar's Update
c) Strategic Plan

DECISION REQUIRED

Recommended Board Motion:

Approve the Strategic Plan for the current year with the changes as circulated.

Purpose

To provide an updated Strategic Plan for the year 2016/17 that incorporates the discussion at the February 16, 2016 Strategic Planning meeting.

Background

At the February Strategic Planning meeting, the Board indicated that the new plan would be a rolling plan beginning March 1, 2016. The Leadership Team was directed to review the outstanding objectives and amend the Plan.

Discussion

The Leadership Team met on March 10, 2016 to review the outstanding items and removed items that were completed, indicated those items that would continue as "core" work and identified those that would continue to be part of the new Strategic Plan and under which goal they fit. The results are attached in the Appendix.

At this same meeting the Leadership Team reviewed notes from the February Strategic Planning meeting. Initial work began to identify objectives that would aid in achieving the three goals that had been developed. We will continue to meet to refine and describe these objectives and will have a more detailed progress report for the June Board Meeting.

Appendix	
1	Strategic Plan

COLLEGE OF PHARMACISTS OF BC

Three (3) Year Strategic Plan & Details Operational Plan
Fiscal Years: 2014/15 to 2016/17

Continue
Remove
On hold

Strategic Plan Areas	Objectives	#	Reporting Milestones	Status	Rationale
1. Public Expectation	(a) Role and value of profession	2	Report on outcomes of networking meetings	Remove	Core work as per February meeting
		3	Report on outcomes of networking meetings	Remove	Core work as per February meeting
	(b) Public Awareness Strategy	5	Decision: Board endorse plan for public awareness program in 16/17	Remove	Core work as per February meeting
		6	Decision: Board approves launch of program	Remove	Core work as per February meeting
		7	Update: Results of public awareness survey available for Board review	Remove	Core work as per February meeting
2. Interdisciplinary Relationships	(a) Work with other regulated healthcare professionals to identify interdisciplinary opportunities for collaboration and improvement in healthcare services.	11	Update: Report on outcomes of collaborative opportunities program	Remove	Core work as per February meeting
		12	Decision: Options presented to Board on refinements to program	Remove	Core work as per February meeting
		13	Update: Report on outcomes of collaborative opportunities program	Remove	Core work as per February meeting
		14	Decision: Options presented to Board on refinements to program	Remove	Core work as per February meeting
	(b) Create opportunities for pharmacists and pharmacy technicians to improve and enhance their practice by establishing a means in which they can deepen their relationships and	16	Update: Report on outcomes of pharmacist/pharmacy technician networking sessions	Remove	Objective completed
		17	Update: Report on outcomes of pharmacist/pharmacy technician networking sessions	Remove	Objective completed
3. Scope of Practice	(a)(i) Enhance availability of continuing education tools and programs	20	Decision: Report on new CE tools and programs, decision on program direction for next fiscal year	Remove	Core work as per February meeting
		21	Decision: Report on new CE tools and programs, decision on program direction for next fiscal year	Remove	Core work as per February meeting
	(a)(ii) Encourage BC pharmacists to enroll in programs that support best practices	23	Update: Report on numbers of pharmacists participating in clinical skills development programs	Remove	Core work as per February meeting
		24	Update: Report on numbers of pharmacists participating in clinical skills development programs	Remove	Core work as per February meeting
	(a)(iii) Provide the University of BC faculty of pharmaceutical sciences and the BC pharmacy technician program institutions with feedback on	26	Update: Report on changes noted in legislation and jurisprudence exam results that will be communicated to educational institutions	Remove	Core work as per February meeting
	(b)(i) Improve the quality of current adaptations by updating the standards, limits and conditions	30	Decision: Board approves updated standards, limits and conditions and policy changes (Phase 1)	Continue	Part of the new Legislation Goal
		31	Update: Report on progress of Phase 1	Continue	Part of the new Legislation Goal
		32	Decision: Board approves updated standards, limits and conditions (including removal of restrictions on PPP58 adaptations)	Continue	Part of the new Legislation Goal

COLLEGE OF PHARMACISTS OF BC

Three (3) Year Strategic Plan & Details Operational Plan
Fiscal Years: 2014/15 to 2016/17

Continue
Remove
On hold

Strategic Plan Areas	Objectives	#	Reporting Milestones	Status	Rationale
	(b)(ii) Changes to standards/limits/conditions for injection authority	33	Decision: Board approves public posting of proposed bylaw changes of updated standards, limits and conditions for injection authority that removes limitation to immunization only and provides guidance around injections of all appropriate drugs	Continue	Part of the new Legislation Goal
		34	Decision: Board approves filing of bylaw changes	Continue	Part of the new Legislation Goal
		35	Update: Legislation in force	Continue	Part of the new Legislation Goal
	(b)(iii) Advanced Pharmacist Practice certification	38	Update: Results of request for regulation changes from MoH.	Continue	Part of the new Improve Drug Therapy Goal
		39	Decision: Board approve public posting of proposed bylaw changes supporting APP certification	Continue	Part of the new Improve Drug Therapy Goal
		40	Update: Presentation of materials and planning supporting launch of APP certification	Continue	Part of the new Improve Drug Therapy Goal
		41	Decision: Board approve filing of bylaw changes with MoH supporting APP certification	Continue	Part of the new Improve Drug Therapy Goal
4. Standards	(a) Review and map standards (HPA/PODSA/PPP/NAPRA) to ensure relevancy and consistency.	43	Decision: Board approve filing of proposed bylaw changes updating 6 standards	Continue	Part of the new Legislation Goal
		44	Update: Package of legislation in force	Continue	Part of the new Legislation Goal
	(b) Develop a comprehensive, integrated policy guide that incorporates standards, guidelines and indicators of good practice and standards	45	Decision: Board approve policy guide for publication incorporating standards and indicators for standards of 4(a)	Remove	Core work as per February meeting
		46	Update: Report on Tools and communication plan developed to support standards of 4(a)	Remove	Core work as per February meeting
	(c) Develop standards for pharmacy workload	48	Decision: Board approve filing of bylaw changes of standards for pharmacy workload	Continue	Part of the new Legislation Goal - June 2016 Board meeting
		49	Update: Legislation in force for new standards for pharmacy workload	Continue	Part of the new Legislation Goal - June 2016 Board meeting
	(d) Strengthen enforcement to improve	56	Update: Confirmation of Hospital Pharmacy Program launch	Remove	Core work as per February meeting
		57	Update: Report on Phase 1 Practice Review Program results, metrics, learnings	Remove	Core work as per February meeting

COLLEGE OF PHARMACISTS OF BC

Three (3) Year Strategic Plan & Details Operational Plan
Fiscal Years: 2014/15 to 2016/17

Continue
Remove
On hold

Strategic Plan Areas	Objectives	#	Reporting Milestones	Status	Rationale
	(d) Strengthen enforcement to improve compliance	58	Update: Report on Phase 1 Practice Review Program results, metrics, learnings	Remove	Core work as per February meeting
		59	Update: Report on Phase 1 Practice Review Program results, metrics, learnings	Remove	Core work as per February meeting
		60	Update: Report on Practice Review Program results, metrics, learnings	Remove	Core work as per February meeting
	(e) Align CE requirements with evolving practice and standards	63	Decision: Board prioritizes required CE tools and programs to support evolving practices and standards arising from new Practice Review Program	Remove	Core work as per February meeting
	(f) Prohibit tobacco products in premises where a pharmacy is located	66	Update: Legislation in place that prohibits tobacco products in premises where a pharmacy is located	On hold	Pending outcome of the Loyalty Points process
5. Technology	(a) Act as a key stakeholder in order to facilitate enhancements to the PNet database such that a more complete drug history is available for	70	Update: Report on status of request to MoH for enhancements to PNet	Remove	Core work as per February meeting
		71	Update: PNet profiles contract renewed	Remove	Core work as per February meeting
	(b) Provide e-access to current and comprehensive drug information	72	Decision: Board determines options for e-library resources	Remove	Core work as per February meeting - Budget decision
		74	Update: Report on results of survey on uptake and effectiveness of e-library. Review if any changes required	Remove	Core work as per February meeting
		75	Update: Report on results of survey on uptake and effectiveness of e-library. Review if any changes required	Remove	Core work as per February meeting

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.iii. February 18 & 19, 2016 Draft Board Meeting Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the Draft February 18 & 19, 2016 Board Meeting Minutes as circulated.

Appendix	
1	Draft February 18 & 19, 2016 Board Meeting Minutes

College of Pharmacists of British Columbia

Board Meeting
February 18th & 19th, 2016
Held at the College of Pharmacists of British Columbia
200-1765 West 8th Avenue, Vancouver, BC

MINUTES

Members Present:
Blake Reynolds, Chair & District 4 Board Member
Anar Dossa, Vice-Chair & District 6 Board Member
Mona Kwong, District 1 Board Member
Ming Chang, District 2 Board Member
Tara Oxford, District 3 Board Member
Frank Lucarelli, District 5 Board Member
Arden Barry, District 7 Board Member
Bal Dhillon, District 8 Board Member
Norman Embree, Public Board Member
Kris Gustavson, Public Board Member (*absent for items 12, 13 and 14*)
Jeremy Walden, Public Board Member
George Walton, Public Board Member

Invited Guests:
Michael Coughtrie, Dean of UBC's Faculty of Pharmaceutical Sciences
Kevin Sin, President of UBC's Pharmacy Undergraduate Society

Staff:
Bob Nakagawa, Registrar
Suzanne Solven, Deputy Registrar
Mary O'Callaghan, Chief Operating Officer
Ashifa Keshavji, Director of Practice Reviews and Quality Assurance
Kellie Kilpatrick, A/Director of Policy and Legislation
Doreen Leong, Director of Registration, Licensure and PharmaNet
Gillian Vrooman, Director of Communications and Engagement
Kitty Chiu, Executive Operations Manager
Lori Tanaka, Board & Legislation Coordinator
Jon Chen, Communications Project Officer

Thursday, February 18th, 2016

1. **WELCOME & CALL TO ORDER**
   Chair Reynolds called the meeting to order at 9:08am on February 18th, 2016.

DRAFT

College of Pharmacists of British Columbia

Board Meeting Minutes
February 18th & 19th, 2016

2. CONSENT AGENDA

a) Items for further discussion

No items were removed from the Consent Agenda and placed onto the regular Agenda for further discussion.

b) Approval of Consent Items (Appendix 1)

It was moved and seconded that the Board:

Approve the Consent Agenda as circulated.

CARRIED

3. CONFIRMATION OF AGENDA (Appendix 2)

It was moved and seconded that the Board:

Approve the February 18 & 19, 2016 Draft Board Meeting Agenda as amended by adding a new item 6(b) Indigenous Cultural Safety Training.

CARRIED

4. SEPTEMBER 2016 BOARD MEETING LOCATION

It was moved and seconded that the Board:

Approve the location of the September 15 & 16, 2016 Board Meetings to be in Kelowna, BC.

CARRIED

5. 125TH ANNIVERSARY WORKING GROUP

a) Terms of Reference (Appendix 3)

Board member and Chair of the 125th Anniversary Working Group Ming Chang presented.

It was moved and seconded that the Board:

That the Board approve the following change to the 125 Year Anniversary Working Group Terms of Reference membership requirements:

From:

Membership

- 4 additional members as appointed by the Board.

To:

Membership

- Additional members as appointed by the Board

CARRIED

b) Committee Appointment

Board member and Chair of the 125th Anniversary Working Group Ming Chang presented.

It was moved and seconded that the Board:

Appoint Aaron Sihota as a member of the working group as recommended by the 125 Year Anniversary Working Group.

CARRIED

DRAFT

College of Pharmacists of British Columbia

c) Plan Update

It was moved and seconded that the Board:

Approve the 125 Year Anniversary Working Group recommendation to hold a destination celebration on September 17, 2016 in Kelowna, BC.

CARRIED

6. a) GOVERNANCE COMMITTEE

Board member and Chair of the Governance Committee Norman Embree presented information as distributed in the briefing package **(Appendix 4)**.

b) INDIGENOUS CULTURAL SAFETY TRAINING

Board member Kris Gustavson led a discussion about the Indigenous Cultural Safety (ICS) online training program developed by the Provincial Health Services Authority (PHSA) Aboriginal Health Program. More information specific to College registrant uptake of the ICS training program will be presented at a future Board meeting.

7. AUDIT AND FINANCE COMMITTEE – BUDGET PRESENTATION

Board member and Chair of the Audit and Finance Committee George Walton presented information as distributed in the briefing package **(Appendix 5)**.

It was moved and seconded that the Board:

Approve the 2016/17 budget totaling $10,298,048 as presented.

CARRIED

8. PRIORITIZING CE FOR NEXT FISCAL YEAR

Chair of the Quality Assurance Committee Gary Jung presented information **(Appendix 6)** as distributed in the briefing package **(Appendix 7)**.

It was moved and seconded that the Board:

Approve the following priorities for development of continuing education for the 2016/17 fiscal year based on the outcomes of the CPBC Learning Needs Survey for BC Pharmacy Professionals 2015:

1. *Expertise in Medications and Medication-use/Drug Distribution Systems*
   - *Knowledge/pharmacology based:*
     - *Diabetes, asthma, COPD, vaccines and mental health, OTC products, natural health products, wound care, ostomy supplies, chemotherapy*
   - *Skills/product preparation based:*
     - *Identifying and resolving drug therapy problems, developing follow-up and monitoring plan, interpreting lab values, pharmaceutical calculations, compounding (sterile, non-sterile, hazardous), preparation of parenteral medications*
   - *Pharmacy services based:*
     - *Medication reviews, immunization*
2. *Safety and Quality*
   - *Preventing and managing dispensing errors and incidents, patient safety and quality improvement, documentation skills and tools, handling hazardous drugs, identifying reliable references and resources, workflow management, hand hygiene*

CARRIED

DRAFT

College of Pharmacists of British Columbia

9. PRACTICE REVIEW PROGRAM – PHASE I AND PHASE II UPDATE

Chair of the Practice Review Committee Mike Ortynsky presented information as distributed in the briefing package **(Appendix 8)**.

10. ITEMS BROUGHT FORWARD FROM THE CONSENT AGENDA

No items were brought forward from the Consent Agenda for further discussion.

11. DRUG SCHEDULE REGULATION AMENDMENT - NALOXONE

Board member and Chair of the Legislation Review Committee Bal Dhillon presented information as distributed in the briefing package **(Appendix 9, and Appendix 10)**.

It was moved and seconded that the Board:

Approve the following resolution on the condition that Health Canada confirms the amendments to the Prescription Drug List regarding Naloxone.

RESOLVED THAT, in accordance with the authority established in section 22(1) of the *Pharmacy Operations and Drug Scheduling Act*, and subject to filing with the Minister as required by section 22(2) of the *Pharmacy Operations and Drug Scheduling Act*, the board amend the Drug Schedules Regulation, B.C. Reg. 181/2015, as set out in the schedule attached to this resolution.

CARRIED

12. CERTIFIED PHARMACIST PRESCRIBER UPDATE

Director of Communications and Engagement Gillian Vrooman presented the Board with an update of the Certified Pharmacist Prescriber initiative **(Appendix 11)**, the updated Draft Framework **(Appendix 12)** and the stakeholder engagement process **(Appendix 13)**.

13. POINT-OF-CARE HIV TESTING: COMMUNITY PHARMACY PILOT

Bob Rai from Medicine Shoppe Pharmacy, and Reka Gustafson Medical Health Officer with Vancouver Coastal Health presented **(Appendix 14)**.

14. IN-CAMERA SESSION

As per HPA Bylaws section 13(7)(f):

'instructions will be given to or opinions received from legal counsel for the college, the board, or a committee.'

ADJOURN FOR THE DAY

The meeting adjourned for the day at 4:00pm.

DRAFT

College of Pharmacists of British Columbia

Friday, February 19th, 2016

CALL TO ORDER
Chair Reynolds called the meeting to order at 9:02am on February 19th, 2016.

15. IN-CAMERA
As per HPA Bylaws section 13(7)(f):

'instructions will be given to or opinions received from legal counsel for the college, the board, or a committee.'

It was moved and seconded that the Board:

Hereby approves the confidentiality commitment and authorizes the College Board Chair to sign that commitment on behalf of the College, as its authorized signatory. The Board further approves, under s. 53 of the Health Professions Act, of disclosure in the public interest of personal and other information to the United States Food and Drug Administration, pursuant to the confidentiality commitment given by the Food and Drug Administration to the College.

16. BC PHARMACY ASSOCIATION – PERSONALIZED MEDICATION IN OUR COMMUNITIES
President of the BC Pharmacy Association Allison Nourse presented **(Appendix 15)**.

17. OPTIMIZING PHARMACEUTICAL CARE FOR POST-TRANSPLANT AND CHRONIC KIDNEY DISEASE PATIENTS
Greg Wheeler, consultant to BC Transplant in the role of Community Pharmacy Project Manager presented **(Appendix 16)**.

18. METHADONE MAINTENANCE TREATMENT UPDATE
Deputy Registrar Suzanne Solven and Senior Investigator George Budd presented **(Appendix 17)**.

ADJOURNMENT
Chair Reynolds adjourned the meeting at 2:06pm.

DRAFT

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.iv. March 1, 2016 Draft Board Resolution Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the Draft March 1, 2016 Board Resolution Minutes as circulated.

Appendix	
1	Draft March 1, 2016 Board Resolution Minutes

College of Pharmacists of British Columbia

Board Resolution
Sent via email March 1st, 2016
By Registrar Bob Nakagawa

MINUTES

The following resolution of the Board of the College of Pharmacists of British Columbia is valid and binding as per section 13(12) of the *Health Professions Act*-Bylaws, and has been signed by the following Board members:

Blake Reynolds, Chair & District 4 Board Member
Anar Dossa, Vice-Chair & District 6 Board Member
Mona Kwong, District 1 Board Member
Ming Chang, District 2 Board Member
Tara Oxford, District 3 Board Member
Frank Lucarelli, District 5 Board Member
Arden Barry, District 7 Board Member
Norman Embree, Public Board Member
Kris Gustavson, Public Board Member
Jeremy Walden, Public Board Member
George Walton, Public Board Member

Be it resolved that the Board approve the tagged appendix, attached to this resolution, amending the BC Drug Schedules Regulation, B.C. Reg. 9/98 for filing with the Minister of Health.

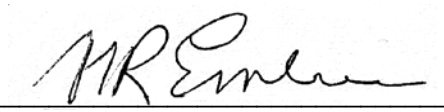
DRAFT

Appendix	
1	Signed Board Resolution and Tagged Schedule of Amendments
2	Board Resolution Briefing Note

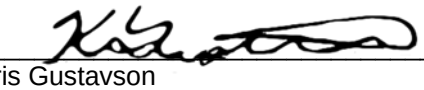
Resolution of the Board of the College of Pharmacists of British Columbia made in accordance with section 13(12) of the *Health Professions Act* – Bylaws.

Be it resolved that the Board approve the tagged appendix, attached to this resolution, amending the BC Drug Schedules Regulation, B.C. Reg. 9/98 for filing with the Minister of Health.

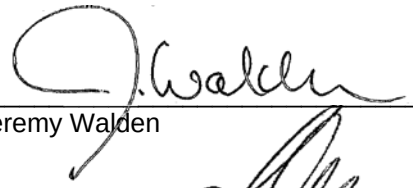
Blake Reynolds	March 3, 2016 Date
Anar Dossa	March 7, 2016 Date
Mona Kwong	March 7, 2016 Date
Ming Chang	March 7, 2016 Date
Tara Oxford	March 7, 2016 Date
Frank Lucarelli	March 7, 2016 Date
Arden Barry	March 7, 2016 Date



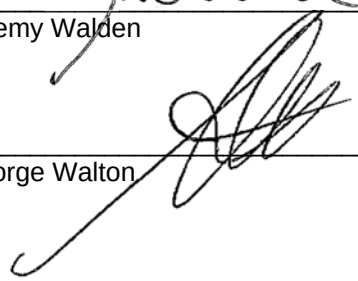
Norman Embree — March 4, 2016
Date



Kris Gustavson — March 7, 2016
Date



Jeremy Walden — March 7, 2016
Date



George Walton — March 7, 2016
Date

APPENDIX

1 ***The Drug Schedules Regulation, B.C. Reg. 9/98, is amended in the Schedules***

(a) by striking out the second entry for "1 Azelaic acid",

(b) by striking out the following:

1 Naloxone and its salts , ***and***

(c) by adding the following:

1 Naloxone and its salts (except when used for opioid overdose emergencies outside hospital settings)

2 Naloxone and its salts when used for opioid overdose emergencies outside hospital settings .

[February 18, 2016] *[For administrative purposes only - R/131/2016/27]*

College of Pharmacists of British Columbia

BOARD DECISION
March 1, 2016

Drug Schedules Regulation Amendments: Azelaic Acid

Recommended Board Resolution:

Be it resolved that the Board approve the tagged appendix, attached to this resolution, amending the BC Drug Schedules Regulation, B.C. Reg. 9/98 for filing with the Minister of Health.

Purpose

To approve the Ministry of Health tagged (approved) schedule of amendments to the BC Drug Schedules Regulation.

Background

On February 18, 2016, the Board approved proposed amendments to the BC Drug Schedules Regulation regarding naloxone. As per usual process, the BC Government's Office of Legislative Counsel (OIC) reviewed the proposed amendments and, at the same time, identified a duplicate entry of "1 Azelaic acid" in the Drug Schedules Regulation. The removal of the duplicate entry was added to the schedule of amendments by the OIC and subsequently tagged, and received by the College on February 22, 2016. As the change regarding azelaic acid now exists on the same tagged schedule as the amendment for naloxone, the tagged schedule must be approved by the Board in order for the amendment regarding naloxone to move forward.

The College is relying on the following legislative provision to expedite Board approval:

Section 13(12) of the *Health Professions Act*-Bylaws:

> A written resolution signed by all board members is valid and binding and of the same effect as if such resolution has been duly passed at a board meeting.

Recommendation

The College recommends that the Board unanimously approve the tagged schedule of amendments to the Drug Schedules Regulation, as circulated, by signing the attached resolution.

Appendix	
1	Board Resolution
2	Tagged Schedule of Amendments

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.v. March 23, 2016 Draft Board Teleconference Meeting Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the Draft March 23, 2016 Board Teleconference Meeting Minutes as circulated.

Appendix	
1	Draft March 23, 2016 Board Teleconference Meeting Minutes

College of Pharmacists of British Columbia

Board Teleconference
March 23, 2016
7:00 pm

MINUTES

Members Present:
Blake Reynolds, Chair & District 4 Board Member
Anar Dossa, Vice-Chair & District 6 Board Member
Ming Chang, District 2 Board Member
Tara Oxford, District 3 Board Member
Frank Lucarelli, District 5 Board Member
Arden Barry, District 7 Board Member
District 8 Board Member (*vacant*)
Norman Embree, Public Board Member
Kris Gustavson, Public Board Member
Jeremy Walden, Public Board Member
George Walton, Public Board Member

Regrets:
Mona Kwong, District 1 Board Member

Staff:
Bob Nakagawa, Registrar
Lori Tanaka, Board & Legislation Coordinator

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1. **WELCOME & CALL TO ORDER**

   Chair Reynolds called the meeting to order at 7:03pm.

   Registrar Nakagawa conducted a roll call to confirm attendance on the call and confirm quorum.

College of Pharmacists of British Columbia

DRAFT Board Meeting Minutes
March 23, 2016

2. CONFIRMATION OF AGENDA

It was moved and seconded that the Board:

Approve the March 23, 2016 Draft Board Teleconference Meeting Agenda as circulated.

CARRIED

3. DISTRICT 8 BOARD APPOINTMENT

Bal Dhillon, District 8 Board member, submitted her resignation from the College Board on February 22, 2016. As the vacancy must be filled in order for the Board to be appropriately constituted, College staff emailed all District 8 registrants seeking expressions of interest from eligible pharmacy technicians. Registrants were given approximately one week to submit a brief biography and general statement.

Expressions of interest for appointment were received from ten District 8 registrants. All interested candidates were verified to be full, registered pharmacy technicians, and in good standing with the College of Pharmacists.

As per HPA Bylaws s.10, the Board may appoint an eligible full pharmacy technician to fill a vacant position until the next election. A regular District 8 election will be held later in 2016 and as such the term of office for the appointed District 8 Board member will end at the start of the November 2016 Board meeting.

It was moved and seconded that the Board:

Appoint Sorell Wellon as the District 8 representative to the Board of the College of Pharmacists of BC to a term ending at the start of the November 2016 Board meeting.

CARRIED

4. LEGISLATION REVIEW COMMITTEE - APPOINTMENTS

a) District 8 Representative

It was moved and seconded that the Board:

Appoint Sorell Wellon as the pharmacy technician Board member to the Legislation Review Committee.

CARRIED

b) New Chair

It was moved and seconded that the Board:

Appoint Jeremy Walden as the Chair of the Legislation Review Committee until the April 2016 Board meeting.

CARRIED

ADJOURNMENT

Chair Reynolds adjourned the meeting at 7:13pm.

DRAFT

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.vi. Committee Annual Reports to the Board

INFORMATION ONLY

Annual reports of committee activities are submitted.

Appendix	
1	Annual Reports for all College committees

College of Pharmacists of British Columbia

Annual Report to the Board for Audit & Finance Committee

Reporting Period: Mar 1, 2015 – Feb 29, 2016

Membership:

George Walton	Blake Reynolds
Norman Embree	Anar Dossa
Bob Nakagawa	Mary O'Callaghan

Chair: George Walton
Vice Chair: Norman Embree

Staff Resource: Bob Nakagawa, Mary O'Callaghan

Mandate: To provide recommendations to the Board relating to the annual audit and financial management of the College.

Responsibilities:

Annual Audit Planning and preparation

- Review with the auditors the scope of the upcoming year's audit, including any areas where the auditors have identified a risk of potential error in the financial condition and/or results of operations.
- Review with College management control weaknesses detected in the prior year's audit, and determine whether practical steps have been taken to overcome them.

Audit results

- Review the auditors' draft report on the financial statements.
- Review auditors' evaluation of internal controls and processes, including internal controls over financial reporting and any material weaknesses or risks of fraud. Assess the steps management has taken to minimize significant risk of exposure. Consider effectiveness of control systems including information technology.
- Enquire into the condition of the records and the adequacy of resources committed to accounting and control.
- Enquire about changes in finance/auditing/control standards that have occurred during the year and whether there is any impact on the College financial systems.
- Meet with the auditors (without College management) to ascertain whether there are concerns that should be brought to the committee's attention.
- Coordinate with College management: the presentation of the audit findings by the auditors to the Board for Board approval; incorporate the Board approved audit report into the College Annual Report; have the auditors' present the results to the College registrants at the AGM.

College of Pharmacists of British Columbia

Auditors' appointment

- Meet with senior management to ensure that management has no concerns about the conduct of the most recent audit.
- Recommend to the Board the auditors to be appointed for the following year, and in consultation with College management determine the appropriate compensation.
- Approve the selected auditors' engagement letter, receive the independence letter, review and approve any related materials.

Financial oversight

- Review the quarterly financial statements at the committee meetings during the year.
- Annually, review the proposed fiscal budget with College management.
- Annually review the College multi-year (2-5 year) financial plan.
- At least annually, review the College investment policy and ensure that the existing policy is being followed.
- Enquire about changes in professional standards or regulatory requirements.
- Ensure financial planning adequately addresses risks and long term planning e.g. insurance, litigation, joint venture, other contingency funds, capital investments.
- Make recommendations to the Board with regard to the above and any other aspects of the financial management of the College as required.

Relevant Statistical information:

- Number of meetings: 2

Accomplishments:

- Reviewed annual audit and auditor's recommendations with the auditors.
- Recommended renewal of the current contract with Grant Thornton for the 2015/16 and 2016/17 audits.
- Reviewed and recommended approval of changes to the Reimbursement of Expenses policy.
- Reviewed and recommended awarding the IT Managed Services competitive bid contract to Xyfon Solutions.
- Reviewed and recommended approval of the 2016/17 annual budget.

Goals for Next Fiscal Year:

- Review the annual audit.
- Review one-time and recurring expenditures and Reserve levels while considering financial sustainability and assess the need for a plan for fee increases.
- Review annual budget.
- Review financial reports.

College of Pharmacists of British Columbia

Annual Report to the Board for Communications and Engagement Advisory Committee

Reporting Period: March 1, 2015 – February 29, 2016

Membership:

Vacant (Chair)	Tiffany Tam
Shivinder Badyal	David Wang
Jagpaul Deol	David Wilson
Norman Nichols	

Chair: Vacant

Staff Resource: Gillian Vrooman

Mandate: To provide recommendations to the Board on matters related to communication and engagement.

Responsibilities:

- Review the College's Engagement and Communications Strategy annually to ensure that it continues to meet the needs of the College in communicating its mission, vision, and mandate.
- Provide the College's professional communications staff with regular opportunities to utilize the knowledge, skills, ability, and experience of pharmacists, pharmacy technicians, and public members serving on the committee to enhance the quality of College communications.
- Provide advice, oversight and make recommendations to the Board on strategies designed to ensure the successful achievement of Strategic Goal 1 (Public Expectations) and that the roles and values of the profession that have been established are aligned with the expectations of the public.
- Make suggestions on topics or issues that should be addressed by the College in its various communications tools, and provide perspective during the development stages of various communications and engagement activities.

Relevant Statistical information:

- Number of meetings: 0

Accomplishments:

- The committee did not meet

College of Pharmacists of British Columbia

Annual Report to the Board for Community Pharmacy Advisory Committee

Reporting Period: Mar 1, 2015 – Feb 29, 2016

Membership:

Ming Chang
Cassandra Elstak-Blackwell
Parveen Mangat
Aaron Sihota
Elijah Ssemaluulu
Tiffany Tam
Cindy Zhang

Chair: Fady Moussa
Vice Chair: Mohinder Jaswal

Staff Resource: Ashifa Keshavji

Mandate: To provide recommendations to the Board on matters relating to community pharmacy practice.

Responsibilities:

- Review issues related to the practice of pharmacy that have been directed to the committee by the Board, Board committee or College staff.
- Assist in the development of policies, procedures, guidelines and legislation pertaining to pharmacy practice issues and standards.
- Assist in the development of information materials for circulation to practicing registrants.
- Recommend appropriate action to the Board regarding pharmacy practice issues.
- Work collaboratively with other College practice advisory committees to ensure a cohesive approach to common practice issues.

Relevant Statistical information:

- Number of meetings: 2

Accomplishments:

- Provided feedback and made recommendations to the Practice Review Committee on Pharmacy Professionals Review for Pharmacy Technicians in community pharmacy practice
- Provided feedback on the bylaw/standards of practice/policy review as identified by the College Board in its current Strategic Plan
    - Certified Pharmacist Prescriber
    - Security Bylaws

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Goals for Next Fiscal Year:

- Continue to support the Practice Review Committee on the maintenance of the Practice Review Program
- Continue to discuss and review current community pharmacy issues
- Review professional practice policies and other standards of practice

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Annual Report to the Board for Discipline Committee

Reporting Period: Mar 1, 2015 – Feb 29, 2016

Membership:

Jerrold Casanova	Chris Kooner
Wayne Chen	Howard Kushner
Suzanne Coughtry	Derek Lee
Jody Croft	Leeza Muir
Bal Dhillon	Annette Robinson
Anneke Driessen	Jeremy Walden
James Ellsworth	Carol Williams
Patricia Gerber	Mable Yen
Nerys Hughes	Marian Yan

Chair: Jerrold Casanova
Vice Chair: Patricia Gerber

Staff Resource: Suzanne Solven

Mandate: Hear and make a determination of a matter referred to the committee regarding a pharmacist's or pharmacy technician's conduct, competency and/or ability to practice, pursuant to legislation.

Responsibilities:

- Conduct hearings of a matter
- Determine disposition of the matter
- Inform respondents, complainants and the public about action taken
- Inform respondents and complainants about the discipline process as applicable

Relevant Statistical information:

- Number of meetings: 1
- Number of hearing days: 1
- Number of discipline files heard in court:
    - Manijeh Farbeh : 2
    - Ali Laal: 1
- Number of pending files: 1 registrant

College of Pharmacists of British Columbia

Current Discipline Cases:

- **Nikhil Buhecha**

  The Inquiry Committee directed the Registrar of the College to issue a citation against registrant Nikhil Buhecha. Mr. Buhecha had been the owner and director of three pharmacies where numerous practice infractions and deficiencies had been identified during an investigation. He had also been the pharmacy manager on record at one of these three pharmacies. In addition, he had been the owner and director of a company that operated an unlicensed pharmacy from unlicensed premises. After reviewing the nature and gravity of these allegations, the Inquiry Committee considered it would be appropriate for the Discipline Committee to assess the investigation results in a formal hearing process. The discipline hearing is expected to take place in mid to late 2016.

College of Pharmacists of British Columbia

Annual Report to the Board for Drug Administration Committee

Reporting Period: March 1, 2015 – February 29, 2016

Membership:
Omar Alasaly
Elizabeth Brodkin
Jagpaul Deol
Aileen Mira
Mitch Moneo
Chris Salgado
Cameron Zaremba

Chair: Cameron Zaremba
Vice Chair: Omar Alasaly

Staff Resource: Doreen Leong

Mandate: To develop, review and recommend the standards, limits and conditions under which a registrant may administer a drug or substance to patients and to maintain patient safety and public protection with respect to authorized pharmacist's administration of injections to patients.

Responsibilities:
- Must review, develop and recommend to the Board standards, limits and conditions respecting the performance by full pharmacists of restricted activities under section 4(1) (c.1) of the Pharmacists Regulation for the purposes of preventing diseases, disorders and conditions.
- May review the role of full pharmacists in regard to the performance of restricted activities under section 4(1) (c.1) of the Pharmacists Regulation.
- May make recommendations to the Board, for submission to the Ministry of Health Services, respecting the standards, limits and conditions for practice and any other requirements it considers necessary or appropriate to support the performance by full pharmacists of restricted activities under section 4(1) (c.1) of the Pharmacists Regulation for the purposes of treating diseases, disorders and conditions.
- May consult, as it considers necessary or appropriate, with registrants or other individuals who have expertise relevant to drug administration by injection or on any other matter considered by the committee.

Relevant Statistical information:
- Number of meetings: 2

Accomplishments:
- Revised the *HPA bylaws* related to drug administration, including the Standards, Limits and Conditions for Drug Administration by Injection and Intranasal Route

College of Pharmacists of British Columbia

- Developed the intranasal drug administration educational module and integrated into the registration re-certification process

Goals for the Next Fiscal Year:

- Review and recommend changes to the *HPA bylaws* related to drug administration, including removing the restrictions on drug administration authority in the Standards, Limits and Conditions for Drug Administration by Injection and Intranasal Route.

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Annual Report to the Board for Ethics Advisory Committee

Reporting Period: Mar 1, 2015 – Feb 29, 2016

Membership:

Cristina Alarcon	Tara Lecavalier
Shivinder Badyal	Vanessa Lee
Alison Dempsey	Robyn Miyata
Dr. Bashir Jiwani	Jing-Yi Ng

Chair: Dr. Bashir Jiwani
Vice-Chair: Robyn Miyata

Staff Resource: Suzanne Solven

Mandate: To provide recommendations to the Board and the registrar on matters relating to the code of ethics, conflict of interest standards and any related policies or guidelines.

Responsibilities:

- Provide advice and guidance regarding ethical questions and dilemmas that have been directed to the committee from the Board, Board committees or College staff.
- Review and recommend updates to the code of ethics and conflict of interest standards as necessary.
- Consult on education program proposals relating to ethics issues.

Relevant Statistical information:

- Number of meetings: 1

Goals for Next Fiscal Year:

- Provide interim guidance for registrants regarding physician-assisted death.
- Update the code of ethics in consideration of physician-assisted death.

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Annual Report to the Board for Governance Committee

Reporting Period: November 20, 2015 – Feb 29, 2016

Membership:

Norman Embree	Bal Dhillon
Blake Reynolds	Anar Dossa

Chair: Norman Embree

Vice-Chair: Bal Dhillon

Staff Resource: Suzanne Solven

Mandate: To provide recommendations to the Board on matters relating to Board Governance.

Responsibilities:

- Review Board policies and manuals and recommend revisions to these documents.
- Review and make recommendations regarding Board member orientation and ongoing development.
- Review and make recommendations on policies and practices related to the recruitment, election and/or appointment of Board and committee members.
- Provide advice and guidance on Board evaluations, including Board meeting evaluations.
- Assess and make recommendations regarding the governance-related needs of the Board.

Relevant Statistical information:

- Number of meetings: 1

Accomplishments:

- The Governance Committee completed a review of all CPBC committees looking specifically at the following criteria:
    - Whether or not the committee was grounded in legislation or bylaw,
    - The purpose and relevance of each committee, and
    - The frequency each committee met.
- The Governance Committee made the following recommendations to the Board based on the findings of their review:
    1. Dissolve the following committees:
        - Communications and Engagement Advisory Committee,
        - Interdisciplinary Relationships Advisory Committee, and
        - Technology Advisory Committee.

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2. Re-structure the following committees as Ad Hoc:
   - Community Pharmacy Advisory Committee,
   - Ethics Advisory Committee,
   - Hospital Pharmacy Advisory Committee, and
   - Residential Care Advisory Committee.

3. Require all committees to provide a report to the Board at least annually, and all committees except ad-hoc committees must update the Board at every Board meeting.

4. Extend all committee member terms until April 2017 to allow the Governance Committee to establish a recruitment and appointment process.

Goals for Next Fiscal Year:

- To establish a recruitment and appointment process for volunteer committee members.
- Review of all committee terms of reference for consistency and relevancy.

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Annual Report to the Board for Hospital Pharmacy Advisory Committee

Reporting Period: Mar 1, 2015 – Feb 29, 2016

Membership:

Elissa Aeng
Joshua Batterink
Lily Cheng
Jennifer Dunkin
Aleisha (Thornhill) Enemark
Ashley Fairfield
Gordon Harper
Anca Jelescu Bodos
Karen Lapointe
Aita Munroe
Fruzsina Pataky

Chair: Keith McDonald
Vice Chair: Anita Lo

Staff Resource: Jonathan Lau

Mandate: To provide recommendations to the Board on matters relating to hospital pharmacy practice issues.

Responsibilities:

- To review issues related to the practice of hospital pharmacy that have been directed to the committee by the Board, Board committees or College staff.
- To assist in the development of policies, guidelines and legislation pertaining to hospital pharmacy issues and standards.
- Recommend appropriate action to the Board regarding hospital pharmacy issues.
- Work collaboratively with other College practice advisory committees to ensure a cohesive approach to common practice issues.

Relevant Statistical information:

- Number of meetings: 3

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Accomplishments:

- Provided feedback and made recommendations to the Practice Review Committee on Phase 2- Hospital Pharmacy Practice of the Practice Review Program
- Provided feedback on the bylaw/standards of practice/policy review as identified by the College Board in its current Strategic Plan
    - Certified Pharmacist Prescriber
- Reviewed College professional practice policies
- Reviewed recommendations from the Extemporaneous Compounding Task Group

Goals for Next Fiscal Year:

- Continue to support the Practice Review Committee on the development and maintenance of Phase 2- Hospital Pharmacy Practice of the Practice Review Program
- Continue to discuss and review current hospital pharmacy issues
- Review professional practice policies and other standards of practice

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Annual Report to the Board for Inquiry Committee

Reporting Period: March 1, 2015 – February 29, 2016

Membership:

Carla Ambrosini	Patricia Kean
Dorothy Barkley	Fatima Ladha
Cindy Bondaroff	Jim Mercer
Karen Callaway	Jing-Yi Ng
Sally Chai	Alison Rhodes
Michael Dunbar	Alana Ridgeley
Norman Embree	Kristoffer Scott
Sukhvir Gidda	Susan Troesch
John Hope	Ann Wicks
George Kamensek	Cynthia Widder

Chair: John Hope
Vice-Chair: Dorothy Barkley

Staff Resource: Suzanne Solven

Mandate: Investigate complaints and concerns regarding a pharmacist's conduct, competency and/or ability to practice and decide on an appropriate course of action pursuant to legislation.

Responsibilities:

- Investigate complaints on its own motion or raised by a complainant as soon as possible,
- Investigate registrants that fail to authorize a criminal records review check as well as registrants presenting a risk of physical or sexual abuse to children as determined by the Registrar of the Criminal Records Review Act,
- Determine disposition of items (1) and (2),
- Inform registrants, complainants and the Health Professions Review Board about the inquiry process and complaint outcomes, as necessary, and
- Report to the Board as applicable.

Relevant Statistical Information:

- Number of in-person meetings: 20
- Number of teleconferences: 39

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Accomplishments:
Fiscal 2015/16 (March 1, 2015 – February 29, 2016)

Total	**Complaint Types (may be more than one type)**	**Disposition Status:**
Total # of complaints received: 850	Medication-related: 34	**Total files reviewed by IC: 136**
Total # of official complaints: 95	Privacy/Confidentiality: 4	Total new files reviewed: 94
Total # of registrants: 142	Professional Conduct/ Competency: 55	Total reconsiderations: 42*
Total # of calls/tips/FYI files: 755	Fitness to practice: 4	Active/Pending: **29
Total # of investigations: 80	Business-related: 3	Disposed and Closed: 70
	Unlawful activity: 2	Disposed and Monitoring: 5
Total # of complaints via HPRB: 0	Sexual misconduct: 0	

** Some files have been reconsidered more than once.*
*** No files were carried over from previous fiscal years.*

<u>Notable Cases of Public Safety:</u>

Extraordinary Suspensions of Pharmacy Licenses

In 2015, in response to serious issues and concerns identified by stakeholders related to the provision of Methadone Maintenance Treatment (MMT) pharmacy services in BC, College inspectors stepped up focused inspections of MMT dispensing pharmacies.

The inspections of the following two pharmacies returned unacceptable findings, and the inspection results were referred to the Inquiry Committee. In both cases, the Inquiry Committee directed extraordinary suspensions of the pharmacy license and limits and conditions on the registration of the pharmacy manager.

- **Native Vancouver Pharmacy:**
  On or about May 27, 2015, the Inquiry Committee made an extraordinary order to suspend the pharmacy license of Native Vancouver Pharmacy, located at 108-50 East Hastings Street in Vancouver, pending completion of an investigation. This order was made in the interest of

College of Pharmacists of British Columbia

public safety following an inspection of the pharmacy by College inspectors, which raised serious concerns with respect to the unhygienic conditions of the pharmacy, and the suitability of the premises to continue operating as a pharmacy.

Examples of such conditions included, but were not limited to:

- Mould found on the floors, walls, and food containers inside the dispensary
- Fecal matter from mice and rats on the floor and other surfaces
- Mouse and cockroach bait traps found in numerous locations within dispensary
- Food, sugar, and coffee whitener left out in the open in the dispensary, accessible to insects and rodents
- No hot running water
- Dirty and dilapidated interior walls, fixtures, and furniture

A pharmacy closure is automatically enacted after 30 consecutive days of suspension of license. To date, this pharmacy remains closed and it will not be issued a new license until it meets licensing requirements, including suitability of the premises for a pharmacy operation.

The Inquiry Committee also directed, for the purposes of public protection, that limits and conditions be placed on the pharmacy practice of the pharmacy manager, in that he may not be a pharmacy manager pending completion of investigation. After an investigation and completed remedial measures, these limits and conditions have been lifted.

- **Downtown Pharmacy:**
  On or about September 9, 2015, the Inquiry Committee made an extraordinary order to suspend the pharmacy license of Downtown Pharmacy, located at 348 Powell Street in Vancouver, pending completion of an investigation. This order was made in the interest of public safety following an inspection of the pharmacy by College inspectors, which raised serious concerns with respect to the unhygienic conditions of the pharmacy, and the suitability of the premises to continue operating as a pharmacy.

  Examples of such conditions included, but were not limited to:

  - Dirty, graffiti-filled exterior (windows, walls, door) of the pharmacy
  - Dirty and dilapidated interior walls, fixtures, flooring, ceiling tiles, and furniture – appearance of stains, cobwebs, dust, and peeling paint
  - Mould and dirt found on the walls, fixtures, and inside of cupboards holding dispensing equipment such as graduated cylinders
  - Mouse bait traps and fecal matter found within dispensary and storage area
  - Old and moldy food products, such as an open package of “Pancake Mix” found in a cupboard above the dispensary sink

College of Pharmacists of British Columbia

A pharmacy closure is automatically enacted after 30 consecutive days of suspension of license. To date, this pharmacy remains closed and it will not be issued a new license until it meets licensing requirements, including suitability of the premises for a pharmacy operation.

The Inquiry Committee also directed, for the purposes of public protection, that limits and conditions be placed on the pharmacy practice of the pharmacy manager, in that she may not be a pharmacy manager pending completion of investigation. After an investigation and completed remedial measures, these particular limits and conditions have been lifted.

Goals for Next Fiscal Year:

- Consideration of utilizing greater opportunity for verbal reprimands and registrant reporting back to the committee to ensure that the registrant/owner/director appreciates the seriousness of the issue at hand and public safety impacts.
- Consideration of making proactive recommendations to the Registrar for potential legislation change where gaps and deficiencies are identified through Inquiry cases.

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Annual Report to the Board for Interdisciplinary Relationships Advisory Committee

Reporting Period: March 1, 2015 – February 29, 2016

Membership:
Karen Dahri
Dana Elliott
Kris Gustavson
Anoop Khurana
Tamar Koleba
Hilda Xiao Min Liu
Dr. Christie Newton
Tommy Pan
Dr. Peter Stevenson-Moore

Chair: Kris Gustavson
Vice Chair: Anoop Khurana

Staff Resource: Doreen Leong

Mandate: To provide recommendations to the Board on matters relating to pharmacy and interdisciplinary relationships.

Responsibilities:

- Responsibilities
  - Review issues related to pharmacy and interdisciplinary relationships that have been directed to the committee by the Board, Board committee or College staff.
  - Promote and enhance collaborative relations with other colleges established under the HPA, regional health boards designated under the Health Authorities Act and other entities in the Provincial health system, post-secondary education institutions and the government.
  - Promote and enhance interprofessional collaborative practice between registrants and persons practicing in another health profession.
  - Promote and enhance the ability of registrants to respond and adapt to changes in practice environments and other emerging issues related to interdisciplinary relationships.
  - Assist in the development of policies, procedures, guidelines and legislation pertaining to pharmacy and interdisciplinary relationship issues and standards.
  - Recommend appropriate action to the Board regarding pharmacy and interdisciplinary relationship issues.
  - Work collaboratively with other College advisory committees to ensure a cohesive approach related to interdisciplinary relationship issues.

Relevant Statistical information:

- Number of meetings: 0

College of Pharmacists of British Columbia

Accomplishments:

- Delivered the Interprofessional Professional Development Program from January – February 2015 in collaboration with the UBC Office of the Vice-Provost Health (OVPH), formerly the UBC College of Health Disciplines. Program consisted of six online modules that builds knowledge of interprofessional collaboration and features an in-person workshop to practice interprofessional skills and abilities. The online modules were launched in January 2015 with 364 registrants accessing the online modules. Of the 364 registrants, 151 participated in the in-person workshops – 50 in Burnaby, 50 in Langley, 35 in Victoria, and 16 in Kelowna. An evaluation survey was sent to participants in April 2015 to inform the ongoing development of the program.

Goals for the Next Fiscal Year: N/A

College of Pharmacists of British Columbia

Annual Report to the Board for Jurisprudence Examination Subcommittee

Reporting Period: March 1, 2015 – February 29, 2016

Membership:
Roberta Walker
Melanie Johnson
Tony Seet
Asal Taheri
Maria Ton
David Wang

Chair: Roberta Walker
Vice Chair: Melanie Johnson

Staff Resource: Doreen Leong

Mandate: To ensure that the Jurisprudence Examination continues as a valid and reliable assessment instrument.

Responsibilities:
- Develop, update and maintain Jurisprudence Examination blueprint and content.
- Establish and validate assessment and assessment standards.
- Develop recommendations and policies for review and approval by the Registration Committee.
- Review correspondence and appeals pertaining to the examination questions and acceptable answers, and recommend outcomes for the Registration Committee's approval.

Relevant Statistical information:
- Number of meetings: 4

Accomplishments:
- All items were recoded using the new blueprint and new exam forms developed.
- Statistical data collated and provided to UBC Faculty of Pharmaceutical Sciences, CCAPP accredited pharmacy technician programs and CCAPP to inform their accreditation requirements.
- Items reviewed for any legislative changes.
- Review of results of past four Jurisprudence Exam sittings, item refined based on statistical analysis.

Goals for Next Fiscal Year:
- Conduct psychometric analysis of items.
- Conduct item review/item writing workshops.
- Explore the feasibility of administering the Jurisprudence Exam online.

College of Pharmacists of British Columbia

Annual Report to the Board for Legislation Review Committee

Reporting Period: Mar 1, 2015 – Feb 29, 2016

Membership: Anar Dossa
Bal Dhillon
Jeremy Walden

Chair: Anar Dossa

Staff Resource: Kellie Kilpatrick

Mandate: To provide advice and recommendations to the Board and the Registrar on matters relating to the development of policy, legislation and other regulatory priorities.

Responsibilities:

- Provide advice and guidance regarding proposed legislation/policy changes that have been directed to the committee from the Board, Board committees or College staff.
- Identify priorities for change within legislation review planning cycle.
- Determine if broader external stakeholder consultation is required.
- Chair of Committee presents priorities to Board for approval.
- Approve final draft of proposed legislation/policy prior to presentation to Board.
- Chair (supported by Policy and Legislation staff) present proposed documents to Board for approval.
- Review public posting comments as necessary.

Relevant Statistical information:

- Number of meetings: 4

Accomplishments:

- Over the past year, the Legislation Review Committee recommended changes to policy, bylaws, forms, Standards of Practice and to the Drug Schedule Regulation.

Legislation	Amendments
Community Pharmacy Standards of Practice	**June 2015** – review of feedback on HPA Schedule F Part 1 Community Standards of Practice re definition, prescription requirements, review of patient record, patient counselling requirements **Sept 2015** – approval of changes to Schedule F Part 4 re Administration by Intranasal Route

College of Pharmacists of British Columbia

Pharmacy Operations and Drug Scheduling Act Bylaws	**June 2015** - review of feedback on PODSA S. 3 (2) workload and quotas **June 2015** –approval of PODSA forms and fees for public posting **Sept 2015** – approval to draft bylaws re Pharmacy Security
Drug Schedule Regulation	**April 2015** - Bisacodyl, minoxidil topical, diclofenac topical, omeprazole; **June 2015** – acyclovir, adrenocortisal hormones, azelaic acid, hydrocortisone acetate, naproxen, triamcinolone acetonide; **February 2016** - naloxone
Professional Practice Policies et al	**June 2015** – approval of guide related to PPP-74 Pharmacy Security

Goals for Next Fiscal Year:

- Develop a legislation framework that will guide the future policy and legislative agenda for CPBC. This framework will be based on principles and will consider specific criteria to ensure the "right touch" is applied to decision-making on future work.
- Conduct a full review/scan of all policies, bylaws, standards of practice to ensure that current College legislation is consistent with the new framework:
    - Identify those policies that require transitioning to bylaw to enable enforceability
    - Identify those areas in bylaw that require clarification or alignment
- Develop a three year policy and legislation plan that reflects the current work; new priorities as determined by the review/scan; Board and Ministry of Health priorities
- Complete other priority work underway:
    - PODSA bylaws re Pharmacy Security (s.11)
    - PODSA bylaws re Workload and Quotas (s. 3(2))
    - HPA bylaws re Community Pharmacy Standards of Practice (s. 2, 6, 11, 12, 13)
    - HPA forms and fees
    - PPP 58- Adaptation – Restrictions and Requirements
    - PPP 66 – Methadone Management
    - PODSA bylaws re Managing a Pharmacy and Ownership
    - New Compounding Standards
    - Regular Drug Schedule Regulation changes
    - Code of Ethics re Physician Assisted Dying

College of Pharmacists of British Columbia

Annual Report to the Board for Practice Review Committee

Reporting Period: Mar 1, 2015 – Feb 29, 2016

Membership:

Patrick Chai
Sean Gorman
Kris Gustavson
Nerys Hughes
Joanne Konnert
Fady Moussa
Alison Rhodes
Helen Singh
Perry Tompkins

Chair: Bob Craigue (To November 20th, 2015)
Mike Ortynsky (From November 20th, 2015)

Vice Chair: Aleisha (Thornhill) Enemark

Staff Resource: Ashifa Keshavji

Mandate: To monitor and enforce standards of practice to enhance the quality of pharmacy care for British Columbians.

Responsibilities:

- Develop and update the Practice Review Program (PRP) processes and policies for approval by the Board as required including but not limited to processes and policies that:
  - outline the Pharmacy Review component;
  - outline the Pharmacy Professionals' Review component;
  - outline follow-up and remediation.
- On a yearly basis review the statistics and outcomes and feedback of the PRP, determine recommendations for improvement and report to the Board as applicable.
- Liaise with the Hospital Pharmacy Advisory Committee, Community Pharmacy Advisory Committee and Residential Care Advisory Committee to make recommendations on current and outstanding issues pertaining to the PRP.
- Liaise with Health Authorities, owners and directors and other stakeholders to address current and outstanding issues pertaining to the PRP.

Relevant Statistical information:

- Number of meetings: 6

College of Pharmacists of British Columbia

Accomplishments:

Phase 1: Community Practice

- Launched registrant feedback survey (1 year of results to be presented to the Board at their June 2016 meeting)
- Outcomes of reviews
    - Revised program policies
    - Referral to the Inquiry Committee
- Revised timeline for pharmacies that primarily provide services to residential care facilities

Phase 2: Hospital Practice

- Created and monitored development plan including:
    - Engaging with stakeholders through meetings and forums to get feedback on program plan
    - Liaising with the Hospital Pharmacy Advisory Committee on development of Phase 2
    - Developed PRP policies for selection, deferral and exemption

Goals for Next Fiscal Year:

- Enhance Pharmacy Professionals Reviews for Pharmacy Technicians
- Develop and launch Practice Review Program Phase 1 Community Practice – Release 2: Incorporate specialty services including residential care, compounding and methadone
- Develop and launch Practice Review Program Phase 2 Hospital Practice

College of Pharmacists of British Columbia

Annual Report to the Board for Quality Assurance Committee

Reporting Period: Mar 1, 2015 – Feb 29, 2016

Membership:

Hani Al-Tabbaa
Norm Embree (From November 20th, 2015)
Sukhvir Sunny Gidda
Emily Hamilton
Jaspaul Hundal
Dorothy Li (Zahn)
Glenda MacDonald
George Walton (To November 20th, 2015)

Chair: Gary Jung
Vice Chair: Bal Dhillon

Staff Resource: Ashifa Keshavji

Mandate: To ensure that registrants are competent to practice and to promote high practice standards amongst registrants.

Responsibilities:

- Monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants.
- Establish and maintain a quality assurance program to promote high practice standards among registrants and continuous learning and professional development.
- Recommend standards of practice for continuing competency for the Board's approval.
- Develop practice guidelines and / or advisory statements when required.
- Establish and maintain a quality assurance program in accordance with current testing standards and assessment practices.
- Set, administer and maintain policies on all matters related to assessment competencies, standards, principles, selection or design and processes.
- Establish sub-committees and ad hoc working groups for Board appointment, to develop, administer and maintain assessments for the purposes of the quality assurance program.

Relevant Statistical information:

- Number of meetings: 5

College of Pharmacists of British Columbia

Accomplishments:

- Made recommendations to the Board to change the CE requirements to include accredited learning which was approved at their November 2015 meeting
- Conducted an educational needs assessment survey for all BC pharmacy professionals
- Made recommendations to the Board for future CE development based on the results of the educational needs assessment survey that were approved at their February 2016 meeting

Goals for Next Fiscal Year:

- Enhance the PDAP Portal:
    - Provide access for those who are in the reinstatement process (return to practice)
    - Launch mobile application
- Continue to recommend the development and monitor the availability of CE in order to meet the needs of registrants as identified in the 2015 Learning Needs Survey results

College of Pharmacists of British Columbia

Annual Report to the Board for Registration Committee

Reporting Period: March 1, 2015 – Feb 29, 2016

Membership:
Laura Bickerton
Carolyn Cheung
Ashley Foreman
Yonette Harrod
Thuy Phuong Hoang
Raymond Jang
Derek Lee
Vanessa Lee
Leonard Ma
Charles Park
Nathan Roeters
Joy Sisson
Jeremy Walden

Chair: Raymond Jang
Vice Chair: Thuy Phuong Hoang

Staff Resource: Doreen Leong

Mandate: To ensure that registrants are qualified to practice.

Responsibilities:

- Review all matters relating to applicants for registration and determine applicants' eligibility for registration including establishing the conditions and requirements for registration.
- Grant registration, including reinstatement and registration renewal, to all individuals who satisfy the Registration Committee that they are qualified to be a registrant, including payment of required fees.
- Develop policies and requirements with respect to the registration of new, renewing and reinstating registrants.
- Set, administer and maintain policies on all matters related to assessment competencies, standards, principles, selection or design and processes.
- Establish sub-committees and ad hoc working groups for Board appointment, to develop, administer and maintain assessments for the purposes of the registration processes.
- Inform registrants, other stakeholders and the Health Professions Review Board, as required about the registration process and outcomes.

College of Pharmacists of British Columbia

Relevant Statistical information:

- Number of meetings: 2 (in-person); 7 (tele-conference)

Accomplishments:

- Key policies, processes and exam results reviewed and approved including the International Pharmacy Technician regulation requirements, Exam Appeal Policy, English Language Proficiency Policy and Jurisprudence Exam results.
- Applications reviewed whereby applicant had issues related to the statutory declaration:
    - Pharmacist Reinstatement Application, less than 6 years in Non-practising or former pharmacist register (N=2)
    - Pharmacist Pre-registration - International Pharmacy Graduate application (N=2)
    - Pharmacy Technician Pre-registration Application (N=2)
    - Pharmacy Technician Pre-registration Application to extend December 31, 2015 deadline (N=4)
    - Pharmacy Technician Reinstatement Application, less than 6 years in Non-practising or former pharmacy technician register (N=1)
- Other application reviewed:
    - Pharmacy Technician Jurisprudence Exam – Exam accommodation (N=1)
    - Pharmacy Technician Jurisprudence Exam – Additional sitting (N=3)
- Developed the intranasal drug administration educational module and integrated with registration re-certification process

Goals for Next Fiscal Year:

- Annual review of all registration policies
- Review and recommend bylaw changes related to pre-registration and registration requirements, number of assessment attempts and transfer from former category to non-practising register and from former to reinstatement category
- Review and recommend bylaw changes related to changes to the Standards, Limits and Conditions for Injection Authority
- Finalize the requirements and processes for International Pharmacy Technician Registration
- Develop and tested online registration pre-registration process

College of Pharmacists of British Columbia

Annual Report to the Board for Residential Care Advisory Committee

Reporting Period: Mar 1, 2015 – Feb 29, 2016

Membership:

Rapinder Chahal
Ming Chang
Anna Kownacki
Aileen Mira
Joyce Quon
Alvin Singh

Chair: Douglas Danforth
Vice Chair: Maria Ton

Staff Resource: Ashifa Keshavji

Mandate: To provide recommendations to the Board on matters relating to residential care pharmacy practice issues.

Responsibilities:

- To review issues related to the practice of pharmacy for residential care facilities and homes that have been directed to the attention of the committee by the Board, Board committees or College staff.
- To assist in the development of policies, guidelines and legislation pertaining to residential care pharmacy practice and standards.
- Work collaboratively with other College practice advisory committees to ensure a cohesive approach to common practice issues.

Relevant Statistical information:

- Number of meetings: 2

Accomplishments:

- Provided feedback and made recommendations to the Practice Review Committee on Pharmacy Reviews for pharmacies that primarily provide services to residential care facilities
- Provided feedback on the bylaw/standards of practice/policy review as identified by the College Board in its current Strategic Plan
    - Certified Pharmacist Prescriber
    - Security Bylaws

College of Pharmacists of British Columbia

Goals for Next Fiscal Year:

- Review the Interpretation Manual for Residential Care and submit it to the Practice Review Committee and the Board for approval.
- Continue to propose legislation changes to the Residential Care Facilities and Homes Standards of Practice.
- Update and recommend any legislation changes required for the Interpretation Manual to reflect new legislation.
- Continue to support the Practice Review Committee on the maintenance of the Practice Review Program

College of Pharmacists of British Columbia

Annual Report to the Board for Technology Advisory Committee

Reporting Period: March 1, 2015 – February 29, 2016

Membership:

Blake Reynolds	Khush Sander
Allen Wu	Rebecca Siah
Tessa Cheng	Brenda Zacharuk
Jason Park	

Chair: Blake Reynolds
Vice-Chair: Allen Wu

Staff Resource: Bob Nakagawa

Mandate: To provide recommendations to the Board on matters related to current and emerging technologies employed in pharmacy practice.

Responsibilities:

- Provide advice, oversight and make recommendations to the Board on strategies designed to ensure the appropriate integration of emerging technologies in to pharmacy practice.
- Review the College's Technology Strategy annually to ensure that it continues to meet the needs of the College in furthering its mission, vision, and mandate.
- Assist in the identification and definition of technology-related issues that influence safe standards of practice.
- Provide guidance in the development of policies and standards pertaining to technology-related issues.

Relevant Statistical information:

- Number of meetings: 0

College of Pharmacists of British Columbia

Annual Report to the Board for Technology Advisory Committee

Reporting Period: March 1, 2015 – February 29, 2016

Membership:

Blake Reynolds
Allen Wu
Tessa Cheng
Jason Park
Khush Sander
Rebecca Siah
Brenda Zacharuk

Chair: Blake Reynolds
Vice-Chair: Allen Wu

Staff Resource: Bob Nakagawa

Mandate: To provide recommendations to the Board on matters related to current and emerging technologies employed in pharmacy practice.

Responsibilities:

- Provide advice, oversight and make recommendations to the Board on strategies designed to ensure the appropriate integration of emerging technologies in to pharmacy practice.
- Review the College's Technology Strategy annually to ensure that it continues to meet the needs of the College in furthering its mission, vision, and mandate.
- Assist in the identification and definition of technology-related issues that influence safe standards of practice.
- Provide guidance in the development of policies and standards pertaining to technology-related issues.

Relevant Statistical information:

- Number of meetings: 0

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.vii. 125th Anniversary Working Group Update

INFORMATION ONLY

Purpose
To update the Board on the progress of planning the College's 125th Anniversary celebration.

Background
The College is celebrating its 125th anniversary in 2016. At the February Board meeting, the Board approved the decision to hold the celebration on Saturday, September 17th at the Delta Grand Hotel Okanagan in Kelowna, BC, following the September 15-16 Board meeting.

Discussion
The current design of the College's 125th Anniversary celebration event is as follows:

	Friday, September 16	Saturday, September 17
Morning	Board meeting	Keynote speaker, panel and CE events
Evening	Welcome cocktail reception	Dinner / Gala

Budget

The Board approved a budget of $150,000 for the 125th Anniversary celebrations. The budget will come from the Communications and Engagement Department.

Planning

The 125th Anniversary Working Group met on March 15, 2016 to discuss the following:

- Commemorative logo (see Appendix 1)
- Results of the College learning needs survey to determine appropriate CE events
- Speakers, panelists and keynote speaker ideas

CE Content

The working group recommends that the CE content be balanced between community and hospital pharmacy practice, and should be designed to add value for both pharmacists and pharmacy technicians. The College will also consider how to encouraging Interprofessional relationship building at the event.

Next Steps

College staff is working to secure a keynote speaker, panelists and CE content, and is coordinating logistics for the venue.

Appendix	
1	College 125th Anniversary Logo


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of British Columbia
125
years

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.viii. Naloxone Update

INFORMATION ONLY

Purpose
To provide the Board with an update on naloxone including the status of Health Canada's amendments to its Prescription Drug List as well as the education sessions for the College of Pharmacists of BC (CPBC) registrants.

Background
Naloxone is an opioid antagonist. It is used to treat an opioid overdose in an emergency situation. To date, it has been classified as a Schedule I drug; this means that it is only available with a prescription. However, in early January 2016, Health Canada proposed to amend the Prescription Drug List to make a non-prescription version of naloxone available.

To support this initiative, on February 18, 2016, the Board approved the resolution to amend BC's Drug Schedules Regulation and classify the anticipated non-prescription version of naloxone as a Schedule II drug. See Appendix 1 for the February 2016 Decision Briefing Note that supported the Drug Schedules Regulation amendment. The purpose of its classification as a Schedule II drug is to ensure that appropriate training is provided to patients and other consumers seeking naloxone. Schedule II drugs require a pharmacist to provide training; training is important as the administration of the drug requires an intramuscular injection.

At the end of March 2016, Health Canada revised its Prescription Drug List to allow non-prescription use of naloxone specifically for opioid overdose emergencies outside hospital settings. The aforementioned proposed amendments to BC's Drug Schedules Regulation followed the changes to Health Canada's Prescription Drug List.

Next Steps
In collaboration with the Ministry of Health and BC CDC, CPBC will be holding live educational sessions in Nanaimo, Surrey, Burnaby, Kamloops and Prince George during the first two weeks of April 2016. In addition, a webinar will be held on April 6, 2016 and will be posted to the CPBC website as an ongoing training resource.

Members of the Board as well as CPBC staff will be at the sessions. Representatives from patient advocacy groups will also be in attendance to provide their unique perspectives. The sessions have filled capacity at higher than anticipated rates of registration.

Materials for the sessions have been developed by BC CDC. These materials will be made available for pharmacists to provide to both patients and consumers. Additionally, these materials will be available for download on CPBC's website for ongoing accessibility and use.

CPBC is working with the Ministry of Health and BC CDC, to develop a joint news release for the launch of the new legislative changes for naloxone, and more specifically, its availability in community pharmacies. In addition, plans are underway to identify other opportunities to provide educational sessions to registrants such as the British Columbia Pharmacy Association Conference, Pharmacy Leaders of Tomorrow, and the 125 Celebration.

Appendix	
1	February 2016 Decision Briefing Note: Drug Schedule Regulation Amendments - Naloxone

College of Pharmacists of British Columbia

BOARD MEETING
February, 18 & 19, 2016

11. Drug Schedule Regulation Amendment: Naloxone

DECISION REQUIRED

Recommended Board Motion:

That the Board approve the following resolution on the condition that Health Canada confirms the amendments to the Prescription Drug List regarding Naloxone.

RESOLVED THAT, in accordance with the authority established in section 22(1) of the *Pharmacy Operations and Drug Scheduling Act*, and subject to filing with the Minister as required by section 22(2) of the *Pharmacy Operations and Drug Scheduling Act*, the board amend the Drug Schedules Regulation, B.C. Reg. 9/98, as set out in the schedule attached to this resolution.

Purpose

To amend the provincial Drug Schedule Regulation to align with Health Canada's proposed amendments. Health Canada is proposing to revise the Prescription Drug List in order to authorize the use of non-prescription Naloxone for opioid overdose emergencies outside hospital settings.

Background

Naloxone is an opioid antagonist. It is used to treat an opioid overdose, be it natural or synthetic, in an emergency situation.

Health Canada's Proposal

Health Canada proposed an amendment to revise the Prescription Drug List to allow non-prescription use of Naloxone specifically for opioid overdose emergencies outside hospital settings. The proposed amendments are in response to the serious public health concern over the large increase in opioid overdose episodes across Canada, many of which have resulted in loss of life.

In its review of Naloxone, Health Canada completed a Benefit-Harm-Uncertainty assessment. This assessment recommended that Naloxone could safely be administered without the direct supervision of a healthcare practitioner if the person administering the drug has appropriate training. Furthermore, Health Canada has publicly stated, evidence from provincial take-home programs indicate that Naloxone can be administered (intramuscularly) by a layperson and its effects monitored successfully without practitioner supervision. Although an opioid overdose

might be mistakenly diagnosed by a layperson, the injection of Naloxone in a person not overdosing on an opioid will not cause serious harm.

A consultation period on Health Canada's proposed amendments is currently underway until March 19, 2016. If the consultation period results in support for the changes to the Prescription Drug List, Health Canada has committed to waiving the six-month implementation period that usually follows a consultation period. Essentially, this proposed change is likely to be in effect by April 2016.

Legislative Authority for the College of Pharmacists of British Columbia (CPBC)
The legislative authority to amend the Drug Schedules Regulation is outlined in section 22 of the *Pharmacy Operations and Drug Scheduling Act*. The *Act* states:

Regulations of the board
22 (1) Subject to the *Food and Drugs Act* (Canada), the board, by regulation, may make drug schedules specifying the terms and conditions of sale for drugs and devices.
(2) A regulation under subsection (1) must be filed with the minister.

Subject to the *Food and Drugs Act* (Canada), Health Canada determines whether a drug must be sold by prescription only or can be sold over the counter (non-prescription status). In the case of Naloxone, Health Canada is proposing a mixed approach where it will be classified as non-prescription if a particular set of conditions are met. Once, the change is approved, BC has the opportunity to classify the drug as per the Drug Schedule Regulation.

Typically, for those drugs determined by Health Canada to be non-prescription, the provinces and territories have looked to the National Association of Pharmacy Regulatory Authorities (NAPRA) to assist with non-prescription drug scheduling to ensure public safety of drug therapy. However, BC is unique in that it has its own regulatory authority to autonomously conduct its own drug scheduling.

BC's autonomous process requires CPBC to submit the proposed regulation amendment to the Ministry of Health, Professional Regulation & Oversight branch for a preliminary review. As the topic of Naloxone has been recognized with a sense of urgency, it has been identified as a high priority by the Province (and nationally) and consequently, CPBC has deviated from the typical process for having the drug scheduling recommendation move forward. CPBC's recommendation is currently under preliminary review by the Ministry of Health. Assuming no issues are identified, the Ministry of Health process will continue with a legal review and formal approval.

Discussion

- Currently, Naloxone is a Schedule I drug requiring a prescription. Once Health Canada finalizes its proposed amendments, BC has the option of scheduling non-prescription use of Naloxone (as per the particular set of conditions) as Schedule II, Schedule III, or unscheduled. The prescription use of Naloxone for inside hospital settings will remain as Schedule I.
- On February 2, 2016, an informal telephone consultation with NAPRA informed CPBC staff that due to NAPRA's drug scheduling recommendation process as per its bylaws, a recommendation will be forthcoming after its June 7-8, 2016 meeting. Anecdotally, it has been indicated that the manufacturer developing a submission for NAPRA is proposing a Schedule II recommendation. Additionally, Quebec will classify Naloxone as Schedule II once Health Canada finalizes its proposed amendments to the Prescription Drug List.
- On February 2, 2016 an in-person consultation was facilitated by CPBC in order to gather insight into the appropriate scheduling of Naloxone. Representatives from the College of Physicians and Surgeons of BC, the College of Registered Nurses of BC, the BC Centre for Disease Control (BCCDC), First Nations Health Authority, and the Ministry of Health all had the opportunity to share their views. A majority consensus in favor of Schedule II was received.
- Rationale for supporting the option for Schedule II include:
    - Aligns with other jurisdictions and NAPRA's anticipated recommendation;
    - Provides an opportunity for education on the delivery method (intramuscularly is the only option in Canada at this time, due to availability of current approved manufactured products); and
    - Provides an opportunity for training by a regulated health professional on the appropriate administration and follow-up care that is recommended by BCCDC.
- Limitations to classifying it as Schedule II include limited access as per the operating hours of a community pharmacy and the risk of patients neglecting to purchase Naloxone from behind the counter due to social stigma.
- CPBC is working with the BCCDC to develop educational sessions for registrants. At this time, the plan is to deliver 4 sessions across BC towards the end of March 2016 in order to orient registrants on the anticipated non-prescription status of Naloxone. There is also intent to video tape one of the sessions and post it to CPBC's website in order to have the educational content accessible to registrants that are unable to attend in person. The content and delivery of the education session will be developed by BCCDC.

Recommendation

The Board approve the proposed drug schedule regulation changes as presented.

Appendix	
1	Draft schedule of Drug Schedule Regulation amendments

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

2.b.ix. Audit and Finance Committee

INFORMATION ONLY

Purpose
To report on the highlights of the January financial reports.

Background
The January financial reports reflect **eleven months** activity, as our fiscal year ends February 29, 2016. Attached are the Statement of Financial Position, a summary Statement of Revenue and Expenditures and more detailed reports on Revenue and on Expenditures for the nine months.

Statement of Financial Position
The College continues to experience an excellent financial position. We are monitoring cash flow closely as we slowly draw down from the short term investments as per the Board approved strategic plan.
The Cash balance of $322,899 was getting low and we cashed in some GIC funds in early February to meet payroll and invoice obligations.
Short Term Investments are still substantial at $8,433,174.
Payables and Accruals are $761,306.

Revenue
Pharmacists and Pharmacy Technician fee projections are lower than anticipated in the budget. These are being monitored, as are expenses, so that expenditures can be adjusted, if needed. Pharmacist registration statistics are meeting budgeted estimates. However, some of the one-time fees, such as JE exams and injection fees are lower than anticipated. Pharmacy Technician registrations are lower than expected.
Grant revenues are lower primarily due to timing and should increase somewhat.

Expenses
With Revenues projected to be lower than budget, we are monitoring expenses closely. Total Year to Date Actual expenses are lower than budget, many due to timing.

Variance updates by department:

Department	Budget	Actual	Comment
Board & Registrar's Office	$639,352	$506,656	The budget contains a contingency related to the loyalty points court case, which has not been used to date.
Grant distribution	$496,625	$118,950	Some contracts have recently been signed and one is still pending but anticipated to be signed before the end of January.
Registration & Licensure	$242,213	$181,858	This variance is primarily due to the delay in the Jurisprudence Exam review project.
Quality Assurance	$653,739	$463,704	The budget includes funding for the expansion of e-library services. One proposal was approved in November. However, there will be a surplus at the end of the year, which will offset some of the revenue shortfall.
Practice Review (Inspections)	$181,683	$151,534	Compliance Officer travel costs have not been as costly as anticipated.
Complaints Resolution (Discipline and Investigations)	$568,198	$342,704	Legal and outside contractors' fees depend upon the timing of Discipline Hearings.
Policy and Legislation	$80,313	$66,650	Due to timing of legal expenditures.
Hospital Pharmacy & Practice (Pharmacist Prescriber)	$385,660	$441,193	Outside consulting fees are higher than budget due to the amount of time and work involved with the Pharmacist Prescriber project.
Public Engagement (Communications)	$490,600	$328,748	This surplus is due to changing priorities and Communications staffing availability.

Finance and Administration	$1,241,557	$1,390,038	The higher than anticipated expenses came from three areas. Some staff were contracted through a temp agency, resulting in fees from the agency rather than salaries and benefits. Legal fees were higher than budgeted, both for HR and for FOI. The Registration Database software (iMIS) upgrade was moved up in timing.
Salaries and benefits	$4,041,932	$3,988,471	Some timing factors and some classification factors - see temporary agency note above.
Amortization	$264,601	$164,190	Timing – as some calculations are done at year end.

Appendix	
1	Statement of Financial Position
2	Statement of Revenue and Expenditures
3	Statement of Revenue
4	Statement of Expenses

College of Pharmacists of British Columbia
Statement of Financial Position
As at January 31, 2016

Assets	**$**
Current	
Cash	322,898.67
Short term investments	8,433,174.41
Receivables	102,435.30
Prepaids and deposits	295,927.68
Investment in Joint Venture	1,595,053.00
	10,749,489.06
Development costs	215,896.10
Property and equipment	831,529.69
	11,796,914.85

Liabilities and Net Assets	**$**
Liabilities	
Current	
Payables and accruals	761,305.79
Deferred revenue	2,533,927.36
Unearned revenue	366,685.42
	3,661,918.57
Capital lease obligations	80,850.32
	3,742,768.89
Net Assets	
Closing Balance	8,054,145.96
	11,796,914.85

College of Pharmacists of BC

Statement of Revenue and Expenditures

For the eleven months ended January 31, 2016

	2015/16 YTD Budget	2015/16 YTD Actual	Variance (Budget vs. Actual) $	Variance (Budget vs. Actual) %
	11 months	11 months	11 months	11 months
REVENUE				
Licensure	**5,395,813**	**5,098,398**	**(297,415)**	**(6%)**
Non Licensure	**2,058,796**	**1,916,329**	**(142,467)**	**(7%)**
Total Revenue Before Transfer from Balance Sheet	**7,454,608**	**7,014,727**	**(439,881)**	**(6%)**
Transfer from Balance Sheet	**1,750,827**	**1,453,770**	**(297,057)**	**(17%)**
TOTAL REVENUE	**9,205,435**	**8,468,497**	**(736,938)**	**(8%)**
TOTAL EXPENSES BEFORE AMORTIZATION	**8,945,500**	**7,980,504**	**964,996**	**11%**
NET SURPLUS (DEFICIT) BEFORE THE FOLLOWING:	**259,935**	**487,992**	**228,058**	
Amortization expenses	264,601	211,920	52,681	20%
TOTAL EXPENSES AFTER AMORTIZATION	**9,210,102**	**8,192,425**	**1,017,677**	11%
NET SURPLUS(DEFICIT)	**(4,667)**	**276,072**	**280,739**	

College of Pharmacists of BC

Statement of Revenue and Expenditures

For the eleven months ended January 31, 2016

	2015/16 YTD Budget	2015/16 YTD Actual	Variance (Budget vs. Actual) $	Variance (Budget vs. Actual) %
	11 months	11 months	11 months	11 months
REVENUE				
Licensure				
Pharmacy Fees	1,632,675	1,651,820	19,145	1%
Pharmacist Fees	3,133,686	3,025,717	(107,969)	(3%)
Pharmacy Technician Fees	629,451	420,860	(208,591)	(33%)
	5,395,813	**5,098,398**	**(297,415)**	**(6%)**
Non Licensure				
Other revenue	1,374,676	1,366,580	(8,096)	(1%)
Grant revenue	234,700	123,500	(111,200)	(47%)
Investment Income - GIC	220,253	202,502	(17,751)	(8%)
Investment Income - JV	229,167	223,747	(5,419)	(2%)
	2,058,796	**1,916,329**	**(142,467)**	**(7%)**
Total Revenue Before Transfer from Balance Sheet	**7,454,608**	**7,014,727**	**(439,881)**	**(6%)**
Transfer from Balance Sheet	**1,750,827**	**1,453,770**	**(297,057)**	**(17%)**
TOTAL REVENUE	**9,205,435**	**8,468,497**	**(736,938)**	**(8%)**

College of Pharmacists of BC

Statement of Revenue and Expenditures

For the eleven months ended January 31, 2016

	2015/16 YTD Budget	2015/16 YTD Actual	Variance (Budget vs. Actual) $	Variance (Budget vs. Actual) %
	11 months	11 months	11 months	11 months
EXPENSES				
Board & Registrar's Office	639,352	506,656	132,697	21%
Grant Distribution	420,253	118,950	301,303	72%
Registration and Licensing	242,213	181,858	60,355	25%
Quality Assurance	653,739	463,704	190,035	29%
Inspections	181,683	151,534	30,150	17%
Discipline and Investigations	568,198	342,704	225,494	40%
Legislation	80,313	66,650	13,663	17%
Hospital Pharmacy and Practice	385,660	441,193	(55,533)	(14%)
Public Accountability and Engagement	490,600	328,748	161,852	33%
Finance and Administration	1,241,557	1,390,038	(148,480)	(12%)
Salaries and Benefits	4,041,932	3,988,471	53,460	1%
TOTAL EXPENSES BEFORE AMORTIZATION	**8,945,500**	**7,980,504**	**964,996**	**11%**
NET SURPLUS (DEFICIT) BEFORE THE FOLLOWING:	**259,935**	**487,992**	**228,058**	
Amortization expenses	264,601	211,920	52,681	20%
TOTAL EXPENSES AFTER AMORTIZATION	**9,210,102**	**8,192,425**	**1,017,677**	11%

College of Pharmacists of British Columbia

Board Meeting

Thursday, April 14th, 2016

CPBC Office, 200 - 1765 West 8th Avenue, Vancouver

DRAFT AGENDA

DAY 1 - THURSDAY, APRIL 14, 2016

9:00am - 12:00pm		***Board Session***	
12:00 - 1:00		***LUNCH***	
1:00 - 1:15	**1.**	Welcome & Call to Order	Chair Reynolds
	2.	Consent Agenda a) Items for further discussion b) Approval of Consent Items **[DECISION]**	Chair Reynolds
	3.	Confirmation of Agenda **[DECISION]**	Chair Reynolds
1:15 - 1:30	**4.**	Items brought forward from Consent Agenda	Chair Reynolds
1:30 - 2:00pm	**5.**	Legislation Review Committee: a) Pharmacy Security Bylaws - Public Posting **[DECISION]**	Jeremy Walden
2:00 - 2:30	**6.**	Genomics Initiative Update and Professorship **[DECISION]**	Corey Nislow
2:30 - 2:45		***BREAK***	
2:45 - 3:15	**7.**	Telepharmacy Update	Doreen Leong
3:15 - 3:30	**8.**	Pharmacy Leaders of Tomorrow (PLoT) Presentation	Ming Chang / Aaron Sihota
		ADJOURN FOR THE DAY	Chair Reynolds

College of Pharmacists of British Columbia

Board Meeting

Friday, April 15, 2016

CPBC Office, 200 - 1765 West 8th Avenue, Vancouver

DRAFT AGENDA

DAY 2 - FRIDAY, APRIL 15, 2016

9:00am		Call to Order	Chair Reynolds
9:00 - 10:00	**9.**	Update from Ministry of Health a) Reference Drug Program b) Methadone Maintenance Program	Barb Walman
10:00 - 10:05	**10.**	Legislation Review Committee: a) PPP-58 Adapting a Prescription - Amendments **[DECISION]**	Jeremy Walden
10:05 - 11:00	**11.**	Medical Assistance In Dying (MAID) a) Presentation b) Interim Guidance Document **[DECISION]**	Heidi Oetter/Debbie Lovett/ Suzanne Solven
11:00 - 11:15		***BREAK***	
11:15 - 12:15	**12.**	Inquiry/Discipline and Administrative Law	Angie Westmacott/ John Hope/ Dorothy Barkley
12:15 - 1:00		***LUNCH***	
1:00 - 1:45	**13.**	Safe disposal of Fentanyl Patches	Bruce Kennedy
1:45 - 2:15	**14.**	DrugSafe BC a) Update b) Recognition	 Gillian Vrooman Chair Reynolds
2:15 - 2:30		***BREAK***	
2:30 - 3:30	**15.**	Physical Assessment Presentation	Sean Spina
3:30 - 4:00pm	**16.**	Governance Committee Recommendations **[DECISIONS]**	Norm Embree
		CLOSING COMMENTS, ROUND TABLE EVALUATION OF MEETING, AND ADJOURNMENT	Chair Reynolds

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

5. Legislation Review Committee: Pharmacy Security Bylaws – Public Posting

DECISION REQUIRED

Recommended Board Motion:

Approve the proposed draft Pharmacy Operations and Drug Scheduling Act bylaws for public posting for a period of 90 days, as circulated.

Purpose

To request that the Board of the College of Pharmacists of BC (the Board) approve the proposed draft Pharmacy Operations and Drug Scheduling Act bylaws for public posting for a period of 90 days, as circulated.

The proposed bylaws (Appendix 1) are made in accordance with the College's bylaw making authority as outlined in section 22 of the *Pharmacy Operations and Drug Scheduling Act*.

Background

In 2013, the Vancouver Police Department contacted the College about its concerns regarding what they noted as an increasing number of community pharmacy robberies. The Board established a Robbery Prevention Working Group (RPWG) to examine the issues and to develop pharmacy security requirements.

After considering the research and evidence obtained, the RPWG drafted a professional practice policy (PPP) and resource guide. These materials, outlined minimum security requirements for community pharmacies in BC.

In February 2015, the Board approved PPP 74 - Community Pharmacy Security (Appendix 3). At the June 2015 Board meeting, College staff presented the draft Community Pharmacy Security Resource Guide (Resource Guide) with options, one of which was to not enforce the requirement for barriers.

After discussion, the Board approved the Resource Guide with amendments that included the requirement for barriers. At present, PPP-74 and the Resource Guide are in effect.

In September 2015, the Board directed the Registrar to draft bylaws to strengthen the pharmacy security requirements through legislation.

Consultation

In order to guide the consultation process, the proposed bylaws were provided to corporate stakeholders. Written feedback was requested; 9 submissions were received (Appendix 4).

Consultations also took place with internal College staff as well as with the Community, Residential Care and Hospital Pharmacy Advisory Committees.

An analysis of the feedback received during consultations confirmed:

- Those requirements that were generally accepted (13)
- Those requirements that warranted College staff to consider minor revisions (2)
- Those requirements that were of the greatest concern to stakeholders (2)

As part of the bylaw change process the College also consulted with the Ministry of Health, Professional Regulation and Oversight Branch. No specific issues were raised.

Furthermore, on January 26, 2016, the College held an in-person engagement with corporate stakeholders to review the written feedback received to date. Participants included representatives from Costco, Loblaws, London Drugs, People's Drug Mart, Pharmasave, Rexall, Shoppers Drug Mart, Walmart, British Columbia Pharmacy Association and Neighbourhood Pharmacy Association.

The analysis was presented and participants were asked to comment on those requirements where with small changes made, agreement could be reached. Based on this discussion, several changes were made including:

- Revision of notification requirements to include what must be reported to the registrar
- Revision of signage requirements to clarify when signage is required and to provide an exception for unmarked pharmacies which are not open to the public.
- Revision of the definition of pharmacy security to include measures which are intended to be achieved

Of the 17 requirements, the consultation resulted in some form of agreement on 15. Two issues remained of significant concern to the corporate stakeholders. These were physical barriers and personal information.

Feedback Regarding Physical Barriers

Requirement:
The proposed draft bylaws require physical barriers for Schedule I, II and III drugs, controlled drug substances and personal information when no full pharmacist is present and the premise is accessible to non-registrants.

Issues:

- lack of evidence that barriers mitigate risks better than other methods of controlling access
- "non-registrants" means cleaning staff cannot have access afterhours when no pharmacist is present
- Cost implications of employing physical barriers – they are expensive

Feedback Regarding Personal Information

Requirement:
The proposed draft bylaws require that pharmacy managers and director or owners establish and maintain measures to protect against unauthorized access, collection, use, disclosure or disposal of personal information.

Issues:

- Privacy breaches are unrelated to drug theft issues
- Protection of personal information is a highly regulated area
- Protection of patient information is already required in PODSA bylaws

Discussion

Physical Barriers

Research shows that security measures are on a continuum which includes – deterrence, prevention, mitigation and investigation. Deterring measures are designed to discourage security breaches. Preventative measures are in place to prevent or increase the difficulty to commit a theft. Mitigation and investigation measures assist authorities in the study of the incident after it occurs. It is suggested that the more barriers that are in place, the greater the psychological deterrent.

Examples of the deterring security measures are:

- Signage
- Motion detectors
- Alarms

Examples of preventative security measures are:

- Safes
- Physical Barriers

Examples security measures that can assist in mitigation and investigation are:

- Security cameras

All risk management strategies must contemplate the continuum of measures. The pharmacy security measures including the requirement for physical barriers are in line with this approach.

Personal Information

The *Personal Information Protection* Act (PIPA) states that an organization must protect personal information in its custody or under its control by making reasonable security arrangements to prevent unauthorized access, collection, use, disclosure, copying, modification or disposal or similar risks. Further to this, a report published by The Office of the Information and Privacy Commissioner of British Columbia titled, Order P15-01 Park Royal Medical Clinic, highlights that personal health information is recognized as one of the most sensitive categories of personal information. Therefore, the level of sensitivity requires an accordingly high level of physical, administrative and technical security measures for protecting the information. It is further stated that physical security is a critical aspect of reasonable security arrangements.

The College worked closely with former Privacy Commissioner, David Loukidelis to ensure that the requirement to protect patient information in the pharmacy complements the existing privacy legislation - PIPA. Mr. Loukidelis also advised the College that the requirement provides pharmacies with a minimum requirement for what is “reasonable” for the purposes of PIPA.

Recommendation

That the Board approve the proposed bylaws for public posting as presented.

Appendix	
1	Red-lined Pharmacy Operations and Drug Scheduling Act bylaws – for approval
2	Revised Community Pharmacy Security Policy (PPP-74) – for information
3	Existing Board Approved Community Pharmacy Security Policy (PPP-74) – for information
4	Corporate Stakeholder Feedback Letters – for information

Pharmacy Operations and Drug Scheduling Act - BYLAWS

Table of Contents

Commented [AS1]: A new section has been added under the Community Pharmacies section of the bylaw to include pharmacy security requirements for community pharmacies.

FORMS

1. New Pharmacy Application
2. Telepharmacy Services Application
3. Hospital Pharmacy Satellite Application
4. Community Pharmacy Licence Renewal Notice
5. Hospital Pharmacy Licence Renewal Notice
6. Education Site License Renewal Notice

Definitions

1. In these bylaws:

"*Act*" means the *Pharmacy Operations and Drug Scheduling Act*;

"central pharmacy site" means a pharmacy authorized under Part IV to provide telepharmacy services;

"community pharmacy" means a pharmacy licensed to sell or dispense drugs to the public;

"*Community Pharmacy Standards of Practice*" means the standards, limits and conditions for practice established under section 19 (1) (k) of the *Health Professions Act* respecting community pharmacies;

"controlled drug substance" means a drug which includes a substance listed in ~~Schedule I, II, III, IV or V of the~~ the Schedules to the *Controlled Drugs and Substances Act* (Canada) or Part G of the Food and Drug Regulations (Canada);

Commented [AS2]: Existing definition is further refined to include Part G of the Food and Drug Regulations.

"controlled prescription program" means a program approved by the board, to prevent prescription forgery and reduce inappropriate prescribing of drugs;

"dispensary" means the area of a community pharmacy that contains Schedule I and II drugs;

"drug" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

Commented [AS3]: The word 'drug' is defined in PODSA and should be used in the bylaw. The term "medicine" and its definition has been removed from the bylaw.

"health authority" means

(a) a regional health board designated under the *Health Authorities Act*, or
(b) the Provincial Health Services Authority, or
~~(b)~~(c) First Nations Health Authority;~~;~~

Commented [AS4]: Minor correction identified by the MoH. The First Nations Health Authority is not included under (a) and (b) therefore it has been added.

"hospital" has the same meaning as in section 1 of the *Hospital Act*;

"hospital pharmacy" means a pharmacy licensed to operate in or for a hospital;

"hospital pharmacy satellite" means a physically separate area on or outside the hospital premises used for the provision of pharmacy services which is dependent upon support and administrative services from the hospital pharmacy;

"Hospital Pharmacy Standards of Practice" means the standards, limits and conditions for practice established under section 19 (1) (k) of the *Health Professions Act* respecting hospital pharmacies;

"incentive" has the same meaning as in Part 1 of Schedule F of the bylaws of the college under the *Health Professions Act;*

~~**"medication"** has the same meaning as "drug";~~

"outsource prescription processing" means to request another pharmacy to prepare or process a prescription drug order;

"patient's representative" has the same meaning as in section 64 of the bylaws of the college under the *Health Professions Act*;

"personal information" has the same meaning as in the *Freedom of Information and Protection of Privacy Act*;

~~**"pharmacy assistant"** has the same meaning as "support person";~~

"pharmacy education site" means a pharmacy

(a) that has Schedule I, II and III drugs, but no controlled drug substances,
(b) that is licensed solely for the purpose of pharmacy education, and
(c) from which pharmacy services are not provided to any person;

"pharmacy security" means

(a) measures to prevent unauthorized access and loss of Schedule I, IA, II and III drugs, and controlled drug substances;
(b) measures providing for periodic and post-incident review of pharmacy security;
(c) measures to protect against unauthorized access, collection, use, disclosure or disposal of personal information

"pharmacy services" has the same meaning as in section 1 of the bylaws of the college under the *Health Professions Act*;

"pharmacy technician" has the same meaning as in section 1 of the bylaws of the college under the *Health Professions Act*;

"prescription drug" means a drug referred to in a prescription;

"professional products area" means the area of a community pharmacy that contains Schedule III drugs;

"professional service area" means the area of a community pharmacy that contains Schedule II drugs;

"Residential Care Facilities and Homes Standards of Practice" means the standards, limits and conditions for practice established under section 19 (1) (k) of the *Health Professions Act* respecting residential care facilities and homes;

"Schedule I, Schedule IA, Schedule II, or Schedule III", as the case may be, refers to the drugs listed in Schedule I, IA, II or III of the Drug Schedules Regulation;

Commented [AS5]: Removed this definition as the word 'drug' is defined in PODSA and should be used in the bylaw.

Commented [AS6]: New definition to clarify what the term personal information means in this bylaw.

Commented [AS7]: Removed this definition as the term "support person" is defined in PODSA and should be used in the bylaw.

Commented [AS8]: New definition.

"pharmacy security" means measures to prevent and respond to incidents of robbery, break and enter, forgery, theft, unexplained drug loss or adulterated drugs at a pharmacy, including:
(a)secure storage of narcotic and controlled drugs,
(b)surveillance systems,
(c)alarm systems,
(d)physical barriers,
(e)protection of confidential patient information,
(f)public notice of security measures,
(g)incident review, and
(h)pharmacy security evaluation

Above was the draft text used for consultations. Through consultations comments were received that this definition stated more than measures. Specifically secure storage of narcotics and controlled drugs and protection of confidential patient information were identified as not being measures. The definition has been revised and reworded to reflect these concerns. The objective is to have measures to prevent unauthorized access to drugs and personal information associated with drugs in a pharmacy.

Commented [AS9]: New definition to clarify that when referenced these terms refer to BC scheduled drugs as listed in the Drug Schedules Regulation and to avoid any confusion with schedules listed in Federal legislation.

"telepharmacy" means the process by which a central pharmacy site operates one or more telepharmacy remote sites, all of which are connected to the central pharmacy site via computer, video and audio link;

"telepharmacy services" means prescription processing or other pharmacy services, provided by or through telepharmacy;

"telepharmacy remote site" means a pharmacy providing pharmacy services to the public, or in or for a hospital,

(a) without a full pharmacist present,
(b) in a rural or remote community, and
(c) under the supervision and direction of a full pharmacist at a central pharmacy site.

Commented [AS10]: Minor correction identified by the MoH. The word pharmacist was missing.

PART I - All Pharmacies

Application of Part

2. This part applies to all pharmacies except pharmacy education sites.

Responsibilities of Pharmacy Managers, Owners and Directors

3. (1) A full pharmacist may not act as manager of more than one pharmacy location, unless the pharmacy of which the full pharmacist is manager includes

(a) a telepharmacy remote site,

(b) a hospital pharmacy,

(c) a hospital pharmacy satellite, or

(d) a pharmacy education site.

(2) A manager must do all of the following:

(a) actively participate in the day-to-day management of the pharmacy;

(b) confirm that the staff members who represent themselves as registrants are registrants;

(c) notify the registrar in writing of the appointments and resignations of registrants as they occur;

(d) cooperate with inspectors acting under section 17 of the *Act* or sections 28 or 29 of the *Health Professions Act*;

(e) ensure that registrant and ~~pharmacy assistant~~support person staff levels are commensurate with the workload volume and patient care requirements at all times;

Commented [AS11]: support person is the correct term to use as defined in PODSA.

(f) ensure that new information directed to the pharmacy pertaining to drugs, devices and drug diversion is immediately accessible to registrants and ~~pharmacy assistants~~support persons;

(g) establish policies and procedures to specify the duties to be performed by registrants and ~~pharmacy assistants~~support persons;

(h) establish procedures for

(i) inventory management,

(ii) product selection, and

(iii) proper destruction of unusable drugs and devices;

(i) ensure that all records related to the purchase and receipt of controlled drug substances are signed by a full pharmacist;

(j) ensure appropriate security and storage of all Schedule I, II, and III drugs and controlled drug substances for all aspects of pharmacy practice including operation of the pharmacy without a registrant present;

(k) ensure there is a written drug recall procedure in place for pharmacy inventory;

(l) ensure that all steps in the drug recall procedure are documented, if the procedure is initiated;

(m) ensure that each individual working in the pharmacy wears a badge that clearly identifies the individual's registrant class or other status;

~~(n) ensure that confidentiality is maintained with respect to all pharmacy and patient records in accordance with all applicable legislation;~~

~~(o)~~(n) make reasonable ~~security~~ arrangements ~~in respect of unauthorized respecting~~to prevent unauthorized access, collection, use, disclosure or disposal of personal information kept on the pharmacy premises;

~~(p)~~(o) notify the registrar as soon as possible in the event that he or she will be absent from the pharmacy for more than eight weeks;

~~(q)~~(p) notify the registrar in writing within 48 hours of ceasing to be the pharmacy's manager;

~~(r)~~(q) ensure the correct and consistent use of the community pharmacy operating name as it appears on the community pharmacy licence for all pharmacy identification on or in labels, directory listings, signage, packaging, advertising and stationery;

(r) ~~ensure that appropriate security is in place for the premises generally~~establish and maintain policies and procedures respecting pharmacy security;

Commented [AS12]: support person is the correct term to use as defined in PODSA.

Commented [AS13]: support person is the correct term to use as defined in PODSA.

Commented [AS14]: Through consultations it was identified that this requirement caused confusion and is very similar to (n). Former Privacy Commissioner David Loukedilis agreed and suggested that this requirement should be removed and consolidated with (n).

Commented [AS15]:
(n) ensure that confidentiality is maintained with respect to all pharmacy and patient records in accordance with all applicable legislation;

(o) make reasonable security arrangements in respect of unauthorized access, collection, use, disclosure or disposal of personal information kept on the pharmacy premises

Both of these were existing requirements in the bylaws. During consultations comments were received that these two existing requirements were "sufficient" enough to prevent access and loss of personal information in a pharmacy. Former Privacy Commissioner, David Loukidelis advised the College that these two subsections should be consolidated. Also, during consultations David clarified to stakeholders that these requirements provide further guidance, and protection, for pharmacies, in fulfilling their PIPA obligations.

As advised by David, (n) and (o) have been consolidated and the revised text is now aligned with PIPA.

Commented [AS16]: The existing requirement which referenced security has been updated.

No comments were received in consultations on this requirement.

(r.1) ensure that pharmacy staff are trained in policies and procedures regarding pharmacy security;

(s) notify the registrar of any incident of loss of drugs or loss of personal information, whether electronic or physical;;

(t) in the event of a pharmacy closure or relocation,

(i) notify the registrar in writing at least thirty days before the effective date of a proposed closure or relocation, unless the registrar determines there are extenuating circumstances,

(ii) provide for the safe transfer and appropriate storage of all Schedule I, II, and III drugs and controlled drug substances,

(iii) advise the registrar in writing of the disposition of all drugs and prescription records at the time of a closure,

(iv) provide the registrar with a copy of the return invoice and any other documentation sent to Health Canada in respect of the destruction of all controlled drug substances,

(v) arrange for the safe transfer and continuing availability of the prescription records at another pharmacy, or an off-site storage facility that is bonded and secure, and

(vi) remove all signs and advertisements from the closed pharmacy premises;

(u) ensure sample ~~medications~~ drugs are dispensed in accordance with the requirements in the Drug Schedules Regulation;

(v) advise the registrar if the pharmacy is providing pharmacy services over the internet, and provide to the registrar the internet address of every website operated or used by the pharmacy;

(w) ensure the pharmacy contains the reference material and equipment approved by the board from time to time;

(x) require all registrants, owners, managers, directors, pharmaceutical representatives, ~~pharmacy assistants~~support persons and computer software programmers or technicians who will access the in-pharmacy computer system to sign an undertaking in a form approved by the registrar to maintain the confidentiality of patient ~~record~~ personal information;

(y) retain the undertakings referred to in paragraph (x) in the pharmacy for 3 years after employment or any contract for services has ended;

Commented [AS17]: This is a new requirement.

No comments were received in consultations.

Commented [AS18]: This is a new requirement.

"Notify the registrar of any breach of pharmacy security" was the draft text used for consultations. Through consultations comments were received that reporting any instance was too broad and. Based on the consultations the text has been revised and the revised PPP-74 provides further details on what and how to report.

Commented [AS19]: The term drug should be used medication has been replaced with drug throughout the bylaw.

Commented [AS20]: support person is the correct term to use as defined in PODSA.

(z) be informed of the emergency preparedness plan in the area of the pharmacy that he or she manages and be aware of his or her responsibilities in conjunction with that plan;

(aa) ensure that no incentive is provided to a patient or patient's representative for the purpose of inducing the patient or patient's representative to

(a) deliver a prescription to a particular registrant or pharmacy for dispensing of a drug or device specified in the prescription, or

(b) obtain any other pharmacy service from a particular registrant or pharmacy.

(bb) notify the registrar of persistent non-compliance by owners and directors with their obligations under the bylaws;

(3) Subsection (2)(~~rq~~) does not apply to a hospital pharmacy, hospital pharmacy satellite or a pharmacy education site.

(4) Owners and directors must comply with subsection (2) (d), (e), (j), ~~(n), (o), (r), (s),~~ (n), (q), (r), (t), (v), (w), (x) and (aa).

(5) An owner or director must appoint a manager whenever necessary, and notify the registrar in writing of the appointment and any resignation of a manager.

(6) Owners and directors must ensure that the requirements to obtain a pharmacy licence under the *Act* are met at all times.

(7) For the purpose of subsection (2)(t), a pharmacy closure includes a suspension of the pharmacy licence for a period greater than 30 days, unless otherwise directed by the registrar.

3.1 Subsection (2)(aa) does not prevent a manager or director, or an owner from

(a) providing free or discounted parking to patients or patient's representatives,

(b) providing free or discounted delivery services to patients or patient's representatives, or

(c) accepting payment for a drug or device by a credit or debit card that is linked to an incentive.

3.2 Subsection (2)(aa) does not apply in respect of a Schedule III drug or an unscheduled drug, unless the drug has been prescribed by a practitioner.

Sale and Disposal of Drugs

4. (1) Schedule I, II, and III drugs and controlled drug substances must only be sold or dispensed from a pharmacy.

Commented [AS21]: New requirement.

"notify the registrar of non-compliance by owners and directors with their obligations under the bylaws" was the draft text used for consultations. Through consultations concerns about the degree of accountability this imposes on managers and the impact on the employment relationships of registrants were raised. It was suggested that pharmacy managers should first address the issues with the owners and directors and if no resolution then notify the registrar. PPP-74 already has this wording so we further refined this requirement to clarify that continued non-compliance must be notified.

Commented [AS22]: Updated existing references to reflect numbering changes in 3(2).

Commented [AS23]: Updated existing references and included new requirements which owners and directors are also responsible for.

(2) A registrant must not sell or dispense a quantity of drug that will not be used completely prior to the manufacturer's expiry date, if used according to the directions on the label.

(3) If the manufacturer's expiry date states the month and year but not the date, the expiry date is the last day of the month indicated.

(4) Every registrant practising in a pharmacy is responsible for the protection from loss, theft or unlawful sale or dispensing of all Schedule I, II, and III drugs and controlled drug substances in or from the pharmacy.

(5) A registrant must not sell, dispense, dispose of or transfer a Schedule I drug except

(a) on the prescription or order of a practitioner,

(b) for an inventory transfer to a pharmacy by order of a registrant in accordance with the policy approved by the board,

(c) by return to the manufacturer or wholesaler of the drug, or

(d) by destruction, in accordance with the policy approved by the board.

(6) Drugs included in the controlled prescription program must not be sold or dispensed unless

(a) the registrant has received the prescription on the prescription form approved by both the board and the College of Physicians and Surgeons of British Columbia, and

(b) the prescription form is signed by the patient or the patient's representative upon receipt of the dispensed drug.

(7) A new prescription from a practitioner is required each time a drug is dispensed, except for

(a) a part-fill,

(b) a prescription authorizing repeats,

(c) a full pharmacist-initiated renewal or adaptation, or

(d) an emergency supply for continuity of care.

(8) Subsection (6) does not apply to prescriptions written for

(a) residents of a facility or home subject to the requirements of the *Residential Care Facilities and Homes Standards of Practice*, or

(b) patients admitted to a hospital.

Drug Procurement/Inventory Management

5. (1) A full pharmacist may authorize the purchase of Schedule I, II, or III drugs or controlled drug substances only from

(a) a wholesaler or manufacturer licensed to operate in Canada, or

(b) another pharmacy in accordance with the policy approved by the board.

(2) A registrant must record a transfer of drugs that occurs for any reason other than for the purpose of dispensing in accordance with a practitioner's prescription.

(3) All drug shipments must be delivered unopened to the pharmacy or a secure storage area.

(4) Non-usable and expired drugs must be stored in a separate area of the pharmacy or a secure storage area until final disposal.

(5) A full pharmacist must not purchase Schedule I, II and III drugs and controlled drug substances unless they are for sale or dispensing in or from a pharmacy.

Interchangeable Drugs

6. When acting under section 25.91 of the *Health Professions Act,* a full pharmacist must determine interchangeability of drugs by reference to Health Canada's Declaration of Equivalence, indicated by the identification of a Canadian Reference Product in a Notice of Compliance for a generic drug.

Returned Drugs

7. No registrant may accept for return to stock or reuse any drug previously dispensed except in accordance with section 11(3) of the *Residential Care Facilities and Homes Standards of Practice* or section 5(2) of the *Hospital Pharmacy Standards of Practice.*

Records

8. (1) All prescriptions, patient records, invoices and documentation in respect of the purchase, receipt or transfer of Schedule I, II and III drugs and controlled drug substances must be retained for a period of not less than three years from the date

(a) a drug referred to in a prescription was last dispensed, or

(b) an invoice was received for pharmacy stock.

(2) Registrants, ~~pharmacy assistants~~support persons, managers, directors, and owners must not, for commercial purposes, disclose or permit the disclosure of information or an abstract of information obtained from a prescription or patient record which would permit the identity of the patient or practitioner to be determined.

Commented [AS24]: support person is the correct term to use as defined in PODSA.

(3) Despite subsection (1), a registrant must not destroy prescriptions, patient records, invoices or documentation until the completion of any audit or investigation currently underway for which the registrant has received notice.

Pharmacy Licences

9. (1) The registrar may issue a licence for any of the following:

(a) a community pharmacy;

(b) a hospital pharmacy;

(c) a pharmacy education site.

(2) An applicant for a pharmacy licence must submit the following to the registrar:

(a) a completed application in Form 1;

(b) a diagram to scale of ½ inch equals 1 foot scale including the measurements, preparation, dispensing, consulting, storage, professional service area, professional products area, entrances and packaging areas of the pharmacy;

(c) the applicable fee set out in Schedule "A";

(d) for a community pharmacy, proof in a form satisfactory to the registrar that the municipality in which the pharmacy is located has issued a business licence for the pharmacy to the pharmacy's owner or manager.

(3) The registrar may renew a pharmacy licence upon receipt of the following:

(a) a completed notice in Form 4, 5 or 6, as applicable, signed by the manager;

(b) the applicable fee set out in Schedule "A".

(4) A pharmacy's manager must submit to the registrar, in writing, any proposed pharmacy design changes or structural renovations together with a new pharmacy diagram for approval before the commencement of construction or other related activities.

(5) If a pharmacy will be closed temporarily for up to 14 consecutive days, the pharmacy's manager must

(a) obtain the approval of the registrar,

(b) notify patients and the public of the closure at least 30 days prior to the start of the closure, and

(c) make arrangements for emergency access to the pharmacy's hard copy patient records.

(6) A pharmacy located in a hospital which dispenses drugs to staff, out-patients or the public and which is not owned or operated by a health authority, must be licenced as a community pharmacy.

(7) Subsections (4) to (6) do not apply to a pharmacy education site.

PART II – Community Pharmacies

Community Pharmacy Manager – Quality Management

10. A community pharmacy's manager must develop, document and implement an ongoing quality management program that

(a) maintains and enforces policies and procedures to comply with all legislation applicable to the operation of a community pharmacy,

(b) monitors staff performance, equipment, facilities and adherence to the *Community Pharmacy Standards of Practice*, and

(c) includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies.

Community Pharmacy Premises

11. (1) In locations where a community pharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy's manager must ensure that

(a) the professional products area extends not more than 25 feet from the perimeter of the dispensary and is visually distinctive from the remaining areas of the premises by signage, and

(b) a sign reading "Medication Information" is clearly displayed to identify a consultation area or counter at which a member of the public can obtain a full pharmacist's advice.

(2) The dispensary area of a community pharmacy must

(a) be at least 160 square feet,

(b) be inaccessible to the public by means of gates or doors across all entrances,

(c) include a dispensing counter with at least 30 square feet of clear working space, in addition to service counters,

(d) contain adequate shelf and storage space,

(e) contain a double stainless steel sink with hot and cold running water, and

(f) contain an adequate stock of drugs to provide full dispensing services.

(3) In all new and renovated community pharmacies, an appropriate area must be provided for patient consultation that

(a) ensures privacy and is conducive to confidential communication, and

(b) includes, but is not limited to, one of the following:

(i) a private consultation room;

(ii) a semiprivate area with suitable barriers.

(4) All new and renovated community pharmacies must have a separate and distinct area consisting of at least 40 square feet reserved as secure storage space.

Community Pharmacy Security

11.1 (1) A community pharmacy must:

(a) Keep Schedule IA drugs in a locked metal safe that is secured in place and equipped with a time delay lock set at a minimum of five minutes;

(b) Install and maintain a security camera system that:

(i) has date/time stamp images that are archived and available for no less than 30 days, and

(ii) is checked daily for proper operation.

(c) Install and maintain motion sensors in the dispensary;

(2) When no full pharmacist is present and the premise is accessible to non-registrants,

(a) the dispensary area of a community pharmacy must be secured by a monitored alarm, and

(b) Schedule I, II and III drugs, controlled drug substances and personal information, are secured by physical barriers;

(3) Subject to subsections (5), a community pharmacy must clearly display at all external entrances that identify the premises as a pharmacy, and at the dispensary counter signage provided by the College;

(4) The pharmacy manager and owners or directors of a community pharmacy that does not stock IA drugs must complete a declaration attesting that Schedule IA drugs are never stocked on the premises;

(5) A pharmacy that is never open to the public and has no external signage identifying it as a pharmacy is exempt from the requirements in subsections (3).

Commented [AS25]: New section for pharmacy security requirements.

Commented [AS26]: No comments were received on this requirement in consultations.

Commented [AS27]: No comments were received in consultations on this requirement.

Commented [AS28]: No comments were received in consultations on this requirement.

Commented [AS29]: No comments were received in consultations on this requirement.

Commented [AS30]: Many comments were received regarding this requirement in consultations. The main concerns were the cost and timing.

Physical barriers prevent access. Other jurisdictions also require barriers when a pharmacy is operating lock and leave. This requirement in the bylaw is for community pharmacies when a full pharmacist is not present and the premise is accessible to non-registrants.

Operation Without a Full Pharmacist

12. (1) Except as provided in subsection (2), a community pharmacy must not be open to the public unless a full pharmacist is present.

(2) A community pharmacy that does not have a telepharmacy remote site licence may operate without a full pharmacist present if all the following requirements are met:

(a) the registrar is notified of the hours during which a full pharmacist is not present;

(b) a security system prevents the public, ~~pharmacy assistants~~support persons and other non-pharmacy staff from accessing the dispensary, the professional service area and the professional products area;

(c) a pharmacy technician is present and ensures that the pharmacy is not open to the public;

(d) Schedule I, II, and III drugs and controlled drug substances in a secure storage area are inaccessible to ~~pharmacy assistants~~support persons, other non-pharmacy staff and the public;

(e) dispensed prescriptions waiting for pickup may be kept outside the dispensary if they are inaccessible, secure and invisible to the public and the requirements of section 12 of the *Community Pharmacy Standards of Practice* have been met;

(f) the hours when a full pharmacist is on duty are posted.

(3) If the requirements of subsection (2) are met, the following activities may be performed at a community pharmacy by anyone who is not a registrant:

(a) requests for prescriptions, orders for Schedule II and III drugs and telephone requests from patients to order a certain prescription may be placed in the dispensary area by dropping them through a slot in the barrier;

(b) orders from drug wholesalers, containing Schedule I, II and III drugs, may be received but must be kept secure and remain unopened.

Outsource Prescription Processing

13. (1) A community pharmacy may outsource prescription processing if

(a) all locations involved in the outsourcing are community pharmacies,

(b) all prescriptions dispensed are labeled and include an identifiable code that provides a complete audit trail for the dispensed drug, and

(c) a notice is posted informing patients that the preparation of their prescription may be outsourced to another pharmacy.

(2) The manager of an outsourcing community pharmacy must ensure that all applicable standards of practice are met in processing prescriptions at all locations involved in the outsourcing.

(3) In this section, “community pharmacy” includes a hospital pharmacy.

PART III – Hospital Pharmacies

Hospital Pharmacy Manager – Quality Management

Commented [AS31]: support person is the correct term to use as defined in PODSA.

Commented [AS32]: support person is the correct term to use as defined in PODSA.

14. (1) A hospital pharmacy's manager must develop, document and implement an ongoing quality management program that

(a) maintains and enforces policies and procedures to comply with all legislation applicable to the operation of a hospital pharmacy,

(b) monitors staff performance, equipment, facilities and adherence to the *Hospital Pharmacy Standards of Practice*,

(c) includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies,

(d) documents periodic audits of the drug distribution process,

(e) includes a process to review patient-oriented recommendations,

(f) includes a process that reviews a full pharmacist's documentation notes in the hospital's medical records,

(g) includes a process to evaluate drug use, and

(h) regularly updates policies and procedures for drug use control and patient-oriented pharmacy services in collaboration with the medical and nursing staff and appropriate committees.

(2) If sample drugs are used within a hospital, the hospital pharmacy's manager must ensure that the pharmacy oversees the procurement, storage and distribution of all sample drugs.

After Hours Service

15. (1) If continuous pharmacy services are not provided in a hospital, the hospital pharmacy's manager must ensure that urgently needed drugs and patient-oriented pharmacy services are available at all times by

(a) providing a cabinet which must

(i) be a locked cabinet or other secure enclosure located outside of the hospital pharmacy, to which only authorized persons may obtain access,

(ii) be stocked with a minimum supply of drugs most commonly required for urgent use,

(iii) not contain controlled drug substances unless they are provided by an automated dispensing system,

(iv) contain drugs that are packaged to ensure integrity of the drug and labeled with the drug name, strength, quantity, expiry date and lot number, and

(v) include a log in which drug withdrawals are documented, and

(b) arranging for a full pharmacist to be available for consultation on an on-call basis.

(2) When a hospital pharmacy or hospital pharmacy satellite is closed, the premises must be equipped with a security system that will detect unauthorized entry.

PART IV – Telepharmacy

Telepharmacy Services

16. (1) The registrar may authorize a community pharmacy or hospital pharmacy to provide telepharmacy services, upon receipt of a completed application in Form 2 and if satisfied that the requirements of this section will be met.

(2) Telepharmacy services may only be provided in or through pharmacies authorized under this Part to provide telepharmacy services.

(3) A telepharmacy remote site must be under the direct supervision of a full pharmacist at the central pharmacy site.

(4) A telepharmacy remote site must be under the responsibility of the manager of the central pharmacy site.

(5) The *Community Pharmacy Standards of Practice* apply to a telepharmacy remote site, unless it is located in, or providing pharmacy services for, a hospital in which case the *Hospital Pharmacy Standards of Practice* apply.

(6) Full pharmacists at a central pharmacy site must comply with section 12 of the *Community Pharmacy Standards of Practice* by using video and audio links.

(7) A sign must be posted at the dispensary counter of a telepharmacy remote site advising patients and staff when the site is operating in telepharmacy mode.

(8) A telepharmacy remote site must not remain open and prescriptions must not be dispensed if

(a) an interruption in data, video or audio link occurs,

(b) a pharmacy technician is not on duty at the telepharmacy remote site, or

(c) a full pharmacist is not on duty at the central pharmacy site.

(9) Prescriptions dispensed at a telepharmacy remote site must be distinguishable from a prescription dispensed at the central pharmacy site and include a unique label and a unique identifier for the prescription.

(10) The manager of a central pharmacy site must

(a) inspect and audit each affiliated telepharmacy remote site at least 3 times each year,

(b) make a written record of all inspections and audits, and

(c) provide a copy of a record described in paragraph (b) to the college on request.

(11) There must be a policy and procedure manual which describes the specific telepharmacy operations that are in place to ensure the safe and effective distribution of pharmacy products and delivery of pharmaceutical care.

PART V – Pharmacy Education Sites

Pharmacy Education Site Manager

17. (1) A pharmacy education site's manager must ensure that only registrants and instructors are present in the pharmacy education site.

(2) A pharmacy education site's manager must comply with section 3(2)(a), (d), (h), (~~p~~o), (~~s~~r) and (t)(ii) and (iii).

Commented [AS33]: Updated existing references to reflect numbering changes in 3(2).

PART VI – PharmaNet

Application of Part

18. This Part applies to every pharmacy that connects to PharmaNet.

Definitions

19. In this Part:

"database" means those portions of the provincial computerized pharmacy network and database referred to in section 13 of the *Act*;

"in-pharmacy computer system" means the computer hardware and software utilized to support pharmacy services in a pharmacy;

"patient keyword" means an optional confidential pass code selected by the patient which limits access to the patient's PharmaNet record until the pass code is provided to the registrant;

"PharmaNet patient record" means the patient record described in section 11(2) of the *Community Pharmacy Standards of Practice* and in the PharmaNet Professional and Software Compliance Standards as the "patient profile";

"PharmaNet Professional and Software Compliance Standards" means the document provided by the Ministry of Health Services specifying the requirements of an in-pharmacy computer system to connect to PharmaNet;

"terminal" means any electronic device connected to a computer system, which allows input or display of information contained within that computer system.

Operation of PharmaNet

20. A pharmacy must connect to PharmaNet and be equipped with the following:

(a) an in-pharmacy computer system which meets the requirements set out in the current PharmaNet Professional and Software Compliance Standards;

(b) a terminal that is capable of accessing and displaying patient records, located in an area of the pharmacy which

(i) is only accessible to registrants and pharmacy assistants,

(ii) is under the direct supervision of a registrant, and

(iii) does not allow information to be visible to the public, unless intended to display information to a specific patient;

(c) the computer software upgrades necessary to comply with changes to the PharmaNet Professional and Software Compliance Standards.

Data Collection, Transmission of and Access to PharmaNet Data

21. (1) A registrant must enter the prescription information and transmit it to PharmaNet at the time of dispensing and keep the PharmaNet patient record current.

(2) A registrant may collect and transmit patient record information to PharmaNet or access a patient's PharmaNet record only

(a) to dispense a drug,

(b) to provide patient consultation, or

(c) to evaluate a patient's drug usage.

(3) A registrant may collect and transmit patient record information to PharmaNet or access a patient's PharmaNet record only for the purposes of claims adjudication and payment by an insurer.

(4) A registrant must revise information in the PharmaNet database pertaining to corrected billings for prescriptions billed to the patient or a payment agency other than PharmaCare and record the reason for the revision within 90 days of the original entry on PharmaNet.

(5) A registrant must reverse information in the PharmaNet database, for any drug that is not released to the patient or the patient's representative, and record the reason for the reversal no later than 30 days from the date of the original entry of the prescription information in PharmaNet.

(6) If a registrant is unable to comply with the deadlines in subsections (4) or (5), he or she must provide the information required to make the correction to the college as soon as possible thereafter.

(7) At the request of the patient, a registrant must establish, delete or change the patient keyword.

(8) Where a patient or patient's representative requests an alteration to be made to the PharmaNet information, the registrant must

(a) correct the information, or

(b) if the registrant refuses to alter the information, he or she must inform the person requesting the change of his or her right to request correction under the *Personal Information Protection Act*.

Confidentiality

22. A registrant must take reasonable steps to confirm the identity of a patient, patient's representative, registrant or practitioner before providing any pharmacy service, including but not limited to

(a) establishing a patient record,

(b) updating a patient's clinical information,

(c) providing a printout of an in-pharmacy or requesting a PharmaNet patient record,

(d) establishing, deleting, or changing a patient keyword,

(e) viewing a patient record,

(f) answering questions regarding the existence and content of a patient record,

(g) correcting information, and

(h) disclosing relevant patient record information to another registrant for the purpose of dispensing a drug or device, and/or for the purpose of monitoring drug use.

College of Pharmacists of British Columbia

Policy Category: Professional Practice Policy – 74
Policy Focus: Community Pharmacy Security

This policy provides guidance to community pharmacies for complying with community pharmacy security requirements. *Pharmacy Operations and Drug Scheduling Act ("PODSA")* Bylaws section 1, section 3(2)(r), section 3(2)(r.1), section 3(2)(s), section 3(2)(bb), section 3(4) and section 11.1 address community pharmacy security.

POLICY STATEMENT(S):

1. Written Policies and Procedures Regarding Pharmacy Security

Pharmacy security policies and procedures should be included in the pharmacy's policy and procedure document. The policies and procedures should contain information on the following:

- Training,
- Pharmacy security equipment,
- Emergency responses,
- Incident review, and
- Pharmacy security evaluation,

Additionally, pharmacy owners and directors should ensure that critical stress debriefing and stress counseling is offered as soon as possible following an incident.

2. Staff Training on Pharmacy Security Policies and Procedures

Pharmacy managers should ensure that staff members are retrained at least annually to maintain knowledge of pharmacy security policies and procedures.

Staff training is critical both to prevent and respond effectively to security breaches. Training includes initial training and periodic review/refresher of skills. Training should include instruction on:

- Operation of security-related equipment, such as security camera, alarms, safes, etc.,
- What to do in the event of a pharmacy security breach, and
- How to handle potential precursors to robbery (e.g., the presence of suspicious customers and phishing style phone calls, etc.).

3. Notification Procedures

Pharmacy managers should notify the pharmacy owner(s) and director(s) immediately as soon as the manager becomes aware that the minimum pharmacy security requirements (as defined in

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Policy Category:	Professional Practice Policy – 74
Policy Focus:	Community Pharmacy Security

PODSA bylaws section 11.1) are not being met by pharmacy staff. The pharmacy manager should ensure that appropriate action is taken to resolve the issue(s).

The CPBC Complaints Resolution Department via the complaints line **778-330-0967** should be used to notify the registrar of any persistent non-compliance by the pharmacy owner(s) and director(s) with community pharmacy security bylaws and/or this policy.

Note: If the pharmacy manager is unavailable, another CPBC registrant can notify the registrar.

As outlined in PODSA bylaws section 3(2)(s), pharmacy managers notify the registrar of any incident of loss of drugs or loss of personal information, whether electronic or physical. This notification should occur within 24 hours of an occurrence through the Robbery Prevention Portal located in e-Services under the "report an incident" tab. Incidents to be reported include any of the following:

a. Robbery (armed/unarmed) or attempted robbery
b. Break and enter
c. Forgery
d. Theft
e. Drug loss (unexplained or adulterated)
f. Loss of personal information (electronic or physical)

Examples of personal information which can be at risk of loss in a pharmacy can include but are not limited to:

- Filled prescriptions waiting to be picked up,
- Hard copies of prescriptions, and
- Computer hard drives

Pharmacy managers should also notify the College Registrar within 24 hours of an incident (via the Robbery Prevention Portal located in e-Services), of the names and counts of the top 5 (by quantity) targeted narcotic and controlled drugs that were taken or diverted.

Additionally, pharmacy managers should provide the College Registrar, within 10 days of an occurrence, with a copy of the Health Canada report **(Form HC 4010 or HC 4004)** via the Robbery Prevention Portal located in e-Services containing the complete inventory of drugs (including the drug count) that were taken or diverted.

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Policy Category:	Professional Practice Policy – 74
Policy Focus:	Community Pharmacy Security

4. Pharmacy Security Equipment

Safe

The safe must be an actual metal safe, a "narcotics cabinet" is not sufficient. The safe must be securely anchored in place, preferably to the floor. The safe should only be open when items are being placed into or removed from the safe. ***It is never appropriate for the safe to be left open; this would defeat the purpose of the time-delay lock security measure*.**

Security Camera System

It is important to ensure that images captured by the security camera system are sufficient to enable law enforcement to identify the criminals. In order to identify a person, specific individual features must be distinguishable.

Experts advise that camera systems are rated on frame rates per second and resolution. The higher the frame rate and resolution the better for detection and identification.

Under the *Personal Information Protection Act* (PIPA) pharmacies are required to post visible and clear signage informing customers that the premise is monitored by cameras. Guidance on the use of cameras, including security arrangements and policies can be found on the Office of Information Privacy Commissioner's site.

Motion Sensors

Security experts recommend that 360 degree motion detectors be installed on the ceiling as wall mounted motion detectors are vulnerable to blind spots.

Monitored Alarms Systems

Independent alarms for the dispensary **are optional**, when a full pharmacist is present **at all times and the premise is accessible by non-registrants.**

Physical Barriers

Physical barriers provide an additional layer of security and deter:

1. Unauthorized access to drugs, including but not limited to:
    - All Schedule I, II and III drugs.

2. Unauthorized access to personal information. Prevents unauthorized individuals from seeing patient and personal health information, including but not limited to:
    - Hard copies of prescriptions,
    - Filled prescriptions waiting to be picked up, and/or
    - Labels, patient profiles, and any other personal health information documents waiting for disposal.

Physical barriers can be tailored to the needs and structure of the particular community pharmacy. Examples of physical barriers include: locked gates, grillwork, locked cabinets, locked doors, and locked shelving units. The physical barriers should prevent access.

When a full pharmacist is present at all times, physical barriers **are optional**.

Signage

The College will send signs to all new pharmacies at the time of licensure approval. In addition, signs can also be ordered via the e-Services portal. Signage provides a consistent province-wide deterrent message that additional layers of security are in place. It is critical that all pharmacies comply with this requirement to ensure that their pharmacy does not become a "soft target".

5. Emergency Response Kit

An emergency response kit should include a step-by-step guide on what to do in the event of a robbery or break and enter and be available to all pharmacy staff.

Pharmacy robberies and break and enters can be very stressful and traumatic events for pharmacy staff. Having an accessible and plain language step-by-step guide on what do if such an event occurs can help pharmacy staff take the steps necessary to appropriately respond to the situation.

6. Incident Review

Incident reviews should be conducted annually to determine concerns about pharmacy security and/or activity trends.

Policies and procedures should be in place regarding a privacy breach response plan consistent with s. 79 of the *Health Professions Act* Bylaws. The plan should provide for notification of affected individuals and other health care providers in appropriate cases. It should also include notification to the College and the Office of the Information and Privacy Commissioner of British Columbia.

7. Pharmacy Security Evaluation

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Policy Category:	Professional Practice Policy – 74
Policy Focus:	Community Pharmacy Security

Pharmacy security evaluations should be conducted on an annual basis to identify areas of risk and needed improvements.

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College of Pharmacists of British Columbia

Policy Category: Professional Practice Policy – 74
Policy Focus: Community Pharmacy Security

POLICY STATEMENT(S):

All pharmacy owner(s) and director(s) must:

- Ensure that written policies and procedures are developed, implemented and maintained to establish pharmacy security requirements for the prevention of robbery and break and enter.
    - The policies and procedures must incorporate the following minimum requirements as set out below.
- Ensure that critical stress debriefing and stress counseling are offered as soon as possible following an incident.

The pharmacy manager must:

- Ensure that existing staff and new hires undergo training on the above mentioned policies and procedures, PPP-74, and the Community Pharmacy Security Resource Guide and are retrained on a minimum yearly basis to maintain knowledge.
- Notify the pharmacy owner(s) and director(s) immediately if the minimum requirements are not being met and take immediate action to ensure compliance with this policy.
- Notify the College Registrar within 24 hours of an occurrence (via e-Services portal) of any of the following:
    - Robbery (armed/unarmed) or attempted robbery
    - Break and enter
    - Forgery
    - Theft
    - Drug loss (unexplained or adulterated)

Note: If the pharmacy manager is not available, notification can be delegated by the pharmacy manager to a CPBC registrant.

- Notify the College Registrar (via e-Services portal) of the name and count of the top 5 (by quantity) targeted narcotic and controlled drugs that were taken or diverted within 24 hours of an occurrence.
- Provide the College Registrar (via e-Services portal) a copy of the Health Canada report **(Form HC 4010 or HC 4004)** that provides the complete inventory of drugs (including the drug count) that were taken or diverted within 10 days of an occurrence.

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

- Notify the CPBC Complaints Resolution Department as soon as possible via the complaints line **778-330-0967** of non-cooperation of the pharmacy owner(s) and director(s) with this policy.

1. Security Equipment

The following security equipment must be installed and maintained in good working order:

A. Safe (for storage of narcotic and controlled drugs) that must:
   1. have a time-delay lock(s) set at a minimum of 5 minutes
   2. be secured in place

B. High Definition (HD) Security Camera System that must:
   1. have date/time stamp images, which must be archived and available for a minimum of 30 days
   2. be checked daily for proper operation

Note:

- *The requirements under 1(B) apply to all new installations and renovations from September 15, 2015 onward. All existing systems will be grandparented under this policy to allow a transition period until September 15, 2020, at which time these requirements must be met.*
- *A policy must be established on video surveillance consistent with the Privacy Commissioner of Canada guidelines: https://www.priv.gc.ca/information/guide/2008/gl_vs_080306_e.asp*

C. Monitored alarm systems:
   1. Premise
      a. Where the pharmacy comprises 100% of the total premises, there must be alarms at all windows and doors.
      b. Where the pharmacy does not comprise 100% of the total premises, the dispensary must be independently alarmed from the rest of the premises.
   2. Alarm code
      a. Only the registrant staff can possess the alarm code

b. Alarm code held on premises for emergency access is permitted providing that:
    - The alarm code is securely stored with the store manager
    - Each access is reported to the pharmacy manager immediately
    - Each access is documented

D. Security barriers
    a. Where the pharmacy does not comprise 100% of the total premises, the dispensary must have security barriers preventing access to the dispensary during hours when the pharmacy is closed.
    b. Only the registrant staff can possess the key
    c. Key held on premises for emergency access is permitted providing that:
        - The key is securely stored with the store manager
        - Each access is reported to the pharmacy manager immediately
        - Each access is documented

E. Motion sensors to detect movement in dispensary

2. Pharmacy Signage

The pharmacy must display highly visible signage, including any signage provided by the College, which identifies the following information:

- A video surveillance system is used in the pharmacy
- Limited targeted drugs are on site
- Narcotics are stored in a time-delay lock safe

3. Inventory Control

A minimum amount of targeted narcotic and controlled drugs must be kept in the dispensary at all times. “Minimum” is defined as the amount of narcotic and controlled drugs stocked on site based on the next available delivery and on pharmacy needs.

4. Emergency Response Kit

Pharmacies must have an emergency response kit that provides a step-by-step guide on what to do in the event of a robbery or break and enter and it must be available to all pharmacy staff.

Policy Category: Professional Practice Policy – 74
Policy Focus: Community Pharmacy Security

5. **Incident Review**
   A review of security incident(s) must be conducted on an annual basis to determine security concerns and/or activity trends.

6. **Pharmacy Security Evaluation**
   A pharmacy security evaluation must be completed on an annual basis to identify areas of risk and improvements.

**These standards supplement PODSA Bylaw 3 and 12*

IMPLEMENTATION TIMELINE

Effective September 15, 2015

All necessary requirements set out in this policy must have been implemented, unless otherwise stated.

BACKGROUND

Statistics Canada reported a 3 percent decline in national robbery rates from 2010 - 2011. In British Columbia, there was little change in the number of pharmacy robberies and break and enters from 2011-2012; however, law enforcement reported a 200 percent increase in the Lower Mainland alone from 2012-2013.

The rate of pharmacy robberies continued to increase through 2014. Experts anticipate that this trend won't change until BC pharmacies implement adequate security measures to prevent robbery and break and enter. The risk of robbery and break and enter presents a growing concern for the safety and security of pharmacy staff and the public.

In 2014, the College Board established a working group to develop pharmacy security requirements to prevent robbery and break and enter in BC pharmacies. Once the process began, the working group expanded the scope of development to include forgery, theft, and loss, as it was recognized that these were also areas of increasing risk and frequency in recent years. The working group was tasked with providing recommendations to the Board regarding pharmacy security standards, policies, and/or bylaws.

5. Legislation Review Committee: Pharmacy Security Bylaws

Jeremy Walden
Chair, Legislation Review Committee

Pharmacy Security Bylaws – Public Posting

Previous Board Decisions:

- In February 2015, the Board approved the PPP 74 - Community Pharmacy Security
- In June 2015, the Board approved the Community Pharmacy Security Resource Guide (Resource Guide).
- In September 2015, the Board directed the Registrar to draft bylaws to strengthen the pharmacy security requirements through legislation.

Current Status:

PODSA bylaws have been drafted and PPP-74 has been revised to compliment the bylaws.

Consultations

December 23, 2015: Draft bylaws and revised policy sent to corporate stakeholders.

January 18, 2016: Consultation with internal staff.

January 18, 2016: Written feedback received from corporate stakeholders.

January 22, 2016: Consultation with registrants of the College's Pharmacy Advisory Committees

January 26, 2016: Consultation with corporate stakeholders.

March 4, 2016: Consultation with the Ministry of Health

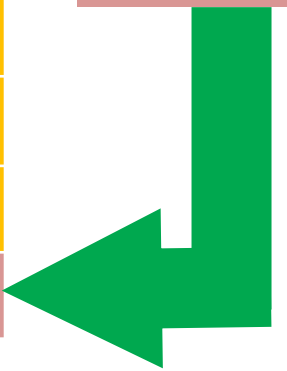
Pharmacy Security Requirements Summary

Pharmacy Security Requirements
Policies and Procedures
Critical stress/counselling
Training
Notify owner/director re. non-cooperation
Notify College of Top 5 Drugs
Health Canada Report
Safe
Security Camera System

Pharmacy Security Requirements Summary

Existing PPP-74
Monitored alarm system
Motion sensors
Emergency Response Kit
Incident Review
Pharmacy Security Evaluation
Notify College of occurrence
Notify College re. owner/ director non-cooperation
Pharmacy Signage
Physical barriers

Protection of confidential patient information



Legislation Review Committee Recommendation

MOTION:

Approve the draft *Pharmacy Operations and Drug Scheduling Act* bylaws for public posting for a period of 90 days, as circulated.

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Pharmaceutical Sciences

UBC 100

Briefing Note:

College of Pharmacists of British Columbia Professorship in Translational Pharmaceutical Care.

A funding request from the Faculty of Pharmaceutical Sciences at UBC, for $750,000 to establish a Professorship, submitted by: Dr. Corey Nislow, Associate Professor, Director, UBC Sequencing Centre and Tier 1 Canada Research Chair in Translational Genomics.

Introduction

The **College of Pharmacists of BC Professorship in Translational Pharmaceutical Care** represents an opportunity for the College to continue to operate on the cutting-edge of innovation in pharmacy practice and patient care delivery in a sustainable manner.

Background

- In January 2016, Dr. Corey Nislow and his research team completed a one-year, 200 patient trial to test the utility and durability of employing Pharmacogenomics in the Community Pharmacy in a real-world interaction between pharmacists and patients.
- In 33 pharmacies across the province, the response was extremely positive, patients saw the potential of this research and pharmacists relished the ability to act as the nexus of patient care and patient education in this area.
- This project was initially funded by the College which was the catalyst for Dr. Nislow to secure additional revenue to make the project a success. Dr. Nislow is now eager to build on the momentum and good will developed in the first phase of the project to expand the work by recruiting an additional researcher/pharmacist onto the team.
- They have shown the value of community pharmacists to research, pharmacy practice and to patients and demonstrated that embedding practising pharmacists in both research and in the pharmacy enables translational research.
- The outcome of this is that Dr. Nislow proposes that the extension of this work into a complete community pharmacy network throughout the province can become a living laboratory that benefits researchers, pharmacists and patients alike.

Proposal

- This will be the first-ever College of Pharmacists of BC Professorship in Translational Pharmaceutical Care. The College can provide suggestions to adjust the title of this Professorship, within UBC guidelines.
- The Professorship will focus on real-world research by taking genomics to the pharmacy with the ultimate goal of improving patient care.
- It will elaborate on training pharmacists by engaging them in research and communicating outcomes while maintaining the highest level of security around patient data. The data will add to the knowledge about individual patients providing them with knowledge to discuss improved medication choices with their pharmacist.

- The opportunity to embed practicing pharmacists in the research enables translation research in a way not experienced before in our profession, although it is already practised in nursing and medical research. In addition, the existing community pharmacy network throughout the province can be a living lab that benefits researchers, pharmacists and patients alike.
- The new professorship holder will be an interfacial researcher-educator, a licensed pharmacist, and excellent communicator with a coherent research focus on enhancing the pharmacist-patient relationship - a first for pharmacy in BC.

Request

At UBC, funding for a Professorship is a five-year commitment of $750,000 total. To maintain our momentum, we respectfully request a commitment of $750,000 over five years and signed Gift Agreement by April 30, 2016. With the first installment of $150,000 to follow soon after the Agreement is signed and the subsequent four installments of $150,000 to be paid annually to 2020.

April 30, 2016	$150,000
April 30, 2017	$150,000
April 30, 2018	$150,000
April 30, 2019	$150,000
April 30, 2020	$150,000

This will allow us to commence the recruitment process in late spring with an appointment, hopefully beginning in the fall of 2016. Recruiting can sometimes take a little longer.

Recognition of this Gift

1. The primary recognition of this gift is to name the Professorship: *College of Pharmacists of BC Professorship in Translational Pharmaceutical Care*, for the duration of the funding.
2. UBC would prepare a media announcement in collaboration with the College to celebrate this Professorship.
3. An annual update will be provided to the College either in writing or as a presentation to the College Registrar and Board.
4. The College will be invited to provide feedback on research ideas relating to the Professorship as requested by the Professorship holder but would not be able to direct the research undertaken.
5. We invite the College to discuss with us, any other ideas around celebrating this unique Professorship such an announcement at the College's 125th anniversary event in September 2016.

Next Steps

We sincerely thank the Board of the College of Pharmacists of British Columbia for considering this funding request to establish the **College of Pharmacists of BC Professorship in Translational Pharmaceutical Care** and look forward to hearing your decision.

Thank you

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THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Pharmaceutical Sciences

UBC 100

Presenter Biography

Corey Nislow

Dr. Corey Nislow completed a bachelor of arts in developmental biology at New College (Sarasota, Florida) and doctor of philosophy in cell and molecular biology at the University of Colorado (Boulder, Colorado). He was also an American Cancer Society postdoctoral fellow. Dr. Nislow served as group leader in two biotechnology companies (MJ Research and Cytokinetics Inc., in the San Francisco Bay Area) and as a senior genome scientist at Stanford University. Prior to joining UBC, Dr. Nislow was associate professor at the University of Toronto and director of the Donnelly Sequencing Centre.

In the UBC Faculty of Pharmaceutical Sciences he is an Associate Professor, Director of the UBC Sequencing Centre and a Tier 1 Canada Research Chair. His work on drug-gene and drug-environment interactions is broad in scope, ranging from yeast to human and, as part of an ongoing collaboration with NASA and Duke University, he has flown experiments on 4 missions to the International Space Station. Nislow was the lead Principal Investigator for the 'Genomics for Precision Drug Therapy in Community Pharmacy' research project, which demonstrated that pharmacists are well positioned to convey pharmacogenomics information both to their patients and the broader healthcare team. He is a passionate advocate for science literacy and his outreach efforts including continuing education courses and working with high school students and their teachers in the laboratory. He has authored 150 peer-reviewed publications and 6 issued patents.

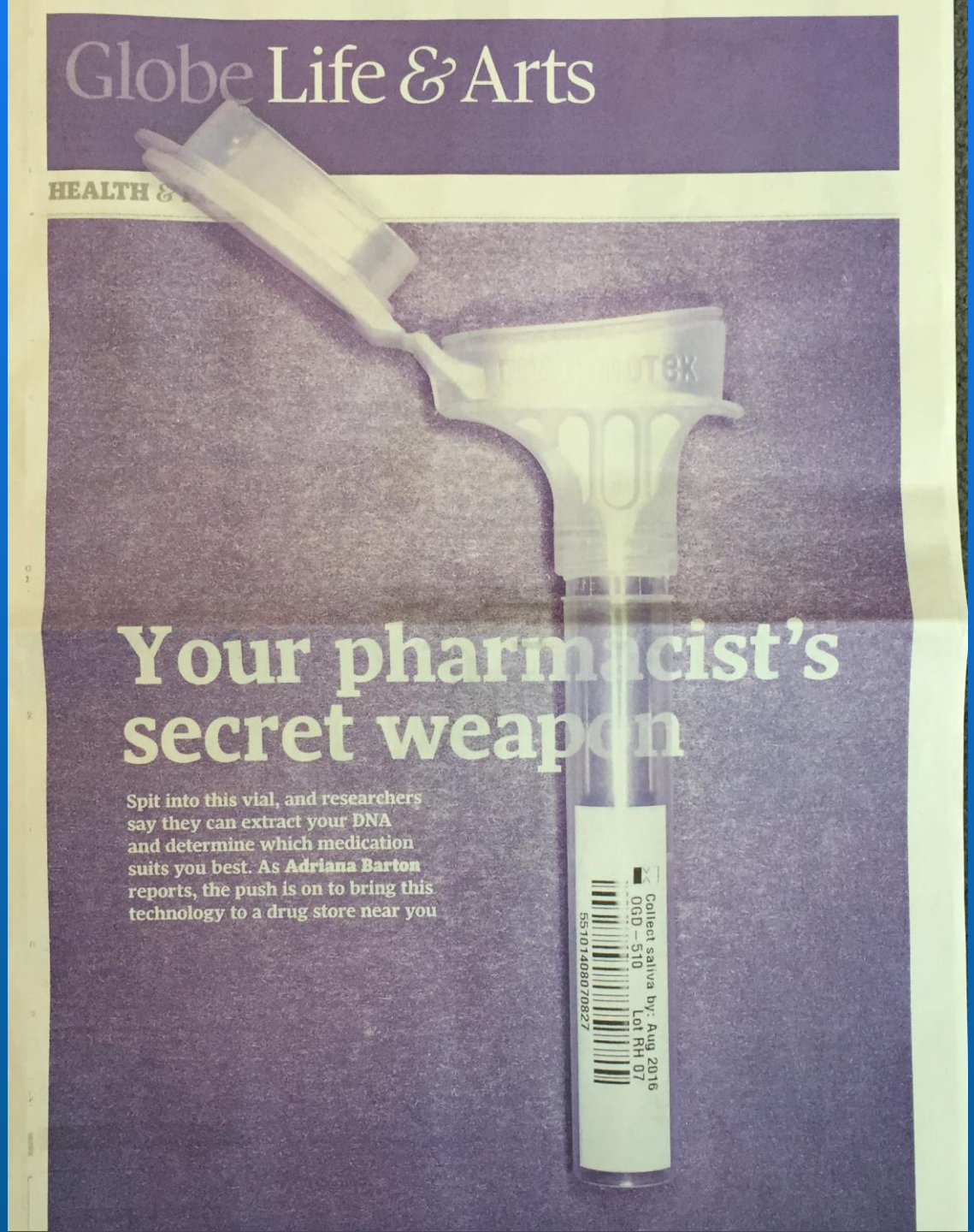
UPDATE: GENOMICS IN THE COMMUNITY PHARMACY

Dr. Corey Nislow

Associate Professor, UBC Faculty of Pharmaceutical Sciences

Director, UBC Sequencing Centre

Tier 1 Canada Research Chair in Translational Genomics



FEBRUARY 15, 2016

OUTLINE

- What we set out to do
- What we accomplished
- Impact on Pharmacists
- Future perspectives

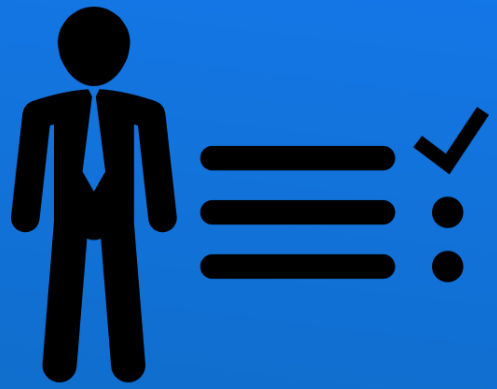
FOCUS ON REAL WORLD OPPORTUNITIES

- What we set out to do

BRING GENOMICS (PGX) TO THE COMMUNITY PHARMACY AND BACK

Privacy & Consent

Logistics & Operations



Quality Assurance

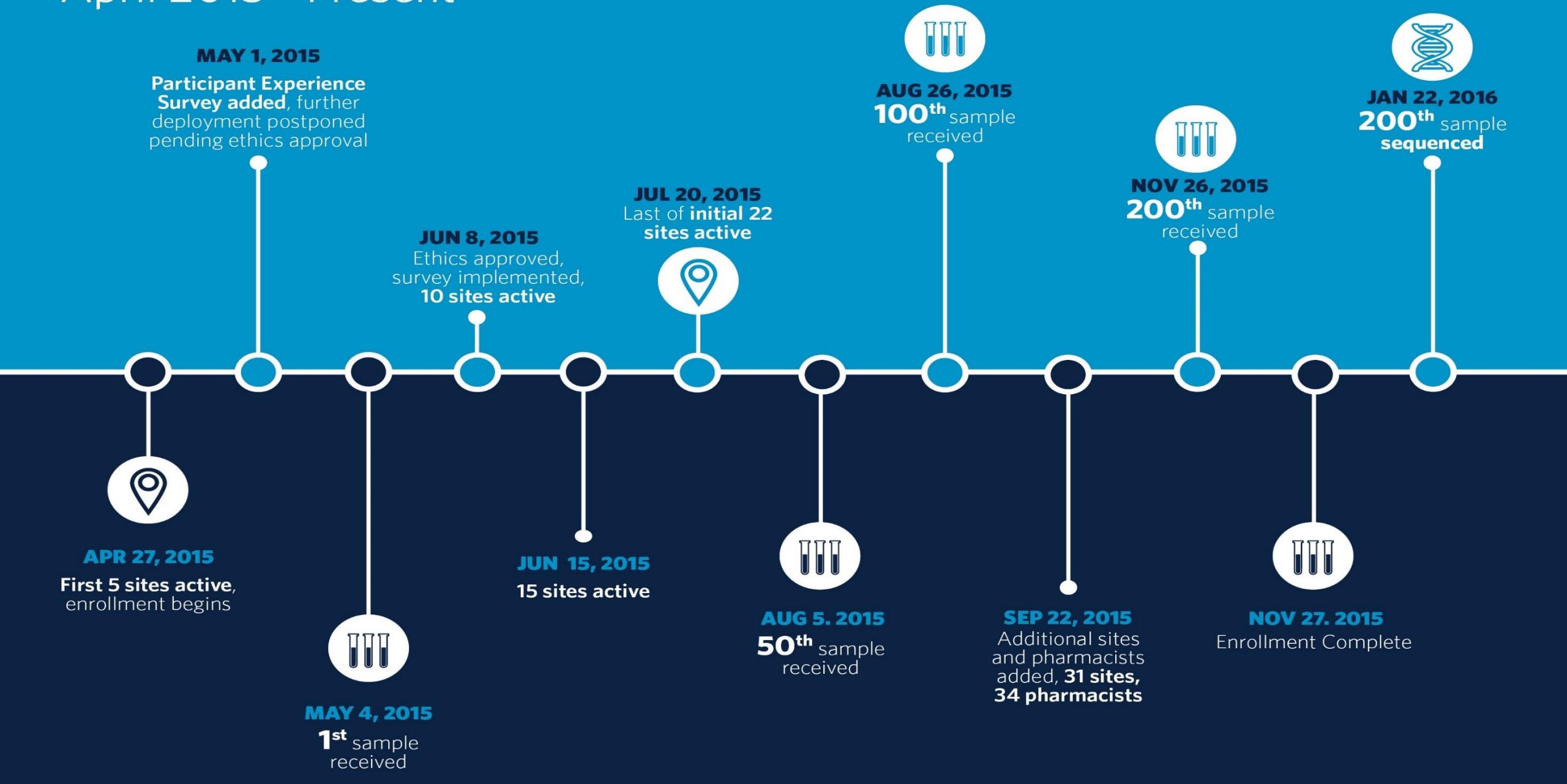
PHARMACIST TRAINING PROCESS: SOPS

1. DNA extraction, quantification, and QC
2. Library preparation, validation, and quantification
3. Sequencing
4. Data conversion
5. Variant analysis & reporting

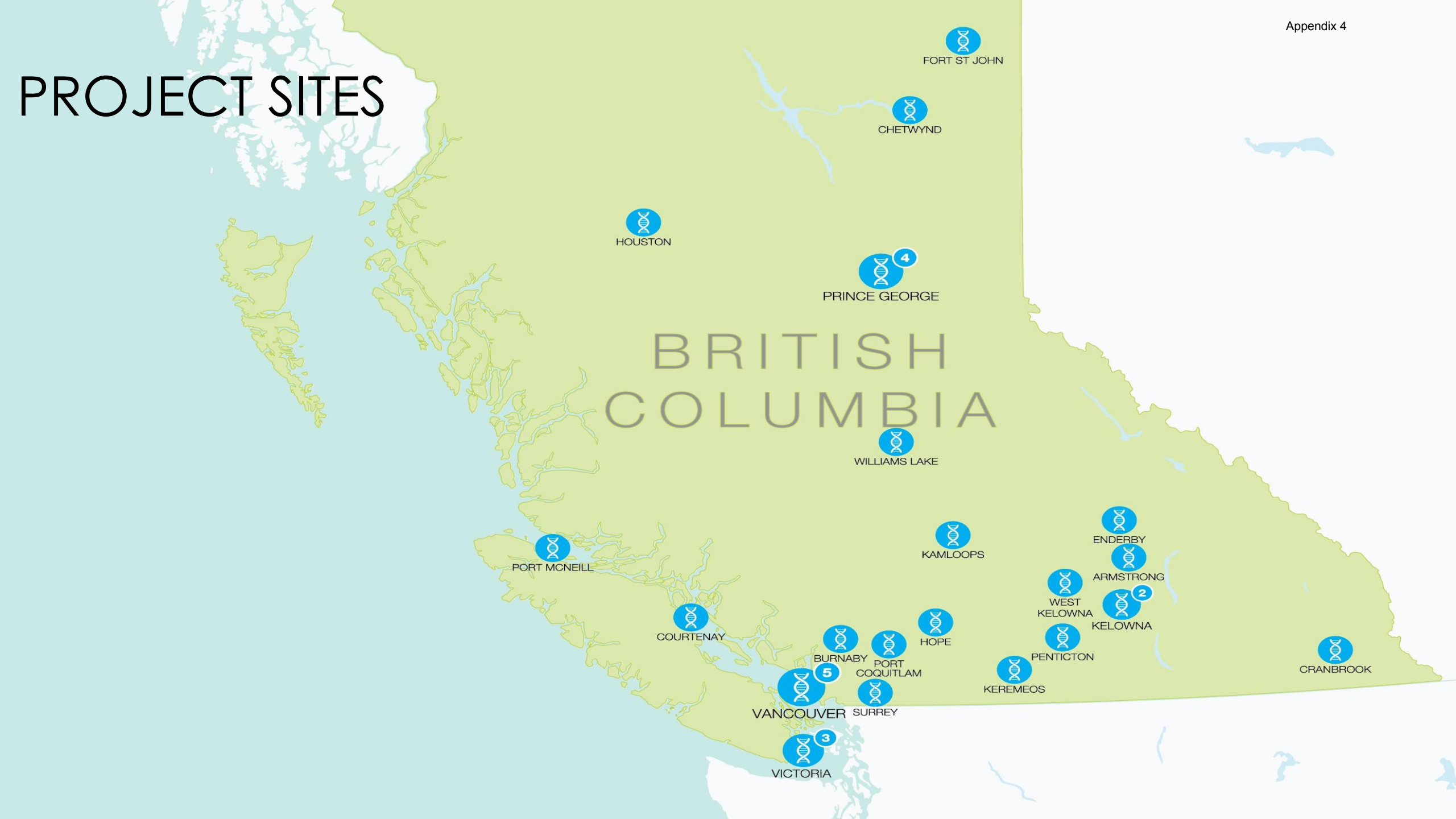
WHAT WE ACCOMPLISHED

DEPLOYMENT

April 2015 - Present

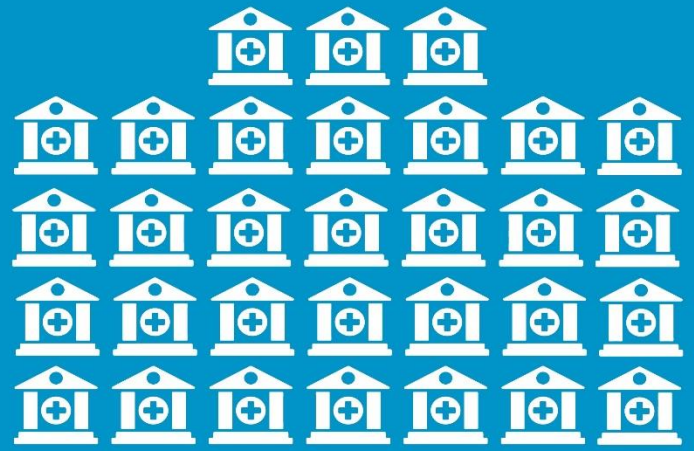


PROJECT SITES

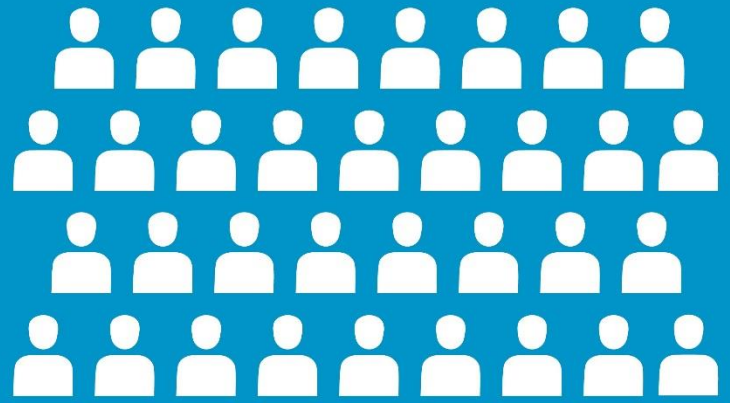


SUCCESS!

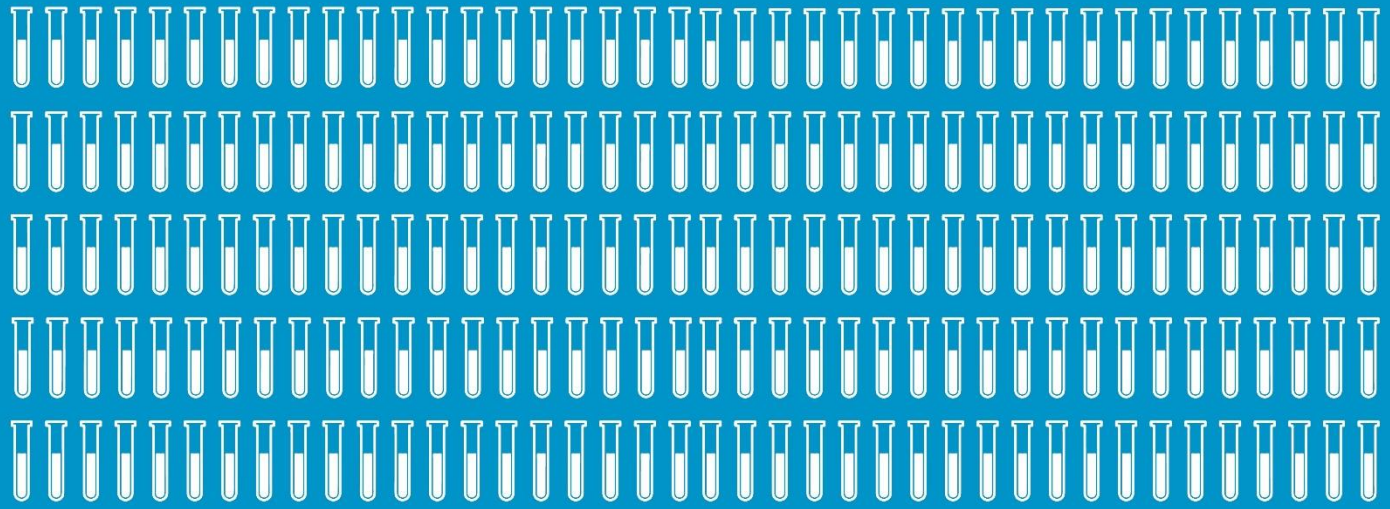
31 Different Pharmacies



34 Pharmacists Trained



200 Samples Collected (100%)



200 Controls Sequenced (100%)

200 Participants Sequenced (100%)

1. Real-world data
2. Patient access in a non-institutional setting
3. Recruitment via pharmacist-patient's trusted relationship
4. Iterative opportunities for feedback and refinement of process

RESEARCHER BENEFITS

Seamless incorporation into existing CODE OF ETHICS:

Standard 2: Protect the Best Interests of their Patients In Achieving their Chosen Health Outcome

Standard 4: Protect the Right to Confidentiality of their Patients

Standard 6: Commitment to Benefiting Society

Standard 10: Commitment to Professional Development

PHARMACIST BENEFITS

1. Their pharmacist becomes the focal point for patient act, acting to the full scope of the Code of Ethics
2. Patient is a partner in their care
3. Paves the way for enhanced care facilitated by knowledge translation from research to practice

PATIENT BENEFITS

- Our efforts show the value of research pharmacists to research, pharmacy practice, and patients
- Embedding practicing pharmacists in the research enables translational research
- Community pharmacy network throughout the province can be a living lab that benefits researchers, pharmacists, and patients alike

MAINTAIN THIS MOMENTUM WITH A NOVEL RESEARCHER-EDUCATOR…..

COLLEGE OF PHARMACISTS OF BC PROFESSORSHIP IN TRANSLATIONAL PHARMACEUTICAL CARE

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THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Pharmaceutical Sciences

PROFESSORSHIP IN TRANSLATIONAL PHARMACEUTICAL CARE

- 5-year commitment: $150,000 annually
  - $750,000 total
- Signed gift agreement: April 2016
- First installment: April 2016
- Recruit candidate: Summer 2016
- Appointment: Fall 2016

Ideal Candidate:

- Conducts real-world research inside and outside of institutional settings
- Licensed pharmacist active in community
- Excellent communicator
- Coherent Research Focus on enhancing the pharmacist-patient relationship

PROFESSORSHIP IN TRANSLATIONAL PHARMACEUTICAL CARE

Establish Professorship 2016

- Media: Funding commitment, Professorship appointment, Research milestones
- UBC to prepare media announcement
- Other opportunities to celebrate this unique commitment *(e.g. CPBC September 17 meeting in Kelowna)*

PROFESSORSHIP IN TRANSLATIONAL PHARMACEUTICAL CARE

PROFESSORSHIP IN TRANSLATIONAL PHARMACEUTICAL CARE: A UNIQUE INTERFACIAL RESEARCHER-EDUCATOR

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

7. Telepharmacy Update

INFORMATION ONLY

Purpose
To provide current updated information to the Board on issues regarding telepharmacy and the requirement to be in compliance with both provincial and federal legislation.

Background
Telepharmacy is the provision of pharmacy services to ensure that British Columbians in rural and remote communities have access to the pharmacy care they need, when they need it and, as much as possible, without having to leave their communities.

Pharmacy Operations and Drug Scheduling Act ("PODSA") – Bylaws define telepharmacy as the process by which a central pharmacy site operates one or more remote sites, all of which are connected to the central pharmacy site via computer, video and audio link.

A telepharmacy remote site means a pharmacy providing pharmacy services to the public, or in or for a hospital

- without a full pharmacist present
- in a rural or remote community[1], and
- under the supervision and direction of a full pharmacist at a central pharmacy site

There are currently 14 telepharmacy remote sites (2 of which are in pre-licensure stage) in BC that are under the supervision of pharmacists in 6 central locations. Appendix 1 provides a listing of the telepharmacy sites, and relevant information regarding the following:

- Its distance from a full pharmacy;
- Whether it is only a weekend telepharmacy;
- Hours of operation (of both the telepharmacy, and of the nearest full pharmacy);
- Whether a pharmacist visits the telepharmacy site on a periodic basis, and if so what that period is (eg once a week, twice a week, other);

Appendix 2 provides a geographical mapping of the sites. The models of each site vary. For example, several are full time telepharmacy sites whereas others operate as telepharmacy remote sites part time during the week and/or on weekends only.

To date, much of the focus has been on ensuring telepharmacy remote sites are operating in compliance with PODSA Bylaws, particularly the provision requiring that remote sites be staffed minimally by a pharmacy technician. A issue has emerged – where in order to operate a site

[1] The terms rural and remote are not defined within the PODSA-Bylaws. However, Pharmacare's Rural Incentive Program provides an example definition for a rural pharmacy. To qualify for Pharmacare's Rural Incentive Program, one of the qualifying criteria is that the nearest pharmacy is at least 25km away.

that stores and dispenses controlled drug substances, under federal legislation the sites must be staffed by a pharmacist.

Provincial Legislative Requirements (PODSA): Pharmacy Technicians
PODSA – Bylaws s. 16 (8) (b) state if a pharmacy technician is not on duty at the telepharmacy remote site, the telepharmacy remote site must not remain open and prescriptions must not be dispensed. This bylaw was amended in 2010 and was effective on January 1, 2011. Previous to that date, non-regulated pharmacy assistants were permitted to staff telepharmacy remote sites.

The rationale for the Bylaw amendment in 2010 was both to enhance public safety and to regulate those pharmacy personnel with access to Schedule I, IA, II and III medications; controlled drug substances; and confidential personal health information. There was a recognition that the risk of unauthorized access to drugs and personal information was greater in telepharmacy sites as personnel worked on their own with only limited access to a pharmacist via video and audio link.

Recognizing the challenges facing rural and remote locations, pharmacy assistants who were currently in practice were provided the opportunity to complete the requirements for the "transition pathway", including the completion of the Pharmacy Technician Bridging Program and the required provincial Jurisprudence Exam and national certification exams. That pathway ended in December 2015.

In addition, an extension to the enforcement date was made in order to ensure the transition occurred without disruption to care. Telepharmacy operators were reminded that the extension would expire on December 31, 2015. The enforcement date was further extended to December 31, 2016 when all telepharmacy sites are required to be compliant with both provincial (PODSA) and federal legislation.

Federal Legislative Requirement: Pharmacists
There are a significant number of drugs that fall under the authority of federal legislation including the *Controlled Drugs and Substances Act* (CDSA); the *Narcotic Control Regulations* (NCR); the *Benzodiazepines and Other Targeted Substances Regulation* (BOTSR) and the *Food and Drug Regulations* – Part G Controlled Drugs (FDR). For the purpose of this note, all drugs covered by the aforementioned legislation will be referred to as 'controlled drug substances'.

The primary concern in BC and across Canada is unauthorized access to controlled drug substances. At this point in time, BC's Drug Schedule Regulation has a wide range of classifications for controlled drug substances. More specifically, the number of controlled drug substances are as follows: Schedule 1 includes 23, Schedule 1A includes 19, and Schedule II includes 2.

Based on the recent clarification obtained from Health Canada and confirmed through a legal opinion, it has become evident that only a pharmacist may possess and dispense those drugs that are regulated by federal legislation (i.e. controlled drug substances).

Discussion

The requirement to be compliant with all legislation will have an impact on the model of telepharmacy in BC. Implications for operators include challenges with staffing (recruitment) and potential increased costs. Implications to rural and remote communities may include a reduction of service.

The College continues to work with telepharmacy operators, key stakeholders, Health Canada and the Ministry of Health to explore options that would allow for full compliance with both provincial and federal legislation without a significant disruption to the continuity of patient care. Accordingly, the College has initiated a project that will seek the following objectives:

- Examine the current practices at each central and remote telepharmacy site;
- Conduct a risk assessment at each site exploring potential impacts;
- Work with the telepharmacy operators to develop recruitment and retention strategies for telepharmacy sites (aligning with existing strategies that have been used to attract other health professionals);
- Customize plans for each viable site; and
- Develop strategies/recommendations for the telepharmacy operators to be able to meet current provincial and federal legislative requirements.

These strategies/recommendations will be provided at the Board meeting.

Appendix	
1	Listing of Telepharmacy Sites in British Columbia and relevant information
2	Map of Telepharmacy Sites in British Columbia

Telepharmacy	Central Site	Remote Site	PCARE Code	Notes	Address	Hours of Operation (Central site)	Hours of Telepharmacy (Remote)	Staff PS / PT (Central site)	Time to Closest City / Pharmacy	Hours of Nearest Full Pharmacy
Pharmasave Health Centre #022 - YVR (Owner = Alan Williamson)	√		Q44	A pharmacist visits the telepharmacy site on a minimum cycle of four times a year (the busier sites of Masset and New Aiyansh are visited more frequently). On each visit a complete narcotic count and audit is done as well as an inventory of the top 200 drugs. Once a year a complete inventory of all RX and front store is completed. Each site visit is typically two days and consist of a systems and procedure check and staff meeting between the owner and the staff.	Suite 1103.8 - 3880 Grant McConachie Way Vanc. Int'l Airport, Domestic Terminal Richmond, BC V7B 0A5	MON-FRI 08.00-18.00 SAT/SUN CLOSED		3 PS 1 PA		
Pharmasave Health Centre #074 - Telepharmacy Dease Lake		√			Box 386 Dease Lake, BC V0C 1L0		MON-FRI 09.00-17.00		8 hr to Terrace Peoples Pharmacy #384	MON-WED 09.00-18.00 THURS-FRI 09.00-21.00 SAT 10.00-18.00 SUN 11.00-17.00
Pharmasave Health Centre #075 - Telepharmacy Hudson's Hope		√			Box 599, 10309 Kyllo Street Hudsons Hope, BC V0C 1V0		MON-FRI 09.00-16.30		1 hr to Fort St. John Shoppers Drug Mart #274	MON-THURS & SAT 09.00-18.00 FRI 09.00-21.00 SUN CLOSED
									1 hr to Chetwynd Peoples Drug Mart # 43	MON-FRI 08.00-21.00 SAT 09.00-18.00SUN 10.00-17.00
Pharmasave Health Centre #076 - Telepharmacy Haida Gwaii (Masset)		√			2520 Harrison Ave. Masset, BC V0T 1M0		MON-FRI 09.00-17.00		2 hr to Queen Charlotte Forbes Pharmacy - Queen Charlotte	MON-FRI 09.00-17.15 SAT 10.00-14.00
Pharmasave Health Centre #077 (Commercial Ave- Vancouver) (Owner = Alan Williamson)	√		I01		1671 Broadway E Vancouver, BC V5N 1V9	MON-FRI 09.00-17.30 SAT/SUN 10:00-17:00		3 PS		
Nisga'a Valley Pharmasave - Telepharmacy (New Aiyansh Pharmasave (Nass Valley))		√	O71		C/o Nisga'a Valley Health Authority 4920 Tait Ave New Aiyansh, BC V0J 1A0		MON-FRI 08:30-17:00 SAT 10:00-17:00 SUN 10:00-12:00		1.5 hr to Terrace Shoppers Drug Mart #266	MON-SUN 08.00-22.00
Peoples Drug Mart #139 (Quathiaski Cove) (Owner = Colleen Hogg)	√		L60	A pharmacist visits the telepharmacy site on a weekly basis on Thursdays	672 Plaza Rd Box 614, Quadra Island Quathiaski Cove, BC V0P 1N0	MON-FRI 09.30-17.30 SAT 10:00-15:30 SUN CLOSED		2 PS 1 FULL PT		
Peoples Pharmacy #239 (Gold River)		√	X20		375 Nimpkish Dr Village Square Shopping Centre Gold River, BC V0P 1G0		MON-FRI 09.30-17.30		1.5 hrs to Campbell River Peoples Drug Mart #123	MON-SAT 09.00-19.00 SUN 10.00-17.00
Munro's Sorrento Prescription (Sorrento) (Owner = Colin Munro)	√		L82	A pharmacist visits telepharmacy sites a minimum of three times per year	Box 239, 1250 Trans Canada Highway Sorrento, BC V0E 2W0	MON-SAT 09.00-18:00 SUN 10.00-16:00		3 PS 1 PA		
Eagle Valley IDA Pharmacy (Sicamous)		√	G60	licensed as community / operates in telepharmacy mode Sundays/Holidays	317 Main St., Box 39 Sicamous, BC V0E 2V0	MON-SAT 09.00-18:00 SUN 10.00-16:00	SUN 10.00-16:00	2 PS 1 PA	20 min to Salmon Arm (note: would likely take longer in winter)	MON-SAT 09.00-18:00 SUN 10.00-16:00
Barriere IDA Pharmacy (Barriere)		√	B22	licensed as community / operates in telepharmacy mode Saturday/Sunday/Holidays	Box 830, 4480 Barriere Town Road Barriere, BC V0E 1E0	MON-SAT 09.00-17:30 SUN 10.00-16:00	SAT 09.00-17:30 SUN 10.00-16:00	1 PS 1 PA	45 min to Kamloops (note: would likely take longer in winter)	MON-SAT 09.00-17:30 SUN 10.00-16:00
Valemount IDA Pharmacy (Valemount)		√	Y04	operates in telepharmacy mode Monday- Saturday/closed Sundays/Holidays	PO Box 432, 1163 5th Ave Valemount, BC V0E 2Z0		MON-SAT 09.00-17:30 SUN 09.00-17:00		3.5 hrs to 100 Mile House Pharmasave #129	MON-SAT 09.00-17:30 SUN 11.00-16:00
Robson Valley IDA Pharmacy (McBride)		√	D81	operates in telepharmacy mode Monday- Saturday/closed Sundays/Holidays	Box 637, 1136 5th Ave McBride, BC V0J 2E0		MON-FRI 09.00-17.00 SAT 09.00-15.00	1 PA	2.25 hrs to Prince George Shoppers Drug Mart #2226	MON-SUN 08.00-22.00 HOLS 09.00-22.00
Logan Lake IDA Pharmacy (Logan Lake)		√	E89	licensed as community / operates in telepharmacy mode Saturday/Sunday/closed Holidays	108 Chartrand Ave., P.O. Box 1130 Logan Lake, BC V0K 1W0	MON-SAT 09.00-17:00	SAT-SUN 09.00-17.00	2 PS 3 PA	30-40 minutes to Merrit Pharmasave Drugs #154	MON-FRI 09.00-19.00 SAT 09.00-18.00 SUN 11.00-17.00
									30-40 minutes to Kamloops Save-on-Foods Pharmacy #931	MON-FRI 08.00-20.00 SAT -SUN 10:00-18:00
New Hazelton IDA Pharmacy (New Hazelton)		√	ZCO	Still in Prelicensure stage	4 - 4571 10 Ave New Hazelton, BC V0J 2J0	Still in Prelicensure stage			1.5 hrs to Terrace Save-on-Foods Pharmacy #983	MON-FRI 08.00-20.00 SAT -SUN 09:00-17:00
									50 min Smithers Shoppers Drug Mart #2257	MON-FRI 09.00-21.00 SAT 09.00-18.00 SUN 10.00-17.00
Elkford IDA Pharmacy (Elkford)		√	ZCN	Still in Prelicensure stage **A new full pharmacy opened In Elkford in April 20, 2015**	814 Michel Rd Elkford, BC V0B 1H0	Still in Prelicensure stage		1 PS	45 minutes to Fernie - N/A Full Pharmacy - Elkford Drug Store	MON-FRI 09.00-18.00 SAT 11.00-14.00

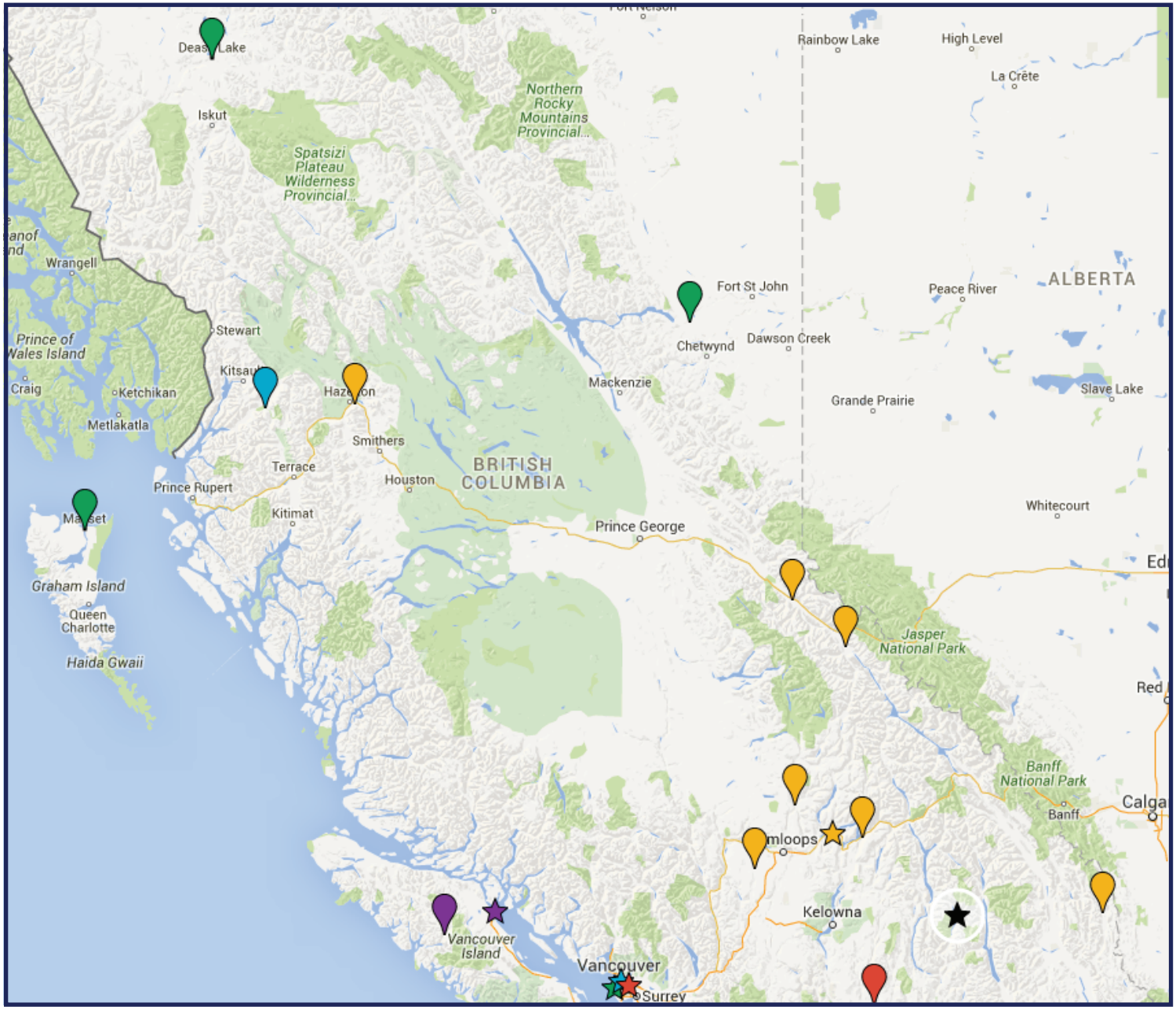
Telepharmacy	Central Site	Remote Site	PCARE Code	Notes	Address	Hours of Operation (Central site)	Hours of Telepharmacy (Remote)	Staff PS / PT (Central site)	Time to Closest City / Pharmacy	Hours of Nearest Full Pharmacy
Lancaster Prescriptions #2 (Burnaby) (Owner = Cris Bennett)	√		S69	regular pharmacy 3 days a week telepharmacy 1 day a week, therefore a pharmacist does not visit telepharmacy site	7487 Edmonds St. Burnaby, BC V3N 1B3	MON-FRI 09.00-17.30 SAT 09.00-16.00 SUN CLOSED		2 PS		
Boundary Pharmacy (Midway)		√	Q03		612 - 6th Avenue Box 400 Midway, BC V0H 1M0		WED-FRI 10.00-17.00	1 PS 1 PA	1 hr to Osoyoos Shoppers Drug Mart # 262	MON-THUR 08.00-18.00 FRI 08.00-21.00 SAT-SUN 09.00-18.00
									45 min to Grand Forks Pharmasave #106	MON-FRI 08.00-18.00 SAT 09.00-17.00 SUN-HOL 10.00-14.00
Kaslo Community Pharmacy (Owner = Ward Colin Taylor)	√		K97	A pharmacist visits telepharmacy site 3 times per week	Box 550 403 Front St Kaslo, BC V0G 1M0	MON-FRI 09:30-17:30		2 PS 1 PT FULL		
New Denver Community Pharmacy		√	ZCD		309 6 Ave Box 39 New Denver, BC V0G 1S0		MON/WED/FRI 10.00-17.00 THURS 10.00-14.00		1.5 hrs to Revelstoke Pharmasave #213	MON-THUR 09.00-18.00 FRI 09.00-21.00 SAT 09.00-18.00 SUN 11.00-16.00
									1.5 hrs to Castlegar Pharmasave #108	MON-THURS 09.00-18.00 FRI 09.00-19.00 SAT 09.00-18.00 SUN CLOSED SUN 11.00-16.00
									1.5 hrs to Nelson Pharmasave #148	MON-THUR 09.00-18.00 FRI 09.00-19.00 SAT 09.00-17.30 SUN 10.00-14.00

Legend for PS = pharmacist, PT = pharmacy technician and PA = pharmacy assistant

Map of Telepharmacy Sites in British Columbia

Legend

- Pharmasave Health Centre #022 - YVR (Central Site)
- Pharmasave Health Centre #074 - Telepharmacy Dease Lake (Remote Site)
- Pharmasave Health Centre #075 - Telepharmacy Hudson's Hope (Remote Site)
- Pharmasave Health Centre #076 - Telepharmacy Haida Gwaii (Masset) (Remote Site)
- Pharmasave Health Centre #077 (Commercial Ave-Vancouver) (Central Site)
- Nisga'a Valley Pharmasave - Telepharmacy (New Aiyansh Pharmasave (Nass Valley) (Remote Site)
- Peoples Drug Mart #139 (Quathiaski Cove) (Central Site)
- Peoples Pharmacy #239 (Gold River) (Remote Site)
- Munro's Sorrento Prescription (Sorrento) (Central Site)
- Eagle Valley IDA Pharmacy (Sicamous) (Remote Site)
- Barriere IDA Pharmacy (Barriere) (Remote Site)
- Valemount IDA Pharmacy (Valemount) (Remote Site)
- Robson Valley IDA Pharmacy (McBride) (Remote Site)
- Logan Lake IDA Pharmacy (Logan Lake) (Remote Site)
- New Hazelton IDA Pharmacy (New Hazelton) (Remote Site)
- Elkford IDA Pharmacy (Elkford) (Remote Site)
- Lancaster Prescriptions #2 (Burnaby) (Central Site)
- Boundary Pharmacy (Midway) (Remote Site)
- New Denver Community Pharmacy



College of Pharmacists of British Columbia

7. Telepharmacy Update

Doreen Leong

Director of Registration, Licensure & PharmaNet

2006

Jun

- Telepharmacy initiated with hospital pharmacies acting as central site for other hospital pharmacies & 1 community health centre (w/ hospital pharmacists' supervision)

2007

Jan

- Pilot project with community telepharmacy
  →Sorrento Central site
  →Sicamous Remote Site

Jul

- Recommendation to continue to run as telepharmacy remote site on weekends
  → Sicamous
- 1 telepharmacy remote site opened
  → Barriere

2009

Mar

- 1 telepharmacy remote site opened
  → Gold River

Apr

- 6 telepharmacy remote sites opened
  → Masset
  → Hudson's Hope
  → Dease Lake
  → McBride
  → Valemount
  → Logan Lake

2010

Jun

- PODSA bylaw revised to require a PT at remote site
- Telepharmacy owners notified of change in PODSA bylaws

Sept

- 1 telepharmacy remote site opened
  → Midway

2011

Jan

- PT title established as a reserved title

2012

Mar

- 1 telepharmacy remote site opened
  → Nisga'a Valley

2014

Jun

- Board meeting – Board member raised an issue about the quality of pharmaceutical care being provided at telepharmacy sites

Sep

- CPBC conducted a review of some telepharmacy services

2015

Jun

- Telepharmacy owners reminded of requirement to have a regulated PT at remote site by Dec.31.2015
- No new telepharmacy applications approved

Sep

- Update provided to Board on current state of telepharmacy and emerging issues
- No recommendations or changes made to legislative requirements

Oct

- 1 telepharmacy remote site opened
  → New Denver

Nov

- CPBC contacted Health Canada to clarify FDA & Regulations and CDSA requirements relating to possession, storage and dispensing of CDS
  → Dec 2015: legal opinion confirmed possession, storage and dispensing of CDS must only be done by a pharmacist

Nov

- Telepharmacy operators indicated they could not meet Dec.31.2015 deadline
  → extension given until Dec 31, 2016
  → No approval of any new or existing applications

Dec

- Transition period ended for current PAs to become regulated

2016

Feb

- Hired external consultants to conduct environmental scan, recruitment strategies, review options, define criteria, and make recommendation on options for these telepharmacies

College of Pharmacists of British Columbia

Legislative Requirements - Provincial

PODSA – Bylaws

- "telepharmacy" means the process by which a central pharmacy site operates one or more telepharmacy remote sites, all of which are connected to the central pharmacy site via computer, video and audio link.
- Telepharmacy remote site means a pharmacy providing pharmacy services:
  - Without a full pharmacist present,
  - In a rural or remote community, and
  - Under the supervision of a pharmacist at the central site.
- If a pharmacy technician is not at the telepharmacy remote site, the site must not remain open and prescriptions must not be dispensed.

Legislative Requirements - Provincial

PPP-55 – Telepharmacy

- Outlines requirement for a policy and procedure manual that outlines specific telepharmacy operations including:
  - Process by which the pharmacy technician at the remote site receives and processes the prescription,
  - Contingency plan in the event of an interruption in data, video, or audio link to the central pharmacy.

Legislative Requirements - Federal

Controlled Drugs & Substances Act (CDSA) state:

- That only a pharmacist can be in possession, store and dispense controlled drug substances

Current State

12 telepharmacy remote sites and 2 in pre-licensure stage, under 6 central pharmacy sites

- 6 are “full-time” telepharmacies
- 3 have a pharmacist on a part-time basis between 1-3 days/week
- 3 are telepharmacies on weekends/holidays, operating as full community pharmacies during the week
- 1 telepharmacy in pre-licensure stage indicates they have a pharmacy technician and are ready to be approved for opening in May 2016

Telepharmacies		Population	Owner Reported Volumes	Pharmacist	Pharmacy Technician	Distance to Alternate Pharmacy Access (km)
FULL-TIME TELEPHARMACY ACCESS	**Dease Lake**	500	~20	No	No	800km to Terrace or 300km to Yukon
	Massett	1,200	~55 – 60	No	No	200km
	Nisga'a Valley	1,000	~45 – 50	No	No	250km
	McBride	1,500	~45 – 50	No	No	200km
	Valemount	1,500	~60 – 70	No	No	300km
	Hudson's Hope	500 – 700	~20 – 25	No	No (potential candidate)	75km
PART-TIME TELEPHARMACY ACCESS	**Gold River**	2,000	~40 – 50	1 day	No	150km
	Midway	1,500	~100 – 120	3 days	No	75km
	New Denver	1,500	~30	3 days	4 days	60km
WEEKEND TELEPHARMACY ACCESS	**Barriere**	1,800	~60 – 70	5 days	No	75km
	Sicamous	2,400	~40 – 50	5 days	No	50km
	Logan Lake	2,200	~25 - 30	5 days	No	50km

Challenges

Telepharmacy owners state:

- Challenges with staff recruitment
- Potential increased costs
- Potential reduction of pharmacy services to rural and remote communities if they must meet requirements

Guiding Principles

Compliance

- Legislation: telepharmacy operations must comply with all relevant federal and provincial legislation

Patient Care

- Access: Telepharmacy should be used to ensure communities have access to safe and quality pharmacy care
- Quality and safety: Pharmacy services including telepharmacy should ensure safe and effective, quality and consistent care, which includes maximizing continuity of care

Operations

- Procedures: Telepharmacy operations should be reviewed and revised based on best practices and to support safe and quality patient care
- Technology: Appropriate use of technology is key to effective implementation of telepharmacy and patient privacy. Technology solutions should be integrated into telepharmacy service delivery as a key tool in providing safe and quality pharmacy care

Criteria to Guide Recommendations

CDSA COMPLIANCE

- Could a pharmacist be recruited to or travel to the community?
- Do reported volumes suggest the community could support a pharmacist?

PODSA COMPLIANCE

- What is the likelihood that a pharmacy technician will be in place by the deadline?
- Is a pharmacy technician more likely to be recruited than a pharmacist?

ACCESS

- Are alternative pharmacies available within driving distance?
- Are other health services available within the community?
- Do they already have a pharmacist available part time?

Possible Strategies for PODSA Compliance

- Reducing hours a telepharmacy is open and providing telepharmacy only when staffed by a pharmacy professional
- Opportunities to expand part-time pharmacist coverage to full time coverage
- Opportunities to make registered pharmacy technician training more accessible in rural and remote locations
- Improving recruitment strategies for pharmacy technicians
- Opportunities for a rural incentive program for pharmacy professionals in telepharmacies
- Contingency plans for communities to receive pharmacy services through other health authority clinics or dispensing providers (physicians, nurse practitioners)

Possible Strategies CDSA Compliance

- Providing access to controlled drug substances (CDS) only when site is staffed by a pharmacist
- Providing access to CDS through an alternate pharmacy with a registered pharmacist, health authority clinic, or other dispensing provider
- Looking at opportunities to expand part-time pharmacist coverage to full time coverage
- Improving recruitment strategies for pharmacists
- Opportunities for a rural incentive program for pharmacists in telepharmacies
- Contingency plans for communities to receive pharmacy services through other health authority clinics or dispensing providers (physicians, nurse practitioners)

Progress to date

Phase 1

- Conducted environmental scan of the current practices at each central and remote site
- Identified real vs perceived challenges within each telepharmacy site
- Conducted a risk assessment at each site exploring potential impacts
- Identified similar sized communities and strategies used to provide pharmacy services and other healthcare services, and recruitment strategies
- Defined criteria for decision making

Next steps

Phase 1

- Finalize recommendations
- Develop strategies for telepharmacy owners to meet legislative requirements
  - Meet with telepharmacy owners
  - Develop recruitment and retention strategies
  - Develop transition strategies for controlled drug substances

Phase 2

- Operationalize recommendations

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

8. PLoT Presentation

INFORMATION ONLY

Ming Chang and Aaron Sihota will be presenting. See briefing note in Appendix 1.

Appendix	
1	Briefing Note and Presenter Biographies – Ming Chang and Aaron Sihota

College of Pharmacists of BC Board Meeting Presentation-PLoT

Rationale

Pharmacy Leaders of Tomorrow-why it was created and how this initiative is working to curate a network of new practitioners and pharmacy innovation solutions in BC.

Objective(s):

- *Explore why Pharmacy Leaders of Tomorrow was created, the vision, and what purpose does it serve? Lessons learned so far, challenges, barriers*
- *The value of the cross-fertilization of ideas and innovations to help re-imagine pharmacy care models*
- *How creating a platform where individuals can collaborate from broad array of fields to create new blueprints that solve real pharmacy problems. How do we find solutions for those who feel more comfortable in a compartmentalized world? New regulations, changing demographics and technological advancement*

Started in the fall of 2015, Pharmacy Leaders of Tomorrow (PLoT) is a pilot initiative launched to educate and assist new community pharmacy practitioners in achieving pharmacy innovation and leadership success. It serves as an intimate platform to connect themselves with each other, but also uniquely emphasizes the importance of building partnerships with the broader community (broader business, digital health and tech, design) to help solve the collective problems we face as a profession. We are accustomed at times to silo'd thinking and only surround ourselves with individuals and ideas that are most familiar, however some of the best innovations come from the cross-pollination of ideas and solutions from divergent industries.

Innovation is the currency of today and almost every industry today is being reimagined and pharmacy should be no exception. Unfortunately we find our profession lags behind in this area. What is unique about PLoT is that it is the first initiative of its kind in Canada to be organized at the grassroots level by a group of community pharmacists from diverse practice settings who want to innovate, inspire and empower. The Canadian Foundation for Pharmacy has supported the initiative for its inaugural year.

Part of the initiative`s goal is also to create a supportive environment for developing new pharmacists' understanding of the various economic and political concepts that shape the profession today. These dynamic meetups address topics ranging from building mutually effective prescriber-pharmacist relations and ways to close the gap in the coordination of your patients' care, to entrepreneurship and the integration of health technology to optimize workflow. We have also looked at pharmacy workplace standards, how one begins to tackle a healthcare culture that has always done things the same way over, and new approaches needed to make a financially sustainable, clinically orientated pharmacy model successful in a challenging patient population.

PLoT is serving an unmet need in our profession is very much emerging as a platform for innovation and inspiration for pharmacists to take new approaches and think about how to create positive change within their respective practice environments. During each monthly meetup, a different guest host facilitates and stimulates discussion and learning, aiming to inspire change in personal and overall practice.

For more info visit: www.facebook.com/pharmacyleadersoftomorrow or www.leadersofpharmacy.com.

"Challenges in Community Pharmacy in BC" Meetup in downtown Vancouver January.21st 2016 hosted by College Registrar Bob Nakagawa and College Board Chair Blake Reynolds. It served as an opportunity for those in attendance to share new ideas, input and thoughts with the College for how community pharmacy practice challenges can be addressed now and in the future.

College of Pharmacists of BC Board Meeting Presentation-PLoT

Young pharmacy practitioners share new approaches and debate how technology can be better incorporated into today's community pharmacy environment to enhance patient care and service delivery.

PLoT Representatives

Aaron Sihota

Aaron Sihota is a recent graduate from the UBC Vancouver Faculty of Pharmaceutical Sciences (2014). He has a keen interest in the application of innovative solutions to address today's healthcare issues and is an actively promotes health and wellness and change leadership in community pharmacy practice as a pharmacist with Pharmasave. He is also assisting patients at Pier Health Resource Center, a newly opened clinical, patient focused pharmacy in the heart of the Downtown Eastside. Pier Health is a pioneer program designed to provide comprehensive outcome based healthcare and best practices research to the most complex residents of Vancouver's inner city, and strives to raise the standard of healthcare services in the area and position itself as a national leader for care delivery. Pier works closely with allied health professionals as well as with the UBC Department of Psychiatry to understand novel drug therapy and psychosocial interventions on patients. Aaron recently helped establish Pharmacy Leaders of Tomorrow, a non-for profit organization dedicated towards fostering professional and business practice innovation in young pharmacists and the first of its kind in Canada. He presented at the 2015 Ehits (e-Health and Innovative Technology Summit) at the UBC Faculty of Medicine looking at how digital health and shifting consumer demands can open up new opportunities to focus on preventative health. Aaron currently serves as a voting member of the College of Pharmacists of BC Community Pharmacy Advisory Committee and Vice-Chair of the South Vancouver Neighborhood House Board of Directors.

College of Pharmacists of BC Board Meeting Presentation-PLoT

As a pharmacy student Aaron served in various leadership roles including a one-year term as President of the student body, and for two terms representing the Faculty on the university's highest academic governing body, the UBC Senate. He has worked with the College of Pharmacists of British Columbia and British Columbia Pharmacy Association to advocate for community practice and healthcare advancement initiatives, including the creation of a Student observer seat on the College's Board of Directors. Aaron is a recipient of the 2015 Canadian Foundation for Pharmacy's Wellspring Leadership Award and the 2014 National Pharmacy Practice + Magazine Commitment to Care Award for Student Leadership and 2014 BC Pharmacy Association Apotex Leader Award. Aaron is regularly called on to share his expertise at digital health conferences. He was the only pharmacist invited to speak at Interface 2014 in Vancouver BC, Canada's only digital health international summit, on the future of healthcare delivery and how to re-imagine and disrupt the retail pharmacy care model and was invited back as a panelist for Interface 2015.

Ming Chang

Ming Chang graduated from the Faculty of Pharmaceutical Sciences from UBC in 2009. Since starting his practice, he has strived to achieve three goals:

1) Provide excellent pharmacy care to the public
2) Promote a strong educational environment for prospective pharmacists
3) Progress pharmacy as a profession

Currently, Ming works for Save-On-Foods Pharmacy, where he practices in both a community and a residential care setting. He enjoys working with patients while acting as a preceptor for pharmacy students. He also has experience in managerial and central-fill settings. Outside of work, Ming serves as a member of key pharmacy organization, such as a Board Member for the College of Pharmacists of BC, and for Pharmacy Leaders of Tomorrow.

Pharmacy Leaders of Tomorrow (PLoT)

BC College of Pharmacists
April.14th, 2016
Aaron Sihota & Ming Chang

What's the problem with pharmacy today?

MaRS

- What We Offer
- Entrepreneur's Toolkit
- What's Happening
- All About MaRS

Appendix 6

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Meridian

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Governor General's Innovation Awards

PARTNER
Saint Elizabeth

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Pearson

PARTNER
Roche

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The Rockefeller Foundation

Innovation

Appendix 6

Three principles of innovation from TD Bank's innovation lab

TD Lab director Ian McDonald has a few simple rules for fostering ideas about next-generation banking

Aug 6, 2015 CB Staff 1

TD Lab staff leading an internal innovation workshop in 2014. (TD)

The TD Lab at the Communitech hub in Waterloo, Ont., is where the bank prototypes and tests out new product ideas. Ian McDonald, director of the skunkworks, shares TD's three principles of innovation:

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How TD's innovation lab is

PHARMACY

LEADERS OF TOMORROW

Appendix 6


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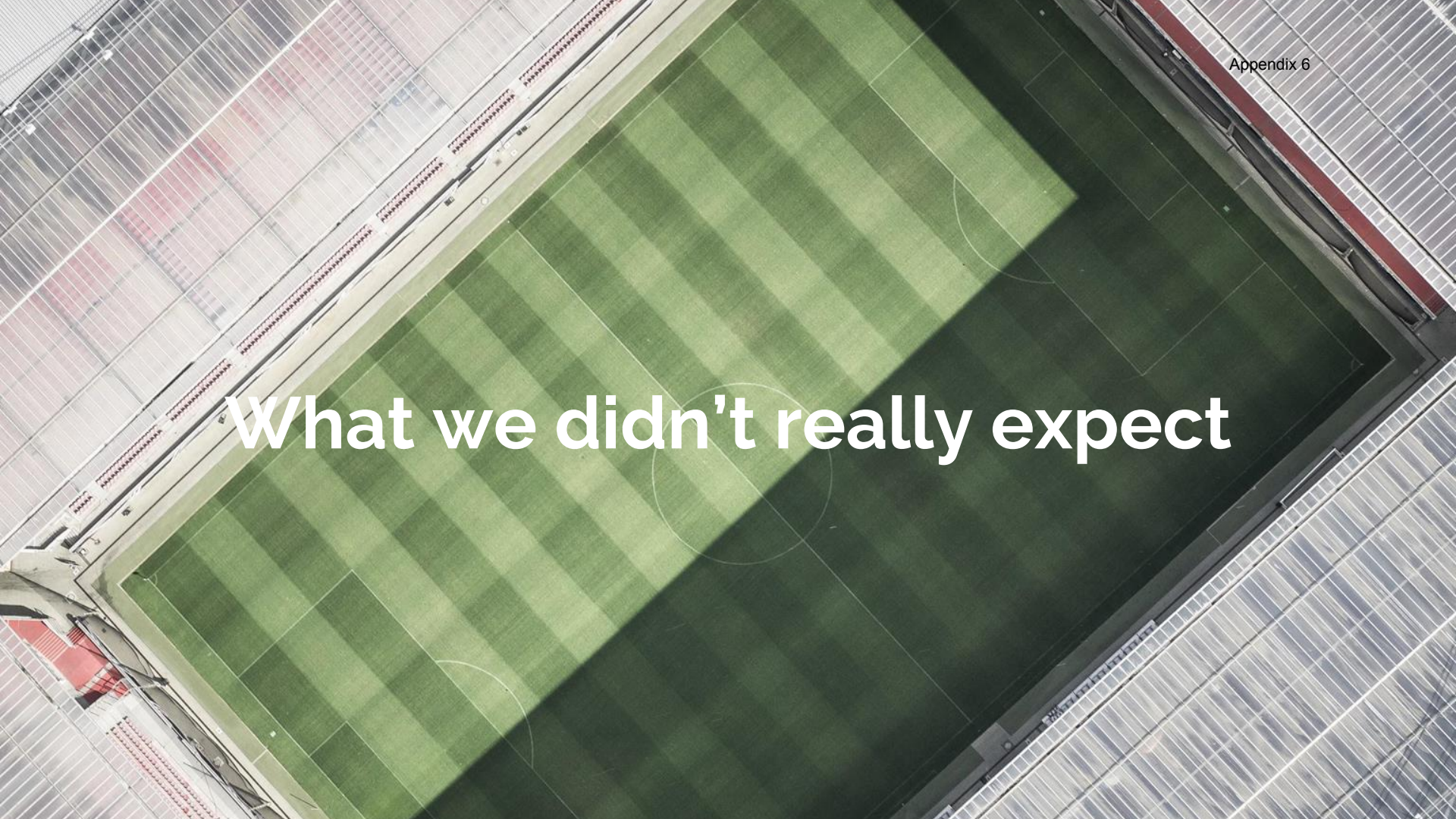
SEPT 2014 Launch

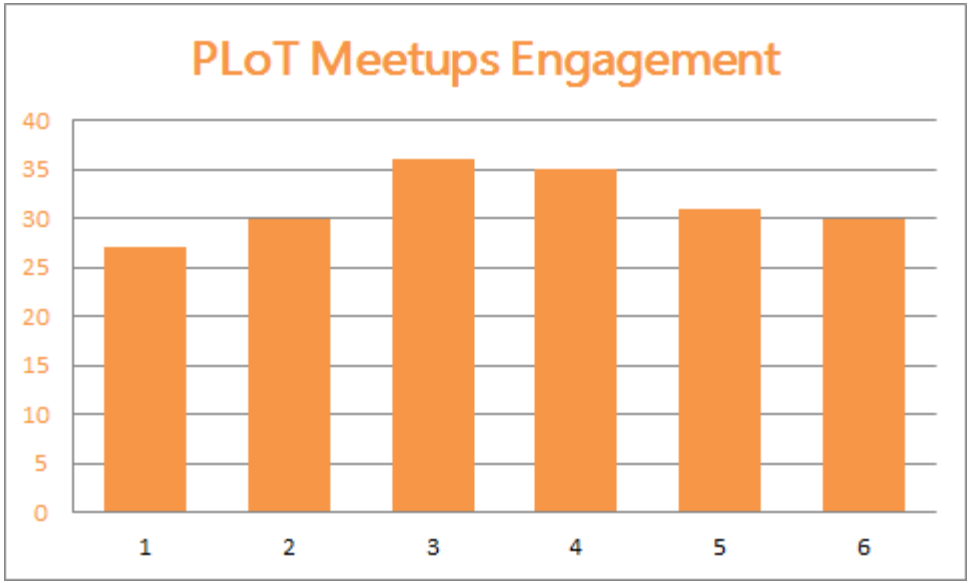
Appendix 6



What we didn’t really expect

More than 150 pharmacists engaged so far via 6 meetups.

FIRST IN **CANADA**



Appendix 6

Appendix 6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PHARMACY LEADERS OF TOMORROW
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Engaging pharmacists in a way they have never been engaged before

Appendix 6

Being nimble and PLoT: a trial fast, fail fast, learn fast culture

Appendix 6

Appendix 6

Proactive Disruption

Building Solutions for Pharmacy

Impactful ideas and solutions

Non-traditional

Culture

Partnerships

- Investment community
- Venture competition


PHARMACY LEADERS OF TOMORROW
www.leadersofpharmacy.com

Appendix 6

Appendix 6

Appendix 6


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Fresh Thinking

The Outside Has A Lot More In Common Than One May Think

Appendix 6


MACY LEADERS OF TOMORROW
leadersofpharmacy.com


EADERS OF TOMORROW
ersofpharmacy.com

Where does the value lie?

Cross-fertilization of ideas, networking, curation of a network of new practitioners and pharmacy innovation solutions in BC.

Appendix 6

What role can the College play?

Certified Pharmacist Prescriber Meetup with the Pharmacy Leaders of Tomorrow

Presented by College of Pharmacists of BC

Thu, Apr 28
6:00 PM

Sheebeen
Vancouver, BC, Canada

Event Information

Register 1

Share your input on the Draft Certified Pharmacist Prescriber Framework at this Pharmacy Leaders of Tomorrow Meetup

Thursday April 28 2016 6:00 PM - 8:30 PM

Sheebeen, 210 Carrall St, Vancouver, BC, Canada

Free Closed

Consultation with PLOT
Certified Pharmacist Prescriber Framework

50 OF 50 TICKETS CLAIMED

What's in the cards for the future of PLoT?

Discussion

Methadone Maintenance Payment Program Review

Medical Beneficiary and Pharmaceutical Services

Ministry of Health

BRITISH COLUMBIA

riority # 1 – Provide patient-centred care

BRITISH COLUMBIA

lients on methadone say that it is eneficial because it:

- Reduces harm from injection drug use
- Reduces anxiety from withdrawal
- Decreases other kinds of substance use
- Reduces involvement in criminal activities
- Builds confidence and self esteem
- Provides stability and routine

10 Qualitative Systems Review, Centre for Addiction Research BC

owever …

BA raises alarm over number of armacies in Langley City

November 28, 2012 | Updated : November 28, 2012 | 7:35 pm

City helps crack down on pharmacies committing methadone fraud

By Emily Jackson
Metro Vancouver

Share this Article Recommend 15 Tweet 6 +1 0

vering addicts feel like 2nd-class citizens in some nacies

ecialists worry the stigma will discourage addicts from getting treatment

News Posted: Mar 18, 2014 5:00 AM ET | Last Updated: Mar 18, 2014 8:24 PM ET

Methadone users 'get pharmacy kickbacks'

VANCOUVER — Health workers on Vancouver's Downtown Eastside say they've complained for years about methadone users being offered kickbacks from pharmacists to fill their prescriptions.

BY VANCOUVER SUN SEPTEMBER 9, 2008

WS SPORTS ENTERTAINMENT OPINION BUSINESS HEALTH LIFE TECHNOLOGY

ner pharmacist and slumlord George Wolsey ed to Surrey clinic

DY OLIVIER, THE PROVINCE MAY 6, 2014

BURNABY July 21, 2014 7:01 pm Updated: July 21, 2014 9:19 pm

Burnaby residents angry over pharmacy dispensing methadone

BRITISH

itial Report Findings – Patients

In January 2015, MBPSD completed an initial analysis

Findings included:

- Vast majority are covered through PharmaCare Plan C (Social Assistance)
- Majority have methadone dispensed daily
- Many have complex drug regimens—raising concerns about patient safety
- Patients' complex drug regimens are dispensed at frequent dispensing intervals

BRITISH COLUMBIA

itial Report Findings – Community Pharmacy

Top 20 methadone dispensing pharmacies:

- Account for over $12 million in methadone paid claims (28% of methadone expenditures)
- Annual revenue from dispensing methadone to patients ranges from $400,000 to $1 million, including professional fees and ingredient costs, and not including dispensing of their other drugs.
- Service nearly exclusively methadone patients
- Largely in Greater Vancouver area (Surrey, DTES)
- Majority have had problematic billing practices noted by PharmaCare Audit

BRITISH COLUMBIA

MMPP Review

Inclusions from our initial report:

Public funding should be used to promote patient care, which we measure as:

- Safe, accessible, acceptable (respectful), effective
- Equitable (fairly distributed), efficient (optimal use of resources)

In some cases, the current payment model for methadone dispensing distorts the quality of patient care in significant ways

BRITISH COLUMBIA

ctions taken by PharmaCare

Joint undercover investigation & closures

Provider Regulation under the *Pharmaceutical Services Act*

MPP Review – Moving forward

Consulted with 15 stakeholder groups in 2015

- Produced a list of 18 recommendations

Beginning work on 8 policy projects

- Related to MBPSD's mandate
- Align with Ministry's 5 strategic priorities

Re-engaging stakeholders

- Started with the College, and the Network for Excellence in Substance Dependence and Related Harms

BRITISH COLUMBIA

Policy Projects

Define optimal standards for pharmacies dispensing methadone to qualify for PharmaCare reimbursement.

Evaluate the witnessed ingestion fee.

Improve access to Suboxone.

Increase the use of medication reviews.

BRITISH COLUMBIA

Policy Projects

Review the payment schemes for methadone prescribing and dispensing.

Develop coordinated delivery models for health care and social services in the DTES and other areas with a high concentration of methadone patients.

Improve collaboration between pharmacists and physicians.

Develop an evaluation framework.

BRITISH COLUMBIA

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

10. Legislation Review Committee: PPP-58 Adapting a Prescription - Amendments

DECISIONS REQUIRED

Recommended Board Motions:

1. *Approve* Professional Practice Policy 58 - Amendment to Orientation Guide – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016).
2. *Approve* Professional Practice Policy 58 - Orientation Guide – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016).

Background

Professional Practice Policy #58 (PPP-58) entitled "Protocol for Medication Management – Adapting a Prescription" approved by the College of Pharmacists of BC (the College) in September 2007, provides the framework to guide pharmacists in the safe and effective adaption of existing prescriptions. The three primary activities considered under the notion of adapting a prescription include change, renew, and substitution. The purpose of this decision is to update the limits and conditions for substitution protocols in an effort to align with the Ministry of Health's PharmaCare program.

The substitution protocols authorized by PPP-58 allow a registrant to adapt a prescription by making a therapeutic substitution. This means a registrant may substitute the drug prescribed with a different drug that is expected to have a similar therapeutic effect, as long as that drug is from the same therapeutic class (i.e., a group of drugs used to treat the same condition). When making a therapeutic drug substitution, a registrant must be satisfied that the dose and the dosing regimen of the new drug the registrant selects will have an equivalent therapeutic effect.

B.C. residents with active Medical Services Plan of B.C. coverage are eligible for coverage under a number of different PharmaCare plans. In an effort to streamline cost and efficiency, PharmaCare's Reference Drug Program (RDP) provides coverage to only a particular number of

drug categories if there are more than one drug in a therapeutic class. The drugs covered by the RDP are called the "reference drug." Reference drugs are normally the drugs considered to be the standard first treatment of choice. If a patient cannot take a reference drug, a health care professional may submit a Special Authority Request for full coverage of one of the non-reference drugs.

Currently, PPP-58 supporting documents (i.e. the Amendment to Orientation Guide) outline six categories of drugs included in the RDP (See page 3 of Appendix 1). However, the RDP has added two new categories: Angiotension Receptor Blockers and Statins. The two new categories must be added to the PPP-58 supporting documents in order to authorize registrants to consider these as options for therapeutic substitution. The Ministry of Health's RDP website will be updated on June 1, 2016 to reflect all current RDP categories.

The proposed amendment directs the approval of therapeutic substitution for all drugs that are now and subsequently will be included in the RDP.

Discussion

In the past, PPP-58 has been updated whenever the Ministry of Health made additions to the RDP. The proposed amendment will allow for a broader statement that moves from a specific listing of categories to an adoption of those approved in the RDP.

In effect, this proposed change will update the approved categories now and will authorize any future changes made to the RDP.

The benefit to this change is that it will provide registrants a timely authorization for any change in the types of therapeutic class categories under the RDP. The Ministry of Health will also benefit by having timely adaption by registrants for any new therapeutic class categories that are included in the program, thereby streamlining cost and efficiency at a faster rate. We will request that the Ministry of Health provides notice to the College every time there is a change to RDP categories, followed by posting changes to the College's website for information purposes in order to make registrants aware of any updates.

Additionally, while creating the change to broaden to the specific therapeutic class categories, small housekeeping amendments have also been proposed for the 'Orientation Guide'. For example, references to the 2008 orientation live sessions have been removed.

Furthermore, it is recognized that there is more outstanding work to be completed on both the policy and the supporting documents, in regards to adapting prescriptions (PPP-58). It is expected that a prioritization of this work, along with other outstanding policy work will occur in the Fall of 2016. Essentially, the scope of this particular proposed change is to enable new categories that have been introduced to PharmaCare's RDP.

Recommendations

1. *Approve* Professional Practice Policy 58 - Amendment to Orientation Guide – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016).
2. *Approve* Professional Practice Policy 58 - Orientation Guide – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016).

Appendix	
1	For information: The six classes of drugs included in the RDP outlined in PPP-58 supporting documents.
2	For decision: Professional Practice Policy 58 - Amendment to Orientation Guide – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011)
3	For decision: Professional Practice Policy 58 - Orientation Guide – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011)

College of Pharmacists of British Columbia

IMPORTANT INFORMATION

Amendment to Orientation Guide – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011)

This update makes minor changes to the December 2008 amendment to PPP58. This update is the result of incorporating feedback expressed by pharmacists after having more than 1 year of experience with the policy. The changes also reflect comments received from other stakeholders, namely the College of Physicians and Surgeons (CPSBC) and the BC Medical Association (BCMA).

There have not been any changes to the seven fundamentals to Adapting a Prescription as outlined in Professional Practice Policy #58 (PPP-58) and pharmacists are required to follow the

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Liability Insurance	Minimum requirements for liability insurance: • Personal professional liability insurance (minimum $2 million)	Section 4.1; Page 17	**December 2008:** Minimum requirements for liability insurance are: • The policy provides a minimum of $2 million coverage, and • The policy provides occurrence-based coverage or claims-made coverage with an extended reporting period of at least three years, and • If not issued in the pharmacist's name, the group policy covers the pharmacist as an ndividual.
			February 2011: No change

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Handwritten notation from prescriber "Do Not Renew / Adapt" (or similar)	"review . . . the acknowledgement of any hand-written notations on the prescription by the prescriber."	Section 2.1.2; Page 7	**December 2008:** • Pharmacists will honour hand-written (not pre-stamped) "Do Not Renew / Adapt" notification on prescriptions • If a prescriber electronically produces their prescriptions they must sign or initial beside the notation
			February 2011: No change
Renewals – specific conditions &/or drugs	No limits and/or conditions stated	n/a	**December 2008:** • Renewals apply to stable, chronic conditions (same medication, with no change, for a minimum of six months) • For psychiatric medications renewals are reserved for pharmacists working in multidisciplinary teams
			February 2011: • Renewals apply to stable, chronic conditions (same medication, with no change) *Note: 'no change' is defined as usually a minimum of six months* • For psychiatric medications renewals are reserved for pharmacists working in multidisciplinary teams
Renewals – length of time	"for whatever period of time felt appropriate as long as it does not exceed the expiry of the prescription"	Section 2.2.2; Page 13 and Section 2.1.3; Page 7	**December 2008:** • Maximum renewal up to 6 months from the date of the original prescription
			February 2011: • For whatever period of time felt appropriate as long as it does not exceed the expiry of the prescription *Note: All prescriptions have an expiry of one year from the date the original prescription is written; oral contraceptives have a 2 year expiry date*

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Change: dose or regimen	No limits and/or conditions stated	Section 2.2.1; Page 13	**December 2008:** Unless in practice settings such as hospital, longterm care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists: • Will not change the dose or regimen of prescriptions for: cancer, cardio-vascular disease, asthma, seizures or psychiatric conditions • Pharmacists can complete missing information on a prescriptions if there is historical evidence to support it
			February 2011: No change
Therapeutic Substitution	No limits and/or conditions stated	Section 2.2.3; Page 14	**December 2008:** Unless in practice settings such as hospital, longterm care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists: • Will limit therapeutic substitution to: Histamine 2 receptor blockers (H2 blockers), Non-steroidal anti-inflammatory drugs (NSAIDs), Nitrates, Angiotension converting enzyme inhibitors (ACE inhibitors), Dihydropyridine calcium channel blockers (dihydropyridine CCBs) and Proton pump inhibitors (PPIs)
			February 2011: No change

College of Pharmacists
of British Columbia

IMPORTANT INFORMATION

Amendment to
Orientation Guide – Medication Management (Adapting a Prescription)
(December 2008 – revised February 2011/June 2016)

This update makes minor changes to the December 2008 amendment to PPP-58. This **second** update (2016) makes minor changes to the original document that was developed in 2008. The **first** update occurred in 2011 and at that time, considered feedback from pharmacists (one year post implementation) and from other stakeholders, namely the College of Physicians and Surgeons (CPSBC) and the BC Medical Association (BCMA)~~This update is the result of incorporating feedback expressed by pharmacists after having more than 1 year of experience with the policy. The changes also reflect comments received from other stakeholders, namely the College of Physicians and Surgeons (CPSBC) and the BC Medical Association (BCMA)~~[1].

There have not been any changes to the seven fundamentals to Adapting a Prescription as outlined in Professional Practice Policy #58 (PPP-58) and pharmacists are required to follow the fundamentals when choosing to renew or adapt any prescription.

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update

[1] Currently known as Doctors of BC.

Liability Insurance	Minimum requirements for liability insurance: • Personal professional liability insurance (minimum $2 million)	Section 4.1; Page 17	**December 2008:** Minimum requirements for liability insurance are: • The policy provides a minimum of $2 million coverage, and • The policy provides occurrence-based coverage or claims-made coverage with an extended reporting period of at least three years, and • If not issued in the pharmacist's name, the group policy covers the pharmacist as an ~~ndividual~~individual.
			February 2011: No change
			June 2016: **No change**

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Handwritten notation from prescriber "Do Not Renew / Adapt" (or similar)	"review . . . the acknowledgement of any hand-written notations on the prescription by the prescriber."	Section 2.1.2; Page 7	**December 2008:** • Pharmacists will honour hand-written (not pre-stamped) "Do Not Renew / Adapt" notification on prescriptions • If a prescriber electronically produces their prescriptions they must sign or initial beside the notation
			February 2011: No change
			June 2016: **No change**
Renewals – specific conditions &/or drugs	No limits and/or conditions stated	n/a	**December 2008:** • Renewals apply to stable, chronic conditions (same medication, with no change, for a minimum of six months)

			• For psychiatric medications renewals are reserved for pharmacists working in multidisciplinary teams **February 2011:** • Renewals apply to stable, chronic conditions (same medication, with no change) *Note: 'no change' is defined as usually a minimum of six months* • For psychiatric medications renewals are reserved for pharmacists working in multidisciplinary teams **June 2016:** **No change**
Renewals – length of time	"for whatever period of time felt appropriate as long as it does not exceed the expiry of the prescription"	Section 2.2.2; Page 13 and Section 2.1.3; Page 7	**December 2008:** • Maximum renewal up to 6 months from the date of the original prescription **February 2011:** • For whatever period of time felt appropriate as long as it does not exceed the expiry of the prescription *Note: All prescriptions have an expiry of one year from the date the original prescription is written; oral contraceptives have a 2 year expiry date* **June 2016:** **No change**

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Change: dose or regimen	No limits and/or conditions stated	Section 2.2.1; Page 13	**December 2008:** Unless in practice settings such as hospital, longterm care facilities or multi-disciplinary environments where

			collaborative relationships or appropriate protocols are established, pharmacists: • Will not change the dose or regimen of prescriptions for: cancer, cardio-vascular disease, asthma, seizures or psychiatric conditions • Pharmacists can complete missing information on a prescriptions if there is historical evidence to support it
			February 2011: No change
			June 2016: **No change**
Therapeutic Substitution	No limits and/or conditions stated	Section 2.2.3; Page 14	**December 2008:** Unless in practice settings such as hospital, ~~longterm~~long-term care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists: • Will limit therapeutic substitution to: Histamine 2 receptor blockers (H2 blockers), Non-steroidal anti-inflammatory drugs (NSAIDs), Nitrates, Angiotension converting enzyme inhibitors (ACE inhibitors), Dihydropyridine calcium channel blockers (dihydropyridine CCBs) and Proton pump inhibitors (PPIs)
			February 2011: No change
			April 2016: Unless in practice settings such as hospital, long-term care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists: • Will limit therapeutic substitution to those categories under the Ministry of Health's Reference Drug Program, the updated list can be accessed here: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/general-coverage-policies#rdp

College of Pharmacists
of British Columbia

Orientation Guide

Professional Practice Policy #58 - Medication Management (Adapting a Prescription)

~~Forward~~Foreword

Medication Management is an umbrella term that encompasses all professional activities that a pharmacist undertakes, as the medication experts, to optimize safe and effective drug therapy outcomes for patients. Pharmacists' involvement in medication management activities will continue to expand as the needs of patients and the demands of the healthcare system continue to increase.

This point was reinforced throughout the February 2008 'Throne Speech' where the provincial government acknowledged the challenges of sustaining the current healthcare system and called on all healthcare professionals to practice to their full scope as a means of helping to alleviate pressure from the system. This led to the introduction of – *Bill 25 – The Health Professions (Regulatory Reform) Amendment Act, 2008* which, specific to the pharmacy profession, formalizes a pharmacist's authority to 'renew existing prescriptions'.

The College of Pharmacists of BC's Professional Practice Policy #58 (PPP-58) entitled *"Protocol for Medication Management – Adapting a Prescription"*, approved by College council in September 2007, provides the framework to guide pharmacists in the safe and effective adaptation, including renewal, of existing prescriptions. PPP-58 is applicable to pharmacists in all practice settings including; community, long-term care, hospital and other institutional pharmacy settings.

This policy, which provides the opportunity for pharmacists to maximize their full educational and professional competencies, also provides structure to, and refines the process of, exercising professional judgment in clinical practice. This becomes increasingly important as pharmacists evolve their role as medication experts and assume accountability for their drug therapy decisions.

Although it is **not mandatory that a pharmacist adapt a prescription**, given that PPP-58 enhances pharmacist's scope of practice, it is mandatory that all registrants:

- Acknowledge that they have read and understood PPP-58 (by signing the Declaration Form included in this Guide) by December 31, 2008

Should a pharmacist choose to adapt a prescription, in addition to having read and understood the Orientation Guide, a pharmacist must:

- Possess personal professional liability insurance (minimum $2 million) and must adhere to all of the seven fundamentals for adapting a prescription as outlined in PPP-58

~~***Note:** Registrants can also choose to attend a 'LIVE' Orientation Session – schedule and registration details are available on the College website www.bcpharmacists.org*~~

Finally, pharmacists' authorization to implement this policy and thereby adapt prescriptions is effective January 1, 2009.

How to Use This Guide

This Orientation Guide (the Guide) is a companion to the actual policy PPP-58 which can be found in Appendix A. The intention of the Guide is to provide further detail and clarity (including practical examples) to assist pharmacists in the implementation of the policy into practice and ensure that adaptations are done safely and effectively. For clarity, a Glossary of Terms specific to PPP-58 can be found in Appendix B. It is important to note that this document is a guide only and is not intended to cover all possible practice scenarios. As with all professional activities, pharmacists must use sound professional judgment when adapting a prescription.

It will take you about 2 hours to read through this Guide. Assuming that after reading the Guide you are confident that you understand the content you need to sign the Declaration Form (final page of Guide) and retain it in your files. Should you require further clarification you ~~are invited to attend one of the free 'live' Orientation Sessions being offered (refer to the College website for schedule and registration details **www.bcpharmacists.org**) or~~may contact the college at **practicesupport@bcpharmacists.org**~~**info@bcpharmacists.org**~~.

Disclaimer

This Guide provides interpretation of PPP-58 under the statutes that govern the pharmacy profession in British Columbia. As a professional health practitioner in a self-regulated profession, you – the pharmacist – are responsible for understanding and practicing according to all relevant requirements and laws. You have a responsibility as a professional for interpreting and applying PPP-58 and the contents of this Guide within the context of your own practice.

Acknowledgement

Thank you to the Alberta College of Pharmacists for sharing their materials and experiences from their work on implementing practice standards for adapting a prescription in Alberta. Thank you to the BC Pharmacy Association for their participation in the Working Group that created this Orientation Guide.

Feedback

Questions and comments about this Orientation Guide are welcome and can be sent to:

~~Marshall Moleschi~~Bob Nakagawa, Registrar
College of Pharmacists of BC
200–1765 West 8th Avenue Vancouver, BC V6J 5C6
Phone: 604.733.2440 or 800.663.1940
Fax: 604.733.2493 or 800.377.8129
E-mail: info@bcpharmacists.org

Table of Contents

1.0 Introduction

1.1 Overview

The Framework of Professional Practice (FPP) provides the framework for good pharmacy practice in British Columbia. It describes what BC pharmacists do in daily practice and how they know they are doing it well. The FPP is designed to help pharmacists enhance their practice and patient outcomes, and to guide their professional development.

Within the current provincial legislative structure, pharmacists have the authority to perform certain professional activities to help people achieve their desired health outcomes. The College develops Professional Practice Policies to more clearly articulate a pharmacist's professional practice authorities and responsibilities. Professional Practice Policy #58 (PPP- 58) entitled *Protocol for Medication Management (Adapting a Prescription) is one such policy and falls under FPP Role 1 – Provide Pharmaceutical Care*.

In adapting a prescription however, in addition to PPP-58, the pharmacist must refer to all applicable legislation and standards. This includes, but is not limited to, the ~~Pharmacist, *Pharmacy Operations and Drug Scheduling Act* (PPODS)~~*Health Professions Act* (HPA), *the Pharmacy Operations and Drug Scheduling Act (PODSA), the Pharmaceutical Services Act (PSA)* and related regulations and bylaws, the *Health Care (Consent) and Care Facility (Admission) Act*, the FPP, ~~the Code of Ethics~~ and other Professional Practice Policies.

Although it is mandatory to know this policy, it is not mandatory that a pharmacist adapt a prescription. The decision to adapt a prescription or not is at the discretion of the individual pharmacist. Whenever a pharmacist chooses to adapt a prescription however, the adaptation must be done in accordance with PPP-58 and within the limits of the pharmacist's own competencies.

This policy is designed to enable continued high quality, safe and effective pharmacy care by BC pharmacists and to serve as a foundation for new professional pharmacist activities in the future.

1.2 Important Facts

Although the Guide will go into specific detail regarding the parameters and application requirements of *Medication Management – Adapting a Prescription (PPP-58)* the following is a list of key facts:

- PPP-58 applies to adapting an **existing** prescription only and does not include initiating a prescription nor activities requiring diagnosis
- Excludes narcotics, controlled drugs and targeted substances
- Does not replace a patient's need to see their physician
- For a pharmacist to adapt a prescription they must have completed the Orientation process and must possess personal professional liability insurance (minimum $2 million)
- Pharmacist authorization to adapt prescriptions **does not** mean obligation

- Once a pharmacist adapts a prescription they take **full responsibility** for and **assume liability** for that adapted prescription
- Although notification to the prescriber is the **final step** in the adaptation process, **prior approval** from the prescriber is not required

1.3 Bottom-line

The implementation of PPP-58 provides pharmacists the opportunity to utilize their professional judgment and practice to the full extent of their knowledge, skills and abilities to optimize health outcomes for their patients.

The evolutionary change in pharmacy practice through the implementation of PPP-58 is that it gives pharmacists independent authority and accountability for the adaptation of a prescription. In doing this, the pharmacist is making the decision, based on their professional judgment, that the prescription is the 'right' prescription for their patient.

Although this additional authority comes with added responsibility and ultimately liability, it allows pharmacists to demonstrate their value, as medication experts, in an evolving patient-centered, clinical care environment.

1.4 Objectives

After reviewing the material in this Guide, you will be able to:

1. Understand the elements of *Medication Management (Adapting a Prescription)*;
2. Understand the professional requirements and expectations when you undertake *Medication Management (Adapting a Prescription)*;
3. Understand the specific consent, documentation and notification requirements of implementing this policy in your practice;
4. Implement specifically defined Medication Management activities; and
5. Optimize the services you provide to patients within your enhanced scope of practice.

2.0 About PPP-58 Medication Management (Adapting a Prescription)

This section provides a detailed description of the following:

2.1 The fundamentals of adapting a prescription

2.2 The categories of adapting a prescription that you are authorized to engage in; and

2.3 Determining when you are NOT adapting a prescription.

2.1 Seven Fundamentals of Adapting a Prescription

PPP-58 outlines that you may dispense a drug contrary to the terms of an existing prescription (adapt a prescription) if the action is intended to optimize the therapeutic outcome of treatment with the prescription drug **and** you have addressed ***all*** of the following seven fundamental elements:

1. **Individual competence;**
2. **Appropriate information;**
3. **Prescription;**
4. **Appropriateness of adaptation;**
5. **Informed consent;**
6. **Documentation; and**
7. **Notification of other health professionals.**

Each of these elements provides structure to, and refines the process for, exercising professional judgment in your practice. When considering an adaptation you must consider the seven fundamentals in sequential order beginning with number 1 – Individual competence. If you are uncomfortable or unsure about any aspect along the way, **do not** adapt the prescription.

2.1.1 Individual Competence (Fundamental 1)

You must practice within your area of competency only. Do not adapt a prescription for any patient unless you have 'appropriate knowledge and understanding' of the condition being treated and the drug being prescribed.

It is not possible to establish parameters to define what is meant by 'appropriate knowledge and understanding', each situation, like each patient, is unique. Therefore, in order for a pharmacist to determine if they feel that they have 'appropriate knowledge and information' they must rely on their own professional judgment.

In doing this, it is helpful to answer the following questions:

1. If someone asks why I made this decision, can I justify it?

2. Would this decision withstand a test of reasonableness (i.e., would another pharmacist make the same decision in this situation)?

2.1.2 Appropriate Information (Fundamental 2)

You must have 'sufficient information' about the patient's health status to be satisfied that adapting the prescription will maintain or enhance the effectiveness of the drug therapy, patient outcomes and will not put the patient at increased risk.

In doing this you must respect and consider all relevant information available to you. This would include, but is not limited to: a review of the patient's health record on local and PharmaNet data bases, the acknowledgement of any hand-written notations on the prescription by the prescriber, and any information obtained directly from the patient or their representative. You may also need to obtain additional information from an appropriate source such as relevant medical literature or other colleagues.

Again, it is not possible to establish parameters to define what is meant by 'sufficient information' as each situation, like each patient, is unique. Therefore, in order for a pharmacist to determine if they feel that they have 'sufficient information' they must rely on their own professional judgment.

In doing this, it is helpful to consider the following questions:

1. If someone asks why I made this decision, can I justify it?
2. Would this decision withstand a test of reasonableness (i.e., would another pharmacist make the same decision in this situation)?

2.1.3 Prescription (Fundamental 3)

You must have a **new or the original prescription**[1] and it must be current, authentic, and otherwise appropriate for the patient. Pharmacists may not adapt a prescription if the original prescription has expired. All prescriptions have an expiry of one year from the date the **original prescription is written**. The exception is oral contraceptives, which have a two year expiry date.

Reminder:
Irrespective of PPP-58, if, upon review of relevant information, your professional judgment is that a drug-related problem exists and the prescription should not be filled or the drug should not be sold, you must refuse to dispense or sell the drug.

Example(s) of Prescription Expiry:
If a prescription is written on January 1, it is valid until December 31 of that same year even though the prescriber may only authorize an initial quantity of 100 days (with no authorized refills).

continued on next page

[1] For purposes of PPP-58, and included in the Glossary of Terms (appendix B), a 'new' or 'original' prescription is defined as the first fill of a prescription and does not need to be the beginning of a new therapy

If after the initial 100 days the pharmacist felt, based on following the Seven Fundamentals laid out in PPP-58 that it was appropriate for the patient, they could adapt (renew) the prescription for any portion of the days remaining – in this case to a maximum of 265 days. *(Note: while the decision to renew can be up to 265 days, it may also be significantly less and the duration is based on the professional judgement of the pharmacist)*

It is never possible, however, for a pharmacist to adapt (renew) the prescription beyond its' validity date – in this case December 31. Therefore, if the patient requested that the pharmacist adapt (renew) the prescription on Dec 1, the pharmacist could only dispense a 30 day supply and must refer the patient back to their prescriber for a new prescription. *(Note: if the patient were to present to the pharmacist after the Dec 31 expiry date, the pharmacist could not adapt (renew) the prescription at all but could, for continuity of care purposes, extend an emergency refill under PPP-31)*

It is also important to remember that the validity of a prescription is based on a period of time – in this example Jan 1 to Dec 31 – not on the overall quantity that could potentially be dispensed over that period of time.

To illustrate this point, ~~lets~~let's assume that the patient has the initial 100 days dispensed on Jan 1 but then does nothing until Dec 1 of that same year. At that point he presents to the pharmacist requesting a renewal for another 100 days. Although there is enough undispensed quantity to accommodate this request the prescription is only valid for 30 more days so the pharmacist could only provide a renewal for up to 30 days and must refer the patient back to their prescriber for a new prescription.

2.1.4 Appropriateness of Adaptation (Fundamental 4)

You must be sure that adapting the prescription is appropriate for the patient under the current circumstances, and will, in your professional judgment, optimize the therapeutic outcome of treatment.

You must maintain your professional independence at all times when making any adaptation and particularly when making therapeutic substitution decisions. You must critically evaluate evidence, clinical practice guidelines, information from pharmaceutical manufacturers, and approved indications. You may also be required to take into account formulary restrictions and other patient-related considerations. To be consistent with general practices and the College's Code of Ethics it is not appropriate to adapt a prescription for yourself or family members.

All decisions must be in the best interest of the patient and must focus on addressing the health needs of that patient. Any indication that a decision is based on benefit to the pharmacist or pharmacy rather than the patient will be considered professional misconduct.

2.1.5 Informed Consent (Fundamental 5)

2.1.5.1 General

In British Columbia, the obligation to obtain informed consent to healthcare from an adult patient, the criteria for consent and how to obtain consent, is defined in the *Health Care (Consent) and Care Facility (Admission) Act*.

The Act, states that every adult patient has the right to give, refuse or withdraw consent to treatment. Adaptation of a prescription in accordance with PPP-58 is a treatment that requires you to obtain consent from a particular patient.

The Act also sets out the criteria and process for obtaining valid consent. You must ensure that the consent has been **voluntarily** given to the proposed treatment by a capable adult patient.

You must also provide the patient with enough information to enable that patient to make an informed decision. Although this may sometimes be difficult to determine, you are required to decide:

What the average prudent and reasonable person in the patient's particular position would agree to or not agree to, if all material and special risks of going ahead (with the treatment) or foregoing it were made known to him.[2]

When advising a patient of risks, you must be familiar with the patient's circumstances, and take into account any special considerations that apply.

Informed consent is specific to the current treatment under consideration and not a blanket consent for any possible treatment. You **must** bring the following matter to the patient's attention:

- The specific condition for which the prescription adaptation is proposed;
- The nature of the proposed adaptation; and
- The risks and benefits of the adaptation that a reasonable patient would expect to be told about.

This list is not inclusive. Other matters may exist that need to be discussed with the patient, depending on the circumstances.

You must also provide an opportunity for the patient to ask questions and receive answers about the adaptation.

2.1.5.2 Substitute Consent - Adult Patients

Pharmacists frequently obtain consent from someone other than the patient being treated. This usually happens when an adult patient is no longer capable of providing an informed consent. In this situation, based upon the information that you have been provided, you must determine whether the patient has demonstrated that he or she is not able to give a valid consent.

[2] Reibl v Hughes, (1980) 14 C.C.L.T. 1 at paragraph 21

When this happens, the Act provides that you may obtain consent from a recognized representative from one of the following three categories:

- A committee appointed by the Supreme Court of British Columbia pursuant to the *Patients Property Act*;
- A representative named in a Representation Agreement validly made pursuant to the *Representation Agreement Act*; or
- A substitute decision maker pursuant to Section 16 of the *Health Care (Consent) and Care Facility (Admission) Act* where there is no committee or representative. The ranked list of acceptable substitute decision makers is:
  1. The patient's spouse;
  2. The patient's child;
  3. The patient's parents;
  4. The patient's brother or sister; or
  5. Any one else related by birth or adoption to the patient.

In order to give substitute consent, substitute decision makers must meet the following criteria. They must:

- Be at least 19 years old;
- Have had contact with the patient in the preceding twelve months;
- Have no dispute with the patient;
- Be capable themselves; and
- Be willing to comply with the duties in Section 19 of the *Health Care (Consent) and Care Facility (Admission) Act*.

If there is no one available to act as a substitute decision maker, you should contact the Health Care Decisions Consultant at the Public Guardian and Trustee for assistance. The Public Guardian and Trustee is authorized to provide consent in appropriate cases.

2.1.5.3 Consent of Minors

In British Columbia, the age of majority is 19 years. Normally a parent or guardian provides consent to healthcare on behalf of the minor. However, this is not always the case. The *Infants Act* provides that a minor may consent to treatment (adaptation of a prescription) if you have explained to and are satisfied that the minor understands the nature, consequences and can reasonably foresee risks and benefits of the treatment; and you have decided that in the circumstances the treatment is in the infant's best interest. A parent or guardian cannot overrule the decision made by the minor and is not entitled to disclosure of the information.

If a parent or a guardian is unavailable to provide consent and the infant is not mature enough to provide his or her own consent, it is customary for you to obtain the consent of grandparents, aunts, uncles, or other relatives as appropriate in the circumstances.

2.1.5.4 Recording of Consent

The Health Care (Consent) and Care Facility (Admission) Act provides that consent may be expressed orally, in writing or may be inferred from the patient's conduct. Therefore, it is not strictly necessary for you to document that you have obtained consent. However, the recommended documentation/notification template form (Appendix D) includes an area to acknowledge, by a tick mark, that consent was obtained and if by a representative, their name.

Such documentation is a useful risk management tool. In fact, written evidence that informed consent has been obtained in a particular situation can have a significant influence on the outcome of a negligence case brought against a healthcare professional for failure to obtain informed consent.

2.1.6 Documentation (Fundamental 6)

You must document all adaptations of all prescriptions in a way that creates an accurate record of the circumstances and details of the adaptation. The documentation must always relate back to the original prescription and include (if applicable) reference to any and all previous adaptations. Attached to this Guide as Appendix D is a recommended documentation and notification template form (an electronic version of this form is available on the college website **www.bcpharmcists.org**). The intention of the form is that once complete it can easily be faxed to the prescriber for notification purposes and then attached to the adapted prescription and maintained in the pharmacy records.

Pharmacists can develop their own documentation process as long as they ensure that the method of record-keeping is consistent with College auditing policies and procedures. In other words, all original prescription hard copies must always be retained, including new prescription hard copies generated as part of the adaptation process. All of the required documentation information, listed below, must be captured and retained with the adapted prescription.

Note:
In the future, when dispensary software is able to accommodate it, all of the required documentation information can be retained electronically.

Documentation must include:

1. Patient (including PHN number) and Pharmacist (including signature and name of Pharmacy) information
2. Original prescription information (including prescribers name and contact information)
3. A description of the adaptation (including all relevant prescription details)
4. The rationale for the decision to adapt the prescription (including pertinent details of your assessment and patient history along with any instructions to the patient and relevant follow-up plan)
5. Acknowledgment of informed consent
6. The date and name of practitioner(s) notified

Note:
~~*As of the publication date of this Guide, the process for capturing the pharmacists' identification number when changing or substituting* **new** *prescriptions in the PharmaNet system had not yet been defined. This process is expected to be available prior to adaptation taking effect on January 1, 2009 and will be communicated to pharmacists through regular College communications including; the website and ReadLinks publications.*~~

When adapting an existing prescription, during the prescription filling process on PharmaNet, you must input your pharmacist identification number in the prescriber field. This will confirm, within the system, that you have adapted the initial prescription and are now responsible for the adapted prescription.

Documentation establishes accountability and responsibility for your professional activities. It is a key component in demonstrating how you exercised your professional judgment and will be the primary tool used to communicate the rationale for your decision. It is also important to remember that every time you document you are creating a health care record. Following are some points to be considered:

- Complete your documentation as soon as possible (preferably immediately) after the activity;
- Use a standard format (preferably the template included with this Guide) for documenting that includes the information outlined above;
- Include all information deemed necessary to support the identification of drug-related problems, recommendations and decisions;
- Use clear, logical and precise language;
- Ensure all documentation is legible and non-erasable; and
- Do not delete, remove or rewrite from any part of the record. If you make an error, cross out the error with a single line and initial it.
- Remember that documentation must always relate back to the original prescription and include, if applicable, reference to any and all adaptations.

2.1.7 Notification of Other Health Professionals (Fundamental 7)

Note:
The College of Pharmacists of BC developed this form with input from the College of Physicians and Surgeon of BC.

At all times, when you adapt a prescription you must notify the **original prescriber**[3]. Notification must take place as soon as reasonably possible, preferably within 24 hours. **You must also notify the patient's most responsible clinician** if you are aware that the original prescriber is not your patient's usual practitioner. Although a requirement of PPP-58, one of the benefits of notification is that it provides enhanced opportunity for collaboration between you, the prescriber and the patient.

[3] For purposes of PPP-58, and included in the Glossary of Terms (Appendix B) the 'original prescriber' refers to the prescriber who authorized the first fill.

As introduced in Fundamental 6 and attached to this Guide as Appendix D is a recommended documentation and notification template form (an electronic version of this form is available on the college website **www.bcpharmcists.org**). The intention of the form is that once complete it can easily be faxed to the prescriber for notification purposes and then attached to the adapted prescription and maintained in the pharmacy records.

Pharmacists can develop their own notification process as long as all of the required notification information, listed below, is included.

Notification must include:

1. Patient (including PHN number) and Pharmacist (including signature and name of Pharmacy) information
2. Original prescription information (including prescribers name and contact information)
3. A description of the adaptation (including all relevant prescription details)
4. The rationale for the decision to adapt the prescription (including pertinent details of your assessment and patient history along with any instructions to the patient and relevant follow-up plan)
5. Acknowledgment of informed consent
6. The date and name of practitioner notified

Experience in other jurisdictions has shown that fax notification is a preferred method for notification of other health professionals. You will need to determine the most suitable notification method for your practice based on what works best for you and the practitioners you usually communicate with. Fax or written notification is the preferred method, however, in certain circumstances, verbal notification may be sufficient, but may lead to extra transcribing work at the receiver's end and introduces a margin of error if the information is transcribed incorrectly.

This Guide also includes, in Appendix E, a sample letter &/or fax directed to prescribers introducing them to PPP-58. You may choose to utilize this document as a means of preparing and informing your prescribers that you will be exercising your authority to adapt prescriptions, starting January 1, 2009, and introduce them to the type of documentation they can expect to see from you.

2.2 Activities considered Adapting a Prescription

Three professional activities are considered to be adapting a prescription within the current scope of pharmacy practice in BC:

Remember: *authorization does not mean obligation*

1. **Change**: Changing the dose, formulation, or regimen of a prescription to enhance patient outcomes;
2. **Renew**: Renewing a prescription for continuity of care; and
3. **Substitution**: Making a therapeutic drug substitution within the same therapeutic class for a prescription to best suit the needs of the patient.

Exceptions:

- PPP-58 **does not** include adapting a prescription for narcotic, controlled drugs or targeted substances. If a change to a prescription for one of these categories of drugs is warranted, the pharmacist must contact the original prescriber to discuss modifying the original prescription.
- PPP-58 **does not** allow for the adaptation of a prescription if the original prescription has expired. All prescriptions have an expiry of one year from the date the original prescription is written. The exception is oral contraceptives, which have a two year expiry date.

You must use professional judgment to evaluate each situation and have addressed all of the seven fundamentals of adapting a prescription as described in Section 2.1 of this Guide.

2.2.1 Changing the Dose, Formulation, or Regimen of a New Prescription

Under PPP-58 you can change the dose, quantity, formulation, or regimen of a drug presented on a prescription without prior authorization from the prescriber if, in your professional judgment, the change will enhance the patient's outcome. This includes adding missing information.

Changing the dose

You can change the dose:

- If the strength of the drug prescribed is not commercially available;
- If the patient's age, weight or kidney or liver function requires you to change the dose; or
- If, in your professional judgment, you are satisfied the changed dose would otherwise benefit the patient.

Changing the formulation or regimen

You can change the formulation or the regimen of the medication to improve the ability of the patient to effectively take the medication.

Miscellaneous

You can also adapt a prescription dose, quantity, formulation or regimen if the information provided is incomplete but you determine what the intended treatment is through consultation with the patient and a review of your records (locally or on PharmaNet).

2.2.2 Renewing a Previously Filled Prescription for Continuity of Care

~~Currently under~~ PPP-31 – Emergency Prescription Refills state~~,~~ pharmacists may exercise professional judgment in in the provision of emergency prescription refill supplies of a medication. This practice is the exception to the rule and not the normal practice. ~~providing prescription refill supplies in emergency situations~~ (see Appendix C). The intention of PPP-31 is to ensure continuity of care by allowing pharmacists to extend a prescription, for a short period of time, to enable the patient to get back to their ~~physician~~ prescriber for ~~further~~ authorization.

Now under PPP-58 pharmacists, by adhering to *the Seven Fundamentals of Adapting a Prescription*, are able to adapt (renew) the prescription themselves on behalf of the patient without prior authorization from the prescriber for whatever period of time felt appropriate as long as it does not exceed the expiry of the prescription (refer to 2.1.3 of this Guide).

By doing this the pharmacist is utilizing their professional judgment and demonstrating that they have enough competence and information about the patient and their condition to determine that the prescription will maintain or enhance the patient's health outcome. PPP-58 provides pharmacists with the opportunity to practice to the full extent of their knowledge, skills and ability and demonstrate their value as medication experts.

Given the authority available to pharmacists under PPP-58, when faced with a situation requiring or requesting the renewal of a prescription for continuity of care, it is recommended that a pharmacist first consider the opportunity to fully adapt the prescription under PPP-58 before deferring to PPP-31.

It is important to remember that unlike PPP-31, where a pharmacist can provide an emergency refill without access to a prescription (evidence such as; an empty prescription vial, a label or a copy of a prescription receipt will suffice), PPP-58 requires that a pharmacist has the original prescription and that it is current, authentic and has not expired.

Illustration:
When a pharmacist is presented with a situation in which a patient has run out of a valid prescription (i.e.; it is current, authentic, appropriate and has not expired) and there are no authorized refills the pharmacist should:

- Step One: Consider adapting the prescription by referring to the first two of the seven fundamentals of PPP-58 and ask:
  a. Do I have 'appropriate knowledge and understanding' of the condition being treated and the drug being prescribed? If yes, then ask,
  b. Do I have 'sufficient information' about the patient's health status to be satisfied that adapting the prescription will maintain or enhance the effectiveness of the drug therapy, patient outcomes and will not put the patient at increased risk? If yes, then the pharmacist should consider adapting the prescription

- Step Two: If on the other hand the pharmacist answers no to either of the questions in step one they should not adapt the prescription but could either try to contact the prescriber to seek approval for a refill or defer to PPP-31 and provide an emergency supply

2.2.3 Making a Therapeutic Drug Substitution within the Same Therapeutic Class

You may adapt a prescription by making a therapeutic substitution. You are making a therapeutic substitution when you substitute the drug prescribed with a different drug that is expected to have a similar therapeutic effect, as long as that drug is from within the same therapeutic class. When making a therapeutic drug substitution, you must be satisfied that the dose and the dosing regimen of the new drug you select will have an equivalent therapeutic effect.

You must be satisfied that the following conditions are met when making a therapeutic substitution decision:

1. The decision is in the best interest of the patient by:
   a. Addressing the health needs of that patient,
   b. Maintaining or enhancing the safety or effectiveness of drug therapy,
   c. Not placing the patient at increased risk,
   d. Considering formulary or payer restrictions and other patient-related information, and
   e. Ensuring the drug is approved for the intended indication by Health Canada or strong evidence supports using the drug for the intended indication (e.g., clinical practice guidelines);
2. Your professional independence has been maintained and you avoid conflict of interest. If a decision is based on benefit to the pharmacist or pharmacy rather than the patient, this will be considered professional misconduct;
3. You have considered all relevant information about the patient, the condition and the drug, and you have effectively communicated this to the patient to ensure they agree with the decision; and
4. You take full responsibility for your decision.

2.3 Determining When You Are Not Adapting a Prescription

2.3.1 When You Call the Original Prescriber to Make a Change

When you identify a drug-related problem during the process of filling a prescription or discussing medication needs with a patient, you may choose to do what you have always done and contact the prescriber to discuss your concerns about the prescription. If, as a result of that conversation, the original prescriber directs you to make a change to the prescription, you may make the change and sign or initial it as you always have. In this case you are not adapting the prescription.

In fact, in any circumstance where you obtain prior authorization from the prescriber to make a change, provide a substitution or refill a prescription you are not adapting a prescription.

2.3.2 When You Dispense an Interchangeable Drug Product

Dispensing an interchangeable drug product, including generic substitution, is not adapting a prescription. ~~and is addressed in Professional Practice Policy #53 (PPP-53) – Drug Product Interchangeability (see Appendix C).~~

2.3.3 When an Approved Protocol Exists

If you practice in environments where a specific hospital board – or College Council – approved protocol exists and applies in that situation, you may be required to make changes to the prescription. In these circumstances, where you are simply applying the policy or treatment protocol (e.g. automatic substitution), and you are not using your professional judgment, you are not adapting a prescription.

2.3.4 When You Are Continuing Therapy by Advancing a Few Doses

As described in PPP-31 – Emergency Prescription Refills (see Appendix C), you are already authorized to assist patients in maintaining continuity of their drug therapy by advancing them a few doses or a few days supply if they run out of medication and an appointment with the prescribing physician is imminent. Advance supplies are not technically prescription renewals and do not fall under PPP-58, but you must evaluate the patient's need for the medication and be satisfied that providing any additional doses will not cause or worsen a drug-related problem for the patient.

3.0 Implementing PPP-58 in Your Practice

In addition to information posted on the College's website (www.bcpharmacists.org) and/or communicated in ongoing College publications such as ReadLinks, there are a number of resources available to support you in the effective implementation of PPP-58 in your practice.

3.1 Support is Available

3.1.1 Practical Resources

The following resources are provided in the appendix of this Guide:

- Appendix B – Glossary of Terms
- Appendix D – Documentation and Notification Template (an electronic version is also available on the College website - www.bcpharmacists.org)
- Appendix E – Sample letter/fax introducing PPP-58 to your prescribers
- Appendix F – Practical Examples
- ~~Appendix G – Frequently Asked Questions~~
- ~~Appendix H – Quick Reference Guide~~

~~3.1.2 "Live" Orientation Sessions~~

~~Live orientation sessions are also being scheduled across the province in Fall 2008 to assist you in understanding the contents of this Guide. Online registration is available now through the College website **www.bcpharmacists.org**. *Instructions: Log into eServices, select "Register for an Event" from the left-hand menu and then select "PPP-58 Orientation Session".*~~

3.1.~~3~~ 2 Need more support?

If you still have questions or concerns and want to implement the policy in your practice, please contact ~~the on-call Quality Outcomes Specialist~~Practice Support through the College office at 604-733-2440 or ~~1-800-663-1940~~by email at practicesupport@bcpharmacists.org.

4.0 Other Considerations

4.1 Liability and Insurance

~~***Note:***~~
~~*In the near future, pharmacists will be coming under the Health Professions Act in BC and liability insurance will be a mandatory requirement of licensure for all registrants under the new Act.*~~

Adapting a prescription is one activity within a pharmacist's current scope of practice that expands the potential for liability. Although a pharmacist is not obligated to adapt a prescription, should they choose to adapt a prescription, they are required to possess personal professional liability insurance – minimum $2 million.

4.2 Consequences for Failure to Follow PPP-58

Any pharmacist who adapts a prescription contrary to the requirements of PPP-58 will be forwarded to the Inquiry Committee process as per current College procedures.

All pharmacists are expected to abide by all aspects of professional practice as described in the College's Framework of Professional Practice, federal legislation (*the Food and Drug Act (FDA) and Regulations and the Controlled Drug and Substances Act*), provincial legislation (*the ~~Pharmacists, Pharmacy Operations and Drug Scheduling (PPODS) Act~~HPA, PODSA, and PSA along with related regulations and bylaws ~~and Bylaws~~*), and the College's *Professional Practice Policies* ~~and the Code of Ethics~~.

4.3 Conflict of Interest

The implementation of PPP-58 may put pharmacists in a position of real or perceived conflict of interest with their patients. The adaptation of a prescription may lead to increased revenue thereby enhancing a pharmacist's financial interests.

Pharmacists must consider first and foremost the interest and well-being of their patients. Prescriptions must not be adapted unless it is in the best interest of a patient to do so.

Any indication that the decision was based on benefit to the pharmacist or pharmacy, rather than the patient, will be considered professional misconduct and reviewed through the Inquiry Committee process.

4.4 Conclusion

These are indeed exciting times for the profession of pharmacy in British Columbia as pharmacist's involvement in medication management activities continues to expand. PPP-58 creates the framework to guide pharmacists in the safe and effective adaptation of prescriptions allowing you to maximize your full educational and professional competencies to optimize therapeutic outcomes for your patients. In addition this policy provides a structure to

the process of using professional judgment in practice and establishes a foundation for the further expansion of pharmacy practice in the future.

Take time to consider your competencies, your work environment, and your current and potential relationships with patients and other health professionals. And the next time you have the opportunity to adapt a prescription – use the seven fundamentals to help determine if it is the 'right' thing to do for your patient.

5.0 Declaration Form

Medication Management
(Adapting a Prescription)
Professional Practice Policy #58 (PPP-58)

Declaration of completion and understanding

I,_____ a registrant on the Register of Pharmacists of the College of Pharmacists of British Columbia, declare that I have thoroughly read and understood the PPP-58 Orientation Guide Medication Management (Adapting a Prescription).

I also declare and understand that although it is not mandatory that I adapt a prescription, should I choose to adapt a prescription in addition to having read and understood the Orientation Guide I must:

- Adhere to all of the seven fundamentals for adapting a prescription as outlined in PPP-58 and possess personal professional liability insurance (minimum $2 million).

Signature:_____ Date:_____

Note:
You must retain this signed Declaration Form in your personal records.

Appendix A: Professional Practice Policy #58 Protocol for Medication Management (Adapting a Prescription)

POLICY STATEMENT(S):

A pharmacist may dispense a drug contrary to the terms of a prescription (adapt a prescription) if the action is intended to optimize the therapeutic outcome of treatment with the prescribed drug and meets **all** of the following elements of a protocol to adapt a prescription:

1. **Individual competence**
   a. Pharmacist has appropriate knowledge and understanding of the condition and the drug being dispensed in order to adapt the prescription.

2. **Appropriate information**
   a. Pharmacist has sufficient information about the specific client's health status to ensure that adapting the prescription will maintain or enhance the effectiveness of the drug therapy and will not put the client at increased risk.

3. **Prescription**
   a. Pharmacist has a prescription that is current, authentic, and appropriate.

4. **Appropriateness**
   a. Pharmacist determines whether adapting the prescription is appropriate in the circumstances.

5. **Informed consent**
   a. Pharmacist must obtain the informed consent of the client or client's representative before undertaking any adapting activity.

6. **Documentation**
   a. Pharmacist must document in the client's record any adaptation of the prescription, the rationale for the decision, and any appropriate follow-up plan.

7. **Notification of other health professionals**
   a. Pharmacist must notify the original prescriber (and the general practitioner if appropriate) as soon as reasonably possible (preferably within 24 hours of dispensing) and this must be recorded in the client's record or directly on the prescription hard copy.

Note: PPP-58 is not a stand-alone document and must be read with the Orientation Manual and the Amendment to the Orientation Manual. For a pharmacist to use PPP-58 they will be required to sign the PPP-58 Declaration Form.

BACKGROUND:

Protocol for medication management (adapting a prescription)

This professional practice policy enables pharmacists to maximize their full educational and professional competencies by providing authorization to adapt existing prescriptions. This policy is not mandatory and the decision whether to adapt a prescription is at the discretion of the individual pharmacist.

To guide decisions with respect to adapting a prescription, where a specific hospital board - or College of Pharmacists of BC - Board approved protocol does not exist, the pharmacist must refer to all applicable legislation and standards. This includes, but is not limited to, the *Health Professions Act, Pharmacy Operations and Drug Scheduling Act*, the Regulation and Bylaws of the College of Pharmacists of BC made pursuant to these Acts, the *Health Care (Consent) and Care Facility (Admission) Act*, the Framework of Professional Practice (FPP), the Code of Ethics and Professional Practice Policies. This specific policy (PPP-58) does not apply to controlled drug substances and cancer chemotherapy agents.

The FPP is the standards of pharmacy practice in British Columbia. In adapting a prescription the pharmacist must follow the FPP Role 1 *Provide pharmaceutical care.* Role 1 elements include:

- Function A – Assess the client's health status and needs
- Function B – Develop a care plan with the client
- Function C – Support the client to implement the care plan
- Function D – Support and monitor the client's progress with the care plan
- Function E – Document findings, follow-ups recommendations, information provided and client's outcomes

Benefits of professional practice policy

The benefits to clients are to:

a) Optimize drug therapy leading to improved client health outcomes
   1) Better therapeutic responses.
   2) Reduced drug errors.
   3) Fewer adverse drug reactions/interactions.

b) Have an effective and efficient health care system
   1) Minimize delays in initiating and changing drug therapy.
   2) Make the best use of human resources in the health care system.

c) Expand the opportunities to identify people with significant risk factors.

d) Encourage collaboration among health care providers.

First approved: 21 Sep 2007 **PPP-58**
Revised:
Reaffirmed: 27 Mar 2009

~~This professional practice policy enables pharmacists to maximize their full educational and professional competencies by providing authorization to adapt existing prescriptions. This policy is not mandatory and the decision whether to adapt a prescription is at the discretion of the individual pharmacist.~~

~~To guide decisions with respect to adapting a prescription, where a specific hospital board or College of Pharmacists of BC council approved protocol does not exist, the pharmacist must refer to all applicable legislation and standards. This includes, but is not limited to, the *Pharmacist, Pharmacy Operations and Drug Scheduling Act* and related Bylaws, the *Health Care (Consent) and Care Facility (Admission) Act*, the Framework of Professional Practice, the Code of Ethics and Professional Practice Policies. This specific policy (PPP-58) does not apply to narcotic and controlled drugs.~~

~~The Framework of Professional Practice (FPP) is the standards of pharmacy practice in British Columbia. In adapting a prescription the pharmacist must follow the FPP Role 1 Provide *pharmaceutical care*. Role 1 elements include:~~

- ~~Function A – Assess the patient's health status and needs~~
- ~~Function B – Develop a care plan with the patient~~
- ~~Function C – Support the patient to implement the care plan~~
- ~~Function D – Support and monitor the patient's progress with the care plan~~
- ~~Function E – Document findings, follow-ups recommendations, information provided and patient's outcomes~~

~~In addition to the FPP, PPP-58 outlines that a pharmacist may dispense a drug contrary to the terms of a prescription (adapt a prescription) if the action is intended to optimize the therapeutic outcome of treatment with the prescribed drug and meets all of the following elements of a protocol to adapt a prescription:~~

1. ~~**Individual Competence**~~
   ~~Pharmacist has appropriate knowledge and understanding of the condition and the drug being dispensed in order to adapt the prescription.~~

2. ~~**Appropriate Information**~~
   ~~Pharmacist has sufficient information about the specific patient's health status to ensure that adapting the prescription will maintain or enhance the effectiveness of the drug therapy and will not put the patient at increased risk.~~

3. ~~**Prescription**~~
   ~~Pharmacist has a prescription that is current, authentic, and appropriate.~~
4. ~~**Appropriateness of Adaptation**~~
   ~~Pharmacist determines whether adapting the prescription is appropriate in the circumstances.~~

5. ~~**Informed Consent**~~
   ~~Pharmacist must obtain the informed consent of the patient or patient's representative before undertaking any adapting activity.~~

6. ~~**Documentation**~~

Pharmacist must document in the patient's record any adaptation of the prescription, the rationale for the decision, and any appropriate follow-up plan.

7. Notification of Other Health Professionals

Pharmacist must notify the original prescriber (and the general practitioner if appropriate) as soon as reasonably possible (preferably within 24 hours of dispensing) and this must be recorded in the patient's record or directly on the prescription hard copy.

The benefits of PPP-58 to patients are to:

1. Optimize drug therapy leading to improved patient health outcomes

a. Better therapeutic responses.

b. Reduced drug errors.

c. Fewer adverse drug reactions/interactions.

2. Have an effective and efficient health care system

a. Minimize delays in initiating and changing drug therapy.

b. Make the best use of human resources in the health care system.

3. Expand the opportunities to identify people with significant risk factors.

4. Encourage collaboration among health care providers.

First Approved: 21 September 2007

Note:

PPP-58 is not a stand-alone document and must be read and interpreted in conjunction with the Orientation Guide to PPP-58.

Appendix B: Glossary of Terms

For the purposes of Professional Practice Policy #58 *Protocol for Medication Management – Adapting a Prescription* – the terms below have the following meaning:

Adaptation	• term used to describe the pharmacists' authority under PPP-58 to adapt an existing prescription when, in their professional judgment, the action is intended to optimize the therapeutic outcome of treatment
Conflict of Interest	• at all times pharmacists must maintain professional independence and adaptation decisions must first and foremost be made in the best interest of the patient with the intention of optimizing the therapeutic outcome of treatment • any indication that a decision is based on benefit to the pharmacist or pharmacy, rather than the patient, will be considered professional misconduct
Continuity of Care (for medication management)	• the assurance of uninterrupted drug therapy for the best health outcome of the patient
Liability	• pharmacist assumes legal responsibility for the adapted prescription and as a mandatory condition of their authority to adapt possesses personal professional liability insurance (minimum coverage $2 million)
New and/or Original Prescription	• refers to the first fill of a prescription and does not need to be the beginning of a new drug therapy
Original Prescriber	• refers to the prescriber who authorized the first fill
Prescription Expiry	• all prescriptions have an expiry of one year from the date the prescription is written (the exception is oral contraceptives, which is two years) • a pharmacist may not adapt a prescription if the original prescription has expired • a pharmacist may not adapt components of a prescription beyond its' expiry date (ie: quantity cannot exceed the time remaining)

Refill	• term used by the prescriber to indicate their authorization to provide a refill(s) to the original prescription
Renew	• term used to describe the extension of a prescription (not beyond its' expiry date) by a pharmacist; the act of renewing a prescription constitutes adaptation and thereby transfers liability to the adaptor
Responsible Clinician	• most responsible physician/provider who manages the patient's care on an ongoing basis (ie: family physician, nurse practitioner)
Therapeutic Drug Substitution	• substitution of the prescribed drug with a different drug, from the same therapeutic class, that is expected to have a similar therapeutic effect • pharmacist must be satisfied that the dose and dosing regimen of the new drug will have an equivalent therapeutic effect

Appendix C: Other Relevant Professional Practice Policies

1 – PPP-31 – Emergency Prescription Refills

Pharmacists may exercise professional judgment in the provision of emergency prescription refill supplies of a medication. This practice is *the exception to the rule and not the normal practice*.

A pharmacist may dispense an emergency refill in the following situations;
- where a patient's medication supply has been exhausted, a refill may be dispensed to ensure continuity of care. OR
- where a patient attends the pharmacy for an authorized refill of a valid prescription but PharmaNet returns the message, '101 Prescriber not found' or 'D3 Prescriber is not authorized' and the pharmacist ensures that the patient is not on Pharmacare's *Restricted Claimants Program*, a refill may be dispensed to ensure continuity of care and to allow time for the patient to find a new prescriber.

The pharmacist must comply with each of the following practice fundamentals;

1. Individual competence

a. Pharmacist has appropriate knowledge and understanding of the condition and the drug being dispensed in order to adapt the prescription.

2. Appropriate information

a. Pharmacist has sufficient information about the specific patient's health status to ensure that dispensing an emergency refill of the prescription will ensure continuity of care and will not put the patient at increased risk.

3. Appropriateness

a. Pharmacist must use their professional judgment to determine whether provision of an emergency refill is appropriate in the circumstances, and must determine an appropriate days supply based on the drug involved and how long it will take the patient to see a prescriber.

4. Informed consent

a. Pharmacist must obtain the informed consent of the patient or patient's representative before undertaking an emergency refill.

5. Documentation

a. Pharmacists must use their CPBC pharmacist registration numbers in the PharmaNet practitioner ID field to identify the responsible decision-maker when providing an emergency supply of a drug to a patient.
b. Pharmacists must document in the client's record any emergency refill of the prescription, the rationale for the decision, and any appropriate follow-up plan. ~~Pharmacists may exercise professional judgment in the provision of emergency prescription refill supplies of a medication to ensure continuity of patient treatment until the physician can be contacted for authorization. This practice is the exception to the rule and not normal practice.~~

~~Pharmacists may use their Pharmacist Identification Numbers (diploma numbers) in the prescriber field to identify the responsible decision-maker when providing an emergency supply of a drug to a patient.~~

First Approved: 29 January 1999
Revised: 20 June 2003/15 Feb 2013
Reaffirmed: 27 Mar 2009

~~**2 – PPP-53 – Drug Product Interchangeability**~~

~~Drug product interchangeability decisions can be based on Health Canada's Declaration of Equivalence, as indicated by the identification of a Canadian Reference Product in a Notice of Compliance for a generic drug.~~

~~Pharmacists may also use their professional judgment in interchanging other products if the products meet the definition of an interchangeable drug. An interchangeable drug is defined as follows in the Pharmacists, Pharmacy Operations and Drug Scheduling Act:~~

> ~~Interchangeable drug means a drug that:~~
> - ~~Contains the same amount of the same active ingredients;~~
> - ~~Possesses comparable pharmacokinetic properties;~~
> - ~~Has the same clinically significant formulation characteristics; and~~
> - ~~Is to be administered in the same way as the drug prescribed.~~

~~First Approved: 2 May 2003~~
~~Revised: 28 November 2003~~

Appendix C: Prescription Adaptation Documentation and Notification Template

(an electronic version of this template is available on the College website www.bcpharmacists.org)

Patient Information

Name: _____

PHN: _____

Pharmacist Information

Name: _____

Pharmacy: _____

Prescriber Information

Name: _____

Phone: _____

Fax: _____

Phone: _____

Fax: _____

Signature: _____

Original Prescription Information

Date of Prescription: _____

Prescription Details: _____

Adaptation Information

Date of Adaptation: _____

Adaptation Details: _____

Rationale for Adaptation (including instructions to patient and follow-up plan)

Rationale

Instructions to Patient

Follow-up Plan

Informed Consent

The patient and/or their representative (name: _____) was provided sufficient information, including the risks and benefits associated with the adaptation and voluntarily provided their consent. ☐

Notification Information

Date of Notification: _____ Name of Practitioner(s) Notified: _____

Method of Notification (fax preferred): _____

☐ Fax # _____ ☐ Phone # _____ ☐ Other _____

The information contained in this fax communication is confidential and is intended only for the use of the recipient named above If the reader of this fax memo is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this fax memo is strictly prohibited. If you have received this fax memo in error, please destroy the memo and notify the sender.

Appendix E: Sample letter/fax introducing PPP-58

[drugstore letterhead]

Date

Doctor name
Address

Re: Introduction to Pharmacists enhanced scope of practice

Dear Dr. _____,

The purpose of this letter is to ensure that you are aware of some recent changes that have evolved the scope of practice for pharmacists in BC. Earlier this year the government introduced Bill 25 which, specific to the profession of pharmacy, formalized pharmacists' authority to 'renew' existing prescriptions.

In conjunction with this the College of Pharmacists of BC (CPBC) has introduced *Professional Practice Policy #58 (PPP-58) Medication Management – Adapting a Prescription* which provides the framework to guide pharmacists in the safe and effective adaptation, including renewal, of existing prescriptions.

Although it is not mandatory that a pharmacist adapt a prescription, it is mandatory that should a pharmacist choose to adapt a prescription they adhere to the guidelines laid out in the PPP-58 Orientation Guide, which includes notification to the original prescriber (a copy of the PPP-58 Orientation Guide is available on the CPBC website www.bcpharmacists.org).

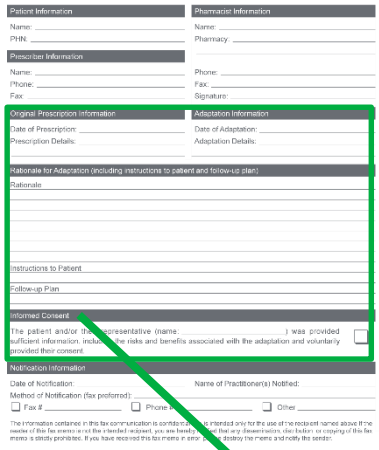
This means that from time to time you may receive a fax notification (sample attached) from a member of our pharmacy team to inform you of a prescription adaptation that has occurred. Pharmacists' authorization to implement this policy and thereby adapt prescriptions is effective January 1, 2009.

We value our professional relationship with you. Please feel free to contact (insert: pharmacy manager name) with any questions or comments you may have.

Sincerely,

The information contained in this fax communication is confidential and is intended only for the use of the recipient named above If the reader of this fax memo is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this fax memo is strictly prohibited. If you have received this fax memo in error, please destroy the memo and notify the sender.

Appendix F: Practical Examples


Patient Information
Name:
PHN:
Pharmacist Information
Name:
Pharmacy:
Prescriber Information
Name:
Phone:
Fax:
Phone:
Fax:
Signature:
Original Prescription Information
Date of Prescription:
Prescription Details:
Adaptation Information
Date of Adaptation:
Adaptation Details:
Rationale for Adaptation (including instructions to patient and follow-up plan)
Rationale
Instructions to Patient
Follow-up Plan
Informed Consent
Notification Information
Date of Notification:
Name of Practitioner(s) Notified:
Method of Notification (fax preferred):
Fax #
Phone #
Other

Example 1 – Changing the Dose:

You receive a new prescription for alendronate 10mg once weekly for an elderly female patient. The PharmaNet record indicates the patient was previously taking alendronate 10mg once daily for the past year. You have a discussion with the patient and determine the following:

- The patient has been having difficulty with compliance of the once daily regimen.
- The physician discussed with her that she was changing the prescription to the once weekly formulation to make it easier for her to remember her dose.

Original Prescription Information

Date of Prescription: January 15, 2009

Prescription Details: Alendronate 10mg once weekly x 6 months

Adaptation Information

Date of Adaptation: January 16, 2009

Adaptation Details: changed Alendronate 10mg once weekly to 70mg once weekly x 3 months with 1 refill

Rationale for Adaptation (including instructions to patient and follow-up plan)

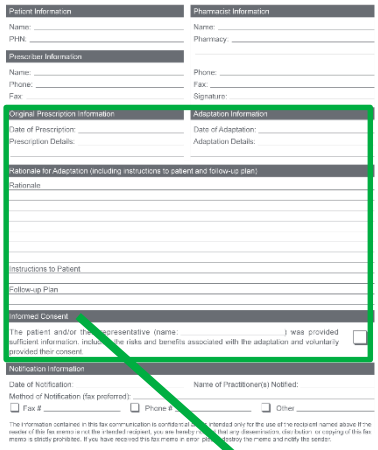
Rationale
- usual dose alendronate 10mg once daily or 70 mg once weekly
– product monograph indicates no dosage adjustment necessary for the elderly or for patients with mild to moderate renal insufficiency
– confirmed with patient that no impaired renal function
– patient confirmed doctor discussed change to weekly formulation for compliance reasons

Instructions to Patient Instructed the patient to take 1 tablet once/week on the same day each week with plenty of water.

Follow-up Plan contact her physician if any GI upset or unusual symptoms.

Informed Consent

The patient and/or their representative (name: _____) was provided sufficient information, including the risks and benefits associated with the adaptation and voluntarily provided their consent. ✓


Patient Information
Name:
PHN:
Pharmacist Information
Name:
Pharmacy:
Prescriber Information
Name:
Phone:
Fax:
Phone:
Fax:
Signature:
Original Prescription Information
Date of Prescription:
Prescription Details:
Adaptation Information
Date of Adaptation:
Adaptation Details:
Rationale for Adaptation (including instructions to patient and follow-up plan):
Rationale
Instructions to Patient
Follow-up Plan
Informed Consent
The patient and/or their representative (name:) was provided sufficient information, including the risks and benefits associated with the adaptation and voluntarily provided their consent.
Notification Information
Date of Notification:
Name of Practitioner(s) Notified:
Method of Notification (fax preferred):
Fax #
Phone #
Other
The information contained in this fax communication is confidential and intended only for the use of the recipient named above. If the reader of this fax memo is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this fax memo is strictly prohibited. If you have received this fax memo in error please destroy the memo and notify the sender.

Example 2 – Incomplete Information:

You receive a new prescription for an adult female patient for Betaderm 0.1% Cream; Apply TID. The patient indicated that her skin is really dry and scaly and that she would prefer a product with more of a moisturizing effect.

You have a discussion with the patient and determine the following:

- She had used Betaderm 0.1% Cream for one month and was getting results with the cream.
- You visually confirm that her skin is dry and scaly.

Original Prescription Information

Date of Prescription: January 15, 2009

Prescription Details: Betaderm 0.1% Cream; Apply TID

Adaptation Information

Date of Adaptation: January 15, 2009

Adaptation Details: changed Betaderm 0.1% Cream to etaderm 0.1% Ointment; Apply TID

Rationale for Adaptation (including instructions to patient and follow-up plan)

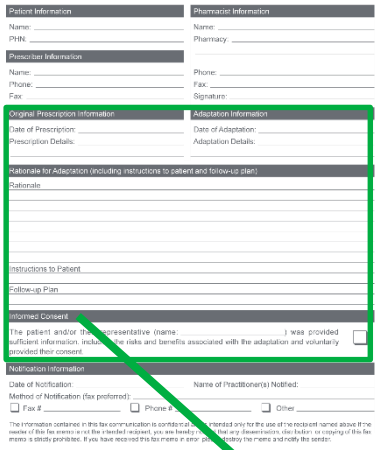
Rationale
- reviewed PharmaNet profile which indicates patient has been using Betaderm 0.1% Cream for one month
- patient indicated that the cream is helping her condition except that the affected area on her skin is dry and scaly
- change in formulation will still provide the same result with a more emollient effect

Instructions to Patient: Apply sparingly to affected area three times a day. If skin condition worsens, contact your doctor.

Follow-up Plan: See your doctor at your regular interval in one month.

Informed Consent

The patient and/or their representative (name:) was provided sufficient information, including the risks and benefits associated with the adaptation and voluntarily provided their consent. ✓


Patient Information
Name:
PHN:
Pharmacist Information
Name:
Pharmacy:
Prescriber Information
Name:
Phone:
Fax:
Phone:
Fax:
Signature:
Original Prescription Information
Date of Prescription:
Prescription Details:
Adaptation Information
Date of Adaptation:
Adaptation Details:
Rationale for Adaptation (including instructions to patient and follow-up plan):
Rationale
Instructions to Patient
Follow-up Plan
Informed Consent
The patient and/or their representative (name:) was provided sufficient information, including the risks and benefits associated with the adaptation and voluntarily provided their consent.
Notification Information
Date of Notification:
Name of Practitioner(s) Notified:
Method of Notification (fax preferred):
Fax #
Phone #
Other

Example 3 – Incomplete Information:

You receive a new prescription for Ramipril – take one tablet daily. No strength is indicated on the prescription. The PharmaNet record indicates the patient has been getting the 10mg strength for the past 6 months.

You have a discussion with the patient and determine the following:

- The patient confirms that the prescription was intended for the same dose (10mg) as before and that the medication is being used for blood pressure control.

Original Prescription Information

Date of Prescription: January 4, 2009

Prescription Details: Ramipril
take 1 tablet daily, Mitte 90, no refills

Adaptation Information

Date of Adaptation: January 4, 2009

Adaptation Details: Ramipril 10mg
once daily Mitte 90, no refills.

Rationale for Adaptation (including instructions to patient and follow-up plan)

Rationale - PharmaNet record indicates patient has been on Ramipril 10mg once daily for 6 months
– Patient confirmed that his regular doctor is on holiday and the locum prescribed his regular medication (he was not expecting any changes)
– Patient confirms his blood pressure is on target (130/75)

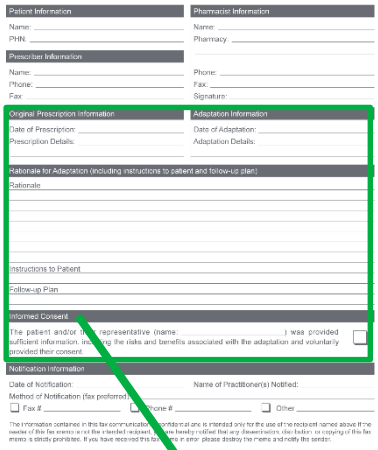
Instructions to Patient Take one Ramipril 10mg daily for blood pressure control.

Follow-up Plan Instructed to continue to check blood pressure regularly.

Informed Consent

The patient and/or their representative (name:) was provided sufficient information, including the risks and benefits associated with the adaptation and voluntarily provided their consent. ✓

Notification Information



Example 4 – Renew a Prescription:

A long standing patient of your pharmacy takes a thyroid supplement and diuretic every day. She comes to the pharmacy and requests a renewal of her prescriptions. You notice in your records that 3 months ago she received the same prescriptions but no refills were authorized. You review the PharmaNet record and determine she has been on the same dose of the same medications for 2 years.

You have a discussion with the patient and determine the following:

- She confirms that her TSH levels are being regularly monitored as well as her blood pressure.
- She confirms that she sees her physician every 6 months and that she is due for her follow-up in 3 months.

Original Prescription Information

Date of Prescription: October 4, 2008

Prescription Details: Hydrochlorthiazide 50mg OD
Synthroid 100mcg 1 OD, no refills

Adaptation Information

Date of Adaptation: January 16, 2009

Adaptation Details: Hydrochlorthiazide 50mg OD
Synthroid 100mcg 1 OD, renewed x 3mth supply

Rationale for Adaptation (including instructions to patient and follow-up plan)

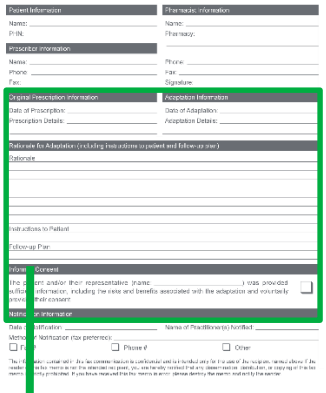
Rationale
- PharmaNet record indicates patient has been on same dosage of both medications for 2 years
- Patient confirmed TSH and blood pressure are regularly monitored
- Patient confirmed she has follow-up with physician every 6 months and is seeing doctor in 3 months
- Most recent original prescription was 3 months ago (Oct. 4/08) therefore prescription is still a valid prescription

Instructions to Patient Take 1 tablet of each medication daily, in the morning, on an empty stomach and continue monitoring your blood pressure regularly.

Follow-up Plan Return for follow-up with your physician in 3 months as scheduled.

Informed Consent

The patient and/or their representative (name: _____) was provided sufficient information, including the risks and benefits associated with the adaptation and voluntarily provided their consent. ☑



Note:
In the 'Notification' section of the form you would indicate that both physicians were notified of this adaptation.

Example 5 – Therapeutic Substitution:

Patient arrives at your pharmacy with a prescription for Prevacid 30mg once daily x 3 months for GERD. You notice the prescription is from the local walk-in clinic physician. You check the PharmaNet profile and determine that the patient has previously been on Rabeprazole 20mg once daily x 6 months and has had Pharmacare coverage through special authorization for the Rabeprazole. You process the prescription for Prevacid 30mg once daily and notice that the patient does not have special authorization for the Prevacid.

You have a discussion with the patient and determine the following:

- The patient receives social assistance and cannot afford the prescription cost for the Prevacid.
- The patient had run out of the Rabeprazole prescription last week and couldn't get to her regular doctor, so went to the walk-in clinic.
- The patient wanted a renewal of the prescription she was previously on for her heartburn, but she couldn't remember the name of it when she went to the clinic and she didn't have her empty vial with her.
- Her previous prescription had been controlling her symptoms very well and she had not had any side effects.
- Patient is anxious to get her Rabeprazole medication as her symptoms have increased over the past week since she has been out of her medication.

Original Prescription Information

Date of Prescription: January 15, 2009
Prescription Details: Prevacid 30mg OD x 3 months

Adaptation Information

Date of Adaptation: January 16, 2009
Adaptation Details: changed to Rabeprazole 20mg OD x 3 months

Rationale for Adaptation (including instructions to patient and follow-up plan)

Rationale
- Patient previously on Rabeprazole 20mg OD over last 6 months
– Patient has Pharmacare special authority coverage for Rabeprazole
- Patient cannot afford cost of Prevacid (no SA for Prevacid)
– Product monograph for GERD Rabeprazole 20mg OD
– Patient confirms she has had good control of symptoms and no side effects on Rabeprazole 20mg
- Patient confirmed she had run out of medication 1 week ago and needed refill ASAP but couldn't remember the name of her Rx when she saw the walk-in clinic physician

Instructions to Patient: Take one tablet daily ½ hour before food. Try non-drug measures to help control symptoms. Elevate the head of the bed, eat smaller more frequent meals. Avoid spicy food and alcohol.

Follow-up Plan: Do a diary of food intake to see what foods make you feel worse or better. Review in 1 month.

Informed Consent

The patient and/or their representative (name: _____) was provided sufficient information, including the risks and benefits associated with the adaptation and voluntarily provided their consent. ☑

Appendix G: Frequently Asked Questions

Why did the College establish PPP-58?

You probably already perform many prescription adaptation-related activities now, such as making minor adjustments to prescription details or giving patients an interim supply of a medication to maintain continuity of care. PPP-58 goes beyond what is available today and gives pharmacists independent authority and accountability for the adaptation of a prescription and provides the framework to guide pharmacists in safe and effective practice.

The policy, which provides the opportunity for pharmacists to maximize their full educational and professional competencies, also provides structure to, and refines the process of, exercising professional judgment in clinical practice. This becomes increasingly important as pharmacists evolve their role as medication experts.

Do I have to adapt a prescription?

No. Authorization does mean obligation. The decision to adapt a prescription or not is at the discretion of the individual pharmacist. Whenever a pharmacist chooses to adapt a prescription however, the adaptation must be done in accordance with PPP-58 and within the limits of the pharmacist's own competencies.

Why should I care about adapting prescriptions?
What are the benefits to my patients and to my practice?

It makes good practical sense that pharmacists are authorized to adapt prescriptions. With your training in drug therapy, being able to adapt prescriptions means that patients will have access to medication management services from pharmacists more effectively than in the past.

Patients will have improved access to drug therapy renewals to ensure uninterrupted continuity of on-going therapy for chronic conditions. Pharmacists will be able to eliminate the delays associated with contacting a prescriber for clarification, modification or improvement of drug therapy with a prescription.

Pharmacist involvement with adapting prescriptions will improve inter-professional communication, documentation of care and patient involvement in decision-making and consent, which are all positive steps for health care.

The bottom line is that British Columbians have asked for quicker, more convenient access to prescription renewals and optimal drug therapies. PPP-58 is the first step in this process and has the potential to also free up physician time to see patients in need of their services.

Are there special requirements needed in order to adapt a prescription?

Yes. In order to adapt a prescription a pharmacist, in addition to having read and understood the Orientation Guide, must possess personal professional liability insurance (minimum $2 million) and must adhere to all of the seven fundamentals for adapting a prescription as outlined in PPP-58.

How will my patients know that I'm qualified to adapt prescriptions?
You are responsible for informing patients of your authority to adapt a prescription and for deciding whether or not you are prepared to make an adaptation when appropriate.

All pharmacists who are licensed in British Columbia are required to have read the Orientation Guide by December 31, 2008 and pharmacists' authority to implement PPP-58, and thereby adapt prescriptions, is effective January 1, 2009.

How will the College ensure quality medication management activities by pharmacists?
The College's mission is to ensure pharmacists in British Columbia provide safe and effective pharmacy care to help people achieve better health. The College's Quality Outcome Specialist Staff will include a review of the processes and procedures required to apply PPP-58 in their on-going site visits.

Will I be able to adapt prescriptions for narcotics?
No. PPP-58 does not authorize pharmacists to adapt prescriptions for narcotics, controlled drugs or targeted substances.

In Alberta, pharmacists are also authorized to provide medications by injection, initiate prescriptions, or modify prescriptions for ongoing therapy – is that being planned for British Columbia?
College council recently, through inclusion in the College's strategic plan, has directed College staff to "develop a plan to encourage the government to authorize advanced professional practice for pharmacists in BC".

Do I have to complete this orientation if I don't plan to adapt prescriptions?
Yes. Although it is not mandatory that a pharmacist adapt a prescription, given that PPP-58 enhances pharmacists' scope of practice, it is mandatory that all registrants acknowledge that they have read and understood PPP-58 (by signing the Declaration Form included in the Guide) by December 31, 2008.

How should I handle a prescription that includes a handwritten notation "no adaptation"?
If the original prescriber writes on the face of the prescription, in his or her own handwriting (a stamped or preprinted order is not acceptable) the words "no adaptation" or similar wording to reflect their wishes that the prescription not be adapted or changed in any way, the pharmacist must carefully consider this when determining if they have 'sufficient information – Fundamental 2' to adapt the prescription.

Does the 1-year expiry on a prescription mean that a patient can request a renewal for a 3-month supply when less than 3 months remain before the prescription expires?
Regardless of how much a patient requests, a pharmacist may only renew a prescription for up to the total number of days remaining before the expiry date (refer to section 2.1.3 of this Guide for further clarification).

Patient Inquiries About Renewals

Over the coming months the public will become more aware of the expanded scope pharmacists have been given which will likely lead to a little confusion and a lot of questions.

The scenario below is an example of a potential conversation between a patient and pharmacist and is intended to help guide you in answering some of the questions which will likely arise.

Patient asks…
"I heard somewhere that you can now renew my prescription – is that true?"

Pharmacist responds…
"Maybe. It is true that pharmacists now have the authority to renew prescriptions however each situation has to be considered independently. What it really depends on is how well I know your condition and your drug therapy. Let's take a look…"

Patient asks…
"How can I trust that you know what you are doing?"

Pharmacist responds…
"Pharmacists really are medication experts and we have more training in drug therapy than almost any other health care provider. But more importantly, I won't renew a prescription unless I'm confident that it will optimize your treatment and you are comfortable with the decision. Once I renew the prescription, I take responsibility for it, so you can be sure that I will be confident in my decision."

Patient asks…
"What about my doctor? Is he going to be upset by this? Does this mean I never have to go back to see him?"

Pharmacist responds…
"My renewal of your prescription in no way replaces the role your physician plays. First of all, as part of the process of renewing your prescription I will be notifying your doctor of what we have done and why. In the unlikely event that your doctor has any concerns about this they will contact one of us. Secondly, I cannot renew your prescription beyond the life of the prescription, which is one year, so at some point I will be referring you back to your doctor."

~~Appendix H: Quick Reference~~

In order for a pharmacist to adapt an existing prescription they must have read and understood the PPP-58 Orientation Guide, possess personal professional liability insurance (minimum $2 million) and sequentially follow the seven fundamentals.

ACTIVITIES CONSIDERED ADAPTING A PRESCRIPTION

CHANGING
the dose, formulation, or regimen of a prescription to enhance patient outcomes

RENEWING
a prescription for continuity of care

SUBSTITUTING
Making a therapeutic drug substitution within the same therapeutic class for a prescription

FUNDAMENTALS OF ADAPTING A PRESCRIPTION

1 Individual Competence
Must have appropriate knowledge and understanding of the condition being treated and the drug being prescribed.

2 Appropriate Information
Must have sufficient information about the patient's health status to be satisfied that adaptation will maintain or enhance the effectiveness of the drug therapy.

3 Prescription
Must have the original prescription and it must be current (not expired), authentic and otherwise appropriate for the patient.

4 Appropriateness
Must be sure the adaptation will optimize the therapeutic outcome of treatment. Any indication that a decision is based on benefit to the pharmacy or the pharmacist, rather than the patient, will be considered professional misconduct.

5 Informed Consent
Must obtain consent from the patient by providing enough information (including potential risks) to ensure they can make an informed and voluntary decision regarding the adaptation.

6 Documentation
Must document the adaptation with the following information; patient and pharmacist information, original and adapted prescription details, rationale for adaptation (including patient instructions and follow-up plan), acknowledgment of informed consent and the date and name of practitioner(s) notified (sample form available online at **www.bcpharmacists.org**).

7 Notification
Must notify the original prescriber and the patients' most responsible clinician, if applicable, as soon as reasonably possible (preferably within 24 hours). The same information as outlined in *Fundamental 6 – Documentation* must be included (sample form available online at **www.bcpharmacists.org**).

Note:
Pharmacists' authority to implement this policy and thereby adapt prescriptions is effective January 1, 2009

10. Legislation Review Committee: PPP-58 Adapting a Prescription

Jeremy Walden
Chair, Legislation Review Committee

PPP-58 Adapting a Prescription - Amendments

Professional Practice Policy #58 (PPP-58) titled "Protocol for Medication Management: Adapting a Prescription"

- The substitution protocols authorized by PPP-58 allow a registrant to adapt a prescription by making a therapeutic substitution.
- PharmaCare's Reference Drug Program (RDP) provides coverage to only a particular number of drug categories (for therapeutic substitution) if there are more than one drug in a therapeutic class.

Proposed Policy Revisions: PPP-58

- The purpose of this decision is to update the approved categories to reflect changes taking effect June 1, 2016, and includes a broader statement that moves from a specific listing of categories to an adoption of those approved in the RDP.

- Small housekeeping amendments have also been proposed to the 'Orientation Guide'. For example, references to the 2008 orientation live sessions have been removed.

Proposed amendment: PPP-58

Therapeutic Substitution	No limits and/or conditions stated	Section 2.2.3; Page 14	**December 2008:** Unless in practice settings such as hospital, ~~longterm~~long-term care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists: • Will limit therapeutic substitution to: Histamine 2 receptor blockers (H2 blockers), Non-steroidal anti-inflammatory drugs (NSAIDs), Nitrates, Angiotension converting enzyme inhibitors (ACE inhibitors), Dihydropyridine calcium channel blockers (dihydropyridine CCBs) and Proton pump inhibitors (PPIs)
			February 2011: No change
			April 2016: Unless in practice settings such as hospital, long-term care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists: • Will limit therapeutic substitution to those categories under the Ministry of Health's Reference Drug Program, the updated list can be accessed here: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/general-coverage-policies#rdp

Legislation Review Committee Recommendations

MOTION:

Approve Professional Practice Policy 58 – **Amendment to Orientation Guide** – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016).

Legislation Review Committee Recommendations

MOTION:

Approve the updated Professional Practice Policy 58 – **Orientation Guide** – Medication Management (Adapting a Prescription) as circulated.

Physician Assistance in Dying

Repeal of portions of the Criminal Code in *Carter v. Canada*

Government of Canada | Gouvernement du Canada

Medical Assistance in Dying

Overview of Federal Government Response

Canada

Supreme Court of Canada *Carter* Decision

Criminal laws prohibiting physician assistance in dying were found to limit the rights to life, liberty and security of the person (s. 7 of the *Charter*)

Declaration that sections 241(b) and 14 of the *Criminal Code* are void:

> "insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition"

Effect of declaration was suspended for 12 months and extended on January 15, 2016 to June 6, 2016 to allow time to develop legislation

In the interim, Superior Courts may grant individual exemptions

Overview of Federal Government Response *to Carter*

Re-enacts general prohibition

Creates exemptions for medical assistance in dying carried out in accordance with rules

Provincial and territorial health jurisdiction

- Other federal measures:
  - work with provinces and territories on options for access to medical assistance in dying
  - support improvements of end-of-life care options
  - further studies on requests by mature minors, advance requests and where mental illness is the sole underlying medical condition, after legislation comes into force

Canada

Key Legislative Objectives

- Recognize personal autonomy and dignity
- Recognize inherent and equal value of every life
- Include robust safeguards to protect vulnerable persons and guard against errors or abuse
- Set out eligibility for competent adults where death is reasonably foreseeable and who are suffering intolerably
- Balance different interests, including personal autonomy toward the end of life and the protection of vulnerable persons
- Encourage consistent approach across Canada

Brief Outline of the Legislation

"Medical assistance in dying" is defined as:

- the administration of substance by medical practitioner or authorized nurse practitioner that causes the person's death (i.e., voluntary euthanasia)

- the prescription or provision of substance by medical practitioner or authorized nurse practitioner that the person self-administers to cause their death (i.e., assisted suicide)

Brief Outline of the Legislation, cont'd

Proposed patient eligibility criteria:

- At least 18 years old and competent
- Has a grievous and irremediable medical condition, i.e.,:
  - serious and incurable illness, disease or disability, and
  - advanced state of irreversible decline in capabilities, and
  - enduring physical or psychological suffering, caused by the medical condition, that is intolerable to the person, and
  - natural death has become reasonably foreseeable (precise proximity to death is not required)
- Voluntary request required
- Informed consent required
- Eligible for publicly funded health care services in Canada

Brief Outline of the Legislation, cont'd

Exemptions from criminal liability would apply to:

- medical practitioner
- nurse practitioner
- pharmacist
- person who aids medical practitioner or nurse practitioner
- other person who aids patient to self-administer substance

Canada

Brief Outline of the Legislation, cont'd

Safeguards that must be respected:

- Medical opinion – patient meets all criteria
- Second independent medical opinion
- Request in writing (or by proxy if patient cannot write) before two independent witnesses
- Right to withdraw request at any time
- 15 day waiting period, unless death or loss of capacity is imminent
- Consent must be confirmed immediately before medical assistance in dying is provided

Medical assistance in dying would not result in loss of federal pensions and benefits

Parliamentary review to occur in 5 years

Federal Monitoring System and Offences

Minister of Health will make regulations on:

- Information to be provided by medical practitioners, nurse practitioners and pharmacists
- Use, protection and disclosure of information

Offences

- Failing to comply with regulations on monitoring
- Failing to comply with safeguards in providing medical assistance in dying
- Forging or destroying documents

Other Federal Reponses (non-legislative)

Studies to look at unique implications of:

- requests by mature minors
- advance requests
- where mental illness is the sole underlying medical condition

Work with provinces and territories to support access to medical assistance in dying while recognizing the personal convictions of health care providers

Support improvements of a full range of end-of-life care options

- multi-year health accord - improvements to home care, including palliative care

Work with provinces and territories on voluntary, interim protocol for the collection of data

- in place until regulations are finalized

Canada

Medical assistance in dying

- Do not need to have a terminal illness to consent to MAID but do need to have a condition that “death is reasonably forseeable”
- Contemplates both patient-administered PAD (Oregon approach) as well as the physician-administered PAD (Quebec approach)

Conscientious objection

- Patients have rights
  - Autonomy
  - Informed decision-making
  - Not be abandoned
- Physicians and organizations have right of conscience but
  - Duty of care and not abandon patient
  - Must provide enough information for the patient to make an informed decision and provide assistance
  - Must not impose their own beliefs
  - Federal report calls for “effective referral”

College position

- “Referral” is unacceptable to those who have conscientious objections
- Must assist and transfer care, not abandon patient
- Transfer is for assessment and service, if eligible.
- Transfer of care must be effective, and not a barrier
- Need health authorities to establish roster of willing practitioners, and help patients and their families coordinate care

Medical certificates of death

- Unclear if amendments will be made to *Coroners Act*
- Best: MAID due to “underlying condition”
- Patients don’t want their deaths invetigated

Oversight body- federal recommendation

- Health Canada to lead a cooperative process with the provinces and territories to create and analyze national reports on MAID
- [Ideally reports should come from the Vital Statistics office via the information on the Medical Certificate of Death]

Other health care providers

- Based on our polling, a significant minority of physicians hold conscientious objections
- Accept that faith based institutions will also have institutional objections
- How will other providers be accommodated for objections?

Action to date

- Both CPSBC and CPBC have developed interim guidance for the profession, high level of collaboration
- CPSBC, CPBC and CRNBC made an application to the Chief Justice seeking assurances that any order of the court authorizing an assisted death during the interim period explicitly recognize the role of pharmacists, pharmacy technicians, and nurses as part of the care team, and need for protection from criminal code
- Jointly answered many technical questions from physicians who are seeking access to oral medications for MAID, where such access is a problem in Canada
- Early stages of working with other agencies (MOH, HAs, regulators, experts, associations) to develop practice guidelines for both patient administered (oral) route and physician administered (IV) route

Next steps

- Urgent need for all BC health authorities to develop and implement a common approach to MAID, including identification of those physicians who are prepared to do assessments and assistance with death
- This includes forms, policies, procedures, decision support tools, CPGs, support, training etc.
- Ideally have a “patient navigator” to facilitate referrals within each health authority

Provincial approach

- A provincial approach designed and fit for purposes for facility based MAID can easily be adapted for community MAID
- Community MAID will require all three colleges to collaborate on professional standards, and will need to incorporate whatever federal law is proclaimed, recognizing the need to put patients first and reconcile the rights of patients with the right of providers to hold an objection of conscience.

Call to action

- Ensure culturally and spiritually appropriate end-of-life care, including palliative care, are available to Indigenous patients
- Better palliative and end-of-life care
- Better mental health supports and services
- Improve the quality of care and services received by individuals living with dementia, as well as their families

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

11. Medical Assistance in Dying/Physician Assisted Dying

DECISION REQUIRED

Recommended Board Motion:

Approve the proposed Interim Guidance Document on Medical Assistance in Dying.

Purpose

On February 2, 2016, the College of Pharmacists of BC (CPBC) Ethics Advisory Committee met and discussed this issue of physician assisted dying (PAD). Based on discussion, and the rapidly evolving nature of the subject matter from both a legal and health practice perspective, the Committee advised the creation of a document for the interim period (defined below) to help guide registrants on this topic.

The purpose of this Decision Note is twofold: first, it is to provide an update on the Supreme Court of Canada (SCC) decision to decriminalize PAD and second, it is to seek Board approval for an Interim Guidance Document on Medical Assistance in Dying (MAID), please see Appendix 1 for a copy of the document. The purpose of the Guidance Document is to provide direction to registrants during the interim period of February 6, 2016 to June 6, 2016.

Heidi Oetter, Registrar of the College of Physicians and Surgeons of BC (CPSBC) will be presenting on its Interim Guidance Document and Debbie Lovett from Lovett Westmacott Lawyers will be in attendance to answer any legal questions.

Background

Last year, on February 6, 2015, the SCC unanimously ruled in *Carter v. Canada* that the federal *Criminal Code* prohibitions on PAD infringe the *Charter of Rights and Freedoms*, particularly the rights to life, liberty, and security. The SCC's ruling states the decriminalization of PAD will be in effect one year later on February 6, 2016. The intention of a 12 month period was to provide time for both the Federal and Provincial governments to develop a legislative framework along with regulatory authorities and associations to develop corresponding policies and guidelines. The Federal government requested an extension and the SCC subsequently ruled that PAD will be decriminalized June 6, 2016 rather than the original date of February 6, 2016.

However, for the interim period of February 6, 2016 to June 6, 2016, Quebec is exempted from the extension as they have enacted a separate physician-assisted dying law as of December 10, 2015. Moreover, the SCC ruled that individual exemptions may be granted (on a case by case basis) to those who apply to a provincial superior court. Chief justices of Ontario Superior Court and BC Supreme Court have each published a notice outlining criteria (albeit with different guidelines)[1] in which they will use to assess exemption cases for PAD. See Appendix 2 for BC`s Court Notice.

On February 25, 2016, a joint Senate-Commons committee released a report titled "Medical Assistance in Dying: A Patient-Centred Approach;" the report outlines 21 recommendations that the Federal government will consider while they draft a new law for June 6, 2016 (see Appendix 3 for a copy of the Parliamentary Report). The Canadian Pharmacists Association contributed submissions that were used to inform this report and to ensure the perspective of pharmacist professionals were included in the development of the recommendations.

The development of the CPBC Interim Guidance Document on MAID involved limited external stakeholder engagement; groups that had the opportunity to comment and review the document include the BC Pharmacy Association, the Ministry of Health, and the College of Registered Nurses of BC, and the CPSBC. Furthermore, the CPBC Ethics Advisory Committee had the opportunity to review and provide comment.

During the limited external stakeholder consultation, the Ministry of Health and the CPSBC commented on the shift in the naming convention for PAD. The Parliamentary Report discussed above recommends using the term 'Medical Assistance in Dying (MAID)' rather than PAD. Based on their recommendations, both the Ministry and CPSBC advised they will start using MAID. The Guidance Document refers to both. For simplicity purposes, this Briefing Note uses the term PAD. The intent is for both terms to be used interchangeably, with the notion that MAID reflects a more collaborate approach amongst health professionals completing the health service.

Discussion

Initially, it was unclear if the role of pharmacists would be exempted in the provision of PAD. Although the SCC permitted provincial superior courts to exempt PAD on a case-by-case basis (for this interim period), the SCC did not say that the exemption applied to pharmacists (or other health professionals).

[1] For example, the Ontario version states applicants should supply evidence from a psychiatrist whereas this was not required for the Alberta case or requirements of the BC Supreme Court.

On February 29, 2016, the Alberta Court of Queen's Bench granted an application for a PAD for an Alberta resident who completed the PAD in British Columbia; this was the first exemption in Canada, outside of Quebec. The Court's order expressly included both the participating physician and the pharmacist (see Appendix 4 for a copy of the Order). At this time, CPBC posted the following excerpt on its website:

To assist with a physician-assisted death, a pharmacist must be authorized by a court order to dispense drugs as part of the physician-assisted dying process in each individual case.

Essentially, Pharmacists participating in a PAD should be satisfied that they are exempted from the *Criminal Code* provisions by the applicable Court order, such as the order made by the Justice in the Alberta case.

Nevertheless, the legislation and policies around PAD are evolving rapidly. Registrants are keen to have more information on this topic. Some further thoughts to consider while considering approval of this Interim Guidance Document on PAD are as follows:

- On January 21, 2016 (revised February 25, 2016), the CPSBC issued an Interim Guide for its registrants on PAD. The Interim Guide outlines the details required of the attending and consulting physicians and sets out standards of conduct for physicians who conscientiously object to PAD. The material aligns with the conditions regarding the patient, which are contained in *Carter v. Canada*. See Appendix 5 for a copy of the Interim Guidance document.
- Many provincial governments, including Ontario, Alberta, and the Northwest Territories have consulted with their respective citizens for suggestions on a PAD Framework from a provincial government perspective. Additionally, many Regulatory Colleges of Pharmacists, such as Alberta and Ontario, have issued guidance documents for their registrants on PAD. There has been no formal public engagement from the Government of BC, at this time. The dialogue between BC health professionals and the greater public on PAD has been limited.
- The topic of conscientious objection is yet to be determined for PAD. The aforementioned Parliamentary Report recommends that the Government of Canada work with the provinces and territories to establish a process to respect health care practitioners' freedom of conscience. The Report states health care professionals should be able to "conscientiously object" to carry out PAD, however, at a minimum, they should be required to then refer the patient to another health professional who would be willing to undergo the procedure. The Report`s recommendation does not align with

the Carter decision, in which it is stated that physicians should not be compelled to take part in PAD and some consider referral to be inclusive of participation.

- The *Health Professions Act* Bylaws, Schedule A outlines the Code of Ethics for registrants. Standard 1(g) (iii) outlines the framework regarding conscientious objection. Conscientious objection is defined as "a sincerely held belief that the provision of a particular product or service will cause the registrant to contravene their personal moral or religious value system." A registrant may object to the provision of a product or service, however they must follow a set of conditions (See Appendix 6 for a copy of the Code of Ethics). The definition and conditions for conscientious objection are similar amongst other Canadian jurisdictions. The proposed CPBC Interim Guidance Document acknowledges the misalignment and states that CPBC is prepared to make changes based on the anticipated Federal legislation on PAD.

Next Steps

CPBC is preparing to modify its legislation (i.e. bylaws, Code of Ethics, and/or Standards of Practice) based on direction provided by federal legislation that is anticipated to be out by June 6, 2016. These next steps will ensure solidified guidance, particularly around conscientious objection.

Recommendation

The CPBC recommends that the Board approve the Interim Guidance Document on MAID.

Appendix	
1	Medical Assistance in Dying: Interim Guidance Document for Pharmacists and Pharmacy Technicians in British Columbia
2	Supreme Court of BC Notice
3	Medical Assistance in Dying: A Patient-Centered Approach
4	Court of Queen's Bench of Alberta Order
5	College of Physicians and Surgeons of BC Interim Guidance for physician-assisted dying
6	HPA, Schedule A, Code of Ethics, Standard 1(g) (iii)

College of Pharmacists of British Columbia

MEDICAL ASSISTANCE IN DYING
(Also known as Physician-Assisted Death)

INTERIM GUIDANCE DOCUMENT FOR PHARMACISTS AND PHARMACY TECHNICIANS IN BRITISH COLUMBIA

Draft: April __, 2016

Table of Contents

1. Purpose

In Carter v Canada (Attorney General)[1], the Supreme Court of Canada (SCC) opened the door for individuals to request physician-assisted death under a specific set of circumstances. This decision has raised a number of challenging questions for pharmacists and pharmacy technicians, many of which remain unanswered. In the absence of federal and provincial legislation, the purpose of this document is to provide **interim guidance** to pharmacists and pharmacy technicians for serving patients who have qualified for, and consented to medical assistance in dying[2]. Our goal is to provide clarity on the process for delivering pharmaceutical care for the purposes of medical assistance in dying, in a manner that is consistent with the *Carter* decision while ensuring consistency with our *Code of Ethics* and Standards of Practice.

We ask that pharmacists and pharmacy technicians continually monitor the College website for updates about medical assistance in dying in the next few months as new legislation, policies and regulations are developed.

2. Background

Historically, medical assistance in dying has been prohibited in Canada under the *Criminal Code*. However on February 6, 2015, in the *Carter* decision, the SCC found that an absolute prohibition on medical assistance in dying violated an individual's right to life, liberty and security of person under the *Canadian Charter of Rights and Freedoms*.[3] In doing so, the SCC struck down the provisions in the *Criminal Code* that prohibit medical assistance in dying (sections 241(b) and 14). However, the SCC suspended the decision for a period of 12 months to February 6, 2016 in order to provide federal and provincial governments time to develop legislation to accommodate its decision. On January 15, 2016, the SCC extended the suspension period to June 6, 2016 and also granted an exemption provision which allows individuals to apply to a court of superior jurisdiction for authorization to proceed with medical assistance in dying during the 4-month extension period. Until June 6, 2016, a court order is required in every instance for a patient to obtain medical assistance in dying.

After June 6, 2016, the SCC's decision will come into effect and the *Criminal Code* provisions that prohibit medical assistance in dying will be struck down. It is expected that by that date, the government will have enacted new laws addressing medical assistance in dying.

The College of Physicians and Surgeons of BC has released its Interim Guidance on Physician Assisted Dying, to which this guidance document is aligned.

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[1] *Carter v Canada (Attorney General),* 2015 SCC 5, [2015] 1 S.C.R. 331 [*Carter*].

[2] "medical assistance in dying" is the term that the College will be using instead of "physician-assisted death" as it more closely reflects that health care teams, and not only physicians, are involved in the process. In addition, this term aligns with recent terminology used by the federal and provincial governments and other regulatory colleges.

[3] *Canadian Charter of Rights and Freedoms*, s 7, Part I of the *Constitution Act*, *1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

DRAFT

3. Qualification Criteria for Medical Assistance in Dying

In the *Carter* decision, the SCC established a specific set of requirements that must be met in order for medical assistance in dying:

1. The patient must be an adult;
2. The patient must clearly consent to the termination of life;
3. The patient must have a grievous and irremediable medical condition;

   The SCC did not limit medical assistance in dying only to patients with a terminal illness. The term medical condition also includes an illness, disease or disability. Also, the patient is not required to undertake treatments that are not acceptable to the individual.

4. The medical condition causes enduring suffering that is intolerable to the patient.

Effectively, the *Carter* decision allows two forms of assisted death: 1) a patient's voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose; and 2) direct administration by a physician of a lethal dose of medication to the patient.

On February 25, 2016, Chief Justice Hinkson of the Supreme Court of British Columbia issued an advisory notice which provides guidance to counsel and parties who wish to bring an application for an exemption from the *Criminal Code* prohibition against medical assistance in dying. (The notice can be found here.)

4. Guidance for Pharmacists and Pharmacy Technicians During the Interim Period

It is important to keep in mind that medical assistance in dying, even though it is usually carried out in collaboration with a health care team, is still a physician-led process. No doubt, pharmacists and pharmacy technicians play a significant role in serving patients who qualify for and consent to medical assistance in dying. Until June 6, 2016, a court order is required in every case and will apply *only* to that specific patient.

As new federal and provincial legislation is enacted and as the landscape of medical assistance in dying matures into a multi-disciplinary framework, the College will review and update its current Standards of Practice and *Code of Ethics* to be in alignment. In the meantime, the College recommends the following guidance for filling a medical assistance in dying prescription.

The pharmacist and pharmacy technician ensures that:

1. He/she has the requisite competency, knowledge and skills to fill the order if he/she wishes to participate in the medical assistance in dying process;

DRAFT

2. There is an order from a Court of superior jurisdiction (note: may be from another province) granting an exemption for the specific individual as well as the pharmacist (and pharmacy technician as required) from the provisions of the *Criminal Code* prohibiting medical assistance in dying
    - the pharmacist may wish to obtain and retain a copy of the court order with the dispensing records if possible;

3. He/she becomes familiar with the available supply chain to order the applicable drugs in anticipation of a court approved patient exemption;

4. He/she does not perform any activity that may imply that they are leading the medical assistance in dying process. This includes but is not limited to:
    - Assessing an individual to determine whether their condition is "grievous or irremediable"
    - Adapting a prescription for this indication;

5. There is a legitimate prescription, written by a licensed physician and it is patient-specific (**not for office use**) and that it fulfills specific requirements that may be in the court order, if any;

6. The prescription is dispensed consistent with the current standards of practice.
    - the prescribing physician may be considered the "patient's representative" and dispensing directly to the prescribing physician may be the preferred option in this circumstance
    - if the prescription is dispensed other than to the prescribing physician, the pharmacist should ensure that the patient's representative is aware of security precautions that should be taken to decrease the potential risk to public safety if the drugs were lost or diverted;

7. Appropriate documentation of medical assistance in dying prescription orders are kept consistent with current standards and may include additional information such as the applicable Court order, delivery of medication(s) and to whom, and consultation with other health care providers involved;

8. A pre-determined process has been collaboratively established with the prescribing physician to ensure that any unused doses of medical assistance in dying medications are documented and returned to the pharmacy (where they were dispensed) as soon as possible;

9. Medical assistance in dying medications that are returned to the pharmacy are destroyed in accordance with applicable legislation.

DRAFT

5. Conscientious Objection

Based on one's values and beliefs, pharmacists and pharmacy technicians may make a personal choice not to dispense medications pursuant to a medical assistance in dying prescription order, in a manner that is consistent with our *Code of Ethics*.

Standard 1(g) of the *Code of Ethics* provides the requirements for conscientious objection. The College recognizes that certain sections of Standard 1(g) are not consistent with the principles set out in the *Carter* decision. That decision noted the following:

> "[132] **In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying.** The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note — as did Beetz J. in addressing the topic of physician participation in abortion in *Morgentaler* — that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the *Charter* rights of patients and physicians will need to be reconciled."

When the anticipated federal legislation is available after June 6, 2016, the College will work to update the *Code of Ethics* to reflect the intent of the new legislation. In the meantime, pharmacists and pharmacy technicians who wish to exercise conscientious objection are required to ensure continuity of care by advising the physician, at the earliest opportunity, that they are unable to fill the medical assistance in dying order. Pharmacists are not required to make a formal referral to a colleague pharmacist but they do have a duty of care for providing compassionate, non-discriminatory and non-judgemental assistance to the requesting physician or the patient's representative. Pharmacists and pharmacy technicians must conduct themselves in a manner that respects patient autonomy and dignity, in accordance with the *Code of Ethics*.

6. Conclusion

The information provided in this interim guidance document is based on our understanding of the *Carter* decision, the information that is available to us at the time of printing, and our *Code of Ethics* and Standards of Practice for Pharmacists and Pharmacy Technicians. This guidance will be updated as more information becomes available to the College. Our preliminary guidance has been provided to:

- Support you to understand decisions that have been made and why medical assistance in dying is important to you;
- Remind you about principles and ethical considerations that you must consider in relation to medical assistance in dying;

  - This includes, but is not limited to the right of conscientious objection and guidance to exercise it; and,
- Encourage you to discuss medical assistance in dying with your peers, pharmacy team members, and other health team members in your community.

Acknowledgement

The College of Pharmacists of BC would like to thank the Alberta College of Pharmacists for their authorization to use excerpts from their document the Alberta College of Pharmacists Physician-Assisted Death (PAD) Preliminary Guidance for the Professions.

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SUPREME COURT OF BRITISH COLUMBIA

Notice Regarding Applications for Exemption

from the *Criminal Code* Prohibition Against Physician Assisted Death

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In *Carter v. Canada (Attorney General)*, 2016 SCC 4, the Supreme Court of Canada directed that applications may be brought to provincial superior courts for exemption from the Criminal Code prohibition against physician assisted death, in accordance with the criteria set out in *Carter v. Canada (Attorney General)*, 2015 SCC 5 ("Carter (2015)").

This notice is intended to provide guidance to counsel and parties who intend to bring an application to the Supreme Court of British Columbia for an exemption from the Criminal Code prohibition. The notice is advisory only and the direction given is subject to any orders made by the judge presiding on the application. Further, for the assistance of counsel and the parties, this notice refers to the types of evidence discussed in Carter (2015), however, the onus rests on the applicant to confirm and meet the evidentiary requirements set out in Carter (2015).

Application to be made by Petition

1. A person wishing to bring an application for an exemption from the prohibition against physician assisted death ("an exemption application") must file a petition, supporting affidavits and a draft of the order sought.

Ancillary Confidentiality Orders

2. An applicant for an exemption order may wish to seek a sealing order, publication ban, anonymity order, or an order that the exemption application be heard in camera (such orders are referred to collectively hereafter as "confidentiality orders"). In that event, a copy of the unfiled petition, supporting affidavits and a draft of the order sought on the exemption application, as well as a draft of the confidentiality orders sought, must be submitted to the Supreme Court Scheduling Manager at the relevant registry before the proceedings are commenced.

Request to Appear

3. The Chief Justice of the Supreme Court or another judge designated by him will hear exemption applications and ancillary applications for confidentiality orders.

4. Counsel or a party wishing to bring an exemption application and/or any of the above mentioned confidentiality orders, must file a Request to Appear before the Chief Justice to set a time for the hearing of the applications, and to seek additional directions. The Request to Appear may be found on the court's website at the following link:

   Request to Appear

Pre-hearing Conference and Directions

5. The Chief Justice or another judge designated by him will review the Request to Appear and the petition, supporting affidavits and the draft order sought on the exemption application, as well as any materials in support of a confidentiality order.

6. The Chief Justice or designated judge will convene a pre-hearing conference to give directions or will provide written directions as to the date for hearing the exemption application.

7. The Chief Justice or designated judge may also give directions in relation to notice, service of documents, filing of responses, issues of standing, timelines for filing materials, or other matters.

Service of Materials in Support of Exemption Application

8. Subject to any directions made by the Chief Justice or designated judge on an exemption application, the petitioner must serve the petition, supporting affidavits and draft order sought on:

   a. the Attorney General of British Columbia;

   b. the petitioner's spouse, if the petitioner is cohabiting with his or her spouse at the time the petition is made; and

   c. any person named as the petitioner's attorney, if that power of attorney is effective at the time the petition is made.

Evidence about the Petitioner

9. On the exemption application, the petitioner must file an affidavit providing the following information:

   a. the petitioner's date of birth;

b. the petitioner's place of residence and the duration of that residency;

c. the petitioner's medical condition (illness, disease, or disability);

d. whether as a result of his or her medical condition, the petitioner is suffering enduring intolerable pain or distress that cannot be alleviated by any treatment acceptable to the petitioner;

e. the reasons for the petitioner's request for an exemption from the prohibition against physician assisted death;

f. whether prior to commencing the petition, the petitioner has been fully informed about his or her medical condition (illness, disease, or disability), diagnosis, prognosis, treatment options, palliative care options, the risks associated with the treatment and palliative care options, and the risks associated with a physician assisted death;

g. the manner, means and proposed timing for the physician assisted death for which the petitioner seeks an exemption;

h. whether the petitioner is aware that his or her request for an exemption for a physician assisted death may be withdrawn at any time; and

i. whether the petitioner is aware that if the order sought in the petition is granted, the decision to use or not use the exemption is entirely the petitioner's to make.

Evidence of Attending Physician

10. On the exemption application, the petitioner must also file an affidavit from the petitioner's attending physician addressing whether, in the opinion of the attending physician:

    a. the petitioner has a grievous irremediable medical condition (illness, disease, or disability) that causes suffering;

    b. as a result of his or her medical condition, the petitioner is suffering enduring intolerable pain or distress that cannot be alleviated by any treatment acceptable to the petitioner;

    c. the petitioner was fully informed about his or her medical condition (illness, disease, or disability), diagnosis, prognosis, treatment options, palliative care options, the risks associated with the treatment and palliative care options, and the risks associated with a physician assisted death;

    d. the petitioner has the mental capacity to make a clear, free, and informed decision about a physician assisted death; and

e. the petitioner has consented without coercion, undue influence, or ambivalence to a physician assisted death.

f. the petitioner is aware that his or her request for an authorization for a physician assisted death may be withdrawn at any time;

g. the petitioner makes the request for authorization for a physician assisted death freely and voluntarily; and

h. the petitioner is aware that if the authorization is granted, the decision to use or not use the authorization is entirely the petitioner's decision to make.

Evidence of Second Physician

11. On the exemption application, the petitioner must also file an affidavit from a second physician, who does not practice in the same clinic or office as the attending physician. The second physician need not be a psychiatrist, unless the petitioner is currently being treated by a psychiatrist, in which case the affidavit should be from that psychiatrist. The affidavit should address whether, in the opinion of the second physician:

    a. the petitioner has a grievous irremediable medical condition (illness, disease, or disability) that causes the petitioner to suffer;

    b. the petitioner has the mental capacity to make a clear, free, and informed decision about a physician assisted death; and

    c. the petitioner has consented without coercion, undue influence, or ambivalence to a physician assisted death;

    d. the petitioner is aware that his or her request for an authorization for a physician assisted death may be withdrawn at any time;

    e. the petitioner makes the request for authorization for a physician assisted death freely and voluntarily; and

    f. the petitioner is aware that if the authorization is granted, the decision to use or not use the authorization is entirely the petitioner's to make.

Evidence of Physician Proposed to Assist the Petitioner

12. On the exemption application, the petitioner must also file an affidavit from the physician who is proposed to be the physician who will assist the petitioner to use the exemption sought, who may be the petitioner's attending physician, the second physician or another physician, indicating:

    a. the manner, means, and proposed timeframe for the physician assisted death;

b. whether the physician is willing to assist the petitioner in dying, if that act were authorized by court order;

c. whether the physician believes that his or her providing assistance would be clearly consistent with the petitioner's wishes;

d. whether the physician is aware that if the authorization is granted, the decision to use or not use the authorization is entirely the petitioner's to make.

General

13. Unless extended, the procedure described in this notice will be in place only until June 6, 2016.

Christopher E. Hinkson
Chief Justice

February 25, 2016

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MEDICAL ASSISTANCE IN DYING: A PATIENT-CENTRED APPROACH

Report of the Special Joint Committee on Physician-Assisted Dying

Hon. Kelvin Kenneth Ogilvie and Robert Oliphant
Joint Chairs

FEBRUARY 2016

42nd PARLIAMENT, 1st SESSION

Published under the authority of the Speaker of the House of Commons

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has the honour to present its

FIRST REPORT

Pursuant to its Orders of Reference from the Senate and from the House of Commons dated December 11, 2015, the Committee has studied Medical Assistance in Dying: A Patient-Centred Approach and has agreed to report the following:

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MEDICAL ASSISTANCE IN DYING: A PATIENT-CENTRED APPROACH

INTRODUCTION

On 6 February 2015, in *Carter v. Canada (Attorney General)* (*Carter*, or the *Carter* decision),[1] the Supreme Court of Canada declared section 14 and section 241(b) of the *Criminal Code*[2] void

> insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.[3]

The Court found that the prohibition infringed the claimants' rights under section 7 of the *Canadian Charter of Rights and Freedoms*.[4] The Court noted that "[i]t is for Parliament and the provincial legislatures to respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in these reasons."[5] While the issue of medical assistance in dying (MAID)[6] is complex and many observers are concerned about protecting vulnerable individuals from being induced to seek MAID, the Court also noted that the trial judge "concluded that a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error. While there are risks, to be sure, a carefully designed and managed system is capable of adequately addressing them."[7]

The Court suspended its declaration of invalidity so that it would not come into effect for 12 months, and then, on 15 January 2016, granted a further four-month extension

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1 For more information on *Carter v. Canada (Attorney General)*, please see Martha Butler and Marlisa Tiedemann, *Carter v. Canada: The Supreme Court of Canada's Decision on Assisted Dying*, Library of Parliament, Background Paper No. 2015-47-E, October 2015.

2 *Criminal Code*, R.S.C., 1985, c. C-46.

3 *Carter v. Canada (Attorney General)*, 2015 SCC 5, para. 127.

4 *Constitution Act, 1982*. Section 7 states that: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

5 *Carter,* 2015, para. 126.

6 The Committee is adopting the term "medical assistance in dying" instead of "physician-assisted dying," as it reflects the reality that health care teams, and not only physicians, will be involved in the process. This report will continue to use the term "physician-assisted dying" in any quotes from witnesses or external material reviewed by the Committee if that is the term that has been used.

For an explanation of other terms relating to medical assistance in dying, please see the section "Terminology" in this report.

7 Ibid., para. 105.

to that suspension. Quebec's *An Act respecting end-of-life care* was exempted from the extension, and the Court also granted an exemption "to those who wish to exercise their rights so that they may apply to the superior court of their jurisdiction for relief in accordance with the criteria set out in para. 127 of our reasons in *Carter*."[8]

On 11 December 2015, motions were passed in the House of Commons and the Senate to establish a special joint committee (Committee) whose purpose is:

> to review the report of the External Panel on Options for a Legislative Response to Carter v. Canada and other recent relevant consultation activities and studies, to consult with Canadians, experts and stakeholders, and make recommendations on the framework of a federal response on physician-assisted dying that respects the Constitution, the Charter of Rights and Freedoms, and the priorities of Canadians.

The motions also stated that "the Committee be directed to consult broadly, take into consideration consultations that have been undertaken on this issue, examine relevant research studies and literature and review models being used or developed in other jurisdictions."[9]

Guided by *Carter*, the Committee held 16 meetings and heard from 61 witnesses (listed in Appendix A). It also received over 100 written submissions (listed in Appendix B). Witnesses highlighted the need to ensure that everyone who meets the eligibility criteria (which the Committee recommends below) has access to MAID, regardless of where they live as reflected in the *Canada Health Act*[10] criteria of accessibility and universality. To further ensure access to this constitutional right, the Committee has provided recommendations not directly addressed in *Carter.* As the Supreme Court of Canada wrote in the decision: "The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought."[11] With respect to accessibility, the Committee also affirms that MAID should be able to be performed in any appropriate location, not only in hospitals, including in a person's home. Our response to the *Carter* ruling must be focused on the needs and wishes of patients. The Committee was unanimous in recognizing the overarching need to have safeguards to protect the vulnerable.

Submissions were both thoughtful and thought-provoking, raising issues that were directly relevant to the Committee's task of proposing a federal framework for MAID. The Committee heard overwhelming support for a collaborative approach among the federal government, the provinces and territories, and the provincial/territorial medical regulatory authorities to develop a framework relating to MAID. Witnesses wanted to avoid what some describe as a "patchwork approach" to the issue, in which the eligibility criteria and process for accessing MAID vary greatly from one province or territory to

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8 *Carter v. Canada (Attorney General)*, 2016 SCC 4, para. 7.

9 House of Commons, *Journals,* No. 7, 1st Session, 42nd Parliament, 11 December 2015, p. 50; Senate, *Journals,* No. 6, 1st Session, 42nd Parliament, 11 December 2015, p. 56.

10 *Canada Health Act*, R.S.C., 1985, c. C-6.

11 *Carter* 2015, para. 127.

another. The recommendations that flow from our hearings relate to who should be eligible for MAID, and what sort of process should be put in place to ensure that only those individuals who are eligible for MAID can avail themselves of it.

The Committee emphasizes the need "to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients" as recommended in the Final Report of the Truth and Reconciliation Commission of Canada.[12] In addition, there was an overwhelming consensus among witnesses that palliative care needs to be improved more generally, and that better supports need to be provided for individuals with disabilities, individuals with mental health issues, and individuals with dementia. We recognize that considerable work needs to be done to ensure that individuals do not seek MAID as a result of a lack of proper community and other supports. The Committee provides recommendations on this issue at the end of this report.

Below, the Committee also puts forward its findings and recommendations for a legislative framework that will include, but not be limited to, amending the *Criminal Code.* The recommendations relate to eligibility for MAID (which are substantive safeguards), procedural safeguards, and oversight. The substantive and procedural safeguards that the Committee recommends are listed below, and are described later in this report.

Substantive Safeguards:

- A grievous and irremediable medical condition (including an illness, disease or disability) is required;
- Enduring suffering that is intolerable to the individual in the circumstances of his or her condition is required;
- Informed consent is required;
- Capacity to make the decision is required at the time of either the advance or contemporaneous request; and
- Eligible individuals must be insured persons eligible for publicly funded health care services in Canada.

Procedural Safeguards:

- Two independent doctors must conclude that a person is eligible;
- A request must be in writing and witnessed by two independent witnesses;

12 Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling for the Future*, Summary of the Final Report of the Truth and Reconciliation Commission of Canada, 2015.

- A waiting period is required based, in part, on the rapidity of progression and nature of the patient's medical condition as determined by the patient's attending physician;

- Annual reports analyzing medical assistance in dying cases are to be tabled in Parliament; and

- Support and services, including culturally and spiritually appropriate end-of-life care services for Indigenous patients, should be improved to ensure that requests are based on free choice, particularly for vulnerable people.

BACKGROUND

A. Division of Powers between Federal and Provincial Governments[13]

1. Criminal Law and Administration of Justice

Sections 91 and 92 of the *Constitution Act*, *1867* assign exclusive legislative authority over certain matters to either Parliament or to provincial legislatures. Section 91(27) of the *Constitution Act, 1867*[14] assigns exclusive jurisdiction over criminal law to the federal government, including criminal procedure. To establish that a law is a valid use of Parliament's criminal law jurisdiction, there must be a prohibition, a penalty and a criminal law purpose (suppression of an evil). Such purposes that have been recognized by the courts include health, morality, public safety and security.

Of note, the administration of justice, including the conduct of most prosecutions, is a provincial power under section 92(14), as is the imposition of punishment for violating provincial laws (section 92(15)).

2. Health

While some health-related subjects are listed in sections 91 and 92 of the *Constitution Act, 1867*, there is no specific reference to "health" as a general matter. Health-related subjects and measures can be characterized as being within the jurisdiction of either Parliament or provincial legislatures depending on the purpose and effect of a particular measure. Parliament can and has exercised its jurisdiction over health matters under its criminal law power (section 91(27)); the federal spending power, which is inferred from its jurisdiction over public debt and property (section 91(1A)); and its general taxing power (section 91(3)).

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13 This section is based on Martha Butler and Marlisa Tiedemann, *The Federal Role in Health and Health Care*, Library of Parliament, In Brief No. 2011-91-E, September 2013.

For more detailed information about the division of powers, see Peter W. Hogg *Constitutional Law of Canada*, Fifth Edition Supplemented, Volumes 1 and 2, Thomson Carswell, Toronto, 2007.

14 *Constitution Act, 1867*, 30 & 31 Victoria, c. 3 (U.K.).

Examples of the use of the federal criminal law power with respect to health matters include the *Food and Drugs Act*,[15] the *Human Pathogens and Toxins Act*[16] and the *Assisted Human Reproduction Act* (AHRA).[17] The test involved in determining whether legislation related to health based on the federal criminal law power is validly enacted is (1) whether the legislation contains a prohibition and a penalty; and (2) whether it is directed at a "legitimate public health evil" (or other criminal law purpose). In a 4-4-1 decision, parts of the AHRA were struck down by the Supreme Court of Canada in 2010 as being outside the power of Parliament.[18] In that case, the majority stated:

> Although a reasoned apprehension of harm necessarily constitutes a criminal law purpose, health, ethics and morality do not automatically arouse such an apprehension in every case. For an activity to fall under the criminal law, it must be found that there is an evil to be suppressed or prevented and that the pith and substance of the provisions in issue is the suppression of that evil or the elimination of that reasoned risk of harm.
>
> When Parliament exercises a power assigned to it, it can establish national standards. However, administrative efficiency alone cannot be relied on to justify legislative action by Parliament (*Margarine Reference*, at p. 52). The action must be taken within the limits of an assigned head. Recourse to the criminal law power cannot therefore be based solely on concerns for efficiency or consistency, as such concerns, viewed in isolation, do not fall under the criminal law. The three criteria of the criminal law must be met.[19]

With the exception of matters that fall under the aforementioned sections, health is for the most part an area of provincial jurisdiction. For example, the province has jurisdiction over most hospitals and health care services, the practice of medicine, the training of health professionals and the regulation of the medical profession, hospital and health insurance, and occupational health. Power over these areas is granted by sections 92(7) (hospitals), 92(13) (property and civil rights) and 92(16) (matters of a merely local or private nature) of the *Constitution Act, 1867*.

However, drawing a clear line between federal and provincial jurisdiction can be difficult, as noted in *Canada (Attorney General) v. PHS Community Services Society*:

> The provincial health power is broad and extensive. It extends to thousands of activities and to a host of different venues.… To complicate the matter, Parliament has power to legislate with respect to federal matters, notably criminal law, that touch on health. For instance, it has historic jurisdiction to prohibit medical treatments that are dangerous, or that it perceives as "socially undesirable" behaviour: *R. v. Morgentaler*, [1988] 1 S.C.R. 30; *Morgentaler v. The Queen*, [1976] 1 S.C.R. 616; *R. v. Morgentaler*, [1993] 3 S.C.R. 463. The federal role in the domain of health makes it impossible to precisely define what falls in or out of the proposed provincial "core." Overlapping federal jurisdiction and the sheer size and diversity

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15 *Food and Drugs Act*, R.S.C. 1985, c. F-27.

16 *Human Pathogens and Toxins Act*, S.C. 2009, c. 24.

17 *Assisted Human Reproduction Act*, S.C. 2004, c. 2.

18 *Reference re Assisted Human Reproduction Act*, 2010 SCC 61.

19 Ibid., paras. 243–244.

> of provincial health power render daunting the task of drawing a bright line around a protected provincial core of health where federal legislation may not tread.[20]

In *Carter*, the Supreme Court concluded:

> In our view, the appellants have not established that the prohibition on physician-assisted dying impairs the core of the provincial jurisdiction. Health is an area of concurrent jurisdiction; both Parliament and the provinces may validly legislate on the topic: *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199, at para. 32; *Schneider v. The Queen*, [1982] 2 S.C.R. 112, at p. 142. This suggests that aspects of physician-assisted dying may be the subject of valid legislation by both levels of government, depending on the circumstances and focus of the legislation. We are not satisfied on the record before us that the provincial power over health excludes the power of the federal Parliament to legislate on physician-assisted dying.[21]

The federal response to *Carter* and implementation of a framework surrounding MAID will need to take into account this complex division of powers and will require close cooperation with the provinces and territories. A number of witnesses expressed concern about a "patchwork" approach to MAID.[22] One option was outlined by constitutional scholar Peter Hogg:

> [A]lthough it would be very nice if the provinces all came out with uniform legislation, you have to recognize that it may not happen. One thing you can do is recommend a provision in the federal law that in effect provides what I call an "equivalence provision", which in effect would say that if the federal Minister of Health or the Governor in Council — you could use any framework — is satisfied that a province or a territory has enacted safeguards that are substantially equivalent to the federal safeguards, then the federal law would not apply in that province.
>
> The advantage of doing that is that it would avoid overlapping legislation. Also, if you don't do something like that, issues of conflict between the federal and provincial law will be quite complicated, and they will be resolved by the rule of federal paramountcy. That would be a bad situation. I think it can be resolved by a so-called equivalence provision.
>
> [I]f a province doesn't have a physician-assisted dying regime, then your legislation will be the only game in town. It will have to operate and it will have to include adequate safeguards against error or abuse.[23]

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20 *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, para. 68.

21 *Carter v. Canada (Attorney General)*, 2015 SCC 5, para. 53.

22 See, for example, Parliament, 1st Session, 42nd Parliament, Special Joint Committee on Physician-Assisted Dying (PDAM), *Evidence*, 27 January 2016, 1705 (Dr. Jeff Blackmer, Canadian Medical Association); PDAM, *Evidence*, 26 January 2016, 1830 (Jennifer Gibson, Co-Chair, Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying).

23 PDAM, *Evidence*, 25 January 2016, 1150 & 1225 (Peter Hogg, Scholar in Residence, Blake, Cassels & Graydon LLP, As an Individual).

B. Quebec's Legislation[24]

The Committee wishes to note Quebec's extensive debate on the issue of MAID, which proved helpful in our deliberations.

The Quebec legislature struck the Select Committee on Dying with Dignity (Select Committee) on 4 December 2009. The Select Committee heard from 32 experts and more than 250 individuals and organizations and received 273 briefs during its work in 2010 and 2011. In March 2012, the Select Committee tabled its report, making 24 recommendations on palliative care, palliative sedation, advance medical directives, end-of-life care, and "medical aid in dying."[25]

In response to the Select Committee's report, the Quebec government appointed an expert panel to explore how to implement the recommended legislative changes. The panel released its report in January 2013. The report recommended that "medical aid in dying," in certain circumstances, be understood as part of the continuum of care. When seen as an element of end-of-life care, "medical aid in dying" could fall under provincial jurisdiction over health care delivery.

On 12 June 2013, Bill 52, An Act respecting end-of-life care, was introduced in the Quebec National Assembly, and received Royal Assent on 5 June 2014. Most of the Act's provisions came into force on 10 December 2015.

The law establishes rights with respect to end-of-life care, rules for those who provide end-of-life care, rules relating to continuous palliative sedation, powers of the Minister of Health and Social Services, rules relating to advance medical directives, and rules relating to "medical aid in dying." The law outlines requirements in order to obtain "medical aid in dying," requirements for physicians prior to administering "medical aid in dying" and various other elements in order to regulate the practice.

C. Federal External Panel on Options for a Legislative Response to *Carter v. Canada*

On 17 July 2015, the federal Minister of Justice and the federal Minister of Health announced the establishment of an external panel to consult Canadians regarding options to respond to the *Carter* decision. The panel was to consult with medical authorities and interveners in the *Carter* case specifically and, through an online public consultation, with Canadians more generally. The panel was to report on its findings and propose options for a legislative response. However, after the election of a new government, a letter to the panel from the new federal Minister of Justice and the new federal Minister of Health released publicly on 14 November 2015 extended the deadline for the panel's report by one month to 15 December 2015 and modified the terms of the mandate, asking the panel

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24 This section is based in part on forthcoming revisions to Julia Nicol and Marlisa Tiedemann, *Euthanasia and Assisted Suicide in Canada,* Library of Parliament.

25 "Medical aid in dying" is the term used in the Quebec law.

to focus on summarizing the results and key findings of its consultations. It was no longer to provide legislative options.

As part of its work, in addition to consulting the groups mentioned in the paragraph above, the External Panel travelled to the Netherlands, Belgium, Switzerland and to the state of Oregon in the United States to learn about how assisted dying is regulated in those jurisdictions. The External Panel's report was submitted to the government on 15 December 2015.

In its final report,[26] the External Panel summarized the evidence it received with respect to the following topics:

- forms of assisted dying and terminology;
- eligibility criteria;
- the request for MAID;
- assessing the request;
- participation and compliance; and
- system oversight.

D. Provincial–Territorial Expert Advisory Group

In mid-August 2015, a provincial–territorial expert advisory group on MAID was announced.[27] The Advisory Group's work was to "complement the work of the federal panel" and "provide advice on the development of policies, practices and safeguards for provinces and territories to consider when physician-assisted dying is legal within their respective jurisdictions."[28]

The Advisory Group's final report, dated 30 November 2015 and posted publicly on 14 December 2015, contained 43 recommendations.[29] Key recommendations include:

- "Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying";

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26 External Panel on Options for a Legislative Response to *Carter v. Canada*, Consultations on Physician-Assisted Dying - Summary of Results and Key Findings, 15 December 2015.

27 All provinces and territories participated in the advisory group except for Quebec, which had passed its own legislation, and British Columbia, which was an observer to the process.

28 Government of Ontario, "Provinces, Territories Establish Expert Advisory Group On Physician-Assisted Dying," News release, 14 August 2015.

29 Provincial–Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report*, 30 November 2015 [Provincial-Territorial Report].

- establishing a program within the publicly funded system that will link patients with an appropriate provider;
- amending the *Criminal Code* to allow MAID by regulated health professionals acting under the direction of a physician or a nurse practitioner, and to protect health professionals who participate in MAID;
- amending the *Criminal Code* to ensure that eligibility for MAID is based on competence rather than age;
- having medical regulatory authorities develop guidance/tools for physicians;
- not requiring a mandatory waiting period between a request and provision of assistance in dying;
- requiring "conscientiously objecting" health care providers "to inform patients of all end-of-life options", including MAID, and requiring providers to give a referral or direct transfer of care or to contact a third party and transfer the patient's records;
- having provincial and territorial governments establish review committee systems to review compliance in all cases of MAID;
- establishing a pan-Canadian commission on end-of-life care (preferably in collaboration with the federal government); and
- providing public education about MAID and engaging the public so that it can inform future developments of related law, policies and practices.

TERMINOLOGY

Euthanasia is the "intentional termination of the life of a person, by another person, in order to relieve the first person's suffering." Voluntary euthanasia is euthanasia performed in accordance with the wishes of a competent person, expressed personally or by advance directive.[30]

Assisted suicide is the act of intentionally ending one's life with the assistance of another person who provides the knowledge, means, or both, of doing so.

Generic terms such as "assisted dying" or "assisted death" are also used to describe both assisted suicide and voluntary euthanasia. "Physician-assisted death" and "physician-assisted dying" are generic terms used when a doctor is involved either directly or in supervising another person who is assisting a suicide.[31]

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30 *Carter v. Canada (Attorney General)*, 2012 BCSC 886, para. 38.

31 Ibid., para. 39.

In the *Carter* decision, the Supreme Court of Canada used the terms "physician-assisted death" and "physician-assisted dying," which were the terms used by the plaintiffs. According to the plaintiffs, these terms include "physician-assisted suicide" and "consensual physician-assisted death." Quebec's *An Act respecting end-of-life care* uses the term "medical aid in dying," which is defined as "care consisting in the administration by a physician of medications or substances to an end-of-life-patient, at the patient's request, in order to relieve their suffering by hastening death."[32] This term includes voluntary euthanasia but not assisted suicide.

Many witnesses who appeared before the Committee discussed the language that should be used in relation to MAID. For example, Joanne Klineberg, Senior Counsel, Criminal Law Policy Section at the Department of Justice, noted:

> Some stakeholders take the view that the expressions "physician-assisted suicide" and "euthanasia" are well defined and clear and must be used in order to avoid confusion and misunderstanding that arise from more general terms like "physician-assisted dying". Others disagree with the use of the terms "physician-assisted suicide" and "euthanasia", believing that they are loaded and stigmatizing terms and that only something more general, like "physician-assisted dying" should be used.[33]

In its report, the External Panel confirmed that some of the experts and organizations they consulted prefer the terms "physician-assisted suicide" and "euthanasia," while others prefer "physician-assisted dying."[34] The Committee heard that other organizations would rather use the term "physician-hastened death."[35] The Committee prefers the term "medical assistance in dying" to "physician-assisted dying", as it reflects the reality that health care teams, consisting of nurses, pharmacists, and other health care professionals, are also involved in the process of assisted dying. The Committee recommends that "medical assistance in dying" (MAID) be used in any future legislation on this topic, and it is also the term that the Committee will use throughout this report.

With respect to the terms "grievous and irremediable," some witnesses suggested to the Committee that they should be defined in legislation,[36] while other witnesses felt that this was unnecessary.[37] Maureen Taylor, Co-Chair of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying stated that "grievous" should be defined as

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32 Civil Code of Quebec, *An Act respecting end-of-life care*, c. S-32.0001, s. 3(6).

33 PDAM, *Evidence*, 18 January 2016, 1405 (Joanne Klineberg, Department of Justice).

34 External Panel Report.

35 PDAM, *Evidence*, 27 January 2016, 1720 (Dr. Monica Branigan, Canadian Society of Palliative Care Physicians); A Network of BC Physicians, *Submission to the Special Joint Committee on Physician-Assisted Dying*.

36 See for example, PDAM, *Evidence*, 4 February 2016, 1925 (Michael Bach, Canadian Association for Community Living); A Network of BC Physicians; Daniel Santoro and Dr. Althea Burrell, *Submission to Special Joint Committee on Physician-Assisted Dying*, received 27 January 2016.

37 See for example PDAM, *Evidence*, 1 February 2016, 1100 (Grace Pastine, Litigation Director, British Columbia Civil Liberties Association); PDAM, *Evidence*, 2 February 2016, 1920 (Dr. Douglas Grant, Nova Scotia College of Physicians and Surgeons); PDAM, *Evidence*, 4 February 2016.

"very severe" or "serious."[38] The Canadian Medical Association had a similar definition ("serious or severe"), and stated that "irremediable" should be defined as "not able to be put right or cured."[39] Jocelyn Downie, a professor at Dalhousie University, and David Baker, a lawyer practising at Bakerlaw, both of whom presented draft legislation on MAID to the Committee, had a number of terms defined in their respective bills, including "grievous and irremediable."[40] The Ontario College of Physicians and Surgeons has defined "grievous" as "a legal term that applies to serious, non-trivial conditions that have a significant impact on the patient's well-being," and "irremediable" as "a broad term capturing both terminal and non-terminal conditions."[41] The Alberta and Manitoba colleges of physicians and surgeons have also defined "grievous and irremediable" in their respective policies.[42]

The Committee agrees with the witnesses who said the terms "grievous and irremediable" do not need to be defined beyond what is set out in *Carter*, and notes that the Court stated that "irremediable … does not require the patient to undertake treatments that are not acceptable to the individual."[43] We believe that these terms are sufficiently well understood to operate without further statutory definition and recommend:

RECOMMENDATION 1

That the terms relating to medical assistance in dying do not require further statutory definition.

ELIGIBILITY CRITERIA FOR MEDICAL ASSISTANCE IN DYING

A. Condition

The Supreme Court of Canada's declaration in *Carter* allows MAID where there is "a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition."[44]

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38 PDAM, *Evidence*, 26 January 2016, 1835 (Maureen Taylor, Co-Chair of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying).

39 PDAM, *Evidence*, 27 January 2016, 1730 (Dr. Cindy Forbes, President, Canadian Medical Association).

40 PDAM, *Evidence*, 28 January 2016, 1845 (Jocelyn Downie, As an Individual); Submission to the Committee, *Presentation to Special Joint Committee on Physician Assisted Dying* (David Baker, Trudo Lemmens, Gilbert Sharpe), 28 January 2016.

41 College of Physicians and Surgeons of Ontario, *Interim Guidance on Physician-Assisted Death*, January 2016.

42 College of Physicians and Surgeons of Alberta, *Advice to the Profession: Physician-Assisted Death*; College of Physicians and Surgeons of Manitoba, *Standards of Practice for Physician-Assisted Death*.

43 *Carter*, 2015, para. 147.

44 Ibid.

There was a strong consensus in the testimony and briefs that there should be no list of included conditions.[45]

1. Terminal Illness as a Requirement

Witnesses diverged in their interpretation of the *Carter* decision and its implications for future legislation. Some witnesses said that only individuals with a terminal diagnosis should be able to access MAID while others said that *Carter* clearly did not include such a requirement. Prof. Hogg argued that, while it was not impossible for Parliament to require that the condition be terminal, such a law would be more susceptible to constitutional challenge.[46]

Imam Sikander Hashmi, representing the Canadian Council of Imams, argued that MAID be limited to individuals "in an advanced state of irreversible decline" and Margaret Somerville, professor at McGill University, expressed the view that only individuals with less than four weeks to live should qualify.[47] In contrast, the External Panel stated that *Carter* did not require a terminal diagnosis.[48] Professor Downie stated:

> [Terminal illness] was not included by the Supreme Court in Carter. It is too vague and indeterminate. It is arbitrary and it has no moral justification as a barrier to access.[49]

A brief from the Centre for Inquiry Canada said that limiting MAID to terminally ill individuals, "would not fully respect the Court's decision and the value of individual autonomy that underpins it."[50]

The Committee agrees with the External Panel and does not interpret *Carter* as limiting MAID to terminally ill individuals. Furthermore, limiting MAID in this way would result in Canadians with grievous and irremediable conditions faced with enduring and intolerable suffering having to continue suffering against their will. For these reasons, the Committee recommends:

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45 See, for example, PDAM, *Evidence*, 3 February 2016, 1700 (Vyda Ng, Executive Director, Canadian Unitarian Council); Dying with Dignity Canada, *7 Legislative Principles for a Patient-Centred Approach to Physician-Assisted Dying,* submission to the Committee.

46 PDAM, *Evidence*, 25 January 2016, 1255 (Hogg).

47 PDAM, *Evidence*, 3 February 2016, 1825 (Imam Sikander Hashmi, Spokesperson, Canadian Council of Imams); PDAM, *Evidence*, 4 February 2016, 1705 (Margaret Somerville, Professor, McGill University, as an Individual). Also see, for example, PDAM, *Evidence*, 4 February 2016, 1925 (Bach); and Canadian Society of Palliative Care Physicians, *Submission to Special Joint Committee on Physician-Assisted Dying,* submission to the Committee dated 27 January 2016, pp. 3-4.

48 External Panel on Options for a Legislative Response to *Carter v. Canada*, *Consultations on Physician Assisted Dying Summary of Results and Key Findings: Final Report*, 15 December 2015, p. 57. Also see, for example, PDAM, *Evidence*, 25 January 2016, 1240 (Jean-Pierre Ménard, Lawyer, Barreau du Québec).

49 PDAM, *Evidence,* 28 January 2016, 1845 (Downie).

50 Centre for Inquiry Canada, written submission to the Committee, 1 February 2016, p. 4.

RECOMMENDATION 2

That medical assistance in dying be available to individuals with terminal and non-terminal grievous and irremediable medical conditions that cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

2. Mental Illness

Because the individuals that brought the case in *Carter* did not have mental health issues, the Court made no pronouncement with respect to MAID and psychiatric conditions. Jeanette Ettel, Senior Counsel, Human Rights Law Section at the Department of Justice, told the Committee that it was open to the Committee to consider whether to include psychiatric illnesses in the conditions that could result in a right to MAID.[51]

As was the experience of the External Panel, the Committee heard widely diverging views on how to address mental health in the context of MAID. Benoît Pelletier, member of the External Panel and an expert in constitutional law noted that the External Panel identified greater support from Canadians for MAID in the context of a physical illness but that, *prima facie*, the *Carter* criteria would also apply to psychiatric conditions.[52] Professor Downie and others supported this position:

> [M]ental illness should not be an exclusion criterion. It was not excluded by the Supreme Court, and not all individuals with mental illness are incompetent. Physicians already routinely determine whether someone is competent, even when they have a mental illness. Furthermore, the suffering that can accompany mental illness can be as excruciating as any suffering that can accompany physical illness. Finally, I would argue that excluding individuals on the basis of mental illness would violate the charter.[53]

A number of witnesses and submissions expressed concern about mental illness in the context of MAID.[54] Dr. K. Sonu Gaind, President of the Canadian Psychiatric Association, outlined some of the challenges that will need to be addressed:

> In terms of what is “irremediable”, careful consideration needs to be given about what this means in the context of mental illness. Irremediable, of course, cannot simply mean incurable. Many conditions in psychiatry and medicine are considered chronic and not curable, but things may be done to remediate or improve the situation.[55]

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51 PDAM, *Evidence*, 18 January 2016, 1530 (Jeanette Ettel, Senior Counsel, Human Rights Law Section, Department of Justice).

52 PDAM, *Evidence*, 26 January 2016, 1750 (Benoît Pelletier, Member, External Panel on Options for a Legislative Response to *Carter v. Canada*).

53 PDAM, *Evidence,* 28 January 2016, 1850 (Downie). See also, for example, Centre for Inquiry, p. 4 and PDAM, *Evidence*, 26 January 2016, 1900 (Taylor).

54 See, for example, *Living with Dignity, Recommendations for the Special Joint Committee on Physician-Assisted Dying*, p. 3, written submission to the Committee; Derek B.M. Ross & Johnathan R. Sikkema, Christian Legal Fellowship, *Submission of the Christian Legal Fellowship to the Special Joint Committee on Physician-Assisted Dying*, 1 February 2016, p. 4.

55 PDAM, *Evidence*, 27 January 2016, 1935 (Dr. K. Sonu Gaind, President, Canadian Psychiatric Association).

Dr. Tarek Rajji, Chief of Geriatric Psychiatry at the Centre for Addiction and Mental Health, told the Committee that:

> [M]ental illness may be grievous to an individual, and symptoms can cause enduring psychological and sometimes physical suffering. However, suffering should not be equated with an irremediable nature, and the lack of inevitable and predictable death by natural history provides us with an opportunity to deliver recovery-based treatment.
>
> [P]eople with mental illness may be vulnerable to the impact of the social determinants of health. They may live in poverty, have poor housing, and lack social support. These circumstances may exacerbate suffering and a person's perception that their illness is irremediable … within a clinical recovery-based environment, there is always the potential for mental illness to be remediable.[56]

In response, Professor Downie reminded the Committee of the following aspect of the *Carter* judgment:

> "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.[57]

The Committee recognizes that there will be unique challenges in applying the eligibility criteria for MAID where the patient has a mental illness, particularly where such an illness is the condition underlying the request. However, where a person is competent and fits the other criteria set out by law, the Committee does not see how that individual could be denied a recognized Charter right based on his or her mental health condition. Furthermore, we do not understand the *Carter* decision to exclude mental illnesses.

Any individual applying for MAID would need to satisfy all the criteria, including irremediability and capacity. As several witnesses reminded the Committee, health professionals will need to strike an appropriate balance between the rights of all Canadians to access this constitutionally protected right, and the protection of those vulnerable persons who might be coerced into requesting MAID. Cases involving mental illness may prove challenging to address for health care practitioners, but the Committee has faith in the expertise of Canadian health care professionals to develop and apply appropriate guidelines for such cases. The difficulty surrounding these situations is not a justification to discriminate against affected individuals by denying them access to MAID. The Committee expects that cases where the underlying condition is a mental health condition will be rare, as is the case in other jurisdictions that have legalized MAID.[58] A more detailed discussion of appropriate safeguards can be found below. The Committee therefore recommends:

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56 PDAM, *Evidence*, 3 February 2016, 1805 (Dr. Tarek Rajji, Chief, Geriatric Psychiatry, Centre for Addiction and Mental Health).

57 *Carter*, 2015, para. 127.

58 Regarding Belgium, for example: neuropsychiatric disorders were 1.2% of cases in 2004/05, 2.8 % (or 58 cases) in 2010/11 and 3.7 % (or 67 cases) in 2013/14 according to Trudo Lemmens, *Why Canada Should Avoid A Belgian-Style Regulatory Regime for Physician Assisted Dying, Memorandum for the Special Joint Committee on Physician-Assisted Dying,* written submission to the Committee, p. 6.

RECOMMENDATION 3

That individuals not be excluded from eligibility for medical assistance in dying based on the fact that they have a psychiatric condition.

B. Suffering

The Supreme Court did not specify in *Carter* whether suffering is limited to physical suffering. Witnesses voiced different opinions, with some advocating for the inclusion of physical suffering only and others recommending that psychological suffering be included as well.[59] The Committee received at least one submission arguing that mental suffering is as severe as physical suffering and should not be excluded from MAID.[60] In addition, the Supreme Court referred to suffering "from the knowledge that they lack the ability to bring a peaceful end to their lives at a time and in a manner of their own choosing," which would be psychological in nature.[61] The requirements that the suffering is enduring and intolerable to the person are safeguards to ensure that someone in temporary or minor pain does not make a rash decision to die. In addition, the suffering must relate to a grievous and irremediable condition. Where mental illness is an issue, Dr. Gaind noted that what is considered enduring and intolerable suffering may be affected by the mental illness itself.[62] The Committee has confidence that health care professionals will proceed cautiously in such cases, as in all cases, and ensure that all criteria are satisfied before accepting a request for MAID and recommends:

RECOMMENDATION 4

That physical or psychological suffering that is enduring and intolerable to the person in the circumstances of his or her condition should be recognized as a criterion to access medical assistance in dying.

C. Informed Consent

There appeared to be a general consensus in the testimony and briefs that the request for MAID must come from the patient in a voluntary manner and after he or she has received sufficient information to make an informed choice. The concern voiced most often during the hearings was about ensuring genuine consent to MAID. All witnesses and authors of briefs were concerned about the protection of vulnerable individuals, though the proposed solutions varied considerably. Prof. Pelletier explained:

> As for vulnerability, it is, of course, a complex and subtle concept. Although the term "vulnerable populations" has been used to describe certain identifiable groups in society, the panel heard from many sources that vulnerability is not simply a characteristic of an

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59 See, for example, PDAM, *Evidence,* 4 February 2016, 1705 (Somerville), regarding limiting MAID to physical suffering; and PDAM, *Evidence*, 1 February 2016, 1155 (Wanda Morris, Dying With Dignity), regarding psychological suffering.

60 Marcia Hogan, *Brief to the Joint Committee on Physician Assisted Dying*, submission to the Committee, p. 2.

61 *Carter,* 2015, para. 14.

62 PDAM, *Evidence*, 27 January 2016, 1935 (Gaind).

> individual or group, but rather is a state that any one of us could be in under certain circumstances. We heard that sometimes people are made vulnerable in particular contexts and situations when personal autonomy, status, wealth, and well-being are compromised in any significant way.
>
> What this means in the context of physician-assisted dying is that all persons are potentially vulnerable. Being vulnerable does not disqualify a person who is suffering intolerably from seeking an assisted death, but it does put that person at risk of being induced to request a death that he or she does not desire. This is the risk that the Supreme Court called upon Parliament and provincial legislatures to address in a complex regulatory scheme.[63]

Jennifer Gibson, Co-Chair of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, suggested that almost all patients considering MAID would be vulnerable, with some facing particular vulnerabilities as a result of issues such as mental illness or social conditions. She suggested that, rather than vulnerability being a barrier to access, the process should take these vulnerabilities into account through safeguards and that training for health care professionals be offered.[64] Biomedical ethics Professor Carolyn Ells of McGill University and others felt that current standards and processes for establishing consent should be used.[65] Ms. Klineberg from the Department of Justice said that:

> It was because the court had expressed confidence that Canadian physicians can assess both mental competence and the vulnerability of a person at the individual level that it felt the absolute prohibition was unconstitutional and you could provide physician-assisted dying to those who wanted it while protecting the vulnerable.[66]

Nonetheless, many witnesses called for further supports for individuals who may be vulnerable as a result of poverty and mental health issues, and identified the need for adequate palliative care and for patients to be provided information about these options in order to make MAID a genuine choice.[67] Some witnesses, such as the Coalition for HealthCARE and Conscience, felt that no safeguards would be sufficient to protect the vulnerable.[68] In contrast, Linda Jarrett, a member of the Disability Advisory Council of Dying with Dignity, told the Committee:

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63 PDAM, *Evidence*, 26 January 2016, 1740 (Pelletier).

64 PDAM, *Evidence*, 26 January 2016, 1915 (Gibson).

65 PDAM, *Evidence*, 2 February 2016, 1745 (Carolyn Ells, Associate Professor, Medicine, Biomedical Ethics Unit, McGill University, As an Individual). See also, for example, PDAM, *Evidence*, 1 February 2016, 1105 (Josh Paterson, Executive Director, British Columbia Civil Liberties Association).

66 PDAM, *Evidence*, 18 January 2016, 1530 (Klineberg).

67 See, for example, PDAM, *Evidence*, 28 January 2016, 1940 (David Baker, Bakerlaw, As an Individual); PDAM, *Evidence*, 28 January 2016, 1750 (Dean Richert, Co-Chair, Ending of Life Ethics Committee, Council of Canadians with Disabilities); PDAM, *Evidence*, 2 February 2016, 1815 (Sharon Baxter, Executive Director, Canadian Hospice Palliative Care Association).

68 PDAM, *Evidence*, 3 February 2016,1705 (Cardinal Thomas Collins, Archbishop, Archdiocese of Toronto, Coalition for HealthCARE and Conscience).

> The members of our disability advisory council strongly feel that the law needs to strike a balance to protect vulnerable people from having an assisted death they don't really want and … to ensure access to assisted death for those who do have an enduring wish for it….
>
> Our diseases and disabilities have robbed us of much, and I ask you, do not add to this burden by compromising our choices and our autonomy.[69]

The Committee understands the concerns with respect to both protecting vulnerable persons and respecting their autonomy, and is recommending a number of safeguards which are both described throughout this report and summarized in the introduction.

As noted by the Supreme Court of Canada in *Carter*:

> The evidence supports … [the trial judge's] finding that a properly administered regulatory regime is capable of protecting the vulnerable from abuse or error.[70]

The Court also noted that "[w]e should not lightly assume that the regulatory regime will function defectively, nor should we assume that other criminal sanctions against the taking of lives will prove impotent against abuse."[71]

As is outlined in further detail below, the Committee endorses recommendations to provide more supports and services to reduce the vulnerabilities of those seeking MAID. At the same time, issues such as poverty and social isolation are general societal and systemic problems that will, unfortunately, not be resolved overnight. Safeguards and oversight are the best way to ensure informed consent and voluntariness while not refusing access to individuals who may be experiencing intolerable and enduring suffering. The process of evaluating a request for MAID must include consideration by the relevant health care provider(s) of any factors affecting consent, such as pressure from others, feelings of being a burden or lack of supports. Training will also be crucial to ensure that such factors are identified appropriately. The Committee fully agrees with the statement of Rhonda Wiebe, Co-Chair of the Ending of Life Ethics Committee of the Council of Canadians with Disabilities who said:

> [T]here are many social, economic, and other environmental factors that increase the vulnerability of persons with disabilities, especially the newly disabled. Careful scrutiny must take place to ensure that there aren't other remedies, besides death, that will lessen the suffering and indignity of these people.[72]

At the same time, though there may be cases where vulnerable persons are affected by external factors to want to die, the criteria should not be overly restrictive, as the Hon. Steven Fletcher, former Member of Parliament reminded the Committee:

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69 PDAM, *Evidence*, 28 January 2016, 1740 (Linda Jarrett, Member' Disability Advisory Council, Dying with Dignity Canada).

70 *Carter*, 2015, para. 3.

71 Ibid, para. 120.

72 PDAM, *Evidence*, 28 January 2016, 1755 (Rhonda Wiebe, Co-Chair of the Ending of Life Ethics Committee of the Council of Canadians with Disabilities).

> Having someone suffer, starving themselves to death, or being in pain or in terrible suffering, down the hall or down the street at the seniors residence or in a hospital or at home, having them live in pain and terror — it doesn't make my life better as a Canadian with a disability. It just makes me sad.[73]

Cases must be assessed on an individual basis to ensure the appropriate balance between protection of the vulnerable and respect for autonomy. The Committee believes that the safeguards and oversight measures outlined below, as well as other measures that the provinces and regulators of health care professionals will develop, will ensure that individuals who do not really want to die are identified, that the vulnerable are protected and that individuals who satisfy the criteria and with a genuine and enduring desire to die are provided with MAID to end their suffering. The Canadian Medical Association's recommendations are reassuring on this point, as one of the foundational principles they include is that:

> All the requirements for informed consent must clearly be met, including the requirement that the patient be capable of making that decision, **with particular attention to the context of potential vulnerabilities and sensitivities in end-of-life circumstances**. Consent is seen as an evolving process requiring physicians to communicate with the patient in an ongoing manner. [bold added][74]

In addition, the Committee notes that section 241(a) of the *Criminal Code,* which addresses counselling to commit suicide, remains in place should a patient be faced with pressure from family or others to request MAID.

The Committee strongly believes that to protect vulnerable individuals, only individuals who are able to provide informed consent to MAID should have access to it. The Committee therefore recommends:

RECOMMENDATION 5

That the capacity of a person requesting medical assistance in dying to provide informed consent should be assessed using existing medical practices, emphasizing the need to pay particular attention to vulnerabilities in end-of-life circumstances.

D. Age

The *Carter* decision dealt with plaintiffs who were adults, so no decision was made with regard to minors' eligibility for MAID. However, as Prof. Pelletier made clear, Parliament can choose to allow minors to access MAID.[75] In response to a comment stating that it was up to the Committee to determine what the age of consent would be in relation to a specific offence, Prof. Hogg replied:

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73 Ibid., 1800 (Hon. Steven Fletcher, as an Individual).

74 Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying*, written submission to the Committee, p. 3.

75 PDAM, *Evidence*, 26 January 2016, 1805 (Pelletier).

> Yes, I think that's right. The Supreme Court, in its order, spoke of a "competent adult person". I don't think it would be open to you, for example, to have 16 as an age of consent for this purpose, because that would not be a competent adult person. Between 18 and 21, I would think you would have some leeway within the word "adult" to decide that.[76]

Certain witnesses, such as the Nova Scotia College of Physicians and Surgeons, chose not to take a position on this issue, simply asking for greater clarity to be provided.[77] Some witnesses who appeared before the Committee and the External Panel recommended that legislation define an age below which MAID would not be available (generally 18 but one submission suggested as old as 25).[78] Other witnesses wanted all individuals who are competent to make the decision to be eligible for MAID.[79] One witness also flagged the need to consider the suffering of children who are not competent, though did not go so far as to suggest including them in any MAID regime.[80] To date, Belgium and the Netherlands are the only two jurisdictions that allow minors access to MAID.[81]

Stakeholders who prefer competency-based criteria, such as the Provincial/ Territorial Expert Advisory Group and the British Columbia Civil Liberties Association, argue that the trend is toward increased recognition of the competence of minors in health care decision making and that age limits are arbitrary.[82] Prof. Pelletier stated that suffering is suffering, regardless of age and that there is a risk that the provisions may be challenged on the basis of section 15 of the Charter (equality rights) if minors are excluded.[83]

The Canadian Paediatric Society advocated against including minors, regardless of competence, in any MAID regime. The organization made this argument for a number of reasons, including the lack of evidence before the court in *Carter* regarding minors; the fact that an age limit is not arbitrary: and the lack of social consensus with respect to MAID for minors. The organization also rejected the idea that a constitutional challenge by excluded minors would clearly be successful. It suggested addressing whether to allow minors to access MAID at a later date, after there has been time to gather data, as was the case in Belgium which legalized minors' access to MAID in 2014, 12 years after adults were granted access.[84]

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76 PDAM, *Evidence*, 25 January 2016, 1240 (Hogg).

77 PDAM, *Evidence,* 2 February 2016, 1940 (Grant).

78 See, for example, PDAM, *Evidence*, 4 February 2016, 1640 (Carmela Hutchison, President of DisAbled Women's Network of Canada) (DAWN); PDAM, *Evidence*, 4 February 2016, 1920 (Bach). Regarding the suggestion of age 25, see Colette Squires, *Physician Assisted Dying Public Consultation, January 30, 2016 in Langley, B.C*., submission to the Committee, p. 4.

79 Provincial-Territorial Report, Recommendation 17. Also see, for example, PDAM, *Evidence*, 2 February 2016, 1735 (Dr. Derryck Smith, Chair of Physicians Advisory Council, Dying with Dignity Canada).

80 PDAM, *Evidence*, 2 February 2016, 1735 (Smith).

81 PDAM, *Evidence*, 18 January 2016, 1415 (Klineberg).

82 PDAM, *Evidence*, 26 January 2016, 1835 (Gibson); PDAM, *Evidence*, 1 February 2016, 1100 (Pastine).

83 PDAM, *Evidence*, 26 January 2016, 1810 (Pelletier).

84 PDAM, *Evidence*, 3 February 2016 (Mary Shariff, Associate Professor of Law and Associate Dean Academic, University of Manitoba, Canadian Paediatric Society).

In contrast, Dr. Derryck Smith, Chair of the Physicians Advisory Council of Dying with Dignity Canada who was head of psychiatry at Vancouver's Children's Hospital for 30 years, argued for a competence-based approach, saying:

> I have worked with many teenagers over the years and I have worked with a number who have been facing death, and I think they would be competent in the legal sense to consent to physician-assisted dying as they would be legally competent to agree to other kinds of medical care.
>
> …Why would we want teenagers to suffer, but we're prepared to relieve adults of suffering?[85]

Other witnesses such as Margaret Birrell, President of the Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society, and Dr. John Soles, President of the Society of Rural Physicians of Canada, were open to minors possibly having access, but felt that this should not be allowed at the present time.[86] Dr. Hartley Stern, Executive Director and CEO of the Canadian Medical Protective Association, said that if "mature minors" are to be entitled to MAID, clarification is needed as to how their competency will be assessed.[87] Quebec's *An Act respecting end-of-life care* restricts "medical aid in dying" to "a person of full age."[88]

The Committee understands the concerns of many witnesses regarding the capacity of minors to understand the implications of such a serious decision. However, it is important to remember, as noted in the External Panel's report, that the Supreme Court has stated that minors have a right "to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding."[89] Allowing competent minors access to MAID would not be eliminating the requirement for competence. Given existing practices with respect to mature minors in health care[90] and the obvious fact that minors

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85 PDAM, *Evidence*, 2 February 2016, 1815 (Smith).

86 PDAM, *Evidence*, 4 February 2016, 1730 (Margaret Birrell, President, Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society); 4 February 2016, 1900 (Dr. John Soles, President, Society of Rural Physicians of Canada).

87 PDAM, *Evidence*, 4 February 2016, 1915 (Dr. Hartley Stern, Executive Director and CEO, The Canadian Medical Protective Association).

88 *An Act respecting end-of-life care*, section 5.

89 *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, para. 69.

90 In *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, the Supreme Court of Canada discusses the ability of minors to consent to medical treatment in the context of protective legislation that allows a court to authorize treatment for a child when it deems it to be in the child's best interest. At para. 46, Justice Abella (for the majority) states:

> The latitude accorded to adults at common law to decide their own medical treatment had historically narrowed dramatically when applied to children. However the common law has more recently abandoned the assumption that all minors lack decisional capacity and replaced it with a general recognition that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding. This is known as the common law "mature minor" doctrine. As the Manitoba Law Reform Commission noted, this doctrine is "a well-known, well-accepted and workable principle which … raise[s] few difficulties on a day-to-day basis" (*Minors' Consent to Health Care* (1995), Report #91, at p. 33). The doctrine addresses the concern that young people should not automatically be deprived of the right to make decisions affecting their medical treatment. It provides instead that the right to make those decisions varies in accordance with the young person's level of maturity, with the degree to which maturity is scrutinized intensifying in accordance with the severity of the potential consequences of the treatment or of its refusal.

can suffer as much as any adult, the Committee feels that it is difficult to justify an outright ban on access to MAID for minors. As with issues of mental health, by instituting appropriate safeguards, health care practitioners can be relied upon to identify appropriate cases for MAID and to refuse MAID to minors that do not satisfy the criteria.

The Committee acknowledges that a competent mature minor who has a grievous and irremediable medical condition should not be forced to endure intolerable suffering. Moreover, there are serious questions whether a restriction of the right to MAID only to competent adults would be consistent with the Charter. However, the Committee realizes that witnesses and briefs received were of differing opinions on the subject of extending the right to MAID to mature minors, and that these differences reflect a divergence of opinion among the Canadian public. After reflecting on the issue, the Committee recommends the following:

RECOMMENDATION 6

That the Government of Canada implement a two-stage legislative process, with the first stage applying immediately to competent adult persons 18 years or older, to be followed by a second stage applying to competent mature minors, coming into force at a date no later than three years after the first stage has come into force; and

That the Government of Canada immediately commit to facilitating a study of the moral, medical and legal issues surrounding the concept of "mature minor" and appropriate competence standards that could be properly considered and applied to those under the age of 18, and that this study include broad-based consultations with health specialists, provincial and territorial child and youth advocates, medical practitioners, academics, researchers, mature minors, families, and ethicists before the coming into force of the second stage.

E. Advance Request

The *Carter* decision dealt with plaintiffs who would remain competent while they faced significant physical decline. It did not address whether an individual who is not competent at the time of death could identify the circumstances in which he or she would choose MAID in advance. With respect to advance requests for MAID, witnesses and briefs outlined diverging opinions, from recommending not to allow such requests, to allowing them only after an individual is diagnosed, to allowing advance requests to be written prior to any illness. There was general agreement however that, if requests are to be allowed in advance, the individual must be competent at the time the advance request is drafted.

An advance request could be considered in three different situations:

- where a person's request has been accepted but the individual loses competence before MAID takes place;

- where a person has been diagnosed with a grievous and irremediable condition but is not yet experiencing enduring and intolerable suffering; and

- prior to diagnosis.

Professor Downie recommended that advance requests be permitted in the first two cases, but not the third. She argued that advance requests prevent the suffering of someone who has been approved for MAID but then loses competence and must continue to suffer. It also prevents individuals from ending their lives earlier than they would otherwise in order to avoid losing competence before the suffering becomes intolerable, something which was a major factor in the *Carter* case.[91] Finally, an advance request allows the process to be undertaken before the suffering is enduring and intolerable. Otherwise, the person would have to continue to endure the suffering during the processing of the request and any waiting period.[92] Linda Jarrett and the Hon. Steven Fletcher, both living with disabilities, also told the Committee they believed advance requests should be respected.[93] Other witnesses also voiced support for advance requests.[94] Wanda Morris, outgoing CEO of Dying with Dignity Canada, argued in a similar vein to Professor Downie:

> In their decision, the Supreme Court justices wrote that to force someone to choose between undergoing a premature, perhaps violent, death and enduring prolonged suffering is a cruel choice. We submit that unless the committee recommends that informed consent be allowed by advance consent, the injustice will continue.
>
> Nowhere does this play out more than around the issue of dementia.…
>
> I think that what we do will actually be life-affirming if we are able to provide a clear advance consent mechanism.[95]

Ms. Morris explained that objective, verifiable criteria must be included in any such request to assist a health care team in assessing whether the criteria outlined in the advance request have been satisfied. As examples, she listed being bedridden, being unable to feed, wash or shave oneself or being unable to speak for 30 days or more. The same safeguards for a contemporaneous request must be in place for an advanced request to confirm informed consent and capacity.[96]

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91 *Carter,* 2015, para. 57-58.

92 PDAM, *Evidence*, 28 January 2016, 1850 (Downie).

93 PDAM, *Evidence*, 28 January 2016, 1735 (Jarrett); 1805 (Fletcher).

94 See, for example, PDAM, *Evidence*, 1 February 2016, 1105 (Paterson); PDAM, *Evidence*, 4 February 2016, 1655 (Angus Gunn, Counsel, Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society); Centre for Israel and Jewish Affairs, *Brief for the Special Joint Committee on Physician-Assisted Dying,* submission to the Committee, p. 4-5.

95 PDAM, *Evidence*, 1 February 2016, 1120 (Morris).

96 Ibid., 1155.

Jean-Pierre Ménard, representing the Barreau du Québec, noted that the panel of legal experts appointed by Quebec's government, of which he was a member, recommended allowing advance requests but that the legislation adopted in Quebec does not permit them for MAID. He explained that there were a number of questions that were raised about how to assess competence at the time an advance request is made: whether the individual would fully understand the decisions being made; how to know whether the individual had changed his or her mind; and whether a third party could act against the interests of the patient. He concluded that there was much debate, with valid arguments on both sides, and that a decision was made in Quebec to prioritize protection of the vulnerable.[97]

Jay Cameron from the Justice Centre for Constitutional Freedoms expressed concerns that advance requests could result in abuse if a patient becomes incompetent and that it would not be possible to verify if the request was made under duress. He also argued that it is too difficult to know how one will feel once in a changed state, such as when one is experiencing the symptoms of dementia.[98] Michael Bach, Executive Vice-President of the Canadian Association for Community Living, argued that the requirement for the suffering of the patient to be intolerable "in the circumstances of his or her condition" bars the use of advance requests.[99] Similarly, Prof. Trudo Lemmens from the Faculty of Law and Dalla Lana School of Public Health at the University of Toronto expressed concern in written submissions after his appearance before the Committee. He felt that someone with dementia who is still enjoying life could end up dying by MAID because he or she met the criteria related to suffering, such as not recognizing family members, that was included in his or her advance request for MAID.[100]

Dr. Jeff Blackmer, Vice-President, Medical Professionalism at the Canadian Medical Association noted that the organization had not consulted its membership on the issue of advance requests because the issue was not addressed in *Carter*. However, he did say that implementing advance directives is "incredibly complex and difficult, because it's very hard to capture all of the nuances and the specifics of a very complicated medical condition and intervention."[101] Dr. Douglas Grant, Registrar and CEO of the College of Physicians and Surgeons of Nova Scotia, without taking a position on whether advance requests should be permitted, also noted that "a myriad of new issues" would need to be addressed if such requests were permitted.[102]

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97 PDAM, *Evidence*, 25 January 2016, 1255 (Ménard).

98 PDAM, *Evidence*, 1 February 2016, 1205 (Jay Cameron, Barrister and Solicitor, Justice Centre for Constitutional Freedoms).

99 PDAM, *Evidence*, 4 February 2016, 1925 (Bach). See also, for example, PDAM, *Evidence*, 4 February 2016, 1930 (Gerald Chipeur, Lawyer, As an Individual).

100 Trudo Lemmens, *Response to Comments Made During the Committee Hearings of January 28, 2016*, 2 February 2016, submission to the Committee.

101 PDAM*, Evidence*, 27 January 2016, 1750 (Blackmer).

102 PDAM, *Evidence,* 2 February 2016, 1925 (Grant). See also, for example, PDAM, *Evidence*, 3 February 2016, 1850 (Rajji).

The Committee understands these challenges but is deeply concerned that by excluding individuals who want access to MAID but have lost competence, such individuals will be left to suffer or end their lives prematurely. This situation was exactly what the *Carter* decision sought to avoid. Allowing advance requests also provides comfort to individuals, reducing their psychological suffering, knowing that their lives will not end in a way that is against their wishes.[103] Limiting the option of advance directives to individuals who already have a diagnosis makes it easier to ascertain that there was informed consent. At that point, the person knows more about what he or she may expect in the future to provide relevant direction in the request. The same safeguards to ensure competence and consent must be in place for advance requests, and consideration could be given to additional safeguards. Thought should be given to encouraging and possibly requiring health care practitioners to communicate regularly with their patients while they are still competent to ensure that their advance requests continue to reflect their wishes. The concerns of Dr. Blackmer, Dr. Grant and others will need to be examined as the system is put in place to minimize the risk of abuse and error, but the Committee is confident that this can and must be done to ensure the autonomy of Canadians and the protection of the vulnerable. The Committee therefore recommends:

RECOMMENDATION 7

That the permission to use advance requests for medical assistance in dying be allowed any time after one is diagnosed with a condition that is reasonably likely to cause loss of competence or after a diagnosis of a grievous or irremediable condition but before the suffering becomes intolerable. An advance request may not, however, be made, prior to being diagnosed with such a condition. The advance request is subject to the same procedural safeguards as those in place for contemporaneous requests.

F. Residency Requirement

Few witnesses discussed the issue of residency as an eligibility requirement for MAID, either before the External Panel or this committee. Prof. Ells argued for eligibility based on eligibility for publicly funded health care services in the province or territory where the request is made. MAID should occur in the context of a patient-physician relationship and the Committee does not want Canada to become a destination for people seeking MAID. For this reason, the Committee recommends:

RECOMMENDATION 8

That medical assistance in dying be available only to insured persons eligible for publicly funded health care services in Canada.

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103 Provincial-Territorial Report, p. 31.

THE PROCESS INVOLVED IN REQUESTING MEDICAL ASSISTANCE IN DYING

The majority of witnesses noted that the process for applying for MAID should have built-in safeguards to identify vulnerable individuals and ensure that an individual meets the eligibility criteria. Witnesses agreed that the request has to come from the person seeking MAID; the request cannot be made by a substitute decision maker. The Committee also agrees and wishes to recognize that witness testimony was invaluable for the Committee's deliberations and consideration of appropriate safeguards.

There was general agreement that there should be a process appropriately documenting a person's request for MAID, that when possible, the request should be made in writing (with alternatives if a person cannot write) and witnessed by someone who has no possible conflict of interest. The person should also be given the opportunity to rescind his or her request. The Committee agrees with these suggestions as well.

The Committee believes that where possible the request should be made in writing, and that it should be witnessed by two people who have no conflict of interest. The Committee therefore recommends:

RECOMMENDATION 9

That the Government of Canada work with the provinces and territories and their medical regulatory bodies to ensure that, where possible, a request for medical assistance in dying is made in writing and is witnessed by two people who have no conflict of interest.

A. Conscientious Objection to Participating in Medical Assistance in Dying

The External Panel's report noted that "the medical profession is divided over the issue of MAID."[104] Many witnesses who appeared before the Committee, and briefs/ letters that were submitted to the Committee, discussed the extent to which health care practitioners should be able to refuse to participate in MAID for reasons of conscience.[105] No one was of the opinion that a health care practitioner should be obliged to perform MAID. As the Supreme Court of Canada stated in *Carter*, "[i]n our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying."[106]

It was argued by some witnesses that strong protections for health care practitioners who refuse to participate for reasons of conscience need to be put in place, including the possibility that such protection be established in legislation.[107]

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104 External Panel Report, p. 98.

105 The issue of freedom of conscience of pharmacists was raised by the Canadian Pharmacists Association (CPhA), PDAM, *Evidence*, 27 January 2016 (Phil Emberley, Canadian Pharmacists Association).

106 *Carter*, 2015, para. 132.

107 See for example, PDAM, *Evidence*, 27 January 2016, 1725 (Branigan); PDAM, *Evidence*, 3 February 2016, 1905 (Hashmi); 1705 (Collins); *Letter to Minister Wilson-Raybould and Minister Philpott*, Canadian Conference of Catholic Bishops, 20 January 2016.

Other witnesses were concerned about the effect a practitioner's refusal to participate in MAID would have both on the individual who was seeking an assisted death and on the availability of MAID more broadly. As Vyda Ng from the Canadian Unitarian Council told the Committee, "[i]t's very much in keeping with Canadian values to put the needs and wishes of Canadians ahead of the values of individual doctors and institutions, and to respect each person's dignity at the most traumatic period of their lives."[108] Some witnesses and submissions to the Committee recommended that a practitioner who conscientiously objects to MAID should be required to provide an effective referral or transfer of care for their patient,[109] while some felt that referring the individual to a third-party organization should be sufficient.[110] Joanne Klineberg from the Department of Justice noted that provinces and territories "have legislation and policies in relation to the rights of physicians to refuse to partake in certain types of medical practices, so it is definitely something that the provinces and territories already are responsible for."[111] In Quebec, a physician must notify a designated individual if he or she refuses to participate in MAID so that a willing physician may be identified.[112]

The Committee notes that the Supreme Court of Canada in *Carter* stated that the Charter rights of patients and physicians will need to be reconciled.[113] The Committee believes that having health care professionals who conscientiously object to MAID provide an effective referral for a patient who seeks MAID is an appropriate balancing of the rights of patients and the conscience rights of physicians. The Committee therefore recommends:

RECOMMENDATION 10

That the Government of Canada work with the provinces and territories and their medical regulatory bodies to establish a process that respects a health care practitioner's freedom of conscience while at the same time respecting the needs of a patient who seeks medical assistance in dying. At a minimum, the objecting practitioner must provide an effective referral for the patient.

Witnesses and briefs also addressed whether a health care facility should be permitted to refuse to either provide MAID or to allow MAID to be provided on its premises. One witness told the Committee that in Quebec, hospices (which the witness stated are largely privately funded) sought and received an exemption from having to provide

108 PDAM, *Evidence*, 3 February 2016, 1705 (Ng).

109 See for example, PDAM, *Evidence*, 26 January 2016, 1900 (Gibson); PDAM, *Evidence*, 1 February 2016, 1125 (Morris); Rhonda Morison, Submission to the Committee, 30 January 2016.

110 PDAM, *Evidence*, 1 February 2016, 1105 (Paterson); submission to the Committee, Vivre dans la Dignité, 2016; Ellen Agger, submission to the Committee, 1 February 2016.

111 PDAM, *Evidence*, 18 January 2016, 1535 (Klineberg).

112 *An Act Respecting End-of-Life Care,* RSQ c S-32.0001, section 31.

113 *Carter,* 2015, para. 132.

MAID.[114] A number of witnesses argued, and the Committee also believes, that if a health care facility is publicly funded, it must provide MAID.[115] The difficulty in transferring a patient from one facility to another was highlighted.[116]

The Committee recommends therefore:

RECOMMENDATION 11

That the Government of Canada work with the provinces and territories to ensure that all publicly funded health care institutions provide medical assistance in dying.

B. Assessments

A number of witnesses maintained that a person who seeks MAID should be assessed by at least two physicians to verify that he or she meets the eligibility criteria.[117] The External Panel Report explained that "[e]very jurisdiction that has enacted legislation permitting assisted dying requires that a second physician (often called a 'consulting physician') confirm the attending physician's approval of a request."[118] Other witnesses felt that to always require two assessments was unnecessary and could act as a barrier to access; and that in the scope of normal medical practice, a physician or other health care provider would seek out a second opinion as needed.[119] In situations where MAID was being sought primarily due to grievous and irremediable suffering caused by a psychiatric disorder, a consultation with a psychiatrist was recommended by some witnesses. Other witnesses argued that a vulnerability assessment should occur.[120] Carmela Hutchison, President of DisAbled Women's Network of Canada, told the Committee that "[w]omen with disabilities need to have had a consultation with peer support groups before being eligible for physician-assisted death."[121]

The Committee strongly believes that having two physicians who are independent of one another carry out two assessments to ensure that the MAID eligibility criteria are met will protect people who may be vulnerable. Considering the need to ensure that the MAID eligibility criteria are met, the Committee recommends therefore:

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114 PDAM, *Evidence, 2* February 2016, 1845 (Baxter).

115 See for example, PDAM, *Evidence*, 3 February 2016, 1700 (Ng); British Columbia Humanist Association, *Allow assisted dying for all who choose it: A brief for the Special Joint Committee on Physician-Assisted Dying*, 25 January 2016; Lori Goodwin, submission to the Committee, 30 January 2016.

116 PDAM, *Evidence,* 2 February 2016, 1850 (Baxter).

117 PDAM, *Evidence*, 27 January 2016, 1745 (Forbes); 1750 (Birrell); 1900 (Soles) 1 February 2016, 1245 (Dr. Francine Lemire, College of Family Physicians of Canada).

118 External Panel Report, p. 79.

119 See for example, PDAM, *Evidence*, 28 January 2016, 1920 (Downie).

120 PDAM, *Evidence*, 4 February 2016, 1950 (Bach); PDAM, *Evidence*, 28 January 2016, 1750 (Richert). David Baker and Gilbert Sharpe also note in their draft bill that a patient deemed to be vulnerable should have counselling.

121 PDAM, *Evidence*, 4 February 2016, 1640 (Hutchison).

RECOMMENDATION 12

That the Government of Canada work with the provinces and territories, and their medical regulatory bodies to establish that a request for medical assistance in dying can be carried out only if two physicians who are independent of one another have determined that the person meets the eligibility criteria for medical assistance in dying.

C. Who Should Provide Medical Assistance in Dying?

Defining which health care professionals can perform MAID is an essential part of the discussion, as those involved will require an exemption from the *Criminal Code* provisions that currently prohibit MAID (sections 14 and 241(b)). Under Quebec's *An Act Respecting End-of-Life Care*, only physicians may provide what is referred to in the law as "medical aid in dying." While for the most part it was agreed that physicians were well-placed to perform MAID, a number of witnesses advocated for nurse practitioners to be able to perform MAID, particularly in regions that have limited access to physicians. It was also recommended that registered nurses and physician assistants, working under the direction of a physician or a nurse practitioner, be able to provide MAID.[122] In such cases, telemedicine could be used to carry out any physician or specialist consultations. The Committee shares these concerns regarding access.

Some witnesses suggested the need for a defined and regulated medical sub-specialty for those physicians who can practice MAID.[123] The Committee is concerned that such a system would affect access.

Regardless of who performs MAID, the Committee recognizes the need for training, particularly with respect to identifying vulnerabilities, as was highlighted by a number of witnesses.[124]

Taking into account the limited access that people living in rural and remote regions of Canada may have to a physician, to ensure access to MAID across Canada, the Committee recommends:

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122 See for example PDAM, *Evidence*, 1 February 2016, 1100 (Paterson); PDAM, *Evidence*, 2 February 2016, 1745 (Ells); PDAM, *Evidence*, 3 February 2016, 1755 (Ng); Provincial-Territorial Report.

123 PDAM, *Evidence,* 4 February 2016, 1705 (Somerville); Constant H. Leung, submission to the Committee: *Physician Hastened Death: Seeking Substantive Safeguards and Effective Access for All Canadians*, 1 February 2016.

124 See for example PDAM, *Evidence*, 25 January 2016, 1110 (Abby Hoffman, Assistant Deputy Minister, Strategic Policy, Department of Health); PDAM, *Evidence*, 26 January 2016, 1915 (Gibson); PDAM, *Evidence*, 27 January 2016, 1725 (Branigan).

RECOMMENDATION 13

That physicians, nurse practitioners and registered nurses working under the direction of a physician to provide medical assistance in dying be exempted from sections 14 and section 241(b) of the *Criminal Code*.

Pharmacists and other health care practitioners who provide services relating to medical assistance in dying, should also be exempted from sections 14 and section 241(b) of the *Criminal Code*.

The Canadian Nurses Protective Society also recommended amending section 241(a) of the *Criminal Code* to protect nurses and other health care professionals who "engage in discussions with patients about end-of-life options and wishes."[125]

The majority of testimony focused on physicians. However, it should be understood, as per the recommendation above, that the Committee supports nurse practitioners, as well as registered nurses working under the direction of a physician, providing MAID as well.

D. Waiting or Reflection Period

There was a great deal of variation in submissions with respect to the concept of a mandatory waiting or "reflection period between the time of the request and the provision of MAID."[126] Some witnesses felt that a fixed waiting period is required, while others felt that the waiting period should be flexible, based in part on a person's prognosis.[127] In particular, it was felt that a waiting period should be required in cases of traumatic injury where a person might still be adjusting to a new condition. Professor Downie claimed that in such situations, a waiting period would not be helpful anyway, as an individual would likely not have the capacity to provide an informed consent, and would therefore not meet the eligibility criteria.[128] The External Panel Report noted that "most groups were of the view that a certain degree of flexibility in the waiting period is necessary."[129] The Committee notes that the waiting periods indicated in various provincial college of physician and surgeon guidelines vary.

The Committee agrees that any waiting period must be flexible, and firmly believes that attending physicians are best placed to determine what an appropriate period of reflection would be, taking into account the patient's medical condition and any circumstances that may be unique to that patient. For that reason, the Committee recommends:

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125 Submission, *Re Canadian Nurses Protective Society Submission on Physician-Assisted Death*.

126 See for example, PDAM, *Evidence*, 28 January 2016, 1835 (Fletcher).

127 See for example, PDAM, *Evidence*, 27 January 2016, 1735 (Blackmer); 1720 (Branigan).

128 PDAM, *Evidence*, 28 January 2016, 1910 (Downie).

129 External Panel Report, p. 90.

RECOMMENDATION 14

That the Government of Canada work with the provinces and territories, and their medical regulatory bodies to ensure that any period of reflection for medical assistance in dying that is contained in legislation or guidelines is flexible, and based, in part, on the rapidity of progression and nature of the patient's medical condition as determined by the patient's attending physician.

E. Prior Review of Medical Assistance in Dying Requests

Some witnesses recommended that to ensure that eligibility criteria are met, the MAID request should be reviewed by some type of panel or a judge.[130] Other witnesses opposed the idea of any prior review of a request for MAID for a number of reasons, including that such prior review "is not a safeguard, it is a barrier."[131] The Hon. Steven Fletcher stated that if there is a panel to approve requests, "you might as well have kept the law the way it is, because the end result is the same. People would not be able to access physician-assisted death, they'll take the actions on their own, and they will suffer in the interim."[132] The External Panel Report listed three prior review options that were put forward by stakeholders they consulted: prior judicial authorization, prior authorization by administrative tribunal, and a MAID panel.[133]

The Committee agrees that requiring a review by either a panel or a judge would create an unnecessary barrier to individuals requesting MAID**.** The Committee recommends therefore:

RECOMMENDATION 15

That the Government of Canada work with the provinces and territories, and their medical regulatory bodies to ensure that the process to regulate medical assistance in dying does not include a prior review and approval process.

F. Ancillary Considerations

The Committee wishes to highlight the need to ensure that health care professionals who are acting in good faith are protected from civil liability, as well as the need to ensure that the estates of individuals whose immediate cause of death was MAID are protected. The Committee feels strongly that MAID should not affect life insurance.

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130 PDAM, *Evidence*, 4 February 2016, 1700 (Somerville); PDAM, *Evidence*, 4 February 2016, 1935 (Chipeur); Baker et al (2016).

131 See for example, PDAM, *Evidence*, 1 February 2016, 1120 (Morris); PDAM, *Evidence*, 1 February 2016, 1240 (Lemire).

132 PDAM, *Evidence*, 28 January 2016, 1810 (Fletcher).

133 External Panel Report, pp. 93-95.

These issues need to be considered by the provinces and territories as they move towards establishing MAID frameworks within their jurisdictions.

Some witnesses noted that Indigenous organizations and communities had not been involved in discussions relating to MAID, and that such conversations would need to take place as the legislative process unfolds, taking into account the need to be respectful of cultural differences and sensitivities to MAID that may be present in communities afflicted with high rates of suicide.[134]

The Canadian Pharmacists' Association highlighted the need to ensure that the drugs recommended for use in MAID are available in Canada, and not subject to a manufacturer back order.[135] The College of Physicians and Surgeons of Nova Scotia also cautioned that "there needs to be a robust system for the return of unused medication, and the college would welcome that this system be mandated through legislation."[136]

OVERSIGHT OF THE MEDICAL ASSISTANCE IN DYING PROCESS: REPORTING REQUIREMENTS AND DATA COLLECTION

Oversight as it was referred to by witnesses can include reviewing specific cases of MAID, as well as reviewing the MAID framework more broadly. Many witnesses stated that oversight of MAID was critical, and many expressed the opinion that this oversight should occur at the federal level. Oversight was seen as desirable for a number of reasons, including that "it would safeguard good processes,"[137] and that it would provide "a pan-Canadian way of ensuring that everybody has access to this service."[138] Joanne Klineberg from the Department of Justice explained to the Committee that representations to the External Panel suggested "that monitoring at a national level would be especially important because otherwise you could have 13 different bodies monitoring and it may become especially cumbersome."[139] Prof. Pelletier from the External Panel stated that:

> [t]he idea of oversight is quite reassuring for the population. The population likes to know that there might be a body or different bodies collecting data and analyzing how physician-assisted dying is provided all across Canada, and maybe doing some study on the impact that it has on human rights in general.[140]

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134 PDAM, *Evidence*, 2 February 2016, 1915 (Dr. Alika Lafontaine, Indigenous Physicians Association of Canada); PDAM, *Evidence*, 1 February 2016, 1635 (Carrie Bourassa, First Nations University of Canada, as an individual).

135 PDAM, *Evidence*, 27 January 2016, 1950 (Carlo Berardi, Canadian Pharmacists Association).

136 PDAM, *Evidence*, 2 February 2016, 1930 (Grant).

137 PDAM, *Evidence*, 3 February 2016, 1705 (Ng).

138 PDAM, *Evidence*, 27 January 2016, 1710 (Branigan).

139 PDAM, *Evidence*, 18 January 2016, 1445 (Klineberg).

140 PDAM, *Evidence*, 26 January 2016, 1810 (Pelletier).

Professor Downie suggested to the Committee that two levels of oversight would be needed: a retrospective case review and oversight of the regulatory framework itself.[141] Jay Cameron recommended that "federal legislation should mandate a parliamentary review board every three to five years to review the physician-assisted suicides that have occurred, and make recommendations for legislative amendments."[142]

The Committee recognizes the importance of having an oversight mechanism that will compile data and analyze medical assistance in dying cases to monitor the operation of the medical assistance in dying framework and to identify any potential areas that require refinement. For that reason, the Committee recommends:

RECOMMENDATION 16

That Health Canada lead a cooperative process with the provinces and territories creating and analyzing national reports on medical assistance in dying cases, and that such reports be compiled on an annual basis and tabled in Parliament. Such reports must ensure respect for the privacy of affected individuals.

RECOMMENDATION 17

That a mandatory statutory review of the applicable federal legislation be conducted by the appropriate committee(s) of the House of Commons and of the Senate every four years after the coming into force of the applicable federal legislation.

IMPROVED SUPPORTS AND SERVICES

The Committee agrees with the witnesses and written submissions that highlighted the need for improved supports and services to accompany implementation of MAID, particularly for individuals with disabilities, mental health conditions and/or socioeconomic challenges.[143]

A. Support for Indigenous Peoples and Communities

Both Professor Carrie Bourassa, Indigenous Health Studies, First Nations University of Canada and Dr. Alika Lafontaine, President of the Indigenous Physicians Association of Canada, emphasized the need to ensure that work in Indigenous communities is culturally appropriate and recognizes the systemic issues and power imbalances between patients and health care workers as well.[144] Keeping these remarks in mind, the Committee recommends:

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141 PDAM, *Evidence*, 28 January 2016, 1850 (Downie).

142 PDAM, *Evidence*, 1 February 2016, 1115 (Cameron).

143 See, for example, 28 January 2016, 1830 (Richert); 1855 (Lemmens).

144 PDAM, *Evidence*, 1 February 2016, 1715 (Bourassa); PDAM, *Evidence*, 2 February 2016, 1910 (Lafontaine).

RECOMMENDATION 18

That the Government of Canada work with the provinces and territories, and their medical regulatory bodies to ensure that culturally and spiritually appropriate end-of-life care services, including palliative care, are available to Indigenous patients.

B. Palliative Care

Though statistics on access to palliative care are incomplete and out-of-date according to witnesses, it is fair to say that many Canadians do not have access to high quality palliative care when they need it. All witnesses who addressed the issue agreed that Canada could and needs to do more in this area, as does the Committee. The Committee was pleased to hear from Abby Hoffman, Assistant Deputy Minister, Strategic Policy, Department of Health, that planned investments in home care services will include support for palliative care, but the Committee feels that more can be done.[145] For this reason, the Committee makes the following recommendations:

RECOMMENDATION 19

That Health Canada re-establish a Secretariat on Palliative and End-of-Life Care; and that Health Canada work with the provinces and territories and civil society to develop a flexible, integrated model of palliative care by implementing a pan-Canadian palliative and end-of-life strategy with dedicated funding, and developing a public awareness campaign on the topic.

C. Mental Health

As noted above, teasing out the impact of mental health issues on requests for MAID will be a challenging aspect of implementation for health care practitioners. Additional services and supports may be needed to assess whether individuals with psychiatric conditions satisfy the requirements for MAID. For this reason, the Committee recommends:

RECOMMENDATION 20

That the Government of Canada support the pan-Canadian mental health strategy, *Changing Directions, Changing Lives*, developed by the Mental Health Commission of Canada and work with the provinces, territories and civil society to ensure that appropriate mental health supports and services are in place for individuals requesting medical assistance in dying.

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145 PDAM, *Evidence*, 25 January 2016, 1105 (Hoffman).

D. Dementia

Witnesses also outlined the difficulties experienced by individuals with various forms of dementia and their families, the care required and the low quality of life experienced by many in the later stages of such conditions. The Alzheimer Society called for a national dementia strategy to address the needs of our growing population faced with these conditions.[146] The Committee agrees and recommends:

RECOMMENDATION 21

That Health Canada and the Public Health Agency of Canada work with the provinces, territories and civil society organizations to develop a pan-Canadian strategy to improve the quality of care and services received by individuals living with dementia, as well as their families.

146 PDAM, *Evidence*, 1 February 2016, 1230 (Mimi Lowi-Young, CEO, Alzheimer Society of Canada).

LIST OF RECOMMENDATIONS

APPENDIX A
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Department of Justice	2016/01/18	2
Jeanette Ettel, Senior Counsel Human Rights Law Section		
Joanne Klineberg, Senior Counsel Criminal Law Policy Section		
Barreau du Québec	2016/01/25	3
Jean-Pierre Ménard, Lawyer		
Marc Sauvé, Director Research and Legislation Services		
Department of Health		
Sharon Harper, Manager Chronic and Continuing Care Division		
Abby Hoffman, Assistant Deputy Minister Strategic Policy		
As an individual		
Peter Hogg, Scholar in Residence Blake, Cassels & Graydon LLP		
External Panel on Options for a Legislative Response to *Carter v. Canada*	2016/01/26	5
Stephen Mihorean, Executive Director Secretariat		
Benoît Pelletier, Member External Panel		
Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying		
Jennifer Gibson, Co-Chair		
Maureen Taylor, Co-Chair		
Canadian Medical Association	2016/01/27	6
Dr. Jeff Blackmer, Vice-President Medical Professionalism		
Dr. Cindy Forbes, President		
Canadian Nurses Association		
Josette Roussel, Senior Nurse Advisor		
Anne Sutherland Boal, Chief Executive Officer		

Organizations and Individuals	Date	Meeting
Canadian Pharmacists Association	2016/01/27	6
Carlo Berardi, Chair		
Phil Emberley, Director Professional Affairs		
Canadian Psychiatric Association		
Dr. K. Sonu Gaind, President		
Katie Hardy, Director Professional and Member Affairs		
Canadian Society of Palliative Care Physicians		
Dr. Monica Branigan		
Council of Canadians with Disabilities	2016/01/28	7
Dean Richert, Co-Chair Ending of Life Ethics Committee		
Rhonda Wiebe, Co-Chair Ending of Life Ethics Committee		
Dying With Dignity Canada		
Linda Jarrett, Member Disability Advisory Council		
As individuals		
David Baker, Lawyer Bakerlaw		
Jocelyn Downie, Professor Faculties of Law and Medicine, Dalhousie University		
Hon. Steven Fletcher		
Trudo Lemmens, Professor Faculty of Law & Dalla Lana School of Public Health, University of Toronto		
Alzheimer Society of Canada	2016/02/01	8
Debbie Benczkowski, Chief Operating Officer		
Mimi Lowi-Young, Chief Executive Officer		
British Columbia Civil Liberties Association		
Grace Pastine, Litigation Director		
Josh Paterson, Executive Director		
College of Family Physicians of Canada		
Dr. Francine Lemire, Executive Director and Chief Executive Officer		

Organizations and Individuals	Date	Meeting
Dying With Dignity Canada	2016/02/01	8
Shanaaz Gokool, Chief Operating Officer and National Campaigns Director		
Wanda Morris, Chief Executive Officer		
Justice Centre for Constitutional Freedoms		
Jay Cameron, Barrister and Solicitor		
Canadian Cancer Society	2016/02/01	9
Kelly Masotti, Assistant Director Public Issues		
Gabriel Miller, Director Public Issues		
As an individual		
Carrie Bourassa, Professor Indigenous Health Studies, First Nations University of Canada		
Canadian Hospice Palliative Care Association	2016/02/02	10
Sharon Baxter, Executive Director		
College of Physicians and Surgeons of Nova Scotia		
Dr. Douglas Grant, Registrar and Chief Executive Officer		
Marjorie Hickey, Legal Counsel		
Criminal Lawyers' Association		
Leo Russomanno, Member and Criminal Defence Counsel		
Dying With Dignity Canada		
Dr. Derryck Smith, Chair of Physicians Advisory Council		
Indigenous Physicians Association of Canada		
Dr. Alika Lafontaine, President		
As an individual		
Carolyn Ells, Associate Professor, Medicine Biomedical Ethics Unit, McGill University		
Canadian Council of Imams	2016/02/03	11
Imam Sikander Hashmi, Spokesperson		
Canadian Paediatric Society		
Dr. Dawn Davies, Chair Bioethics Committee		
Mary J Shariff, Associate Professor of Law and Associate Dean Academic, University of Manitoba		
Canadian Unitarian Council		
Vyda Ng, Executive Director		

Organizations and Individuals	Date	Meeting
Centre for Addiction and Mental Health	2016/02/03	11
Dr. Tarek Rajji, Chief Geriatric Psychiatry		
Kristin Taylor, Vice-President Legal Services		
Coalition for HealthCARE and Conscience		
Cardinal Thomas Collins, Archbishop Archdiocese of Toronto		
Laurence Worthen, Executive Director Christian Medical and Dental Society of Canada		
Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society	2016/02/04	12
Margaret Birrell, President		
Angus M. Gunn, Counsel		
Canadian Association for Community Living		
Michael Bach, Executive Vice-President		
DisAbled Women's Network of Canada		
Carmela Hutchison, President		
Society of Rural Physicians of Canada		
Dr. John Soles, President		
The Canadian Medical Protective Association		
Dr. Hartley Stern, Executive Director and Chief Executive Officer		
As individuals		
Gerald Chipeur, Lawyer		
Margaret Somerville, Professor McGill University		

APPENDIX B
LIST OF BRIEFS

Organizations and Individuals

A Network of British Columbia Physicians

Abramson, Jana and Abramson, Kenneth

Adams, Andrew

Advance Practice Nurses of the Palliative Care Consult Service in the Calgary Zone of Alberta Health Services

Advocacy Centre for the Elderly

Agger, Ellen

Alliance for Life Ontario

Altschul, Denise

Anglican Church of Canada

Association of Registered Nurses of Prince Edward Island

Baker, David

Bennett Fox, Sara

Bracken, Susan

Brienen, Arthur-Leonard

British Columbia Civil Liberties Association

British Columbia Humanist Association

Brooks, Jeffery

Brzezicki, Barbara

Canadian Association for Community Living

Canadian Bar Association

Canadian Civil Liberties Association

Canadian Coalition for the Rights of Children

Organizations and Individuals

Canadian Conference of Catholic Bishops

Canadian Council of Imams

Canadian Federation of Nurses Unions

Canadian Medical Association

Canadian Medical Protective Association

Canadian Nurses Association

Canadian Nurses Protective Society

Canadian Paediatric Society

Canadian Pharmacists Association

Canadian Society of Palliative Care Physicians

Canadians Advocating for Ethical Hospice Palliative Care

Catholic Organization for Life and Family

Centre for Addiction and Mental Health

Centre For Inquiry Canada

Centre for Israel and Jewish Affairs

Chipeur, Gerald

Christian Legal Fellowship

Christian Reformed Churches in Canada

Clay, Pat

Clemenger, Lauren

Coalition for HealthCARE and Conscience

College of Physicians and Surgeons of British Columbia

College and Association of Registered Nurses of Alberta

College of Registered Nurses of Nova Scotia

Organizations and Individuals

Congress of Union Retirees of Canada

Congress of Union Retirees of Canada – Hamilton, Burlington and Oakville Chapter

Council of Canadians with Disabilities

DisAbled Women's Network of Canada

Downie, Jocelyn

Dying With Dignity Canada

Dyment, Alan

Dyrholm, Joan

Eayrs, Jonathan

Euthanasia Prevention Coalition

Evans, David

Evangelical Fellowship of Canada

Farrow, Douglas

Fernihough, William

Fischer, Marilyn

Fleming, Loretta

Frazee, Catherine

Frizzell, Sue

Gobbi, Greg

Goodwin, Lori

Guichon, Juliet; Alakija, Pauline; Doig, Christopher; Mitchell, Ian; and Thibeault, Pascal

Hammond, Katherine

Hartman, James

HealthCareCAN

Organizations and Individuals

Hogan, Marcia

Holmen, Denise

Holub, Robert

Hudgins, Janet

Inch, Carolyn

Johnson, Shirley

Justice Centre for Constitutional Freedoms

Koch, Jule

Kuchta, Gay

L'Arche Canada

Lemmens, Trudo

Leung, Constant

Lindstrom, Lena

Living With Dignity

Lods, Margot

Lovell, Jane

Lydon, Patrick

Mackay, John

MacLellan, Pat

Mandel, Ezra

Maple, Doris

Marchand, Michele

Martin, Mary

Maryon, Betty

Organizations and Individuals

McPhee, Margaret

Meaney Svec, Katherine

Mental Health Commission of Canada

Morison, Rhonda

Mount, Balfour

Munroe, Pamela

Nurses Association of New Brunswick

Perks, Alan

Peterson, Heather

Physicians' Alliance against Euthanasia

Protection of Conscience Project

Rankmore, Carol

REAL Women of Canada

Registered Nurses Association of the Northwest Territories and Nunavut

Saba, Paul

Salvation Army

Santoro, Daniel and Burrell, Althea

Secular Connexion Séculière

Seeley, Patricia

Shapray, Howard

Somerville, Margaret

Spencer, Richard

Squires, Colette

Sullivan, William

Organizations and Individuals

Sumner, Wayne

Surgeon General, Canadian Forces Health Services Group

Toujours Vivant-Not Dead Yet

Underwood, Katherine

UNICEF Canada

United Church of Canada

Vandenberghe, Joris

von Fuchs, Ruth

Walker, Ken

Warren, John

Widas, Mary

Willoughby, Annette

Wilson, John

Wilson, Linda

MINUTES OF PROCEEDINGS

A copy of the relevant Minutes of Proceedings (Meetings *Nos. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16*) is tabled.

Respectfully submitted,

Hon. Kelvin Kenneth Ogilvie and Robert Oliphant
Joint Chairs

More Safeguards are needed for the Vulnerable

Special Joint Committee on Physician-Assisted Dying: Dissenting Report

This dissenting report reflects the views of the following Members of Parliament who served on the Special Joint Committee on Physician Assisted Dying (the "Committee"): Michael Cooper (Co-Vice Chair of the Committee, St. Albert-Edmonton), Mark Warawa (Langley-Aldergrove), and Gérard Deltell (Louis-St-Laurent), as well as, Harold Albrecht (Kitchener-Conestoga), who participated in a majority of the Committee meetings as an alternate member.

Background

On February 6, 2015 in its ruling *Carter v. Canada*, 2015 SCC 5, the Supreme Court of Canada (the "SCC") unanimously stuck down Canada's longstanding criminal prohibition against voluntary euthanasia and assisted suicide ("physician-assisted dying or PAD"), ruling that it was in contravention of the right to life, liberty, and security of the person guaranteed under Section 7 of the *Charter of Rights and Freedoms* (the "*Charter*"). Specifically, the SCC found the *Criminal Code* prohibition against PAD to be void because it deprived:

> A competent adult of such assistance where (1) the person affected clearly consents to the termination of life; and (2) the person has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.[1]

The SCC has stayed its ruling until June 6, 2016 to allow Parliament to craft a legislative response.[2]

The Committee has been tasked by Parliament to make recommendations to the Government on how to best respond to the *Carter* decision.

Reasons for a Dissenting Report

In *Carter*, the SCC aptly described the difficult task now before Parliament: "it must weigh and balance the perspective of those who might be at risk in a permissive regime against that of those who seek assistance in dying."[3] The SCC agreed that there would be real risks to the vulnerable without a blanket proscription of PAD but that these risks could be managed "through a carefully designed and monitored system of safeguards."[4]

Additionally, the Committee heard from many groups representing healthcare professionals, including the Canadian Medical Association, about the need to protect

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1 *Carter v. Canada*, 2015 SCC 5, at para. 4

2 We note here our *significant* concern that under these timelines it will be virtually impossible to sufficiently analyze the far reaching consequences of allowing PAD in Canada. Quebec took six years and three different administrations to finally come to a model that they deemed acceptable.

3 *Carter v. Canada*, 2015 SCC 5, at para. 98

4 Ibid., para. 117

the *Charter* rights of health professionals and health institutions that may conscientiously object to taking part in PAD.

Unfortunately, the regime recommended in the Committee's main report falls *far* short of what is necessary to protect vulnerable Canadians and the *Charter* protected conscience rights of health professionals.

Moreover, the SCC gave a reasonably straightforward roadmap for Parliament to follow in its legislative response. Regretfully, the Committee failed to adhere to the roadmap contemplated in *Carter*. On the contrary, the Committee recommends a legal framework that does not conform to *Carter*.

Taken together, we as Members of Parliament on the Committee, therefore, feel that it is our duty to our constituents, to Canadians, and to future generations to respectfully present this dissenting report.

The Quebec Experience

Quebec is the only Canadian province to have adopted a law on end of life care. The Committee's main report presents the chronology of events leading to the adoption of Quebec's legislation but omits the most important factors.

In Quebec, only patients aged 18 and older, with severe and incurable physical illnesses and whose medical condition is characterized by an advanced and irreversible decline can request medical help to die. The law does not allow for advanced directives.

The attending physician must ensure that his or her patient has clearly consented to PAD, ensuring among other things that it is not the result of external pressure; provides the patient with a full prognosis on the condition and possible treatment options, along with likely consequences. The physician must also ensure the continuation of consent with interviews with the patient held at different times, spaced by a reasonable time, having regard for the patient's condition.

Quebec physicians are free to act according to their conscience. If they do not want to proceed, they must refer the patient to an independent body which will contact another physician. Two independent physicians must confirm that the patient meets all the criteria prescribed by the subject legislation.

The work leading to the adoption of the law took place over a period of six years under three different legislatures in a non-partisan working process. Ultimately, the legislation was passed in a free vote of members of the National Assembly: 94 members voted in favor of the legislation and 22 against. All votes against were from members of the governing party, including 11 cabinet ministers.

Overall, we acknowledge that the Quebec experience is a result of a careful, thoughtful and serious approach that better respects individual autonomy and better protects vulnerable persons than the proposal set out in the main report of the Committee.

The Committee's Report Fails to Respect *Carter*

The *Carter* decision is the law of the land. Any legislative response must adhere to the parameters set out in *Carter*. Unfortunately, the Committee has recommended a legal framework that fails to adhere to *Carter*.

Opening the door to minors contrary to *Carter*

The Committee, in Recommendation 6b of the main report, has recommended allowing PAD in cases expressly excluded by *Carter*, including the possibility of mature minors at a future date. The SCC was clear in saying that PAD should be available to "competent adult persons".[5] If the SCC wished to extend PAD to mature minors, it would have said so. Instead, the SCC went out of its way to expressly preclude this. This is supported by the evidence of Professor Peter Hogg, Canada's foremost constitutional scholar who said:

> The Supreme Court, in its order, spoke of a "competent adult person". I don't think it would be open to you, for example, to have 16 as an age of consent for this purpose, because that would not be a competent adult person. Between 18 and 21, I would think you would have some leeway within the word "adult" to decide that.[6]

Likewise, a senior official from the Department of Justice concurred with Professor Hogg, stating "the court clearly limited its ruling to mentally competent adults."[7]

Further, the Committee heard important evidence about policy reasons for why PAD should be available only to adults. The Canadian Pediatrics Society, whose opinion on this matter carries significant weight, was unequivocal: "I think for the purposes of your legislation, I would say 18 is an adult. I would be as conservative as you can possibly be;"[8] and again: "today I am here to speak to the matter of children, and with respect to children I would argue that you should not go beyond the Supreme Court's pronouncement."[9]

No Safeguards for the Mentally Ill

Additionally, the Committee's proposed legislative framework fails to sufficiently balance respect for individual autonomy with the need to protect vulnerable persons, as Parliament was called upon to do by the SCC in *Carter*. For example, shockingly, neither in Recommendation 3 of the main report, nor anywhere else in the Committee's main report is there are requirement forpatients diagnosed with an underlying mental health challenge to undergo a psychiatric assessment by a psychiatric professional to determine whether they have the capacity to consent to PAD. This, notwithstanding that the Canadian Psychiatric Association was of the opinion, and we think that the vast

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5 *Carter v. Canada*, 2015 SCC 5, at paras. 4, 68, 127, and 147

6 Peter Hogg, *Special Joint Committee on Physician-Assisted Dying* (January 25, 2016).

7 Joanne Klineberg, *Special Joint Committee on Physician-Assisted Dying* (January 18, 2016).

8 Dr. Dawn Davies, *Special Joint Committee on Physician-Assisted Dying* (February 3, 2016).

9 Dr. Mary Shariff, *Special Joint Committee on Physician-Assisted Dying* (February 3, 2016).

majority of Canadians would strongly agree, that in instances where a person seeking PAD has a mental condition a "psychiatrist needs to be involved to do a proper assessment as soon as the request is made."[10]

The SCC ruled that PAD *could* be practiced in a way that protects the vulnerable *provided* it is accompanied by stringent safeguards. A regime that is not rigorous enough to protect the vulnerable, if challenged, would almost certainly be found to violate the *Charter* as well. There is little sense in replacing a law that was found to violate the *Charter* in one way with a law that violates the *Charter* in another way. Unfortunately, the Committee in its main report fails to strike the right balance between individual autonomy and the need to protect vulnerable persons.

Other Concerns with the Main Report

We are of the view that the Committee's main report should have placed greater concern in three other areas: (1) palliative care; (2) conscience protections for physicians and health institutions; and (3) advanced directives.

Palliative Care

During Committee hearings witness after witness highlighted the importance of palliative care in the context of PAD. We also heard about the overall lack of proper palliative care services across Canada. The Canadian Cancer Society highlighted the "serious gaps in palliative care across the country."[11] The Canadian Society of Palliative Care Physicians also described the training given to providers of palliative care as "woefully inadequate."[12]

The importance of palliative care in the context of PAD is effectively stated in the *Final Report of the External Panel on Options for a Legislative Response to Carter v. Canada*: "a request for physician-assisted death cannot be truly voluntary if the option of proper palliative care is not available to alleviate a person's suffering."[13] A genuinely autonomous choice for a person to end their life is not possible if they are not offered palliative care as they will see their choice as only intolerable suffering or PAD. Testimony by the Canadian Cancer Society confirmed this: "any responsible policy on assisted dying must guarantee access to quality palliative care for all Canadians."[14]

We therefore believe that it is essential that the federal government work with the provinces and territories and provincial/territorial medical regulatory authorities to ensure that the option of palliative care is offered and available to any person contemplating PAD.

Conscience Protections

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10 Dr. K. Sonu Gaind, *Special Joint Committee on Physician-Assisted Dying* (January 27, 2016).

11 Gabriel Miller, *Special Joint Committee on Physician-Assisted Dying* (February 1, 2016).

12 Dr. Monica Branigan, *Special Joint Committee on Physician-Assisted Dying* (January 27, 2016).

13 Dr. Harvey Max Chochinov, Professor Catherine Frazee, Professor Benoît Pelletier, "Final Report on Options for a Legislative Response to *Carter v. Canada*" (December 15, 2015), page vii.

14 Gabriel Miller, *Special Joint Committee on Physician-Assisted Dying* (February 1, 2016).

Section 2 of the *Charter* guarantees all Canadians "freedom of conscience and religion."[15] There was near unanimous agreement amongst witnesses that physicians who object to taking part in PAD for reasons of conscience should not be forced to do so. Unfortunately, the Committee in its main report does not sufficiently protect the *Charter* rights of physicians and health institutions.

The Committee recommends that physicians who conscientiously object to PAD be obliged to refer patients through an "effective referral". We believe that such a regime is unnecessary and would infringe on the *Charter* rights of physicians. We note that Canada would be first jurisdiction in the world to require an effective referral regime. Instead, we believe that there are better models which protect *Charter* rights of physicians and provide access to PAD for patients in other jurisdictions, including Quebec. Physicians who conscientiously object to PAD are required to provide information to patients on how to access PAD, and to advise a government agency of the patient's request. The government agency then connects the patient to a physician willing to provide PAD.

Likewise, healthcare institutions that object to offering PAD should be exempted in accordance with the Supreme Court's determination that individual and collective aspects of freedom of religion and conscience guaranteed under the *Charter* are "indissolubly intertwined".[16]

Advanced Directives

We are concerned about the advanced directive regime proposed in the Committee's main report. The regime proposed falls outside the parameters set by *Carter*. Moreover, several witnesses recognized that from a policy perspective the type of regime proposed is inadvisable, including the Canadian Medical Association.[17]

We further note that issues respecting advanced directives are extremely complicated. Significant more time than was given to the Committee is required to explore the legal and policy implications of advanced directives.

Conclusion

We strongly encourage the Government to craft legislation that takes full stock of the abovementioned thoughts, concerns, and recommendations. We recognize the need for law to comply with the *Charter* as interpreted by the SCC in *Carter*. The Committee failed to adhere to the parameters set out in *Carter*, and likewise failed to propose meaningful safeguards, as Parliament was called upon to do in *Carter*. In light of the foregoing, the Committee's main report is not supportable. We hold out hope, however, that the Government will take note of the glaring flaws contained in the Committee's main report and do much better when it introduces its legislative response to *Carter*.

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[15] *Constitution Act* (1982), s.2a

[16] *Loyola High School v. Quebec (Attorney General)*, 2015 SCC 12, at paras. 92 to 94

[17] Dr. Jeff Blackmer, *Special Joint Committee on Physician-Assisted Dying* (January 27, 2016).

Respectfully submitted,

Michael Cooper, M.P.
St. Albert-Edmonton

Mark Warawa, M.P.
Langley-Aldergrove

Gérard Deltell, M.P.
Louis-St Laurent

Harold Albrecht, M.P.
Kitchener-Conestoga

Supplementary Opinion

Submitted to the Special Joint Committee on Physician-Assisted Dying by New Democrat MPs Brigitte Sansoucy (Saint-Hyacinthe-Bagot) and Murray Rankin (Victoria)

The committee has worked diligently—in spite of its short timeline and deeply sensitive subject—to deliver a report that honours the diversity of evidence it heard and makes important recommendations for the government to consider in its legislative response. It is a report in which we invested much time and care in shaping and are proud to support. We thank each of the 61 witnesses who made themselves available to the committee as well as the staff whose support was essential for the committee to deliver on its mandate in due time.

We offer this supplementary opinion to provide Canadians with additional information, beyond what could be included in the main report, that we believe they will find helpful in understanding the context in which the committee worked and the options now facing the government. As the government moves forward, it must continue to engage with Canadians.

A principles-based approach to legislating on medical aid in dying

In making health policy, New Democrats believe in putting the patient first. In the case of medical aid in dying, that approach is the only way to be respectful of the complex and sensitive issues facing patients and their families, as well as responsive to the urgency of their suffering. And yet for five months following the Supreme Court's unanimous decision in Carter, the previous government chose to neither take action in Parliament nor consult with Canadians. Their failure to act was an affront to this patient-centred approach and a derogation of their duty to govern for all Canadians, particularly those whose suffering was the concern of the Court and this committee. Those five wasted months created additional challenges which the committee worked admirably to overcome. Having now received the committee's report, the government must move efficiently to introduce legislation that protects the Charter rights of these patients.

This legislation must consider not only the specific recommendations found in the committee's main report, but the principles that drove our deliberations. It must ensure that every eligible patient's right to access medical aid in dying is upheld, and protect any healthcare professional who objects for reasons of conscience from disciplinary action. It must honour patients' autonomy and self-determination—ensuring that their privacy is not violated or their rights undermined by arbitrary bureaucracy—while still maintaining effective safeguards to protect vulnerable individuals. Recognizing the initiatives by provinces and territories since *Carter*, as well as the exemplary consultation process adopted by Quebec with respect to Bill 52, the federal government

must adopt an approach of collaborative federalism, respecting provincial jurisdiction while providing the leadership necessary to avoid a regional patchwork.

As parliamentarians, New Democrats approach the question of medical aid in dying with the understanding that, however our views may differ, every parliamentarian is guided by deeply held values and the best interests of their constituents, and that the views of each Canadian must be respected as we seek to protect the Charter rights of all. We were pleased that the committee shared this desire to work in a non-partisan and respectful manner. This is the approach Canadians expect of Parliament, and we are hopeful that it can be maintained in the coming months as Parliament considers legislation relating to the committee's report.

Respecting the priorities of Canadians: expanding palliative care, supporting caregivers

In its mandate from Parliament, the committee was tasked with providing recommendations on a federal response that "respects the Constitution, the Charter of Rights and Freedom, and the priorities of Canadians."

The fact that palliative care can and must be improved was emphasized by every witness who testified on the subject before our committee, was repeatedly affirmed by representatives of all parties and both chambers of Parliament, and was recently the subject of a motion tabled by NDP MP Charlie Angus (Timmins – James Bay) and passed with near-unanimous support in the House of Commons in 2014. We can imagine no more conclusive proof that palliative care is truly a priority for Canadians and inextricably linked to the issue of medical aid in dying.

It is our view that making recommendations on the improvement of palliative care fell squarely within the committee's mandate and remains essential to any balanced response to medical aid in dying. To that end, we introduced a package of concrete measures to improve palliative care.

Several motions introduced by Mr. Rankin on February 4, 2016, were adopted as recommendations in the final report, including:

- ✓ Re-establishing a secretariat on palliative care
- ✓ Creating a properly funded Pan-Canadian Strategy on Palliative and End-of-Life Care
- ✓ Providing culturally and spiritually appropriate services to Indigenous communities

At the same time, New Democrats believe the report could have gone further, to include steps that were within the committee's mandate to recommend and are necessary for the government to take. These omissions are an opportunity missed but not yet lost. Alongside the recommendations in the main report, the government can now:

1. **Demonstrate leadership by providing palliative care within federal jurisdiction.**

Palliative care can and must be improved, and the government has significant scope to do so. The federal government is the fifth largest healthcare provider in Canada, providing direct health services to specific populations such as First Nations and Inuit peoples, veterans and active members of the Canadian Forces. Providing palliative care for those within direct federal health responsibility would help a significant number of Canadians and demonstrate leadership to provinces and territories.

2. **Help every Canadian family by improving Compassionate Care benefits.**

Family members can experience chronic financial, physical, and emotional stress when caring for a loved one. Helping caregivers provides significant benefits, both for the individual families and the health care system.

Under pressure, the last government adopted the NDP's proposal to extend EI Compassionate Care benefits from 6 weeks to 6 months. Unfortunately, they failed to address the narrowness of eligibility criteria so too many families caring for loved ones will still be left out.

We believe that families should be able to access these supports not just when a loved one faces a terminal illness, but also when other serious family health events require time away from work.

Recognizing the broader health context

The committee report touched on several issues it described as "ancillary considerations," including the needs for meaningful consultation with Aboriginal peoples, better support for mental health, improved palliative care, and a national dementia strategy.

We wish to recognize initiatives by several parliamentarians who have worked hard to address these priorities for Canadians, including former MP Libby Davies' Continuing Care Act, former MP Claude Gravelle's bill to create a National Dementia Strategy, and MP Charlie Angus' motion to establish a Pan-Canadian Palliative and End-of-Life Care strategy.

New Democrats see these issues as not only intrinsically linked to the issue of medical aid in dying, but fundamental to a successful model of public healthcare in Canada for the 21st century. Canadians want better access to primary care, as a well as a stronger continuum of care, including home care, long term care and palliative care. They want greater equality of access and outcomes, regardless of their postal code. They want a

government that not only strongly supports the *Canada Health Act*, but that is committed to ensuring its full implementation from coast to coast to coast. And they want to see the shameful deficiencies in on-reserve healthcare addressed and Aboriginal peoples respected as full partners in the development and implementation of health programs.

We therefore urge the government not to address medical aid in dying in a vacuum, but to consider its connections to other aspects of health policy, including social determinants of health. New Democrats recognize that social determinants—such as income and social status, education, employment conditions, social environments and support networks, gender, and healthy child development—play a role in health outcomes. These must be considered in relation to medical aid in dying to determine how they may affect health outcomes, access to care, and potential vulnerability. The government must take action to fight poverty, tackle rising food insecurity and address the affordable housing crisis so that Canadians are on more equal footing as they make end-of-life decisions.

In conclusion, we are proud to support the committee's main report and wish to recognize the hard work of all our colleagues who worked alongside us throughout its development. Having taken a broader viewer of the committee's mandate, we urge the government to take note of the additional issues and recommendations put forward in this supplementary opinion and to seize this opportunity to respond to the priorities of all Canadians.

Court of Queen's Bench of Alberta

Citation: HS (Re), 2016 ABQB 121

2016 ABQB 121 (CanLII)

Date: 20160229
Docket: 1601 01683
Registry: Calgary

In the Matter of H.S. and
In the Matter Of ***Carter v Canada (Attorney General)***, 2015 SCC 5, [2015] 3 SCR 331

Restriction on Publication

By Court Order, no one may publish information that may identify the assisted person.

NOTE: This judgment is intended to comply with the restriction so that it may be published.

Memorandum of Decision
of the
Honourable Madam Justice S.L. Martin

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1. Introduction

[1] Ms. S. is an adult woman in the final stages of amyotrophic lateral sclerosis ("ALS") who seeks to end her life by means of physician-assisted death. Under existing law, it remains a crime in Canada to assist another person in ending her own life. However, two recent Supreme Court of Canada decisions operate to permit physician-assisted death if certain criteria are met.

[2] On January 6, 2016, the Supreme Court granted a personal constitutional exemption for competent adult persons who (1) clearly consent to the termination of life and (2) have a

grievous and irremediable medical condition that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition and that cannot be alleviated by any treatment acceptable to the individual.

[3] The Supreme Court ruled that individuals wishing to avail themselves of such exemption may apply to the superior court of their jurisdiction for relief until June 6, 2016. The applications for judicial authorization concerning physician-assisted death introduced by the Supreme Court have a defined scope and are intended to operate for a limited duration.

[4] Ms. S. makes such an application to this Court on an expedited basis. This is the first application of its kind in this Province and no applications from other Canadian jurisdictions have been brought to my attention.

[5] The singular question before this Court is whether Ms. S. qualifies for the exemption granted by the Supreme Court. For the reasons that follow, I find that Ms. S. has met the test and qualifies for a personal constitutional exemption allowing a physician-assisted death.

2. The Applicant

[6] Ms. S. is a long-time resident of Calgary. She is a retired clinical psychologist who obtained a Masters degree in psychology. She worked in a psychiatric hospital for four years and then worked in the healthcare system in Calgary for a further 34 years. She says "I am happy looking back at my career" and describes those decades as "very healthy, productive years and most rewarding."

[7] Before her diagnosis, she was in good physical and mental health and was very physically active. She enjoyed jogging, swimming, yoga, hiking and traveling. She was a member of a hiking group for 23 years and loved the mountains and national parks. She was an award-winning dancer for many years, dancing three or four nights per week. She also loved reading, music, opera and studying languages.

[8] After she retired, she developed a speech impairment and was eventually diagnosed with ALS in April 2013. ALS is a degenerative neurological disease in which the motor neurons are destroyed. The nerve fibers lose their conductivity and the muscles do not receive impulses. This causes increasing weakness of the majority of muscles, including those of the tongue, lips, arms, legs, hands, feet, neck, chest and others. The cause of this disease is unknown but it is progressive, not treatable and terminal.

[9] Her disease progressed rapidly. She attended and received ongoing treatment from the Calgary ALS and Motor Neuron Disease Clinic until October 2015. She stopped attending when there was nothing more they could do to slow the progress of her illness.

[10] Ms. S. is presently in the final stages of ALS, with at most six months to live. She describes herself as "severely disabled, quite weak and in my wheelchair." She is mentally alert, can make certain sounds, but is unable to speak. She is almost completely paralyzed. Her bodily movements are limited to a few gestures and "still moving my left hand a little." This allows Ms. S. to communicate by typing or using a device that will speak from the text she can produce. Even this form of communication is rapidly declining.

[11] She is in significant pain and requires constant care and support. She cannot swallow any liquids and water is pumped into her stomach via a gastric tube. While grateful for the physiotherapy she receives, she also has frequent muscle cramps, aching joints, pains in her

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shoulders and neck due to stiffness and lack of motion. She is in constant discomfort but takes little pain medication because she prefers to be alert. She must be moved every two hours to prevent bedsores. She has lost the ability to pursue the independent life she so valued.

[12] In the last two months she reports more frequent breathing problems. Several times during the night she has episodes of choking due to saliva and mucus in her throat or trachea that require suction.

[13] She has no children and the two remaining members of her family do not live in Canada. She lives with her spouse, who is her constant companion and has become her main caregiver. She states that despite their challenges, they have managed to keep a positive attitude and remain strong. She says their nine-year relationship has been the happiest of her life: "as I look back upon my life prior to this illness which began three years ago, I feel happy, as I have had a very healthy, productive and fulfilled life."

[14] She seeks a physician-assisted death in which two named physicians would provide her with medication to induce death. Those physicians are located in British Columbia. She plans to die on private property in Vancouver and no nurses will be involved.

[15] In her words:

> I am not suffering from anxiety or depression or fear of death. I would like to pass away peacefully and am hoping to have physician-assisted death soon. I do not wish to have continued suffering and to die of this illness by choking. I feel that my time has come to go in peace.

3. The Legal Landscape: *Carter 2015, Carter 2016* and Subsequent Developments

[16] The distinctive nature of this application and the defined scope of this hearing are the product of the two recent decisions of the Supreme Court of Canada: ***Carter 2015*** and ***Carter 2016***.

A. *Carter 2015*

[17] First, in ***Carter v Canada (Attorney General)***, 2015 SCC 5, [2015] 1 SCR 331 ("***Carter 2015***"), a unanimous Supreme Court decided that provisions of the *Criminal Code*, RSC 1985, c C-46, which prohibit physician-assisted dying violate an individual's s. 7 *Charter* right to life, liberty and security of the person in a manner that does not accord with the principles of fundamental justice.

[18] The Supreme Court understood it was being asked to balance competing values of great importance: the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition on the one hand and the sanctity of life and the need to protect the vulnerable on the other.

[19] The Supreme Court noted that the evidentiary record before it was voluminous. In ***Carter 2015,*** the Court heard from the three parties, as well as from nineteen intervenors, including many Attorneys General and organizations representing diverse points of view.

[20] The Court explained that the trial judge had canvassed evidence, from Canada and from the permissive jurisdictions, on medical ethics and current end-of-life practices, the risks associated with assisted death, and the feasibility of safeguards. The Court also reviewed its

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previous reasons in ***Rodriguez v British Columbia (Attorney General)***, [1993] 3 SCR 519, a case in which a divided Court refused physician-assisted death to a person with ALS. The Court also outlined legislative initiatives and reports from various organizations, and highlighted a change in the legislative landscape in which eight Western democracies now permit assistance in dying.

[21] One of the claimants in ***Carter 2015*** was Ms. Gloria Taylor, who suffered from ALS. The Court record in ***Carter 2015*** contained much information about this degenerative and terminal disease. The Supreme Court recognized at para 11:

> ALS patients first lose the ability to use their hands and feet, then the ability to walk, chew, swallow, speak and eventually breathe. Like Sue Rodriguez before her, Gloria Taylor did "not want to die slowly, piece by piece" or "wracked with pain"...

[22] The Court also quoted from Ms. Taylor's testimony in which she described the progression of her illness and her desire for a peaceful rather than an "ugly death." The Supreme Court noted at para 14 a constant theme running through the extensive evidence of all the witnesses. Whether they suffered from a motor neuron disease, Huntington's disease or advanced-stage cancer, "they suffer from the knowledge that they lack the ability to bring a peaceful end to their lives at a time and in a manner of their own choosing."

[23] The Court framed the issue in this way at para 1:

> It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.

[24] The Supreme Court agreed with the trial judge that the prohibition on assisted dying infringed Ms. Taylor's s. 7 rights by interfering with fundamentally important personal medical decision-making, imposing pain and psychological stress and depriving her of control over her bodily integrity. She was denied the opportunity to make a choice that may be very important to her sense of dignity and personal integrity and that is consistent with her lifelong values and life experiences. Ms. Taylor's security of her person was also impaired as she was forced to suffer physical and psychological pain.

[25] The Supreme Court recognized at para 67 that the law has long protected patient autonomy and medical decision-making. The Court said the right to decide one's own fate entitles adults to direct the course of their own medical care and underlies the concept of informed consent and s. 7's guarantee of liberty and security of the person.

[26] The s. 7 liberty interests are engaged when the state affects important and fundamental life choices. People seeking physician-assisted death do so out of deeply personal and fundamental beliefs about how they wish to live or cease to live. Such a decision is rooted in their control over their bodily integrity and represents their deeply personal response to serious pain and suffering. The Supreme Court held that by denying them the opportunity to make that choice, the prohibition infringes on their liberty and security of the person. While s. 7 recognizes the value of life, it also honours the role autonomy and dignity play at the end of that life.

[27] At para. 66 the Supreme Court said:

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> An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The law allows people in this situation to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment, but denies them the right to request a physician's assistance in dying. This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty. And, by leaving people like Ms. Taylor to endure intolerable suffering, it impinges on their security of the person.

[28] The Court then canvassed the principles of fundamental justice and concluded that the prohibition on assisted dying was overbroad. While the impact of the prohibition was severe, they made no finding in regards to gross disproportionality.

[29] The Court found the impugned provisions could not be saved under s. 1. The Court accepted that the purpose or object of the impugned criminal prohibition against assisted death is to protect vulnerable persons from being induced to take their own lives in times of weakness. The Court explicitly rejected a submission that the purpose of the prohibition should be defined as simply "the preservation of life." While protecting the vulnerable was a legitimate purpose, the prohibition was not a reasonable limit on the applicant's s. 7 rights because an absolute prohibition is not minimally impairing. The Supreme Court stated at para 117 that the risks associated with physician-assisted death could be managed by a carefully designed and monitored system of safeguards.

[30] As a result of these findings, the Supreme Court of Canada struck down those provisions of the *Criminal Code* prohibiting physician-assisted death, stating at para 127:

> The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the *Criminal Code* are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable," it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought.

[31] The Supreme Court suspended its declaration of invalidity for 12 months, ending February 6, 2016.

[32] Earlier in the action, the trial judge had struck down the impugned provisions and suspended the declaration of invalidity for one year: see ***Carter v Canada (Attorney General)***, 2012 BCSC 886, 261 CRR (2d) 1 ("***Carter 2012***"). The trial judge also granted a personal constitutional exemption to Ms. Taylor during that period of suspension and the final order outlined certain requirements before Ms. Taylor could avail herself of that exemption. On October 4, 2012, Ms. Taylor died from complications of her medical condition, without seeking to invoke her personal exemption.

[33] In ***Carter 2015***, the Supreme Court specifically declined to create a mechanism for personal exemptions during the 12-month period in which its declaration of invalidity was

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suspended. Ms. Taylor had died by the time the Supreme Court heard the matter and none of the remaining litigants sought a personal exemption. The Court held at para 125 that legislators were best suited to enact the type of complex regulatory regime required and that stand-alone constitutional exemptions had the potential to create uncertainty, to undermine the rule of law and to usurp Parliament's role.

B. Developments after *Carter 2015*

[34] Many governments and organizations worked diligently to respond to ***Carter 2015***. Criminal law is a federal power, but health law may involve both federal and provincial governments. As the Supreme Court stated in ***Carter 2015*** at para 53, "Health law is an area of concurrent jurisdiction; both Parliament and the provinces may validly legislate on the topic... This suggests that aspects of physician-assisted dying may be the subject of valid legislation by both levels of government, depending on the circumstances and focus of the legislation."

[35] The Québec government enacted *An Act Respecting End-of-Life Care*, CQLR c S-32.0001 to govern physician-assisted dying in that province. The stated purpose of the legislation, which came into force in December 2015, is to ensure that end-of-life patients receive care that respects their dignity and their autonomy. Section 2 states:

> The provision of end-of-life care is to be guided by the following principles:
>
> (1) respect for end-of-life patients and recognition of their rights and freedoms must inspire every act performed in their regard;
>
> (2) end-of-life patients must be treated, at all times, with understanding, compassion, courtesy and fairness, and with respect for their dignity, autonomy, needs and safety; and
>
> (3) the healthcare team providing care to end-of-life patients must establish and maintain open and transparent communication with them.

[36] End-of-life care is defined to include palliative care and medical aid in dying. Section 5 gives statutory form to the right patients have under civil law to refuse or withdraw consent to life-sustaining care. See ***Nancy B v Hôtel-Dieu de Québec***, [1992] RJQ 361, 86 DLR (4th) 385 (Qc Sup Ct).

[37] Québec's *Act* permits medical aid in dying to patients who meet the criteria in section 26. In particular, eligible patients must:

1. be of full age;
2. be capable of giving consent to care;
3. be an insured person within the meaning of the *Health Insurance Act*, RSQ c A-29;
4. be at the end of life;
5. suffer from a serious and incurable illness;
6. be in an advanced state of irreversible decline in capability; and
7. experience constant and unbearable physical or psychological suffering which cannot be relieved in an manner the patient deems tolerable.

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[38] In Québec, a patient must initiate the request for medical aid in dying, using a standard form. The form must bear the patient's signature and be witnessed by a health or social services professional. The *Act* establishes an exception to the general rule requiring the patient to sign the form if the patient is physically unable to do so: section 26. A patient may withdraw his or her request or delay aid at any time and by any means: section 27.

[39] The *Act* then sets out prerequisites that the physician must satisfy before he or she may provide medical aid in dying: section 29. This includes, among other things, taking steps to ensure a patient meets the criteria noted above in section 26, verifying the reliability of the patient's consent, informing patients of their prognosis and alternative therapies that may be available, verifying the persistence of a patient's suffering, confirming at regular intervals that the patient still wishes to die, discussing the request with members of the patient's care team, discussing the request with the patient's "close relations" if the patient so wishes, ensuring that patients have had an opportunity to discuss the request with anyone they wish to contact, and obtaining a second physician's opinion as to whether section 26's criteria have been met.

[40] Finally, section 30 compels the physician who ensured that all of these conditions were met to personally administer medical aid in dying to the patient. The physician must also stay with the patient until death.

C. *Carter 2016*

[41] In October 2015, Canadians elected a new federal government. The Attorney General of Canada sought a six month extension of ***Carter 2015***'s suspended declaration of invalidity on the basis that Canada needed more time to craft an appropriate legislative response. Those opposing the extension argued that it created hardship and severe harm to force individuals who qualified for physician-assisted death under ***Carter 2015*** to wait another six months. They also argued that it would be unfair to allow Québec residents to access medical aid in dying under Québec legislation, when others in similar circumstances but different jurisdictions lacked comparable access.

[42] In ***Carter v Canada (Attorney General)***, 2016 SCC 4 ("***Carter 2016***"), all members of the Supreme Court of Canada granted an extension but limited it to four months, being the amount of time the federal government's work on a legislative response to ***Carter 2015*** was interrupted by the intervening election and change of government. As a result, the Supreme Court's declaration of invalidity from ***Carter 2015*** will now expire on June 6, 2016.

[43] In ***Carter 2016***, the Supreme Court split on what should happen in this interim four-month period to persons seeking physician-assisted death in Québec and elsewhere. The four-judge minority, for reasons already articulated in ***Carter 2015*** at para 125, would not have exempted Québec from the extended suspension or allowed personal exemptions.

[44] The five-judge majority granted both exemptions and in terms that are very important.

[45] The majority noted that the Attorney General of Canada and the provincial Attorneys General who participated in the hearing did not oppose Québec's request for an exemption. Québec argued that such an exemption was necessary to clarify the legal position in that province, given that it had already enacted legislation dealing with end-of-life assistance. The majority expressed no view as to the validity of the Québec legislation but stated "we would

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grant the exemption." Thus physician-assisted death in Québec will, during the four-month extension, be governed by its legislation and applicants must meet its requirements.

[46] The majority also granted a personal constitutional exemption to the group of individuals who meet the requirements of para 127 in ***Carter 2015***—that is, competent adults who consent to physician-assisted death and have a grievous and irremediable medical condition that causes intolerable enduring suffering. They did so in the following terms at para 6:

> This is the first time the Court has been asked to consider whether to grant individual exemptions during an *extension* of a suspension of a declaration of invalidity. Parliament was given one year to determine what, if any, legislative response was appropriate. In agreeing that more time is needed, we do not at the same time see any need to unfairly prolong the suffering of those who meet the clear criteria we set out in [***Carter 2015***]. An exemption can mitigate the severe harm that may be occasioned to those adults who have a grievous, intolerable and irremediable medical condition by making a remedy available now pending Parliament's response. The prejudice to the rights flowing from the four-month extension outweighs countervailing considerations. Moreover, the grant of an exemption from the extension to Québec raises concerns of fairness and equality across the country. We would, as a result, grant the request for an exemption so that those who wish to seek assistance from a physician in accordance with the criteria set out in para. 127 of our reasons in [***Carter 2015***], may apply to the superior court of their jurisdiction for relief during the extended period of suspension. Requiring judicial authorization during that interim period ensures compliance with the rule of law and provides an effective safeguard against potential risks to vulnerable people. [Underlining added, italics in original]

[47] The underlined words show that the Court was not merely saying that a person could apply to a court for a personal constitutional exemption, pending Parliament's response. Rather, they were granting that remedy immediately to those adults who have a grievous, intolerable and irremediable medical condition.

[48] The majority has thus already granted the remedy of a constitutional exemption to all those who meet its criteria. The role given to authorizing courts is to hear individual applications and determine whether a particular claimant is inside or outside the group which has already been granted the constitutional exemption. The judicial task of the authorizing court is therefore limited to determining whether a particular claimant satisfies the terms of para 127 of ***Carter 2015***.

[49] This important distinction is worth exploring as there appears to have been some confusion on this point. Under general legal principles, any individual may attack state action and challenge its constitutionality under the *Canadian Charter of Rights and Freedoms*. While most claimants seek a general declaration that the state action is invalid, a claimant may seek a remedy by way of a personal exemption. Usually this involves an allegation that even if the state action is generally valid, it becomes unconstitutional in its application to the applicant's particular circumstances. The applicant mounts a full-blown constitutional challenge. Notice is generally given to the relevant Attorneys General and the claimant bears the burden of proving an infringement of his or her *Charter* rights. If an infringement is established, the burden will shift to the government to demonstrate that the state action can be saved under s. 1. This is what

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occurred in ***Carter 2015***. Ms. Taylor produced a voluminous record on multiple topics, attacked criminal prohibitions against assisted death and sought a personal exemption. After a full review of all constitutional rights and interests at play, the trial judge granted a personal exemption as a remedy to Ms. Taylor.

[50] Had ***Carter 2016*** not been decided in the manner it was, it would have been open to any individual to ask a court for a personal exemption to allow him or her to have a physician-assisted death during the period in which the declaration of invalidity had been suspended. A court application for the remedy of a personal exemption would also require a full constitutional analysis.

[51] By contrast, in the case at bar, this Court is not being asked to grant a constitutional exemption. That exemption was granted by the majority of the Supreme Court in ***Carter 2016***. The role of this Court is limited to applying or authorizing an existing constitutional exemption and determining whether a particular person qualifies for that exemption. Given the majority's decision in ***Carter 2016,*** the narrow question in this application is therefore whether Ms. S. is a person to whom the Supreme Court has already granted an exemption.

[52] That the majority in ***Carter 2016*** already has granted an exemption for a group of qualifying individuals is clear from the paragraph quoted above, as well as the express wording of other parts of their judgment. For example, they frame the issue at para 1 in the following way: "the appellants and certain interveners ask this Court to grant a constitutional exemption for individuals who wish to seek assistance in ending their life during the period of any extension."

[53] At para 5 they again articulate the issue as:

> The third question is whether, during the four-month extension, the Court should grant an exemption for those who wish to seek assistance in ending their life on the bases articulated in our reasons in [***Carter 2015***]. The appellants argue that fairness and equality require this, particularly if Québec is exempted from the extension.

[54] Their express wording in para. 7 is a further demonstration of their clear intention to grant the exemption:

> Finally, during the four-month extension period, we grant an exemption to those who wish to exercise their rights so that they may apply to the superior court of their jurisdiction for relief in accordance with the criteria set out in para 127 of our reasons in [***Carter 2015***]. [Emphasis added.]

[55] Moreover, there would have been no need for the Supreme Court to address exemptions if all they were doing was allowing people a right to mount individual constitutional challenges and to seek personal constitutional exemptions. That option exists without comment from the Court and an ability to apply for an exemption would not have generated the controversy that resulted in four judges dissenting.

[56] Further, given that Québec was granted an exemption, only the actual granting of a similar exemption to others would support the majority's desire for fairness and equality. Thus, the majority has established parallel grants. In Québec, claimants must meet that province's legislative requirements. For people in jurisdictions without legislation, the majority have granted an exemption that is accessed through a process of judicial authorization, in which the motions court applies the criteria established in ***Carter 2015***.

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[57] That the majority have already granted the constitutional exemption as a remedy to the group who qualify under para 127 of ***Carter 2105*** has important implications for the nature and scope of the hearing to be conducted on such applications before the motions judge. The judge is not called upon to conduct a full-blown inquiry as to whether a claimant has established an individual case for a personal constitutional exemption, a balancing exercise that would require the participation of Attorneys General and perhaps other affected parties.

[58] Instead, the job of the motions judge is simply to determine whether a particular claimant meets those articulated criteria. The singular question the Supreme Court has directed the superior courts to answer in this type of application is whether the applicant falls within that group. This limited inquiry is individual- and fact-specific. The motions judge must be mindful of the legal framework and overall constitutional context of the inquiry; it is a rights-rich context. However, there is no opportunity or need to re-litigate the various rights and interests fully considered by the Supreme Court's unanimous decision in ***Carter 2015***.

[59] The question, properly understood after ***Carter 2016,*** is: does this person fall within the group of persons to whom a constitutional exemption has already been granted?

4. The Issue

[60] Given this analysis, Ms. S. has stated the issue correctly when she asserts:

> The issue before the court is whether or not the applicant meets the criteria set out in ***Carter 2015*** for a declaration by this court that she is eligible for a physician-assisted death.

[61] In the following sections I first canvass issues of process and evidence. I then review each requirement in para 127 of ***Carter 2015*** and conclude that Ms. S. has satisfied the Court that she meets all the criteria from ***Carter 2015*** and therefore qualifies for the constitutional exemption granted by the Supreme Court in ***Carter 2016***.

5. Process and Evidence

[62] The Supreme Court of Canada in ***Carter 2016*** charged the motions court with the task of screening individual applications for physician-assisted death based on the criteria it had established in ***Carter 2015***. The Court did not prescribe particular procedures or evidence for the superior courts to consider in conducting the requisite factual inquiry. In this section I address issues relating to notice, confidentiality and evidence. Before doing so, I would like to make two comments.

[63] First, shortly after the release of ***Carter 2016***, the Chief Justice of the Ontario Superior Court of Justice published a *Practice Advisory – Application for Judicial Authorization of Physician Assisted Death*. In addition, on the day of the hearing of this application, the Chief Justice of the British Columbia Supreme Court published a *Notice Regarding Applications for Exemption from the Criminal Code Prohibition Against Physician Assisted Death*. These protocols lack legislative force and are intended as practice advisories or practice notes within their provinces on such issues as notice, confidentiality, and the type, amount and form of evidence, as well as matters of timing and scheduling.

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[64] While both protocols are based on the two ***Carter*** decisions and have certain similarities, each province has adopted slightly different rules and approaches. In my view, some of the suggestions or requirements are broader and more onerous than how I read the ***Carter 2015*** requirements.

[65] Alberta does not have such a protocol. In this province, the proceedings should be based on what ***Carter*** says (and does not say), supplemented, as necessary, by general principles and any guidance thought appropriate from the Québec legislation and these two provincial protocols.

[66] Second, Ms. S. provided this Court with the *Final Report on Consultations on Physician-Assisted Dying* from the federal government dated December 15, 2015 and the *Final Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying*. On the day of the hearing, a special Parliamentary committee published its recommendations in a report entitled *Medical Assistance in Dying: A Patient-Centred Approach*.

[67] I have reviewed these documents which contain a full consideration of relevant issues, from the viewpoint of possible legislative and regulatory responses. While they provide background and context, they address different and larger questions, compared with the more narrow focus of individual judicial authorizations. For example, the federal *Final Report* recognized that there were many legislative options available, saying at page 52 that ***Carter 2015*** established "a floor, and not a ceiling" in respect of the constitutional rights at play. Parliament is free to consider issues beyond those addressed in ***Carter 2015***. However, this Court is bound to stay within the four corners of the ***Carter 2015*** analysis.

[68] Further, legislators are called upon to contemplate and address general rules, for all foreseeable types of cases and in relation to every "illness, disease or disability" considered in ***Carter 2015***. The various reports show a great diversity of opinion on what would constitute appropriate legislative requirements and safeguards. Again, by contrast, the focus of the judicial authorization process established in ***Carter 2016*** is on a particular person, his or her particular condition, and the actual record before the court.

A. Notice

[69] Notice of this application was given to the Attorneys General of Canada, Alberta and British Columbia. Attorneys General are to be given notice of constitutional challenges to state action within their jurisdiction. Both the Ontario and British Columbia protocols require notice to the Attorney General of Canada and the relevant provincial Attorneys General.

[70] The Attorney General of Canada provided no response to counsel and did not attend or participate in the hearing. The Attorney General of Alberta took no position on the application but had a lawyer attend the hearing. The Attorney General of British Columbia wrote to counsel for Ms. S. and asked counsel to bring its comments and suggestions to the attention of this Court. That was done and this letter forms part of the Court record.

[71] Counsel for Ms. S. argued that notice was given only as a courtesy as the Supreme Court has already dealt fully with the constitutional dimensions of the application by granting an exemption in ***Carter 2016.*** There is some merit in this position, especially given the limited factual inquiry to be undertaken in the process of judicial authorization. However, there is practical merit to providing notice to allow the Attorneys General the opportunity to make

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submissions in the public interest. The comments of the Attorney General of British Columbia in the case at bar supported a more complete consideration of the issues.

[72] No notice was required to Ms. S.'s family members who live outside Canada. Her evidence is that she has informed those close to her of her plans for a physician-assisted death. In addition, her spouse and best friend were in Court with her as this application was made.

[73] Several organizations have sent letters to the Chief Justice, providing information and asking to be notified of applications for physician-assisted death. Such organizations include Alberta Health Services, the Alberta College of Pharmacists, and regulatory organizations representing nursing professions in Alberta. Alberta Health Services says "it takes no position regarding whether physician-assisted death is appropriate in any specific patient's circumstances."

[74] In my view, this is the correct approach as such organizations have no apparent role to play on the merits of an application when the focus is on whether a particular individual meets the criteria established in ***Carter 2015***. Questions such as whether an applicant is enduring intolerable suffering and consents to the termination of life are not issues amenable to evidence from these organizations. As previously stated, the constitutional dimensions of physician-assisted death have been fully canvassed in ***Carter 2015.***

[75] Depending on the circumstances, it may, however, be appropriate to seek the assistance of some or all of such organizations in the crafting of an order if the court finds that the criteria are met. These organizations have said they are available to assist lawyers who take such applications. The plan for physician-assisted death placed before the court in the application will likely guide which non-parties, if any, may provide useful information or wording. In the case at bar, for example, only physicians and no nurses will be involved in the death of Ms. S. There is therefore no need to seek input from nurses. Similarly, since Ms. S. intends her physician-assisted death to occur at a private place in British Columbia, there is no need to involve Alberta Health Services.

[76] Therefore, I find there has been sufficient notice.

B. Confidentiality Concerns

[77] At the outset of the hearing, counsel for Ms. S. asked that the proceedings be held *in camera*. I heard from a representative of the media who argued the public's right to know should be protected. A lawyer who represents physicians was also in attendance and explained why he requested to watch a new type of application of interest to his clients.

[78] At the hearing, counsel for Ms. S. also requested various forms of confidentiality orders: sealing the Court file, sealing the affidavits, a publication ban on Ms. S.'s name, and the use of initials to protect the identities of Ms. S. and of the physicians and others involved in this matter.

[79] It is preferable for matters of confidentiality to be addressed when the Originating Application is filed to allow the motions judge to consider whether there is any need for preliminary orders. However, as this is the first application of its kind in this province and the matter is time-sensitive, I am prepared to deal with these requests in the context of the overall hearing.

[80] The Court is very mindful of the important reasons underlying the open court principle. The Supreme Court of Canada has held that this principle is "a hallmark of a democratic

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society", that it ensures "that justice is administered in a non-arbitrary manner, according to the rule of law" and that it is "inextricably linked to the freedom of expression protected by s. 2(b) of the *Charter*": see ***Dagenais v Canadian Broadcasting Corp.***, [1994] 3 SCR 835, ***R v Mentuck***, [2001] 3 SCR 442, 2001 SCC 76 and ***Re Vancouver Sun***, 2004 SCC 43, 2 SCR 332.

[81] However, in the circumstances, I determined that Ms. S.'s privacy, dignity and autonomy were the more important interests and the hearing was held *in camera*. This application pertains to Ms. S.'s medical state and to the fundamental life choice she wishes to make. Nothing could be more personal and, in my view, the need to protect Ms. S.'s privacy outweighs the benefit of an open courtroom in the circumstances of this case. I also note that the subject of the hearing, being her medical diagnosis and current physical condition, falls within the category of information that ordinarily would be protected under privacy legislation.

[82] Further, this written judgment provides an alternative mechanism for achieving accountability and transparency and respects the fundamental principles behind the open court principle. It provides what the Supreme Court of Canada in ***Re Vancouver Sun*** called the openness "necessary to maintain the independence and impartiality of courts."

[83] In ***Dagenais*** and in ***CBC v New Brunswick (Attorney General)***, [1996] 3 SCR 480, cases referred to in ***Re Vancouver Sun***, the Supreme Court of Canada set out the test for a publication ban. More recently, the Supreme Court refined the test in the companion cases of ***Mentuck*** and ***R v ONE***, 2001 SCC 77, 3 SCR 478. The following comments from para 32 of ***Mentuck*** are instructive:

> The ***Dagenais*** test requires findings of (a) necessity of the publication ban, and (b) proportionality between the ban's salutary and deleterious effects. However, while ***Dagenais*** framed the test in the specific terms of the case, it is now necessary to frame it more broadly so as to allow for consideration of the interests involved in the instant case and other cases where such orders are sought in order to protect other crucial aspects of the administration of justice. In assessing whether to issue common law publication bans, therefore, in my opinion, a better way of stating the proper analytical approach for cases of the kind involved herein would be:
>
> > A publication ban should only be ordered when:
> >
> > (a) such an order is necessary in order to prevent a serious risk to the proper administration of justice because reasonable alternative measures will not prevent the risk; and
> >
> > (b) the salutary effects of the publication ban outweigh the deleterious effects on the expression, the right of the accused to a fair and public trial, and the efficacy of the administration of justice.

[84] I find that the circumstances of this case demonstrate the necessity of confidentiality orders as required by ***Dagenais***. Further, it is to be hoped the presence of a written judgment strikes the appropriate balance between the salutary and deleterious effects of such an order and achieves the openness and public access discussed in ***Re Vancouver Sun***.

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[85] In addition, this Court has the ability to issue restrictions pursuant to the Alberta Rules of Court, Alta Reg 124/2010, *Rule* 6.28, which is contained within **Division 4—Restriction on Media Reporting and Public Access to Court Proceedings**, and provides as follows:

> 6.28 Unless an enactment otherwise provides or the Court otherwise orders, this Division applies to an application for an order
>
> (a) to ban publication of court proceedings,
>
> (b) to seal or partially seal a court file,
>
> (c) permitting a person to give evidence in a way that prevents that person or another person from being identified,
>
> (d) for a hearing from which the public is excluded, or
>
> (e) for use of a pseudonym.

[86] I note that these general provisions are subject to a significant proviso: unless the Court otherwise orders. In my view, the Court may exercise its discretion to depart from these general rules in this distinctive type of application. Accordingly, I am satisfied that it is appropriate in this case to have proceeded *in camera*. Further, I order that the Court file and affidavits in this matter will be sealed, and that this judgment will be released with the parties and people involved identified by initials only.

C. Evidence

[87] The task set by the Supreme Court in ***Carter 2016*** is to determine whether an individual applicant meets the ***Carter 2015*** criteria. The Court did not prescribe or dictate what type or amount of evidence would satisfy its stated criteria. As such, it becomes a matter for the motions judge to make the determination based on evidence he or she considers sufficient.

[88] Under accepted general principles, the claimant carries the burden to establish that she falls within the constitutional exemption granted in ***Carter 2016.*** She is entitled to meet her burden based on any form of admissible, authentic and reliable evidence. The motions judge retains the discretion to accept all, some or none of the admissible evidence.

[89] Ms. S. provided evidence in the form of two affidavits: an Initial Affidavit dated February 19, 2016 and a Supplementary Affidavit dated February 23, 2016. Attached as exhibits to her Initial Affidavit were statements from her treating physician, the physician who plans to assist her death, medical records and statements from various other physicians from the Calgary ALS and Motor Neuron Disease Clinic, a letter from her best friend of 38 years and a letter written by Ms. S. to her counsel describing her life. Ms. S. attests that all the information contained in those statements is accurate and correct.

[90] In my view, it is preferable to have affidavits sworn by the physicians themselves, but attaching evidence as an exhibit to a sworn affidavit is a common practice and an accepted mode of presentation. Such practice may affect the weight a judge is prepared to place upon the evidence but such evidence is clearly admissible. There is no challenge to the authenticity of any of the exhibits to Ms. S.'s Initial Affidavit and I find them to be authentic and reliable.

[91] This record is not deficient simply because it is not as extensive or in the form proposed by Ontario's *Practice Advisory* or British Columbia's *Notice*. For example, no affidavits have been provided from Ms. S.'s attending physician, from a consulting psychiatrist or from the

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physician proposed to assist death. The Ontario protocol provides what "should" be done and contemplates affidavit evidence from four persons: the applicant, the attending physician, a consulting psychiatrist and the physician proposed to assist death. The British Columbia protocol requires affidavits from the applicant and two physicians. The two physicians can be the treating physician and the physician assisting in the death. There is no requirement for an affidavit from a psychiatrist or psychologist. By way of further contrast, the Québec legislation does not require sworn testimony at all. The applicant need only fill out a prescribed form and the required statements of two physicians need not be sworn. Québec also does not require evidence from a psychiatrist or psychologist.

[92] Based on ***Carter 2016***, I conclude that I am entitled to take a flexible approach to the evidence on this kind of application. I note that I am bound only by the Supreme Court's directive and not by the Ontario, British Columbia or Québec approaches. It will be up to the individual judge in an individual case to assess the admissibility, authenticity and reliability of the evidence before him or her.

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6. The *Carter 2015* Criteria

[93] Has Ms. S. demonstrated, based on admissible, authentic and reliable evidence that she satisfies all the criteria in para 127 of ***Carter 2015*** and therefore qualifies for the constitutional exemption granted by the Supreme Court in ***Carter 2016?***

[94] Ms. S., like Ms. Taylor in the ***Carter*** cases, is in the final stages of ALS. The Supreme Court had this very condition before it when it established the criteria in para 127 of ***Carter 2015***. I conclude Ms. S. has met her burden because:

A. she is a competent adult person;
B. she clearly consents to the termination of life;
C. she has a grievous and irremediable medical condition;
D. her condition causes enduring, intolerable suffering; and
E. her suffering cannot be alleviated by any treatment acceptable to her.

A. Ms. S. is a competent adult

[95] I find that Ms. S. is a competent adult. While competence is presumed, the record also is clear that she is mentally alert. There is no suggestion in any of the medical reports attached to her Initial Affidavit that her illness has in any way affected her mental capacity. Statements from her treating physician, assisting physician and her long-time friend support her competence. Indeed, her treating physician was "very impressed by [Ms. S.'s] clarity of thought." I note that Ms. S. attended the hearing of this application and it was clear to me from seeing her in the courtroom that she was fully engaged in and attentively following the proceedings.

[96] In the absence of any suggestion that Ms. S. lacks competence, there is no need to have evidence from a psychiatrist. Nowhere in the Supreme Court's decision is there a requirement for psychiatric evaluation. Such is not required in the Québec legislation or the British Columbia *Notice*. Only the Ontario *Practice Advisory* suggests that the applicant should include evidence from a psychiatrist. I am confident in these circumstances that the Court may make findings in respect of the ***Carter 2015*** criteria without the assistance of a psychiatrist.

[97] In ***Carter 2012***, the trial judge placed great emphasis on the issue of depression, referring to it at para 640 as a "crucial issue." The Supreme Court adopted a differently worded test, but what is paramount is that the evidence establishes that Ms. S. is not depressed. Indeed, she attests to that in her Initial Affidavit and I am mindful of her background as a clinical psychologist. In addition, her best friend M.V., a retired social worker, confirms that Ms. S. is fully competent mentally and is not depressed.

[98] There was some reference in part of the evidence to a one-time score on an ALS depression test which indicated a "possible mild depression." However, going back to the original source of this statement, dated July 22, 2015, her palliative care physician at the Calgary ALS and Motor Neuron Disease Clinic noted that on that day Ms. S. reported that "her mood is actually quite good and stated unequivocally at today's visit, 'I am not depressed.'"

[99] That physician concluded:

> I actually do not think that [Ms. S.] is depressed, although she does meet the criteria for mild depression on the ALS depression index.

[100] In a subsequent letter dated October 14, 2015, the same physician said:

> [Ms. S.] has no current plans to end her life, however, and feels that her mood is quite good. Looking at her ALS depression index, I would say that she is doing better than at our last visit as she is able to say that she is still finding meaning in life, looking forward to each day and no longer feels "empty inside" most of the time. Her score is no longer reflective of mild depression.

[101] Accordingly, I need take no position on whether depression should be considered as part of determining an applicant's competence as Ms. S. is not depressed.

[102] The Attorney General of British Columbia argued that any order should require that competence be established both at the time of application to the superior court and at the time of death. I do not believe this is necessary for two reasons. First, I am of the view that an ongoing determination of competence is part of and flows from the physician-patient relationship. I do not believe it is necessary for a court order to require this. Second, as a practical matter, the evidence before me is that, if her application is granted, Ms. S. will seek a physician-assisted death in the very near future. Therefore, I see no need to order a reassessment of her competence beyond the obligation placed on physicians to obtain genuine, ongoing, and informed consent to treatment.

B. Ms. S. clearly consents to physician-assisted death

[103] I am satisfied that Ms. S. fully and freely consents to the termination of her life. She clearly states this in her Affidavit.

[104] Her application is not made in a moment of weakness and her desire for physician-assisted death is long-standing. The evidence is that, since her diagnosis, she has explored various options around physician-assisted death. At various points in time she explored going to Switzerland, Basel and Québec. Her friend M.V. confirms this, stating that Ms. S. has been thinking about physician-assisted death for two years. The letters attached to Ms. S.'s Affidavit from the Calgary ALS and Motor Neuron Disease Clinic indicate that she had discussions with professionals there by at least July 2015. Those letters indicate that Ms. S. also discussed this

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subject with her spouse and her friends. She sought out the physician who will assist her. Ms. S. also expressly states that she waited until the release of ***Carter 2016*** before making this application. She states that she "would like to pass away peacefully and [is] hoping to have physician-assisted death soon."

[105] There is no suggestion in any of the documentation before the Court that Ms. S. was not rational or was being subjected to external pressure. Indeed, it appears that her spouse, who is her primary caregiver, was tearful, said he did not want her to die, and was resistant at first. After months of discussion, he respects her right to make this choice. Ms. S.'s friend M.V. confirms that Ms. S. is under no pressure from her husband or friends. Her treating physician notes that Ms. S. "has not swayed from her resolve of ending her life in a peaceful manner."

[106] Ms. S. understands her medical diagnosis and prognosis. She attended the Calgary ALS and Motor Neuron Disease Clinic and has been informed of the feasible treatments, including options in relation to palliative care. She has received counselling in relation to palliative care.

[107] Ms. S. has been informed of the risks associated with physician-assisted death and the probable result of the medication proposed for use in her physician-assisted death.

[108] She understands fully that it is her choice and that she has a continuing right to change her mind about terminating her life.

C. Ms. S. Suffers from ALS, a grievous and irremediable medical condition

[109] I have no difficulty in concluding that ALS is a grievous and irremediable medical condition. It is widely understood to be a progressive and ultimately terminal disease that has no cure. Indeed, it is the disease suffered by Ms. Taylor, one of the applicants in ***Carter 2012***. After discussing the meaning of "grievously and irremediably ill persons," Justice Smith of the British Columbia Supreme Court granted a constitutional exemption to Ms. Taylor, holding at para 1411 that "The circumstances of this case fit within the narrow range of cases in which a constitutional exemption is appropriate under ***Ferguson*** [2008 SCC 6, [2008] 1 SCR 96]." Justice Smith also noted the evidence before her respecting ALS at para 47:

> ALS is a neurodegenerative disorder that causes muscle weakness and eventually progresses to near total paralysis. As neurologists Dr. Sharon Cohen and Dr. Scott Meckling explain, while cognition and sensation remain generally intact, ALS patients become increasingly incapacitated. They lose the ability to use their hands and feet; the ability to walk, to chew and to swallow; the ability to make their speech intelligible to others; and, ultimately, the ability to breathe. The average time from diagnosis to death is three years.

[110] Ms. S.'s assisting physician states that Ms. S.'s illness is terminal and that her prognosis is less than six months.

D. Ms. S.'s ALS is causing her enduring, intolerable suffering

[111] The fourth criterion from ***Carter 2015*** is that the applicant's medical condition must cause enduring suffering that is intolerable to the individual. Ms. S. attests expressly to this criterion in her Supplementary Affidavit. In both her Affidavits, she refers to her desire to avoid dying by choking on her own bodily fluids. It is clear that she suffers from frequent choking incidents. She is unable to get restful sleep because of the need for her to be moved frequently throughout the night. The letters from the Calgary ALS and Motor Neuron Disease Clinic

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indicate that she has ongoing issues with pain. She states in her Initial Affidavit that she is in constant discomfort but chooses not to take much pain medication because she prefers to remain alert.

[112] Ms. S. states that she needs constant care, with her spouse acting as her primary caregiver. Her friend M.V. notes that Ms. S. finds her near total dependence on others very difficult. Her assisting physician states that, in addition to her constant discomfort, Ms. S. suffers because she has permanently lost control over her bodily functions and is losing her ability to communicate.

[113] In my view, Ms. S. has provided sufficient evidence to ground a finding by this Court that her condition causes enduring and intolerable suffering.

E. Ms. S.'s suffering cannot be alleviated by any treatment acceptable to her

[114] Letters from two physicians at the Calgary ALS and Motor Neuron Disease Clinic speak to Ms. S.'s "ever declining state of health" and to her "deteriorating steadily at each visit." In her Initial Affidavit, Ms. S. states that she has stopped attending the Clinic because there is nothing they can do to slow the progress of her illness. It is clear that there is no treatment that will reverse or halt Ms. S.'s ALS. Her assisting physician confirms in her letter exhibited to Ms. S.'s Initial Affidavit that Ms. S.'s condition is terminal.

[115] There is reference in the letters from the Calgary ALS and Motor Neuron Disease Clinic attached to Ms. S.'s Initial Affidavit to a medication prescribed to her for the purpose of thinning her secretions. However, her email to her counsel dated February 8, 2016 and exhibited to her Initial Affidavit states that repeated choking continues to cause her distress. Thus, I conclude that this treatment does not alleviate this aspect of Ms. S.'s suffering. Further, there is reference both in Ms. S.'s Initial Affidavit itself and in the letters exhibited thereto to continuous pain and to Ms. S.'s reluctance to take prescription medication for her pain.

[116] Ms. S. expressly states in her Supplementary Affidavit that her suffering cannot be alleviated by any treatment acceptable to her. She states that there are no palliative care options that are acceptable to her and that "it is not acceptable to me to live sedated to the point of unconsciousness until I choke on my own bodily fluids."

[117] Based on all of this, I find that Ms. S. meets this criterion from ***Carter 2015*** as well.

F. Conclusion and Terms of Order

[118] Based on the foregoing analysis, I find that Ms. S. meets the criteria set forth at para 127 of ***Carter 2015*** and is therefore entitled to the constitutional exemption granted by the Supreme Court of Canada in ***Carter 2016***. Like Ms. Taylor, she is not a vulnerable person who requires the protection of those sections of the *Criminal Code* impugned in ***Carter 2015***.

[119] If, however, I am wrong in my reading of ***Carter 2016*** and the application to which the Supreme Court of Canada referred is an application to this Court for a constitutional exemption, then I would grant the exemption. Like the majority of the Court in ***Carter 2016*** at para 6, I do not "see any need to unfairly prolong the suffering of those who meet the clear criteria ... set out in [***Carter 2015***]." It is clear that Ms. S. is such a person.

[120] Counsel for Ms. S. suggested that the order need only declare that Ms. S. qualifies for a physician-assisted death. In my view, a greater role and responsibility on the court was intended

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when judicial authorization was established as the safeguard to protect the rule of law and the vulnerable.

[121] Other considerations also arise as Ms. S. has averred that she intends to have the assistance of two physicians in British Columbia and to die on private property in Vancouver. These physicians are named in the documents filed in Court but will not be specifically mentioned in the order. The Québec legislation requires that the physician personally perform what is called "medical aid in dying" and stay until death ensues. The evidence before me is that this is also what is contemplated in relation to Ms. S. The order should reflect this.

[122] The Attorney General of British Columbia questions whether an Alberta order would grant the necessary authority for medical practitioners in British Columbia, but made no submissions on this point. Notwithstanding this cross-jurisdictional aspect of this matter, I am satisfied that I have jurisdiction to hear this application and to grant a permissive and protective order. Persons who seek a physician-assisted death are told by the Supreme Court in ***Carter 2016*** to apply "to the superior court of their jurisdiction." I take this to mean the applicant's jurisdiction of residence which, in Ms. S.'s case, is Alberta. The constitutional exemption for which Ms. S. qualifies is personal to her and should accompany her throughout Canada, a country where she enjoys mobility rights. The constitutional exemption for which she qualifies flows from her *Charter* rights and such rights are part of the supreme law of the land. Her constitutional exemption is also granted in relation to a countrywide, federal prohibition.

[123] Further, while the constitutional exemption is personal to her, it clearly contemplates the assistance of others. That those individuals may be in a different jurisdiction than the jurisdiction in which she is obliged to apply, is secondary to the fact of the exemption. Had Ms. S. attempted to obtain a declaration in British Columbia, she might have been met with an argument that she has habitually resided in Alberta.

[124] The Supreme Court of Canada at para 40 of ***Carter 2015*** defined "physician-assisted death" or "physician-assisted dying" as "...the situation where a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient." Exactly who is protected under the Supreme Court's use of that term has generated much debate, especially in health care settings where physicians work as part of treatment teams that involve nurses, nurse practitioners, pharmacists, technicians and others. Given the evidence that only physicians will be involved with Ms. S., it is not necessary for this Court to address this question in respect of nurses and others.

[125] However, Ms. S.'s Supplementary Affidavit outlines the medications recommended by the physicians to bring about her death. In written submissions provided to counsel for Ms. S. and the Court, the Attorney General of British Columbia argued that pharmacists, as well as physicians, should be included in any order granted.

[126] It is clear to me that licensed pharmacists who prepare and provide medications are necessarily and definitionally protected under the term "physician-assisted death." The Supreme Court expressly incorporates medication into its definition of physician-assisted death. What is contemplated is not death by a doctor, but a physician-assisted process designed to allow for a relatively painless and peaceful death through the use of pharmaceuticals. For the goals of ***Carter 2015*** to be achieved, the medications to be used must be capable of being accessed in a safe and professional manner. In my view, pharmacists are part of the term "physician-assisted death"

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because, without them, physicians would be incapable of providing medication and assisting in the manner contemplated in ***Carter 2015***. Nevertheless, I accept that an express protection provides greater certainty and a licensed pharmacist who prepares and provides the medication prescribed by the physician will also be exempt from the operation of the impugned provisions of the *Criminal Code*.

[127] I am satisfied, based on the evidence before me, that Ms. S. meets all the criteria under para 127 in ***Carter 2015***. Ms. S. is permitted a physician-assisted death if she so chooses.

Heard on the 25th day of February, 2016.
Dated at the City of Calgary, Alberta this 29th day of February, 2016.

S.L. Martin
J.C.Q.B.A.

Appearances:
Olivier Fuldauer
Courtney Aarbo Fuldauer LLP
for the Applicant, Ms. S.
Nancy McCurdy
for the Attorney General of Alberta
Leah Greathead
for the Attorney General of British Columbia (by written submission)

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College of Physicians and Surgeons of British Columbia

Interim Guidance

Physician-assisted Dying

Preamble

On February 6, 2015, the Supreme Court of Canada (SCC) in *Carter v. Canada* struck down the provisions in the Criminal Code prohibiting physician-assisted dying (PAD) (sections 241(b) and section 14). However, the SCC suspended the decision for a period of 12 months. On January 15, 2016 the SCC extended the suspension for an additional four months from February 6, 2016 to June 6, 2016.

The SCC decision establishes PAD as a charter right for "a competent adult person who clearly consents to the termination of life and has a grievous and irremediable medical condition (including an illness, disease or disability) that causes suffering that is intolerable to the individual." The decision allows both assisted suicide, where the patient is provided assistance in intentionally ending his or her own life, and voluntary euthanasia, where a physician directly administers a lethal dose of medication in accordance with the wishes of the patient. The SCC also stated that "nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying."

The SCC, in its decision to extend the suspension to June 6, 2016 also granted an exemption to the suspension. The exemption permits individuals who wish to seek PAD in accordance with the criteria established by the SCC in *Carter* to apply to the Supreme Court of British Columbia for approval relief during the four-month extension.

On February 25, 2016 the Chief Justice of the Supreme Court of British Columbia posted the following notice for the benefit of those wishing to bring an application for an exemption from the Criminal Code prohibition against physician-assisted dying: Notice Regarding Applications for Exemption from the Criminal Code Prohibition Against Physician Assisted Death.

Where the court grants an exemption for PAD, any direction provided by the court in evaluating and/or granting this exemption takes precedence over the College's interim guidance, found below.

Registrants are expected to be aware of and comply with their legal, professional and ethical obligations and are encouraged to seek the guidance of legal counsel, or medical legal advice from the Canadian Medical Protective Association (CMPA). Registrants may also contact a member of registrar staff at the College to discuss professional and ethical obligations.

The College recognizes that there may be federal and/or provincial legislation in the near future that will address PAD. In the interim, the College acknowledges that it is in the public interest and in the interest of registrants to establish a process for physicians to follow when PAD issues

arise. When legislation relating to PAD is enacted, the provisions of the legislation will take priority over the provisions of this document.

Carter Decision

In its decision, the SCC established certain requirements that must be met in order for a physician to assist a patient to die:

A. The patient must be an adult.

B. The patient must consent.

   The SCC used the phrase a "competent adult person who clearly consents." PAD cannot be provided to patients who cannot provide consent.

C. The patient must have a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the patient.

   The SCC did not limit PAD only to patients who have a terminal illness. The term medical condition would include an illness, disease or disability. Nor is the patient required to undertake treatments that are not acceptable to the individual.

Rights and Autonomy

Patients have the right to make decisions about their bodily integrity (autonomy) and to have access to unbiased and accurate information about relevant medical issues and treatments. Physicians have an obligation to provide their patients with health information and health services in a non-discriminatory fashion and an obligation not to abandon their patients.

Physicians have the right to decide whether or not to perform physician-assisted dying.

Conscientious Objection

Physicians may make a personal choice not to assess patients for and/or perform PAD, based on their values and beliefs. The College expects the physician to provide patients with enough information and assistance to allow them to make informed choices for themselves. This includes consulting with other experts on relevant medical facts and, when needed, competency assessments.

Physicians who object to PAD on the basis of their values and beliefs are required to provide an effective transfer of care for their patients by advising patients that other physicians may be available to see them, suggesting the patient visit an alternate physician or service and, if authorized by the patient, transferring the medical records as required.

Where needed, physicians must offer assistance to the patient and must not abandon the patient. While a physician is not required to make a formal referral on behalf of their patient, they do have a duty of care that must be continuous and non-discriminatory.

Physicians should not discuss in detail their personal beliefs and should not pressure patients to disclose or justify their own beliefs. In all cases, physicians must practise within the confines of the legal system, and provide compassionate, non-judgemental care according to the CMA *Code of Ethics*.

Process

The process respecting PAD involves the opinion of two physicians, the attending physician and the consulting physician, and the patient's consistent expression of a desire for PAD over a reasonable period of time.

1. Both the attending and consulting physician in a situation of physician-assisted dying must:
    a. have the appropriate competencies, qualifications, experience and training to render a diagnosis and prognosis of the patient's condition, together with the appropriate technical knowledge and competency to provide PAD in a manner that is respectful to the patient
    b. have a complete and full discussion about PAD with the patient; physicians are expected to provide patients with all the information required to make informed choices about treatment and to communicate the information in a manner that is easily understood by the patient
2. The attending and consulting physician must agree that the patient meets the criteria as set out by the SCC:
    a. the patient has a grievous medical condition
    b. the condition must not be remediable using treatment that the patient is willing to accept
    c. the patient's suffering must be intolerable to the patient

    Physicians must assess a patient's suitability for PAD against the above criteria. A request for PAD is contextual to the patient's medical condition, its natural history and prognosis, treatment options, and the risks and the benefits associated with each option. Both the attending and consulting physician are responsible to ensure that the patient understands such factors, and is able to communicate a reasoned decision based on that understanding. When it is unclear whether these criteria have been met, a psychiatric or a registered psychologist's consult is required to evaluate the patient's decision-making capacity (or limitations) in greater detail.
3. Both the attending and consulting physician must be licensed for independent practice in their respective Canadian jurisdictions, and at least one physician must be licensed in British Columbia. The attending and consulting physician must not be related to the patient.
4. The attending and consulting physician should be independent of each other (for example, not be in the same practice group), recognizing that in small, rural or remote communities that this may not be possible.
5. Either the attending physician or the consulting physician, but not both, may provide their opinion by videoconferencing provided that there is a physician in physical attendance with the patient. At least one of the attending or consulting physicians must meet with the patient in person.
6. The patient must be an adult and eligible for publicly funded health care services.
7. The patient must be competent and able to give free and informed consent.
    a. Both the attending physician and consulting physician must be satisfied that the patient is

i. mentally capable of making a free and informed decision at the time of the request and throughout the process, and

ii. capable of giving free and informed consent to PAD.

b. If either physician is unsure whether the patient has the capacity to consent, the patient must be referred to a physician with special expertise in capacity assessments, such as a psychiatrist, neurologist or geriatrician, for further capacity assessment.

c. The patient must maintain mental capacity for PAD to proceed. If at any time during the progression of the patient's condition, the patient loses the mental capacity to rescind his or her decision, PAD ceases to be an option.

d. PAD cannot be provided to patients who are not able to give consent including when consent is given by an alternate or substitute decision-maker, or through a personal advance directive.

8. The consent must be voluntarily given by the patient.

    a. Both the attending and consulting physician must be satisfied on reasonable grounds that

        i. the patient’s decision to undergo PAD has been made freely, without coercion or undue influence from family members, health-care providers or others,

        ii. the patient has a clear and settled intention to end his or her life after making an informed decision, and

        iii. the patient has requested PAD himself or herself, thoughtfully and repeatedly in a free and informed manner.

9. The patient must be informed by the attending and consulting physician of the following and the information must be included in the patient’s medical record with a copy provided to the patient:

    a. patient's diagnosis and prognosis

    b. feasible alternatives (including comfort care, hospice care and pain control)

    c. option to rescind the request for PAD at anytime

    d. risks of taking the prescribed medication

    e. probable outcome/result of taking the medication

    f. recommendation to seek legal advice on life insurance implications

    In addition, the following information also needs to be included in the patient’s medical record:

    a. all written and oral requests for PAD and a summary of the discussion

    b. confirmation that, after the completion of all documentation the patient was offered the opportunity to rescind the request

    c. a note from the physician who prescribes/administers the medication that all the requirements have been met, including the steps taken and the medication prescribed

d. a copy of the medical certificate of death

10. The physicians must ensure that the patient has consistently expressed a desire for PAD over a reasonable period of time. What is a reasonable period of time will depend on the patient's medical condition and circumstances. In most situations, 15 days would be a reasonable period of time.
11. After the reasonable waiting period and following the completion of all documentation the patient is to be offered the opportunity to confirm or rescind the request.
12. The patient's decision to proceed with PAD requires a formal request which may be written by the patient or be oral and transcribed by another party. Both the attending and the consulting physician must obtain the written request from the patient. The request should confirm that the patient has given free and informed consent to PAD and that the requirements for PAD have been met. The written request must be dated, signed by the patient, and include the signature of a witness attesting to the identity of the patient. In both cases, the witness should not be: the attending or consulting physician; a relative; entitled to any portion of the estate; or an owner, operator, or employee of a health care facility where the patient is receiving treatment.
13. The medical certificate of death should indicate PAD arising out of the underlying grievous and irremediable medical condition.

Approved by Board January 21, 2016
Effective February 6, 2016
Revised February 25, 2016

Code of Ethics - Detailed
College of Pharmacists of British Columbia

Responsibility to Patients

Standard 1: Registrants Protect and Promote the Health and Well-Being of Patients

Guidelines for Application

a) Registrants are committed first and foremost to protecting and promoting the health and well-being of their patients.

b) Registrants practice only within the scope of their education, training and competence.

c) Registrants are aware of the limitations of their knowledge and expertise and refer as necessary and appropriate.

d) Registrants are knowledgeable of, and adhere to, national and provincial legislation, standards of practice and policies relevant to the practice of pharmacy.

e) Registrants maintain appropriate resources to facilitate their efforts to deliver services according to the standards of practice.

f) Registrants dispense, distribute, recommend and advertise drugs and health-related products that are approved by Health Canada.

g) Registrants must provide pharmacy services requested by patients and may only refuse to provide these services for any of the following reasons:

   i. the drug or product requested is not available

   ii. the registrant does not possess the knowledge, skills and abilities to provide the service or product

   iii. the registrant objects to the provision of the product or service on the basis of conscientious objection (a sincerely held belief that the provision of a particular product or service will cause the registrant to contravene their personal moral or religious value system). In the event of a conscientious objection to the provision of a product or service, registrant must ensure the following;
      - that they have informed and explained to their pharmacy manager and employer their conscientious objection before they accept employment.
      - that if the belief is formed after employment is accepted, they inform the pharmacy manager and employer at the earliest opportunity
      - that they do not, at any time, express their conscientious objection directly to the prescriber or the patient
      - that they, in goodwill, participate in the development and delivery of a system designed to respect the patient's right to receive products and

services in a timely and convenient manner which minimizes suffering and hardship to the patient
- that should the system developed to ensure the timely delivery of the product or service fail the registrant, not withstanding their conscientious objection, has a duty to the patient to provide the product or service requested
- that they do not utilize an appeal to conscientious objection in order to discriminate against any patient on morally irrelevant grounds including those outlined in *Standard 3, Guideline g* of this Code.

iv. the patient is unable or unwilling to provide payment for the requested pharmacy service or product

v. the patient is abusive physically or mentally to the registrant

Note: In the case of the above (g) the registrant must refer the patient as appropriate.

h) Registrants must provide essential pharmacy care throughout the duration of any job action or pharmacy closure.

i) In the event of either a patient emergency or a public emergency, registrants take appropriate action to provide care within their professional competence and experience.

Standard 2: Registrants Protect the Best Interests of their Patients In Achieving their Chosen Health Outcome

Guidelines for Application

a) Registrants utilize their professional judgment to protect the best interests of their patients in achieving their chosen health outcome.

b) Pharmacists support patients in making informed choices about their medical care by providing them with the benefits and risks associated with medication therapy. Risks are defined as the most frequent and serious adverse effects.

c) Pharmacists provide information that is evidence based, relevant, up-to-date and consistent with the standard of care.

d) Registrants provide information in an understandable and sensitive manner and respond to patients' questions.

e) Registrants respect their patient's right to accept or refuse any drug or health product related recommendation.

f) Registrants ensure that they obtain the patient's informed, implied or expressed and voluntary consent prior to the provision of pharmacy services.

g) Registrants recognize and respect the autonomy of a competent minor to provide informed consent and make decisions about their healthcare.

h) Registrants recognize and respect persons authorized either through personal directives or proxy designations to act as surrogate decision-makers in the case of incompetent patients.

Standard 3: Registrants Practice Respect for Patients

Guidelines for Application

a) Registrants respect the value and dignity of patients.

b) Registrants respect the patient's autonomy and freedom of choice.

c) Registrants recognize the power imbalance inherent in professional relationships (registrant-patient relationship) and maintain appropriate professional boundaries.

d) Registrants act in the best interests of their patients and do not exploit the professional relationship for any personal, physical, emotional, financial, social or sexual gain.

e) Registrants treat patients with sensitivity, caring, courtesy and respect.

f) Registrants provide pharmacy care that is respectful of the values, customs and beliefs of patients.

g) Registrants ensure that their personal beliefs and values do not prejudice patient care and do not engage in discrimination based on age, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, lifestyle, disability, socio-economic status or any basis proscribed by law.

Standard 4: Registrants Protect the Right to Confidentiality of their Patients

Guidelines for Application

a) Registrants respect their patient's right to privacy and confidentiality.

b) Registrants do their utmost to protect patient confidentiality when they share patient information with colleagues or other healthcare professionals.

c) Registrants do not disclose confidential information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

d) Registrants maintain confidentiality in creating, storing, accessing, transferring and disposing of records they control.

Standard 5: Registrants Participate in Ethically Valid Research

Guidelines for Application

a) Registrants ensure that any research they participate in is evaluated both ethically and scientifically and is approved by a research ethics board that meets applicable standards recognized by National Council on Ethics and Human Research (NCEHR) requirements for research involving human participants. (http://www.pre.ethics.gc.ca/policy-politique/tcps-eptc/docs/TCPS%20October%202005_E.pdf)

b) Registrants ensure that before proceeding with their research study they have obtained the informed consent of the patient or proxy and advised the patient that they have the right to withdraw from the study at any time without penalty.

c) Registrants inform the patient of the purpose of the study, its source of funding, the risks of harm and benefits, and the nature of their participation including any applicable compensation.

d) Registrants ensure that they inform research participants that all participant information will be kept confidential and not disclosed without the participants approval and consent.

Responsibility to Society

Standard 6: Registrants are Committed to Benefiting Society

Guidelines for Application

a) Registrants have an ethical duty to uphold public trust and confidence in the profession by acting with honesty and integrity.

b) Registrants have a responsibility to report incompetent or unethical behavior by colleagues or other healthcare professionals to the appropriate regulatory authority.

c) Registrants recognize the professions' responsibility to society to participate in*:
   i. advocacy
   ii. research
   iii. public education programs

d) Registrants endeavor to advance the quality of pharmacy services and care provided to the public

e) Registrants contribute to the future of the profession by participating in student, intern and resident education including multidisciplinary and collaborative experiences as appropriate.

f) Registrants ensure that they maintain appropriate professional boundaries in pharmacy student/instructor and supervisor/subordinate relationships.

g) Registrants recognize the responsibility of the profession to provide access to pharmacy services and resources.

h) Registrants have a responsibility for ensuring the provision of cost-effective pharmacy services in overall healthcare delivery.

i) Registrants provide safe disposal of drugs and health related products and support environmentally friendly practices.

*It is understood that this is not an obligation of all individual registrants but rather a responsibility of the profession as a whole.

Responsibility to the Profession

Standard 7: Registrants are Committed to Personal and Professional Integrity

Guidelines for Application

a) Registrants have an ethical duty to act conscientiously and avoid unethical behavior.

b) Registrants act with honesty and integrity in all professional relationships and fulfill their responsibilities as described in the Code of Ethics and companion documents: Conflict of Interest Standards and Patient Relations Program.

c) Registrants uphold the spirit of the Code of Ethics and its intent as well as its written articulation.

d) Registrants comply with legislation, standards of practice and accepted best practice guidelines.

e) Registrants do not justify unethical behavior by rationalizing that such behavior is not explicitly captured in a standard or guideline and therefore ethically permissible.

f) Registrants shall resist any influence or interference that could undermine their professional integrity.

g) Registrants have a responsibility to protect and maintain their physical and mental health and well-being and seek care and support as appropriate.

h) Registrants must discontinue the provision of professional services if their physical or mental health poses a risk of harm.

i) Registrants take appropriate steps to prevent and report the misuse or abuse of substances by patients, colleagues, other healthcare professionals or other pharmacy employees.

j) Registrants recognize that professional obligations override management policies, and take all reasonable steps to resolve situations where management policies and professional obligations are in conflict.

k) Registrants report any policies, systems or working conditions to the College that pose a risk of harm to the public.

l) Registrants cooperate with investigations into their own or another healthcare professionals' fitness to practice and abide by undertakings or limitations and conditions placed on their practice.

m) Registrants enter only into relationships, contracts and agreements in which they can maintain their professional integrity and safeguard the interests of their patients.

Standard 8: Registrants are Sensitive to and Avoid Conflict of Interest

Guidelines for Application

a) Registrants must consider first the health and well-being of the patient and avoid situations that are, or may reasonably be perceived to be, a conflict of interest.

b) Registrants abide by and conscientiously follow the Code of Ethics companion document, Conflict of Interest Standards.

c) Registrants inform relevant parties, if they are involved in a real, perceived, or potential, conflict of interest scenario and resolve the situation as outlined in the Conflict of Interest Standards.

d) Registrants avoid dual or multiple relationships and other situations which may present a conflict of interest and potentially reduce their ability to be objective and unbiased in their professional judgment.

Standard 9: Registrants Participate in Ethical Business Practices

Guidelines for Application

a) Registrants do not participate in, condone, or are associated with dishonesty, fraud, misrepresentation or any other kind of unethical or illegal behavior.

b) Registrants do not make false, deceptive or fraudulent statements concerning their training, experience, competence, academic degrees or credentials, affiliations, services, research, fees, etc.

c) Registrants conform to legal and professional norms that support the integrity and dignity of the profession.

d) Registrants use only truthful, accurate, fully informative and non-deceptive information in their marketing and public education programs.

e) Registrants do not make false claims for any purpose.

f) Registrants are transparent in the fees they charge, consider the ability of the patient to pay and discuss options with the patient.

g) Registrants ensure that any comparison to the business services of competitors is fair and accurate.

h) Registrants only enter relationships with industry which are appropriate and in compliance with the Code of Ethics and Conflict of Interest Standards and maintain the integrity of the fiduciary relationship between the registrant and the patient.

i) Registrants refrain from participating in activities that could undermine patient trust in registrants and society's trust in the pharmacy profession.

Standard 10: Registrants are Committed to Professional Development

Guidelines for Application

a) Registrants keep up to date with new pharmacy knowledge and practices by participating in continuous lifelong learning.

b) Registrants participate in continuous evaluations of their practice and are responsive to the outcomes of evaluations and reviews by undertaking constructive change or further training if necessary.

c) Registrants endeavour to advance the knowledge and skills of the profession and make relevant information available to patients, colleagues and the public.

d) Registrants participate in professional development opportunities that support learning in professional ethics and the development of sound professional judgment in ethical decision making.

e) Registrants develop, promote and participate in quality assurance and accountability processes.

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

12. Inquiry Committee Dispositions and Administrative Law

INFORMATION ONLY

Purpose

Angie Westmacott, Q.C. will present to the Board on the application of Administrative Law principles for College Inquiry Committee processes and dispositions. John Hope, Chair of the Inquiry Committee, and Dorothy Barkley, Vice-Chair of the Inquiry Committee, will be participating in the discussion to offer their perspectives and experiences.

Background

During the past year, much discussion has occurred at the Board table regarding alleged unsafe practice happening at certain methadone dispensing pharmacies and public safety concerns in relation to other high profile Inquiry Committee cases. Board members have articulated that they are concerned that the College is not taking stringent enough action and is focusing too much attention on remediation rather than on punitive measures.

The Inquiry Committee processes have been established to adhere to the requirements outlined in the *Health Professions Act (HPA)*, the *Pharmacy Operations and Drug Scheduling Act (PODSA)*, and administrative law principles. The articulated requirements and principles ensure procedural fairness, reasonableness, impartiality and transparency of process for both the complainant and the registrant. A duty of procedural fairness is owed to the registrant, even in the most egregious of cases, registrants have the right to be heard and a registrant cannot have their registration suspended based on allegations.

Discussion

Debbie Lovett will review the administrative law principles in conjunction with the requirements of the HPA and PODSA and will highlight their application in recent case examples.

John Hope will provide his perspective on the work of the Inquiry Committee and will outline the process of how the Inquiry Committee assesses each complaint on its own merits and arrives at an objective and appropriate disposition. John will also discuss the challenge of balancing administrative law principles with the strength of the evidence before the committee, and the challenge of remaining objective on cases that may generate an “emotional” response.

Administrative Law Principles and the Inquiry Committee Process

A Presentation for the Board of the College of Pharmacists of British Columbia

Presented by:
Angela Westmacott, QC
Partner, Lovett Westmacott

April 15, 2016

LOVETT WESTMACOTT
LAWYERS + MEDIATORS

INTRODUCTION

This presentation will address:

- administrative law principles
- the inquiry committee process under the HPA and PODSA
- Inquiry Committee dispositions

ADMINISTRATIVE LAW PRINCIPLES

- Administrative law principles are developed by judges to ensure that decision-makers act within their jurisdiction and in a procedurally fair manner
- Acting within jurisdiction means that a decision-maker must strictly follow its legislation
- Decisions must be based on evidence and the relevant law, and not on extraneous considerations

- The duty to act in a procedurally fair manner requires that the registrant has:
    - the right to know the allegations
    - adequate notice of the case that the registrant must meet
    - the right to be heard
    - the right to have an impartial and unbiased decision-maker
    - the right to reasons for the decision

THE INQUIRY COMMITTEE PROCESS UNDER THE HPA AND PODSA

- The HPA requires the College to establish an inquiry committee to investigate complaints
- The complaint and discipline process under the HPA also applies to directors and owners of pharmacies under s. 20 of PODSA
- Inquiry and discipline processes must be **"transparent, objective, impartial and fair"** - s. 16(2) of HPA

- This codified duty of fairness extends to both complainants and registrants
- Part 3 of the HPA governs the complaint, inquiry and discipline process
- A person has the right to make a “written complaint” to the Registrar
- A written complaint frames the scope of investigation and provides notice to registrant

- Subject to 32(3), Registrar “must” deliver the complaint as soon as practicable to inquiry committee
- The inquiry committee has a mandatory duty to investigate the complaint as soon as possible
- The inquiry committee has no authority to resolve credibility disputes or make conclusive findings of fact regarding complaint allegations - such findings can only be made in a discipline hearing

- Matters can also come before the inquiry committee:
    - by an “own motion investigation“ under s. 33(4) in relation to:

      (a) a contravention of this Act, the regulations or the bylaws

      (a.1) a conviction for an indictable offence

      (b) a failure to comply with a standard, limit or condition imposed under this Act;

(c) professional misconduct or unprofessional conduct;

(d) competence to practice the designated health profession;

(e) a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs his or her ability to practice the designated health profession.

- by a statutory duty to report under s. 32.2 (duty to report if danger to public)
- by statutory duty to report under s. 32.3 (hospitalized registrant)
- by statutory duty to report under s. 32.4 (sexual misconduct)

- The inquiry committee may appoint an inspector to assist with the investigation
- Inspectors have limited statutory power to conduct examinations and must provide written report to the inquiry committee
- Inspectors have additional powers to inspect under s. 17 of PODSA

- The inquiry committee may also authorize a search and seizure application under s. 29
- The inquiry committee must “request” registrant to provide information under s. 33(5)
- The inquiry committee has extraordinary power to take action to protect the public during the investigation by suspending or setting limits or conditions on practice although this power must be used sparingly

- The inquiry committee must complete its investigation within prescribed timelines under the Health Professions General Regulation

- Following the investigation, inquiry committee must make one of four “dispositions”:

  (a) take no further action if the inquiry committee is of the view that the matter is trivial, frivolous, vexatious or made in bad faith or that the conduct or competence to which the matter relates is satisfactory,

(b) in the case of an investigation respecting a complaint, take any action it considers appropriate to resolve the matter between the complainant and the registrant,

(c) act under section 36 (by seeking a consent agreement), or

(d) direct the issuance of a citation (for a discipline hearing) under section 37.

- The inquiry committee must provide written decision outlining the basis for disposition

- Complainant may seek review of a disposition under s. 33(6)(a), (b) and (c) by the HPRB

Inquiry Committee Dispositions

- Limited tools available to inquiry committee to address concerns regarding a registrant's conduct
- Outcome generally depends on seriousness of conduct, reason for conduct, availability of evidence and, to some degree, on registrant's cooperation
- Where there is evidence to support a complaint, and there are no broader public interest concerns, inquiry committee may seek to mediate under s. 33(6)(b)

- Where broader public interest concerns arise, inquiry committee may seek a consent undertaking under s. 36:

  36(1) In relation to a matter investigated under section 33, the inquiry committee may request in writing that the registrant do one or more of the following:

  (a) undertake not to repeat the conduct to which the matter relates;
  (b) undertake to take educational courses specified by the inquiry committee;
  (c) consent to a reprimand;
  (d) undertake or consent to any other action specified by the inquiry committee.

- Terms of a consent undertaking should be proportionate to the nature of the misconduct and adequate to protect the public
- If misconduct attributable to mental or physical condition, registrant cannot be “punished”
- For egregious conduct, inquiry committee may seek a consent undertaking that contains the terms that the College would seek in a discipline hearing

- Whether terms of consent undertaking focus on remediation or on punitive measures, or a combination of the two, will depend on a variety of factors

- The determination is informed by the types of factors considered in discipline hearing context:

    - The nature and gravity of the conduct
    - The age and experience of the offending professional
    - The previous character of the professional and in particular the presence or absence of any prior complaints or convictions
    - The age and mental condition of the offended patient and impact
    - The number of times the offence occurred

- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and thereby to protect the public and ensure the safe and proper practice of the profession
- The need to maintain the public's confidence in the integrity of the profession
- The degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct; and
- The range of sentence in other similar cases.

- If consent undertaking cannot be obtained, only other regulatory option is to direct the issuance of a citation for a discipline hearing or refrain from taking further action
- Issuance of citation may not be feasible if there are evidentiary issues or the cost of proceeding outweighs the public interest benefit

Angela R. Westmacott, QC
Lovett Westmacott
Barristers & Solicitors
848 Courtney Street, Suite 300
Victoria, BC V8W 1C4
www.lw-law.ca

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BOARD MEETING
April 14 & 15, 2016

13. Safe Disposal of Fentanyl Patches

INFORMATION ONLY

Purpose

The purpose of this document is to discuss current issues related to fentanyl, particularly the inconsistent application of safe disposal techniques and its impact on public safety. Additionally, this document seeks to provide information to the Board on the College of Pharmacists of BC (CPBC) plan to update its information sources on fentanyl in an effort to promote awareness and remind registrants on best practices related to managing the safe and legitimate use of fentanyl transdermal patches, and more broadly high-risk opioid drugs.

Background

What is Fentanyl?

Fentanyl is a synthetic opioid that is used to treat pain; it is prescribed as a transdermal patch. There is a high risk of overdose with fentanyl as it is 50-100 times more potent than morphine.[1]

A primary risk associated with fentanyl is how much of the residual content is leftover on a used patch. The patch has been reformulated and consequently the residual content has increased from 28% to 57-59%. This increase in residual content may make used patches a target for abuse and may perpetuate risks associated with misuse of the drug.

Fentanyl Related Fatalities in BC

BC is experiencing an increase of fentanyl detected deaths (13 in 2012 to 139 in 2015).[2] Many of these deaths are attributed to the prevalence of fentanyl in the illicit street drug market. Alberta has seen a similar increase in fentanyl detected overdose deaths with 29 in 2012 to 272

[1] Tanner Z, Matsukura M, Ivkov V, Amlani A, Buxton JA. *British Columbia Drug Overdose and Alert Partnership report*. BC Drug Use Epidemiology (September 2014) BCCDC, page 23. Accessed from: http://www.bccdc.ca/prevention/HarmReduction/BCDrugUseEpid/default.htm

[2] http://www.cbc.ca/news/canada/british-columbia/fentanyl-suboxone-izzy-death-hastings-bailey-vancouver-b-c-spike-opiate-overdose-1.3421053.

in 2015.[3] The prevalence of overdose deaths in other Canadian jurisdictions, such as Ontario, are unknown, mostly due to the lack of available statistics.[4]

Pharmacies, Illicit labs and Diversion

Reports indicate the predominant form of fentanyl that results in overdose deaths is illegally manufactured in laboratories, most of which are located in China. The illegally manufactured product is primarily sold as oxycodone pills or heroin powder. However, the contents of patches are also diverted from therapeutic use and abused in the street drug market. Patches are also diverted within health care facilities and amongst staff and inadvertently accessed by children and pets through poor drug disposal methods.[5] These types of diversion avenues create risks to public safety in the form of potential overdoses.

Unsafe Disposal

The risk to public safety is continued as methods of drug disposal for used patches is inconsistent. For example, anecdotally, patients tend to discard patches with the contents of their regular waste collection. Conversely, some patients are directed to drop off their used patches at their local pharmacy. There is a risk to others in the form of used patches being re-used on individuals the drug was not prescribed for, having children and pets being exposed to discarded patches, and/or being a target for drug users who are seeking out used patches. Disposing patches in a safe and consistent manner can prevent intentional abuse as well as unintentional toxicity of others including waste management workers.

Medication Return Program

Most pharmacies in BC, but not all, participate in the voluntary Medication Return Program. The program is administered by the Health Products Stewardship Association and funded by brand-owners selling medications in British Columbia. This program provides the health products industries with a collective means of adhering to the requirements of the British Columbia Recycling Regulation. Participants in this program will accept expired/non-reusable drugs from the public and then dispose them into a specific blue bin from the program. If a pharmacy is not enrolled in the program, they may not accept any drugs from the public.

Health Canada - Controlled Drug Disposal

[3] http://www.health.alberta.ca/health-info/AMH-Naloxone-Take-home.html

[4] http://www.theglobeandmail.com/news/national/surge-in-overdoses-prompt-fears-fentanyl-use-is-rising-in-ontario/article28530648/

[5] Tanner Z, Matsukura M, Ivkov V, Amlani A, Buxton JA. British Columbia Drug Overdose and Alert Partnership report. BC Drug Use Epidemiology (September 2014) BCCDC, page 68. Accessed from: http://www.bccdc.ca/prevention/HarmReduction/BCDrugUseEpid/default.htmIbid.

Controlled drug substances and narcotics must follow exceptional disposal requirements that have been mandated by Health Canada. For pharmacies participating in the aforementioned program, these types of drugs cannot be placed directly into the blue bin. Regardless of whether they are returned by patients or expired products from the pharmacy inventory, registrants are required to apply to Health Canada before they destruct/dispose of the drugs. Once they receive authorization from Health Canada, registrants must ensure that these drugs are rendered useless prior to disposing them into the blue bin. CPBC has guidelines published on its website regarding the direction for destroying Controlled Drugs and Substances (e.g. fentanyl). See Appendix 1 for a copy of the guideline.

Other Mitigation Strategies

The increased prevalence of fentanyl related deaths has influenced Health Canada to change the prescription status for **naloxone** (an opioid antagonist). At the February 2016 Board meeting, the Board approved amendments to BC's Drug Schedules Regulation which will classify the anticipated non-prescription status of naloxone as a Schedule II drug in order to increase access to the lifesaving drug along with provide training on its administration.

Vancouver police and provincial health officials have launched new campaigns to raise awareness about fentanyl. For example, Vancouver Coastal Health developed a public service **anti-fentanyl awareness campaign** which consists of reminders in the form of decals for nightclub bathrooms with key messages such as "anything can be cut with fentanyl".

A national jurisdictional scan highlights how Ontario's government recently enacted the *Safeguarding our Communities Act (Fentanyl Patch for Patch Return Policy)* on December 10, 2015. Its purpose is to establish a program that aims to limit patches from being diverted for illicit use. The program requires patients to return any patches previously dispensed to them back to the pharmacy before they are able to receive their next round of patches. Essentially, the Ontario government has prioritized policy that will compel physicians, pharmacists and patients to limit the supply of patches in the public domain.

Discussion

Any successful legislative solution requiring safe drug disposal involves obligations on patients, prescribers and dispensers (e.g. pharmacies). CPBC only has jurisdiction over pharmacies and registrants, therefore, legislative options for CPBC action are limited. An effective program would require a collaborative effort amongst prescribers (e.g. physicians and nurses), dispensers and patients.

There are opportunities outside of legislation that could be used to increase awareness about the need for safe disposal of patches (and other high-risk opioid drugs). The most recent CPBC publication on fentanyl was in 2008. Prior to that, in 2005, CPBC published an Alert outlining best practice advice on disposing fentanyl patches (see Appendix 2). This type of document needs to be brought up to date to ensure its advice is current. Further, by providing updated information on best practices, this will increase awareness on the current and emerging issues related to fentanyl and other high-risk opioid drugs.

Next Steps

CPBC will be updating its informational resources related to fentanyl and safe drug disposal on its website in the coming weeks.

Appendix	
1	Controlled Drugs and Substances Destruction Request Guidelines
2	Alert: Fentanyl/Duragesic® Patches (March 2005)

College of Pharmacists
of British Columbia

Controlled Drugs and Substances Destruction Request Guidelines

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To destroy any expired narcotics and controlled drug substances a request for "Authorization to Destroy" must be made to the Health Protection Branch. Using the "Controlled Drugs and Substance Destruction Request" Form, prepare a list of expired drugs and quantities requiring destruction and **mail** or **fax** to:

Office of Controlled Substances
Compliance, Monitoring and Liaison Division
Drug Strategy and Controlled Substances Program
Health Canada
Address Locator: 3502B
Ottawa, Ontario K1A 1B9

Phone No: (613) 954-1541
Fax No: (613) 957-0110

When the written "Authorization to Destroy" is received, the drugs may be disposed of in a safe and effective manner (rendering them unusable/irretrievable).

Authorization is not required to destroy benzodiazepines and other targeted substances. However, records including the name, strength per unit and quantity of the targeted substance destroyed must be kept for three years. Click here for more information.

ALERT

March 2005

Fentanyl/Duragesic® Patches

A number of coroners' reports have recently been reviewed by the College of Physicians and Surgeons of British Columbia, the College of Pharmacists of British Columbia and the Registered Nurses Association of British Columbia. The cause of death in each case was overdose due to fentanyl. The deceased had used fentanyl patches that had been prescribed for someone else.

A used fentanyl patch may contain enough residual drug to cause harm. Studies have found that after three days of continuous use, fentanyl patches may still contain 30% to 50% or more of the labelled amount of fentanyl. Therefore, the appropriate disposal of used and unused patches is important in both health care facilities and in the community.

Health care facilities should have policies in place for the proper disposal of fentanyl patches. Policies should instruct the nurse to remove the patch from the patient and fold the patch in half so the adhesive backing is folded together and adheres to itself. The patch should then be disposed of in a sharps container. Gloves should be worn when handling the patch. This process should be undertaken by a nurse and witnessed by another nurse. This disposal should be documented on the patient's MAR and initialled by both the nurse and witness.

Patients in the community who have leftover unused, used or expired fentanyl patches should be encouraged to place them in a tamperproof, childproof container and return them to a community pharmacy for appropriate disposal or to use the manufacturer's recommendations for disposal.

The manufacturer's product monograph recommends flushing used and unused patches down the toilet. Given concerns about the environmental impact of drugs in the water supply other disposal methods should be considered when possible. This is not a suitable alternative in locations with septic fields or septic tanks.

The product monograph advises that the gel from the drug reservoir must not accidentally touch the skin and if it does the skin should be flushed with water only. Soap, alcohol and other solvents should not be used to remove the gel from the skin because they may increase the drug's ability to penetrate the skin.

Pharmacy managers must ensure that returned or expired fentanyl patches are made unusable or inaccessible until they can be appropriately destroyed. Pharmacists must educate patients and care givers about the safe administration, removal and disposal of fentanyl patches.

200–1765 West 8th Avenue, Vancouver, British Columbia V6J 5C6 Toll-free 800.663.1940 Tel 604.733.2440 Fax 604.733.2493 www.bcpharmacists.org

College of Pharmacists Board Meeting

Transdermal Fentanyl Presentation

Friday April 15th 2016

13:00 – 13:45

200 - 1765 West 8th Ave,
Vancouver, BC

Bruce Kennedy

Clinical Pharmacy Specialist – Palliative Care x 11 years

- Serving Fraser Health areas of Surrey, White Rock, Delta
- Office in Surrey at Surrey Memorial Hospital

Tel 585-5666 ext 778659

Cell 604-614-6328

email Bruce.Kennedy@fraserhealth.ca

Bruce.kennedy@telus.net

Current Landscape

- A significant rise in prescribed opioids
- A significant rise in misuse, abuse of opioids – both illegal and legal
- Greater illegal supply, production of the very potent fentanyl with growing proximity
- A rise in fentanyl opioid overdoses
- Naloxone moved to Schedule 2 to improve access
- Public and health care professionals are generally unfamiliar with fentanyl

We can do better

I need your support

My First Hope

- Improve awareness and action to properly dispose of fentanyl transdermal patches
  - Fraser Health patient disposal brochure created
  - Safeguard waste management staff from improper disposal and handling of patches in waste
  - Prevent accidental misuse, and harm to children and pets, minimize diversion
  - Educate that about 57% of the fentanyl remains as a residual amount after 3 days of use – enough to be lethal

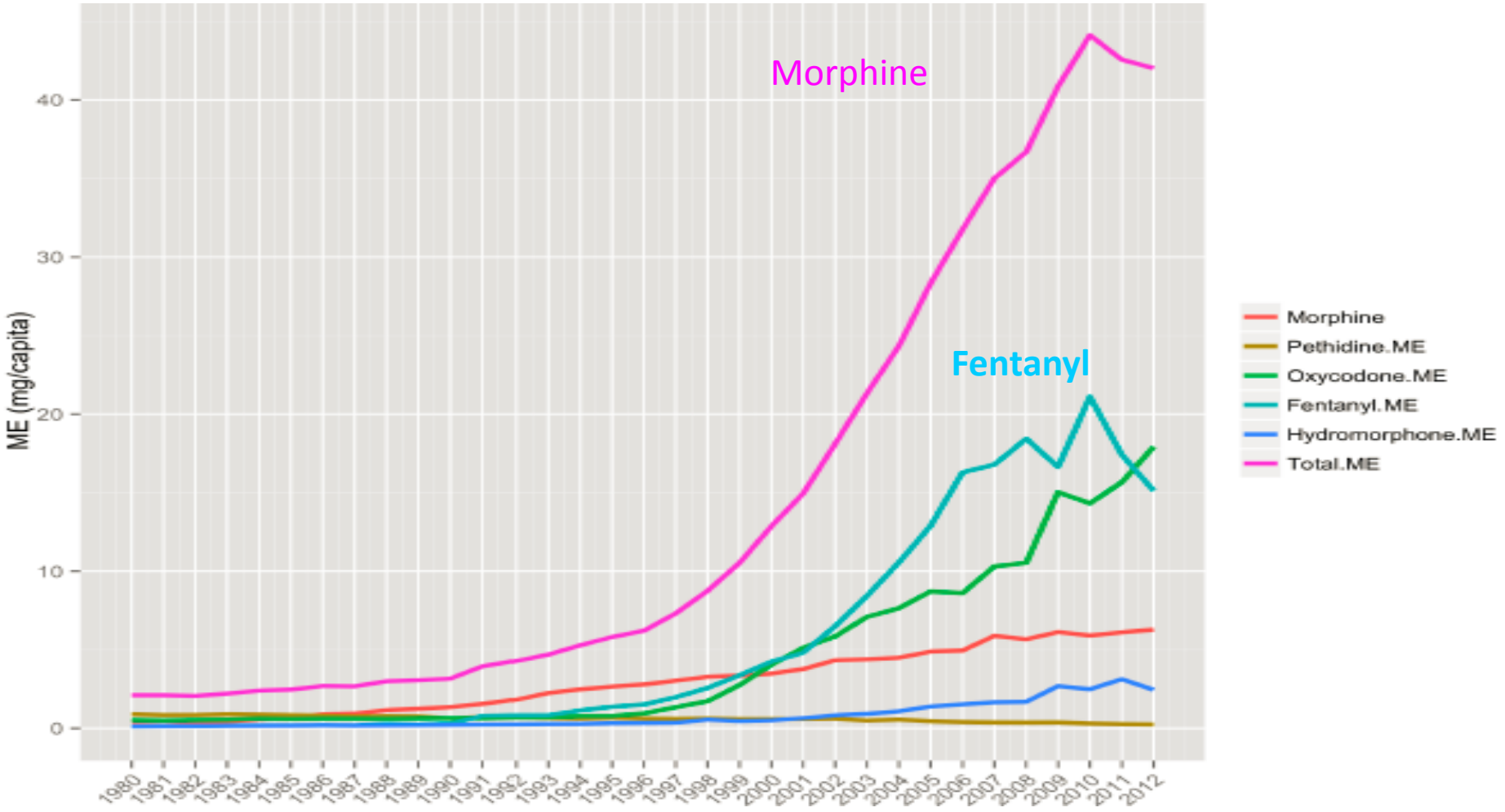
My Second Hope

- Educate pharmacists, physicians, nurses, and public that patients need to demonstrate adequate opioid tolerance prior to starting use of fentanyl transdermal patches – at ANY strength
  - Prescribers shown to bypass this safety measure
  - E.g., starting patients on one-half or one-third of a full patch i.e., doses of 6.25 mg/hr or 4.125 mcg/hr placing patients at significant risk of intolerance

Opioid, Fentanyl Growth Chart

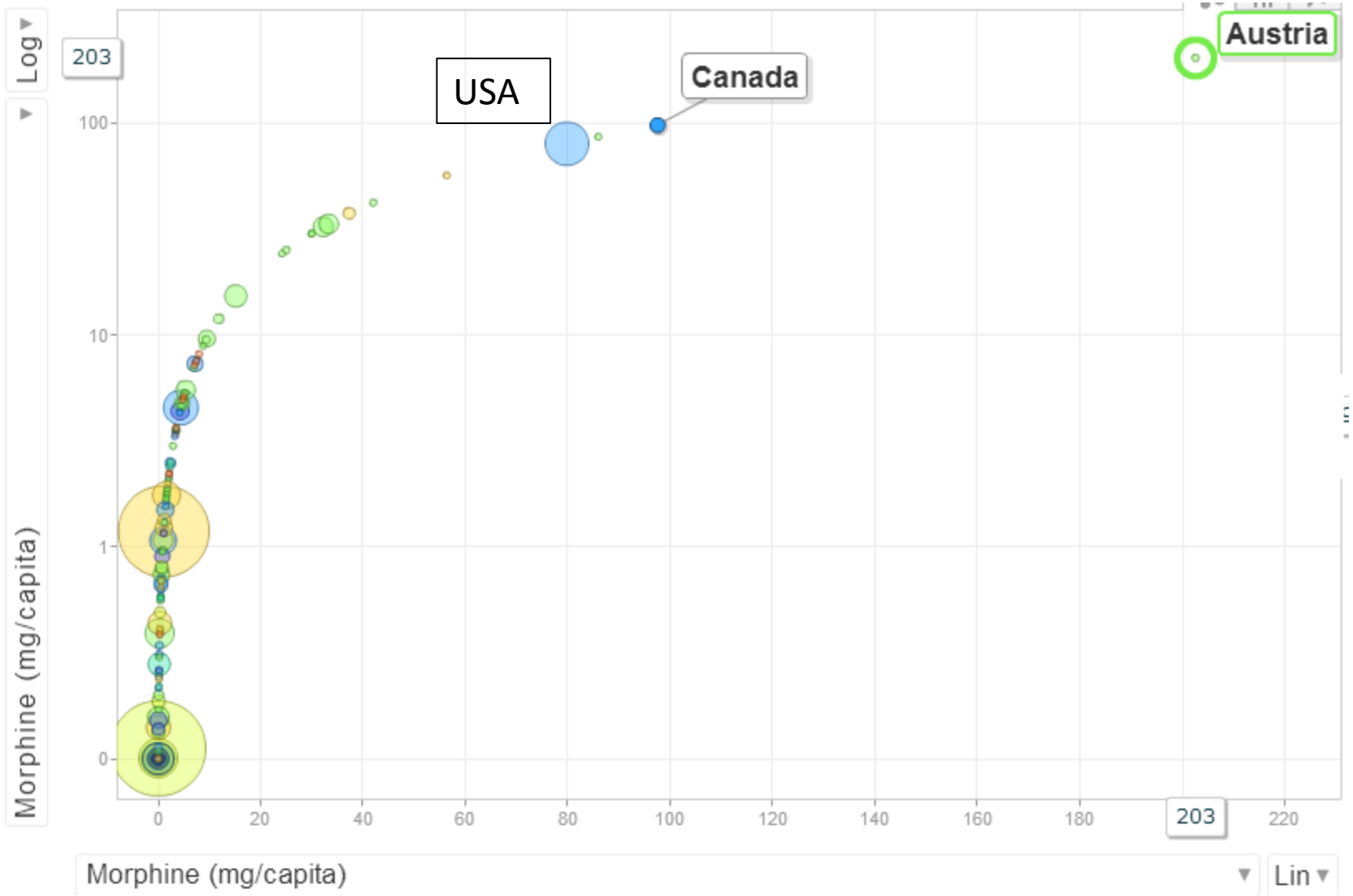
Global opioid consumption in Morphine Equivalence (ME) milligram per person, 1980 to 2011

http://www.painpolicy.wisc.edu/global



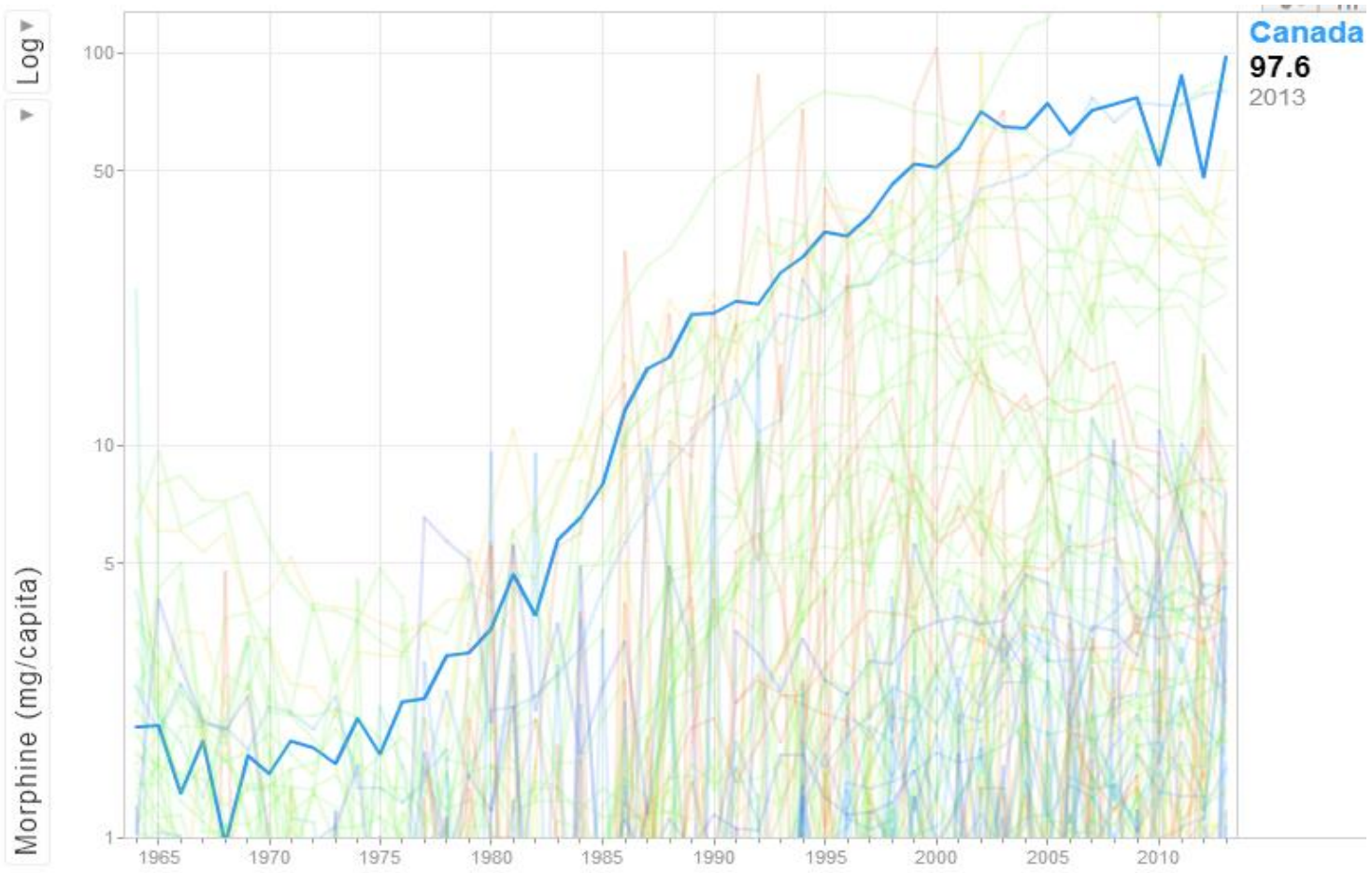
Sources: International Narcotics Control Board; World Health Organization population data
By: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2014

Canada 2nd highest opioid use per capita



https://ppsg.medicine.wisc.edu/chart

Opioid Consumption Growth Chart
1965 to 2013

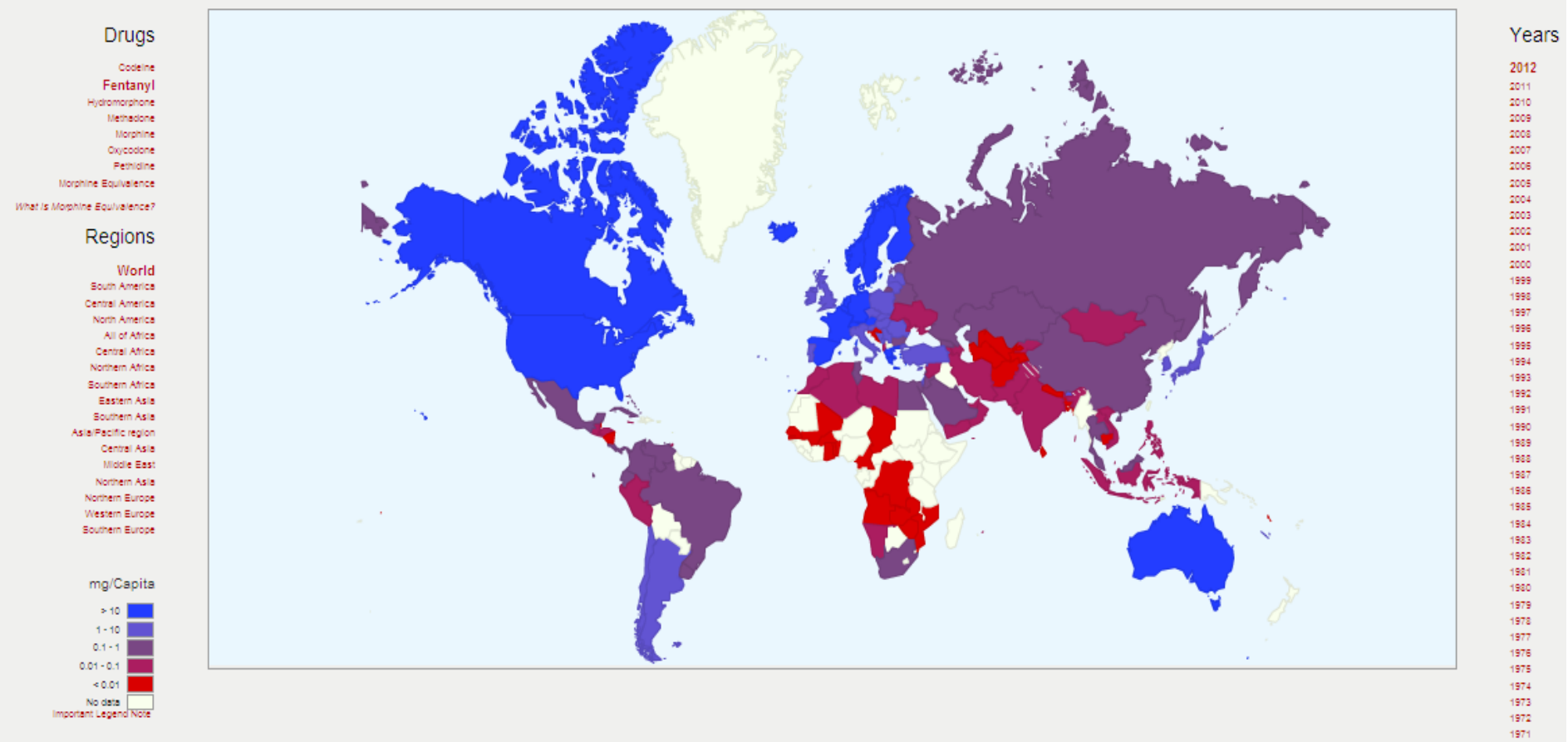


Pain & Policy Studies Group University of Wisconsin-Madison. Opioid Consumption Maps (interactive) [cited 2014 Dec 18] Available from: https://ppsg.medicine.wisc.edu/ This displays the aggregate of 6 principal opioids (fentanyl, hydromorphone, morphine, oxycodone, methadone and meperidine) in Canada

Opioid, Fentanyl Growth Chart

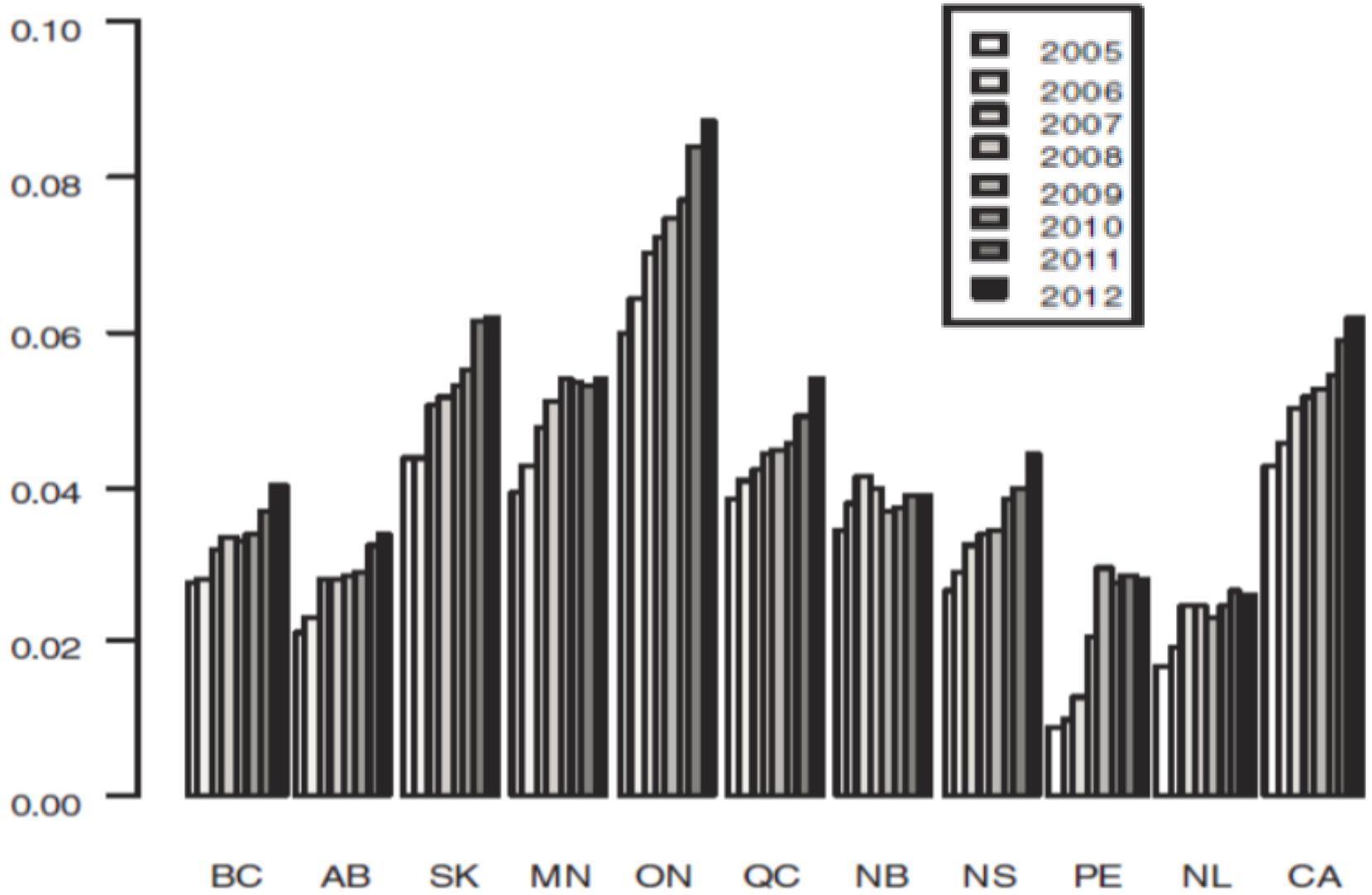
Opioid Consumption Maps – milligram per capita, 2012 Pain & Policy Studies Group University of Wisconsin-Madison from reference 30: https://ppsg.medicine.wisc.edu/

- This shows that the dark blue area countries are the largest, per capita, users of fentanyl



Fentanyl annual opioid dispensing in Canada 2005 – 2012,

in Defined Daily Doses per 1000 population per day. http://www.biomedcentral.com/1472-6963/14/90



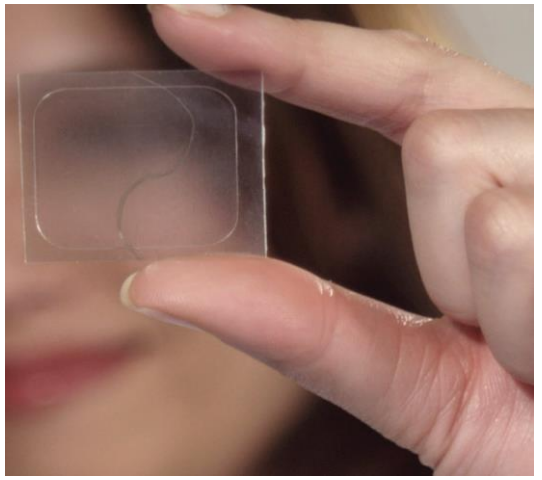
New Fentanyl Transdermal Guidelines

- Go directly to them on the internet:

  http://www.fraserhealth.ca/media/HPC_SymptomGuidelines_Opioid.pdf#page=23

- Or go via www.fraserhealth.ca
  - Then use search terms such as
    - hospice, palliative, palliative care guidelines
- March 2016 updated Principles of Opioid Management
  - **Appendix A pertains to Fentanyl Transdermal Page 23**

Fentanyl Transdermal Patch
Quick Overview



- Is a pain relieving topical patch
- Fentanyl is a synthetic opioid that is approximately 100 times more potent than the natural opioid morphine
- Patches are available in six different strengths that deliver a dose of 12, 25, 37, 50, 75 or 100 micrograms per hour
- Drug is absorbed through the skin, into the subcutaneous skin layer, then off into the blood stream towards pain receptors
- Old patch typically removed after 72 hours, & a new patch applied
- Often useful pain reliever when patient has swallowing difficulties

Fentanyl Transdermal Patch

Where is it useful and indicated?

- Topical, non-invasive alternative to oral medications
- Poor absorption of oral opioids
- To manage persistent severe pain; that is stable and controlled for at least 48 hours
- To provide around the clock opioid treatment and improve patient compliance/adherence
- To potentially lower opioid adverse effects of constipation, nausea, and histamine release
- Renal failure

http://www.fraserhealth.ca/media/HPC_SymptomGuidelines_Opioid.pdf#page=23

Fentanyl Transdermal Patch
Why it deserves awareness

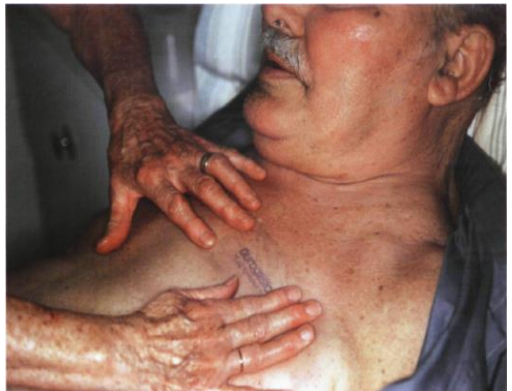
- On high risk/high alert medication safety list
- On Sound-a-like, Look-a-like medication safety list
- On Confused Drug Names medication list
- Often within top 10 list of medication errors
- Potency means considerable concern with risk of respiratory depression and death if overdosed
- Despite apparent simplicity for medication delivery, it is more complex, and often unfamiliar
- Can be abused – with similar to heroin effects
- Many recent media stories about fentanyl

http://www.edrugbook.com/looksoundalikedrugs.html
http://www.ismp.org/tools/confuseddrugnames.pdf

Fentanyl Transdermal Patch

2 Key goals with updated guideline

- Improved dosing information
  - **Switching to and from other opioid pain relievers**
    - **More extensive range of doses**
  - **4 charts to help simplify understanding with dose changing or sufficient provision of “as needed” breakthrough pain relief**
  - **Preferred skin sites to use and how to minimize irritation**
  - **Timeframes for increasing regular doses**



Fentanyl Transdermal Patch

2 Key goals with updated guideline

- Safety
  - **Starting safe – provides requirements before beginning use**
    - **Need to first show opioid tolerance to safeguard toxic effects**
  - **Raise awareness regarding high amount of residual drug in used patch**
  - **Calls for improvements in used patch disposal, has patient brochure**
  - **Alerts to preventing patches falling off – and means to help stop this by using tape like Tegaderm completely overtop of patch when necessary**
  - **Alerts to not cutting patch or using half of a patch**
  - **Alerts to not write on the patches**
  - **Alerts to safe storage**
  - **Alerts to use of TALLman lettering per i.e., fentaNYL**

Safety should not be a Patchy Event using transdermal fentanyl

- Now only indicated in Canada for SEVERE Pain (and not moderate)
- Effective Aug 18th, 2014 due to concerns
- Also ALL long-acting opioids
- **Reason: Risks and Serious Negative health impacts, even at recommended doses**
- Seeks to reduce risk of addiction, misuse and abuse while preserving access for those who need them most

Health Canada. Label changes for controlled-release opioid pain medicines encourage **more targeted prescribing and safer use**. Available from: http://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2014/41157a-eng.php

Residual Fentanyl in Patches

- Each new patch contains a fixed drug content, expressed in milligrams. Larger patches have a larger starting amount.
- Upon application to the skin each patch begins to transfer a portion of the drug into the skin.
- The larger the size of the patch, the greater the amount of fentanyl transferred into the skin, providing greater pain relief.
- To assure sufficient drug delivery over a 72 hour use period, patches are purposefully made with extra medication content.
- The extra content, or residual fentanyl remaining is;
  - 57.1 to 58.9% of the new patch content after 72 hours of use or
  - 71.4 to 72.6% after 48 hours

But residual will vary

- Residual was 28 % to 84.4% with old reservoir patches
  - this study used 2.5 mg & 10 mg patches ~ 12 & 67 mcg/hr
- They estimated that the potential lethal dose for a 70 kg person to be 1036 micrograms
  - This means **all used patch strengths contain sufficient after 2 or 3 days of use to be lethal**
  - Even the lowest strength when used for three days still contains "on average " 1236 mcg residual fentanyl
  - The highest strength, a 100 mcg matrix patch, contains a residual of 9600 mcg of fentanyl which is a 9 fold lethal amount
- 1994 study concluded that adequate disposal policies are currently not established and need to be implemented

1994 Annals of Pharmacotherapy 29(10):969-71 Fentanyl remaining in a transdermal system following three days of continuous use.

This is what regret looks like

http://fox4kc.com/2013/05/14/girl-12-dies-after-putting-on-pain-fighting-patch/

Safety should not be a Patchy Event using transdermal fentanyl

Accidental - Child

- 2 year old boy, Blake Seamonson, from USA
- Visited great-grandmother at care facility
- November 2011, Nazareth Health and Rehabilitation Center in Stoughton, Wisconsin

Outcome	Death

2014 Home Healthcare Nurse. Mom hopes son's overdose spurs preventative efforts p 502

http://www.lawyersandsettlements.com/articles/duragesic/duragesic-fentanyl-lawsuit-patch-8-18001.html

Circumstances

Details
Died 3 days after visit. "He was just being a little boy." The pained words of a lamenting mother.
Theory was boy may have run over a used fentanyl patch on the floor while playing with his toy truck in great-grandmother's room. The patch probably stuck to his Tonka truck, later he may have peeled off the patch and put it in his mouth. It stuck in throat, where absorption occurred. Later investigators found at the facility used patches on a bedside table, stuck to bed railings, and in other unsecured patient areas and that patches had been disposed of in the trash pail in the room.

Accidental. Misuse. Preventable. Healthcare worker

Lesson for practice is:	

2012 April 25 National Alert Network Proper disposal of fentanyl patches is critical to prevent accidental exposure

Misuse, Abuse and Diversion

- Definitions as article states pertains to opioid analgesics:
  - Misuse: intentional therapeutic use in an inappropriate way
  - Abuse: intentional, non-therapeutic use to achieve a desirable psychological or physiological effect e.g., euphoric, anxiolytic, sedative
  - Diversion: any intentional act that results in transferring a prescription from lawful to unlawful distribution or possession
- Most common drug class abused = marijuana and 2nd most common is prescription opioid analgesics
- Most common source of prescription opioid analgesics for abuse is;
  - Family and friends
- 0.7% of population currently abuse prescription opioids
- BC population (Oct 1, 2015) is 4,703,939 - 0.7% of that is 33,000 persons

2016 Postgraduate Medicine 128;1:85-96 Routes of abuse of prescription opioid analgesics; a review and assessment of the potential impact of abuse-deterrent formulations
http://www.tandfonline.com/doi/abs/10.1080/00325481.2016.1120642
BC Population from: http://www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationEstimates.aspx

Opioid Abuse

- **States drivers of abuse include:**
  1. Increased therapeutic availability
  2. History of illicit substance abuse or abuse or a substance use disorder
  3. Comorbid mental health disorder
- **Fentanyl**
  - Has the widest range of methods in which it is abused
  - No known abuse-detterent product formulations in the pipeline for patches
    - Is unlike oral tablets/capsules where abuse-detterent formulations are being developed

2016 Postgraduate Medicine 128;1:85-96 Routes of abuse of prescription opioid analgesics; a review and assessment of the potential impact of abuse-deterrent formulations
http://www.tandfonline.com/doi/abs/10.1080/00325481.2016.1120642

Safety should not be a Patchy Event using transdermal fentanyl

Diversion by Funeral Home Transporter/Employee

- 31 one year old man (J.G.) from USA
- Applied 1 x 75 mcg & 1 x 100 mcg reservoir patches
- Blood level was 15 mg/mL

Outcome	Death

1996 Journal of Forensic Studies 41(2):320-1 Fentanyl patches left of dead bodies – potential source of drug for abusers.
1997 Nursing p 20 Cohen MR Medication errors Transdermal patches unauthorized use

Circumstances

Details
One day before death man had transported a deceased nursing home pt
White male had gone fishing with his employer's son at 10:45 am. Two and ½ hours later he fell to knees alongside the pond, complained of feeling dizzy, nauseated and weak. He collapsed and young boy summoned assistance. EMS found him prone on ground, snoring respirations, tachycardia, BP 210/110. He developed cyanosis of the face and extremities, RR 2/min. Progressed to full cardiac arrest, and aggressive attempts at resuscitation were unsuccessful. He had a history of drug abuse and was believed to have removed the patches from the woman's body from the nursing home.

Misuse

Lesson for practice is:	

1996 Journal of Forensic Studies 41(2):320-1 Fentanyl patches left of dead bodies – potential source of drug for abusers.
1997 Nursing p 20 Cohen MR Medication errors Transdermal patches unauthorized use

Fentanyl Transdermal Patch ways in which it gets abused

1. Topically (e.g. multiple patches, heated up)
2. Inhalation (smoked)
3. Injection of extracted patch contents
4. Chew or suck
5. Swallow whole
6. Rectal insertion
7. Boil to make tea, then ingested

2016 Postgraduate Medicine 128;1:85-96 Routes of abuse of prescription opioid analgesics; a review and assessment of the potential impact of abuse-deterrent formulations http://www.tandfonline.com/doi/abs/10.1080/00325481.2016.1120642
Butler et al. Harm Reduction Journal 2011, 8:29 http://www.harmreductionjournal.com/content/8/1/29

States $400 for a new 100 mcg patch, $150 for a used 100 mcg patch

Bill 33 Safeguarding our Communities Act (Patch for Patch Return Policy)

Introduced Private Member's Bill that received Ontario's Royal Assent, and status is current

http://www.cbc.ca/news/canada/sudbury/fentanyl-patch-return-bill-put-forward-by-nipissing-mpp-vic-fedeli-1.2810749

http://www.ontla.on.ca/bills/bills-files/41_Parliament/Session1/b033.pdf

Safety should not be a Patchy Event using transdermal fentanyl

- Fentanyl – is on the street, China likely source
- CBC story – can “order” powder over the internet, as fentanyl is not a regulated substance in China
- Vancouver likely port of entry
- Made into tablets- appearing like OxyContin
- Street names “green apples, green beans, Shady 80’s, fake Oxy’s. Gangs involved
- Can buy the tablet making machines in Canada (unregulated), unlike USA where is regulated

http://www.cbc.ca/news/canada/calgary/calgary-s-fentanyl-supply-sourced-in-china-say-police-1.3093383

Delta Police Chief Neil Dubord said that "without question, this seizure will save lives."

Fentanyl lab bust story accessed March 22, 2016 from:
http://blogs.vancouversun.com/2016/03/21/204318/

BC Fentanyl Overdose Statistics

Year	Deaths	Info Source
2012	13	www.ccsa.ca
2013	49	www.ccsa.ca
2014	~75	www.knowyoursource.ca
2015	471	Neil Dubord/FH
2016 (two months data)	132	Neil Dubord/FH

http://www.ccsa.ca/Resource%20Library/CCSA-CCENDU-Fentanyl-Deaths-Canada-Bulletin-2015-en.pdf
http://knowyoursource.ca/questions-about-fentanyl/bc-faq/
Verbal communication Chief Constable Delta Police Neil Dubord April 6, 2016 – stated Fraser Health data source

April 6th Discussion – Chief Dubord

- Recent Bust:
  - Had a large tablet making machine on premises
  - Large quantities of fentanyl powder on hand
  - Used vinegar to darken the white fentanyl enabling it to more closely mimic natural light brown coloring of heroin
    - Alteration cuts fentanyl into the more expensive heroin
  - Ongoing news story on ~April 12/13/14th

This is what regret looks like

Fentanyl being branded as heroin. Extracted from transdermal fentanyl patches

https://www.youtube.com/watch?v=85Tye8tNd44&ebc=ANyPxKoFnsQJ8WvF_BM81Qqo9M-Z5uTR1NLeUtnf_fgCgPHS0gFVw64eIiHekSXU8kwyVzEMlN7nd_lzb3PCteRcqpciFoh85g

This is what regret looks like

Kamloops family – fentanyl (described as Oxycontin) overdose CTV News story

https://www.youtube.com/watch?v=D9Xhcoeot7U

This is what regret looks like

Brother died of heroin laced with fentanyl

http://www.surreyleader.com/news/294710971.html Knowyoursource.ca

This is what regret looks like

18 year old son put fentanyl in mouth and died

https://www.youtube.com/watch?v=f8I_TtTBOp4

And so, so many other stories

- Fentanyl: Canada's deadliest, strongest, and cheapest drug. States several facts, stories
  - https://www.youtube.com/watch?v=efB7kuvNG_Y
- Mother of fentanyl overdose victim sounds alarm on addiction. Mayne Island, BC
  - https://www.youtube.com/watch?v=OOgAt8SUb-Q CTV News
- ❖ Death by Fentanyl, The 'serial killer' of drugs Mariana Van Zeller Investigative Correspondent
  - https://www.youtube.com/watch?v=vbl19waROcA&ebc=ANyPxKp3m8P6f-GYJIg2Bknxu_nWzSi32OH-dfnYDyTDr3RfAj2h4WS4OI20Qf2GZkfghwApLqEvLPcYWQ4UZHkj-cRvNLAZnw&nohtml5=False Feb 1, 2016
- Fentanyl Misuse: The Patch-for-Patch Solution (2014) Documentary Short Guelph, Ontario
  - https://www.youtube.com/watch?v=WskLpoXb0Q8&nohtml5=False
- ❖ Clear addiction: new opiate patch could lead to abuse Global News interviews Toronto professor
  - ❖ https://www.youtube.com/watch?v=1mN8okFdz6A&ebc=ANyPxKprehYV3K-6BfrEFCQAtD3pn1slRUr_wH3GOgZu1Hi7XIoFE9ore9Y6bMI1J7K0Kh-Z0THlU5Lq5zA9W_LuqylPE3PpqA&nohtml5=False
- Fentanyl overdose press conference Sheriff's office (USA)
  - https://www.youtube.com/watch?v=dJSy-1T8dnM
- FADED – the impact of fentanyl 45 minute documentary – North Dakota
  - https://www.youtube.com/watch?v=U2zVFIVgLyI&ebc=ANyPxKqa0exLjogx7jKB8V3N5k9QZ0EvRmyw9TmMwh_QPWM3Ff510G2CyQckLfq61cxtbCw6TulGSU9teKU0UQV2eKxO2UrejA&nohtml5=False
- Fentanyl in Kamloops
  - https://www.youtube.com/watch?v=xEU8f1TXhQI
- Lives shattered by Fentanyl
  - https://www.youtube.com/watch?v=RJbYtG37J0U&ebc=ANyPxKoX_suP9Kg6tgLCsvpj2BG3sDNus6WAGqsL2ygQVGstvSc_uQWWaJ5Yz7tyLqfwFpAiI-btyAKGh5sb8d6JpBxckgidhw&nohtml5=False
- Heroin vs. Fentanyl what is the difference. Dr. Thomas Andrew Chief Medical Examiner
  - https://www.youtube.com/watch?v=y0FoMm5nLHA
  - States that fentanyl cheaper to make than heroin, coming from sources like Mexico, Chinese chemists taught Mexicans to make

This is what regret looks like

http://www.vancouversun.com/video+healthcare+worker+dies+after+morphine+overdose/11703025/story.html?__lsa=93da-3a48

Medical Waste as source of drugs for abuse, but death resulted

- http://www.vancouversun.com/video+healthcare+worker+dies+after+morphine+overdose/11703025/story.html?__lsa=93da-3a48
- Kerri O'Keefe was a highly regarded 36 year old nurse's aid in the ER at VGH for nearly 20 years. She died recently after succumbing to an overdose of morphine and other drugs she stole from the ER out of the hospital biohazard bins. She was secretly but long addicted to these hospital drugs and it came as a shock to all that she was stealing drugs over a period of many months. A coroner is on to the case now to determine how she got access and how to prevent these tragedies.
- © Copyright (c) The Vancouver Sun

Future In the Hospital ?

- Smart Sink ™

www.cactusLLC.net

What are community pharmacists saying about patch disposal?

Survey question:

How do you counsel patients for disposal of used fentanyl patch?

Pharmacy responses

1 Refer patient to product monograph in the box
2 Refer patient to product monograph in the box
3 Refer patient to product monograph in the box
4 Throw in garbage
5 Flush down toilet
6 Throw in garbage (after sticking the 2 sticky sides together)
7 Flush down toilet
8 Never to flush down toilet (as it is not biodegradable). Thrown in garbage (after cutting it and putting it in the original sleeve) or bring back to pharmacy.
9 Flush down toilet
10 Throw in garbage
11 Disposal information not included in counseling (as it is not a legal requirement). If asked by the patient, patient is referred to the product monograph in the box.
It is ok if patients bring their used patches in a plastic bag and the pharmacy can dispose of them properly for the patient.

Pharmacist Khushminder surveyed some of the pharmacies that have Palliative Kits about the counseling they do for disposal of fentanyl patches. Provided by Sue North to Bruce Kennedy July 15, 2013

Manufacturers Newest Instructions*

DURAGESIC® MAT should never be disposed of in household trash. Disposal via a pharmacy take-back program is recommended.

Used patches still contain a considerable amount of drug. Unused patches should be removed from their pouch, folded so that the adhesive side of the patch adheres to itself, and disposed of similarly to used patches. If temporary storage is required before disposal, a sealed child-proof container, such as a biohazard waste container or a lockable medication box could be obtained from a pharmacy.

*e.g. Duragesic product and patient brochure information: http://www.janssen.ca/product/114
& others; Sandoz, Mylan

Safety should not be a Patchy Event using transdermal fentanyl

Safer storage and medication transfer

- Lockable medication storage box
  - suggested by some recent Fentanyl patch product monographs*
  - E.g., Lockmed boxes and bags
    - Canadian distributer: http://www.wellbeings.ca/store
    - US “home” website: www.LockMed.com

- http://www.healthsteward.ca/news/i-dont-flush-public-awareness-campaign-launched-ontario

*e.g. Duragesic product and patient brochure information: http://www.janssen.ca/product/114 & others; Sandoz, Mylan,

Bruce: there maybe other distributors of lockable medication containers, although I am not aware of any. I have no association with either of these firms.

Why a sharps container is not the ideal disposal method for used fentanyl patches

1. **No studies of effectiveness**
2. **“Just a default” - historical, and best that could be done**
3. **Are not child-proof**
4. **Does not inactivate the active drug**
5. **Costly for public to purchase, more $ than a disposal vial**
6. **Most all sharps containers are “one-time” use only**
7. **Many community pharmacies do not accept them for disposal**
8. **Current BC Medication disposal program guidelines prevents pharmacists accepting sharps containers through the www.healthsteward.ca program**
9. **Home care nurses do not give out, & not supposed to transport if full**
10. **Risks harm to person trying to extract patch when needles contained in the sharps container**
11. **Are very accessible within hospitals – in each room per WBC regulations**
12. **Mixes medications in with “true biohazards” for waste disposal**
13. **FH disposal of hospital Sharps containers involves sterilization using water, then placement into a landfill. They are not incinerated.**

Safety should not be a Patchy Event using transdermal fentanyl

Do not place used pain patches in the garbage

- **Patients should return used patches to community pharmacies**
- Use a prescription vial, child resistant top
  - Label
    - “Used patches to take back to the pharmacy”
    - “Keep out of reach of children”
  - Vials are easy for pharmacist to dump out and place into their pharmacy disposal container
  - Vials are re-usable. Re-use of vial minimizes burning of plastic, packaging, bulk when sent for final incineration placing only used patches in bin
  - Inexpensive

Safe Disposal of Used Pain Patches at Home [English] *Active*

Brochure On FH Pulse: https://patienteduc.fraserhealth.ca/search/results/78982

fraserhealth

Safe Disposal of Used Pain Patches at Home

Pain patches are placed on the skin to help relieve pain. After you remove it, there is still a lot of medicine left in the patch. To reduce the chances of the used patch hurting other people, always remove and get rid of used pain patches safely.

If used by accident or misused by others, used pain patches can cause harm or death to adults, children, and pets.

There is also a growing concern about medicine in our waste and water systems.

STOP **Never** place used pain patches in the garbage.

How to safely remove your patch

1. Remove the patch from your skin.
2. Fold the used patch in half, sticky side to sticky side.

3. Safely dispose of patch – see instructions on 'How to safely get rid of a used patch'.
4. Clean your hands **with water only.**

   Do not use soap. If the sticky surface of the patch touches your hands, the soap can make it easier for the medicine to pass through your skin.

How to safely get rid of a used patch

There are 2 ways to get rid of your used patch.

1. Store the used patch in a childproof, hard to open container.

   You could get a large medicine bottle with a childproof lid from your pharmacy. Ask the pharmacy to add a sticker: 'Keep out of reach of children'

   Label the container: 'Used patches to take back to the pharmacy'.

   Store the container out of sight and out of reach of others, including children and pets.

   Return it to the pharmacy as soon as you can.

2. Flush the patch down the toilet.

   Only use this method if you need to get rid of the patch right away when you need to keep it from being reused, misused, stolen, or abused. Whenever possible, do not to choose this way unless you have to. We want keep medicines out of our waste and water system.

   If you have a septic tank or septic field, **do not** flush patches down the toilet.

For more information, go to
British Columbia Medication Returns Program
www.healthsteward.ca

Sample
For Educational Purposes Only

www.fraserhealth.ca
This information does not replace the advice given to you by your health care provider.
Catalogue #264650 (December 2015)
To order: https://patienteduc.fraserhealth.ca

Brochure On FH Pulse: https://patienteduc.fraserhealth.ca/search/results/78982

Return used patches in the community setting to the community pharmacy

More than 95% of BC community pharmacies participate in the Medications Return Program

http://www.healthsteward.ca/collection/british-columbia

Sent: Mon 11/10/2014 9:51 AM

From: Sharon Kerr <Sharon.Kerr@bcpharmacists.org>
To: Kennedy, Bruce
Cc:
Subject: RE: labelling for used fentanyl patch vial

Mon 11/10/2014 1:10 PM

Hi Bruce,

I like your proposed label for the child proof vial. It is a good reminder.

Sincerely,

Sharon

Sharon Kerr, B.Sc.(Pharm), R.Ph.
Inspector/Practice Consultant | College of Pharmacists of BC
778.968.4239 | 800.663.1940 | www.bcpharmacists.org

Safety should not be a Patchy Event using transdermal fentanyl

Avoid flushing patches down the toilet

- General medication disposal educational programs
  - Ontario “I Don’t Flush” awareness campaign Oct 17, 2014
  - BC Fish don’t do drugs www.youtube.com/watch?v=CKnxEjrhhmc Jan 15, 2015
  - www.healthsteward.ca
- Avoid flushing if septic tank….
- Exceptional circumstances when flushing patches down the toilet would be your last resort as a means of disposal
  - Risk of misuse, harm, diversion
  - Unable to lock up safely

5 % of BC Pharmacies do not accept medications for disposal*

- Why not? Nearly everyone else does!! (95%)
- Isn't it fair for all of us to bear the responsibility?
- If we are not going to (or are we able to?) mandate pharmacies, - even new pharmacies on opening- to require accepting medications for disposal – should we not be exploring/understanding/supporting how to better move this 5% group to accept returns?

* http://www.bcpharmacy.ca/medication-disposal

5 % of BC Pharmacies do not accept medications for disposal

- What could we perhaps do?
  - Study it and ask some questions
    - Hire a consultant, student to assist
  - Work with the BC Pharmacy Association, Healthsteward.ca, Stericycle, Provincial Ministries, municipalities
  - Understand factors leading to non-availability of disposal service
    - Is it business economics for non-participation?
    - Merely “not interested” How disinterested? Could complacency be influenced?
    - Are there barriers related to pick up of medication?
    - Which geographic locations do not accept – is it really only rural? Unknown
    - Are there any large regional provincial areas lacking supporting pharmacies?
- Should all pharmacies who do not provide medication disposal service be required/encouraged to **refer** to another local pharmacy who does offer this service?

http://www.bcpharmacy.ca/medication-disposal

http://www.healthsteward.ca/

HEALTH PRODUCTS STEWARDSHIP ASSOCIATION

Stericycle employee Jessica Meyer said their medication pick up service is province wide across British Columbia!

- either they pick up, or
- a courier pick up service is arranged

OnCall PHARMACIST INFORMATION LINE

Questions and Answers

ReadLinks Vol. 32 No. 6 November/December 2007

Q Does a pharmacy have to have a sharps disposal system in place?

A If a pharmacy sells syringes to patients, it should also have a disposal service in place to accept sharps back from patients. A list of sharps disposal companies can be found on our website. The *Framework of Professional Practice* (Role 2, Function D) addresses this issue. Some pharmacies may charge patients for the disposal, if the syringes were purchased elsewhere. That is a business decision which is outside the college's jurisdiction.

Hey wait.... If a pharmacy should have..... a disposal service for sharps (if selling), then

if a pharmacy is selling medications, like fentanyl transdermal patch... should they not also have a disposal service in place to accept them back from patients?

P.S. The BC Medications Returns Program is cost free to pharmacy participants

http://library.bcpharmacists.org/H-Resources/H-3_ReadLinks/ReadLinks-NovDec2007.pdf

Framework of Professional Practice

Roles and Functions

Role 2 Produce and distribute drug preparations and products

Function A	Produce drug preparations and products
Function B	Store drug preparations and products
Function C	Distribute drug preparations and products
Function D	Dispose of drug preparations and products

Function D Dispose of drug preparations and products

Activity 1 Identify products requiring disposal

Indicators of good practice

- Inventory is checked regularly for items requiring disposal
- Products received from others requiring disposal are identified

Activity 2 Store products requiring disposal securely

Indicators of good practice

- Products for disposal are stored in a suitable container and clearly identified
- Products for disposal are stored separately

Activity 3 Remove products from pharmacy for disposal

Indicators of good practice

- Methods for disposal are safe and environmentally responsible
- Secure disposal service providers are identified and utilized
- Products are disposed of in a manner that meets legal and professional requirements

Function D, Activity 3 says practice should function to utilize Disposal Service Providers

http://library.bcpharmacists.org/D-Legislation_Standards/D-2_Provincial_Legislation/1009-FPP.pdf

Manitoba Study

- Time Frame: 12 years; 2001 - 2013
- Data Base: Manitoba Drug Information Network
- 11, 063 patients started using fentanyl patches
- **74.1 % deemed unsafe**
  - As prior opioid exposure was inadequate
- Improved in more recent years, but still over entire study period one-half of fentanyl prescriptions written with inadequate prior opioid exposure

2016 CMAJ Safety of fentanyl initiation according to past opioid exposure among patients newly prescribed fentanyl patches. http://www.cmaj.ca/content/early/2016/04/04/cmaj.150961

Manitoba Study

- States that “one important issue, and a factor under the control of prescribers, is the recommendation that first-time users of the fentanyl patch have adequate prior exposure to opioids.”

2016 CMAJ Safety of fentanyl initiation according to past opioid exposure among patients newly prescribed fentanyl patches. http://www.cmaj.ca/content/early/2016/04/04/cmaj.150961

Avoid ½ patches, cutting patches

- Opioid tolerance not assured
- No published or standard procedure for half-patching
  - Errors occurring in hospitals
  - Confusion occurring in home health helping patients
- Health Canada reported that one patient died from half-patch method*
- All monographs warn to not cut patches
- Fraser Health to issue practice bulletin shortly

*McMorran M, Longo M. Fentanyl transdermal patch and fatal adverse reactions. Canadian Adverse Reaction Newsletter 2008(3):447-50.Available from: http://www.hc-sc.gc.ca/dhp-mps/medeff/bulletin/carn-bcei_v18n3-eng.php

How should the College Board respond to this presentation?

- Provide educational support to pharmacists, technicians, and pharmacy sites
  - To safeguard public via improved awareness
  - To improve disposal of used fentanyl transdermal
- Review opportunities with partners
  - Together could disposal and other efforts be heightened?
- Reflect on jurisdictional supportive actions
  - How can pharmacy practice be moved to improve?
    - Which areas are most important?
    - Which areas are most amenable to influence?
    - Where is drug risk management most concerning?

End of Presentation

Thanks for your interest, attention

What questions do you have?

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

14. DrugSafe BC
a) Update

INFORMATION ONLY

Purpose
To provide a six month impact update of the DrugSafeBC campaign and related pharmacy security measures.

Background
Pharmacy robberies in British Columbia have increased dramatically over the past seven years, accompanied by increasing levels of violence. By July 2014, the number of pharmacy robberies and break-ins had already surpassed the total number of incidents in all of 2013.

On September 15, 2015, the College launched DrugSafeBC, the public awareness campaign to inform British Columbians about new pharmacy security measures designed to deter pharmacy robberies. The purpose of DrugSafeBC is to reduce pharmacy robberies and the amount of narcotics that end up on our streets. Time delay safes and standard signage are critical security measures to achieving these goals. In addition to standard signage provided to all community pharmacies, the DrugSafeBC campaign featured print, radio and television ads, and social media, to build awareness of the new time delay safes.

Discussion
Six months Results

In the six months following the launch of the DrugSafeBC campaign there have been four confirmed pharmacy robberies reported. With over 40 pharmacy robberies occurring in the months leading up to the changes (January 1 to September 15), and 39 robberies in 2014, the College is hopeful the downward trend is here to stay. While this is still early days, the College is encouraged by this reduction of pharmacy robberies over the past six months.

The College is also closely monitoring the number of pharmacy break and enters. Since the new pharmacy security measures have come into place 18 break and enters have been reported to the College. Only 17 break and enters were reported to the College from January to September 15, 2015.

Further analysis and time is required to review any pharmacy break and enter trends or assess any unintended consequences of the increased security measures. We also realize that it will take time for individuals to test the new security measures and discover they are unable to easily obtain drugs.

Incident Reporting Requirements

We recognize the challenges we have with the data that is available to us for tracking pharmacy robberies, theft of personal information and break and enters. A robust data set would require efforts from both registrants and the College. Currently, the data is inconsistent, sometimes incomplete and at times, otherwise flawed. The tracking system is basic and relies on entry from an administrative support person without the clinical or investigative perspective.

The College is in a unique position to collect pharmacy security incident data that could be used for multi-purposes including tracking trends, highlighting areas where registrants may need support to be compliant with the requirements and for program evaluation. To not leverage this is a missed opportunity.

College staff are reviewing the pharmacy security incident reporting requirements and the data collected to date, looking to see what other jurisdictions are doing, and identifying ways to maximize the quality of the data collected without creating a process that is onerous to registrants. The review is expected to be completed by early June.

PRIME-BC

PRIME-BC is the Police Records Information Management Environment for the province of British Columbia. Designed to streamline the records management system, PRIME-BC provides a common information system focused on supporting police officers and the delivery of community policing. BC is the first jurisdiction in North America where actual policing and real-time information and investigational tools are in every area of our province on the same exact system in a timely manner.

The Robbery Prevention Working Group identified the value of having pharmacy incidents differentiated within the PRIME-BC database. With the help of the Vancouver Police Department, the proposal for pharmacy specific location code for PRIME-BC has been approved and is currently in the process of being implemented. Pharmacy specific location codes will allow for better tracking of incidents in pharmacies by police officers across BC.

Pharmacy Security Evaluation

As part of seeking Board approval to proceed with strengthening pharmacy security requirements, a commitment was made to evaluate the program. The planning for this work is underway with Dr. Martin Andresen of Simon Fraser University. This the evaluation will be

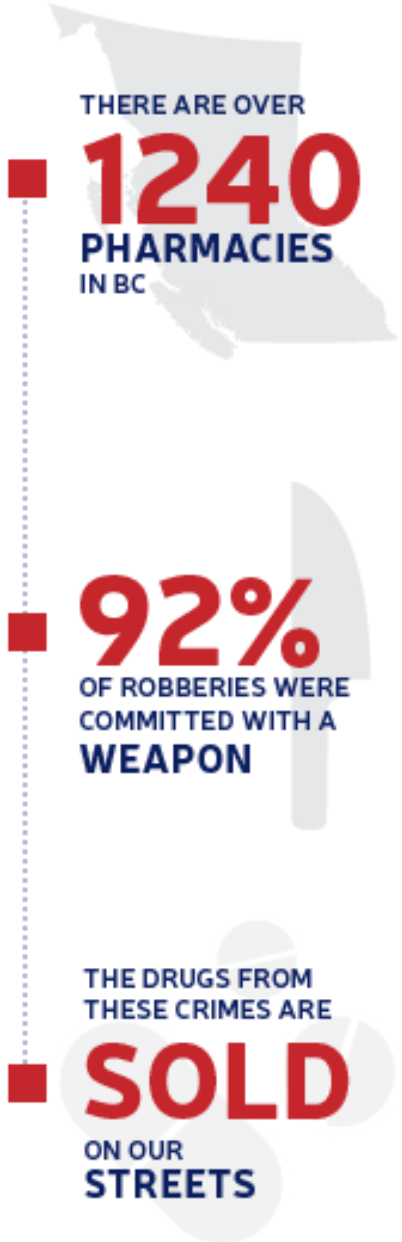
conducted in partnership with Vancouver Police Department who are able to share additional data sets for the same incidents. This project highlights continued collaboration and a shared responsibility for tackling what was identified as a significant issue in the province.

The specific analysis of the data will likely begin in September 2016, following the one year anniversary of the DrugSafeBC campaign, in order to use a full 12 months' worth of data in the evaluation of the new pharmacy security measures.

14. DrugSafeBC
a) Update

Gillian Vrooman
Director of Communications and Engagement

Pharmacy Security in BC



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Community Pharmacy Security Resource Guide (2015)

A companion document to
Professional Practice Policy – 74 Community Pharmacy Security.

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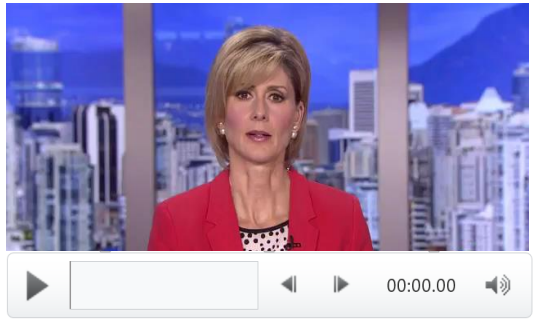
TIME IS UP
FOR DRUG THIEVES

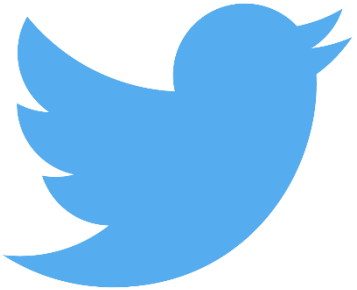
DRUG SAFE BC

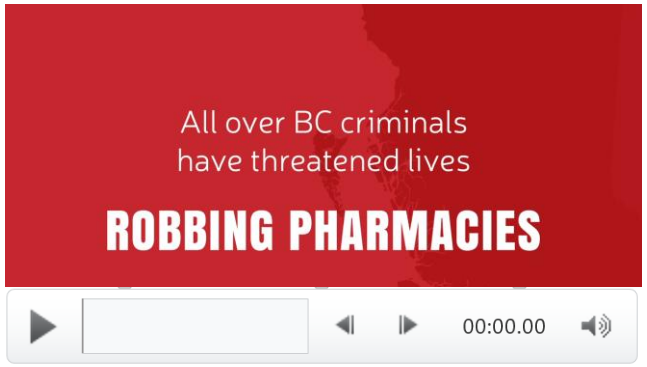
College of Pharmacists of British Columbia

A PROGRAM OF College of Pharmacists of British Columbia

College of Pharmacists of British Columbia







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Twitter - #DrugSafeBC

Facebook Ads - Over 225, 000 people reached

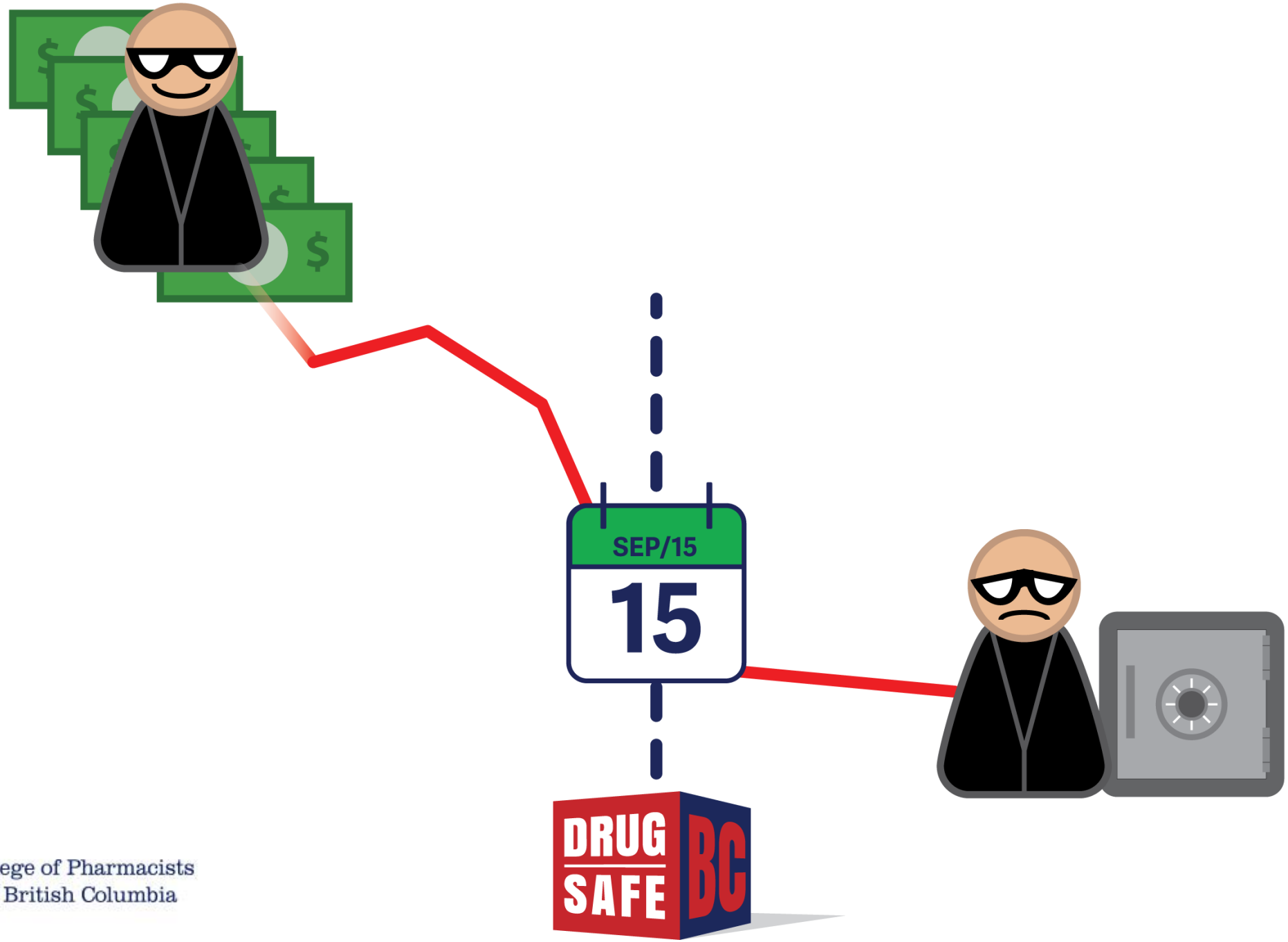
YouTube Ads - Over 90, 000 video views

Google Ads - Over 4.5M impressions

TV Ads - Over 8M estimated audience

Radio Ads - Over 200,000 people reached

Newspaper Ads - Over 900,000 papers circulated



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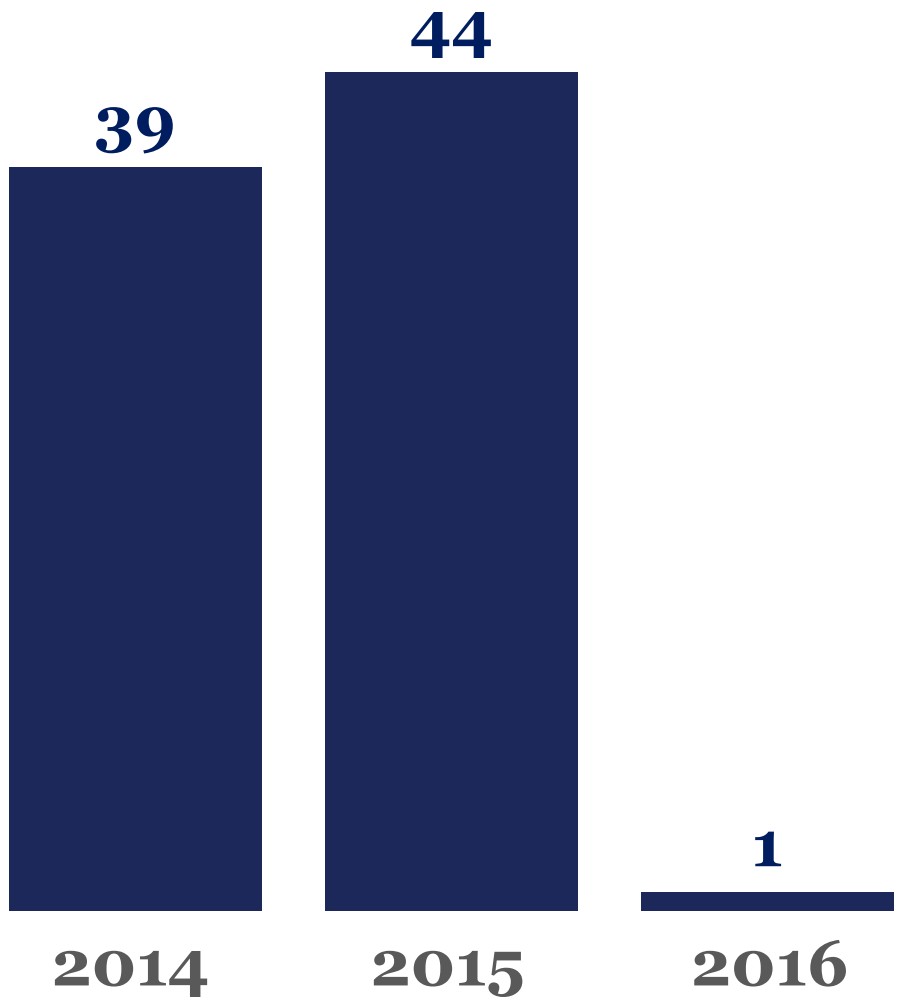
of British Columbia

robberies



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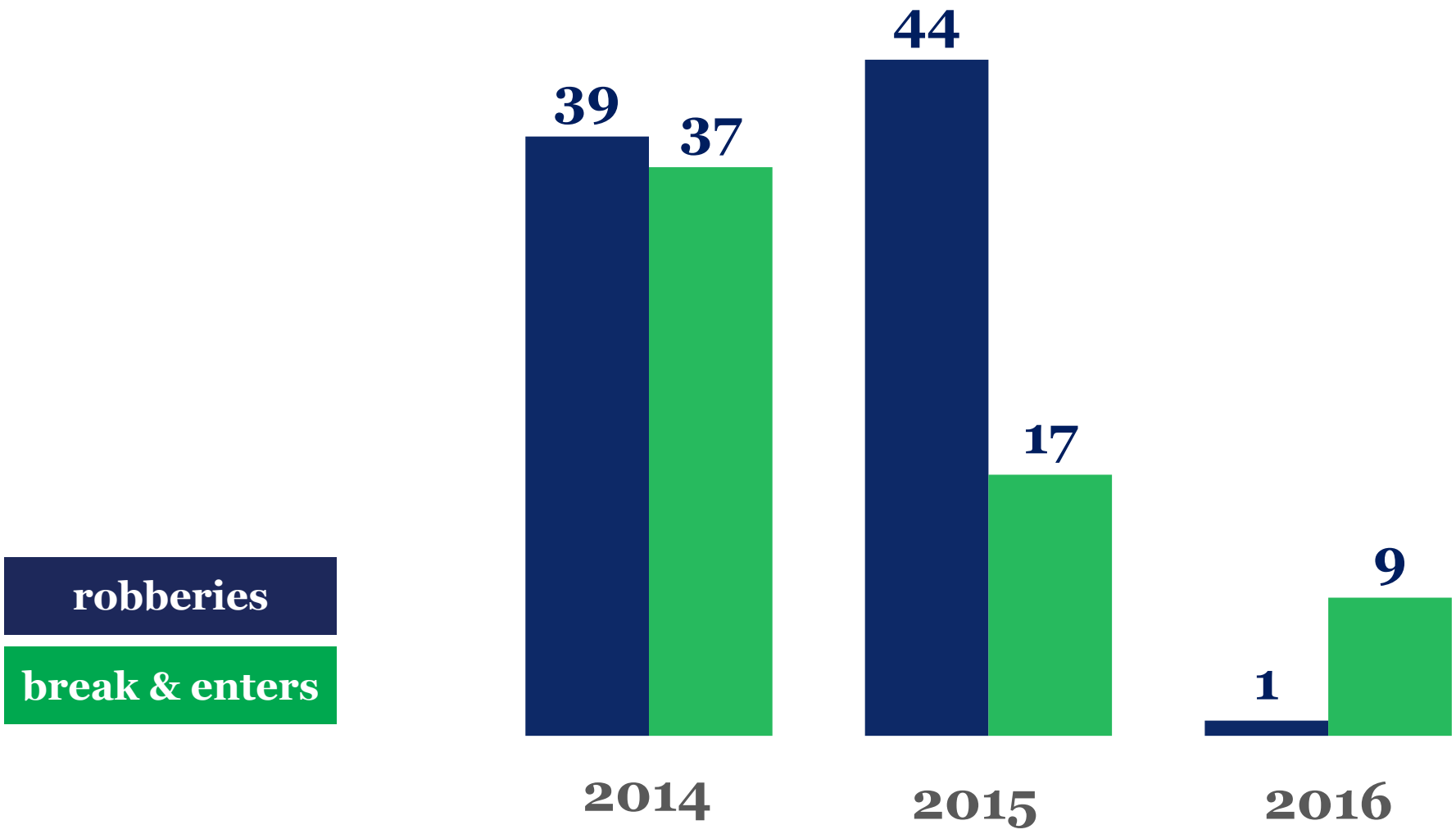

College of Pharmacists of British Columbia

Royal Canadian Mounted Police

Canada

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enters

s that have occurred over the past few

ers to smaller, independent pharmacies
nected based on the method in which

ntain various narcotics. While the safes
information to identify those responsible.

e suspects involved," says Surrey
r additional information."

rd pickup, an older blue four door sedan,
d suspects breaking into neighbouring

d property," says Cpl. Schumann. *"If you*
al police department."

he College," said Blake Reynolds, Chair
cies across BC will help deter others

urrey RCMP's website
eview the Community Pharmacy Security

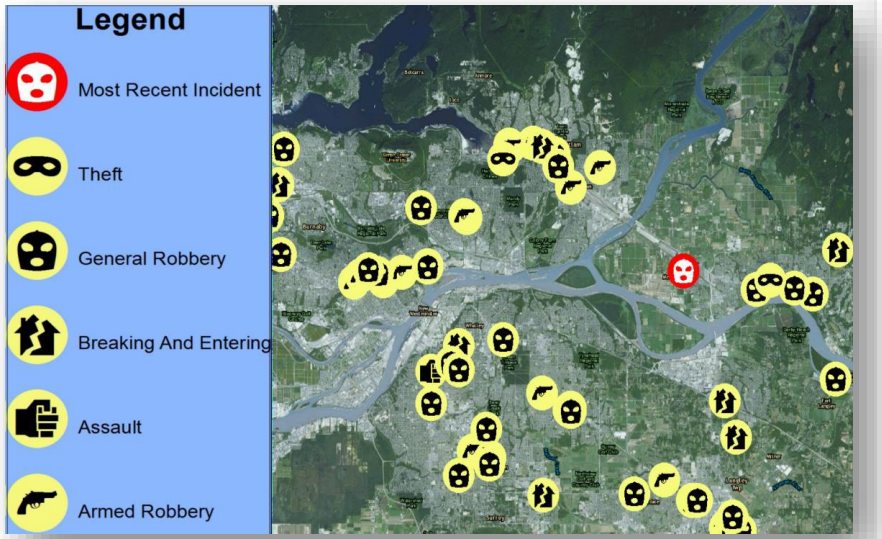
Resource Guide provided by the College of Pharmacists of BC.

Protecting the safety of patients and pharmacy professionals and preventing the diversion of drugs is very important to the College, said Blake Reynolds, Chair of the College of Pharmacists of BC. Getting the word out about new security measures and time-delay safes in pharmacies across BC will help deter others from targeting pharmacies.

Home » News »

College of Pharmacists of British Columbia

Incident Reporting Requirements



Incident Form

All incidences must be reported within 24 hours.

PHARMACY INCIDENT

Pharmacy Name: TEST PHARMACY
200 1765 8th Ave W
Vancouver BC V6J 5C6

Pharmacare #: 000

Date of Incident: 1/12/2015

Time of Incident:

Incident Category: Robbery

Sub-Category: Other

Comments:

INCIDENT DETAIL (Forgeries and Pads)

Patient Name Used:

PHN Used:

Doctor Name Used:

Practitioner ID:

City of Practice:

Duplicate Folios #:

Rx Dispensed: Yes No

Non Dispensed Drugs Involved:

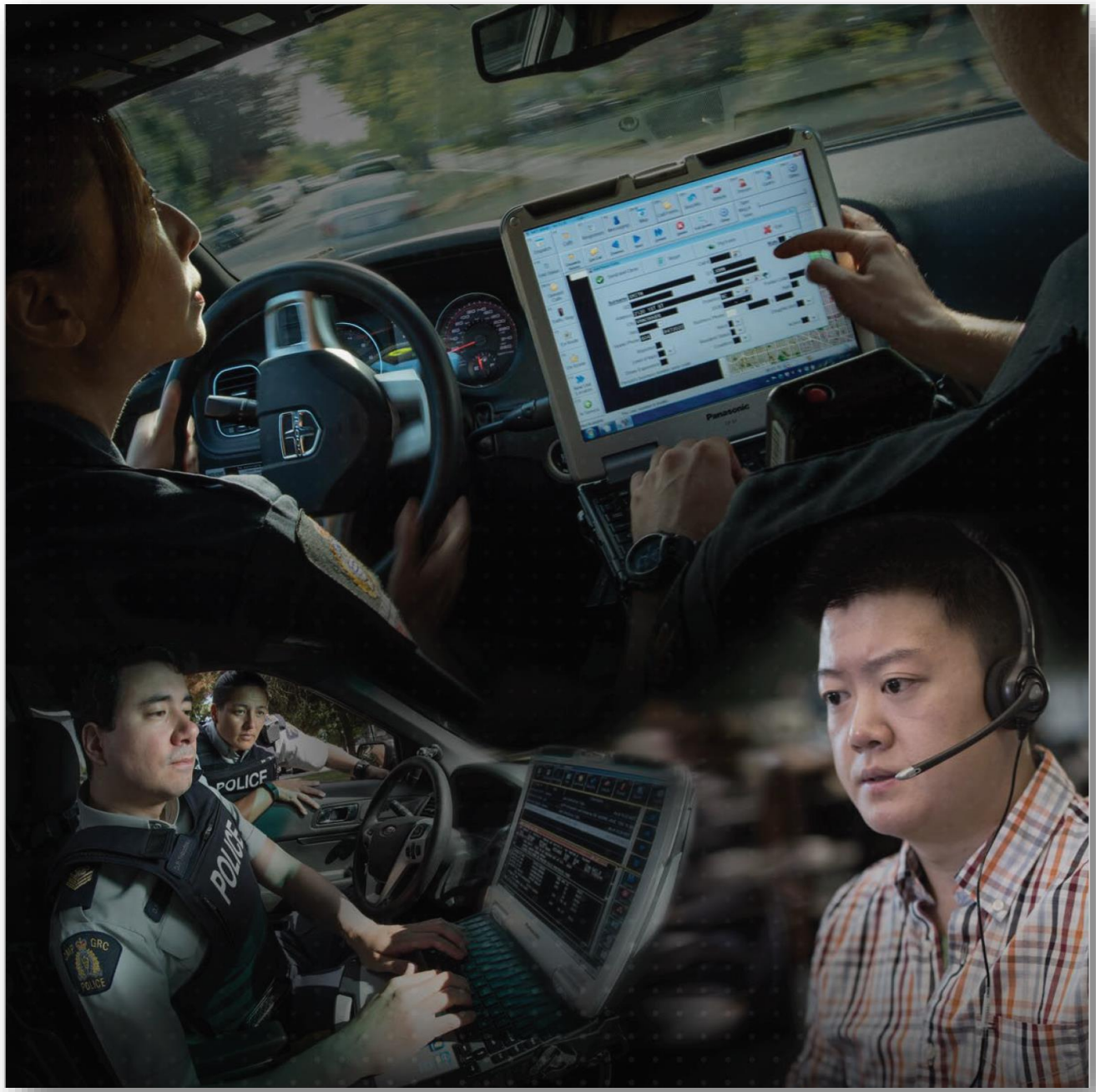
Health Canada Form: (Form 4004)

Select

Allowed file types: pdf,gif,jpg,jpeg,png,tif
Maximum file size: 2MB

College of Pharmacists of British Columbia

PRIME-BC Pharmacy Incident Tracking



College of Pharmacists of British Columbia

Pharmacy Security Evaluation

SFU

College of Pharmacists of British Columbia

VANCOUVER POLICE

Questions?

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

15. Physical Assessment Presentation – Presenter Biography

INFORMATION ONLY

Dr. Sean Spina – Biography

Dr. Spina graduated from the University of British Columbia Faculty Of Pharmaceutical Sciences with his Bachelor of Science in Pharmacy in 2000. He then did his hospital Residency at Royal Columbian Hospital where he was formally trained in physical examination techniques. After completion of his residency in 2001, he worked in Internal Medicine for 4 years before he earned his Doctor of Pharmacy degree from UBC in 2007. Dr. Spina then moved to Vancouver Island where he is currently a Clinical Pharmacotherapeutic Specialist in Internal Medicine and is the Coordinator of Clinical Services at Royal Jubilee Hospital in Victoria, BC. Sean has always been an advocate for pharmacist performed physical assessment for the purposes of monitoring medication therapy. Sean formally teaches physical examination techniques to pharmacists in a variety of settings and was a consultant on the first in Canada, Canadian Society of Hospital Pharmacists – BC Branch Physical Examination Course for pharmacists.

Physical Examination & Clinical Pharmacy Practice in British Columbia

April 15, 2016

Sean P Spina, BScPharm, ACPR, PharmD, FCSHP

Clinical Coordinator - Vancouver Island Health Authority

Clinical Assistant Professor - University of British Columbia

Presenter Disclosure
Sean Spina

- Speaker has no current or past relationships with commercial entities related to this talk.
- This presentation has received no financial or in-kind support from any commercial or other organization.
- Speaker is a strong believer that the future of our profession requires pharmacists to perform physical examination.

Presenter Disclosure
Sean Spina

CSHP2015

Targeting Excellence in Pharmacy Practice

Join the New CSHP 2015 e-Forum!

- CSHP members can now ask their CSHP 2015 related questions and share their experience and successes on the new CSHP 2015 e-Forum!

ARE WE ON TARGET FOR PHARMACY PRACTICE EXCELLENCE?

Oct 2012 Issue No. 8

"Learn, Discuss, Act, Share"

Monthly updates keep you informed of all the latest CSHP 2015 news, activities, resources and education to help you reach your targets.

Hospital Pharmacy Leaders Speak Up About Their Priorities and Progress Towards CSHP 2015

Check out the results of a survey completed by hospital pharmacy directors and managers! CSHP conducted an online survey from January to April 2012 to determine both, ***the level of activity*** for each of the 36 CSHP 2015

Objectives

- Understand rationale for pharmacist performed PE
- Appreciate the value of physical examination by pharmacists
- Understand how pharmacist performed physical examination can be used to monitor patients for efficacy and toxicity of drug therapy

Outline

- Presentation 35min
- Questions 25min

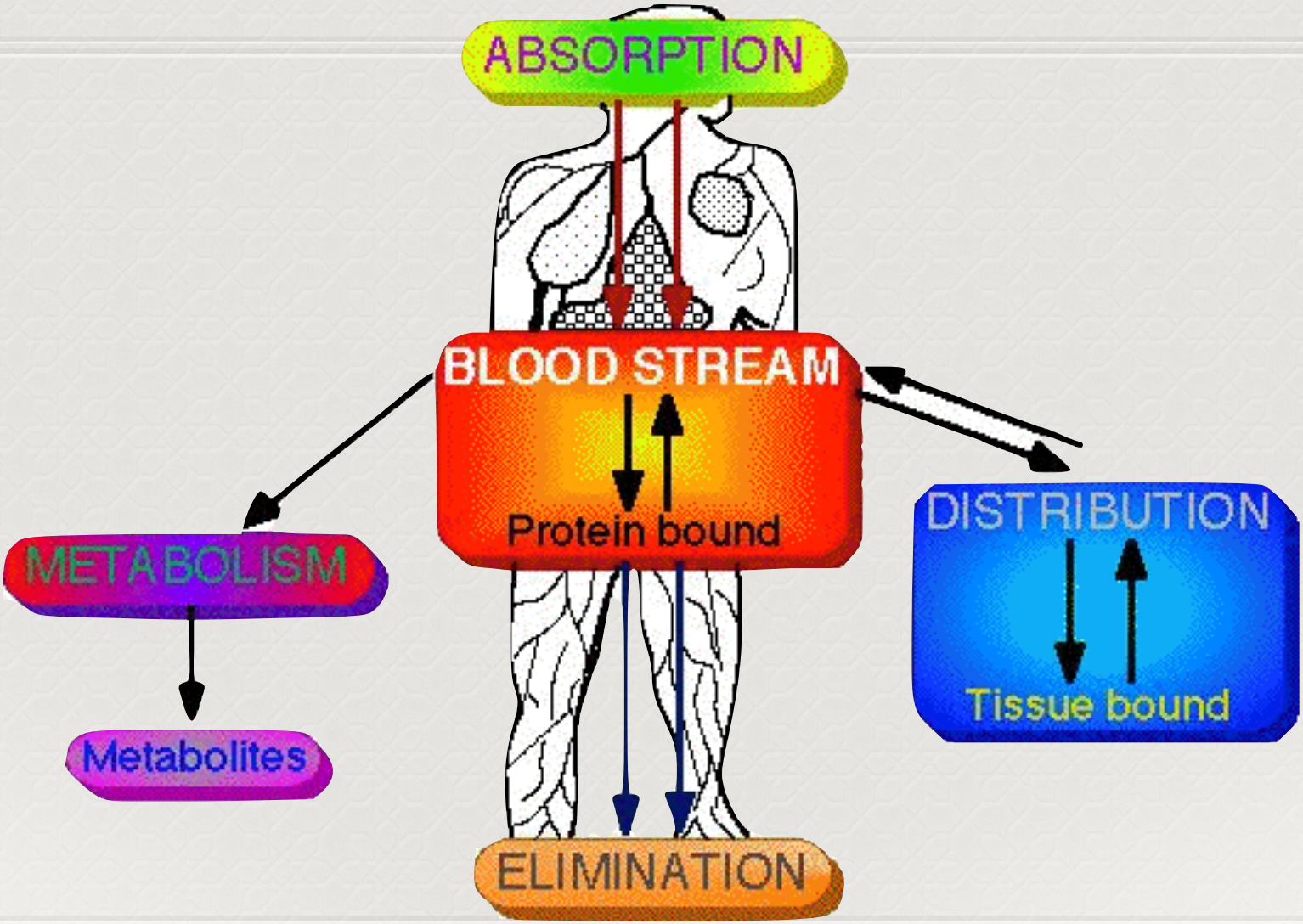
"Clinical Pharmacy"

"the practice of providing patient care that optimizes medication therapy and promotes health, wellness and disease prevention"

"Pharmacists broaden their role in the primary care environment to include PE as a function of collaborative drug therapy management"

Pharmacotherapy 2008; 28:816-7 *Am J Health Syst Pharm 1999; 56:1665-7*

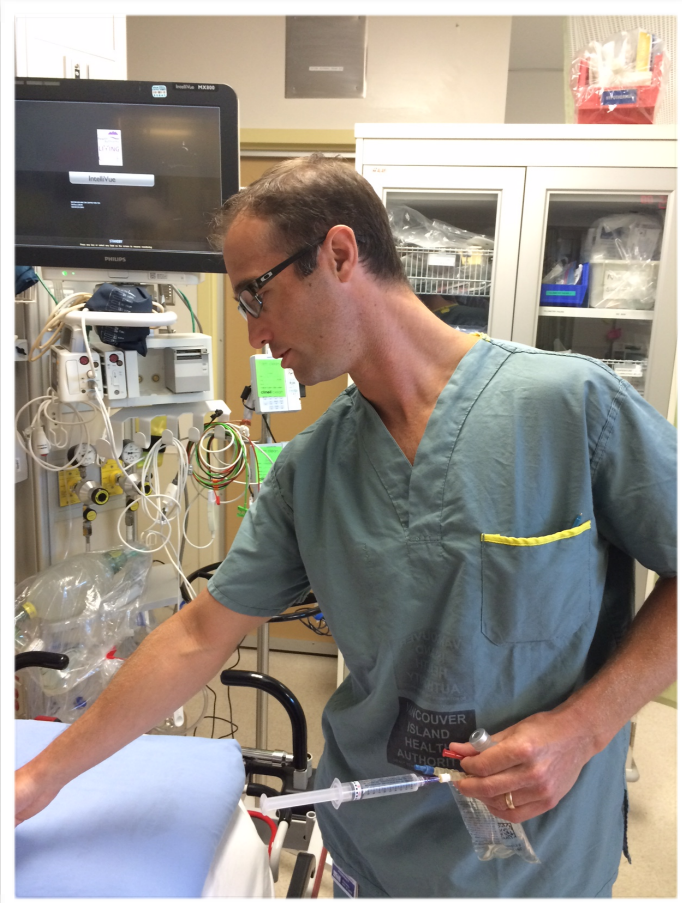
ADME


ABSORPTION
BLOOD STREAM
Protein bound
METABOLISM
Metabolites
DISTRIBUTION
Tissue bound
ELIMINATION

"Scenario A"

Dr. Reg Smith, PharmD

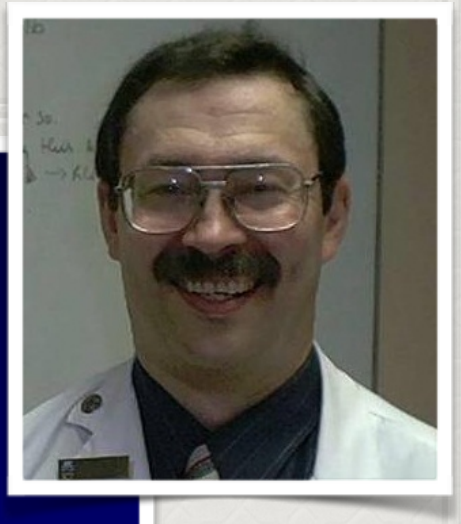
"Scenario B"

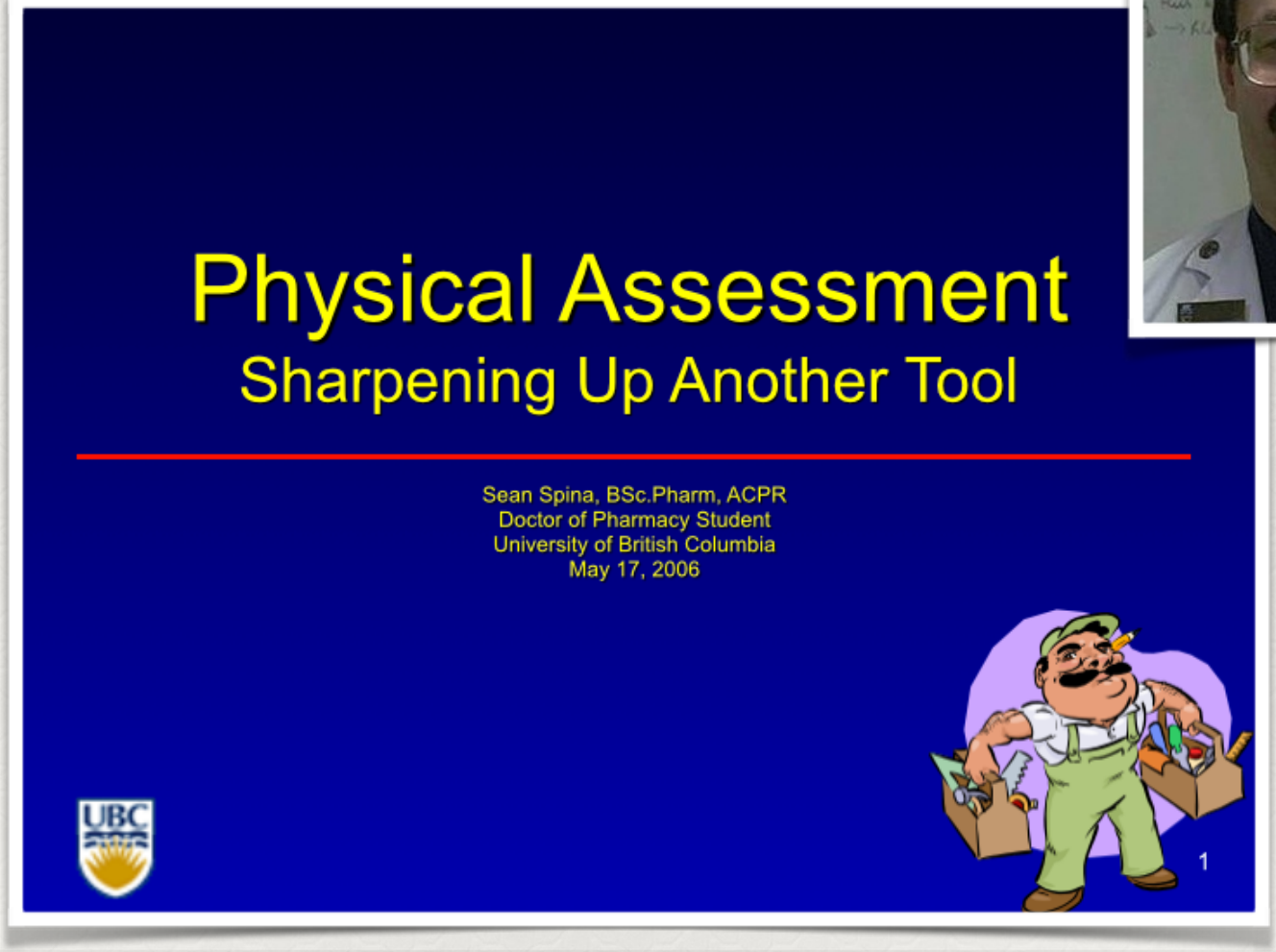


Dr. Richard Wanbon, PharmD

“Scenario C”

2016...10 years later





Physical Examination

..is the use of observation and physical techniques to elicit information about the patient's bodily functions and conditions

The systematic process by which a clinician investigates the body of a patient for signs of disease and the response to treatment. It generally follows the taking of the history....

Together with the history, the physical examination aids in determining the correct assessment and devising the treatment plan.

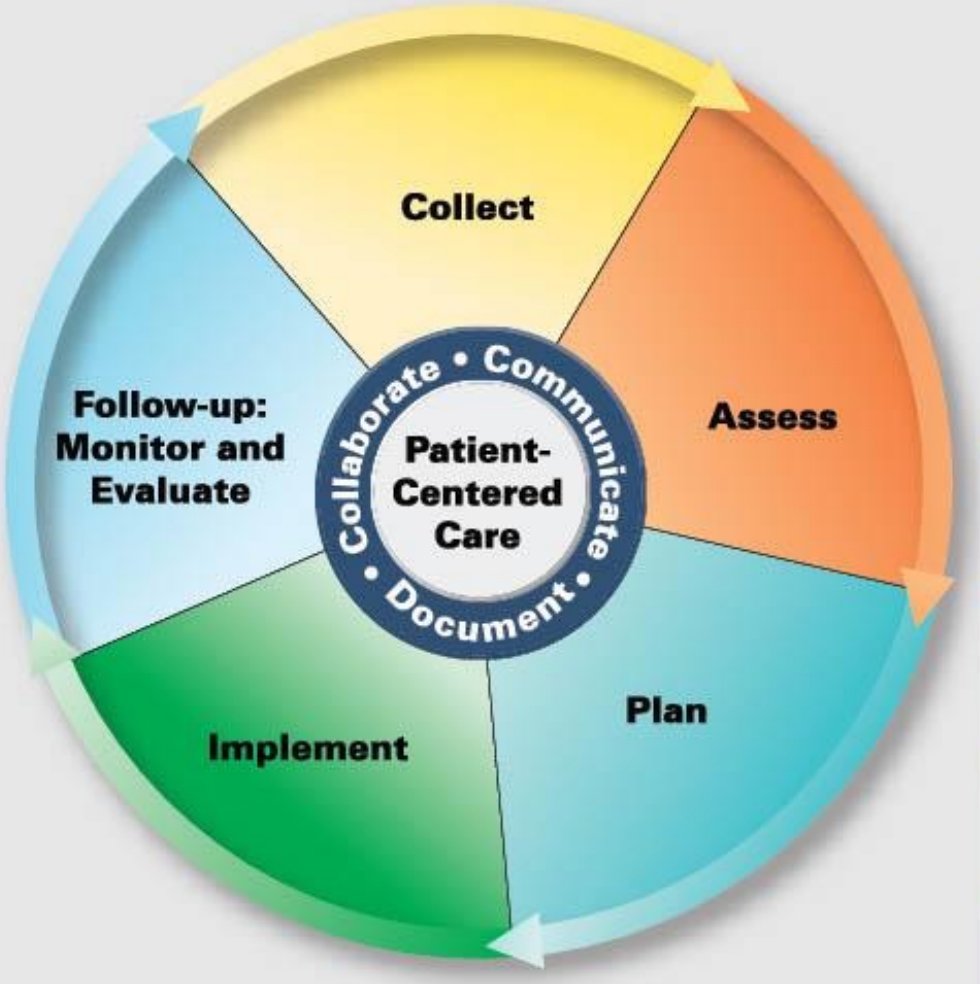
Dorland's Illustrated Medical Dictionary (25th ed)

Drug Intell Clin Pharm 1977;11:200-3.

Barry, CPJ/RPC 2012;145:174-179

Pharmacists' Patient Care Process

The Joint Commission of Pharmacy Practitioners, a coalition of national pharmacy associations that includes APhA, recently adopted the Pharmacists' Patient Care Process to promote consistency in patient care delivery within the profession.



Source: http://www.pharmacist.com/sites/default/files/JCPP_Pharmacists_Patient_Care_Process.pdf

Pharmacists' Patient Care Process

Pharmacists use a patient-centered approach in collaboration with other providers on the health care team to optimize patient health and medication outcomes.

Using principles of evidence-based practice, pharmacists:

Collect
The pharmacist assures the collection of the necessary subjective and objective information about the patient in order to understand the relevant medical/medication history and clinical status of the patient.

Assess
The pharmacist assesses the information collected and analyzes the clinical effects of the patient's therapy in the context of the patient's overall health goals in order to identify and prioritize problems and achieve optimal care.

Plan
The pharmacist develops an individualized patient-centered care plan, in collaboration with other health care professionals and the patient or caregiver that is evidence-based and cost-effective.

Implement
The pharmacist implements the care plan in collaboration with other health care professionals and the patient or caregiver.

Follow-up: Monitor and Evaluate
The pharmacist monitors and evaluates the effectiveness of the care plan and modifies the plan in collaboration with other health care professionals and the patient or caregiver as needed.

CLINICAL PHARMACIST'S NOTE re :

CC: patient's chief complaint
- what symptoms brought patient to hospital?

HPI: - sudden or slow onset? What makes better or worse? Describe pain.
- has this occurred before? What did pt do?
- see GP? Rx? OTC? Who brought to ER? Time?

PMHx: - include number of years

RxPTA: - include number of years, OTCs, herbals and recreational drugs

Allergies: Type of reaction? True, possible, side-effect

Family/Social Hx: Etoh, smoking, recreational drugs, Ht and Weight

Medical Problems:

S - medications used, drug effect, adverse effects, drug administration information

0 - physical findings, lab / investigation data
CNS:
HEENT:
CVS:
RESP:
ABD:
MS/SK:
Labs:
Rx PTA:
Rx hospital
time of first dose, any doses missed
statement – "all doses charted as given"
efficacy and toxicity
statement – "no adverse effects to therapy were documented"

A – What is status of the problem?
- how severe is it?
- stable, getting worse or improving?

Is drug therapy indicated /optimal?
Duplication of therapy?
Recent inappropriate changes in therapy?
Potential drug interactions?

Any ADRs from current therapy?
Experiencing any drug interactions?

Compliant with medications prior to admission to hospital?
Receiving all current medications in hospital?

P – what pharmacist plans to monitor
- what recommendations (medication changes: labs) to make to patient's physician or other health professionals
- what topics pharmacist will counsel patient on.

Name
Pager #

Dr. Sean Spina
Clinical Coordinator
Vancouver Island Health Authority
Clinical Instructor
Faculty of Pharmaceutical Sciences, University of British Columbia

Question #1

List 5 reasons why pharmacists should perform physical examination on patients

- 1 - accountability
- 2 - responsibility
- 3 - appropriateness
- 4 - adjuvant knowledge
- 5 - monitoring

Dr. Greg Egan, PharmD

Question #2

List 5 reasons why pharmacists should NOT perform physical examination on patients

- 1 - turf
- 2 - not trained
- 3
- 4
- 5

Dr. Arden Barry, PharmD

Question #3

List 3 professions in hospital who work on the wards and don't physically assess patients

- 1 - Social Work
- 2
- 3

Teaching PE to Rx

TABLE 2 Baseline assessment of PE

Parameter	*n*	%
Have you ever received formal education in PE? (*n* = 34)		
Yes	6	17.6
No	28	82.4
In my practice, I currently use PE in my routine assessment/monitoring of a patient's drug therapy (*n* = 34)		
Yes	13	38.2
No	21	61.8
Types of PE used in practice (*n* = 25)		
Blood pressure	12	48.0
Blood glucose	4	16.0
Heart rate	3	12.0
Rash	2	8.0
Peripheral edema	1	4.0
Diabetic foot	1	4.0
Blood lipids	1	4.0
Inspection of minor cuts	1	4.0

PE = physical examination.

TABLE 4 Follow-up survey results (*n* = 12)

Question	*n*	%
Did you perform PE in your practice prior to the session?		
Yes	7	58.3
No	5	41.7
Having attended the educational session on PE, do you now perform some PE as part of routine assessment/monitoring of a patient's drug therapy in your practice?		
Yes	7	58.3
No	5	41.7
Would you attend another continuing education session in the future on PE?		
Yes	12	100.0
No	0	0.0

PE = physical examination.

Barry, CPJ/RPC 2012;145:174-179

Hurdles

TABLE 3 Identified barriers to PE ($n = 28$)

Barrier	*n*	%
I have never received any formal education in PE	26	92.3
I feel uncomfortable performing PE on patients	12	42.9
I feel as though patients would be uncomfortable with having a pharmacist performing PE	11	39.3
I feel as though I do not need to perform PE as I have access to PE information from other health care professionals	9	32.1
I feel as though I am "treading on the turf" of other health care professionals	5	17.9
I do not see value in performing PE in my practice	4	14.3
Other (lack of work area privacy)	2	7.1
Other (lack of time)	1	3.6

PE = physical examination.


A. Barry

Barry, CPJ/RPC 2012;145:174-179

Clinical Pharmacy Workshop Presentations

Physical Parameters for Monitoring Patient Care — A New Direction in Clinical Pharmacy Education

George E. Downs, Peter H. Vlasses, Thomas J. Cali and John A. Gans
Department of Pharmacy, Philadelphia College of Pharmacy and Science, Philadelphia PA 19104

1976 AJHP

Francke has been lauded as "Pharmacy's Man of the Century"

EDITORIALS

by DONALD E. FRANCKE

Physical Assessment and the Clinical Pharmacist

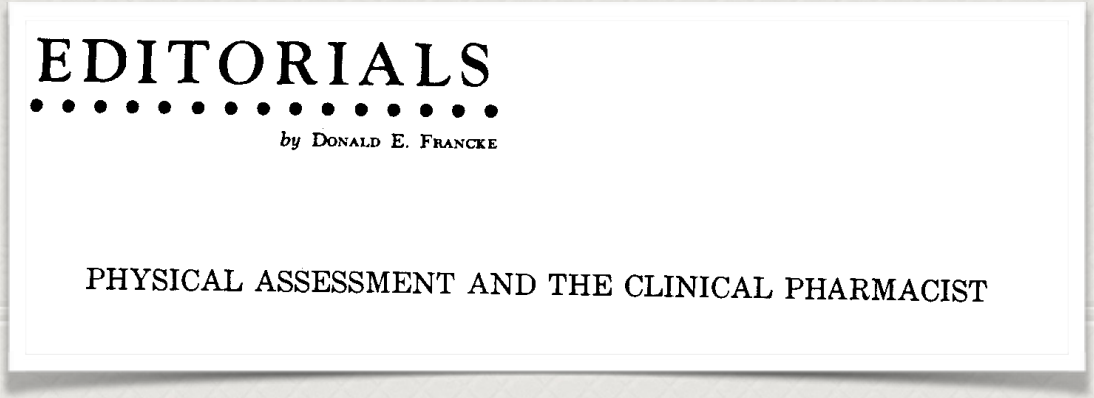
R. Leon Longe
Jon C. Calvert

Abstract

This article introduces a series of articles on physical assessment and the clinical pharmacist. The primary objective of the articles is to present basic knowledge and methods of physical assessment used to monitor drug effect. A post-test based on the competency objectives will be included in a future issue.

PHYSICAL ASSESSMENT AND THE CLINICAL PHARMACIST

1977 Drug Intel Clin Pharm 1977;11:200-3



EDITORIALS

by Donald E. Francke

PHYSICAL ASSESSMENT AND THE CLINICAL PHARMACIST

- Enables the pharmacist to more competently monitor the patient
- It improves the skills of observation, perception and data collection
- Enhances role of the pharmacist on care team
- Makes pharmacist a more valuable member of care team
- Improves effective communication
- It is an ESSENTIAL tool for monitoring for ADR and DI
- Helps clarify the significance of information in the patients chart
- "Past generations of Rx have been seriously hampered by their lack of PE. We are glad to see this new direction in pharmacy education"

1977 Drug Intel Clin Pharm 1977;11:200-3

Role of Pharmacist (1977)

Physical Parameters for Monitoring Patient Care
A New Direction in Clinical Pharmacy Education

- Rely on subjective data collection methods for basic drug therapy decisions
- Rx PE findings → objective parameters to complete the data collection and monitoring skills of pharmacist in clinical setting

Philadelphia College of Pharmacy and Science 1977

Role of Pharmacist (2016)

Physical Parameters for Monitoring Patient Care
A New Direction in Clinical Pharmacy Education

- Rely on subjective data collection methods for basic drug therapy decisions
- Rx PE findings → objective parameters to complete the data collection and monitoring skills of pharmacist in clinical setting

Philadelphia College of Pharmacy and Science 1977

Purpose of PE in Pharm Schools

Physical Parameters for Monitoring Patient Care
A New Direction in Clinical Pharmacy Education

- Rx cannot properly monitor the drug effects on disease process without a thorough understanding of and ability to perform physical examination
- Establish a baseline improve/worsen
- Rx physical exam — objective parameters for drug therapy monitoring
- Relevant information in chart was ignored because lack of understanding of terms

Philadelphia College of Pharmacy and Science 1977

ASHP Statement on the Pharmacist's Clinical Role in Organized Health-Care Settings

A fundamental purpose of the profession of pharmacy is to serve society by ensuring the safe and appropriate use of drugs. A fundamental goal of the profession is to promote health and prevent disease. ASHP believes that pharmacists should pursue these goals by promoting optimal use of drugs (including prevention of improper or uncontrolled use of drugs) and by providing authoritative drug information to other health-care professionals, patients, and the public.

ASHP believes that pharmacists in organized health-care settings bear a significant responsibility for ensuring optimal clinical outcomes from all drug therapy. Fulfillment of this responsibility is enhanced through the provision of comprehensive pharmaceutical services—the informational, clinical, and drug distribution components of which are managed as integrated systems.

ASHP believes that pharmacists should develop and provide clinical pharmacy services commensurate with the needs of each organized health-care setting and individual patients in that setting. Clinical activities should be performed when necessary through direct contact with patients

g. Physical signs and clinical symptoms relevant to the patient's drug therapy.

appropriately used.

1. Drug therapy monitoring and communicating relevant findings and recommendations to other health-care professionals who are also responsible for the patient's care. Drug therapy monitoring includes an assessment of
   a. The therapeutic appropriateness of the patient's drug regimen.
   b. Therapeutic duplication in the patient's drug regimen.
   c. The appropriateness of the route and method of administration.
   d. The degree of patient compliance with the prescribed drug regimen.
   e. Drug–drug, drug–food, drug–laboratory, or drug–disease interactions.
   f. Clinical and pharmacokinetic laboratory data to evaluate the efficacy of drug therapy and to anticipate side effects, toxicity, or adverse effects.
   g. Physical signs and clinical symptoms relevant to the patient's drug therapy.

   Findings from drug therapy monitoring activities enable pharmacists to make appropriate interventions to increase the effectiveness and minimize potential risks of drug therapy. Interpretation of such data may stimulate the formulation or revision of therapeutic plans in consultation with prescribers and other health-care practitioners. Drug therapy monitoring should be conducted as an ongoing activity in all health-care settings, although not every aspect of such monitoring may be needed for every patient.
2. Documentation of pharmaceutical care in the patient's medical record.
3. Preparation of medication histories for the patient's permanent medical record or other databases (e.g., medication profiles), or both.
4. Provision of oral and written consultations with other health-care professionals regarding drug therapy selection and management.
5. Patient education and counseling regarding drug therapy and drug-related disease prevention.
6. Participation in the drug therapy management of medical emergencies.
7. Development of patient-specific drug therapy management plans and therapy endpoints.
8. Control of medication administration in the patient-care area.
9. Monitoring, detecting, documenting, reporting, and managing adverse drug reactions.
10. Education of health-care practitioners regarding drug

and other committees where input concerning drug use and drug policy development is required.

14. Provision of accurate and comprehensive information about drugs and patient-specific drug information to other pharmacists, other health-care professionals, and patients as appropriate.
15. Initiation of and participation in drug and drug-related (e.g., medication administration devices) research, including formal clinical drug investigations.

ASHP believes that pharmacists have a responsibility to communicate advances in the development and delivery of these and other clinical pharmacy services to the health-care community and the public through appropriate publications, presentations, and programs.

Approved by the ASHP House of Delegates, June 5, 1989, and the ASHP Board of Directors, November 16, 1988. Developed by the ASHP Council on Professional Affairs. Supersedes earlier versions approved by the House of Delegates on May 15, 1978, June 7, 1983, and June 6, 1988.

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The bibliographic citation for this document is as follows: American Society of Hospital Pharmacists. ASHP statement on the pharmacist's clinical role in organized health-care settings. *Am J Hosp Pharm.* 1989; 46:2345–6.

Physical Assessment in the Community Pharmacy

Pharmacists can use assessment to ensure positive outcomes of pharmaceutical care.

by Timothy Pauley, PharmD, Ray Marcrom, PharmD, and Richard Randolph, PharmD

BETH GWINN

Pharmacist Ray Marcrom of Marcrom's Pharmacy, Manchester, Tenn., checks patient Kim Roberts for possible ear infection. Privacy is critical for introducing physical assessment to community practice.

Learning Objectives

Upon successful completion of this continuing education program, the pharmacist should be able to:

- Define physical assessment as it fits into the delivery of pharmaceutical care.
- Describe how to perform a medical history, make an assessment, and develop a plan to solve a problem.
- Explain the "review of systems" method for physical assessment.
- Explain why a pharmacist would require physical data on patients.
- Describe the appropriate steps to follow once the patient's physical data are collected.

Program Preview

With national attention being placed on health care reform and with regional and state reforms moving large numbers of patients into managed care, emphasis is being placed on identifying methods to manage patients' total health. This total-management concept requires the pharmacist to monitor patients' therapy and progress to ensure positive outcomes. To develop the pharmacist's role as a care manager, pharmacists must enhance or add to their many skills and duties that help ensure positive outcomes. Needed skills include gathering both objective and subjective information and using these data to evaluate a patient's physical condition appropriately and quickly.

Because pharmacists possess a unique body of knowledge with regard to disease states and their treatment[1] and are accessible to patients daily, they are in a position to act as gatekeepers, evaluating patients' conditions and directing them toward appropriate care or medical intervention.

America Pharmacy, May 1995, volume NS35

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Physical Assessment for the Community Pharmacist, Part One

Raylene M. Rospond, Pharm.D., BCPS; Angela Tice, Pharm.D.; Brad Tice, Pharm. D.

Upon successful completion of this article, the pharmacist should be able to:

1) Explain how physical assessment fits into the delivery of pharmaceutical care.

2) Explain why a pharmacist would require physical examination data in order to provide pharmaceutical care.

3) Identify which physical assessment skills are most relevant to a community pharmacy practice.

4) Outline resources available to pharmacists wishing to learn or improve physical assessment skills.

5) Describe the changes in a pharmacy that would be required in order to introduce physical assessment into a community practice.

The incorporation of the pharmacist care model into the provision of pharmacy services requires that practitioners have the ability to assess a patient and his or her likely response to therapy. Patient assessment in pharmacies, however, is not new. Community pharmacists are commonly asked for and routinely provide recommendations for minor health problems.

Prior to making such a recommendation, the pharmacist must assess the problem and the patient before selecting an appropriate treatment option. In the past, the patient profile and medication refill history were the only objective sources of information available to the pharmacist. Today, identifying and resolving drug therapy problems (Table 1) requires pharmacists to expand their abilities in the area of patient assessment.

This level of patient assessment often involves obtaining subjective data through the completion of a health history, medication history, or a patient interview.[1] In addition, physical assessment of the patient is one of the most valuable tools the pharmacist can have for gathering information to make an informed decision about a patient's health-related problems.

Physical assessment in the delivery of pharmacist care can be defined as "the systematic acquisition of physical data and symptomatology of patients for the purpose of initial evaluation and care recommendations, in-process case management, medical referral, or outcomes assessment."[2] Too often, when community pharmacists face the idea of performing physical assessment, images of invasive examinations enter their mind. It is important to remember that evaluation of physical data by the pharmacist is not intended to replace that of a primary practitioner; rather it is intended to augment the management of a patient's medical problems.

Community pharmacists routinely provide recommendations for minor health problems

Many community pharmacists today are already involved in laboratory testing or in training their patients on self-testing devices, such as home pregnancy tests, blood glucose meters, blood cholesterol meters, and clotting tests. Physical assessment skills will allow community pharmacists to extend their basic skills, provide a higher level of pharmacist care to their patients, and thereby set the stage for reimbursement of these services.

Theoretically, the incorporation of physical assessment skills into a community pharmacy practice seems appropriate. However, the practicality of their application is often called into question. These two articles outline common applications of physical assessment skills in community practice and address some of the most common barriers confronting today's practitioners.

Application of Physical Assessment Skills

Physical assessment skills can play a vital role in providing quality pharmacist care; however, when it comes to incorporating these skills into daily pharmacy practice, it is often hard to visualize their application. Through the use of cases, this section will provide the pharmacist with examples of ways in which physical assessment skills can be used in resolving drug therapy problems as well as in monitoring a current pharmacist care plan.

Pfizer *An educational series sponsored by Pfizer*

BC College of Pharmacists

Patient-oriented pharmacy services

86. (1) The pharmacist must actively monitor medication therapy to ensure that the patient receives safe and appropriate medication therapy and to protect the patient from medication-related problems.

(2) The pharmacist must actively monitor the progress of the patient's medication therapy at a frequency appropriate for the medical condition(s) treated.

(3) The pharmacist must take responsibility to detect, resolve and prevent medication-related problems using

(a) patient record and/or health record,

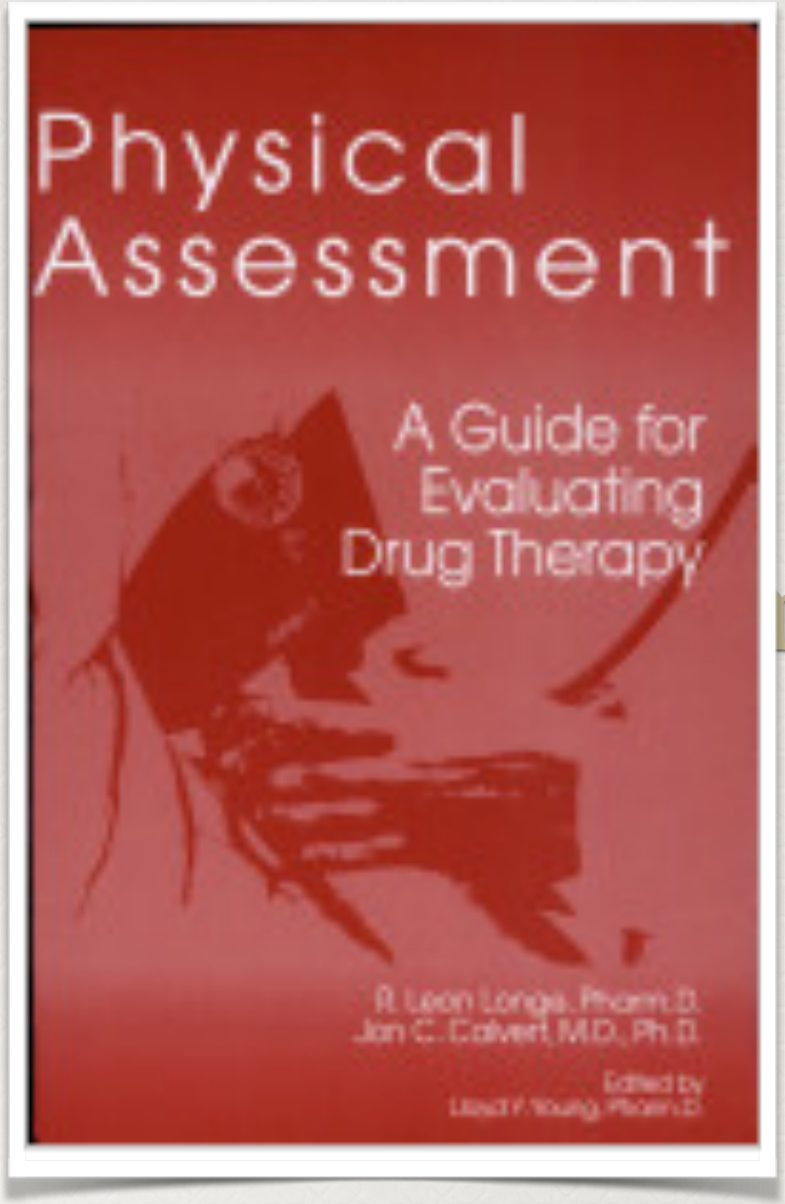
(b) discussion with the patient, practitioner, and/or other appropriate individual, and

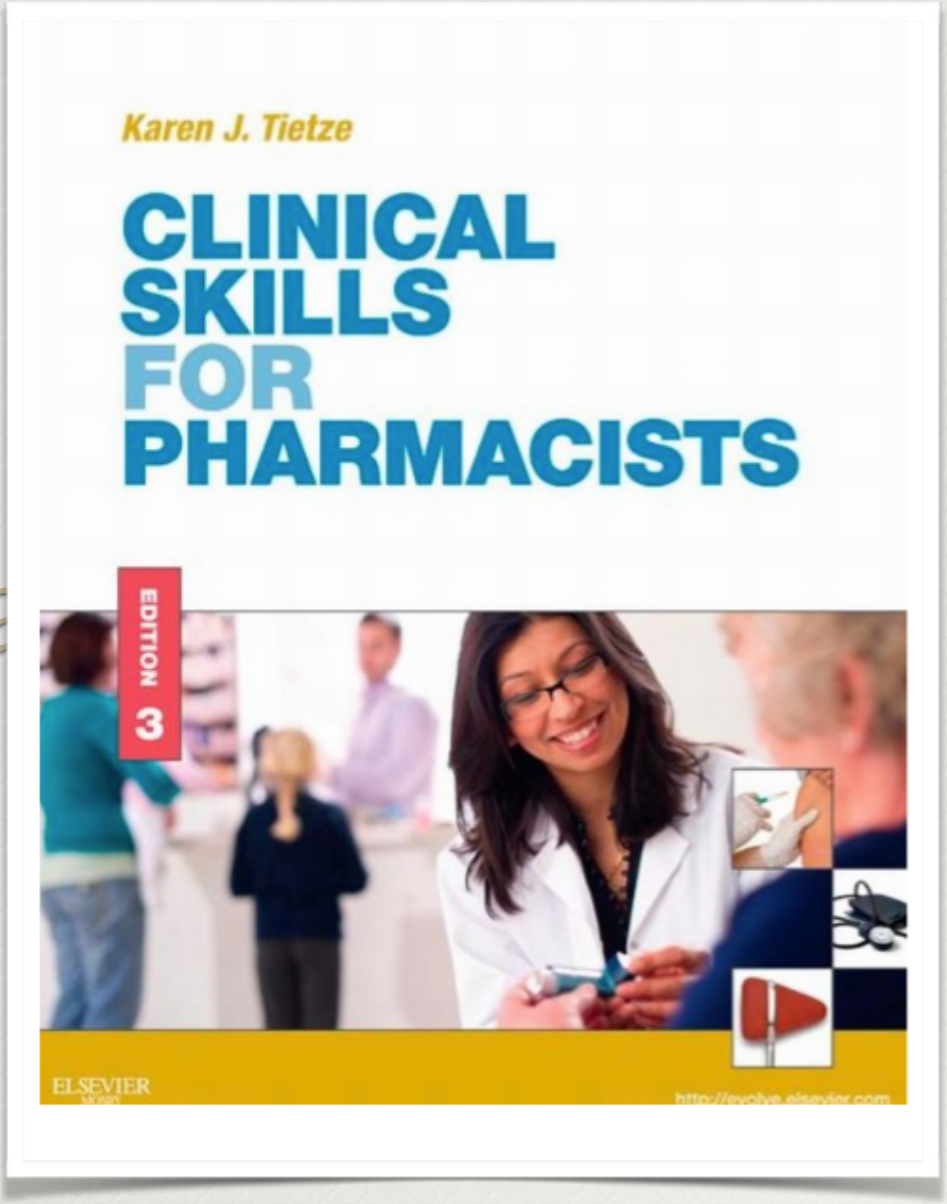
(c) physical assessment skills, when trained to do so.

Bylaws of BC College of Pharmacists 2006

A Report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011.

Barry, CPJ/RPC 2012;145:174-179 *Longe, Am Journ Pharm Ed 1995;59:151*





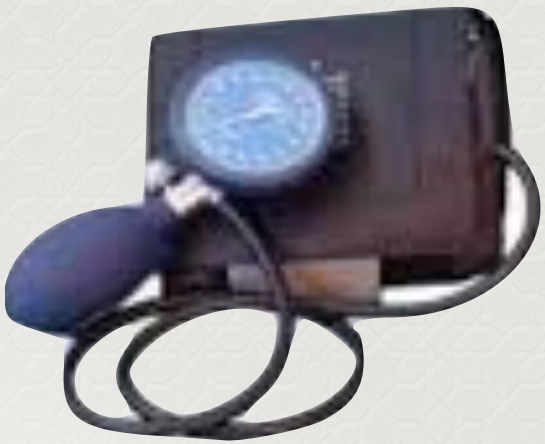
Tietze KJ 2012, Clinical Skills for Pharmacists, Elsevier, St. Louis Missouri

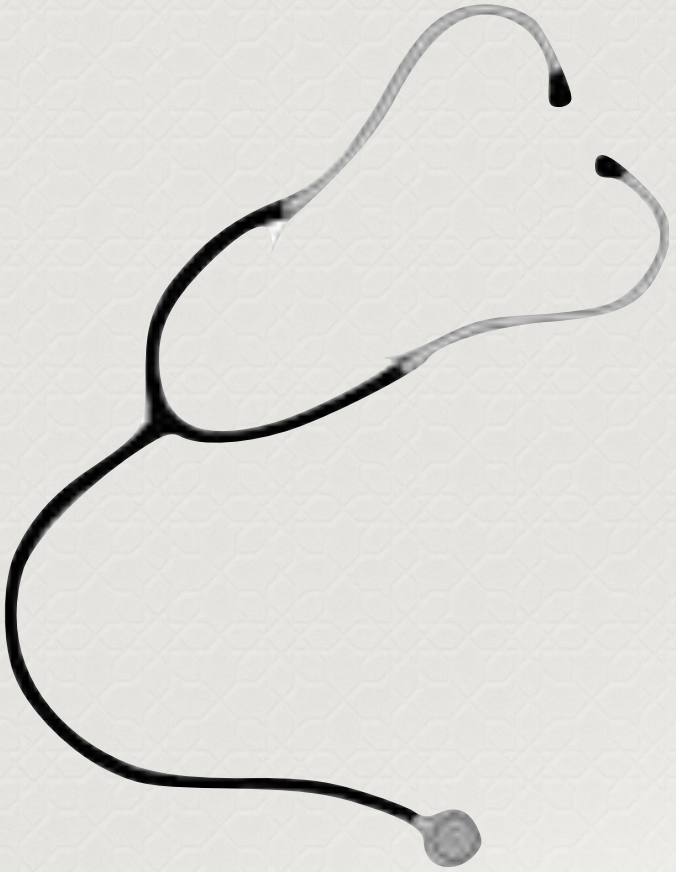
Longe RL & Calvert JC 1994, Physical Assessment, Lippincott Williams &Wilkins, Baltimore

Fitting In....

Essential Member

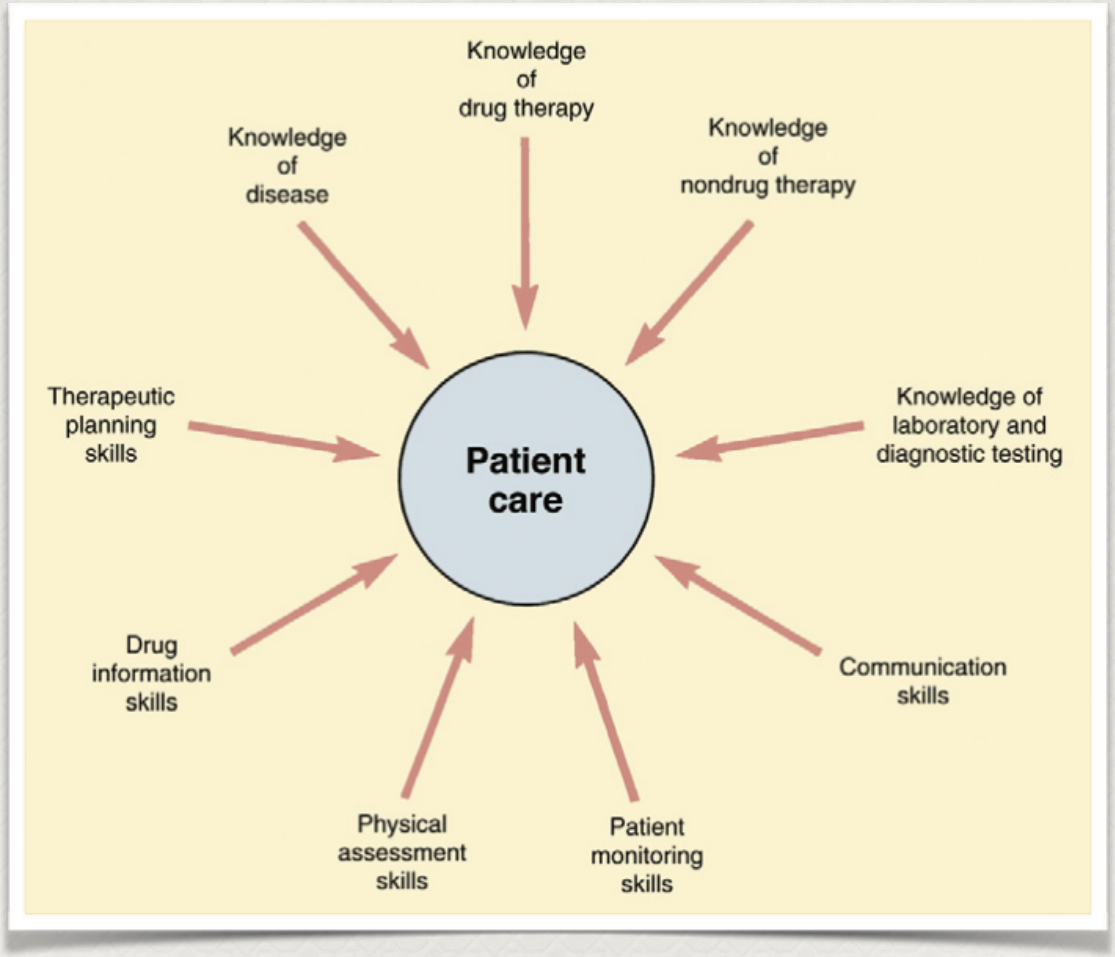
Tools





Talking Same Language...

Patient Care



Tietze KJ 2012, Clinical Skills for Pharmacists, Elsevier, St. Louis Missouri

PE Principles

Purpose

- Identify, solve and prevent DTP's

Approach

- Inspection
- Palpation
- Percussion
- Auscultation

Inspection

The observation of the physical signs displayed by the patients and depends on knowledge of examiner.

Longe RL & Calvert JC 1994, Physical Assessment, Lippincott Williams &Wilkins, Baltimore

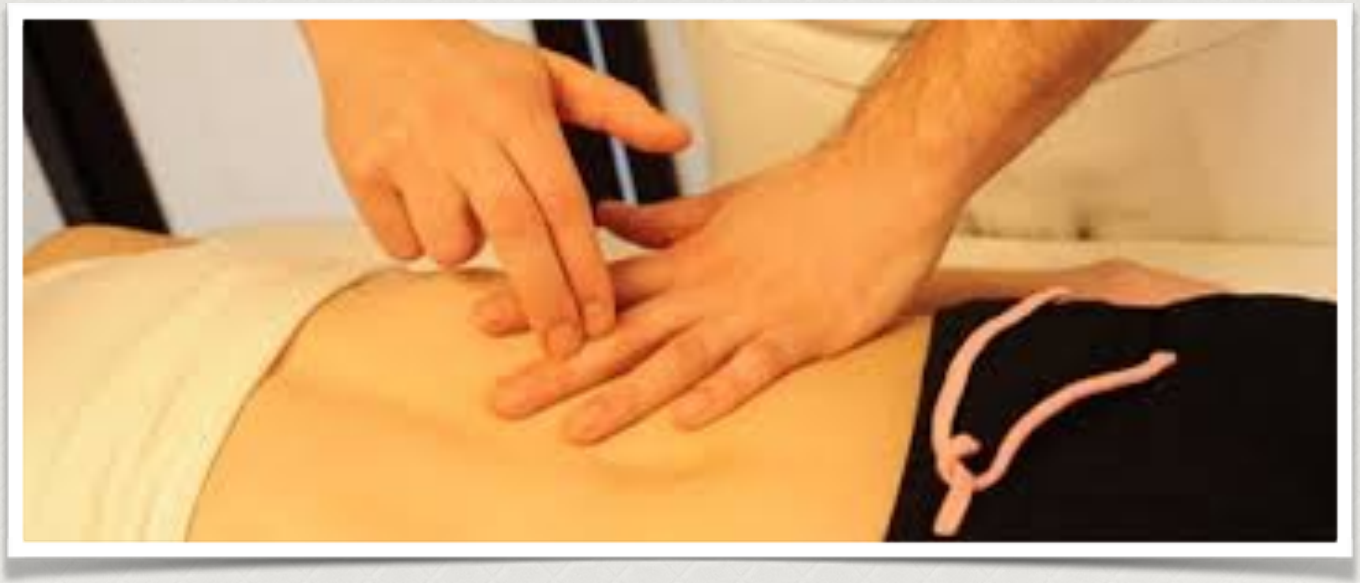
Palpation

Encompasses the various ways of perceiving by the sense of touch.

Longe RL & Calvert JC 1994, Physical Assessment, Lippincott Williams &Wilkins, Baltimore

Percussion

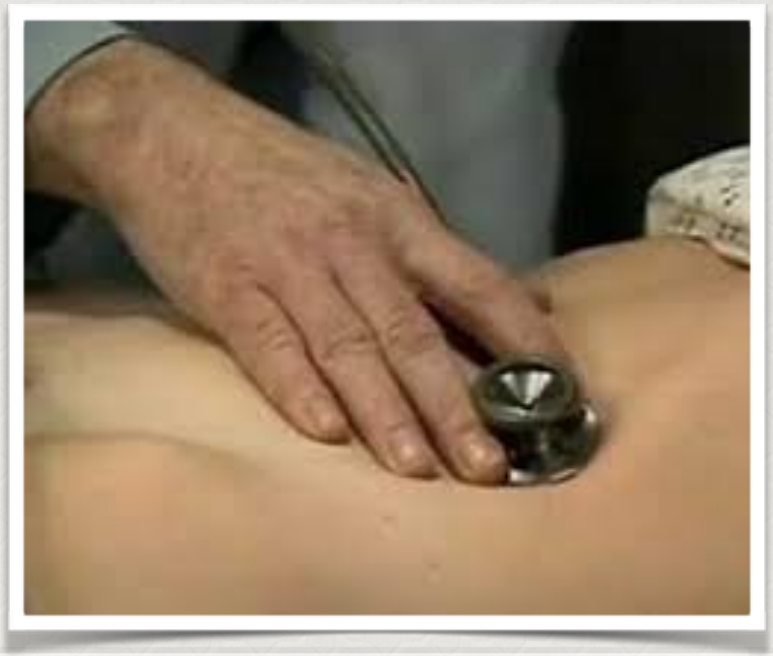
Procedure used to evaluate structures lying no deeper than 4 to 5cm under skin.



Longe RL & Calvert JC 1994, Physical Assessment, Lippincott Williams &Wilkins, Baltimore

Auscultation

The process of listening to sounds originating within an organ or body cavity and is usually augmented by use of an stethoscope.



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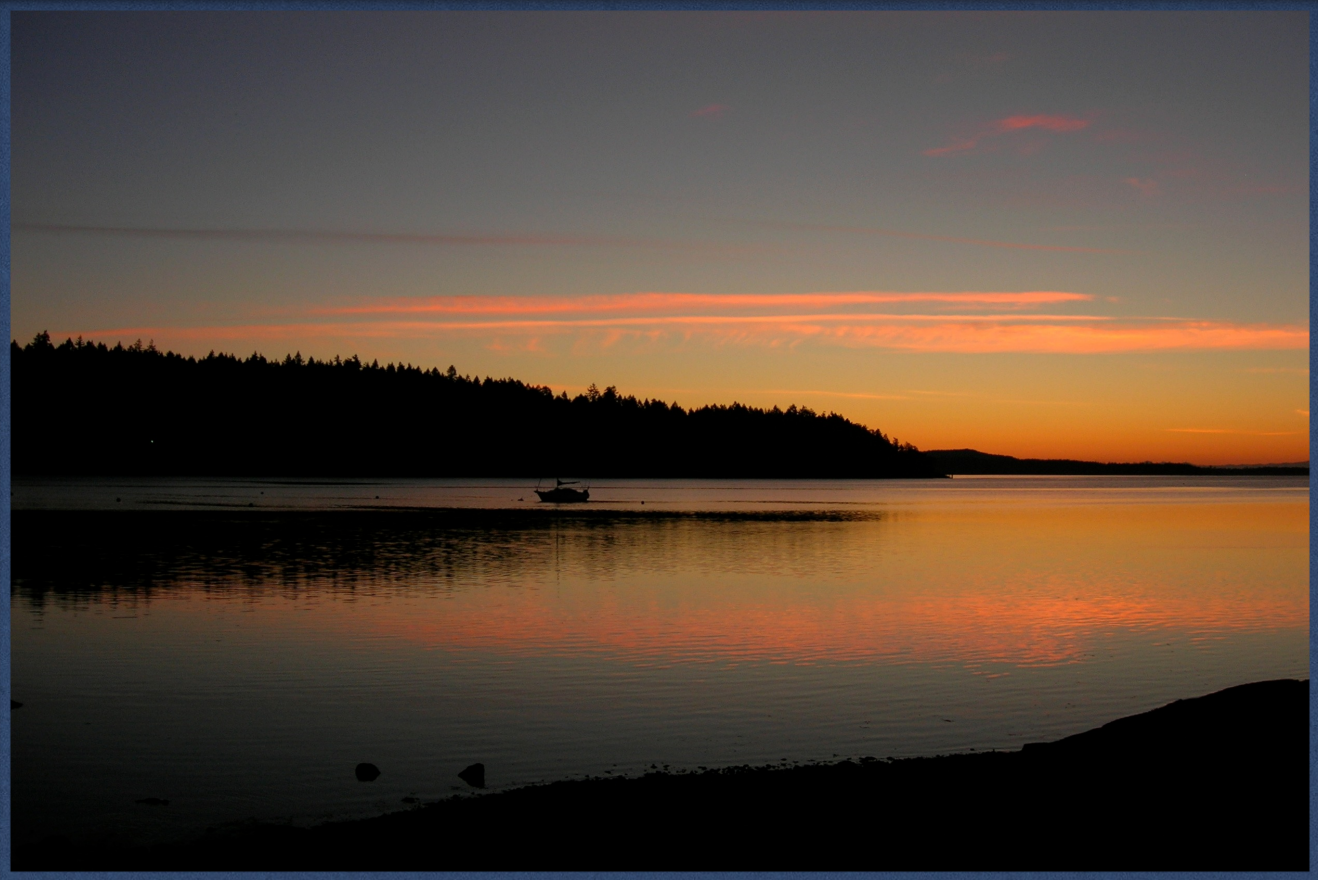

Summary

Pharmacist PE Summary

- Extension of what is currently utilized by pharmacists
- Clinicians can make a more confident decision based on physical assessment of the patient
- Essential for pharmacists to perform in the future
  - Disease State Management clinics
  - Certified Pharmacist Prescriber

British Columbia Branch

CSHP PE Course

- First in Canada
- Sold out within 4 days
- Langara College
- 59 Pharmacists
- 2016 - Victoria


The Future
is Ours to CREATE....
Thank You
Sean Spina
sean.spina@viha.ca
250-216-9203

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College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

16. Governance Committee Recommendations

DECISIONS REQUIRED

Recommended Board Motions:

Dissolve the following committees: Communications and Engagement Advisory, Interdisciplinary Relationships Advisory, and Technology Advisory.

Move the following committees from standing committees to ad-hoc committees: Community Pharmacy Advisory, Hospital Pharmacy Advisory, Residential Care Advisory and Ethics Advisory.

Extend committee volunteer appointments to April 30, 2017 as circulated.

Appoint new committee volunteers for terms beginning April 14, 2016 to April 30, 2017 as circulated.

Direct the Registrar to provide an update to the Board at every Board meeting of all committees except ad-hoc committees.

Purpose

To provide an update and recommendations from the Governance Committee on Board Committees.

Background

The Governance Committee met on March 11, 2016 and reviewed previous discussions of the Board regarding Board committee structure and membership. The Board had requested that the Governance Committee review the current number of Board committees and consider efficiency, role and value for each committee.

As a result the Governance Committee has made a recommendation regarding the dissolution of 3 committees: Communications and Engagement, Interdisciplinary Relationships and

Technology. The Committee felt that the work of these committees can be absorbed into the core work of the College and brought forward to the other advisory committees as necessary.

The Committee also recommends that the advisory committees: hospital, community, residential care and ethics all be moved from standing committees to ad hoc committees to more accurately reflect their role and work. As ad-hoc advisory committees they will only meet when work is tasked to them to ensure efficiency of staff and budget resources.

In addition, the Committee discussed the plan to review the committee appointment process as well as orientation and training. With the Governance Committee being a newly struck committee of the Board it did not have the opportunity to review the committee appointment process and therefore is recommending as an interim measure the extension of all committee members for a one year period.

Lastly the committee reviewed committee appointments in the areas of: vacancies as a result of members not wishing to be extended for the one year period, additions to committees to ensure mix of expertise and knowledge and new board member appointments to committees. Arising out of that discussion recommendations were made for new committee appointments.

Recommendation

Approve the Governance Committee recommendations as presented and circulated.

Appendix	
1	2016 Committee Member Appointments and Term Extensions

College of Pharmacists of British Columbia

BOARD MEETING
April 14 & 15, 2016

16. Governance Committee Recommendations

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Recommendation

Approve the Governance Committee recommendations as presented and circulated.

Appendix	
1	2016 Committee Member Appointments and Term Extensions

2016 Committee Member Appointments and Term Extensions

Indicates new appointee
Indicates appointee term expiring

Certified Pharmacist Prescriber Working Group

Name	Member Type	New Appointment	Term Expiry
Steve Shalansky (Co-Chair)	Pharmacist		April 30, 2017
John Shaske (Co-Chair)	Pharmacist		April 30, 2017
Shirin Abadi	Pharmacist		April 30, 2017
Richard Bachand	Pharmacist		April 30, 2017
Arden Barry	Pharmacist/Board	Yes	April 30, 2017
Shakeel Bhatti	Pharmacist		April 30, 2017
Anar Dossa	Pharmacist/Board	Yes	April 30, 2017
David Forbes	Pharmacist		April 30, 2017
Marylene Kyriazis	Pharmacist		April 30, 2017
Gregory Shepherd	Pharmacist		April 30, 2017
Jordan Stewart	Pharmacist		April 30, 2017
Kris Gustavson	Public/Board		April 30, 2017
Hafeez Dossa	Student		April 30, 2017
Jackson Stewart	Student		April 30, 2017
Doreen Leong	Staff		n/a

Community Pharmacy Advisory Committee (ad-hoc)

Name	Member Type	New Appointment	Term Expiry
Fady Moussa (Chair)	Pharmacist		April 30, 2017
Mohinder Jaswal (Vice-Chair)	Pharmacist		April 30, 2017
Ming Chang	Pharmacist/Board		April 30, 2017
Cassandra Elstak-Blackwell	Pharmacist		April 30, 2017
Tara Oxford	Pharmacist/Board	Yes	April 30, 2017
Parveen Mangat	Pharmacist		April 30, 2017
Aaron Sihota	Pharmacist		April 30, 2017
Elijah Ssemaluulu	Pharmacist		April 30, 2017
Cindy Zhang	Pharmacist		April 30, 2017
Tiffany Tam	Pharmacy Technician		April 30, 2017
Ashifa Keshavji	Staff		n/a

Discipline Committee

Name	Member Type	New Appointment	Term Expiry
Jerry Casanova (Chair)	Pharmacist		April 30, 2017

2016 Committee Member Appointments and Term Extensions

Patricia Gerber (Vice-Chair)	Pharmacist		April 30, 2017
Wayne Chen	Pharmacist		April 30, 2017
Jody Croft	Pharmacist		April 30, 2017
Christopher Kooner	Pharmacist		April 30, 2017
Derek Lee	Pharmacist		April 30, 2017
Annette Robinson	Pharmacist		April 30, 2017
Mabel Yan	Pharmacist		April 30, 2017
Amparo Yen	Pharmacist		April 30, 2017
Suzanne Coughtry	Pharmacy Technician		April 30, 2017
Bal Dhillon	Pharmacy Technician		April 30, 2017
Anneke Driessen	Public		April 30, 2017
James Ellsworth	Public		April 30, 2017
Nerys Hughes	Public		April 30, 2017
Howard Kushner	Public		April 30, 2017
Leza Muir	Public		April 30, 2017
Jeremy Walden	Public/Board		April 30, 2017
Carol Williams	Public		April 30, 2017
Suzanne Solven	Staff		n/a

Drug Administration Committee

Name	Member Type	New Appointment	Term Expiry
Cameron Zaremba (Chair)	Pharmacist		April 30, 2017
Omar Alasaly (Vice-Chair)	Pharmacist		April 30, 2017
Jagpaul Deol	Pharmacist		April 30, 2017
Aileen Mira	Pharmacist		April 30, 2017
Elizabeth Brodkin	Public		April 30, 2017
Mitch Moneo	Public		April 30, 2017
Chris Salgado	Public		April 30, 2017
Doreen Leong	Staff		n/a

Ethics Advisory Committee (ad-hoc)

Name	Member Type	New Appointment	Term Expiry
Cristina Alarcon (Chair)	Pharmacist	Chair	April 30, 2017
Robyn Miyata (Vice-Chair)	Pharmacy Technician		April 30, 2017
(vacant)	Ethicist		
Shivinder Badyal	Pharmacist		April 30, 2017
Arden Barry	Pharmacist/Board	Yes	April 30, 2017
Tara Lecavalier	Pharmacist		April 30, 2017

2016 Committee Member Appointments and Term Extensions

Jing-Yi Ng	Pharmacist		April 30, 2017
Vanessa Lee	Pharmacy Technician		April 30, 2017
Alison Dempsey	Public		April 30, 2017
Bashir Jiwani (Chair)	Ethicist		April 30, 2016
Suzanne Solven	Staff		n/a

Governance Committee

Name	Member Type	New Appointment	Term Expiry
Norman Embree (Chair)	Public/Board		April 30, 2017
Anar Dossa (Vice-Chair)	Pharmacist/Board	Vice-Chair	April 30, 2017
Blake Reynolds	Pharmacist/Board		April 30, 2017
George Walton	Public/Board	Yes	April 30, 2017
Suzanne Solven	Staff		n/a

Hospital Pharmacy Advisory Committee (ad-hoc)

Name	Member Type	New Appointment	Term Expiry
Keith McDonald (Chair)	Pharmacist		April 30, 2017
Anita Lo (Vice-Chair)	Pharmacist		April 30, 2017
Elissa Aeng	Pharmacist		April 30, 2017
Lily Cheng	Pharmacist		April 30, 2017
Karen Dahri	Pharmacist	Yes	April 30, 2017
Jennifer Dunkin	Pharmacist		April 30, 2017
Aleisha Enemark	Pharmacist		April 30, 2017
Ashley Fairfield	Pharmacist		April 30, 2017
Anca Jelescu Bodos	Pharmacist		April 30, 2017
Karen LaPointe	Pharmacist		April 30, 2017
Fruzsina Pataky	Pharmacist		April 30, 2017
Aita Munroe	Pharmacy Technician		April 30, 2017
Joshua Batterink	Pharmacist		April 30, 2016
Gordon Harper	Pharmacist		April 30, 2016
Ashifa Keshavji	Staff		n/a
Jonathan Lau	Staff		n/a

Inquiry Committee

Name	Member Type	New Appointment	Term Expiry
John Hope (Chair)	Pharmacist		April 30, 2017
Dorothy Barkley (Vice-Chair)	Public		April 30, 2017

2016 Committee Member Appointments and Term Extensions

Carla Ambrosini	Pharmacist		April 30, 2017
Cindy Bondaroff	Pharmacist		April 30, 2017
Sally Chai	Pharmacist		April 30, 2017
Ming Chang	Pharmacist/Board	Yes	April 30, 2017
Sunny Gidda	Pharmacist		April 30, 2017
Fatima Ladha	Pharmacist		April 30, 2017
Jing-Yi Ng	Pharmacist		April 30, 2017
Susan Troesch	Pharmacist		April 30, 2017
Cynthia Widder	Pharmacist		April 30, 2017
Karen Callaway	Pharmacy Technician		April 30, 2017
Alana Ridgeley	Pharmacy Technician		April 30, 2017
Michael Dunbar	Public		April 30, 2017
George Kamensek	Public		April 30, 2017
Tricia Kean	Public		April 30, 2017
James Mercer	Public		April 30, 2017
Alison Rhodes	Public		April 30, 2017
Ann Wicks	Public		April 30, 2017
Kris Scott	Pharmacist		April 30, 2016
Suzanne Solven	Staff		n/a

Jurisprudence Examination Subcommittee

Name	Member Type	New Appointment	Term Expiry
Roberta Walker (Chair)	Pharmacy Technician		April 30, 2017
Melanie Johnson (Vice-Chair)	Pharmacist		April 30, 2017
Anthony Seet	Pharmacist		April 30, 2017
Asal Taheri	Pharmacist		April 30, 2017
Maria Ton	Pharmacist		April 30, 2017
David Wang	Pharmacist		April 30, 2017
Doreen Leong	Staff		n/a

Legislation Review Committee

Name	Member Type	New Appointment	Term Expiry
Jeremy Walden (Chair)	Public/Board		April 30, 2017
Anar Dossa	Pharmacist/Board		April 30, 2017
Sorell Wellon	Pharmacy Technician/Board		April 30, 2017
Kellie Kilpatrick	Acting Staff		n/a