From the College

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This newsletter is forwarded to every licenced medical practitioner in the Province of Manitoba. Decisions of the College on matters of standards, amendments to regulations, by-laws, etc., are published in the newsletter. The College therefore expects that all practitioners shall be aware of these matters.

In This Issue… …

From the New President
Dr. Margaret Burnett

Prescription Opioid Misuse: It's Time to Be Part of the Solution

Numerous recent media reports have highlighted concerns over the growing misuse and abuse of prescription opioids in Canada. Prescription opioids used in conjunction with other sedating medication and/or alcohol have been implicated in the accidental deaths of 83 Manitobans in the past 5 years. The latest statistics from Ontario suggest that prescription drugs are now implicated in more deaths than AIDS. The Sept 3, 2011 edition of The Globe and Mail featured a chilling account of widespread prescription opioid use by professional athletes and drew parallels with the recent deaths of three high profile NHL players. As physicians, we have always been concerned with addressing the morbidity and mortality associated with substance abuse. In the past, illegal drugs and alcohol were the major sources of concern. Now the focus has shifted to prescription drugs, such as oxycodone. This turn of events has increased our responsibility dramatically. By virtue of our prerogative to prescribe these medications, we are now a central part of the problem itself.

There are a number of possible reasons why prescription medications have become popular on the street. The most obvious is accessibility. Opioids are essential for the effective management of acute and chronic pain. They are widely prescribed for a multitude of indications. "Left-over" medication may be shared, sold or stolen. Experienced "patients" may obtain prescriptions by pretending to have medical conditions for which

opioids are frequently prescribed. I know of Manitoba physicians who have been enticed, cajoled, coerced, or just plain duped into writing these scripts. I am one of those physicians. I remember a gentleman who made an appointment to see me on my very first day in practice as a family physician. He told me that he had just moved into the City and was looking for a family doctor. He had Crohn's Disease and was able to provide me with a good history of symptoms consistent with that disorder. At this early point in my career, I was too naïve to realize that a "textbook" case might actually have been gleaned from a textbook. In any case, I dutifully wrote up the requested prescriptions for sulfasalazine and hydromorphone. I would have been none the wiser had my "patient" not altered the dose on the prescription of hydromorphone from 1mg to 2mg. An astute pharmacist questioned the validity of the script and called me (from across town) to verify it. This experience taught me that appropriate opioid prescribing requires considerably more than good intentions.

New physicians and those in isolated practice settings or walk-in clinics are more likely to be vulnerable. I have spoken with many young doctors who are poised to enter practice. Some have decided not to prescribe opioids at all in an effort to protect themselves from the pitfalls of inappropriate prescribing. This solution seems simple enough for the individual doctor. Unfortunately, should this option be adopted by a significant number of practicing physicians, we will end by undermining the wellbeing of the very people we have promised to serve our patients. Over the 28 years or so that I have been in practice, I have cared for many patients whose suffering has been eased by the judicious use of prescription narcotics. Opioids, when appropriately prescribed, are among our most powerful therapeutic modalities. Blanket refusal to prescribe these drugs, when we have the "exclusive" right to prescribe them, is contrary to our professional duty of care. A far better solution is to rigorously support appropriate prescribing. The College has a duty to assist its members to better care for patients living with acute and chronic pain. As physicians, we also have an important responsibility to help prevent, diagnose and treat substance abuse.

The Canadian Guideline on the Safe and Effective Use of Opioids for Chronic Non-Cancer Pain was developed by the CPSO and published in the CMAJ in June 2010. It is an excellent resource for the appropriate prescribing of opioids. It also outlines practical strategies for risk management when treating patients who require long-term narcotics. This Guideline should be required reading for anyone who intends to prescribe opioids. A link to this guideline is available on the CPSM website.

We are in urgent need of a comprehensive, meaningful drug-surveillance program in our Province. Treating physicians and pharmacists need better access to patient profiles so inappropriate prescribing is less likely to continue unabated. Finally, as professionals and medical educators we have an urgent responsibility to educate ourselves, our students and our patients about the risks and benefits of these important drugs.

Addiction to prescription opioids is quickly becoming an epidemic among young people across Canada. We encourage interested physicians who are willing to participate in the Manitoba Methadone Monitoring Program to contact the College. Compared to other Canadian provinces, we are drastically underserviced in this area, particularly in rural areas. This is a very high-risk group of patients with significant associated mortality. This Methadone Monitoring Program is a newly minted initiative being led by Dr. Lindy Lee. Please consider participating in this program and help our profession move toward being part of the solution.

Sincerely,
Margaret Burnett
President

NOTES FROM THE REGISTRAR

ANNUAL GENERAL MEETING OF COUNCIL JUNE 17TH, 2011

Dr. José François, Associate Dean of Continuing Professional Development, spoke about the University's Conflict of Interest policy.

SUMMATIVE ASSESSMENT:

■ At the December, 2010 Council meeting, it was noted that *The Regulated Health Professions Act* will not come into effect for the CPSM until 2012 or later. As a result, Council approved a request to government for the Summative Assessment to be implemented under *The Medical Act*. This is a review process created by the Department of Continuing Professional Development as a route to full registration. Council was supportive and it was contemplated that the issue would be brought back to Council when the draft regulation was in hand. There were also some aspects of the proposed process which required further discussion.

MANQAP STANDARDS OF PRACTICE:

■ The MANQAP Standards of Practice have undergone intense revision and reworking over the past three years. Council approved the new Standards of Practice for Laboratory and Diagnostic Imaging. These will now be the Standards used for all future Laboratory and DI accreditation processes.

CPSM COUNCIL MEETING SEPTEMBER 16TH, 2011

Ms Diane Wilson-Maté, Executive Director of the College of Registered Nurses of Manitoba, spoke to Council about the new Extended Practice Regulation changes for Nursing.

GOVERNANCE REVIEW:

■ Council reviewed the College's Mega End and Ends and gave direction to the Registrar about further review in the future. In addition they reviewed the educational needs and ownership linkage suggestions for the future.

STATUTORY AGENDA ITEM – SUMMATIVE ASSESSMENT:

■ Council was provided with a review of the background to the Summative Assessment [as noted above at the June 2011 Council meeting]. The Summative Assessment concept was approved in principle in June 2008 by Council. Following that, the Dean and the Registrar made a submission to Manitoba Health for funding. This was approved and Dr. François's Department of Continuing Professional Development has been implementing and proceeding on this process since that time. Council was presented with a series of draft principles as well as a first draft of the amendment to the Regulation. Council approved in principle the amendments to the Regulation and approved in principle the policies governing the entire process. The President and President-Elect were granted authority to approve the final draft of the Regulation amendments and policies.

■ The MANQAP Annual Report and Report to the Minister of Health were provided as information to Council.

In this newsletter our President, Dr. Margaret Burnett, addresses the issue of misuse of prescription opioid medications. Although this has always been an issue for the public and our profession, the broad ranging implications have been magnified in the last years. When I meet with the other Registrars at national meetings, it is clear that this problem is not only a Manitoba problem but is truly national in scope and distribution. As well, it is a problem that affects all levels of society and all ages of patients.

Last year, Manitoba Health passed *The Prescription Drug Cost Assistance Amendment Act.* This will permit Manitoba Health to provide the College with more information about physicians' prescribing practices related to monitored drugs and the utilization of monitored drugs by patients. The intent is to identify patterns or trends that might indicate inappropriate prescribing, and abuse or misuse of monitored drugs. The College is part of a working group to define how this will operate. As it becomes more concrete, we will keep you updated in future newsletters.

MPAR: The first physicians to be reviewed under MPAR have been contacted and their information packages are being exchanged. The first meeting of the Physician Practice Enhancement subcommittee will be in the new year. It is very exciting that we will be participating in this educational and supportive program. Both the College of Physicians & Surgeons of Alberta and the College of Physicians & Surgeons of Nova Scotia have been using it for some years and we are the beneficiaries of their more recent modifications.

Bill Pope,
Registrar

EXTENDED PRACTICE REGULATION AMENDED

Manitoba's Nursing Extended Practice Regulation was recently amended to expand the prescriptive authority for RN(EP)s (nurse practitioners) in the province. The changes were effective August 10, 2011. Please visit the College of Registered Nurses of Manitoba website (www.crnm.mb.ca) for more info.

If you have any questions about the amendments, please contact Geraldine Selkirk, Nursing Practice Consultant via email at gselkirk@crnm.mb.ca or via phone at (204) 784-6467.

MALARIA IN RETURNING TRAVELLERS

Each year, many Manitobans travel to countries where malaria is endemic and in the past 5 years, 104 people have been diagnosed with malaria in the Winnipeg Health Region. More than 20% of these cases satisfied the laboratory criteria for severe falciparum malaria. Some of these severe malaria cases were due to preventable delays in diagnosis and treatment. Furthermore, a 10 year retrospective study of malaria diagnosed at the Winnipeg Children's Hospital identified 38 cases, of which 3 were classified as severe malaria, 2 required ICU admission, and none died. Twenty of the cases sought medical care prior to hospital presentation, of which only 11 had a smear performed. Sixteen had a ≥24 hour delay before presenting to the hospital.

Those at particularly high risk of acquiring malaria are travellers originally from countries with high endemnicity returning to visit friends and relatives after a prolonged (>1 year) residence in Canada, but any traveller to endemic areas is at risk. Individuals returning from sub-Saharan Africa and Papua New Guinea account for most of the cases in returned travellers. However all tropical and subtropical areas are potential risk zones. Furthermore, even perfect adherence to anti-malarial prophylaxis will not completely eliminate the risk of acquiring malaria.

Untreated malaria can have a >20% mortality; accordingly, clinicians must maintain a very high degree of suspicion and investigate malaria in all travellers from endemic areas presenting with a complaint of fever (for an up-to-date list of malaria zones, see:

http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s1/index-eng.php).

Frequently, fever and/or headache are the only symptoms of malaria. The most sensitive and specific diagnostic test available in Manitoba is the "thick and thin blood smear for malaria". Ideally, three smears should be ordered at 8 – 12 hour intervals. In the event of a positive test, the smear will also reveal the degree of parasitemia, which is an important factor in determining the severity of disease. According to the WHO definition, any parasitemia of 2% or greater in patients not living in countries with high endemnicity is indicative of severe malaria regardless of signs and symptoms. Additionally, if malaria is diagnosed or suspected, renal function tests, haemoglobin, platelet, glucose, bicarbonate and lactate levels should be ordered, as these will help define severity.

Management of malaria is complex and new anti-malarials for the treatment of severe malaria are only available via an Infectious Diseases consultation (e.g. artesunate). Chloroquine is no longer effective for most falciparum malaria and quinine, formerly commonly prescribed for malaria, is no longer considered first line treatment due to its relatively high incidence of side effects and the availability of more effective agents (e.g. artesunate for severe malaria and atovaquone-proguanil (Malarone™) for uncomplicated malaria). Because patients with falciparum malaria who appear clinically stable can rapidly deteriorate without warning, consideration should be given to short admission in hospital until confirmation of clearance of parasitemia can be demonstrated. Because of the high morbidity and mortality of severe malaria, all patients who fit the WHO criteria for severe malaria should be referred to a tertiary care centre with intensive care capabilities. Clinicians with any questions about the management of a patient with malaria or suspected malaria are encouraged to contact the Adult or

Pediatric Infectious Diseases consultant on call for their hospital or if none is locally available, the consultant for the WRHA who may be reached by calling (204) 787-2071.

(http://whqlibdoc.who.int/publications/2010/9789241547925_eng.pdf)

Faculty of Medicine Up-Date

The Class of 2015 began with an Inauguration Exercise attended by faculty and families. Minister Theresa Oswald reminded us all that a compelling requirement of all physicians was to "be worthy" respecting our role in the community.

Dr. Hugh O'Brodovich (Class of 1975), Chair of Pediatrics – Stanford University – gave the keynote address drawing the parallels between the mission of the Faculty and how that translates into our role in the community.

The highlight of the Exercise remains, for me at least, with the recitation of the Hippocratic Oath, where we are so poignantly reminded of our special place in society and the special responsibilities that privilege requires.

The committee examining the role of medical training in Brandon has begun and will be exploring options regarding enhancing the educational role in Brandon of a broader distributed education model.

We undertook a review of where physicians go after training. Preliminary data suggests that our success in keeping medical students coming from other Provinces is poor. When we educate students in our medical school we keep about half in the Province. When we educate them through medical school and a residency program, we keep about three-quarters of them in the Province.

Clearly, we have some important reflection to undertake regarding this data. We will be establishing a review committee involving the University, Manitoba Health, College of Physicians & Surgeons of Manitoba, faculty and students to undertake the review and to recommend changes that may be necessary. The review will include the role of the CaRMS Match. I will also be visiting our rural education sites once again this fall where these issues will be discussed.

There is growing interest in how we promote interdisciplinary education without health facilities, which the University has organized into a health cluster, for the purposes of discussion.

Brian Postl, MD, Dean
Faculty of Medicine, University of Manitoba

University of Manitoba

From The Investigation Committee

Recently the Investigation Committee reviewed a case where a patient was diagnosed with a bowel obstruction. The patient subsequently died. The attending physician's impression after the fact was that the patient likely had small bowel ischemia and that this was the cause of the presentation and possibly of death.

The Committee noted that the patient had an elevated white blood cell count, metabolic acidosis and severe abdominal pain and that the patient had documented vascular disease. This combination was suggestive of ischemic bowel.

The Committee reminds the profession of the need for a low threshold for consideration of surgical referral in patients who may have ischemic bowel.

From The Investigation Committee

Recently, the Investigation committee reviewed a case of coma which was self-induced by a mixed drug overdose. The patient made a complete recovery despite being unresponsive for several days after extubation and discontinuation of intravenous fluids. Physicians are reminded that recovery time in these cases can be unpredictable, particularly in the setting of hypothermia.

The Winnipeg Police Service Missing Persons Unit

The Winnipeg Police Service Missing Persons Unit has had calls over the course of the past few months which involved seniors in their 80's, with both of them still having valid driver's licenses and access to vehicles. In both of these incidents, it appears the individuals were further suffering from confusion and signs of dementia.

One case resulted in extreme tragedy with the individual being found weeks later deceased in a remote location in another province with his vehicle nearby and in the other case a senior drove around in his vehicle in a confused state for hours in various locations within and just outside the city. After being missing for a period of over 24 hours, he became involved in a motor vehicle accident. These and other recent traffic accidents in the city which have resulted in death and/or harm to others show the need for us all to recognize and take action when individuals are no longer able to meet the demands of driving. I understand how no one wants to lose the freedom of having a valid driver's license and access to a vehicle. This form of independence is hard to give up but there comes a point in time, for every one of us who drives, where that need will exist to prevent severe harm to oneself or others.

Physicians can help us to keep our community safe. When individuals are beginning to show signs that their ability to drive a vehicle is now hindered due to their mental and/or physical state, it needs to be documented so that action can be taken. The reality is there are still other means for these individuals to utilize to get to where they want to go safely when their driving independently is no longer an option. I firmly believe these alternatives need to be promoted and are far better than things ending in a heart-breaking tragedy.

Detective Sergeant Shaunna Neufeld #1882
Winnipeg Police Service Missing Persons Unit
(204) 986-4510, (204) 391-3643
sneufeld@winnipeg.ca

Some Quick Facts for Physicians Providing Immunization Services to Applicants to the Faculty of Nursing, University of Manitoba

PLEASE SEE THE COLLEGE WEBSITE FOR THE ABOVE

Information to specific questions about vaccine administration can be found at:

Canadian Immunization Guide, Seventh Edition, (2006). Public Health Agency of Canada.

www.phac-aspc.gc.calpublicat/ cig-gci/pdfl cig-gci - 2006 e. pdf.

Canadian Tuberculosis Standards, Sixth Edition, (2007). Public Health Agency of Canada and the Canadian Lung Association/Canadian Thoracic Society.

www.phac-aspc.gc.caltbpc-atb/pubs/pdf/tbstand07e.pdf.

Government of Manitoba - Public Health Division - Medical Officers of Health.

http://www.gov.mb.calhealthlpublichealthl contactlist.html.

Diabetes Education Resource for Children & Adolescents

New onset diabetes in a child 0 – 18 years of age is a medical emergency. In 2007, to prevent delay in diagnosis and treatment of a child with new onset diabetes, the Diabetes Education Resource for Children and Adolescents (DER-CA) partnered with Diagnostic Services of Manitoba to create an automatic computer-generated alert for any plasma blood glucose level ≥11.1 mmol/L in a child less than 18 years of age. This medic alert states "If patient not known to have diabetes, recommend urgently contact provincial pediatric diabetes program at Diabetes Education Resource for Children and Adolescents through physician on call: 787-2071".

This alert is not used by private laboratories in Manitoba. Differentiation of type 1 and type 2 diabetes in a child is difficult. If healthcare professionals are suspicious of new onset diabetes in a child, immediate referral to the Pediatric Endocrinology and Diabetes Services at Children's Hospital is recommended by calling paging at (204) 787-2071.

Heather J. Dean, MD, FRCPC
Professor, Department of Pediatrics
Section of Endocrinology & Metabolism
University of Manitoba

Talk to Your Patients About Manitoba's Healthy Baby Program

Do you see any of the following patients: Low-income women who are pregnant? Teen moms who are expecting? Other low-income families with a newborn or young infant?

If the answer is Yes to any or all of the above, you can improve the chances of your patients having healthier pregnancies, births and infants by referring them to Manitoba's Healthy Baby program.

Since 2001, the province has offered this 2-part program, composed of the Manitoba Prenatal Benefit (up to $81.41 per month during pregnancy for low-income families) and Healthy Baby Community Support Programs (friendly, community-based group sessions available in every region of the province, for both prenatal and postnatal support up to age 1).

An independent evaluation of Healthy Baby, released in November 2010 by the Manitoba Centre for Health Policy (MCHP), found that the program was effective in increasing adequate prenatal care, reducing low birth weight births and preterm births, and increasing breastfeeding initiation. The evaluation also found that more low-income families and teen moms need to be reached by the program. Physicians working with these patients can help.

For more information on the Healthy Baby program (including a downloadable application form for the prenatal benefit and downloadable lists of community support locations in and outside of Winnipeg):
http://www.gov.mb.ca/healthychild/healthybaby/index.html

Please call 945-2266 or 1-888-848-0410 to request a Healthy Baby program brochure display (complete with application forms and program locations) for your clinic or office. Patients may also go in person to the Healthy Child Manitoba Office to pick up this information: 3rd floor – 332 Bannatyne Ave or call the numbers above.

For more information on the MCHP evaluation of the Healthy Baby program:
Full report:
http://mchp-appserv.cpe.umanitoba.ca/reference/Healthy_Baby.pdf
Summary:
http://mchp-appserv.cpe.umanitoba.ca/reference/Healthy_Baby_summary.pdf

Submitted by:
Lynne Warda, MD, Medical Consultant
Child Health Standards Committee

Treatment of Group A Beta-Hemolytic Streptococcal Pharyngitis (GABS) in Children and Youth:

Is Your Practice Evidence-Based?

Sore throat is a common presenting complaint for children and adolescents in ambulatory care and urgent care settings. No single clinical feature reliably differentiates GABS pharyngitis from viral causes, which are more common than GABS in this age group. Known exposure to GABS, documented fever, tonsillar/ pharyngeal exudates, petechiae on the palate, and absence of cough and runny nose are more predictive of GABS than other signs and symptoms. The modified Centor score can assist clinicians in determining which patients should be tested and those who should receive empiric treatment.

Scores 0-1	No test/treatment
2-3	Culture and await result
≥4	Treat empirically

	Score
Temperature >38°C	1
Absence of cough	1
Anterior cervical adenopathy	1
Tonsillar swelling/exudate	1
Age 3-14	1

Patients started on empiric treatment should have throat culture or rapid antigen detection testing performed; this is particularly useful for management of treatment failure and recurrent symptoms. Throat swabs that include the posterior pharyngeal wall and both tonsils may reduce the risk of false negative cultures. Negative rapid tests should be confirmed by culture (throat swab).

Antibiotic treatment of GABS reduces suppurative complications such as otitis media, cervical lymphadenitis, and peritonsillar abscess, and reduces the incidence of acute rheumatic fever. The following summarizes current evidence regarding antibiotic selection:

- Penicillin remains the treatment of choice, given its narrow spectrum, low cost, safety, effectiveness and lack of resistance worldwide. An entire 10 day course should be completed; shorter duration is associated with higher rates of treatment failure. Penicillin V dose: 40mg/kg/24h ÷ tid or 250mg bid for children <27kg; 500mg bid for children >27 kg, adolescents, adults. Amoxicillin is equally effective and is more palatable. Recent recommendations include the option of once daily dosing for 10 days (50mg/kg once daily, maximum 1000mg, for 10 days).
- In penicillin-allergic patients (with no history of anaphylaxis to penicillins) a 10 day course of a narrow-spectrum cephalosporin is recommended (eg. cephalexin).
- Macrolides may also be used in patients with penicillin allergy but are not recommended for first-line treatment. Clinicians should be aware that macrolide resistance is increasing in Canada, with rates as high as 12-16%. Azithromycin 12 mg/kg once daily (maximum 500 mg) for 5 days is more effective than lower doses and shorter courses and is equivalent to a 10 day course of penicillin. Disadvantages of using macrolides include cost, palatability, broad spectrum, resistance, and QT prolongation.

Symptomatic treatment includes hydration (cool/warm fluids) and analgesia (acetaminophen, ibuprofen). Patients may return to school or child care after 24 hours of antibiotic therapy. Severe or increasing pain, inability to swallow liquids, and drooling suggest a serious complication (peritonsillar abscess, retropharyngeal abscess, epiglottitis) and should be assessed by a physician on an urgent basis.

Submitted by the Child Health Standards Committee and the Section of Pediatric Emergency Medicine, Children's Hospital, Winnipeg

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7. Tanz RR, Shulman ST, Shortridge VD, Beall B, Cederlund E, Rippe J, Dale JB. Macrolide resistance among pediatric pharyngeal Group A streptococci is high in Canada and increasing in the US. International Congress Series 2006 (1289):95-98.

CENSURE: IC1516
DR. BHUPINDER SINGH BEDI

On November 23, 2011, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee of the College censured Dr. Bhupinder Bedi with respect to the breaches of his undertaking with the College.

PREAMBLE:

An undertaking given by a member of the College to the College is a solemn and express promise by the member. By the undertaking, the member takes upon himself or herself a commitment to the College to adhere to the terms of the undertaking. The College expects any member who signs an undertaking to fully comply with the terms of that undertaking.

II. THE RELEVANT FACTS ARE:

1. On or about July 2, 2008, Dr. Bedi signed an undertaking to the College which, amongst other terms, included a commitment to:
   a. abstain from consuming alcohol;
   b. participate in a body fluid monitoring program; and
   c. attend caregivers and support programs on a schedule set out in the undertaking.
2. Dr. Bedi's compliance with the undertaking was monitored through the Physician Health Program operated by the Standards Committee of the College.
3. In January 2010, Dr. Bedi was referred to the Investigation Committee with respect to concerns that he had not fully complied with the terms of his undertaking.
4. The Investigation Committee accepted Dr. Bedi's explanations with respect to these concerns and made certain adjustments to the undertaking to address changes in his circumstances. It closed its investigation with a specific warning to Dr. Bedi that future breaches of the undertaking would not be tolerated.
5. Dr. Bedi's revised undertaking took effect on March 10, 2010.
6. On or about April 13, 2010, Dr. Bedi was required to attend for body fluid monitoring, and did not attend within the specified time period.
7. On or about May 31, 2010, Dr. Bedi's body fluid monitoring tests revealed blood alcohol levels of .082 on the initial test and .074 on the subsequent test.
8. At the request of the College, Dr. Bedi agreed not to practice. Dr. Bedi sought further treatment

and remained out of practice until August 2011, at which point he re-entered practice with increased supports.

9. In his written response to the College and in his interview with the College, Dr. Bedi acknowledged the breaches of the undertaking to the College. Dr. Bedi explained the personal circumstances in his life at the time, and his current efforts in recovery.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. BEDI'S CONDUCT, IN PARTICULAR THE BREACHES OF HIS UNDERTAKING TO THE COLLEGE SET OUT ABOVE.

In addition to appearing before the Investigation Chair, Dr. Bedi paid the costs of the investigation in the amount of $1873.75.

Meetings of Council for the 2011-2012 College Year

Council meetings for the upcoming College year will be held on the following dates:

- Wednesday, December 14th, 2011
- Friday, March 16th, 2012
- Wednesday, June 6th, 2012 (AGM)

If you wish to attend a meeting, you must notify the College in advance. Seating is limited.

Officers & Councillors

Officers and Councillors 2011-2012

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Westman	Dr. A. Vorster, Treherne
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	Dr. R. Lotocki
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University of Manitoba	Dean B. Postl
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Public Councillor	Ms L. Read
Associate Members Register	Dr. E. Tan (exp. Sept. 2012)

Term expiring June 2014

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