From the College

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This newsletter is forwarded to every licensed 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.

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The President's Letter

The planning, preparation and implementation of physician profiling was completed successfully. I wish to thank the members for their cooperation through this process. I also wish to thank the staff at CPSM for all the time that they contributed to ensure the successful implementation of this new legislation.

Annually there is a presidential tour to rural areas. This year we elected to modify the format. All four Registrars were invited to attend along with the President and President-Elect. We entitled the visit "Ask the College". There was high interest and a diverse range of questions put forth by the members in the communities we visited. We spent our day in Beausejour, Selkirk and Gimli. These visits have always taken place in the rural area. It is hoped that it can be extended to urban regions.

Council last met November 18, 2005. Council respects and appreciates all of the work and commitment of staff to the College's core responsibilities. Through a priority planning exercise Council provided direction to the CEO and Registrars of the areas considered to be most

important. The two areas with greatest priority were physician resources, including assessment and orientation for international medical graduates and revalidation which included mandatory continuing professional development and physician achievement reviews.

Dr. Sarah Kredentser a recent President of Council had undertaken professionalism as an important goal for physicians in the province. During her tenure she began discussions on the area of after hours coverage. Council endorses a review and decision of this professional issue.

I wish all of my colleagues and their families a Very Prosperous New Year!

Roger Graham, M.D., FRCPC

Note from the Registrar

Firstly, on behalf of all of us at the College, let me wish you a very happy and healthy 2006.

The last months have been extremely busy ones for your College. In particular:

- ***Physician Profiles*** – Well, we did it! The implementation of the Physician Profiles system, along with the College's new website and the renewal process, required gargantuan efforts. Your staff at the College spent countless hours perfecting this new process and we are very grateful. In particular, the registration staff, led by Maxine Miller, Qualifications Manager, and Susan Wiebe, our Information Technology expert, were able to put it all together and make it happen.

  This is one of the biggest operations the College has ever done and we are pleased to say it was successful. Of some interest is the fact that the system was overwhelmed on days 2 and 3 of operation. This reflected some 50,000 – 60,000 "hits" on each of those days. Things have now settled down and members may access information immediately on the College website at www.cpsm.mb.ca followed by clicking on "Physician Profiles".

  This project has been a successful cooperative effort

jointly with Manitoba Health with support from the Manitoba Medical Association.

- ***Manitoba Prescribing Practices Program*** – The College will no longer be operating this program related to the total financial package to College programs from Manitoba Health. The Manitoba Pharmaceutical Association is now the contact organization for new prescription pads. The contact telephone number remains the same. Once the present supply of prescription pads is exhausted, a new duplicate form will be used. We hope in the future to reduce this to a single page.

- ***Changes to The Medical Act for Conditional Registration*** – In August, Government approved a change to the legislation which will permit applicants for conditional registration as family physicians to undergo a clinical assessment with patients as well as the CAPE Assessment. This will allow a broader review of clinical skills to ensure that successful applicants are able to practise competently in Manitoba. The College is working with Manitoba Health and the Faculty of Medicine to implement a new process for these assessments.

- ***Changes to The Evidence Act*** – Also in August, The Evidence Act protection for standards was changed. This was a government decision to permit protection of Critical Clinical Occurrence reports. Protection for standards material remains and is strengthened. However, the change to the regulation will permit release of certain information about actual occurrences to the patient from a standards document if that information is not available in other documentation. The Standards Department will be preparing information for Standards Committees over the next year to help clarify this situation for them. Members with questions should address these directly to Standards at the College.

- ***Revalidation*** – All the Colleges of Physicians and Surgeons across the country are looking at some aspect of "revalidation". This phrase was used by the General Medical Council in the United Kingdom to encompass continuing professional development, physician assessments, and various processes which need to be undertaken for us as physicians to demonstrate that we remain competent and safe to practise.

  In some provinces, it has given rise to great anxiety that the College will be intrusive and that the processes will be difficult, invasive and unpleasant. Your College will be working to ensure that any new processes introduced to Manitoba will be primarily educational and directed to the practice needs of physicians.

  Your Council approved the requirement for all physicians to participate in the continuing professional development programs of either the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada several years ago. We will be working over the next year to implement this policy. Please stay tuned.

Info on Methamphetamine

Crystal Methamphetamine is a highly addictive psycho-stimulant which may become one of the most serious illegal drugs in Manitoba with significant health and social consequences. As a result, Manitoba Health and addictions professionals are increasing public awareness and education activities to inform the public and service providers of the risks of the drug.

What is it?

- A psycho-stimulant used in the 1930's as a nasal decongestant, it is still prescribed in the U.S. as a treatment for obesity. Meth is not legally available in Canada and most of it is made in illegal labs.
- Jibb is a slang term used for Meth. The powdered form is commonly referred to as speed, Meth or chalk and the crystal form as crystal Meth, ice, shards or glass.

Who is using it?

- The low cost and easy manufacture of Methamphetamine has led to a rise in use among a variety of people. While users are found among all sectors of society, the most frequent users include:
  - young people at raves and nightclubs;
  - cocaine users who substitute Meth for its cocaine-like effects.
- Females are at greater risk, being 30-40% more likely to be using Meth than males. Females often begin use hoping to achieve the weight loss and energizing effects that are associated with this drug.

Effects:

- Alertness, high energy level, talkativeness, confidence;
- Little need for food or sleep;
- Racing heart and chest pain;
- Increased blood pressure and body temperature;
- Dryness of mouth, nausea, vomiting and diarrhea;
- Physical tension, feeling "wired", restless, uncontrolled/repetitive movement, irritable; and
- Extreme and alarming effects can include: paranoid delusions, hallucinations, aggressive behaviour and impulsive violence.
- Can cause tachycardia and hypertension and on overdose can result in seizures, hyperthermia, fatal cardiac arrhythmias, coronary artery vasoconstriction leading to ischemia, "heart attack", stroke and death.

Long-term effects:

- premature tooth wear, tooth loss and cavities;
- malnutrition, vitamin deficiencies, weight loss;
- speech and thought disturbances;
- depression, sleeping problems;
- damage to heart, lungs, liver, kidneys and nerve cells; and
- temporary or permanent psychosis, symptoms of this include hallucinations delusions, paranoia and bizarre and violent behaviour

What are the symptoms of withdrawal for dependent users?

- intense craving for the drug
- headaches, shortness of breath
- hunger, stomach pain
- convulsions
- tiredness and depression
- cognitive impairments: impulse control, verbal memory, decision-making, ability to experience pleasure and learning may be impaired for up to two years after discontinuation of use.

For help, please refer to your local office of the Addictions Foundation of Manitoba.

New Statement: Permanent Closure of a Medical Practice

Background

A physician may close his or her medical practice for many reasons, including personal health issues, retirement, change in pattern of practice (e.g. to an administrative position), or a relocation out of Manitoba. A practice may also close as a result of a physician's death.

The primary issues to consider when closing a medical practice are:

1. arrangements for the continuing care of patients;
2. notifications;
3. arrangements for medical records.

Scope

This Statement applies to circumstances where a physician is permanently closing his or her practice.

Recommendations

1. Alternate Arrangements for Care

- The physician who intends to close his or her practice must attempt to make some arrangements for alternate care of patients, particularly those who are in the course of treatment at the time of the closure.
- The physician must document efforts to make a suitable alternate arrangement for the care of patients. Even when the physician is unable to make suitable alternate arrangements for the care of his/her patients, the physician must be able to demonstrate reasonable efforts to make suitable alternate arrangements.
- If the physician is a specialist, the care of the patient may be returned to the referring family doctor with agreement.
- Notwithstanding the closure, physicians must be careful to ensure that any outstanding test results or reports will be reviewed and acted upon notwithstanding the closure.

2. Notification

The following must be given reasonable notice of the intended closure:

- patients
- colleagues (referring and consulting)
- College of Physicians and Surgeons of Manitoba
- Manitoba Health
- any Regional Health Authority where the physician has privileges
- Canadian Medical Protective Association (CMPA)
- Manitoba Medical Association.

- The physician who intends to close his or her practice must provide reasonable notice to patients.
- The College regards reasonable notice as 90 days. Physicians are reminded of obligations to provide emergency care to patients for 30 days following notice of termination.
- The notice may be by notice posted in the office and in local newspapers.
- The notice to patients must include the date of closure and particulars of any arrangements for care that have been made for the patient.
- The physician who is unable to make suitable alternate arrangements for the care of patients must make arrangements to ensure patients or their caregivers have appropriate access to information contained in the patient's medical record.

3. **Medical records**

- The primary concerns for the physician managing patient records on termination of practice should be:
  (a) assuring continuity of patient care;
  (b) assuring timely accessibility to appropriate persons;
  (c) security of records;
  (d) destruction of records.

- For physicians planning to leave clinical practice or leaving the jurisdiction, it may not be convenient to retain the records. Therefore, it may be difficult to respond to requests for information from these records. The records should not be sold to a second physician, but it may be appropriate to transfer the records to the custody of a second physician. The transfer should be documented in a written agreement. The following factors should be considered and addressed in the agreement:
  (a) permitting free access to the records by the original doctor;
  (b) the need for patient consent (express or implied) to have the custodian of the files take over any records;
  (c) when the records may be ultimately destroyed;
  (d) whether the custodian of the files will abstract relevant facts for a third doctor upon request.
  (e) patient rights under applicable privacy laws.
  (f) patient costs to obtain or forward their information.

  Physicians are urged to obtain legal advice regarding any such agreement.

- If a physician closing his or her medical practice is unable to provide ongoing management of patient medical records, either personally or through a colleague, the records should be put into commercial storage for custody, transferred as necessary, or destroyed when that is appropriate.

- It is the physician's responsibility to arrange for the secure storage and accessibility of these records. Records should be retained for a minimum of ten (10) years following the date of last service; in the case of minor patients, they should be kept at least until two (2) years past the age of majority or for ten (10) years, whichever is longer. There may be particular circumstances where a physician must keep a medical record beyond the ten year period to benefit the patient. If there is any question about retention, the physician is advised to seek legal advice.

- Disposal of records must be in accordance with the requirements of *The Personal Health Information Act*, where applicable, the *Personal Information Protection and Electronic Documents Act*, and other relevant privacy laws.

A statement is a formal position of the College with which members shall comply. Statements are available on the College website.

Community-Associated Methicillin Resistant Staphylococcus aureus – CA-MRSA

Physicians should be aware of CA-MRSA infections in individuals in the community. Illnesses caused by these strains include boils, skin and wound infections, skin abscesses, ear and eye infections. These illnesses have been seen throughout the province, and reflect clones of organisms that have methicillin (cloxacillin) resistance genes and may have other virulence genes. Other provinces have reported CA-MRSA infections resulting in necrotizing pneumonia and death.

Not all infections caused by CA-MRSA require antimicrobial treatment. The laboratory should be used to guide antibiotic treatment for cases of CA-MRSA infections where antibiotics are indicated. In Manitoba, the predominant CA-MRSA strains are usually sensitive to co-trimoxazole, doxycycline and are often sensitive to erythromycin. (Note that co-trimoxazole does not provide coverage for Group A beta-hemolytic streptococcus.)

A document prepared by a national working group consisting of public health, infectious disease and laboratory medicine specialists is currently being drafted and will be made available on the Manitoba Health website once completed.

For management of challenging cases, please call Infectious Disease consultants on-call at 787-2071, or call directly to an individual ID specialist.

Tamiflu Access for Healthcare Facility Outbreaks of Influenza

Physicians and pharmacies may have recently received a letter from Roche, manufacturer of Tamiflu® indicating how to access Tamiflu® in the event of an influenza virus outbreak in a facility.

To access publicly funded Tamiflu® for influenza outbreak control and to assure the facility is not invoiced, Manitoba Health requires consultation with the Regional Medical Officer of Health (MOH). If you do not know how to reach your MOH, call your local public health office. The after hours number for physician access to a Medical Officer of Health is 788-8666.

For additional information about influenza outbreak management and accessing publicly funded Tamiflu®, free of charge, click on the Manitoba Health Website: http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html, and scroll down to Other and look for "Oseltamivir (Tamiflu™) for Institutional Outbreak Control".

WRHA Routine Practices Initiative

Issues regarding infection prevention and control practices for healthcare professionals have been a concern, particularly when dealing with specific infectious diseases like SARS, MRSA and VRE.

The WRHA has implemented a Routine Practices Project for all healthcare workers, including physicians, within the region to educate them about Routine Practices and other infection prevention and control practices.

The Project began in September 2005 and is currently being rolled out to all health care workers in community, acute, long term care and personal care home sites. This project was timed to coincide with the annual influenza campaign and the implementation of a new regional Infection Prevention and Control Manual in the hospitals.

Routine Practices is the basic level of care and standard practice recommended by the Public Health Agency of Canada (Health Canada) to prevent infection transmission.

Routine Practices focuses on activities such as hand hygiene and the use of Personal Protective equipment, including gloving, gowning and masking. It also includes many other preventative measures such as equipment cleaning.

For further information, or to obtain a RP Educational Kit, please contact Brenda Dyck, Regional Director IP&C at 926 - 7112 or Rose Dziadekwich, Project Manager at 926 - 7031.

The Canadian Adverse Drug Reaction Monitoring Program

The Canadian Adverse Drug Reaction Monitoring Program at Health Canada collects and assesses adverse reactions that have been submitted by health care professionals or consumers.

Information on all reported adverse reactions is maintained in a computerized database at www.hc-sc.gc.ca/dhp-mps/medeff/databasdon/ index_e.html).

To download a copy of the adverse reaction reporting form, or to receive the *Canadian Adverse Reaction Newsletter* and health product advisories by email, go to www.hc-sc.gc.ca/dhp-mps/medeff/subscribe-abonnement/index e.html..

Suspect an adverse reaction? Report it. for the benefit of all! Tel. 1-866-234-2345; Fax 1-866-678-6789 or www.healthcanada.gc.ca/medeffect

Important Notice - Medical

Reports for Commercial Drivers

In January 2006, Manitoba Public Insurance and Driver and Vehicle Licencing implemented National Safety Code Standard 6. Consequently all Class 1, 2, 3 and 4 drivers and drivers with authorized instruction in these classes will be required to file mandatory medical reports at an increased frequency as follows:

Class 1, 2, 3 & 4:

- on application
- every 5 years to age 45
- every 3 years from ages 46 to 64
- annually at 65 and over

Drivers with medical conditions may be required to file medical reports more frequently.

Lessons Learned…

- ***From the Complaints Committee***

A recent case before the Investigation Committee involved a specialist who cancelled a scheduled appointment on the basis that the patient was HIV positive. The physician felt that the patient should be seen in a hospital where a higher degree of sterilization is present. The patient was seen by another physician in that physician's office without incident. The patient complained of discrimination.

The Committee was concerned that there had been discrimination based on health status. All physicians must employ universal precautions for all patients. Many individuals carry diseases. Some may not know their status. Some may not disclose their status. Universal precautions protect all patients and the physician.

Upon receipt of this complaint, the physician who was the subject of the complaint acknowledged the concern and changed practices.

- ***From the Investigations Committee***

The Investigation Committee recently reviewed a complaint involving a patient who presented to a physician with a salicylate overdose. The physician was not familiar with the treatment of this particular type of overdose. The physician consulted a textbook, but did not contact the Poison Control Centre. Physicians are reminded that the Poison Control Centre is an excellent resource for physicians treating a patient who has taken an overdose. The Centre is accessible 24 hours a day at 787-2591. The Poison Control Centre can provide advice and can arrange a consultation with the Poison Control Centre Director if required.

In addition, there are physicians on staff at the Health Sciences Centre with expertise in toxicology related issues who can be accessed through the paging centre.

Prescribing Antidepressant Medications – Recent Recommendations

Serotonin reuptake inhibitors (SSRIs), serotonin and noradrenaline reuptake inhibitors (SNRIs), and other novel antidepressant medications (e.g. bupropion, mirtazapine) are recommended as first line treatments for major depressive disorder in contemporary clinical practice guidelines.

Recent reports have reviewed the potential of these agents to contribute to or cause suicidality or aggressive behaviour. Regulatory authorities in Canada, the US and the UK have mandated changes in the product monographs for newer antidepressants as a result of these concerns.

The Canadian Psychiatric Association recently published a position statement entitled "Prescribing Antidepressants for Depression in 2005: Recent Concerns and Recommendations" (R. Lam & S. Kennedy, Canadian Journal of Psychiatry Vol 49, No 12 – insert).

The main recommendations in this paper were as follows:

1. In adults there are clear benefits of antidepressant medications and the evidence linking antidepressants with emerging suicidality is not substantial. Accordingly, the newer antidepressants (SSRIs, SNRIs, novel agents) remain first-line treatment options for depression in adults.

2. In children and adolescents, evidence of antidepressant benefit is clear only for fluoxetine. There is some evidence of an increased risk of suicidality with newer antidepressants. Accordingly, only fluoxetine is considered a first line treatment for depression in children and adolescents. Other SSRIs can be considered as second-line therapies especially if a depressive disorder is severe or chronic and/or psychological treatments such as cognitive therapy have not worked.

3. Careful monitoring for suicidality is important in the clinical management of all patients with depression, especially in the early phases of treatment. When an antidepressant medication is prescribed, there should be a discussion of potential side effects that could contribute to suicidality, including anxiety, agitation, hostility, and hypomania.

4. Additional studies are necessary to further elucidate the specific benefits and risks of antidepressants in different age groups including children, adolescents and the elderly.

The complete position paper is available through the Canadian Psychiatric Association website: www.cpa-apc.org/Publications/Position_Papers/Position_Papers.asp

Disasters and Docs (*Part I of IV*)

Situating Disasters

It is a safe bet the Winnipeg Health Region will never suffer a hurricane, a volcano eruption, a tidal wave, or an earthquake. But when it comes to almost anything else, all bets are off!

We know from recent local history that the flood plain on which we live is prone to rising waters; local roadways and parks serve as improvised landing strips for air traffic; backyards and strip malls are receiving areas for derailed train cars; and there is little escape from the character building weather that typifies our seasons.

We also know that there are no designated "Dangerous Goods" routes through the City of Winnipeg, rail yards are prevalent and hazardous material including biologics are routinely transported through heavily populated areas. Power is disrupted from time to time, gas main leaks explode, and meth labs are volatile.

Influenza pandemic planning is the order of the day, and there will, for some time, be uncertainty as to the location, means, and extent of the next act of terrorism.

We are indeed fortunate here not to be able to recall either the last mass casualty incident or the last significant act of destruction requiring our urgent response and then our recovery.

Nevertheless, in the past few years we have witnessed from afar a deadly heat wave in France, a catastrophic Tsunami in South East Asia, ruinous hurricanes in the Gulf of Mexico, a cataclysmic earthquake in Kashmir, not to mention the World Trade Center collapse, the Bali Bombings, and the London Subway Attacks.

Common to all forms of disaster, whether natural, technological, or man-made, is the necessary health response.

Invariably, there will be victims invariably suffering from any one or a combination of the following: trauma, burns, chemical contamination, biological contamination, radiological contamination, and mental health effects.

The overall health and medical aspects of disasters are vast and varied and health services may quickly be overwhelmed.

Consequently, there is a requirement to involve private practice and primary care physicians in planning for, responding to and recovering from disaster events.

This is the first in a series of articles which follow a Winnipeg Regional Health Authority presentation made to the College of Physicians and Surgeons of Manitoba on September 28, 2005 on the topic of Disaster Management. Subsequent articles will speak to **Managing Disasters** describing the Incident Command System; **Docs in Disasters** broaching the topic of physician roles in Disaster Management; and finally **Tracing the Way Ahead** proposing a number of suggestions which may help travel the way ahead.

New Fentanyl Warnings

If you prescribe, administer or dispense fentanyl patches, we strongly encourage you to thoroughly review the alert from the U.S. Food and Drug Administration (http://www.fda.gov/cder/drug/advisory/fentanyl). Some patients and their healthcare providers may not be fully aware of the dangers of these potent narcotic products and the important recommendations regarding their safe use. There have been recent fatalities which have been documented in patients who have been treated with fentanyl.

Prescription Information Services of Manitoba (PrISM), a non-profit, independent pilot project set up by the Manitoba Pharmaceutical Association (MPhA) and Manitoba Health, distributed a newsletter about transdermal Fentanyl in March 2005. It can be found at www.prisminfo.org If you have any questions, you are invited to contact PrISM at manitobaprism@mts.net

Key Messages from PrISM:

- The fentanyl patch is efficacious in the management of chronic, stable, cancer and non-cancer pain.
- Provision of the fentanyl patch to an opiate naïve patient can lead to severe adverse events including death.
- Safe and effective use of the fentanyl patch is dependent on appropriate patient selection and close follow-up for therapeutic benefit and adverse effects.
- The shortest interval for up-titration of the fentanyl patch should be every 3 days. Changing the patch more frequently can predispose patients to adverse drug events.

SIDS Prevention Recommendations Updated

On October 10, 2005, the American Academy of Pediatrics (AAP) released an updated policy statement on "The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment and New Variables to Consider in Reducing Risk".

This statement recommends against bed sharing. It recommends that infants sleep in a crib in the parents' bedroom. The AAP further recommends using a pacifier for naps and at bedtime. In breastfeeding babies, a pacifier should be introduced after 1 month of age. Side sleeping is no longer recognized as a reasonable alternative to fully supine. The policy statement is available at www.aap.org.

Congratulations!

- To Dr. Krish Sethi, College Councillor since 1990, who was honored as Manitoba's Family Physician of the Year for 2006 by the Manitoba College of Family Physicians.

Management of Diabetic Ketoacidosis (DKA) in Children and Adolescents

If a child presents with symptoms of hyperglycemia, a random blood glucose should be done immediately. If the blood glucose level is not available within an hour, a urine dipstick should be done immediately. If the urine is positive for glucose or the random blood sugar is >11.1, the pediatric endocrinologist on-call at Children's Hospital should be contacted **immediately at 204-787-2071**. You can also call the Manitoba Diabetes Education Resource for Children and Adolescents (DER-CA) at Children's Hospital at 204-787-3011 for non-urgent issues.

Most children with new-onset type 1 diabetes appear well. Do not let their clinical appearance fool you. Immediate referral is mandatory to avoid rapid deterioration. If the child appears ill, diabetic ketoacidosis (DKA) is likely.

Treatment of DKA in children has important differences from adults. The WRHA Standards Committee has identified DKA in children as a **low-volume high-risk condition**. Because of the higher rate of cerebral edema in children, it is recommended that management be directed by a pediatric diabetes specialist (available through Health Sciences Centre paging at 787-2071).

Report of Disciplinary Proceedings

CENSURE: IC05-03-10
DR. NASEEM A. KHAN

On September 7, 2005, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Khan as a record of its disapproval of the deficiencies in her care and management of a patient. Censure creates a discipline record which may be considered in the future by the Investigation Committee or an Inquiry Panel when determining the action to be taken following an investigation or hearing

I. PREAMBLE

Where a physician finds iron deficiency anemia in a patient, the physician should always conduct investigations to determine the cause. If symptoms include rectal bleeding and constipation, the possibility of a gastrointestinal malignancy is very high in the differential diagnosis and prompt and complete investigation is required.

II. THE RELEVANT FACTS ARE:

1. Ms. "X", born September 22, 1954, became Dr. Khan's patient in 1998.
2. Dr. Khan's medical record documents:
   a. On September 19, 2003, Ms X complained of blood in her stool on 3 or 4 occasions, and of constipation. Examination documented in the record is a blood pressure, a weight (179 pounds), lung auscultation and an abdominal examination (which revealed no tenderness). Dr. Khan concluded that she may be suffering from hemorrhoids and prescribed Anusol suppositories and Metamucil. Dr. Khan ordered hemoglobin, which was reported as 116 and various other laboratory investigations.
   b. On January 4, 2004, Ms X's weight was documented as 173. Dr. Khan ordered hemoglobin, which was reported as 101, and ferritin, which was reported as 11.8.
   c. When Ms X returned on February 6, 2004, Dr. Khan prescribed an iron supplement. The only recorded examination is her blood pressure.
   d. On March 5, 2004, Ms X reported feeling better. Her weight was 173 pounds. The only other recorded examination is her blood pressure.
   e. On April 6, 2004, Ms X reported having lost some weight. Dr. Khan noted that she was taking an iron supplement. Her record does not document any examination. The note states Dr. Khan's intent to recheck her hemoglobin and thyroid.
   f. On June 11, 2004, Dr. Khan documented Ms X's weight as 170 pounds and checked her blood pressure. She ordered blood work, including hemoglobin, which was reported as 95.
   g. On June 25, 2004, Dr. Khan noted the hemoglobin result, and that Ms X was taking iron supplements, was usually constipated, and stated she did not have hemorrhoids and her periods were not heavy. Dr. Khan advised her to continue with Metamucil to relieve the constipation.
   h. On August 6, 2004, Ms X complained of constipation and Dr. Khan noted that she was taking Metamucil. She complained of having had a couple of incidents of pain in her left side followed by diarrhea. Dr. Khan documented her weight as 168 and her blood pressure. No other examination is noted on the file. Dr. Khan advised her to decrease the iron supplement. She ordered blood work, including hemoglobin, which was reported as 89. A note on the laboratory results states that an appointment was required to discuss the results.
   i. On August 26, 2004 Ms X complained of rectal bleeding and Dr. Khan conducted a digital rectal examination. Dr. Khan reported that the examination was negative.
   j. On September 17, 2004, Ms X returned to see Dr. Khan, complaining of constipation, for which she continued to take Metamucil. Dr. Khan noted that she was continuing to take iron. She recorded Ms X's weight as 165 and her blood pressure. No other examination is recorded.
3. Ms X stated that throughout the period January 2004 to September 2004, her main complaint to Dr. Khan was of being tired. She stated that in March 2004 she complained to Dr. Khan that she was bleeding when she had a bowel movement and that by June 2004, she was always having blood in her stool. Dr. Khan disputed that she complained of rectal bleeding other than on September 19, 2003 and August 26, 2004.
4. On November 12, 2004, Ms X attended another physician complaining of lots of bleeding from her rectum, with clots and mucus, ongoing for about 3 to 4 months. On rectal examination, the physician

detected a large golf ball size fungating tumor, palpable rectally, and made a preliminary diagnosis of colon cancer.

5. In Dr. Khan's response:
   a. she acknowledged that Ms X's weight had decreased. However, Dr. Khan understood that she was on a weight loss program and trying to lose weight, and Dr. Khan assumed she may be eating poorly following her mother's death in 2003.
   b. Dr. Khan acknowledged that Ms X's hemoglobin dropped from 116 on September 19, 2003, to 89 at her August, 2004 visit.
   c. Dr. Khan stated that she assumed that Ms X's dropping hemoglobin was due to heavy menstrual cycles and poor diet, but she acknowledged that she made no inquiries of Ms X respecting these issues other than on June 25, 2004 when she denied having heavy periods. Dr. Khan acknowledged that management of patients should not be based on assumptions.
   d. Dr. Khan stated that following the September 17, 2004 visit, she intended to make a gastroenterology referral but Ms X never returned to the clinic.
   e. Dr. Khan acknowledged that earlier initiation of GI investigation was required.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. KHAN'S CARE AND MANAGEMENT OF MS X. IN PARTICULAR:

She failed to investigate the cause of the patient's progressive iron deficiency anemia.

In addition to appearing before the Investigation Committee and accepting the Censure, Dr. Khan paid the costs of the investigation in the amount of $1,532.00.

CENSURE: IC05-04-06
DR. ELZBIETA SOCHOCKA

On September 7, 2005, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Sochocka as a record of its disapproval of her care and management of a patient. Censure creates a discipline record which may be considered in the future by the Investigation Committee or an Inquiry Panel when determining the action to be taken following an investigation or hearing

I. PREAMBLE

Physicians should have an adequate tracking system to determine if patients have received follow-up on abnormal test results, subject to the patient's right to decline recommended care. When a physician receives an abnormal test result, the physician is responsible to convey that result to the patient, and to recommend appropriate follow-up care.

II. THE RELEVANT FACTS ARE:

1. Mrs. X was Dr. Sochocka's patient from 1998 to August, 2003. She consulted her with respect to a variety of complaints and for complete physical examinations.
2. On March 28, 2003, Dr. Sochocka saw Mrs. X for a complete physical examination, which included a pap smear.
3. Mrs. X returned to see Dr. Sochocka on April 7, 2003 with respect to a specific complaint. At that time, she discussed the results of blood work ordered at the time of her complete physical examination. Dr. Sochocka stated that she did not have Mrs. X's pap smear test results at the time of that visit.
4. On August 18, 2003, Mrs. X consulted another family physician, who sent to Dr. Sochocka a request for transfer of Mrs. X's records. Dr. Sochocka promptly provided the records.
5. Upon receipt and review of the records, Mrs. X's new physician noted that the report of the pap smear taken by Dr. Sochocka on March 28, 2003, and reported on April 3, 2003 read: "Abnormal cells consistent with adenocarcinoma of endometrial origin. Further investigation is indicated."
6. The physician called Mrs. X to her office to discuss this result. Mrs. X stated that she was unaware of this result, and had had no follow-up.
7. Mrs. X had further assessment done and was diagnosed with primary peritoneal cancer with surface disease on the ovaries.
8. In response to this complaint, Dr. Sochocka stated that:
   a. At the time, it was her usual practice to review test results.
   b. At the time, upon receipt of an abnormal test result, she made a note on the result that she would like to see the patient, and left the result for her staff to arrange an appointment with the patient.
   c. She was unable to say why Mrs. X's abnormal test result was placed upon the chart without being seen by her.
   d. Upon notification of this complaint, she changed her practice to review and to sign all test results.
   e. She accepts her responsibility for follow-up on abnormal test results.
9. She sincerely apologized to Mrs. X for the delay in her diagnosis.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. SOCHOCKA'S CARE AND MANAGEMENT OF MRS. X, IN PARTICULAR:

As a result of Dr. Sochocka not establishing and maintaining an adequate system in relation to follow-up on abnormal test results, she failed to take any steps to advise Mrs. X of the abnormal pap smear result dated April 3, 2003 or to recommend follow-up care to Mrs. X.

In addition to accepting the Censure, Dr. Sochocka paid the costs of the investigation in the amount of $1,291.00.

CENSURE: IC03-03-01
DR. MOHAMMAD H. NAGARIA

On September 15, 2005, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Nagaria as a record of its disapproval of his conduct. Censure creates a discipline record which may be considered in the future by the Investigation Committee or an Inquiry Panel when determining the action to be taken following an investigation or hearing

I. PREAMBLE

In or about February 2002, the College published in its newsletter the full text of Statement 805 on prescribing practices as follows:

> "Prescribing of medications by physicians based solely on information received without direct patient contact fails to meet an acceptable standard of care and is outside the bounds of professional conduct. There is no direct patient contact when the physician relies upon

a mailed, faxed or an electronic medical questionnaire or telephone advice to the physician."*

Counter-signing a prescription without direct patient contact fails to meet an acceptable standard of care and is outside the bounds of professional conduct.

In order to meet an acceptable standard of practice, the physician must demonstrate that there has been:

1. a documented patient evaluation by the Manitoba physician signing the prescription, including history and physical examination, adequate to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indications;
2. sufficient direct dialogue between the Manitoba physician and patient regarding treatment options and the risks and benefits of treatment(s);
3. a review of the course and efficacy of treatment to assess therapeutic outcome, and
4. maintenance of a contemporaneous medical record that is easily available to the Manitoba physician, the patient, and the patient's other health care professionals.

*An exception exists for physicians who are fulfilling responsibility as part of a call group."

Statements of the College represent the formal position of the College on a topic, and members of the College are expected to comply with Statements. Members of the College are also expected to be aware of all items published in the College newsletter.

Article 12 of the Code of Conduct provides

"12. Provide your patients with the information, alternatives and advice they need to make informed decisions about their medical care, and answer their questions to the best of your ability."

In the absence of direct contact with the patient, the physician has no direct knowledge of whether the patient has received information regarding the medication from the originating physician and it is not possible for the physician to obtain the informed consent of the patient in accordance with the requirements of Article 12 of the Code of Conduct.

Pursuant to Regulation 25/03, physicians are required to possess and maintain professional liability coverage that extends to all areas of the physician's practice, through either or both of membership in the Canadian Medical Protective Association and a policy of professional liability insurance that meets the requirements stipulated in Regulation 25/03.

Article 29 of By-Law No. 1 of the College requires members to maintain medical records on every patient.

Physicians in Manitoba practice pursuant to a system of defined registration and licensure. A physician with a specialty registration and licensure must confine his or her practice to the scope of that specialty.

II. THE RELEVANT FACTS ARE:

1. In or about August 2002, Dr. Nagaria entered an arrangement with a pharmacy that he would counter-sign prescriptions for American patients who were customers of that pharmacy.
2. Pursuant to the arrangement with this pharmacy, during the period from on or about August 2002 to in or about March, 2003 Dr. Nagaria received from the pharmacy packages containing the patients' prescriptions, and patient information forms. Dr. Nagaria reviewed these documents and, if it was acceptable to him, he counter-signed the prescriptions.
3. Commencing in January 2003, Dr. Nagaria entered similar arrangements with two additional pharmacies to counter-sign prescriptions for American patients who were the customers of those pharmacies.
4. Dr. Nagaria had telephone conversations with at least 2 of the patients for whom he counter-signed prescriptions, but otherwise had no direct patient contact with the patients before counter-signing the prescriptions.
5. Two of the prescriptions Dr. Nagaria counter-signed were for animals.
6. Several of the prescriptions Dr. Nagaria counter-signed were intended to treat conditions outside of the scope of his specialty practice.
7. Upon receipt of correspondence from the College questioning Dr. Nagaria's counter-signing practice, he ceased counter-signing and took appropriate steps to ensure that the pharmacy did not use his counter-signed prescriptions for any renewals or refills.
8. In his response to the College, Dr. Nagaria stated that:
   a. He was not aware of the College's position on counter-signing prescriptions without direct patient contact until he received the College's letter dated March 17, 2003 questioning his role in counter-signing prescriptions.
   b. He had not seen the items published in the College newsletter respecting Statement 805.
   c. He acknowledged having breached the Statement.
   d. He understood the College's concern that counter-signing prescriptions without direct patient contact fails to meet an acceptable standard of care.
   e. On reflection, he accepted the validity of the College's position, and he accepted responsibility for his actions in failing to meet an acceptable standard of care when he counter-signed prescriptions without direct patient contact.
   f. He counter-signed the prescriptions for animals in error, and acknowledged not having spent adequate time reviewing the material provided to him in relation to these requests for prescriptions.
   g. Although he believed that he was familiar with the medications he was prescribing, on reflection he acknowledged that several of the prescriptions were intended to treat conditions outside of the scope of his specialty, and therefore he did practice outside of the scope of his specialist registration.
   h. He did not really consider the issue of professional liability coverage at the time he was counter-signing.
   i. He has no medical records with respect to any of the patients for whom he counter-signed prescriptions, having returned to the respective pharmacies all of the material provided to him by the pharmacies.
   j. He has not participated in counter-signing prescriptions since receipt of the College's letter, and wishes to now devote his full attention to his practice.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. NAGARIA'S CONDUCT, IN PARTICULAR:

1. Counter-signing prescriptions for American patients in violation of Statement 805 of the College and in violation of the requirements of the Code of Conduct.
2. Practising without professional liability insurance coverage that extended to all areas of his practice in

violation of Regulation 25/03.
3. Failing to maintain patient records in accordance with the requirements of By-Law No. 1 of the College.
4. Counter-signing 2 prescriptions for animals.
5. Counter-signed prescriptions to treat conditions outside of the scope of his specialist registration.

In addition to appearing before the Investigation Committee and accepting the Censure, Dr. Nagaria paid the costs of the investigation in the amount of $4,743.30.

Notices, etc…

Changes of Address

Occasionally a doctor has failed to receive communications from the College because of a change of address which has not been given to us. Bylaw #1 requires that all members must notify the College of any change of address within 15 days so that communications can be kept open. The College cannot be responsible for failure to communicate to registrants who have not notified us of address changes.

Accepting Visiting Medical Students for Electives (Undergraduate and Postgraduate)

Are you considering sponsoring a medical student and/or resident for an elective ALL visiting medical students and residents must be registered with the University of Manitoba and the College of Physicians and Surgeons of Manitoba. There is a defined process with eligibility criteria that must be met.

For more information please contact the appropriate person at the University of Manitoba:

Undergraduate Medical Students:
Ms. Tara Petrychko; Tel: (204) 977-5675
Email: petrych@ms.umanitoba.ca
Residents (Postgraduates):
Ms. Betty Caron; Tel: (204) 789-3453
Email: caronej@ms.umanitoba.ca
Website:
http://www.umanitoba.ca/faculties/medicine/education/index.html

The Medication Information Line for the Elderly (MILE)
is located at the
University of Manitoba

Please visit MILE at

Room 111 University Centre
(204) 474-6493
Toll Free 1-800-432-1960
(ask for MILE; ext. 6493)

9:30am to 2:30pm Monday to Thursday
email: mile_resource@umanitoba.ca

Emergency Medicine Update Symposium

When: Friday, March 24, 2006
Where: Theatre "A" Basic Medical Sciences Building
730 William Avenue, Winnipeg, Manitoba

This symposium is designed to provide an overview and update on important Emergency Medicine issues through a series of lectures.

Physician (Advanced)	$150.00
Same day registration	$175.00
RN/Allied Health Professional (Advanced)	$60.00
Same day registration	$75.00
Resident (Advanced)	No Fee
Same day registration	$25.00

Medical Students: No fee for auditing sessions.
(Workshops, course materials and food not included.)

For information or to receive a brochure call 789-3660.

Moving? Retiring?

If you are leaving the province or retiring from practice, By-law #1 requires that you advise where your records will be stored, so that we may note it on your file and advise interested parties.

The By-Law requires that any member who has not practised in the province for a period in excess of two years without the permission of Council shall, in accordance with section 16(1) of The Medical Act, be struck from the Register. The effective date of erasure shall be two years after that member's cessation of practice.

Approved Billing Procedure

When physicians wish to recruit a colleague to carry out the practice of medicine in their place and bill in their names, the College must be advised ***in advance*** and approve the specific time interval. Only when written approval is received may a physician act in place of another.

Without written approval as a locum tenens, one physician may replace another, but must act and bill independently.

Officers and Councillors 2005-2006

President:	*Dr. R. Graham*
President Elect:	*Dr. H. Domke*
Past President:	*Dr. M. Roy*
Treasurer:	*Dr. B. MacKalski*
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Deputy Registrar:	*Dr. T. Babick*
Assistant Registrar:	*Dr. A. Ziomek*
Assistant Registrar:	*Ms. D. Kelly*
Chair of Council:	*Dr. R. Graham*

Term expiring June 2006

Central Plains	*Dr. L. Antonissen, Portage*
Interlake	*Dr. C. Chapnick, Gimli*
Interlake	*Dr. R. Graham, Selkirk*
Northman	*Dr. K. Sethi, Flin Flon*
Parklands	*Dr. D. O'Hagan, Ste.Rose*
Winnipeg	*Dr. A. Alvi*
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	Dr. A. MacDiarmid
	Dr. S. Sharma
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	Dr. R. Suss
University of Manitoba	*Dr. W. Fleisher*
Public Councillor	*Mr. W. Shead*
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Term expiring June 2008

Brandon	*Dr. B. MacKalski*
Eastman	*Dr. B. Kowaluk, Oakbank*
Northman	*Dr. N. Nwebube, Thompson*
Westman	*Dr. S. Chapman, Neepawa*
Winnipeg	*Dr. A. Arneja*
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	Dr. R. Lotocki
University of Manitoba	*Dean D. Sandham*
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Clinical Assistant Register (expires 2006)	*Mr. Y. Abdulrehman*