From the College

Telephone: (204) 774-4344 or
Toll Free within Manitoba 1-877-774-4344
Fax: (204) 774-0750

Publications Mail Agreement #40051985
Return Undeliverable Canadian Addresses to
1000 – 1661 Portage Avenue, Winnipeg, MB R3J 3T7
Website: www.cpsm.mb.ca

Volume 49 Number 1 January 2013

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 YOUR PRESIDENT
DR. BRUCE KOWALUK

Ok, so I know I said in the September College Newsletter that the College did more than just simply audit and discipline physicians. I listed some of the programs that the College ran that helped to ensure safe and competent care for all Manitobans, and a structured environment for physicians to work in.

Recently, at a dinner meeting with a collection of doctors and nurses, I discussed the collaboration of the CPSM with the University Of Manitoba Faculty Of Medicine regarding courses in professionalism and communication for medical learners.

Regrettably, for a variety of reasons, not all licensed physicians in Manitoba have received the benefit of these insightful lectures. That is apparent when one looks at the quantity and character of complaints that are filed against physicians. While the nature of the allegations varies wildly, a number of recurring themes appear. Communication or lack thereof, is one of the most common complaints that confront physicians. It's not just what was said, but how it was said that raises patients' ire.

I thought what I would do with this article is provide some practical advice to members based on what I have learned from reviewing hundreds of complaints over the years.

1. First and foremost, act professionally and respectfully towards your patients and coworkers. Treat people as you would want to be treated yourself. Don't forget about patients' family members either - they are often offended when physicians snub them and subsequently lodge complaints.

2. Do not let other people's inappropriate behaviour make you lose your composure and draw you into an altercation. Patients and other health care workers are becoming increasingly intolerant towards physicians' inappropriate behaviour.

3. Communicate in an appropriate fashion with your patients. Take the time to inform and educate them about their diagnosis. If you're not sure or don't know, don't try to disguise your uncertainty in arcane references and terminology. There is no shame in admitting you don't know all the answers, and seeking another opinion.

4. Ensure that you personally reassess significant changes in your patients' status when brought to your attention. A number of physicians have been burned over the years by either accepting someone else's assessment, or not doing their own in a timely fashion.

5. Maintain legible, coherent and timely notes. In the eyes of the College, and the courts, if you didn't document your history and examination, it didn't happen. If you find yourself the subject of a complaint, or a legal proceeding, the lack of comprehensive notes will leave you vulnerable. Be very careful about adding or editing notes after the fact. Electronic charts have audit trails, and paper charts are easily recognized by experts as altered.

I recognize that most of what I have said above is common knowledge and common sense. However, given the frequency of complaints that arise involving these characteristics, it bears repeating. I hope these tips help you to practice safe, competent, compassionate, and enjoyable medicine.

Sincerely,
Bruce Kowaluk
President

NOTES FROM THE REGISTRAR

CPSM Council December 14th, 2012

- Dr. Jerry Gray (Dean Emeritus, Asper Business School) attended the College Council meeting and provided an overview on Policy Governance. His information was very helpful.

- Length of term for CPSM President – Council discussed whether the term of the President should be one year or two years. Mr. Giesbrecht, Legal Counsel, will look into options for this and further discussions will occur at the March 2013 Council meeting.

- Nominating Committee meeting for President-Elect – 2013/2014. Two names were approved by Council. The election was held over Christmas and ballots were counted on January 14th, 2013. The President-Elect for 2013/2014 is Dr. Brent Kvern. Congratulations, Dr. Kvern.

- Standards of Practice – This Regulation is required for the *Regulated Health Professions Act.* It is a new concept. The Standards of Practice will be law. Many of the items from previous statements are included in the Standards of Practice with some further issues identified. The Standards of Practice draft Regulation was approved by Council. It has now been returned to government and will in due course be put on the website for comments from any physician member of the CPSM.

- Manitoba Laboratory Standards for Cytology – Further standards were identified at the request of Program Review. They were approved by Council. They will be put on the website in the near future.

- Joint Statement on electronic transmission of prescriptions – The statement inserted in this newsletter was approved by Council on December 14th, 2012. Members should read this very carefully. The use of an electronic prescription is now acceptable to the Manitoba Pharmaceutical Association and the statement is applicable to pharmacy, medicine, nursing, dentistry and veterinary medicine. We are all delighted that this issue is finally settled. Physicians should be extremely careful, however, to ensure that all the necessary safeguards are in place.

- Use of SharePoint for Council and committee meetings – Epic Information Solutions, our IT providers, presented a plan to provide all agendas for College meetings paperless with a program called SharePoint. The College will move forward with implementing this in the future.

Other issues are also occurring at the College as we speak:

- Fairness Commissioner Review – The Office of the Fairness Commissioner will be reviewing the processes of the CPSM for registration of physicians at this College. The review will occur between January 1st and April 30th, 2013. This is a complex process and the final report from the Fairness Commissioner will be published in Hansard and made available to the public.

- College office renovations – After significant planning, the College offices will undergo renovations over the next six months to provide a more appropriate space for all of the College's operations. Committee meetings may need to be scheduled outside of the building. We apologize for any inconvenience to those who are visiting the College during this time.

On behalf of all here at the CPSM offices, I wish you a very happy New Year.

William D.B. Pope
Registrar/CEO

FACULTY OF MEDICINE UP-DATE

The Academic Structure Initiative of the University of Manitoba, and in particular the Health Sciences area, continues to be engaged in an extensive period of discussion respecting the benefits and risks of a more integrated structure. Benefits that have been considered in light of key emerging trends include increasing emphasis on team-based, multi-and-inter-disciplinary research as signaled by CIHR, CIHI and others; a clinical focus on inter-disciplinary health care as a means to improve quality of care and patient safety; and an increasing importance placed on the need for interprofessional education and consistent standards of care by all professional accreditation bodies.

The Deans/Directors of the Faculties and Schools in the Health Sciences area are now in a position to propose two options for a more integrated structure:

Option One: Create a new Faculty of Health Sciences by uniting five existing faculties (Dentistry, Medicine, Nursing, Pharmacy, Human Ecology) and two existing schools (Dental Hygiene, Medical Rehabilitation). Dentistry, Medicine, Nursing, Pharmacy, along with Medical Rehabilitation, would be Colleges within the new Faculty of Health Sciences. Departments in the Faculty of Human Ecology (Family Social Sciences, Human Nutritional Sciences, and Textile Sciences) would become part of the College of Medicine. The School of Dental Hygiene would be a School within the College of Dentistry.

Option Two: Create a new Faculty of Health Sciences by uniting four existing faculties (Dentistry, Medicine, Nursing, Pharmacy) and two existing schools (Dental Hygiene, Medical Rehabilitation). Similar to option one, Dentistry, Medicine, Nursing, Pharmacy, along with Medical Rehabilitation, would be Colleges within the new Faculty of Health Sciences and the School of Dental Hygiene would be a School within the College of Dentistry. This option also includes the creation of a new and separate unit or faculty structured around the concept of "healthy living" by uniting two existing faculties (Kinesiology and Recreation Management, Human Ecology) and exploring possible alignment of other University units within this new faculty.

In either option, the Deans and Directors believe that a more integrated structure creates powerful and unique alliance among the health sciences. As well, it provides an opportunity to create a substantial, integrated focus on health and healthy living by uniting faculties and perhaps other units with a primary focus in this area. We are looking for feedback on these options. Please go to http://umanitoba.ca/admin/vp_academic/strategic_planning/3736.html for more information and to provide feedback.

As well, in the last issue, it was noted that the Faculty of Medicine has been looking at its retention rate of our students, as data has suggested that our success in keeping medical students coming from other Provinces is poor. We are committed as a faculty to attracting the majority of our graduating medical students to U of M residency programs who will, ultimately, meet the health care needs of Manitobans across the province. The Faculty of Medicine's Student Retention Steering Committee recommended a number of changes to the 2013 Canadian Resident Matching Service (CaRMS) process for international

medical graduates (IMGs) and Canadian medical graduates (CMGs). We are taking the following actions to recruit and retain 70% of our graduates and Manitoba residents to U of M residency program positions in 2013:

- Departments/programs must interview all U of M grads and self-identified MB residents during the CaRMS process.
- We are developing formal weighting criteria relating to the students' connection to Manitoba, in ranking applicants in the CaRMS match process.
- We will allocate a much larger percentage of spaces for U of M and CMGs. In 2013, 116/138 spots (84%) will be filled by CMGs compared to 85 in 2012.
- Like the majority of Canadian medical schools, we will run two parallel streams for CMGs and IMGs during the CaRMS match. Last year IMGs filled 36 spots. In 2013, IMGs can fill a maximum of 22 positions (or 16%).
- Any unfilled positions after the first iteration will be blended into a single stream for the second iteration and will be open to all eligible candidates.

Why are we doing this? We know that where doctors earn their MDs, and where they complete their residency training, have an effect on where they might practice. Seventy-three per cent of physicians who completed both undergraduate and postgraduate medical education in Manitoba practiced in Manitoba 2 years after completing their training (65% practiced in Manitoba 5 years after training, and 58% after 10 years). We want our graduating students, many of whom were born and bred here, to choose to stay in Manitoba for postgrad training because we offer high quality residency programs with broad clinical experiences.

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

UNIVERSITY OF MANITOBA

eChart MANITOBA

eCHART MANITOBA BENEFITS MANITOBA'S HEALTHCARE PROVIDERS

eChart Manitoba is a secure electronic system that connects authorized health-care providers to key health information contained in a single, safe electronic record currently collected from multiple points of care. The system has been running for almost two years and as of September 28, 2012, was available in 75 locations across Manitoba.

As part of ongoing improvement initiatives, the program recently completed a benefits evaluation, conducted by G. Braha and Associates, of the first 33 primary care and emergency departments that went live with eChart Manitoba between December 2010 and July 2011. The evaluation feedback provided insights into when eChart is used and which clinical information areas are being accessed.

Information in a single spot

eChart usage is increasing among physicians, nurses and nurse practitioners. The evaluation revealed that the system is used more frequently when clinicians see new patients or those with several or complex medical conditions. Users indicated that eChart provided relevant, important and reliable information that assisted them in making informed and timely decisions about their patients' care. Frequent users were enthusiastic about improved speed and ease of accessing information, particularly for those without prior direct access to DPIN or MIMS. As one doctor stated, "eChart takes away some of the detective work that the physician would have likely had to do."

Improved patient service, patient safety, and quality of care

Study respondents indicated that the system allowed them to access and use information that ultimately provided better patient-centered care.

eChart was found useful in avoiding repeat patient visits by identifying and addressing additional needs in the same visit. Respondents conveyed that they were able to focus on patient care rather than spending time gathering information and liked having the ability to share a visual display of clinical information. Another benefit cited was improved continuity of care and exchange of information with other clinicians. "eChart provides for a richer, more fruitful patient visit," stated one nurse.

Information is the best medicine

Respondents indicated that they were able to access information to support best practice and select appropriate interventions, such as an emergency visit follow-up in a primary care setting. They also commented that the system supports care for "challenging patients" such as those with drug-seeking behavior or chronic diseases.

Clinicians who participated felt that they had ready access to accurate information and were able to follow through on information viewed in eChart, including identifying the need to reassess medications, verifying that medications were being taken as prescribed and altering interventions based on viewable results. One nurse stated, "eChart provides more safety for the patient by helping to avoid duplication in prescriptions; it offers 'peace of mind' for both the patient and the clinician."

eChart Manitoba will utilize these findings to improve the program to support the long-term vision of connecting care throughout Manitoba's health-care system.

For more information on eChart Manitoba or to read the Benefits Evaluation Executive Summary go to: www.connectedcare.ca/echartmanitoba.

ENHANCED FAMILY DOCTOR CONNECTION PROGRAM

In 2013, the province will implement a major upgrade of the existing Family Doctor Connection Program. The enhanced program is part of a more comprehensive strategy to help ensure every Manitoban has access to a family physician by 2015. The province, the College of Physicians and Surgeons of Manitoba, and the Manitoba College of Family Physicians will be continuing discussions in regards to the program and other initiatives. The enhanced program is expected to be operational by June 2013.

There are two key differences between the existing service and the enhanced program. Instead of being given contact information for clinics willing to receive calls and accept new patients, callers will leave *their* contact information with the program. The second difference is that regional staff functioning as primary care connectors (Care Connectors) will:

1. establish relationships with family physicians, nurse practitioners and paediatricians in their geographic area and understand under what conditions these providers are willing to accept new patients;
2. match prospective patients to a provider/clinic in their preferred geographic area; and,
3. link primary care clinics, by request, to services that can help them increase their capacity to accept new patients.

How will the enhanced Family Doctor Connection Program work?

Manitobans seeking a family physician will call the current provincial phone number. A Manitoba Health representative will use a database to record basic demographic and contact information, as well as the person's first and second preferences for provider location and language. For example, first preference might be for a provider close to work; second preference might be for a provider close to home. Care Connectors will receive this information and will work to find a provider/clinic who will accept the person as a patient. Once a patient has been accepted by a provider/clinic, the request will be considered complete.

What will primary care physicians be asked to do to support the program?

Primary care physicians/clinics will be contacted by the Care Connector to determine whether they will accept new patients and under what conditions.

The Care Connector will also try to understand barriers to the clinic's accepting new patients, and will explore whether these can be addressed through regional or provincial assistance.

If the physician/clinic agrees to accept new patients, the Care Connector will provide contact and demographic information of prospective patients to the clinic. The physician/clinic may decide to meet with the person before they mutually decide whether to establish an ongoing care relationship. If there is a meeting, the physician/clinic will be requested to notify the Care Connector of the outcome.

What supports will be available to physicians through the program?

Care Connectors will do the legwork in finding potential patients and referring them to a clinic, at a volume that physicians can manage. They will maintain regular contact with the physician and be available to help problem-solve and/or discuss opportunities to support the practice. Manitoba Health is also considering a number of initiatives to assist physicians, which may have an impact on their ability to accept new patients.

For more information:
Contact Tom Fogg, Manitoba Health at 204-788-6481 or Tom.Fogg@gov.mb.ca.

CONGRATULATIONS

CONGRATULATIONS TO:

- Dr. Brian Postl on receiving the Order of Manitoba for promoting excellence in health care in Manitoba and across Canada.
- Dr. Harvey Max Chochinov received the Frederic Newton Gisborne Starr Award given by the Canadian Medical Association. This was given for his significant contribution to the field of palliative care.

CANADIAN MEDICAL HALL OF FAME ACKNOWLEDGES DR. ARNOLD NAIMARK

Canada has an enduring culture of health care excellence – an achievement worth celebrating yet something we don't do often enough. The Canadian Medical Hall of Fame – the only one of its kind in the world – aims to change that.

Every year, The Canadian Medical Hall of Fame elevates a select few of our country's most brilliant minds to laureate status. Laureates are those who have pushed the boundaries of discovery and innovation beyond the realm of possibility to make the world a better place.

"These remarkable individuals have earned their place of honour among Canada's most distinguished medical heroes. Their legacy will live on through the Hall of Fame where people everywhere can learn about their great service to humankind and be inspired to follow in their footsteps.

Worthy of the world's recognition, The Canadian Medical Hall of Fame is proud to announce the 2013 inductees and among them is:

> **Dr. Arnold Naimark** transformed a "clinically-focused Prairie school" (i.e. the University of Manitoba) into a school with areas of research excellence second-to-none in Canada. During his tenure as Dean of the Faculty of Medicine, he created the Northern Medical Unit which became a model for health care delivery to the First Nations, Metis and Inuit. As university President, Dr. Naimark built, shaped and reengineered an unfathomable number of organizations and institutions. His leadership, powerful analytical skills, strategic insight, and deep wisdom has to this day put him in high-demand on the national and international health circuit where he continues to contribute to initiatives that aim to address the world's most pressing health issues.

NEW PROVINCIAL GUIDELINES FOR CERVICAL CANCER SCREENING

CervixCheck has updated guidelines for cervical cancer screening in Manitoba. Changes have been made to the recommendations for screening initiation and the screening interval, and to aim to maximize the benefits of screening while minimizing the harms. Please visit www.TellEveryWoman.ca to find out more information, order resources and register for an informative webinar.

WCB OPIOID MANAGEMENT POLICY

The Workers Compensation Board of Manitoba (WCB) supports safe and effective prescribing practices. To this end, on November 1, 2011, the WCB implemented an Opioid Management Policy. The WCB is very appreciative of the support the medical community has shown for the Opioid Management Policy over the past year and thanks Manitoba physicians for their ongoing cooperation and assistance in returning injured workers back to health and work.

Some physicians remain unclear as to what medications fall within the Opioid Management Policy. We would like to clarify that any prescribed opioid, including Tylenol No. 3 and Tramacet are subject to the WCB's Opioid Management Policy and associated funding guidelines.

On November 25, 2012, the patent on OxyContin expired, allowing generic long acting Oxycodone to enter the market. It is the WCB's preference to fund long acting Oxycodone in the form of OxyNeo rather than the generic forms of long acting Oxycodone, within the scope of the Opioid Management Policy. The WCB would appreciate that physicians keep this in mind when consideration is given to prescribing long acting Oxycodone to injured workers.

Dan Holland
Director, Healthcare Services
Workers Compensation Board

PRESCRIBING CONCERNS

An addiction physician has received reports that some patients are still able to buy generic OxyContin locally. Physicians are encouraged to be aware of the risk/benefit concerns for all patients who are prescribed opiates. OxyNeo has less abuse potential than generic OxyContin. In general physicians are encouraged to avoid prescribing generic OxyContin. Further information from the Canadian Guide for Opioid Use is available on the CPSM website at www.cpsm.mb.ca or at http://nationalpaincentre.mcmaster.ca/opioid/documents.html

FROM THE COMPLAINTS COMMITTEE:

TERMINATING THE CARE OF PATIENTS USING OPIOID MEDICATION

In July 2012 the College was in discussion with the Head of the Pain Clinic at the Health Sciences Centre who shared his concerns about family physicians terminating the physician/patient relationship when patients are taking opioids for pain control. As per CPSM guidelines family physicians provide patients with 30 days of medication. However, many of these patients cannot find another physician who is willing to take over their care and narcotic prescribing within that allotted time. The patient is then at significant risk of narcotic withdrawal and often visits Emergency Departments or contacts the Pain Clinic to obtain further opioid prescriptions.

Dr. Intrater suggests that when discharging a patient, the final prescription should be a weaning protocol so the patient does not suffer from acute withdrawal.

Dr. Intrater indicated that the Pain Clinic is prepared to provide telephone consultation services to family physicians to delineate appropriate weaning strategies. The patient would then be “safe” while trying to find another family physician.

LATEX ALLERGIES

The College recently received concerns from a complainant regarding the lack of physician awareness about latex allergies. It is important for all physicians to know that latex allergies may be triggered by airborne particles as well as direct contact with latex gloves or specific materials. Physicians should be particularly aware of this risk to patients as it is wide spread in the community. Offices and clinics should attempt to have a "latex free area" where patients will not be put at risk.

FROM THE STANDARDS COMMITTEE:

DOCUMENTATION FOR IMMUNIZATIONS

Information on the immunizing agents available in Canada, their use in the prevention of communicable diseases and recommendations on routine immunizations are discussed in the Canadian Immunization Guide, available at

http://www.phac-aspc.gc.ca/publicat/cig-gci/pdf/cig-gci-2006_e.pdf

The Guide also outlines the documentation requirements as follows:

Vaccines administered to an individual should be recorded in three locations:

1. the personal immunization record held by the person or his or her parent/guardian;
2. the record maintained by the health care provider who gave the immunization; and
3. the local or provincial registry.

Each method of recording should include the following:

- trade name of the product;
- disease(s) against which it protects;
- date given (day month and year);
- dose;
- site and route of administration;
- manufacturer;
- lot number;
- name and title of person administering the vaccine.

Refer to the Guide for further information regarding the three types of records.

FROM THE PROGRAM REVIEW COMMITTEE:

The College has received information that some patients have been altering test requisitions by adding extra laboratory tests onto their requisition before having their blood taken. As a result some physicians have complained to the diagnostic laboratories that they are receiving extra test results that were not ordered for their patients. Members are asked to remind patients that blood tests are only part of the information required to make a diagnosis of a medical condition and that only a patient's physician can decide which tests are appropriate for their patient and order them.

FROM THE CHILD HEALTH STANDARDS COMMITTEE:

CHILD ABUSE, NEGLECT, AND MEDICAL NEGLECT OF CHILDREN:

WHEN TO REPORT?

The Child Health Standards Committee has been asked to remind physicians of several important issues related to the duty to report suspected child abuse and neglect in Manitoba.

First, it is helpful to review a few definitions in the Child and Family Services Act. The Act requires that *anyone* who has information to *reasonably believe* that a child is *in need of protection* must report this concern to a child and family services agency or the child's parent or guardian. You must report to the agency (not just to the parent/guardian) when the concern is regarding the child's parent or guardian. This is a *legal responsibility* that physicians and others caring for children must follow.

A child is considered *in need of protection* "where the life, health or emotional well-being of the child is endangered by the act or omission of a person". Most physicians have no difficulty identifying that physical or sexual abuse or child exploitation are reasons to report; however some may encounter

more difficulty with regards to potential cases of neglect.

Potential situations arise when the child "is in the care, custody, control or charge of a person (i) who is unable or unwilling to provide adequate care, supervision or control of the child, or (ii) whose conduct endangers or might endanger the life, health or emotional well-being of the child or (iii) who neglects or refuses to provide or obtain proper medical or other remedial care or treatment necessary for the health or well-being of the child or (iv) who refuses to permit such care or treatment to be provided to the child when the care or treatment is recommended by a duly qualified medical practitioner (Child and Family Services Act subsection 17(2)). The latter situation is also referred to as *medical neglect*. All of these situations are considered reportable and a physician is under a *legal obligation to report* to Child and Family Services.

How do you report? Call the province-wide intake and emergency after-hours Child and Family Services telephone number 1-866-345-9241 or consult the interactive map online at http://www.gov.mb.ca/fs/childfam/dia_intake.html (Family Services/Children and Families/Designated Intake Agency interactive map).

For more information, visit the website of the Provincial Advisory Committee on Child Abuse (www.pacca.mb.ca) and read the **Revised Manitoba Guidelines on Identifying and Reporting a Child in Need of Protection** (including child abuse) and the **Child Protection and Child Abuse Manual** (Part A and B pertaining to physicians). If your clinic or practice group is interested in additional training on this issue please contact the Child Health Standards Committee at jmartin@cpsm.mb.ca or 204-774-4344. If there is sufficient interest, a CME session may be arranged for Spring 2013.

Lynne Warda, MD, FRCPC
Medical Consultant
Child Health Standards Program (CHSC)

SEVERE COMBINED IMMUNODEFICIENCY (SCID) IN MANITOBA INFANTS

Background

Primary immunodeficiencies refer to a group of inherited disorders which typically present within the first year of life with a common clinical presentation which may include recurrent infections, chronic or recurrent thrush, chronic diarrhea and failure to thrive. Immunodeficiency diseases may involve T cells and/or B cells as well as the complement system. The most severe form, severe combined immunodeficiency (SCID) involves both the T and B cells.

At birth, babies are protected from infections by maternal IgG antibodies which cross the placenta. The level of these IgG antibodies slowly decreases after birth. Babies who are breastfed continue to receive antibodies, primarily IgA, which are protective for the GI tract. IgG antibodies are present in breast milk but at a reduced concentration as compared with IgA antibodies. The amount absorbed may therefore not be protective. By the age of two months, at the time that routine immunizations begin, babies with a normal immune system, are capable of producing antibodies.

Functional B lymphocytes are required for antibody production and infants who are immune deficient cannot produce antibodies to foreign antigens. Therefore, as the maternal antibody levels decrease, recurrent infections occur.

Babies with SCID also have non-functional T cells so do not have normal cellular immunity. They are therefore at high risk of overwhelming infections from viruses and fungi, as well as bacterial infections as noted above.

Babies with SCID are often not identified until at least three to six months of age or even older, depending to some extent, on the type of viruses/bacteria they may have been exposed to and the severity of the infection that brings them to medical attention. Chronic diarrhea, poor weight gain and/or feeding problems may also be present.

The type of immune deficiency depends on what component of the immune system is affected, T

cells, B cells or both. In SCID, both T and B cells do not function normally even though they may be present. Functional T cells are required for B cells to make antibodies.

Severe combined immunodeficiency (SCID) can be treated if it is diagnosed early, preferably in the first few months of life. Otherwise, it will likely be fatal within the first year of life. The treatment of choice is a bone marrow transplant.

Treatment

Stem cell transplant is the only curative treatment for SCID, in that the infant is given a normal immune system. The donor may be an HLA-compatible sibling or rarely a parent. Alternate donors include matched unrelated donors or cord blood.

Gene therapy is another treatment approach currently being studied although to date has had limited success.

How is SCID diagnosed?

History

A complete and detailed history and physical examination are essential for the diagnosis of SCID.

1. Recurrent and severe bacterial, viral, and fungal infections early in life
2. Chronic thrush (recurrent or severe)
3. Chronic diarrhea
4. Failure to thrive:
    - Infants with SCID may grow normally in the first few months of life. However, recurrent infections plus chronic diarrhea lead to poor weight gain and declining growth, usually before 6 months of age.
5. Key risk factors include:
    - family history of SCID
    - family history of infant death
6. Athabascan-speaking Native Americans
7. Infants of Mennonite or Amish heritage

Recommendations

1. Regular weights with careful documentation of weight at:
    - Birth and first follow up
    - Before each immunization, 2, 4 and 6 months, 9 months and 1 year
2. Early referral to the **Pediatric Hematology/ Oncology/Blood & Marrow Transplant Section** for a complete immune work up, if there are any concerns. Please call 204-787-7095 for an appointment.
3. If the case is urgent, please send the child to the Emergency Department at Children's Hospital (204-787-4244) with a recommendation to contact the Pediatric Hematologist/Oncologist on call.

Immunizations

Children with suspected immune deficiency should not be immunized with vaccines that contain live organisms like BCG, or live viruses — such as the chickenpox (varicella) or measles, mumps, and rubella (MMR) vaccines. The infants do not make antibodies and their T cells do not inhibit viral replication. Overwhelming infections such as measles, pneumonia, or disseminated BCG may lead to death.

Prognosis

Without treatment, children with SCID usually die in the first 2 years of life as a result of infections. The primary cause of mortality is infection, most commonly viral, in infants in whom this diagnosis is not considered. Early diagnosis, followed by stem cell transplant, is essential and results in a cure in over 90% of cases.

Lynne Warda, MD, FRCPC
Marlis Schroeder, MD, FRCPC

COULD IT BE KAWASAKI DISEASE?

The Child Health Standards Committee reminds clinicians to consider Kawasaki Disease in the differential diagnosis of infants and children with prolonged and unexplained fever. Prompt treatment can prevent coronary artery aneurysms and associated complications, morbidity and mortality.

The diagnosis of Kawasaki Disease requires fever for 5 days without any other explanation AND at least 4 of the following criteria:

1. Bilateral conjunctival injection
2. Oral mucous membrane changes, including red or fissured lips, injected pharynx, or strawberry tongue
3. Peripheral extremity changes, including erythema of palms or soles, edema of hands or feet (acute phase), and periungual desquamation (convalescent phase)
4. Polymorphous rash
5. Cervical lymphadenopathy (at least one lymph node >1.5 cm in diameter)

However some children, in particular infants, may have an "incomplete" (or "atypical") form of Kawasaki in which all of the above criteria are not met. These children do not appear to differ from those with classic Kawasaki Disease except that they do not completely meet the case definition. About 10% of patients treated for possible Kawasaki Disease have incomplete disease; however the incidence of incomplete disease is much higher in infants (almost 50%). Mucous membrane changes (90%), peripheral extremity changes (60%) and rash (50%) are the criteria most commonly met in incomplete Kawasaki. Infant's ≤six months of age with unexplained fever for seven days should be evaluated for Kawasaki Disease, even if they have no clinical findings. The AHA/AAP clinical practice guideline for Kawasaki Disease includes an algorithm for assessment of atypical or incomplete cases.[1]

[1] Newburger JW, Takahashi M, Gerber MA, et al. Diagnosis, treatment, and long-term management of Kawasaki disease: a statement for health professionals from the Committee on Rheumatic Fever, Endocarditis and Kawasaki Disease, Council on Cardiovascular Disease in the Young, American Heart Association. Circulation 2004; 110:2747.

Lynne Warda, MD, FRCPC
Medical Consultant
Child Health Standards Committee (CHSC)

Evaluation of suspected incomplete Kawasaki disease (KD)*

NEW STATEMENTS ON ELECTRONIC TRANSMISSION OF PRESCRIPTIONS - #808 AND FACSIMILE TRANSMISSION OF PRESCRIPTIONS - #804.

At the meeting in December, 2012, Council approved joint Statements with Pharmacy, Nursing, Dentistry and Veterinary Medicine. Inserted in this newsletter is the new Statement which permits electronic transmission of prescriptions. Furthermore, the Statement on facsimile transmission of prescriptions has been updated and this Statement is inserted as well. We are very pleased that this has finally been enacted. Members should be very sure that all electronic and ethical requirements are followed when they provide prescriptions to pharmacies by electronic transmission.

NOTE: THE STATEMENT ON ELECTRONIC TRANSMISSION OF PRESCRIPTIONS - #808 WILL BE ACTIVE ON 01 APRIL 2013

ASSOCIATE MEMBER ELECTION RESULTS

Congratulations to Dr. Elisa Cohen, who was elected as your Associate Member to Council on November 14th, 2012. Dr. Cohen will be a member of Council until September 2013.

MEETINGS OF COUNCIL FOR THE 2012-2013 COLLEGE YEAR

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

- Friday, March 15th, 2013
- Wednesday, June 5th, 2013 (AGM)

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

OFFICERS AND COUNCILLORS 2012-2013

President:	Dr. B. Kowaluk
President Elect:	Dr. D. Lindsay
Past President:	Dr. M. Burnett
Treasurer:	Dr. H. Domke
Investigation Chair:	Dr. A. MacDiarmid
Registrar:	Dr. W. Pope
Deputy Registrar:	Dr. T. Babick
Assistant Registrar:	Dr. A. Ziomek

TERM EXPIRING JUNE 2013

Associate Members Register (exp. Sept. 2013)	Dr. E. Cohen

TERM EXPIRING JUNE 2014

Central	Dr. E. Persson, Morden
Interlake	Dr. D. Lindsay, Selkirk
Northman	Dr. H. Tassi, Thompson
Parkland	Dr. J. Elliott, Grandview
Winnipeg	Dr. M. Burnett
	Dr. A. MacDiarmid
	Dr. R. Onotera
	Dr. B.T. Henderson
	Dr. W. Manishen
University of Manitoba	Dr. I. Ripstein
Public Councillor	Mr. R. Dawson
Public Councillor	Mr. R. Dewar

TERM EXPIRING JUNE 2016

Brandon	Dr. S. J. Duncan
Eastman	Dr. K. Bullock Pries
Westman	Dr. A. Vorster, Treherne
Winnipeg	Dr. H. Domke
	Dr. B. Kvern
	Dr. M. Boroditsky
	Dr. H. Unruh
University of Manitoba	Dean B. Postl
Public Councillor	Dr. E. Boldt
Public Councillor	Ms L. Read

INQUIRY: IC1544
DR. RANDY RAYMOND ALLAN

On September 11, 2012, a hearing was convened before an Inquiry Panel (the Panel) of the College of Physicians & Surgeons of Manitoba (the College), for the purpose of conducting an Inquiry pursuant to Part X of *The Medical Act*, into charges against Dr. Randy Raymond Allan (Dr. Allan), as set forth in an Amended Notice of Inquiry dated December 14, 2011.

The Amended Notice of Inquiry charged Dr. Allan with various acts of professional misconduct, and with contravening By-Law No. 1 of the College, and Article 2 of the Code of Conduct of the College, and Statement 805 of the College, and with displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

Among other things, the Amended Notice of Inquiry alleged that Dr. Allan:

a) Failed to maintain appropriate boundaries with two female patients (hereinafter referred to as Patient A and Patient B), and specifically that he had personal and sexual relationships with them during the same periods that he was providing medical care to them.

b) Issued prescriptions for Oxycontin to both Patients A and B because of his personal and sexual relationships with them.

c) Did not create an accurate or complete medical record in respect of each of the narcotic prescriptions he issued to Patient A and Patient B. In some instances he created misleading records with respect to the narcotic prescriptions; in some instances he created no records with respect to the narcotic prescriptions, and in other instances he made no chart entries in relation to the narcotic prescriptions.

d) Caused a bill to be issued to Manitoba Health with respect to Patient A on the basis of a reported house call to Patient A, when in fact he saw Patient A by reason of his personal and sexual relationship with her. Further, he caused bills to be issued to Manitoba Health with respect to Patient B on the basis of a purported house call and on the basis of office visits respecting low back pain when in fact he saw Patient B on those occasions by reason of his personal and sexual relationship with her.

The hearing proceeded before the Panel on September 11, 2012, in the presence of Dr. Allan and his counsel, and in the presence of counsel for the College.

At the outset of the hearing, Dr. Allan entered a plea of guilty to all of the charges outlined in paragraphs 1 through 9 of the Amended Notice of Inquiry, thereby acknowledging that he:

a) was guilty of professional misconduct;

b) had contravened By-Law No. 1 of the College, Article 2 of the Code of Conduct of the College, and Statement 805 of the College; and

c) was guilty of displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

The Panel reviewed and considered the following documents, which were filed as exhibits in the proceedings with the consent of Dr. Allan:

1. The Notice of Inquiry;

2. The Amended Notice of Inquiry;
3. A Statement of Agreed Facts;
4. A Book of Documents which contained, among other things:
    a) Copies of four Oxycontin 40 mg prescriptions issued between June 25, 2009 to September 2, 2009 to Patient A in various quantities, ranging from 40 to 90 pills;

    b) A medical chart respecting Patient A;

    c) Copies of four portions of a transcript of an interview conducted by the College of Dr. Allan on March 30, 2011 relating to his relationships and interactions with both Patient A and Patient B;

    d) Excerpts from Manitoba Health billing records respecting billings by Dr. Allan for Patient A in June, 2009;

    e) Copies of twenty three Oxycontin 40 mg prescriptions issued between January 8, 2010 and May 21, 2010 to Patient B in various quantities, ranging from 10 to 52 pills;

    f) A medical chart respecting Patient B;

    g) Manitoba Health billing records respecting billings by Dr. Allan for services to Patient B;

    h) Article 2 of the applicable Code of Conduct;

    i) Statement 805 of the College with respect to prescribing practices;

    j) Article 24 of the College's By-Law No. 1;

5. A Joint Recommendation as to Disposition made by counsel for the College and counsel for Dr. Allan.

DECISION

Having considered all of the above-noted exhibits, and the submissions of counsel for the College and counsel for Dr. Allan, the Panel is satisfied that all of the charges have been proven. The Panel is also satisfied that the joint recommendation as to disposition is appropriate and ought to be accepted. The Panel's specific reasons for its decision are outlined below.

REASONS FOR DECISION

Background:

Dr. Allan graduated from the Faculty of Medicine at the University of Manitoba in 1980. He completed a rotating internship in British Columbia in 1981, and returned to Manitoba in that year and practiced in Manitoba as an emergency physician until 1983. He then undertook a residency in pathology in British Columbia. He obtained his Royal College certification in 1987 and practiced as a pathologist in British Columbia until 1994.

In 1994, Dr. Allan returned to Manitoba and enrolled in the University of Manitoba Computer Engineering Program in the Faculty of Science. After obtaining his degree, he returned to the practice of medicine in Winnipeg in 1996. Initially, Dr. Allan worked with Envoy Medical Dispatch as a house call physician. Around the same time, he also began to work part time as a pathologist. Dr. Allan continued those positions until approximately 2001, when he went to work in Kenora, Ontario as a pathologist. He remained in that position, doing strictly pathology work, until 2004.

In 2004, Dr. Allan returned to Winnipeg and re-entered general practice. He worked at a medical clinic from 2004 to approximately June, 2009. He then did a locum in Kenora at a walk-in clinic for July and August, 2009. Dr. Allan returned to Winnipeg in September, 2009 and worked at a different medical clinic where he did house calls and primary care in the office setting. Dr. Allan remained at that clinic until he ceased practising medicine on June 18, 2010.

After the matters which are the subject of the allegations in the Amended Notice of Inquiry came to the attention of the College, Dr. Allan signed an undertaking pursuant to which he agreed not to practice medicine without the express written permission of the Chair of the Investigation Committee of the College. Dr. Allan has not practiced medicine in Manitoba or elsewhere since June 18, 2010.

Dr. Allan has no discipline record with the College. However, he was convicted of a criminal offence while he was in British Columbia as a result of actions he undertook in that province, which were unrelated to the practice of medicine. Those actions were committed while he was under a significant amount of stress and was experiencing financial pressures and health problems. The criminal charges were disposed of by way of a guilty plea and a fine of $1,000.00. In 1998, Dr. Allan received a pardon under *The Criminal Records Act* in relation to the criminal offences.

In the course of the College investigation into the matters which are the subject matter of the Amended Notice of Inquiry, Dr. Allan has advised the College that from the time he returned to Winnipeg in 1994, he visited massage parlours for the purposes of having casual sex. At a particular massage parlour, he met both Patient A, and later Patient B. In each case, his relationship with those women was that he was initially a customer for prostitution services in the massage parlour. However, in the case of both women, Dr. Allan entered into a personal and sexual relationship with them outside of the massage parlour and in each case he prescribed Oxycontin to them at the same time as he was involved in a personal and sexual relationship, firstly with Patient A, and latterly, (after his relationship with Patient A had ended), with Patient B.

Background facts with respect to Patient A:

In early 2009, Dr. Allan met Patient A at the massage parlour. He saw Patient A a number of times at the massage parlour where she was working. On some of those occasions, they engaged in sexual activity, for which Dr. Allan paid. In the spring of 2009, Dr. Allan and Patient A began a social and sexual relationship outside of the massage parlour. Once they began to see each other outside of the massage parlour, Dr. Allan ceased paying for sex with Patient A.

At some point after they began seeing each other outside of the massage parlour, Patient A advised Dr. Allan that she was addicted to Oxycontin and wished to get into the Methadone Program. She asked him for a prescription for Oxycontin to help with her withdrawal. Prescription records document that Dr. Allan provided Patient A with four prescription for Oxycontin between June 25, 2009 and September 2, 2009. Their personal and sexual relationship continued until in or about August, 2009.

Background facts with respect to Patient B

In or about November, 2009, Dr. Allan met Patient B at the massage parlour where she was working and subsequently saw Patient B on a number of occasions at the massage parlour. On many of those occasions, they engaged in sexual activity for which Dr. Allan paid.

Commencing in late November, early December, 2009, Dr. Allan and Patient B began a personal and sexual relationship outside of the massage parlour, at which time Dr. Allan ceased paying for sex with Patient B. At some point during their encounters at the massage parlour, Patient B told Dr. Allan that she was addicted to Oxycontin. Subsequently, she told Dr. Allan that she was purchasing Oxycontin on the street and could not

afford the cost. Dr. Allan began prescribing Oxycontin to Patient B and provided her with twenty three prescriptions between January 8, 2010 and May 21, 2010.

Dr. Allan's personal and sexual relationship with Patient B ended in or around May, 2010.

Medical records and billings to Manitoba Health

Dr. Allan created medical records relating to both Patient A and Patient B. He has acknowledged that the medical records he created were not accurate and were seriously misleading in many respects, including that:

i) With respect to some prescriptions no records were created, and with respect other prescriptions, no entries were made in the applicable chart;

ii) In some instances, false information was included in the record with respect to the reason for the visit or attendance, or as the reason for the prescription;

iii) The medical records did not record that either Patient A or Patient B was addicted to Oxycontin and that Patient B was buying the drug on the street.

Dr. Allan has admitted that he billed Manitoba Health for visits and attendances in relation to both patients, when in fact the reason for the visits and attendances was personal or sexual, not medical. In his interview with the College, Dr. Allan has acknowledged that doing so was wrong and characterized his own conduct in relation to billing for some of the visits as being "horrible conduct, absolutely inappropriate".

THE AMENDED NOTICE OF INQUIRY

The Amended Notice of Inquiry contains eight specific allegations against Dr. Allan (four with respect to Patient A, and four with respect to Patient B), and a further general allegation (based on the other eight allegations) of displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

With respect to both Patient A and Patient B, it is alleged by the College, and admitted by Dr. Allan, that:

a) He failed to maintain appropriate boundaries, or exploited the patients for his personal advantage, in violation of Article 2 of the College's Code of Conduct;

b) Issued prescriptions for Oxycontin to both patients because of his personal and sexual relationships with them, thereby committing acts of professional misconduct;

c) He did not create accurate or complete medical records in respect of each of the narcotic prescriptions he issued to both patients, in breach of Statement 805 of the College, and the record keeping requirements of By-Law No. 1;

d) Billed Manitoba Health inappropriately in relation to both patients thereby committing act of professional misconduct.

The Panel, on the basis of Dr. Allan's guilty plea and the facts outlined in the Statement of Agreed Facts, and on the basis of its review of the documents in the Book of Documents, is absolutely satisfied that each of the nine counts in the Amended Notice of Inquiry have been proven. In the result, it has been established that Dr. Allan:

i) is guilty of professional misconduct;

ii) contravened By-Law No. 1 of the College;

iii) contravened Article 2 of the Code of Conduct of the College;

iv) contravened Statement 805 of the College;

v) displayed a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

Given Dr. Allan's plea of guilty to the allegations in the Amended Notice of Inquiry, his admission of serious wrongdoing, and his acceptance of responsibility for his actions, it is not necessary to comment extensively on the seriousness of Dr. Allan's behaviour and acknowledged professional misconduct.

However, it is necessary to state in the strongest possible terms, that Dr. Allan's actions and behaviour were reprehensible. He exploited the personal circumstances of two women, who, by virtue of their addictions, were particularly vulnerable. He also did so in a way which breached his professional responsibilities and contravened the reasonable standards of the profession, which were well known and understood by him. There were also elements of financial gain and sexual gratification involved in Dr. Allan's actions, all of which make his conduct particularly repugnant and wholly unacceptable.

THE JOINT RECOMMENDATION AS TO DISPOSITION

Given the seriousness and unacceptability of Dr. Allan's conduct, this Panel must decide upon the appropriate disposition pursuant to Section 59.6 of *The Medical Act*. The Panel has been greatly assisted in its task by the Joint Recommendation as to Disposition made by counsel for the College and counsel for Dr. Allan.

In determining the types of orders to be granted pursuant to Section 59.6 of *The Medical Act*, it is useful to carefully consider the several objectives of such orders. In general terms, those objectives are:

a) The protection of the public in a broad context. Orders under Section 59.6 of *The Medical Act* are not simply intended to protect the particular patients of the physician involved, but are also intended to protect the public generally by maintaining high standards of competence and professional integrity among physicians;

b) The punishment of the physician involved;

c) Specific deterrence, in the sense of preventing the physician involved from committing similar acts of misconduct in the future;

d) General deterrence, in the sense of informing and educating the profession generally as to the serious consequences which will result from breaches of recognized standards of competent and ethical practice;

e) Protection against the betrayal of the public trust in the sense of preventing a loss of faith on the part of the public in the medical profession's ability to regulate itself;

f) The rehabilitation of the physician involved in appropriate cases, recognizing that the public good is served by allowing properly trained and educated physicians to provide medical services pursuant to conditions designed to safeguard the interests of the public.

The Panel, having carefully reviewed the Joint Recommendation, is satisfied that the disposition being recommended fulfills the above-noted objectives.

The essential elements of the Joint Recommendation as to Disposition are as follows:

i) A suspension of Dr. Allan's license to practice medicine, to commence at 24:00 on September 11, 2012, and to continue for a period of 18 months. The period of active suspension to be served by Dr. Allan will be six months, with the balance of the suspension being remitted, provided that certain specific conditions are met. A relevant factor in determining the period of active suspension is that Dr. Allan, as a result of the subject matter of these proceedings, has not been practicing medicine since June 18, 2010.

ii) Dr. Allan shall remain suspended from the practice of medicine, notwithstanding the period of suspension referred to in paragraph i), until such time as Dr. Allan has demonstrated to the satisfaction of the Investigation Committee of the College that he is fit to return to the practice of medicine. In assessing Dr. Allan's fitness to return to practice medicine, the Investigation Committee must accept a written report from the Program Assessors, referred to below, that in their opinion, Dr. Allan is fit to practice medicine.

iii) Pursuant to Section 59.6 of *The Medical Act*, various conditions will be imposed upon Dr. Allan's entitlement to practice medicine, including attending and successfully completing a multi-disciplinary assessment program (the Program) chosen and approved by the Investigation Committee in accordance with specific terms as more particularly outlined in the Joint Recommendation.

iv) Prior to Dr. Allan's return to practice, and at his own cost, he must comply with all recommendations arising from the Program and provide written confirmation to the Investigation Committee of such compliance. Such compliance must be in accordance with specific terms as more particularly outlined in the Joint Recommendation.

v) Prior to Dr. Allan's return to practice, and at his cost, Dr. Allan must participate in ongoing psychiatric and/or psychological counselling to address the conduct which forms the subject matter of these proceedings and the appropriate management of ethical boundary and professional issues. Dr. Allan's participation in ongoing psychiatric and/or psychological counselling must be in accordance with specific terms, as more particularly outlined in the Joint Recommendation.

vi) If a full or focused reassessment is recommended by the Program Assessors, prior to Dr. Allan's return to practice, Dr. Allan, at his cost, must attend and successfully complete the reassessment, which must be as recommended by the Program Assessors (the Reassessment). The Reassessment will be done by the Program Assessors, or by another multi-disciplinary assessment team jointly chosen and approved by the Investigation Committee and Dr. Allan. Dr. Allan's participation in the Reassessment must be in accordance with specific terms and conditions as more particularly outlined in the Joint Recommendation.

vii) Prior to Dr. Allan's return to practice, and at his cost, Dr. Allan must attend an interview with the Investigation Committee at the College offices for the purposes of discussing his prior misconduct and his current understanding of ethical boundary and professional issues in the physician/patient relationship, and Dr. Allan's proposed plans for return to practice. The Investigation Committee will be entitled to further assess and decide the conditions of Dr. Allan's licensure upon his return to practice.

viii) Pursuant to Section 59.6 of *The Medical Act*, a series of specific conditions will be imposed upon his entitlement to practice medicine as more particularly outlined in the Joint Recommendation, but which will include complying with any conditions recommended by the Program Assessors or Reassessment assessors, a prohibition against prescribing any substances listed in Schedules I, II, III, IV, V or VI to the *Controlled Drugs and Substances Act*, (or any substitute legislation), and the monitoring of his practice in a manner acceptable to the Investigation Committee.

ix) Dr. Allan must pay to the College costs of the investigation and inquiry in the amount of $12,893.40.

x) There will be publication, including Dr. Allan's name, as determined by the Investigation Committee.

A critically important component of the Joint Recommendation as to Disposition is the multi-disciplinary Assessment Program. The assessment is to be independent of both Dr. Allan and the College, although the Assessment Program will be chosen and approved by the Investigation Committee of the College.

The multi-disciplinary Assessment Program is very important because the Program Assessors are ultimately to provide a written report to the Investigation Committee as to whether, in their opinion, Dr. Allan is fit to practice medicine. Further, whether Dr. Allan will be obliged to undergo a focused Reassessment will be a decision to be made by the Program Assessors, and Dr. Allan will also be obliged to comply with all recommendations arising from the Assessment Program, including any recommendations arising from a Reassessment. Moreover, if Dr. Allan does ultimately resume the practice of medicine, the specific conditions pursuant to which he will return to the practice of medicine will include complying with any conditions recommended by the Program Assessors.

Given the importance of the multi-disciplinary Assessment Program, the Panel asked counsel for the parties a series of questions as to the nature of the proposed assessment, the length of time the assessment may take, and the background qualifications and experience of the Director of the Program. The answers provided to the Panel to those questions were responsive and helpful in assisting the Panel in understanding the nature and scope of the Assessment Program.

The Panel also asked questions of counsel for the parties about the information sharing that would or could take place as between the Program Assessors, and Dr. Allan's psychiatric or psychological counsellors/caregivers. Specifically, the Panel asked whether the Program Assessors would receive written assessments from Dr. Allan's counsellors/caregivers and whether the Program Assessors would be providing information which they gathered during their assessment process to Dr. Allan's counsellors/caregivers. The Panel was advised that such information sharing was not a specific condition or requirement of the Program, but that the Program Assessors could ask for information from, and provide information to Dr. Allan's psychiatric and psychological counsellors/caregivers if they thought it necessary or advisable to do so, and that there would be a variety of reasons why Dr. Allan's psychiatric and psychological counsellors/caregivers may respond favourably to any request for information from the Program Assessors.

The Panel recognizes that the responsibility for selecting and monitoring the Program is the responsibility of the Investigation Committee. The Panel also recognizes that the Program is only one element of the Joint Recommendation as to disposition. However, given the College's responsibilities relating to public protection, it is extremely important that the Program function as intended, and that the Program Assessors be conscientious, rigorous and thorough in the discharge of their responsibilities.

The Panel has concluded that the Joint Recommendation properly reflects the seriousness of Dr. Allan's professional misconduct and his contraventions of applicable professional standards. The recommended disposition is designed to protect the public by a variety of means, including the requirement that Dr. Allan participate in a program to determine his fitness to practice medicine, and that his ultimate return to practice will be subject to a series of specific detailed conditions. The recommended disposition also involves punishment of Dr. Allan (by the imposition of a fine, a suspension, and the publication of his name). It also fulfills the objective of general deterrence, by allowing for publication of the background circumstances and the outcome of these proceedings as a means of informing and educating the profession that serious misconduct will result in serious consequences. The combination of all of the above-noted factors in the disposition should reinforce the informed public's faith in the medical profession's ability to regulate itself.

Accordingly, it is the decision of the Panel that:

1. Dr. Allan's license to practice medicine is suspended, commencing at 24:00 on September 11, 2012, subject to the conditions more particularly set forth in the Resolution and Order of this Panel, issued concurrently herewith and attached hereto.

2. In the event Dr. Allan shall return to the practice of medicine, certain conditions shall be imposed upon Dr. Allan's entitlement to practice medicine, as more particularly set forth in the Resolution and Order of this Panel, issued concurrently herewith and attached hereto.

3. If there is any disagreement between the parties respecting any aspect of the Panel's Resolution and Order, the matter may be remitted by either party to a Panel of the Inquiry Committee for further consideration, and the Inquiry Committee hereby reserves jurisdiction for the purposes of resolving any such disagreement.

4. Dr. Allan must pay to the College costs of the investigation and inquiry in the amount of $12,893.40 forthwith.

5. There will be publication, including Dr. Allan's name, as determined by the Investigation Committee. The College, at its sole discretion, may provide information regarding this disposition to such person(s) or bodies as it considers appropriate.

IN THE MATTER OF:

"*THE MEDICAL ACT*", R.S.M. 1987, c.M90;

AND IN THE MATTER OF:

Dr. Randy Raymond Allan, a member of the
College of Physicians & Surgeons of
Manitoba

RESOLUTION AND ORDER OF AN INQUIRY PANEL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

WHEREAS Dr. Randy Raymond Allan (Dr. Allan), a member of the College of Physicians and Surgeons of Manitoba (the College) was charged with professional misconduct, and with contravening By-Law No. 1 of the College, Article 2 of the Code of Conduct of the College, and Statement 805 of the College, and with displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine, as more particularly outlined in a Notice of Inquiry dated December 14, 2011;

AND WHEREAS Dr. Allan was summoned and appeared before an Inquiry Panel (the Panel) of the College with legal counsel on September 11, 2012;

AND WHEREAS an Amended Notice of Inquiry dated December 14, 2011, outlining the charges and particularizing the allegations against Dr. Allan was filed as an exhibit in the hearing before the Panel;

AND WHEREAS Dr. Allan entered a plea of guilty to all of the counts relating to all of the charges outlined in the Amended Notice of Inquiry;

AND WHEREAS the Panel reviewed the exhibits filed, heard submissions from counsel for the College and counsel for Dr. Allan, and from Dr. Allan himself, and received a Joint Recommendation as to the disposition of the charges and allegations outlined in the Amended Notice of Inquiry;

AND WHEREAS the Panel decided that the Joint Recommendation was appropriate in the circumstances;

NOW THEREFORE BE IT AND IT IS HEREBY RESOLVED AND ORDERED THAT:

1. Pursuant to Section 56(3) of *The Medical Act* R.S.M., the identities of third parties, and particularly the patients of Dr. Allan, shall be protected in the record of these proceedings by referring to them in a non-identifying manner.

2. Dr. Allan is guilty of professional misconduct, and of contravening By-Law No. 1 of the College, and Article 2 of the Code of Conduct of the College, and Statement 805 of the College, and of displaying a lack of knowledge of, or a lack of skill or judgment in the practice of medicine.

3. Pursuant to Section 59.6 of *The Medical Act*, Dr. Allan's license to practice medicine be suspended, commencing at 24:00 on September 11, 2012 and, subject to paragraphs 2 and 3 hereof, continuing for a period of 18 months, subject to the following conditions:

   a) Dr. Allan must serve a period of 6 months of active suspension from the practice of medicine; and

   b) the balance of the suspension will be remitted if Dr. Allan meets the conditions set forth below.

4. If the Program Assessors referred to in paragraph 5 hereof find Dr. Allan unfit to practice medicine, Dr. Allan shall remain suspended notwithstanding the suspension imposed in paragraph 1 above having expired, until such time as Dr. Allan has demonstrated to the satisfaction of the Investigation Committee that he is fit to return to the practice of medicine. In assessing Dr. Allan's fitness to return to practice, the Investigation Committee must accept a written report from the Program Assessors stating that, in the opinion of the Program Assessors, Dr. Allan is now fit to practice medicine, provided that the report:

   a) is in a form acceptable to the Investigation Committee; and

   b) addresses all issues to the satisfaction of the Investigation Committee.

5. Pursuant to Section 59.6 of *The Medical Act*, the following conditions are imposed upon Dr. Allan's entitlement to practice medicine:

   a) Prior to Dr. Allan's return to practice and at Dr. Allan's cost, Dr. Allan must attend and successfully complete a multi-disciplinary Assessment Program chosen and approved by the Investigation Committee (the Program);

   b) Dr. Allan's participation in the Program must be in accordance with the following terms:

      i) The Investigation Committee must provide to the Program Assessors any information in the possession of or available to the Investigation Committee pertaining to the subject matter of the discipline and any other information in the possession of or available to the Investigation Committee which, in its sole discretion, it considers relevant, including information from any other disciplinary action(s) and complaint(s) which the Investigation Committee considers relevant.

ii) The Investigation Committee and Dr. Allan must each provide to the other a list of all information which is provided to the Program, and, upon request, copies of any items on the list.

iii) The Investigation Committee must ask that the Program Assessors make any requests for clarification or for additional documents or information in writing so that they may be shared with both parties.

iv) Dr. Allan must fully and frankly discuss with the Program Assessors all conduct pertaining to the admissions made at the Inquiry.

v) The Investigation Committee may, at its sole discretion, directly contact the Program Assessors to discuss any matters pertaining to the assessment(s) and the Program Assessors may directly contact the Investigation Committee. If such direct contact occurs, Dr. Allan must be invited to participate in the discussion.

vi) The Program Assessors may provide to the Investigation Committee all information pertaining to and all reports resulting from the Program.

vii) At the conclusion of the Program, Dr. Allan must promptly provide to the Investigation Committee a current report from the Program in a form that is acceptable to the Investigation Committee. The report must address all issues to the satisfaction of the Investigation Committee, and must include an opinion on the risk of recurrence of misconduct in future practice.

c) Prior to Dr. Allan's return to practice and at Dr. Allan's cost, Dr. Allan must comply with all recommendations arising from the Program and provide written confirmation to the Investigation Committee of such compliance.

d) Dr. Allan's compliance with and confirmation of compliance with the Program recommendations must be in accordance with the following terms:

i) Dr. Allan must promptly notify the Investigation Committee of his proposed plan for compliance, including specific information on any treatment program or course, and, if necessary, consult with the Investigation Committee on his plan for compliance before implementing the plan.

ii) Dr. Allan must provide documentation to the Investigation Committee confirming successful completion of any treatment program or course in a form acceptable to the Investigation Committee.

e) Prior to Dr. Allan's return to practice and at Dr. Allan's cost, Dr. Allan must participate in ongoing psychiatric and/or psychological counselling to address the conduct admitted and the concept and appropriate management of ethical, boundary and professional issues.

f) Dr. Allan's participation in ongoing psychiatric and/or psychological counselling must be in accordance with the following terms:

i) The Investigation Committee must provide to the psychiatrist(s) and/or psychologist(s) any information in the possession of or available to the Investigation Committee pertaining to the subject matter of the discipline and any other information in the possession of or available to the Investigation Committee which, in its sole discretion, it considers relevant, including information from any other disciplinary action(s) and complaint(s) which the Investigation Committee considers relevant.

ii) The Investigation Committee and Dr. Allan must each provide to the other a list of all information which is provided to the psychiatrist or psychologist and, upon request, copies of any items on the list.

iii) In attending for the counselling, Dr. Allan must fully and frankly discuss with any psychiatrist(s) and/or psychologist(s) all conduct pertaining to the admissions made at the Inquiry.

iv) Dr. Allan must comply with any recommendations arising from psychiatric and/or psychological counselling.

g) If a full or a focused reassessment is recommended by the Program Assessors, prior to Dr. Allan's return to practice and at Dr. Allan's cost, Dr. Allan must attend and successfully complete the reassessment, which must be full or focused as recommended by the Program Assessors (the Reassessment). The Reassessment will be done by the Program Assessors, but if the Program Assessors are unable or unwilling to complete the Reassessment, the Reassessment must be by a multi-disciplinary assessment team jointly chosen and approved by the Investigation Committee and Dr. Allan.

h) Dr. Allan's participation in the Reassessment must be in accordance with the following terms:

i) The Investigation Committee must provide to the Reassessment Assessors any information in the possession of or available to the Investigation Committee pertaining to the subject matter of the discipline and Dr. Allan's remediation, and any other information in the possession of or available to the Investigation Committee which, in its sole discretion, it considers relevant, including information from any other disciplinary action(s) and complaint(s) which the Investigation Committee considers relevant.

ii) The Investigation Committee and Dr. Allan must each provide to the other a list of all information which is provided to the Reassessment Assessors, and, upon request, copies of any items on the list.

iii) The Investigation Committee must ask that the Reassessment Assessors make any requests for clarification or for additional documents or information in writing so that they may be shared with the parties.

iv) Dr. Allan must fully and frankly discuss with the Reassessment Assessors all conduct pertaining to the admissions made at the Inquiry.

v) The Investigation Committee may, at its sole discretion, directly contact the Reassessment Assessors to discuss any matters pertaining to the Reassessment and the Reassessment Assessors may directly contact the Investigation Committee. If such direct contact occurs, Dr. Allan must be invited to participate in the discussion.

vi) The Reassessment Assessors may provide to the Investigation Committee all information pertaining to and all reports resulting from the Reassessment.

vii) At the conclusion of the Reassessment, Dr. Allan must promptly provide to the Investigation Committee a current report from the Reassessment Assessors. The report must address all issues to the satisfaction of the Investigation Committee and must include an opinion on the risk of recurrence of misconduct in future practice.

i) Prior to Dr. Allan's return to practice and at Dr. Allan's cost, Dr. Allan must attend an interview with the Investigation Committee at the College offices for the purposes of:

   i) discussing the conduct admitted, Dr. Allan's current understanding of ethical, boundary and professional issues in the physician/patient relationship, and Dr. Allan's proposed plans for return to practice; and

   ii) allowing the Investigation Committee to further assess and decide the conditions of Dr. Allan's licensure upon return to practice.

6. Pursuant to Section 59.6 of *The Medical Act*, upon Dr. Allan's return to practice, the following conditions are imposed upon Dr. Allan's entitlement to practice medicine:

a) Any conditions recommended by the Reassessment Assessors.

b) Any conditions which are objectively and rationally connected to the conduct admitted, and which the Investigation Committee determines necessary following the interview with Dr. Allan.

c) Dr. Allan must have a chaperone approved by the Investigation Committee present for all female breast and pelvic examinations.

d) Dr. Allan must document the attendance of the chaperone in a form acceptable to the Investigation Committee, and Dr. Allan must require the chaperone to maintain a daily list of all attending patients and the reason for the attendance.

e) Dr. Allan must place in the office reception and examination rooms conspicuous signage respecting the requirement for a chaperone. The signage must be in a form and with content acceptable to the Investigation Committee.

f) Upon request, Dr. Allan must produce to the Investigation Committee records evidencing compliance with the chaperone and signage requirements.

g) Dr. Allan must not prescribe any substance that is listed in Schedules I, II, III, IV, V or VI to the *Controlled Drugs and Substances Act* (or legislation substituted therefor) in force from time to time during the currency of these conditions.

h) Dr. Allan must notify all clinical and office staff at Dr. Allan's practice location(s) of the conditions imposed on Dr. Allan's licence. The notification must be in a form and with content acceptable to the Investigation Committee.

i) Dr. Allan must participate in continuing medical education in the areas of ethics, boundaries and professionalism as directed by the Investigation Committee, and provide to the Investigation Committee a written report or confirmation of successful completion of such continuing medical education. The report or confirmation must be in a form and with content acceptable to the Investigation Committee.

j) Upon request, Dr. Allan must attend a meeting(s) with the Investigation Committee or a nominee of the Investigation Committee to discuss the education undertaken and Dr. Allan's current understanding in these areas.

k) Dr. Allan must comply with the monitoring of his practice established by and acceptable to the Investigation Committee. Such monitoring must include:

   i) attendance at interviews with the Investigation Committee or a nominee of the Investigation Committee upon request.

   ii) providing the Investigation Committee or a nominee of the Investigation Committee with access to the medical office records of Dr. Allan; and

   iii) providing reports required.

l) Dr. Allan must pay for all costs related to the conditions on his licence, including the costs of any continuing medical education, any reports, any mentoring and any monitoring.

7. If there is any disagreement between the parties respecting any aspect of the Panel's Order, the matter may be remitted by either party to a Panel of the Inquiry Committee for further consideration, and the Inquiry Committee hereby expressly reserves jurisdiction for the purpose of resolving any such disagreement.

8. Dr. Allan must pay to the College costs of the investigation and inquiry in the amount of $12,893.40, on the basis of the attached cost calculation payable in full by certified cheque or Dr. Allan's lawyer's firm's trust cheque on or before the date of the Inquiry.

9. There will be publication, including Dr. Allan's name, as determined by the Investigation Committee. The College, at its sole discretion, may provide information regarding this disposition to such person(s) or bodies as it considers appropriate.

DATED this 4th day of October, 2012.

CENSURE: IC1664
DR. WILLEM GEORGE ROETS

On November 30, 2012, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Roets as a record of its disapproval of the deficiencies in his conduct. Censure creates a disciplinary 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

When a physician is on call for an Emergency Department which does not have an Emergency Medical Officer, the physician on call is obliged to attend as required by the patient's condition. Not all patients are necessarily seen by a physician, as nursing staff may be able to handle certain conditions. However, the physician on call has a duty to follow patients diligently and attend to patients as required by their condition and any changes in their condition.

II. THE RELEVANT FACTS ARE:

1. Dr. Roets is a family physician who provides emergency call services to the Emergency Department at a rural hospital.
2. On September 24, 2010 Dr. Roets was the physician on call for the Emergency Department and, at all times material to the telephone calls placed by nurses to him as set forth below, Dr. Roets was at a location which is less than 100 yards from the hospital.
3. The triage record documents the patient arrived at 0729 with a decreased level of consciousness, seizing and with an irregular pulse of 34 and a blood sugar of 32. The lab was called in and a cardiac monitor was established. The triage record also documents that Dr. Roets was contacted, but does not state the time of contact.
4. The patient record completed by nurses documents the following sequence of events:

    - 0730 hours – The patient's respiratory rate was 16 and his blood pressure was 97/58. The monitor showed PVC and asystole.
    - 0740 hours – Diazepam, 5 mg. IV given and blood was drawn.
    - 0745 hours – The patient had intermittent seizures and irregular pulse on palpation. The ECG showed multiple rhythms and only P-waves, no QRS complexes during seizure activity.
    - 0745 hours – Diazepam, 5 mg. IV given. Blood results came back with sodium of 139 and potassium of 6.5.
    - 0752 hours - The patient's pulse was 40 and respiratory rate 20. The nurses gave Atropine 1 amp. IV and Epinephrine 1 amp IV.
    - 0754 hours – 22U regular Insulin IV push given. The nurse had called Dr. Roets three times and he was on the way. The ECG showed sinus tachycardia at 103 rate.
    - 0758 hours – Atropine 1 amp given.
    - 0759 hours – Epinephrine 1 amp given. The patient's pulse was 40-60. The lab reported troponin at 0.03.
    - 0800 hours – The patient's heart rate increased to 68 – 91 after the second Atropine and

Epinephrine. The blood sugar was 27 mmol and oxygen saturation was 99% on 10L.

- 0803 hours – The patient's blood pressure was 163/93, and he had seizures at 0802.
- 0805 hours - The nurses telephoned Dr. Roets for the fifth time, and informed Dr. Roets that the patient was unstable and he needed to come in.
- 0806 hours – The patient's pulse was 36.
- 0806 hours – The nurses telephoned Dr. Roets for the sixth time, and informed him that the heart rate was dropping at 30-60. Dr. Roets asked that another dose of Atropine be given. The nurses informed Dr. Roets to come in.
- 0807 hours – Atropine 1 amp. given.
- 0808 hours – Epinephrine 1 amp. given. The patient's blood sugar was 33.2 mmol.
- 0809 hours – The patient's pulse was 65, respiratory rate 18, and blood pressure 134/85.
- 0810 hours – The patient's oxygen saturation was 97%. A foley was inserted.
- 0812 hours – The patient's pulse was 89, respiratory rate 16, and blood sugar 24.8 mmol.
- 0814 hours – The patient's pulse was 55, blood pressure 194/80 and oxygen saturation was 95% with 10L mask
- 0815 hours - The patient's pulse was 36 – 51.
- 0817 hours – The nurses paced the patient at 70 beats per minute and 30 mA and it was capturing. The patient's blood pressure was 132/69.
- 0820 hours – The patient's pulse was 70-84, respiratory 24 and blood sugar was 24.5 mmol.
- 0825 hours - The nurses telephoned Dr. Roets for the seventh time, and insisted that he needed to come as the patient could "code" at any time.
- 0826 hours – The patient's pulse was 32 – 97, respiratory rate 22 and blood pressure 132/70. The monitor still showed many rhythms and the heart rate was fluctuating.
- 0835 hours – Dr. Roets arrived at the hospital, reviewed the results and treatments, and found a complete heart block. Dr. Roets determined that the patient should be transferred to HSC for a pacemaker. Arrangements were made with EMS for the transfer.

5. The nurse manager completed an incident report which states:

- 0735 hours - The ER nurse telephoned Dr. Roets and asked him to come in immediately as there was a patient who was unstable and needed immediate medical attention. Dr. Roets gave verbal orders to do laboratory work and to give Diazepam for the seizures.
- 0745 hours - The ER nurse telephoned Dr. Roets again after the patient had another seizure and episode of asystole. Dr. Roets ordered another dose of Diazepam. The ER nurses reminded Dr. Roets to come in immediately.
- 0752 hours - The ER nurse telephoned Dr. Roets for the third time and he ordered one more dose of Atropine and Insulin Humulin R22 units, IV push. The ER nurse insisted Dr. Roets come in.
- 0800 hours – The ER nurse telephoned Dr. Roets for the fourth time and provided the

laboratory results. Dr. Roets was asked to come in as the patient was in critical condition. Dr. Roets said he would come in.

- 0805 hours – The nurse manager called Dr. Roets (the fifth call to him) and asked Dr. Roets to come in immediately as the patient was unstable. The nurse manager reported that the heart rate was dropping even though the patient had had 2 doses of Atropine and Epinephrine. Dr. Roets ordered another dose of Atropine and said he would come.

- 0806 hours – The nurse manager called Dr. Roets (the sixth call to him) to come in immediately as the patient could crash at any time. The nurses had given maximum Atropine and 3 doses of Epinephrine, but the heart rate was dropping and the blood sugar was 33.2 mmol. Dr. Roets said he would come in.

- 0817 hours – The nurses decided to pace the patient even though they had no orders to do so.

- 0825 hours – The nurse manager called Dr. Roets (the seventh call to him) updating Dr. Roets on the patient's condition and insisting he come in immediately and reminded him that the patient could code at any time.

- 0835 hours – Dr. Roets arrived at the hospital.

6. The ER nurse and the nurse manager state that on each telephone call to Dr. Roets, they asked him to come in to see the patient and on every call, Dr. Roets said that he was coming.
7. At 0900 Dr. Roets was no longer on call.
8. The record documents that EMS arrived at 0932 and the patient was readied for transport. However, EMS staff returned to hospital to advise that the patient's heart rate continued to drop despite administration of Epinephrine. Staff tried to reach Dr. Roets by paging him in the hospital and calling his office and his home, but were unsuccessful, and so contacted the physician on call to see and assess the patient. This physician instructed staff to return the patient to the ER and gave orders for treatment and laboratory work. At 1045 hours, when Dr. Roets learned there had been a problem with the patient's pacing he attended and reassessed the patient. The patient was transferred to Winnipeg by ambulance. Dr. Roets initially instructed two nurses to accompany the patient, but the nurses felt that it was unsafe, and Dr. Roets agreed to accompany the patient.
9. In Dr. Roets' response to the Investigation Committee, he stated that:

   a. when he was first called about this patient at approximately 0735, he was advised that the patient had arrived in the ER with seizure like activity that had been present on and off for several days and the patient had not wanted to come to hospital for fear of losing his driver's licence, and that the patient had a blood sugar of 32. Dr. Roets gave an order for Diazepam 5 mg IV and ordered that blood work be done, including electrolytes with potassium levels, CBC and EKG.

   b. when Dr. Roets was first notified of the patient's arrival, he was not asked to come immediately in the first call, and was not informed of the patient's pulse rate as recorded on the triage record (irregular and 34).

   c. Dr. Roets was not informed of the asystole in the second call.

   d. Dr. Roets was made aware of the slow pulse (40) by the third call (at 0752) and he then regarded it as urgent that he attend to see the patient.

   e. Dr. Roets was not made aware until the third call at 0752 of any cardiovascular problems. Dr. Roets believed that he ordered Atropine and, if that was not effective, Epinephrine was to be added. As the potassium levels were available, Dr. Roets ordered Insulin Humulin R22 units.

f. when Dr. Roets called back to learn the effect of the Atropine, he was advised that the pulse rate was 65 and he then thought it not as urgent that he attend immediately.

g. Dr. Roets was not advised of the seizures occurring at 0802. At 0803, he was advised that the patient's vital signs were essentially normal.

h. it was not until the fourth or fifth call that the nurse asked "Are you coming in "right now?".

i. Dr. Roets was not made aware that the patient had had several doses of Atropine and Epinephrine.

j. Dr. Roets was not advised that the patient's pulse dropped to 36.

k. Dr. Roets was not made aware at any time before he arrived at the Hospital that the patient was being paced.

l. had Dr. Roets been aware of the low pulse rate and asystole, he would have been more concerned.

m. Dr. Roets was not asked by the nurses to come in during every call.

n. a patient who is receiving transcutaneous pacing requires a physician to be present.

o. the decision to accompany the patient to Winnipeg was made by Dr. Roets after balancing the needs of this patient and the needs of other patients, including the impact of cancellation of his fully booked clinic for the day and the dialysis unit for which he was also responsible that day.

10. The patient recovered and returned to the community after treatment in Winnipeg.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. ROETS' LACK OF CARE, SKILL AND JUDGMENT IN THIS CASE, PARTICULARLY: Dr. Roets failed to attend to the patient in a timely fashion when he had a life-threatening condition.

Dr. Roets paid the costs of the investigation in the amount of $3,284.15.