

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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FROM YOUR PRESIDENT DR. DANIEL LINDSAY



THANK YOU

All of us have had “those moments” when through the wisdom and help of a colleague our professional life was enhanced. For some it was a fellow surgeon, for others it was a knowledgeable colleague, but for all of us the gratitude that we expressed paled in the context of what we had received.

It is in this context that I want to thank Dr. Bill Pope on behalf of Manitoba physicians and citizens alike for what he has so tirelessly given to us. Dr. Pope has announced his intention to retire.

William Duncan Bernard Pope, Registrar, Chief Executive Officer, Physician, Graduate of Law, Section Head, Assistant Dean, Chief Medical

Officer, mentor, friend and colleague. An institution is the embodiment of the history, the morals, the values and yes, the camaraderie of a unique group of individuals. Dr. Pope has been the face and the voice of the College of Physicians & Surgeons of Manitoba for as long as most of us can remember. Dr. Pope has led and guided the changes of our unique institution for 15 years, having been the Assistant Registrar during the preceding 5 years. This in addition to his never ending and ongoing support of the Arts in Manitoba.

It has been said that leadership has the capacity to transform vision into reality. As a leader Dr. Pope has acted both as a CEO and as the Registrar of the College. These roles are different, both requiring unique skills. In an era of ever increasing accountability and transparency, Dr. Pope has balanced the public's "need to know" and the rights of physicians to privacy. Dr. Pope understands the importance of the day to day operation of the College. He was able to integrate the roles of the CEO and the Registrar, accommodating and respecting the demands of all of the stakeholders.

As CEO, Dr. Pope understood early in his career the importance of collaboration and has maintained and promoted interprofessional, university, regulatory and governmental relationships. The working relationships fostered by Dr. Pope are admired and recognized not only by our fellow Colleges in Canada, but internationally as well.

As Registrar, Dr. Pope was able to see further than most. There are few who know as well the history of medicine in Canada and understand the breadth of influence and the responsibility that the regulatory bodies such as our College have within the Canadian context. He has been a visionary in his role of Registrar and has guided the organization through governance model changes, the introduction of the International Medical Graduate (IMG)

programs, the institution of the Physician Assistant Education Program (PAEP) and was instrumental in the introduction of the Manitoba Physician Achievement Review program (MPAR) and the Manitoba Practice Assessment Program (MPAP). He was President of the Federation of Medical Regulatory Authorities of Canada (FMRAC) in 2005-06, the year that FMRAC signed its subscriber's agreement with the Healthcare Insurance Reciprocal of Canada. Hot topics that year included internet prescribing (Dr. Pope was the ideal person to meet with the Federal Government, including the Minister of Health, on this time-consuming issue) as well as emergency preparedness, again working with the Federal Government and chairing the 2006 FMRAC AGM on that topic. Dr. Pope has been a leader in the paradigm shift from the institutional certification of physicians to the imperative of competency based evaluation. Manitoba, through Dr. Pope's leadership, has promoted maintenance of physician competency while facilitating alternate routes to licensure for those who are truly qualified.

Frank Lloyd Wright, when asked what makes a person successful, replied: "dedication, hard work and an unrelenting devotion to the things that you want to see happen". I congratulate Dr. Pope in what has been the most successful of careers. Thank you as well to Elizabeth, for her grace and support in helping her husband of 38 years achieve so many goals.

This is to be my final letter as your President. It has been an honour to serve as your President during the past year and to have had the opportunity to thank Dr. Pope for being Dr. Pope.

Bill, Registrar, mentor and friend – thank you!

Sincerely yours
Daniel J. Lindsay, MD FRCPC

NOTES FROM THE REGISTRAR



Council Meeting December 13th, 2013:

The weather at the time of the December Council meeting was decidedly wintery. Unfortunately, there seems to be no change at the time that I write this note (February 28th, 2014)!

A number of Practice Directions which have already been approved for implementation when *The Regulated Health Professions Act* becomes law were approved as Statements at this Council meeting. These Statements are included in this newsletter. They will be implemented on May 1st, 2014. We encourage all members to be aware of them.

RHPA – Standards of Practice/Code of Ethics:

The 2 months of consultation on these 2 documents are now over. Your comments are being collated and will be reviewed by the President's Working Group for further discussion at the Annual General Meeting on June 4th, 2014.

Other RHPA Regulations:

At this time the time line has not changed from the previous newsletter. We hope that the Medicine part of *The Regulated Health Professions Act* will be formally implemented at renewal time on September 1st, 2015. We will do our best to keep you up to date on these issues.

Registrar's Retirement:

At this time I am writing to notify the profession that I will be retiring on December 31st, 2014. I have had the extraordinary privilege of working for the College of Physicians & Surgeons of Manitoba since October 1994 and have been Registrar for the past 15 years. It has been an enormous honour to work with all of you and in particular my passion has been to ensure that as physicians, we retain significant input into the practice of medicine in our province. In the past years, your Council has been extremely responsible. Whenever an issue arises, they look at the matter from the point of view of good health care for the patients of Manitoba. You are well represented in these matters and I very much appreciate the support from all the Presidents with whom I have worked since 1999.

Your President-Elect, Dr. Brent Kvern, is chairing the Search Committee and a notice to this effect is placed elsewhere in this newsletter.

Thank you all for the honour of working for you in the best interest of the patients of Manitoba for the past 15 years.

William D.B. Pope
Registrar/CEO

FACULTY OF MEDICINE UP-DATE

New Faculty of Health Sciences

As physicians, we increasingly work in multi-disciplinary, patient-centred health care teams that serve to improve patient safety and health outcomes. Growing evidence indicates that physicians, nurses, pharmacists, therapists and other health-care professionals working together as part of an inter-professional team improve the quality of care.

The University of Manitoba is poised to become a leader in inter-professional health education, research and practice by bringing together the existing Faculties of Medicine, Dentistry, Pharmacy, Nursing, and Schools of Dental Hygiene and Medical Rehabilitation in the new Faculty of Health Sciences in 2014.

In January 2012, University of Manitoba President & Vice-Chancellor David Barnard launched an Academic Structure Initiative designed to improve the U of M's complex academic structure and better reflect our size and scope while enhancing our academic work.

Beginning with the health cluster, Vice-President (Academic) & Provost Joanne Keselman convened a committee of health deans/directors to identify options for a new health cluster.

During the last two years, I chaired this committee, which discussed and assessed the benefits and risks of a more integrated health faculty.

We also established a number of thematic working groups (with representatives of all units involved in health cluster discussions) to examine potential areas of collaboration; and engaged with faculty, staff and students to receive feedback and ideas throughout the process.

The University of Manitoba Board of Governors approved the Senate's recommendation to establish a new Faculty of Health Sciences on October 8.

Why a new Faculty of Health Sciences? It reflects the health care sector's evolving focus on inter-professional models of care and is congruent with the Province's new Regulated Health Professions Act, which will redefine boundaries between health professions, and the scope and nature of health-care practice.

Furthermore, as a research-intensive university, the new faculty will enhance our research competitiveness, given the increasing emphasis on team-based, multi-and interdisciplinary research by the country's major funding agencies.

I will lead the new Faculty as Vice-Provost and Dean, Faculty of Health Sciences and Dean of Medicine. Each of the member Colleges (Dentistry, Nursing, Pharmacy and Medical Rehabilitation) will be led by College Deans who will be accountable for professional programs and other academic functions within their colleges.

It is an exciting time in our Faculty of Medicine's 130 year history and we should be proud of our role at the forefront of collaborative health science professions' education, training, practice, research and community engagement.

Brian Postl MD

Dean of Medicine, Dean, Faculty of Health Sciences & Vice-Provost (Health Sciences),
University of Manitoba



UNIVERSITY
OF MANITOBA

Congratulations

Congratulations to Dr. Brian Postl on his appointment to Dean of the Faculty of Health Sciences and Vice-Provost (Health Sciences).

REGISTRAR SEARCH COMMITTEE

A committee has been formed to undertake the search process for a new Registrar & CEO for the College of Physicians and Surgeons of Manitoba. The Search Committee members are as follows:

- **Brent Kvern - Chairperson** (President-Elect)
- **Margaret Burnett** (Councillor – Past President)
- **Doreen Kelly** (Legal Counsel – CPSM Staff Member)
- **Bob Menzies** (Rural Member – Past President)
- **Brian Postl** (Councillor & Dean)
- **Laurie Read** (Councillor – Public Representative)
- **Blair Graham** (External Support - CPSM Board Legal Counsel)

An executive search firm has been engaged. Please look for updates in the CPSM Newsletter.

Brent Kvern, MD, CCFP, FCFP
Chair, Registrar Search Committee

SIGNATURES ON PRESCRIPTIONS

It has been brought to the attention of the College that many members are electronically generating prescriptions and providing their patients with the paper copy of the prescription without actually signing these prescriptions.

Members are reminded of the College Statements #804 and #808 regarding paper, verbal, fax, and electronic prescriptions permitted.

If a paper prescription is given to the patient to take to the pharmacy it must be signed by the physician. An electronically generated signature is not permitted in those situations.

Prescriptions may also be transmitted by facsimile or by electronic means. In both of those situations the pharmacy will not receive the original of the physician's signature. However, the pharmacist can verify the authenticity of the prescriber initiating the document.

Although some pharmacists have not been requiring the original signature on hand delivered prescriptions, it is a requirement of joint Statement #802 of the College of Pharmacy of Manitoba and the College of Physicians and Surgeons of Manitoba. Therefore all members must comply with the Statements regarding Prescribing. The Statements can be found on the College website.

IDENTIFICATION OF AND INTERVENTION IN POST-PARTUM DEPRESSION

*A*s members will be aware, a case last summer of serious post-partum depression resulted in a tragic outcome in the death of a mother and 2 children. Just before Christmas, the Chief Medical Examiner referred this matter to the College and directed that we further educate members on this potentially fatal illness.

In discussion with the Winnipeg Regional Health Authority, the Mood Disorders Association, The College of Registered Psychiatric Nurses of Manitoba and the College of Registered Nurses of Manitoba, we present the following notice:

It is important that all physicians be aware of the insidious nature of post-partum depression. The following url's present various materials that attending physicians may provide to their patients. It is very important that all physicians be aware of the potentially tragic results that can occur when a mother who has serious post-partum depression slips through the cracks or intervention is not started early enough. Post-partum depression may become a serious life threatening illness.

**Please read the following material and
consider it carefully:**

**Key Messages on Post-Partum Mental Health
Awareness for Health Care Regulatory Colleges**
March 2014

Goals

1. To create awareness amongst health care professionals about post-partum mental health.
2. To stress the importance of early recognition of symptoms of post-partum depression, anxiety and psychosis.

3. To support health care professionals in finding the tools and resources needed to best serve their patients.

Key Messages

1. Attention to perinatal and post-partum mental health is crucial to the well-being of both mother and child.
2. Awareness and early recognition is essential because postpartum mental health issues can be silent. Helpful treatment options include counselling, medication and support.
3. Health care professionals must work together to provide comprehensive care to women and children during the perinatal and post-partum periods.
4. You can find resources to support your practice in the following places:
 - WRHA Perinatal Quick Reference Guide for Health Care Providers:
http://www.wrha.mb.ca/healthinfo/prohealth/files/MentalHealth_Perinatal.pdf
 - Mental Health Resource Guide for Winnipeg
www.cmhawpg.mb.ca/resources.htm
 - Fact sheet for public education on postpartum depression
www.heretohelp.bc.ca/publications/factsheets/postpartum
 - Culture of Wellbeing: Guide to Mental Health Resources for First Nations, Metis and Inuit People of Winnipeg
www.wrha.mb.ca/aboriginalhealth/services/resources.php
 - www.postpartum.org
 - www.postpartum.net
 - Women's Health Clinic (204) 947-1517
5. Crisis resources are available in the following places:
 - Crisis Services
<http://www.gov.mb.ca/healthyliving/mh/crisis.html>

This document or appropriate modification will be published by all the Regulated Health Professions in Manitoba in their next newsletters and will appear on their websites.

EDUCATION EVENING FOR PHYSICIANS AND HEALTH CARE PROVIDERS

The Winnipeg Regional Health Authority Mental Health Program in partnership with Manitoba Association of Mood Disorders will host an education evening for physicians and health care providers on:

Addressing and Treating Perinatal Mental Health Issues

With an expert panel including:

Dr. Carrie Lionberg, Clinical Psychologist

Dr. Tanya Sala, Psychiatrist

Nellie Kennedy, Patient

Date: Tuesday, May 20th, 2014

Time: 7 pm – 9:00 pm

Place: Norwood Hotel
112 Marion Street
Winnipeg Manitoba

Please RSVP via email to Jaspreet Kaur
jkaur@wrha.mb.ca



Important Billing System Information From Manitoba Health

Manitoba Health, Healthy Living and Seniors (HHLS) is introducing a new claims processing system. The province's current claims processing computer system, first implemented in 1975, requires updating, and the opportunity presented to enhance the technology supporting the system. The new Claims Processing Solution (CPS) will be introduced later in 2014. HHLS will work with vendors and service bureau in the coming months to ensure they are aware of the software requirements of the new system.

HHLS has issued a special February edition of the *Physician's Newsletter* with more in-depth information about the changes associated with the new CPS. Physicians and their staff responsible for billing need to be aware of these changes as they will affect their billing practices. Similar to regular editions of the Physician's newsletter, the special February edition is accessible by logging on to WebLink or the SIS Application Portal and opening the PDF document called *February Physicians Newsletter.PDF*. You may also contact Betty Melvin-Harder by email at Betty.Melvin-Harder@gov.mb.ca for a copy.

HHLS will continue to lead policy development related to processing and payment of medical claims, and continue to process these claims in-house with provincial employees. They are committed to working with practitioners to support the transition to the new CPS. HHLS will continue to provide you with updates on this project on an ongoing basis. Please watch for additional information in upcoming editions of the *Physician's Newsletter*.

Manitoba IMPR_xOVE Program

On behalf of Manitoba Health, Comprehensive Neuroscience of Canada administers the Manitoba IMPR_xOVE Program. The goal of the IMPR_xOVE Program is to improve the safety and health outcomes for Manitobans. This is accomplished by providing physicians with additional resources with respect to the care of and the prescribing of medications for specific patients.

The program is designed around four key principles:

1. Information is evidence based and academically credible;
2. The intent is educational and non-punitive;
3. Information is targeted and patient-specific; and
4. Prescribers maintain the ability to use clinical judgment and knowledge to make the best prescribing and treatment decisions for patients.

The program reviews the prescribing practices of physicians based on a review of DPIN data. Physicians receive letters from Manitoba IMPR_xOVE when a three month review of DPIN data has triggered a quality indicator for one or more patients.

Based on the information gleaned from the DPIN data, the program informs the physician of potential clinical issues and considerations with respect to prescribing, and identifies evidence based resources upon which recommendations are made.

The College wishes to remind physicians that the IMPR_xOVE Program may be used to gain credits for Continuing Professional Development (CPD). The time taken by the physician to review the data and the considerations presented and, if required, to implement changes in their prescribing pattern should be logged and submitted for CPD credits.

Any questions may be directed via email to Dr. Ziomek, Assistant Registrar at the College.
Email: aziomek@cpsm.mb.ca

Notice to All Members Working in Labour and Delivery

The Manitoba Government passed new legislation on September 13th, 2013, the *Universal Newborn Hearing Screening Act*. The Act requires that health professionals attending the birth of an infant must ensure that:

1. The parent or legal guardian of the infant is offered the opportunity to have the infant screened for hearing loss; and
2. The parent or guardian wishes to have the infant screened:
 - if the infant is born in a hospital, the infant is screened for hearing loss before being discharged; or
 - if the infant is born outside a hospital, the infant is referred to a health care facility for screening.

Please note that this Act does not come into force until SEPTEMBER 1st, 2016 in order to enable time to establish the required resources, processes and procedures to implement the legislation.

FROM THE PROVINCIAL MEDICAL LEADERSHIP COUNCIL

*F*or many years, Standards Committees have been an important venue for physicians to participate in peer review activities, and identify opportunities to improve care for patients, with confidence that their deliberations will remain confidential. Physician participation in Standards is high in Manitoba, relative to many other jurisdictions. However, changes such as the shift to program management in the mid-nineties, the shift from quality assurance to quality improvement, the emergence of patient safety and critical incident reviews, and the current interest in better integrating and coordinating services provincially, make this an opportune time to consider how Standards should further evolve.

The Provincial Medical Leadership Council (PMLC), that includes Chief Medical Officers from the five regional health authorities in Manitoba, CancerCare Manitoba, Diagnostic Services Manitoba, e-Health, Public Health, and the Registrars of the CPSM, recently met with Standards leaders from across the province to consider the future of Standards. Following robust discussions, there was agreement that Standards remains a crucial activity for our self-governing profession. However, we need to continue to focus on what Standards does relative to quality improvement and patient safety and continue to engage other professional groups.

In an effort to ensure more consistent standards across the province, the group decided to support the establishment of two new “provincial” Standards Committees – one in Diagnostic Imaging and one in Orthopedics. These Standards Committees will have representatives, approved by CPSM, from across the province and will report to PMLC. It is expected that over time additional provincial

Standards Committees will be established.

For those interested in Standards of Practice and improving care, this is an exciting time to become involved in Standards activities. With pressure on provinces to ensure that provincial health care systems are truly integrated and coordinated, there are opportunities for Standards Committees to play an increasingly important role.

Dr. Brock Wright
CMO - WRHA

SMD PARKING PERMITS

*E*ffective February 1, 2014, Manitoba Infrastructure and Transport (MIT) has approved a fee increase for the Manitoba Disabled Parking Permit. The fee will rise from \$12.50 to \$15.00. The \$15.00 fee is a onetime fee for the length of the permit which can be anywhere from 3 months to 3 years.

The new forms can be downloaded from the MIT website, www.smd.mb.ca in both English and French as well as a copy of the permit holder’s responsibilities. We appreciate everyone’s cooperation in introducing the new applications.

Please feel free to contact Jean Forest should you have any questions or concerns.

Jean Forest, Manager
SMD Wheelchair Services &
Parking Permit Program
Ph. 204-975-3249 Fax. 204-975-324

Medical Corporations

*F*or those members practising medicine through a medical corporation, it is important to be aware of the legal requirements for the medical corporation to provide the CPSM with current information about the corporation and to file annual documentation with the Companies Office and CPSM.

Annual Return of Information – Companies Office

The Companies Office requires every corporation to file an Annual Return of Information with them. This applies to medical corporations as well. This is independent of any requirements from the CPSM.

A copy of the Annual Return of Information, which is filed with the Companies Office, must also be provided to CPSM. This is required by the College to ensure that the medical corporation continues to be in good standing with the Companies Office. A copy of the most recent annual return must be submitted to CPSM at the time the medical corporation files its Statement of Particulars.

Statement of Particulars – CPSM

CPSM requires that a medical corporation file a Statement of Particulars every year prior to the expiry of the Permit to Practice Medicine as a Professional Corporation. The Statement of Particulars provides up to date information about the medical corporation. At least 30 days prior to the permit expiry date, the College will send a notice to renew the medical corporation. This is sent to the address provided by the corporation on its previous year's renewal or as updated during the permit year.

Medical Corporation Information Changes

By-Law #7 of CPSM requires that a medical corporation must provide the College with notice of all changes in the particulars of a medical corporation within 15 days of the change. This may include changes in the corporate structure of the medical corporation, new contact information for the corporation, the names of physicians who are practising through the medical corporation, and the names of shareholders, directors and officers. The changes are to be reported on the prescribed Statement of Particulars form.

If the member is practising medicine in another province but also continues to practise as a medical corporation in Manitoba, the member must provide a Manitoba address for the medical corporation.

It is important to note that notifying the Qualifications Department at the College of a change of address for a licensed practitioner, is NOT considered notice to the Medical Corporation Department. Many physicians use an alternate address for their medical corporation. For this reason a separate change of address notice must be sent to the Medical Corporations Department at the CPSM.

Corporate address changes may be made by emailing corporateservices@cpsm.mb.ca and the changes will be recorded in the Medical Corporation Registry.

Late or Non-renewal of Medical Corporation

The annual Statement of Particulars and the renewal fee must be filed with the College prior to the date the Permit to Practice Medicine as a Professional Corporation expires. If it is not filed by the date the permit expires, but is filed within 30 days of that date, the College will process the renewal upon payment of a late fee of \$25.00.

If the Statement of Particulars, along with payment of the fee and penalty, is not filed within 30 days following the date the permit expires, the physician will have to apply for a new permit in accordance with the application requirements for a new medical corporation. The College will require a new application, a new Certificate of Status from the Companies Office, a copy of any Articles of Amendment, and the fee required for the initial application.

If a member takes a leave of absence from practice for a period of time for reasons such as parental leave or illness, the medical corporation may request the Registrar use his or her discretion in permitting a late renewal of the medical corporation. The member must specify the reason for the request. The Registrar has some discretion to permit a late renewal of a medical corporation without charging a penalty for certain specified reasons. **Please note this discretion does not apply to a late renewal of individual licenses.**

If you have any questions or concerns they may be directed to the Medical Corporation Department of the College at corporateservices@cpsm.mb.ca.

FROM THE STANDARDS DEPARTMENT

CPD REVIEWS ARE CURRENTLY BEING CONDUCTED

Reminder: Regulation 25/2003 requires all physicians to participate in one of the two national College's tracking programs for continuing professional development. You may expect to receive a letter from the Deputy Registrar:

- If you have not enrolled in either of the two CPD tracking programs of the CFPC or RCPSC (or failed to renew);
- If you have not met the College's yearly CPD minimum credits, or
- If your 5-year cycle is ending in 2014 or 2015 and you are in jeopardy of a shortfall.

For further details please visit the College's website – www.cpsm.mb.ca - Go to "About the College"; "Standards" and then "Continuing Professional Development" for detailed requirements.

If you have any questions, please do not hesitate to call either Carol Chester-McLeod, Standards Manager directly at 204-786-0263 or Dr. Terry Babick at (204) 774-4344.

FROM THE MATERNAL & PERINATAL HEALTH STANDARDS COMMITTEE

Documentation of Cause of Death on Death Certificate

Concerns have been raised by the Provincial Chief Medical Examiner that causes of death listed on death certificates may not be appropriately recorded, particularly in listing disease or conditions directly leading to death or in listing antecedent factors.

Examples of such inappropriate causes for death include such diagnosis as “withdrawal of support” or “cardiorespiratory arrest”, especially without indicating antecedent conditions that lead to such deaths.

There are two educational tools that could improve recording of the acceptable causes of death:

- Service Nova Scotia and Municipal Relations published a handbook for physicians and medical examiners titled “Medical Certification of Death and Stillbirth”, which is available at:
<http://www.gov.ns.ca/snsmr/pdf/ans-vstat-physicians-handbook.pdf>
- A CME exercise online, with post-test questions, which is eligible for Medscape CME credit:
http://www.cdc.gov/pcd/issues/2012/12_0071.htm#post

Physicians are encouraged to review these learning tools.

Dr. Michael Helewa
Medical Consultant, MPHSC

NEW STATEMENTS APPROVED BY COUNCIL

Effective May 1, 2014

- #176 Accounting and Billing
- #177 Addressing Multiple Concerns
- #186 Assessing the Mental Capacity of a Patient
- #178 Collaboration in Patient Care
- #179 Consent and Informed Consent
- #180 Medical Services Requiring Accreditation Outside of Hospitals
- #181 Members Religious or Moral Beliefs
- #184 Transfer of Care from an Institutional Facility
- #183 Use of Social Media
- #185 Web Sites

All above statements are included in this newsletter for you to review.

RESULTS OF 2014 ELECTIONS TO COUNCIL

**Four year term
expiring in 2018**

Central E.D.	Persson, Enok
Interlake E.D.	Lindsay, Daniel
Northman E.D.	Tassi, Hasham
Parkland E.D.	Elliott, Jacobi
Winnipeg E.D.	Manishen, Wayne
	Pinchuk, David
	Riese, Nichole
	Sigurdson, Eric
	West, Michael

Need Assistance?

PHYSICIANS AT RISK

Phone 204-237-8320 (24 hours)

Moving? Retiring?

If you are leaving the province or retiring from practice, By-law #1 requires that you advise the College where your records will be stored. This is so we can make note of it on your file to advise interested parties.

PLEASE UPDATE YOUR EMAIL ADDRESS

Some members did not receive their Council election ballots, which were sent out by email, as we did not have your most recent email address. Last year on your renewal notices, Council mandated that all members provide us with a valid email address.

Please provide all information on your renewal form and remember that when you make any changes in your contact information, you must notify the College immediately, so that we can ensure we have the most up to date information when we need to reach you.

MEETINGS OF COUNCIL FOR THE 2013-2014 COLLEGE YEAR

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

- Wednesday, June 4, 2014

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

OFFICERS AND COUNCILLORS 2013-2014

President:	Dr. D. Lindsay
President Elect:	Dr. B. Kvern
Past President:	Dr. B. Kowaluk
Treasurer:	Dr. A. Vorster
Investigation Chair:	Dr. A. MacDiarmid
Registrar:	Dr. W. Pope
Deputy Registrar:	Dr. T. Babick
Assistant Registrar:	Dr. A. Ziomek

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 SEPTEMBER 2014

Associate Members Register	Mr. I. Jones
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TERM EXPIRING JUNE 2016

Brandon	Dr. S. J. Duncan
Eastman	Dr. K. Bullock Pries, Steinbach
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

STATEMENT No. 176

Accounting and Billing

1. A member must keep an accounting record showing the date every health service was rendered by the member to a patient, the type of service, and the charge made.
2. A member must provide care that is clinically required in all cases that are not elective or when no other member is reasonably available, despite the fact that collection of a fee may not be possible.
3. A member may charge a reasonable fee when he or she performs a health service that is not insured by the provincial fee schedule.
4. A member must inform a patient or third party of any fee to be charged before an uninsured health service is provided, except in the case of emergency care where it is impossible or impractical to inform the patient.
5. A member's agent may give preliminary information to a patient about the billing policies in the member's medical practice, but the member remains responsible for the final decision and explanation to the patient if the patient disputes a fee or requests clarification.
6. A general notice to patients in a member's office is not sufficient, by itself, to fulfill the requirements of subsections 4 and 5.
7. A member may not demand payment in advance of urgently required health services that are not readily available elsewhere.
8. A member must not charge a fee in advance for "being available" to render insured health services.

A statement is a formal position of the College with which members shall comply.

STATEMENT No. 177

Addressing Multiple Concerns in a Medical Visit

The College recognizes that demands on individual physician services are increasing and it is challenging to meet a patient's expectation. The College also recognizes that many patients do not understand the significance of symptoms they may be experiencing and may be using disproportionate time when meeting with their physician.

Some physicians have been dealing with this by posting signs, or otherwise, limiting patients' ability or desire to deal with all of their concerns in one visit. Some physicians have put up signs stating that only one problem will be dealt with in one patient visit.

The College stresses that patients are not always able to determine which symptoms or concerns may reflect a significant problem. Serious conditions can present with an array of symptoms but may not be recognized if the patient is limited in what he or she can report to the physician. Instituting a rule that a patient can only report one concern per visit may not only upset the patient, but may also compromise patient care.

Physicians possess more medical knowledge and skill than their patients. Therefore it is reasonable to expect physicians to make decisions about which problems can wait and which cannot wait. The College encourages physicians to use common sense and good communication when approaching this issue in order to ensure that significant health concerns of patients are dealt with on a timely basis.

Managing patient expectations is an integral part of what physicians do every day. Being patient centered does not mean that the patient's every expectation must be met. It may not be possible or reasonable to deal with every problem a patient presents in a single visit. Being patient centered does mean that the physician should place the patient's best interest before his/her own and remain open and flexible so that serious matters are appropriately addressed in a timely fashion.

A statement is a formal position of the College with which members shall comply.

STATEMENT No. 178

Collaboration in Patient Care

1. If a member or a patient suggests a referral to another health care professional, the member must discuss the purpose of the consultation with the patient.
2. When a member believes that referral to another health care provider is appropriate but the patient does not, the member must discuss and document in the patient's record the difference of opinion and the implications for the patient's care and
 - (a) a member must continue to provide care within any limits imposed by the patient's decision; but
 - (b) the member must not practice beyond his or her competence or provide care that the member does not believe is in the best interest of the patient.
3. A member must respect a patient's reasonable request to be referred to other health care providers or to receive a second opinion.
4. Despite section 3, a member is entitled to refuse to make a referral that, in his or her opinion, is unlikely to provide a clinical benefit to the patient.
5. A member must tell the patient about any fees that may not be covered by Manitoba Health if the referring member knows the consultant will likely charge fees that will be payable by the patient.
6. A member must recognize that the patient has the right to disagree with the choice of consultant or service to whom a referral is made, and the member must try to accommodate the patient's request.
7. A member must make or confirm a request for a consultation, in writing, to the consultant or service unless the circumstances are urgent and the consultant agrees to accept care of the patient after oral discussion.
8. In the case of a referral for emergency care, the member must discuss the referral with the consultant or the emergency physician (if referral to an emergency department is being made) or otherwise ensure acceptance of care by the consultant or service.
9. A referring member must perform a preliminary work-up of the patient within his or her scope of practice and the available resources and ensure those results are available to the consultant or service.

10. If a consultation is requested solely for the purpose of providing information to a third party (for example an insurance company), the referring member must, at the time of the request for consultation, clearly identify that the consultation is requested for that purpose.
11. Except in an emergency situation, a referral request by a member must be provided in writing and include at least the following information:
 - (a) the identity of the referring member;
 - (b) the identity of the patient, including the Manitoba Health number and contact information;
 - (c) the identity of the consultant or service to whom the patient is being referred;
 - (d) the date of the referral;
 - (e) the purpose of the referral as intended by the referring member, including whether an opinion only or transfer of care is requested;
 - (f) pertinent clinical information, including results of clinical investigations.
12. A consultant member or member's service must respond to the patient and member verbally or in writing to a request by a member for a non-urgent consultation within 30 days of receipt of the request, and must notify the patient and the referring member of the anticipated appointment date.
13. If a request for a consultation is declined, the consultant member must provide reasons and whenever possible, provide suggestions to the referring member for alternative consultants or services.
14. If a consultant member agrees to see a patient, the consultant or a designate must contact the patient directly to schedule the appointment (including information such as the date, time, and place, and special instructions) and send a copy of that information to the referring member, unless otherwise agreed to by the referring member.
15. If a consultant member arranges to see a patient without a referral, the consultant must not insist on a request for consultation from the patient's primary care physician.
16. A member who is a consultant must make information available about the process by which referrals are accepted; for example, by telephone, facsimile, secure e-mail or verbally and
 - (a) a member should generally be available to respond to requests for consultation;
 - (b) the college will assess, on a case by case basis, complaints by referring members or patients about how a consultant member manages his or her response to referral requests.
17. A consultant member must, as soon as possible but generally within 30 days of having seen a patient for the first time, report in detail to the referring member all pertinent findings and recommendations with respect to a patient seen by the consultant.
18. If the consultant's conclusions require further investigation or treatment, the consultant must provide an interim report to the referring member and a final written report at the conclusion of the consultant's involvement.

19. Unless a patient explicitly requests otherwise, a consultant member's report must include, when applicable:
 - (a) the identity of the consultant;
 - (b) the identity of the patient;
 - (c) the identity of the referring member and, if different, the identity of the patient's primary care physician;
 - (d) the date of the consultation;
 - (e) the purpose of the referral as understood by the consultant;
 - (f) information considered, including history, physical findings, and investigations;
 - (g) diagnostic conclusions;
 - (h) the treatments initiated, including medications prescribed;
 - (i) recommendations for follow-up by the referring member;
 - (j) recommendations for continuing care by the consultant;
 - (k) recommendations for referral to other consultants, but, except in the case of an emergency, such referral must only be made with the approval of the referring member;
 - (l) the advice given to the patient.
20. If a patient explicitly requests all or some information not to be disclosed, the consultant member must advise the referring member that the patient withholds consent for release of information.
21. If the consultant member requires further investigation before reaching a definitive diagnosis, the consultant must not delegate arrangement and follow-up of those investigations to the referring member without prior agreement with the member.
22. A consultant member must obtain informed consent for any procedure from the patient directly and cannot rely on the referring member to obtain the consent.
23. A consultant member must explain to the patient the consultant's role, if any, in the continuing care of the patient and the advisability of follow-up care by the consultant.
24. A consultant member must contact the referring member at the time the patient is returned to the referring member for ongoing care and provide written information as soon as possible thereafter to assist with the patient's continuity of care.
25. A member may not charge another member for exchange of limited patient information, for example, a copy of a discharge summary.

A statement is a formal position of the College with which members shall comply.

STATEMENT No. 179

Consent and Informed Consent

1. A member is responsible for ensuring that consent, which may be implied or may be expressed orally or in writing, is obtained from a patient before performing an examination or treatment or before disclosing the patient's personal health information, except where permitted by law to act without consent. A member must:
 - (a) be aware of authoritative advice on informed consent, such as that of the Canadian Medical Protective Association, before establishing a policy on consent procedures in his or her medical practice;
 - (b) consider the risks to the patient, the potential for pain and discomfort, and the invasiveness of the procedure when deciding on the type of consent required;
 - (c) if relying on implied consent, be certain that the actions of the patient would be interpreted by others as having implied permission for the member's actions;
 - (d) if possible, ensure that written consent is obtained before performing a surgical operation;
 - (e) consider the knowledge and expertise of trainees and staff if delegating the consent procedure.
2. A member must determine a patient's capacity to give consent in accordance with Statement #186, "Assessing the Mental Capacity of a Patient".
3. A member who obtains consent from a substitute decision maker on behalf of a patient must comply with applicable laws.
4. A member must respect the right of a patient to withdraw consent at any time.
5. In obtaining full and informed consent for disclosure of personal health information or for procedures of higher risk of harm for the patient, a member must discuss, at a minimum:
 - (a) the exact nature and the anticipated benefits of the proposed examination, treatment or release of personal health information;
 - (b) reasonable and accepted alternative examinations or treatments that are generally available;
 - (c) the natural history of the medical condition at issue;

- (d) consequences of not undertaking the examination or treatment or disclosing personal health information;
 - (e) the common and significant risks of the examination or treatment or disclosure and alternatives;
 - (f) serious risks, even if unlikely;
 - (g) special risks, that although uncommon, may have particular relevance to the patient;
 - (h) any questions the patient may have.
6. A member who obtains consent from a patient for participation in research must also comply with direction and advice from the applicable research ethics board.

A statement is a formal position of the College with which members shall comply.

STATEMENT No. 180

Medical Services Requiring Accreditation Outside of Hospitals

1. A member may not perform or supervise a diagnostic or treatment procedure outside an institutional setting unless the member is approved for that purpose by the Facility Director and the Facility Director must be approved by the Program Review Committee of the College.
2. A member must not practice in a facility which requires accreditation under the College's by-laws unless the facility holds full or conditional accreditation.
3. If a member is employed or engaged to provide medical care in a non-institutional setting, and in that setting there is non-compliance with *The Medical Act*, CPSM's By-Laws, Statements or Guidelines, the member must
 - (a) notify his or her employer or the person in operational or management control of the non-compliance;
 - (b) if the non-compliance is not remedied, cease to provide medical care in that setting until the non-compliance is remedied.

A statement is a formal position of the College with which members shall comply.

STATEMENT No. 181

**Members Moral or Religious Beliefs
Not to Affect Medical Care**

1. A member must communicate clearly and promptly to a patient or prospective patient about any treatment or procedure that the member chooses not to provide because of his or her moral or religious beliefs.
2. A member must not withhold information about the existence of a procedure or treatment even if providing that procedure or treatment or giving advice about them conflicts with his or her moral or religious beliefs.
3. A member must not promote his or her own moral or religious beliefs when interacting with a patient.
4. If the moral or religious beliefs of a member prevent him or her from providing or offering access to information about a legally available medical treatment or procedure, the member must ensure that the patient who seeks that advice or medical care is offered timely access to another member or resource that will provide accurate information about all available medical options.

A statement is a formal position of the College with which members shall comply.

Effective MAY 1, 2014

STATEMENT No. 183

Use of Social Media

The College proposes the following guidelines for physicians who participate in social media and online networking forums:

1. Do not initiate an invitation to patients or patients' family members to be your online friends.
2. Carefully consider an invitation from a patient to become an online friend. In general, avoid entering into dual relationships with patients by becoming online friends but be considerate of patients' feelings when declining the invitation.
3. Respect patients' privacy by carefully managing information acquired about them from online sites or other sources. Consider whether it is medically necessary to view patients' websites or online profiles and, if so, seek permission to access these sites. Do not enter collateral information obtained from social media about patients in your records without their knowledge.
4. Exercise restraint when disclosing personal information on social media or online networking forums. Assume content on the internet is public and accessible to all.
5. Read, understand, and use the strictest privacy settings in order to maintain control over access to your personal information. Be aware that privacy settings are imperfect and can be compromised.
6. Be mindful of your own internet presence and be proactive in removing content which may be viewed as unprofessional.
7. Be aware of the potential for establishing online therapeutic relationships through medical advice and discussion posted to the internet. Also be aware of the potential for breaching patient confidentiality by conveying medical information in anecdotal form in an internet post.

A statement is a formal position of the College with which members shall comply.

STATEMENT No. 184

**Transfer of Care from an
Institutional Setting**

1. A member who discharges a patient from an institutional setting with the expectation of follow-up care by another member outside that facility; and a member who has provided health care to a patient in an emergency setting and who has ordered tests or recommended follow-up care by another member or by the patient's primary care physician must:
 - (a) prepare a legible summary of laboratory test results, active medical problems and treatment plans at discharge for the accepting member or the primary care physician before the follow-up care appointment is expected to occur;
 - (b) unless the hospital or health care facility has an acceptable procedure in place, if the follow-up care is required within two (2) weeks of discharge, contact the accepting member or the primary care physician directly to facilitate the patient's follow-up care appointment and to transfer necessary medical information.
2. A member who transfers care to another member within the same or institutional setting must ensure the accepting member has the necessary clinical information to assume care, including a summary of laboratory test results, active medical problems and a treatment plan for the patient.
3. Despite paragraphs 1 and 2, the member is not responsible for delays in the transcription and delivery of the discharge summary that are not under his or her control, but is responsible for his or her own clinic and practice.

A statement is a formal position of the College with which members shall comply.

STATEMENT **No. 185**

Web Sites

1. A member's web site from which medical services are provided is a practice location of the member and any change in that location, including opening or closing of the web site, must conform to College requirements regarding notification of address change.
2. A member who offers medical services by a web site must clearly disclose on the web site the member's identifying information, including name, practice location, all jurisdictions in which licensure is held, the member's financial interest in any products recommended, and the member's fees for providing the medical services.
3. A member must ensure that any transmission of information to or from the web site remains confidential and complies with all the confidentiality and privacy requirements of the *Personal Health Information Act*, *The Medical Act*, and the College's Code of Conduct, Standards, and Guidelines.

A statement is a formal position of the College with which members shall comply.

STATEMENT No. 186

**Assessing the Mental Capacity
of a Patient**

1. A member conducting an assessment of a patient's mental capacity must:
 - (a) attempt to obtain the patient's agreement to participate in the assessment;
 - (b) assess the patient's capacity to understand information relevant to the topic at hand;
 - (c) assess the patient's capacity to understand the decisions to be made;
 - (d) assess the patient's capacity to understand the risks and benefits of actions that may be undertaken or the medical care that could be provided;
 - (e) assess the patient's ability to justify his or her choices;
 - (f) use accepted clinical means to determine a patient's mental capacity.

A statement is a formal position of the College with which members shall comply.

INQUIRY: IC1595 - DR. STEPHEN JOHN COYLE

On April 25, 2013, 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. Stephen John Coyle (Dr. Coyle), as set forth in an Amended Notice of Inquiry dated October 30, 2012.

The Amended Notice of Inquiry charged Dr. Coyle with various acts of professional misconduct, and with contravening By-Law No. 1 of the College, and Articles 1 and/or 2 and/or 10 and/or 11 and/or 15 of the Code of Conduct of the College, and with contravening Statements 148 and/or 805 of the College, and with displaying a lack of, or a lack of skill and judgment in the practice of medicine.

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

- a. Exploited patients for personal advantage through unethical and inappropriate prescribing practices, including issuing prescriptions for narcotics in the names of various patients when in fact the prescriptions were for his own use;
- b. Initiated actions which caused claims to be submitted in the name of a particular patient to that patient's private insurer, which resulted in payments for certain prescriptions in the name of that patient being paid by the patient's private insurer, on the basis that the prescriptions were for the patient's use, when in fact the prescriptions were for the use of Dr. Coyle;
- c. Created false and/or misleading medical records thereby breaching Statement 805 of the College and/or the record keeping requirements of By-Law No. 1 of the College and therefore committing acts of professional misconduct;
- d. Caused claims to be submitted to Manitoba Health for fictitious visits with respect to three particular patients, thereby committing acts of professional misconduct;
- e. Inappropriately prescribed medications for not less than 10 patients, including narcotics and benzodiazepines and/or opioids, thereby committing acts of professional misconduct;
- f. Failed to create and maintain adequate clinical records in respect of not less than 10 patients thereby breaching the record keeping requirements of By-Law No. 1 of the College and/or Statement 805 of the College and/or committing acts of professional misconduct;
- g. Inappropriately terminated the doctor/patient relationship with two patients without ensuring that another suitable physician had assumed responsibility for their care, or without giving adequate notice that he intended to terminate the relationship thereby breaching Article 10 of the Code of Conduct and/or committing acts of professional misconduct;
- h. Violated his ethical obligation to maintain proper boundaries with two patients by giving them money to assist in paying certain of their expenses;

- i. During the period between in or about September, 2009 and September, 2010, participated in the creation of misleading medical records by allowing a nurse practitioner who performed office visits and/or house calls to record the visits and/or house calls as if Dr. Coyle had seen the patient and created the records when in fact he had not, thereby breaching the record keeping requirements of By-Law No. 1 of the College and/or Statement 805 of the College and/or committing acts of professional misconduct;
- j. Initiated actions which caused claims to be submitted to Manitoba Health for services as if he had provided the services when in fact the services had been provided by another person who was not a physician, thereby committing acts of professional misconduct;
- k. Engaged in the practice of medicine while under the influence of injectable Demerol and/or benzodiazepines while his ability to practice medicine was impaired, thereby committing acts of professional misconduct;
- l. Prescribed medications to himself on various occasions between October, 2008 and March, 2010 thereby breaching Article 11 of the Code of Conduct and Statement 148 of the College;
- m. Attempted to mislead the College on various occasions between September 16, 2010 and March 3, 2011; and
- n. As a result of all of the foregoing, displayed a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

The hearing proceeded before the Panel on April 25, 2013 in the presence of Dr. Coyle and his counsel, and in the presence of counsel for the Investigation Committee of the College.

At the outset of the hearing, Dr. Coyle entered a plea of guilty to all of the charges outlined in paragraphs 1 through 14 of the Amended Notice of Inquiry thereby acknowledging that the facts alleged in the Amended Notice of Inquiry were true and also acknowledging that he:

- a) was guilty of professional misconduct;
- b) had contravened By-Law No. 1 of the College;
- c) had contravened Articles 1 and/or 2 and/or 10 and/or 11 and/or 15 of the Code of Conduct of the College;
- d) had contravened Statements 148 and/or 805 of the College;
- e) had displayed 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. Coyle:

- i. the Notice of Inquiry;
- ii. the Amended Notice of Inquiry;
- iii. a Statement of Agreed Facts which was 35 pages in length;
- iv. a Book of Documents consisting of 32 sets of documents, including but not limited to Manitoba Health Billing Summaries relating to certain patients, the electronic medical records (EMR) relating to various patients, portions of the medical charts relating to certain patients, printouts from the Drug Programs Information Network (DPIN) relating to certain patients, and statements from Manitoba Health relating to house call and clinic visit billings for services by a nurse practitioner for a period between February 15 to 28, 2010, and Manitoba Health Psychotherapy Billings for a period between March and September, 2010;
- v. a Statement of the Joint Recommendation of the parties as to Penalty; and
- vi. various reports from physicians and psychologists who have either treated Dr. Coyle or have been consulted with respect to his circumstances, all of which were tendered by consent at the Inquiry.

REASONS FOR DECISION

Having considered the above-noted exhibits, and the submissions of counsel for the Investigation Committee of the College and counsel for Dr. Coyle, 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.

Background:

1. In 1975, Dr. Stephen John Coyle graduated from Newcastle Upon Tyne University Medical School, England. He completed his medical education and training in the United Kingdom in 1978 and immigrated to Manitoba. He became a member of The College of Physicians & Surgeons of Manitoba in October 1978. He practiced as a family physician in Shoal lake, Manitoba from 1978 to 1981. From 1981 until April 2004, he maintained a family practice at the Charleswood Medical Clinic. From 1981 to 1996, he held a staff position at the Grace Hospital. From July 2004 to February 2008, he was the Chief Medical Officer at the Misericordia Health Centre in Winnipeg, Manitoba, where he continued his family practice. In 2008, from February to July, he worked as a director for research for a private company in British Columbia. From July 2008 until September 2010, he was the Medical Director and maintained a family practice at the Four Rivers Broadway Clinic in Winnipeg, Manitoba.

2. Concerns that Dr. Coyle may have been inappropriately prescribing and abusing narcotics were brought to the attention of the College by colleagues from and the owner of the Four Rivers Broadway Clinic. The College did not receive any complaints from patients about Dr. Coyle's care.
3. When Dr. Coyle was initially confronted by the College about the concerns relating to suspected abuse of narcotics and benzodiazepines, he denied the allegations. Later, by letter dated October 8, 2010, Dr. Coyle admitted to having abused and diverted narcotics, including injectable Demerol ("Meperidine HCl") and Diazepam.
4. On September 20, 2010, Dr. Coyle signed a voluntary undertaking agreeing not to practice without the express written permission of the Investigation Chair. He sought treatment in relation to his addiction and has been diagnosed as having an opiate dependence (in full remission) and major depressive disorder (symptoms in remission).
5. Dr. Coyle did not practice between September 20, 2010 and March 27, 2012, with the exception of a portion of one day in April 2011 when he made an unsuccessful attempt to resume his practice under strict conditions. At the request of the Investigation Chair of the College, Dr. Coyle signed another undertaking on April 28, 2011 agreeing not to practice without the express written permission of the Investigation Chair. Pursuant to a written undertaking with the College dated March 14, 2012, Dr. Coyle resumed practice on March 27, 2012. He is currently practicing at the Crestview Clinic, Winnipeg under the supervision of an on-site physician supervisor acceptable to the Investigation Committee pursuant to that undertaking. The undertaking includes restrictions and conditions on his practice, including prescribing, and is monitored by the Investigation Chair of the College.

Summary of facts with respect to Admitted Allegations in Notice of Inquiry

Abuse and Diversion of Narcotics and Benzodiazepines

6. Dr. Coyle has stated that:
 - a) For a number of years, his treating physicians had prescribed injectable Demerol to him for relief of symptoms related to hemiplegic migraines and Diazepam for relief of restless leg syndrome.
 - b) In or about 2008, Dr. Coyle started to experience symptoms of depression, which led to him abusing these medications and becoming addicted to them.
 - c) It is difficult for Dr. Coyle to recall exactly when he started to abuse these medications, but it is clear that his use escalated over time and he became increasingly dependent upon them.
 - d) His dependency led to him abusing his position as a physician to divert narcotics and benzodiazepines for his own use.

7. There are two categories of patients involved in Dr. Coyle's inappropriate prescribing as it relates to diversion of narcotics and benzodiazepines for his own use:
- a) Patients with whom Dr. Coyle had a close personal relationship to whom Dr. Coyle issued prescriptions without their knowledge and created fictitious records to cover up his own use of the narcotics and benzodiazepines. There were primarily two patients in this category.
 - b) Patients to whom Dr. Coyle provided care and wrote prescriptions for Demerol without an adequate assessment of the patients' medical condition and/or inadequate medical rationale. In respect to these patients, Dr. Coyle has acknowledged that he prescribed to them partially for the purpose of using a portion of the Demerol prescribed to them for his own use. There were nine patients in this category.
8. Dr. Coyle's activities and misconduct in relation to the patients in the two categories noted above were extensive. His activities commenced in late 2007/early 2008 and escalated over time, and persisted until August/September, 2010. Dr. Coyle's activities involved issuing well over 100 prescriptions of various quantities of narcotics and benzodiazepines with a large proportion of the prescriptions involving Demerol.
9. Dr. Coyle has now admitted that:
- a) He was no doubt motivated, at least in part, to use injectable Demerol to treat some or all of these patients so that some Demerol would be left for his own use.
 - b) He believes that he injected most or all of these patients with some of the Demerol he prescribed and used leftover Demerol in the vials for his own use on occasion, but he cannot recall when and in respect to which prescription.
 - c) There is no real justification for the use of injectable Demerol for any of these patients. Although he does not specifically recall diverting Demerol prescribed to them for his own use, he has little doubt that he did so. He states there is no excuse for his actions other than his own addiction and depression.
 - d) He has no recollection of picking up any Demerol prescriptions for these patients but says he may well have done so. He believes some of these patients took Demerol with them to inject at home but he is not completely certain which ones. For patients injected in the office, Dr. Coyle did keep remnants of some of the vials for his own use, but again cannot be certain for which specific patients. Dr. Coyle believes he provided some patients with training on how to inject themselves at home.
 - e) Many of his chart entries during the period of his addiction, particularly ones that refer to prescriptions for injectable Demerol, are inadequate.
 - f) The medical records relating to prescriptions for Demerol to these patients are not only inadequate, but in many instances were most likely for the purpose of covering up Dr. Coyle's own narcotic use rather than creating accurate reflections of encounters with the patients.

- g) In respect to each of these patients, he prescribed injectable Demerol without taking an adequate history and/or conducting an adequate physical examination to evaluate the patient's medical condition and the appropriateness of that medication for the patient's condition.

Inappropriate Prescribing of Narcotics, Benzodiazepines and Opioids

- 10. Dr. Coyle has admitted to inappropriately prescribing narcotics, benzodiazepines and opioids to not less than nine patients, some, but not all of whom were also patients affected by his misconduct as earlier described in these Reasons.
- 11. With respect to the several patients with respect to whom Dr. Coyle inappropriately prescribed narcotics, benzodiazepines and opioids, Dr. Coyle has advised that:
 - a) In some cases, his charting practices were clearly inadequate and any physician who viewed his chart would not be able to follow what was going on with the patient.
 - b) Dr. Coyle has no excuse for his deficient charting practices. The only explanation he has provided was that he was depressed and becoming increasingly addicted to Demerol and benzodiazepines.
 - c) In many cases, Dr. Coyle prescribed medications without any medical justification whatsoever, and without making any entry on the patient's chart.
 - d) Some of the patients involved in this category were abusing street narcotics. Dr. Coyle's method of dealing with these patients, including the dosages he prescribed did not meet appropriate clinical standards, and he failed to follow the recommendations available from a specialist in addictions medicine as to how to manage such patients. As a result, Dr. Coyle switched many of these patients from one medication to another around May/June of 2010, but did not have an adequate plan in place to deal with withdrawal symptoms or ongoing management of those patients' underlying conditions. These events were taking place at the height of Dr. Coyle's addiction in the late spring and summer of 2010.
- 12. With respect to several of the patients in this category, Dr. Coyle inappropriately terminated the doctor/patient relationship without giving the patients involved any notice of the termination of the relationship, nor making any alternative arrangements for the patients' ongoing care.

Boundary Violation - Gift of Money

- 13. Dr. Coyle has admitted that he gave at least two patients money to assist them with certain expenses.

Inappropriate Billing to Manitoba Health and Participation in the Creation of Misleading Medical Records

Nurse Practitioner (NP)

14. Dr. Coyle has stated that:

- a) In September of 2009, an NP who had been employed at the Four Rivers Broadway Clinic entered into a new working and financial arrangement with Dr. Coyle and the Clinic.
- b) The arrangement involved patients being seen by the NP in the Clinic and on a house call basis and those visits being billed by the Clinic to Manitoba Health using Dr. Coyle's billing number.

15. The information contained in the Statement of Agreed Facts with respect to inappropriate billing and the creation of misleading medical records was lengthy and detailed. The Statement of Agreed Facts included a comprehensive description of the clinical practices and procedures and the billing procedures of Dr. Coyle, the NP and the Clinic, and the method of sharing those billings between the Clinic, Dr. Coyle and the NP with respect to both clinic billings and house call billings. It is not necessary to outline or summarize all of the information contained in the Statement of Agreed Facts on this topic. The Panel recognizes that Dr. Coyle may not have been fully knowledgeable about how those types of matters should have been handled, but Dr. Coyle has admitted that:

- i) It was never intended that he would be present for the entire or every encounter that the NP had with a patient by use of the video stream technology or otherwise. His involvement was only required when requested by the NP.
- ii) Dr. Coyle did not see most of the patients that the NP would see either at the Clinic or during house calls, by video stream technology or otherwise. In respect of approximately 75% of the house calls, Dr. Coyle was not present with the video link at all during the patient encounter. The NP would only contact Dr. Coyle if he had a question or concern.
- iii) In retrospect, Dr. Coyle has recognized that the billing arrangement was inappropriate and that he should have been more diligent and met with Manitoba Health in advance and made sure it was appropriate. Dr. Coyle said that he should have been clear that he was not involved in the visits in any way and that another billing method should have been used.
- iv) There may have been times when Dr. Coyle was not present in the Clinic when the NP saw patients and billed the visits in Dr. Coyle's name.

Clinical Assistant - Daughter

16. Dr. Coyle has stated that he hired his daughter as his clinical assistant in the spring of 2010. She took notes while Dr. Coyle spoke to patients and assisted him with doing procedures. He paid her a salary out of his own income. She also did some counselling of Dr. Coyle's patients. When it came to counselling:
- a) Dr. Coyle would introduce her to the patients.
 - b) He did some of the initial counselling and she would take over. Dr. Coyle would return and go over what transpired and then go from there.
 - c) Dr. Coyle's daughter provided counseling and psychotherapy or cognitive therapy.
 - d) All of the visits involving counselling by Dr. Coyle's daughter were billed to Manitoba Health as psychotherapy services provided by him.
 - e) Dr. Coyle has acknowledged that the billings submitted to Manitoba Health for psychotherapy services provided by his daughter were inappropriate.

Practicing while under the Influence of Demerol

17. Dr. Coyle has acknowledged that his use of Demerol was increasing throughout the spring of 2010 and into the summer of that year. He initially injected Demerol at night, or would leave work in the afternoon to inject, so as not to be practicing medicine while under the influence of Demerol. However, at some time in 2010 he reached the point at which he was injecting Demerol while at work and was practicing medicine under the influence of Demerol. Dr. Coyle cannot remember the specific dates when he did so, or the frequency with which he did so.

Prescribing to Self

18. Dr. Coyle has also acknowledged that on not less than 8 occasions between October 21, 2008 and March 31, 2010, he prescribed certain medications to himself. Dr. Coyle has acknowledged that he should not have self-prescribed and that he should take medications only if and when they are prescribed by his treating physicians. He can only explain that his self-prescribing was the result of his depression and addiction to narcotics and benzodiazepines, and the impact these matters had on his judgment.

Misrepresentations to the College

19. After the College became involved in reviewing concerns about Dr. Coyle, he initially denied to the College that he was inappropriately prescribing and abusing narcotics. He has subsequently acknowledged that he made a number of false and misleading statements in his communications with the Registrar, Deputy Registrar, and the Investigation Chair between September 16, 2010 and March 3, 2011.

THE JOINT RECOMMENDATION AS TO DISPOSITION

On the basis of the above-noted summary of the background facts, it is self-evident that Dr. Coyle's misconduct and contraventions of the Code of Conduct of the College and of various Statements of the College are extremely troubling and problematic. It is noteworthy that Dr. Coyle's actions and his misconduct were multi-faceted involving the exploitation of vulnerable people, failing to meet appropriate standards in terms of prescribing medications for certain patients, failing to properly manage the care of certain patients, inadequate and incomplete charting and record keeping practices, the submission of false claims to Manitoba Health, engaging in the practice of medicine while his ability to do so was impaired, boundary violations of various types, displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine, and misleading the College on multiple occasions.

Although the Panel recognizes that much of Dr. Coyle's misconduct occurred during a time when he was struggling with the worst effects of his addiction to opiates and from a major depressive disorder, those factors do not alter the fact that Dr. Coyle's actions were reprehensible and entirely unacceptable.

Given the seriousness and unacceptability of Dr. Coyle'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 Investigation Committee of the College and counsel for Dr. Coyle.

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 Joint Recommendation is detailed, and has been thoughtfully conceived. Its essential elements are:

- i) A reprimand of Dr. Coyle, pursuant to Section 59.6(1)(a) of *The Medical Act*;
- ii) A suspension of Dr. Coyle from the practice of medicine for a period of 18 months, deemed to have been served during the period he was out of practice from September 20, 2010 until March 27, 2012, pursuant to Section 59.6(1)(b) of *The Medical Act*;
- iii) Conditions imposed upon Dr. Coyle's entitlement to practice medicine pursuant to subsections 59.6(1)(e) and 59.6(2) of *The Medical Act*, which include:
 - a) prohibitions against Dr. Coyle ingesting any of the drugs on an extensive list known as Schedule "A" and any acetaminophen with codeine, any benzodiazepines, or any alcohol;
 - b) prohibitions against prescribing any drug listed in Schedule "A", any acetaminophen with codeine, or any benzodiazepines;
 - c) compliance with the College's rigorous program of random body fluid monitoring;
 - d) mandatory attendance each and every week at Physicians-at-Risk group meetings, Alcoholics/Narcotics Anonymous meetings, and any other meetings recommended to Dr. Coyle by his treating physicians;
 - e) mandatory attendance upon his psychiatrist, his family physician, and his specialist in addiction medicine;
 - f) compliance with the treatments prescribed by his treating psychiatrist, his family physician, and/or his specialist in addiction medicine for the continuing management and monitoring of his addiction;
 - g) compliance with any direction from his treating psychiatrist, family physician or specialist in addiction medicine with respect to restricting, suspending or ceasing the practice of medicine for a temporary or an intermittent period subject to a right on the part of Dr. Coyle to object to such direction to the College, pursuant to a process particularized in the Joint Recommendation;
 - h) the restriction of Dr. Coyle's practice to clinical practice at the Crestview Clinic in accordance with the practice plan approved by the Investigation Committee from time to time with the additional requirement that Dr. Coyle must not change his practice location without the prior written consent of the Investigation Committee of the College;
 - i) a prohibition against Dr. Coyle providing care to any patient with a chemical dependence or a substance abuse disorder;
 - j) a requirement on the part of Dr. Coyle to create a complete and accurate record of each patient encounter in accordance with the requirements of By-Law No. 1 of the College.

Without limiting the generality of the foregoing, for each prescription written by Dr. Coyle, he must fully document this patient's history, his examination, any investigation ordered, and his diagnosis and treatment plan;

- k) a requirement to practice under the supervision of an onsite physician supervisor acceptable to the Investigation Committee;
 - l) a stipulation that payment for the services of the practice supervisor shall be Dr. Coyle's responsibility;
 - m) a restriction preventing Dr. Coyle, without the prior written consent of the Investigation Committee, from engaging in any research, teaching or lecturing, or taking after-hours call services or making house calls, or employing any clinical assistant, nurse practitioners, or other individuals to assist him with the assessment and treatment of his patients;
 - n) a requirement that Dr. Coyle restrict his volume of services in accordance with a practice plan, which must be approved by the Investigation Committee;
 - o) the continued monitoring of Dr. Coyle's practice of medicine, including his compliance with all of the conditions listed above;
 - p) a requirement that Dr. Coyle shall pay any and all costs arising from or incidental to the conditions imposed and the monitoring by the Investigation Committee of Dr. Coyle's practice and his compliance with the conditions imposed on his practice;
- iv) A requirement that Dr. Coyle shall pay to the College the costs of the investigation and inquiry in the amount of \$40,000.00, payable in full by way of certified cheque or a trust cheque from Dr. Coyle's lawyers;
- v) Publication, including Dr. Coyle's name, as determined by the Investigation Committee.

ANALYSIS

On the basis of the Statement of Agreed Facts, the materials in the Book of Documents, the guilty plea of Dr. Coyle to all of the counts in the Amended Notice of Inquiry, and the submissions of counsel for the Investigation Committee, and counsel for Dr. Coyle, the Panel has determined that Dr. Coyle is guilty of professional misconduct, of contravening By-Law No. 1 of the College and Articles 1 and/or 2 and/or 10 and/or 11 and/or 15 of the Code of Conduct of the College, of contravening Statements 148 and/or 805 of the College, and of displaying a lack of skill or judgment in the practice of medicine.

Section 59.6(1) of *The Medical Act* outlines the types of orders which an Inquiry Panel may make, once determinations such as those noted above have been made. The Panel may make one or more of various types of orders, including reprimanding the member, suspending the member's license for a period of time that the Panel determines appropriate, suspending the member's license until the member has obtained treatment or counselling and has demonstrated that any disability or addiction has been overcome, imposing conditions on the member's entitlement to practice medicine, and/or cancelling one or both of the member's registration and license.

As stated above, the objectives of orders under Section 59.6 of *The Medical Act* include the protection of the public, the punishment of the physician, specific deterrence, general deterrence, and the rehabilitation of the physician in appropriate cases.

This Inquiry Panel has undertaken a review of the above-noted objectives in the context of the Joint Recommendation as to Penalty to satisfy itself that the objectives of the orders which may be granted pursuant to Section 59.6 of *The Medical Act*, will be fulfilled if the Joint Recommendation is accepted.

The Panel first turned its mind to the protection of the public, not only the protection of the patients of Dr. Coyle, but also the protection of the public in the broader sense of maintaining high standards of competence and professional integrity among physicians.

As a result of a variety of events and developments, this matter did not come before the Inquiry Panel until Dr. Coyle had:

- i) withdrawn from practice for the period from September 20, 2010 until March 27, 2012 (with the exception of one day in April, 2011 when Dr. Coyle made an unsuccessful attempt to resume his practice under strict conditions). On September 20, 2010, Dr. Coyle had signed an undertaking agreeing not to practice without the written permission of the Investigation Chair; and
- ii) resumed practice from March 27, 2012 to the present, at the Crestview Clinic under the supervision of an on-site physician supervisor acceptable to the Investigation Committee and with the written permission of the Investigation Chair.

There were several reasons why an Inquiry Panel hearing was not convened until April 25, 2013. Those reasons included the complexity of the investigation into Dr. Coyle's misconduct, the length of the treatment which Dr. Coyle received for his depression and opiate addiction, significant delays encountered in obtaining records from Manitoba Health, and the usual type of challenges encountered in scheduling proceedings involving several lawyers, physicians and busy public representatives.

As a result of those delays, Dr. Coyle has been practicing medicine under significant limits and conditions, and under the supervision of an on-site physician supervisor for over a year. The Inquiry Panel has been advised that Dr. Coyle's resumption of practice since March 27, 2012 has been successful.

That factor, namely the successful resumption of practice pursuant to strict restrictions, and under the supervision of another physician, was of particular interest and significance to the Inquiry Panel when considering whether the public interest will best be served by the Joint Recommendation.

As outlined elsewhere in these Reasons, the restrictions on Dr. Coyle's practice are very significant. Those restrictions and conditions have had and will continue to have a major effect on Dr. Coyle's daily activities as a practicing physician. They are designed to protect the public, both in the sense of assuring that Dr. Coyle's patients will receive an acceptable standard of care and of demonstrating that there are effective means of maintaining high standards of competence and professional integrity among physicians, even physicians who have encountered serious difficulties in their professional and personal lives.

The fact that Dr. Coyle has successfully resumed the practice of medicine and has practiced pursuant to those very strict conditions for over a year, demonstrates that the conditions are practical and efficacious, and that the public good can be served by allowing a trained and educated physician, like Dr. Coyle, to practice medicine pursuant to a carefully designed set of conditions designed to safeguard the interests of the public.

In terms of the other objectives of orders under Section 59.6 of *The Medical Act*, the Joint Recommendation fulfills the objectives of punishing Dr. Coyle and specifically deterring him from committing similar acts of misconduct in the future. The results of his misconduct, and of these proceedings, will have a significant negative financial impact upon him. He has been forced to forego 18 months of professional income. He has also paid to the College the costs of the investigation and inquiry in the amount of \$40,000.00; the College has acknowledged the receipt of those funds.

With respect to Dr. Coyle's actions which caused claims to be submitted to Manitoba Health for fictitious visits involving three patients, Dr. Coyle's counsel has advised the Inquiry Panel that Dr. Coyle has reimbursed Manitoba Health for the amounts involved in relation to those fictitious visits in the amount of \$2,393.75. Counsel for Dr. Coyle also advised that Dr. Coyle is in an ongoing dialogue with Manitoba Health with respect to the inappropriate billings to Manitoba Health with respect to the NP and the clinical assistant, and that the amount of those billings is substantial (in excess of \$285,000.00). Although it has not yet been determined what portion of that amount will be Dr. Coyle's responsibility to repay, it is likely that he will face a significant financial liability in that regard.

In addition to the adverse financial consequences being sustained by Dr. Coyle, there are other punitive aspects of the Joint Recommendation. The reprimand is an expression by the Inquiry Panel of its disapproval and denunciation of Dr. Coyle's conduct and behaviour. The publication of the factual background and outcome of these proceedings, including Dr. Coyle's name, will be a source of embarrassment and humiliation to him.

The objective of specific deterrence, in the sense of preventing Dr. Coyle from committing similar acts of misconduct in the future, will be achieved by the \$40,000.00 cost award, the reprimand and the publication. It will also be achieved by various conditions imposed on his practice, most notably being his participation in the body fluid monitoring program, the restrictions on his ability to prescribe certain medications and the requirement that he be supervised by an onsite physician supervisor.

General deterrence, within the profession, will be achieved by a publication of the background and outcome of these proceedings.

Before addressing the remaining objectives of an order under subsection 59.6(1) of *The Medical Act*, namely protection against the betrayal of the public trust in the medical profession, and the rehabilitation of the physician involved, it is also useful to consider the appropriateness of an alternate order under subsection 59.6(1), which was not part of the Joint Recommendation, namely the cancellation of one or both of Dr. Coyle's registration and license.

The Inquiry Panel did consider the advisability of cancelling Dr. Coyle's registration and/or license and has decided against such cancellation for several reasons, which are:

- i) The Investigation Committee has reviewed this matter thoroughly. It is knowledgeable of the factual background, the nature and extent of Dr. Coyle's misconduct, the treatment of his depression and addiction, and his efforts to rehabilitate himself. The Investigation Committee has not recommended the cancellation of Dr. Coyle's registration and/or license.
- ii) The Investigation Committee has spent considerable effort in designing conditions which will protect the interests of Dr. Coyle's patients, and the public interests generally, while allowing Dr. Coyle to make productive use of his education, training and experience.
- iii) The Joint Recommendation is reasonable in relation to fulfilling the objectives of orders under subsection 59.6(1) of *The Medical Act*, and is also reasonable when compared to other decisions made by this College, and Colleges in other Canadian jurisdictions. The Inquiry Panel does not think the Joint Recommendation is either unfit, unreasonable, or contrary to the public interest. Therefore, the Inquiry Panel is satisfied that it ought to follow the Joint Recommendation (see *Pankiw v. The Chiropractors' Association* (2009) 336 Sask.R. 43 and *Matheson v. The College of Physicians & Surgeons (Prince Edward Island)* 2010 Carswell PEI 16).

- iv) Although the Inquiry Panel is aware that subsection 59.6(1) of *The Medical Act* contemplates the possible cancellation of a member's registration and license, the Panel is also aware that *The Medical Act* contemplates the potential reinstatement of a person whose registration or license has been cancelled, subject to any conditions that the Executive Committee may prescribe (see Section 59.13 of *The Medical Act*). On the basis of the information it has received in these proceedings, including the Joint Recommendation, the Inquiry Panel believes it is well able to decide whether Dr. Coyle should be able to continue to practice medicine, and if so, on what conditions.
- v) As noted above, the conditions pursuant to which Dr. Coyle is now practicing were designed and implemented following a period of 18 months during which he was not practicing medicine. Those conditions have now been in place for over a year and have proven themselves to be both workable and protective of the interests of Dr. Coyle's patients.

With respect to objectives relating to maintaining the public's trust in the profession, and the rehabilitation of Dr. Coyle, although the College generally adopts a rehabilitative approach towards many types of contraventions by physicians of applicable standards, the College immediately recognized that as a result of the nature and extent of Dr. Coyle's misconduct, a disciplinary response was required. An investigation was conducted and a Notice of Inquiry was issued. Significant discipline is being imposed upon Dr. Coyle as a result of these proceedings.

In circumstances such as this case, in which a disciplinary approach is required, the College must nonetheless be sensitive to mitigating circumstances. There are mitigating circumstances in this case. Over a period of many years, Dr. Coyle demonstrated that he was a capable and competent physician. His misconduct and contraventions of various By-Laws of the College, the Code of Conduct of the College, and various College Statements were the result, either in whole or in part, of his opiate dependence and major depressive disorder.

He has sought and obtained treatment for those conditions from appropriately qualified professionals and has participated meaningfully and conscientiously in his treatment and in the various programs which have been recommended by his caregivers.

Opinions from qualified professionals have been obtained which state that Dr. Coyle's opiate dependence is in full remission and the symptoms of his major depressive disorder are also in remission. Those professionals have also opined, and the Investigation Committee has agreed that Dr. Coyle was ready to resume the practice of medicine on March 27, 2012. Since that date, Dr. Coyle has demonstrated that he can do so safely, provided appropriate conditions are in place.

The Inquiry Panel has therefore concluded that a properly informed public will not lose faith in the medical profession's ability to regulate itself if the Joint Recommendation is accepted. Similarly, the Inquiry Panel has concluded that Dr. Coyle is capable of successfully rehabilitating himself and is making sincere and concerted attempts to do so.

The Inquiry Panel recognizes that pursuant to the Joint Recommendation, the Investigation Committee will have full and complete authority to vary the terms and conditions upon which Dr. Coyle shall practice, and that Dr. Coyle shall bear the onus of proving that any variation will be in the public interest. The Inquiry Panel is strongly of the view that any variation whereby Dr. Coyle will be able to prescribe any of the drugs listed in Schedule "A", or any acetaminophen with codeine, or any benzodiazepine, should be preceded by a period of further education in the safe use of opiates and benzodiazepines in practice, according to the most recent Canadian recommendations.

Accordingly, it is the decision of the Inquiry Panel that:

1. Dr. Coyle is hereby reprimanded;
2. Dr. Coyle will be suspended from the practice of medicine for a period of 18 months, deemed to have been served by Dr. Coyle during the time he was out of practice from September 20, 2010 until March 27, 2012;
3. Conditions will be imposed upon Dr. Coyle's entitlement to practice medicine as more particularly set forth in the Resolution and Order of this Panel, issued concurrently herewith and attached hereto;
4. If there is any disagreement between the parties respecting any aspect of The Inquiry Panel Order, the matter may be remitted by either party to a Panel of the Inquiry Committee for further consideration, and the Inquiry Committee expressly reserves jurisdiction for the purpose of resolving any such disagreement;
5. Dr. Coyle must pay to the College costs of the investigation and Inquiry in the amount of \$40,000.00 forthwith;
6. There will be a publication, including Dr. Coyle's name, as determined by the Investigation Committee. The College, at its sole discretion, may provide information regarding this disposition to such a 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. Stephen John Coyle, 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. Stephen John Coyle (Dr. Coyle), 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, Articles 1 and/or 2 and/or 10 and/or 11 and/or 15 of the Code of Conduct of the College, and Statements 148 and/or 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 October 30, 2012;

AND WHEREAS Dr. Coyle was summoned and appeared before an Inquiry Panel (the Panel) of the College with legal counsel on April 25, 2013;

AND WHEREAS an Amended Notice of Inquiry dated October 30, 2012, outlining the charges and particularizing the allegations against Dr. Coyle was filed as an exhibit in the hearing before the Panel;

AND WHEREAS Dr. Coyle 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, including a detailed Statement of Agreed Facts and a comprehensive Book of Documents, heard submissions from counsel for the Investigation Committee of the College and counsel for Dr. Coyle, and from Dr. Coyle himself, and received a Joint Recommendation as to Disposition of the charges and allegations outlined in the Amended Notice of Inquiry;

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

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

- I. Pursuant to Section 56(3) of *The Medical Act* R.S.M., the identities of third parties, and particularly the patients of Dr. Coyle, shall be protected in the record of these proceedings by referring to them in a non-identifying manner.
- II. Dr. Coyle is guilty of professional misconduct, and of contravening By-Law No. 1 of the College, and Articles 1 and/or 2 and/or 10 and/or 11 and/or 15 of the Code of Conduct of the College, and of Statements 148 and/or 805 of the College, and of displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.
- III. Dr. Coyle is hereby reprimanded by the Panel pursuant to Section 59.6(1)(a) of *The Medical Act*;

- IV. Dr. Coyle will be suspended from the practice of medicine for a period of 18 months, deemed to have been served by Dr. Coyle during the time he was out of practice from September 20, 2010 until March 27, 2012 pursuant to Section 59.6(1)(b) of *The Medical Act*;
- V. The following conditions are imposed upon Dr. Coyle's entitlement to practice medicine pursuant to Sections 59.6(1)(e) and 59.6(2) of *The Medical Act*:
1. Subject to paragraph 2 herein, Dr. Coyle must not ingest in any manner whatsoever:
 - a) any drug that is listed in Schedule "A" hereto,
 - b) any acetaminophen with codeine, or
 - c) any benzodiazepine or any alcohol.
 2. If a physician prescribes to Dr. Coyle for medical reasons any of the drugs listed on Schedule "A" hereto, any acetaminophen with codeine or any benzodiazepine:
 - a) Dr. Coyle must ingest the drug only if it is prescribed for medical reasons, and
 - b) Dr. Coyle must instruct the prescribing physician to provide to the College and to the Monitoring Physician within 14 days of the date of the prescription, full particulars of the medical indications for the prescription and of the treatment plan.
 3. Dr. Coyle must not prescribe:
 - a) any drug that is listed in Schedule "A" hereto,
 - b) any acetaminophen with codeine, or
 - c) any benzodiazepine.
 4. Dr. Coyle must comply with the College's program of random body fluid monitoring ("the Program") which Program includes:
 - a) Monitoring by a physician(s) to be appointed by the College;
 - b) Authorization for the monitoring physician(s) and any subsequent monitoring physician(s) to report the results of any analysis to the College;
 - c) Dr. Coyle must submit to all requests for testing with no more than six hours' notice;
 - d) All specimens are to be collected at a place or places designated from time to time by the monitoring physician(s);
 - e) All testing shall follow uniform Department of Transport procedures completed by the designate of the monitoring physician collected under the direct observation of the Monitoring Physician or his/her designate;

- f) Testing shall include all drugs listed on Schedule "A" hereto, acetaminophen with codeine, benzodiazepines and alcohol;
 - g) Dr. Coyle will be required to attend for testing at least 12 times per year;
 - h) Dr. Coyle must not leave Manitoba for a period in excess of 72 hours without notice to the monitoring physician(s). If requested to do so, Dr. Coyle shall submit to testing prior to and upon return to Manitoba;
 - i) Dr. Coyle must pay all costs associated with the Program which will include laboratory services and payment to the monitor physician(s). Dr. Coyle must pay the costs to the College within 30 days of any account rendered to him;
 - j) In the event of a positive test result or in the event Dr. Coyle refuses to provide a specimen when requested to do so, such conduct shall constitute and be deemed to be a breach of these terms and conditions.
- 5. Dr. Coyle must attend the following meetings each and every week:
 - a) Physicians-at-Risk group meetings;
 - b) Alcoholics / Narcotics Anonymous meetings; and
 - c) Any other meetings recommended to Dr. Coyle by his treating physicians.
- 6. Dr. Coyle must continue to attend his psychiatrist, or such other psychiatrist as may be approved in writing by the Investigation Committee, as his treating psychiatrist. Attendance must be in accordance with the frequency of attendance fixed by the Investigation Committee from time to time.
- 7. Dr. Coyle must continue to attend his family physician, or such other physician as may be approved in writing by the Investigation Committee, as his family physician. Attendance must be in accordance with the frequency of attendance fixed by the Investigation Committee from time to time.
- 8. Dr. Coyle must continue to attend his specialist in addiction medicine, or such other specialist in addiction medicine as may be approved in writing by the Investigation Committee, as his specialist in addiction medicine. Attendance must be in accordance with the frequency of attendance fixed by the Investigation Committee from time to time.
- 9. Dr. Coyle must comply with the treatment prescribed by his treating psychiatrist, his specialist in addiction medicine and/or his family physician for the continuing management and monitoring of his addiction.
- 10. If Dr. Coyle's treating psychiatrist, specialist in addiction medicine and/or family physician advises him to restrict, suspend or cease the practice of medicine for a temporary or intermittent period, Dr. Coyle must comply with that direction subject to his right to take issue with it as set out in paragraph 11 herein.

11. In the event that Dr. Coyle disagrees with any direction referred to in paragraph 10 herein, he must give written notice of his objection to the College whereupon the College will appoint an independent psychiatrist to whom Dr. Coyle must attend. Any direction given to Dr. Coyle by his family physician, specialist in addiction medicine or treating psychiatrist in accordance with paragraph 10 shall continue unless the independent psychiatrist appointed by the College determines that Dr. Coyle is fit to safely practice medicine without the restriction imposed pursuant to paragraph 10 herein.
12. Dr. Coyle's practice must be restricted to clinical practice at the Crestview Clinic and must be in accordance with the plan approved by the Investigation Committee from time to time.
13. Dr. Coyle must not change his practice location without the prior written consent of the Investigation Committee and he must not practice at any location which has not been approved by the Investigation Committee in writing prior to any practice at the location.
14. Dr. Coyle must not provide care to any patient with chemical dependence or a substance abuse disorder. To comply with restrictions on prescribing certain medication and on caring for patients with dependency issues, Dr. Coyle will ensure that front staff are advised that no patients should be directed to him if they indicate on presentation that their care would involve one of the restricted prescriptions or care related to the restricted conditions. If Dr. Coyle inadvertently attends upon a patient who is requesting or who might appropriately require a restricted prescription, if no reasonable alternative prescription is available, or if it is revealed in the patient history or otherwise that the patient has or may have one of the restricted conditions, Dr. Coyle will not provide any medical care or advice and will bring the patient to the waiting room so that the patient could be seen by another physician within the Clinic. That patient would thereafter not be scheduled to attend upon Dr. Coyle.
15. Dr. Coyle must create a complete and accurate record of each patient encounter in accordance with the requirements of By-Law No. 1 of the College. Without limiting the generality of the foregoing, for each prescription written by Dr. Coyle, he must fully document the patient's history, his examination, any investigation ordered, his diagnosis and his treatment plan.
16. Dr. Coyle must practice under the supervision of an on-site physician supervisor acceptable to the Investigation Committee who must:
 - a) On a monthly basis, until otherwise directed by the Investigation Committee, review Dr. Coyle's chart entries from a minimum of 15 charts selected by the Practice Supervisor, without input from Dr. Coyle as to the chart's selected, in addition to any specific charts identified by Dr. Coyle in respect to which he is seeking his Practice Supervisor's advice, guidance or instruction, and discussing with him with the patient care provided, and providing advice, instructions or guidance as to the proper management of the patients;
 - b) Document any advice or instructions provided to Dr. Coyle.

17. The requirement for on-site supervision does not prohibit Dr. Coyle from practising if his Practice Supervisor is temporarily unavailable during the day for period of not more than two hours (e.g. for lunch, personal errands, etc.).
 18. Payment for the services of the Practice Supervisor shall be Dr. Coyle's responsibility.
 19. Dr. Coyle will not, without the prior written consent of the Investigation Committee:
 - i. engage in any research, teaching or lecturing;
 - ii. take after hours call services and will not make house calls;
 - iii. employ any clinical assistants, nurse practitioners or other individuals to assist him with assessment and treatment of his patients.
 20. Dr. Coyle will restrict his volume of services in accordance with a practice plan which must be approved by the Investigation Committee.
 21. If Dr. Coyle wishes to change practice locations or if Dr. Coyle wishes to change his practice arrangement, he must provide a copy of these terms and conditions to:
 - a) The Chief Medical Officer of any Regional Health Authority where he applies for privileges;
 - b) The supervisor or chief executive officer at any facility or business whatsoever where he obtains employment or acts as an independent contractor, and
 - c) Any physician with whom he proposes to enter a practice arrangement, whether as a partner, associate or otherwise.
 22. The Investigation Committee shall continue to monitor Dr. Coyle's practice of medicine, including his compliance with the conditions herein.
 23. The Investigation Committee shall have full and complete authority to vary these terms and conditions, provided that the onus is on Dr. Coyle to prove that variance is in the public interest.
 24. Dr. Coyle shall pay any and all costs arising from or incidental to the conditions described herein and the monitoring by the Investigation Committee described in paragraph 22.
- VI. If there is any disagreement between the parties respecting any aspect of The Inquiry Panel 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.

- VII. Dr. Coyle must pay to the College costs of the Investigation and Inquiry in the amount of \$40,000.00, on the basis of an agreement between Dr. Coyle and the College as to the amount of the costs, payable in full by certified cheque or Dr. Coyle's lawyer's firm's trust cheque on or before the date of the Inquiry pursuant to Section 59.7 of *The Medical Act*.
- VIII. There will be publication, including Dr. Coyle'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 pursuant to Section 59.9 of *The Medical Act*.

DATED this 6 day of August, 2013.

CENSURE: IC2090 – MR. CHRISTOPHER WESTBROOK MANCUSO

On December 4, 2013, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Mr. Mancuso 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

Medical students are members of the College and are required to conduct themselves with the same professionalism and high standard of ethical behaviour expected of physicians. Attempts to mislead through the creation of false documents and forged signatures reflect a lack of honesty and integrity and, as such, are egregious breaches of the ethical and professional standards expected of medical students.

II. THE RELEVANT FACTS ARE:

2. At all material times, Mr. Mancuso was a fourth year medical student at the Faculty of Medicine, University of Manitoba, and enrolled on the Educational Register of the College.
3. As part of his medical education, Mr. Mancuso was scheduled to participate in an Emergency Medicine elective during the period April 2 to April 20, 2012, consisting of 13 shifts at the Health Sciences Centre Emergency Department.
4. Mr. Mancuso attended the first shift of the Emergency Medicine rotation, but did not attend any of the remaining 12 shifts.
5. On or about April 27, 2012, Mr. Mancuso completed 11 end-of-shift feedback and evaluation forms for his Emergency Medicine elective, forged the signatures of physicians on the said forms and submitted the said forms to the Undergraduate Medical Education office.
6. Mr. Mancuso was scheduled to graduate on May 10, 2012.
7. On or about May 7, 2012, for the purpose of preparing his Final In-Training Evaluation Report on the Emergency Department elective, one of the physicians whose signature Mr. Mancuso had forged reviewed the end-of-shift feedback and evaluation form Mr. Mancuso had created and reported that the signature on that form was not his signature and the comments were not his comments. As a result, the Undergraduate Program Director reported the matter to the Associate Dean, Undergraduate Medical Education.
8. Mr. Mancuso did not reveal his actions in relation to the end-of-shift feedback and evaluation forms to anyone until he was notified of the concerns on May 7, 2012 by the Undergraduate Program Director.

9. On May 8, 2012 Mr. Mancuso's graduation was suspended pending investigation.
10. On May 8, 2012 Mr. Mancuso sent an e-mail to the Associate Dean, Undergraduate Medical Education in which he admitted the forgeries, and stated: Besides medicine, in medical school I learned to lie, cheat and steal, but, I don't want to be a coward too.
11. At a meeting with the Associate Dean, Undergraduate Medical Education on May 11, 2012, Mr. Mancuso expressed his remorse. By e-mail dated May 11, 2012 Mr. Mancuso stated that the May 8th e-mail was written in a "moment of crisis" and was not a reflection of his true intentions.
12. On or about June 26, 2012, the Dean of the Faculty of Medicine imposed disciplinary action on Mr. Mancuso, as follows:
 - a. Permanent expulsion from the Faculty of Medicine;
 - b. Failing mark in the Emergency Medicine elective;
 - c. Expulsion and failure to appear to Mr. Mancuso's permanent academic record; and
 - d. Notification to the College.
13. Mr. Mancuso admitted the conduct, but appealed the Dean's decision as to disciplinary action arising from that conduct. On August 1, 2012 the Faculty of Medicine Student Appeals Committee upheld the Dean's decision on disciplinary action. On September 28, 2012, the University Discipline Committee upheld the Dean's decision on disciplinary action.
14. In Mr. Mancuso's meeting with the Investigation Chair, he:
 - b. acknowledged that it was unprofessional not to have attended for the Emergency Department shifts;
 - c. described his decision to submit the forged documents as a panicked decision which arose when he was informed on April 26 that if he submitted those forms he could graduate with his classmates rather than defer graduation as he had expected would occur;
 - d. stated that he realized on April 27, 2012 that what he had done was wrong and he attempted to retrieve the forms, but the Undergraduate Medical Education office had already sent them for processing;
 - e. stated that after April 27, 2012 he did not take further steps to intercept the documents or report what he had done as he feared the repercussions and felt guilty about his actions;
 - f. expressed remorse for his actions.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE NOTED THE PENALTY IMPOSED UPON MR. MANCUSO THROUGH THE DEAN'S DISCIPLINARY ACTION, UPHELD ON APPEALS, AND RECORDS ITS DISAPPROVAL OF MR. MANCUSO'S CONDUCT IN:

1. completing 11 end-of-shift feedback and evaluation forms for his Emergency Medicine elective, forging the signatures of physicians on the said forms and submitting the forms to the Undergraduate Medical Education office, and
2. despite having recognized that his actions were wrong, failing to promptly report what he had done and take responsibility for his actions.

Mr. Mancuso paid the costs of the investigation in the amount of \$2,080.00

CENSURE: IC2185 - DR. RICHARD LLOYD LETKEMAN

On January 30, 2014, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Letkeman 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

Physicians are expected to be familiar with the terms and conditions which must be met in order to be entitled to payment for a patient house call visit and must not permit bills for patient visits to be submitted to Manitoba Health if all applicable terms and conditions are not met. Physicians who rely on clinic owners or staff to submit bills using the physician's billing number must exercise due diligence by taking all available reasonable steps to ensure that all applicable terms and conditions are met before submitting a bill for a service.

A physician who assumes responsibility for the care of a patient in a house call service is responsible for the record in relation to the care provided. When a nurse involved in patient care under the physician's supervision creates the record, the record must reflect the physician's involvement and the physician is responsible to sign off on the care provided.

II. THE RELEVANT FACTS ARE:

The Committee assessed the facts as follows:

1. In or about November 2010, Dr. Letkeman entered into an arrangement with a nurse practitioner and with the clinic in which they both worked. The arrangement included the following:
 - a. Dr. Letkeman agreed to supervise the nurse practitioner's care of patients during house call visits.
 - b. For the purposes of the supervision, the nurse practitioner had the use of a mobile, hand-held camera intended for use at the patient's location, and Dr. Letkeman had access to a computer based application on a computer at the clinic. When activated, this camera system permitted Dr. Letkeman to see and hear what was occurring at the patient's location. Communication between Dr. Letkeman and the nurse practitioner while the nurse practitioner was at the patient's location would occur via cell phone.
 - c. Dr. Letkeman was not required to be present via the camera system for the nurse practitioner/patient encounters which Dr. Letkeman was supervising.

- d. Dr. Letkeman was required to be available when the nurse practitioner contacted him for assistance because the nurse practitioner had a question or a concern about patient care.
 - e. The nurse practitioner was responsible for making a record of the visit, using the electronic medical record used by the clinic for house calls.
 - f. The patient visits were billed to Manitoba Health using Dr. Letkeman's billing number.
 - g. Fees for the nurse practitioner/patient visits which Dr. Letkeman was responsible to supervise were split 70% to the nurse practitioner and 30% to Dr. Letkeman, and each of them were responsible to pay the clinic for overhead expenses.
2. Dr. Letkeman did not place any restrictions on the type of patient or type of health concern which the nurse practitioner could deal with during the visits for which Dr. Letkeman assumed responsibility, although Dr. Letkeman did instruct the nurse practitioner to immediately contact him if the nurse practitioner attended to any condition which the nurse practitioner believed was serious or required additional advice or assessment.
 3. The camera system was used on the first day of Dr. Letkeman's arrangement with the nurse practitioner on about two occasions in the clinic setting as a test for the purpose of demonstrating to Dr. Letkeman that it would work. However, thereafter, it was never actually used in a patient house call during the entire period of time Dr. Letkeman supervised the nurse practitioner's work.
 4. Dr. Letkeman did remain available to the nurse practitioner via telephone contact. However, the nurse practitioner did not request Dr. Letkeman's assistance at all during the period of time he was supervising the nurse practitioner.
 5. The nurse practitioner did make records of the house call visits which Dr. Letkeman was responsible to supervise.
 6. At the outset of the arrangement, Dr. Letkeman did view some of the records created by the nurse practitioner for the purpose of monitoring the quality of care provided by the nurse practitioner, but these were charts selected by the nurse practitioner for review. At no time did Dr. Letkeman review all of the records of the nurse practitioner's patient care for which Dr. Letkeman had assumed responsibility.
 7. None of the records of the nurse practitioner/patient encounters for which Dr. Letkeman was responsible contain any indication of Dr. Letkeman's involvement in the care or any indication that Dr. Letkeman had reviewed the record and signed off on the care provided.
 8. Dr. Letkeman continued with the arrangement described above until in or about April 2011, when he became aware that Manitoba Health was conducting an investigation into billings for the visits made by the nurse practitioner.
 9. During the period from approximately November 2010 to April 2, 2011 a total of approximately \$39,055.54 was billed to Manitoba Health using Dr. Letkeman's billing number for visits to patients by the nurse practitioner.

10. In an interview with the Investigation Chair, Dr. Letkeman stated that:

- a. At the material time, Dr. Letkeman was aware that one requirement for billing Manitoba Health was that the physician personally see the patient.
- b. Dr. Letkeman relied upon assurances from the clinic owner that if the bills in question were challenged, the clinic owner would succeed in a dispute with Manitoba Health.
- c. Dr. Letkeman's only independent inquiry as to the propriety of the billing system for the nurse practitioner's house call visits was one telephone call to someone at Manitoba Health to ask if Manitoba Health had policies governing billing for the work of a nurse practitioner. When told there were no such policies, Dr. Letkeman made no further inquiries of Manitoba Health or anyone else.
- d. In retrospect, Dr. Letkeman recognizes that the documents filed with Manitoba Health for billing purposes would lead Manitoba Health to believe Dr. Letkeman saw the patients in that there was no indication to Manitoba Health that he did not see the patients.
- e. Dr. Letkeman was familiar with the nurse practitioner's quality of care from past work with the nurse practitioner in the clinic setting and he believed that the nurse practitioner was competent to provide the house call services.
- f. In retrospect, Dr. Letkeman recognizes that it was inappropriate for him not to have documented his role in the care of the patients seen by the nurse practitioner, at least by signing off on the records created by the nurse practitioner.
- g. Dr. Letkeman takes full responsibility for his actions.

11. Dr. Letkeman has repaid Manitoba Health the sum of \$39,055.54.

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

1. failing to exercise due diligence to ensure that billings submitted for patient visits under Dr. Letkeman's billing number met all of Manitoba Health's terms and conditions applicable to billing for those patient visits.
2. permitting claims to be submitted to Manitoba Health for services as if Dr. Letkeman had provided the services, when in fact the services were provided by a nurse practitioner.
3. failing to maintain patient records with respect to Dr. Letkeman's supervision of a nurse practitioner.

Dr. Letkeman paid the costs of the investigation in the amount of \$6,974.60.

