From the College

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

In this Issue . . . .

From Your President

DR. ALEWYN VORSTER

I hope everyone had a healthy and meaningful introduction to 2016 with their family and friends and are enjoying the glorious May weather as much as I am.

At the College of Physicians and Surgeons of Manitoba (CPSM), projects are continuously in motion. As your President, I want to take the time to thank all the Members and Councillors for the quality and quantity of feedback we received during recent consultations and collaborations in regard to current and significant issues. It genuinely facilitates appropriate decision making to move forward, if we have a true understanding of how our peers and colleagues perceive certain changes, which are looming over our profession. Some issues are mandated and we have to find the most seamless way in which to incorporate them into our system. Other issues are driven by the profession itself in order to enhance the quality of our service.

At the December 2015 Council meeting, CPSM replaced the previously well-known Statements and Guidelines system with By-Law #11. Mandatory Standards of Practice and Practice Directions are now featured in By-Law #11. Therefore, it is important for all members to read and understand the new By-Law #11, which is available on the CPSM website. There are significant differences between the old and new system. Many of these changes were made in anticipation of *The Regulated Health Professions Act* (RHPA) coming into force with respect to the CPSM. Council has also decided, after serious deliberation, that a two year presidential term would be more beneficial for the CPSM. This change was also implemented at the Council meeting in December 2015. It is my honour and privilege to serve you and our profession as the first President of CPSM with a two year term.

Since the Supreme Court of Canada decided in February of 2015 that Physician Assisted Death (Now referred to as Medical Assistance in Dying "MAID") would no longer be illegal, an enormous amount of work has gone into the creation of the College's Standard of Practice for MAID. It is found in Schedule M of By-Law #11, which is available on the CPSM website. The drafting of this new standard was made more challenging as it had to happen in a legislative void. The Supreme Court's declaration of invalidity of the relevant Criminal Code provisions was suspended until February 6, 2016 and then extended again to June 6, 2016, to allow time for legislation to be enacted. Currently CPSM is awaiting the enactment of the proposed federal legislation which addresses the situation once the Criminal Code provisions become invalid on June 6, 2016. The CPSM will need to evaluate if the Schedule needs to be amended once legislation is enacted.

Statement 190 – Afterhours care was not incorporated into By-Law #11 as it was decided to create a second working group to provide additional feedback on after hours/holiday urgent care. The membership of this Phase II working group is in the process of being finalized. In the initial consultation the specialists group was not significantly represented. I would like to thank the specialist group for the huge number of responses to the request for specialist physicians who were willing to serve on this new working group. It is once again wonderful to see how much physicians care to be involved in improving our system. Professionalism is the key word in this context. I would also like to say thank you very much to the physicians who are already providing this service.

With the political elections this spring, the work on the Regulated Health Professions Act related to CPSM has slowed down, but we expect it will become a major focus again once the new Minister of Health becomes familiar with the health portfolio.

One of the bold new directions CPSM is moving further into is CPD - Continuing Professional Development. As our profession changes and evolves, we as individuals bear the responsibility to stay current and up to date. This is crucial for the development of both our skill sets and confidence. With integrated competency comes the experience and increased capability in our chosen fields. We have many options for advancement, be it from formal courses, conferences, internal learning opportunities, peer review or simply reading material found on the Internet. This teaches us to admit and improve upon our weaknesses and focus on our strengths. Our career fields are broad, however mentors and leaders are to be found everywhere, helping us to achieve our personal goals and hone our 'people' skills. We learn to deliver good and bad news with empathy and reflection while our growing depth of knowledge allows us to ever raise the bar in the service of our profession.

Technology is advancing so swiftly that it seems that every day new doors open to enhance and improve all aspects of care from diagnostics to treatments. We are indeed living in exciting and privileged times. While striving to keep challenging ourselves, we should remember that all work and no play makes for dull human beings. Work life balance is an important component of quality care. Mark Twain said, "Whenever you find yourself on the side of the majority, it is time to pause and reflect". As long as we remember to keep reflecting and sharing our input, we will grow and develop; and if we remember to laugh, we will grow older, while keeping our perspective healthy.

I wish you all a pleasant summer and great personal and professional development in the next few months.

Sincerely yours
Alewyn Vorster, MBChB CCFP

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Notes from the Registrar

Council Elections

There have been a number of elections over the last couple of months for council members as well as a public representative. Some councillors were re-elected and some are new.

The elected councillors are:

Eastman	Dr. Nader Shenouda
Westman	Dr. Alewyn Vorster
Brandon	Dr. Stephen Duncan
Winnipeg	Dr. Heather Domke
	Dr. Candace Bradshaw
	Dr. Florin Padeanu
	Dr. Jose Silha
Public Representative	Ms Priti Shah

I would like to congratulate the new councillors and I look forward to working with them for the next four years.

I would also like to thank the outgoing councillors, Dr. Brent Kvern, Dr. Helmut Unruh and Dr. Michael Boroditsky, for all their hard work and dedication to the College and the public.

On-Line Licence Renewals

License renewal time is fast approaching and I want to remind members that again this year the College is requiring on-line renewal.

National Application

The College is preparing to launch a new application process through physiciansapply.ca. This new process will require applicants who wish to apply for registration with the CPSM to have a physiciansapply.ca account.

Starting November 1, 2016 physicians applying for full or conditional registration will be directed to physiciansapply.ca to complete the online "Application for Medical Registration".

Medical Assistance In Dying (MAID) formerly Physician Assisted Dying

On April 14, 2016 the federal government introduced its proposed legislation on Medical Assistance in Dying (MAID) (Bill C-14). The shift in terminology from "physician assisted dying" in the proposed legislation was made for the following reasons:

1. Assistance in dying would only be legally permitted in a medical context.
2. The word "medical" as opposed to "physician" indicates that medical professionals other than physicians could provide medical assistance in dying, specifically nurse practitioners.
3. The words "in dying" suggest that eligibility would be limited to patients who are dying, i.e., nearing a natural death, without requiring a specific life expectancy.

The CPSM believes that it is appropriate that the proposed legislation addresses the fact that it is not only physicians who are involved in providing MAID. The legislation appears to provide protection from criminal prosecution to physicians and other healthcare providers who become involved. The concept of limiting MAID to patients who are nearing a natural death without requiring a specific life expectancy is more problematic. The proposed legislation defines "grievous and irremediable medical condition" in a manner that appears to require that only a patient who can establish that there is some causal or time related link between the patient's medical condition and the patient's expected natural death is eligible for MAID. Exactly what is meant by the words "their natural death has become reasonably foreseeable" in the definition may require clarification. We anticipate that this and other issues will be addressed through debate in Parliament before there is a vote on the legislation. It should also be noted that Bill C-14 does not allow for advance care directives for MAID and limits the availability of MAID to adults. These issues will also be the subject of substantive debate before the legislation is finalized.

The CPSM will be monitoring the activities in parliament and at the provincial government level to ensure that CPSM's Standard of Practice (Schedule M to By-Law #11) will align with whatever legislation is ultimately passed with respect to the delivery of MAID in Manitoba at both the federal and provincial levels. In the meantime, the College will continue to engage dialogue and work with stakeholders.

June 6, 2016, or until there is legislation in place (whichever is earlier), patients who seek MAID must continue to submit an application to the Courts. The CPSM has not been involved and does not anticipate becoming involved with individual applications. The CPSM Standard of Practice is known to the Court, the Department of Justice and physicians.

Links to Bill C-14 and detailed information on the proposed legislation follow:

http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8183660

http://www.justice.gc.ca/eng/cj-jp/ad-am/index.html

Federation of Medical Regulatory Authorities of Canada (FMRAC)

I, along with some other staff members, will be attending the FMRAC Annual General Meeting in June. The conference theme this year is "*Unravelling the Knot – Medical Regulation and the Opioid Crisis"* and *"Medical Aid in Dying".* Both topics are critically important to our members and the public.

Proposed change to By-Law #11 Section 24 – Method of Prescribing M3P Drugs

The College has a Joint statement (Section 24 of By-Law #11) on "Facsimile Transmission of Prescriptions" with the following:

- The Dental Association of Manitoba;
- The Manitoba Veterinary Association;
- The College of Registered Nurses of Manitoba; and
- The College of Pharmacists of Manitoba.

Currently By-Law #11 provides:

A. Method of Prescribing M3P Drugs

24 Medications which must be prescribed using a Manitoba Prescribing Practices Program (M3P) prescription may not be sent via facsimile transmission, except when the prescription is for a resident of a personal care home.

The College is communicating with all the signatory organizations describing a proposed change to the practice for the limited purpose of prescribing **methadone and suboxone for maintenance purposes only**. We are advising them that the CPSM will be asking its Council to amend the CPSM By-Laws #5 and #11 to permit this change. Conditional on the CPSM Council approving this change, we are asking the signatories to this Joint Statement to approve an amendment to the existing Joint Statement on "Facsimile Transmission of Prescriptions" for this limited purpose. The proposed amendment would allow a prescription for methadone or Suboxone to be sent via fax providing it is solely for the purposes of a maintenance program.

This is an important proposed change that will benefit patients in rural Manitoba as they will have easier access to the care they require when it comes to addictions. Please forward any feedback you may have on this issue to the Registrar at TheRegistrar@cpsm.mb.ca. All feedback received will be taken into consideration.

Arrangements for Expected Death at Home Update

When the College replaced the former Statements and Guidelines with the now enacted By-Law #11, we removed the Guideline "Arrangements for Expected Death at Home" as it was very out of date, especially the clinical components. A working group is looking at pulling together current information for healthcare providers. In the meantime, as there have been a number of inquiries, we have uploaded some information from the former Guideline, except for the clinical, until a new resource is available. Please be aware that this information is not current but will give you an idea of the forms and agencies to contact to assist you with an expected death at home. The document can be found at:

http://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/Death%20at%20Home%20Document.pdf

Newsletter – Format and Content

Here at the College we have been attempting to keep you informed about the happenings both inside and outside of the College, as well as information from other organizations, on issues/changes that affect our members.

Now I would like to hear from you!

I would appreciate any suggestions regarding topics or issues of concern that you feel would be beneficial, informative, and of interest to members.

Please provide any feedback/suggestions you may have for the newsletter or other means of communication to the Registrar at TheRegistrar@cpsm.mb.ca.

I hope you all have a wonderful summer!!

Anna M. Ziomek, MD
Registrar/CEO

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College of Medicine
Faculty of Health Sciences

UNIVERSITY OF MANITOBA

Message from
Brian Postl, MD FRCPC
Vice-Provost (Health Sciences)
Dean, Faculty of Health Sciences
University of Manitoba

The last few months have been exciting at the Bannatyne campus and for the University of Manitoba's Front and Centre campaign following the announcement of a transformational gift from the provincial government.

In January, the Bannatyne campus hosted the historic funding announcement by the Manitoba government in support of the university so students can study and conduct research in state-of-the-art facilities. This generous investment of $120 million will support the critical places and space pillar of the U of M's $500 million fundraising campaign.

There is no doubt this funding will have major impact for our campus and the surrounding community for generations to come. Part of this funding will go towards the construction of the new Inter-Professional Health Education Complex at the Bannatyne campus. This new building will consolidate health researchers across the U of M into one space and serve as a catalyst for inter-disciplinary research and innovation in public health.

This new centre will also see the college of nursing join the colleges of medicine, dentistry, pharmacy, rehabilitation sciences and other health-care programs in a single location. The College of Rehabilitation Sciences' respiratory therapy program – currently located at the Health Sciences Centre – will also be relocated to Bannatyne campus.

This new physical environment will foster inter-professionalism by bringing learners and faculty members and researchers from multiple disciplines together to explore innovative solutions. It strengthens U of M's capacity to educate and train our health-care providers and bolster our ground-breaking research and will lead to higher quality patient care.

While we're excited and grateful about new buildings and facilities, we never lose sight of the people. We currently accommodate approximately 2,000 students and 1,600 faculty and staff. This is a large population with varied needs and this support will allow the university to meet these needs.

This generous investment will usher in an exciting and transformative era for the Faculty of Health Sciences and the University of Manitoba.

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The Medical Examiner's Corner

CPSM continues to attend regular Adult Inquest Review Meetings at the Medical Examiner's Office.

It has come to the College's attention that some Manitoba Physicians are prescribing fentanyl patches to opioid naïve patients and/or to patients with inadequate tolerance to other opioids prior to being switched to fentanyl.

Fentanyl patches should **never** be prescribed to **opioid naïve patients**. Fentanyl patches should **never** be used for acute pain management or the management of post-operative pain. Fentanyl patches are also contraindicated in mild pain or intermittent pain (prn use).

Fentanyl patches should **only** be prescribed to patients who have chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment, not well controlled with shorter-acting analgesics and who have demonstrated **adequate opioid tolerance.**

Physicians should consult opioid conversion tables to assist in safely switching patients to an appropriate fentanyl transdermal dose based on pre-existing opioid doses that the patient has been taking**.** An example of such a conversion table can be found as part of the "Opioid Manager", a valuable practice tool when it comes to prescribing opioids. See:

http://nationalpaincentre.mcmaster.ca/documents/opioid_manager_switching_opioids.pdf

Overestimating the fentanyl dose, when converting patients from another opioid analgesic, may result in fatal overdose with the first dose of fentanyl.

Many factors influence an individual patient's risk for opioid toxicity. In general, 60 – 134 mg of morphine is considered equivalent to a 25 mcg/h transdermal fentanyl patch. With a dose reduction of 25-50% for presumed incomplete cross tolerance, that means that an adult patient needs to demonstrate tolerance to at least 37 – 45 mgs of morphine equivalent per day for a 12 mcg fentanyl patch and 75 – 90 mgs of morphine equivalent for a 25 mcg fentanyl patch.

Physicians who are prescribing the fentanyl patch should ensure that their patients and their caregivers understand important safety information about this powerful medication.

A summary of the **Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain** and more useful practice tools may be found at:
http://nationalpaincentre.mcmaster.ca/documents/practicetoolkit.pdf

Marina Reinecke MD
Medical Consultant

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The Use of Suboxone in the Treatment of Opioid Addiction

Suboxone is a sublingual tablet used in the treatment of opioid use disorder (opioid addiction). This is an alternative to methadone for patients who can benefit from opioid replacement therapy. Most patients with diagnosed opioid use disorder have improved outcomes with opioid replacement therapy when compared to abstinence-based detox and treatment approaches.

Suboxone is a combination of buprenorphine (a partial opioid agonist) and naloxone (an opioid antagonist). The latter has negligible bio-availability with sublingual administration, but acts as a deterrent to intravenous use.

Suboxone is becoming increasingly popular in the treatment of opioid use disorder due to its increased safety in an overdose situation (decreased risk for respiratory depression due to its unique pharmacology) and favorable side effect profile. It is under part 3 EDS and patients therefore have to meet criteria to qualify for Pharmacare coverage. In some cases methadone may still be the only treatment option that is covered by Pharmacare.

Suboxone is prescribed in large clinics dedicated to opioid replacement therapy services, but also by family physicians as part of their community clinic or private practices.

Special permission is required to prescribe Suboxone and physicians may contact the CPSM at KSorenson@cpsm.mb.ca for more information regarding the training and approval process. Training is free and usually occurs on a monthly basis.

Marina Reinecke MD
Medical Consultant

Practice Address

It is important that if you are changing your practice location you must notify the College immediately so that your College records and Physician Profile can be updated and current. You can email your change of location to cpsm@cpsm.mb.ca.

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Choosing Wisely Manitoba

An update to the College of Physicians and Surgeons of Manitoba – November 2015

More is not necessarily better when it comes to health care treatment. Unnecessary tests, treatments and procedures undermine our ability to provide care by potentially exposing patients to delays and even unintended harm; unnecessary testing takes away resources from our health care system that are required for new and improved diagnostics. This issue is a global phenomenon with many jurisdictions beginning to realize the importance of appropriate testing guidelines and the need for information and leadership to help address the growing volume of test requests.

In early 2014 Diagnostic Services Manitoba partnered with the George and Fay Yee Centre for Healthcare Innovation (CHI) to form Choosing Wisely Manitoba (CWM), an initiative to improve health outcomes, patient and provider experiences as well as health system efficiencies and sustainability.

CWM is focusing on a number of projects where there is an opportunity, specific to Manitoba, to improve the appropriate use of diagnostic testing in our province by reducing tests, treatments and procedures that evidence overwhelmingly shows, provide no benefit to patients. The initiative's executive co-sponsors are Jim Slater, DSM Chief Executive Officer, Dr. Brock Wright, Senior Vice President of Clinical Services and Chief Medical Officer of the Winnipeg Regional Health Authority and Dr. Eric Bohm, Director, Health Systems Performance with CHI.

CWM is counted among the Early Adopters of Choosing Wisely Canada. Over the past two years efforts have focused on the information and processes needed to challenge test practices and to move toward a model where tests are more appropriately ordered. By engaging key stakeholders in CWM, such as the College of Physicians and Surgeons of Manitoba, we hope to create a culture among primary care and specialty physicians that will facilitate adoption of the growing list of recommendations for increasing the appropriate use of diagnostic testing.

With the groundwork laid, CWM Project teams are now focused on several initial Choosing Wisely recommendations, such as increasing appropriate use of Vitamin D testing and preoperative diagnostic testing. Vitamin D test volumes have grown dramatically in recent years with an estimated 90% of testing completed on patients where there is no medical indication. An intervention strategy to address this sharp increase has been developed and includes new guidelines for Vitamin D testing criteria and Vitamin D specific ordering requisition, to be distributed in the coming months. Adoption

of the guidelines and form could result in the redirection of up to $800,000 to other critical diagnostic areas. CWM is committed to supporting physicians in 'choosing wisely' with their patients, ensuring that Vitamin D tests ordered are medically indicated. This includes a physician/patient toolkit with awareness and education materials.

The preoperative diagnostic testing project targets the highest volume surgical specialties of Ophthalmology, Orthopedic and General Surgery. These three specialties account for 70% of unnecessary preoperative tests. We are developing strategies to ensure the sustainable implementation of standardized, evidence-informed clinical practice guidelines that will reduce unnecessary surgery delays, reduce patient inconvenience and discomfort and avoid stressful 'false positive' results that could potentially result in further unnecessary investigation. A 25% reduction of unnecessary preoperative diagnostic testing will result in savings of approximately $400,000 that can be repurposed to more appropriate areas of health care. Extensive stakeholder consultations have taken place and a revised Cataract H&P form that supports the guidelines has been implemented. Next steps include a user evaluation of the new form, standardization of the orthopedic surgeon preoperative package and revision of preoperative diagnostic testing guidelines.

Future planned projects of Choosing Wisely Manitoba include D-Dimer/Imaging for DVT and PE, imaging for lower back pain, imaging for headache and head pain and fecal occult blood tests (FOBT).

Choosing Wisely Manitoba is seeking the support of the College of Physicians and Surgeons of Manitoba to advocate for the importance of appropriate use of diagnostic testing and assist with communication and engagement among your membership, who are key stakeholders in the success of CWM initiatives. As a supportive partner, CPSM can contribute to the growing awareness and momentum for CWM by sharing our messages through communication vehicles such as your newsletter and website. Together we can influence important change in our health system for the benefit of Manitoban patients.

The November 2016 update can be found via this link: November 2015 Project Update
Links to the Choosing Wisely websites are - Choosing Wisely Manitoba - Choosing Wisely Canada

Need Assistance?

PHYSICIANS AT RISK

Phone 204-237-8320 (24 hours)

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Inflectra™

Biologics are medicinal products created using biologic processes in living cells. The more common small molecule drugs, typically delivered in oral form, are chemically synthesized. Biologics are complex, large molecule drugs manufactured using live cells and are generally administered as an injectable. Biologics provide new treatment options for serious illnesses, such as cancer, multiple sclerosis, and rheumatoid arthritis, and have enabled treatment where no effective therapies were previously available.

Subsequent Entry Biologics (SEBs), also known as "biosimilars" or "follow-on biologics" in Europe and the USA, are follow-on versions similar to an original biologic drug. SEBs are sometimes mistakenly called "generic" versions of innovative biologics. Unlike generics, which are identical copies of chemically synthesized drugs, SEBs are similar to, but not identical to the original innovator drug. This is due to the inherent complexities of large molecule drugs and their manufacturing process.

The high cost of biologics has created a demand for SEBs as a cost-saving alternative. Biologics are expected to represent 20% of the pharmaceutical market over the next decade; this will result in significant financial pressure on health care budgets.

Inflectra™ is a subsequent entry biologic (SEB) or "biosimilar" version of infliximab based upon the reference product Remicade®. It was approved by Health Canada and supported by the national Common Drug Review for the indications stated below based upon data demonstrating similarity and no meaningful differences compared to the reference product.

In Manitoba, Remicade for all indications was the top drug expenditure in the past year. Through national price negotiations, public drug plans negotiated a significantly lower public list price for Inflectra which allows savings to be invested into other health priorities.

Effective April 18, 2016, Manitoba Health, Healthy Living and Seniors is pleased to announce that it will cover infliximab (Inflectra™) for the treatment of eligible rheumatology and dermatology indications according to the existing Exception Drug Status (EDS) criteria.

As of the effective date of the Bulletin (April 18, 2016), all initial EDS requests for coverage of infliximab for ankylosing spondylitis, psoriatic arthritis, plaque psoriasis and rheumatoid arthritis received will be approved for the Inflectra brand of infliximab only. The Remicade brand of infliximab will not be approved for new infliximab starts for patients with these conditions as of this date.

Coverage of the Remicade brand of infliximab will continue for patients previously approved for Pharmacare coverage of Remicade; they will also be eligible for coverage of the Inflectra brand should they choose to switch.

When the Inflectra brand is desired, please specify "Inflectra" on the prescription to allow the

pharmacy to dispense this specific formulation.

If you have questions about how Inflectra can be obtained, infusion sites or the patient support program for Inflectra, please contact:

Claudia Watson
(Navigator for Manitoba)
Email cwatson@innomar-strategies.com
Program Call Center Phone: 1-844-466-6627
Program Call Center Fax: 1-844-295-0219

For information on Health Canada's decision, please see the Summary Basis of Decision available at http://www.hc-sc.gc.ca/dhp-mps/prodpharma/sbd-smd/drug-med/sbd_smd_2014_inflectra_159493-eng.php

For Common Drug Review's review and recommendation, please see https://www.cadth.ca/infliximab-18

Exposure to Lead (Pb) at Firing Ranges

Recently, Public Health and Workplace Safety and Health have become aware of a risk of lead exposure in firing ranges due to lead in ammunition. High blood levels have been identified in several people working or shooting at the ranges in Manitoba. These blood lead levels were well in excess of the current blood lead guideline level of < 0.48 umol/L (10ug/dL). The mean Canadian blood lead level is 0.05 umol/L (1.1 ug/dL).

Firing ranges in Manitoba have received an information package to assist them in reducing lead exposure and have been requested to distribute a fact sheet to range workers and users. This fact sheet is available at http://www.gov.mb.ca/health/publichealth/factsheets/leadfiringranges.pdf

A person acting in good faith (including a health care provider) ***may*** *report a suspected health hazard even if it includes personal health information under section 40 of The Public Health Act. To report to public health, please call 204-788-8666.*

Public Health and Workplace Safety and Health are currently working with firing range operators to reduce lead exposure at these facilities.

Susan Roberecki, M.D., FRCPC, MSc.
Medical Officer of Health - Environmental Health
Public Health and Primary Health Care Division
Manitoba Health, Healthy Living and Seniors

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Practice Coverage - Critical Test Results

The College of Physicians and Surgeons of Manitoba's (CPSM) By-Law #11 - *Standards of Practice of Medicine*, states: ***"When ordering tests, members must a) provide the diagnostic facility with a telephone number at which the member or the member's designate may be reached and which may be used by the diagnostic facility to communicate critical test results to the member or the member's designate."***

Over the past six months there were approximately 20 cases in which DSM was unable to contact the physician to relay these critical results in a timely manner; these critical test results included elevated troponin, glucose, PTT and INR results which required urgent medical attention.

This is a critical patient safety requirement and is also a standard requirement of laboratory accreditation administered under College of Physicians and Surgeons of Manitoba – the Manitoba Quality Assurance Program (MANQAP).

We are working with the College of Physicians and Surgeons of Manitoba to identify confidential means to receive and house a provider telephone registry in order to meet the By-Law #11 requirements.

Dr. Amin Kabani, CMO
Diagnostic Services Manitoba

By-Law #11 Section 18

18(1) "Critical test results" are test results that are significantly out of the normal range and which need to be communicated to the member urgently.

18(2) Each member, including members who provide episodic care, is responsible to ensure that specific arrangements are in place for the member to receive communication respecting critical test results.

18(3) The member who receives communication respecting critical test results is responsible to promptly assess whether the results require urgent follow up and take the appropriate action on behalf of the patient.

18(4) When ordering tests, members must

- *(a) provide the diagnostic facility with a telephone number at which the member or the member's designate may be reached and which may be used by the diagnostic facility to communicate critical test results to the member or the member's designate;*
- *(b) provide pertinent information about the patient for use by the diagnostic facility to help determine whether a test result is critical.*

18(5) If a member is unable to be personally available to receive the critical test results, the member must make arrangements with another member to be available to receive the critical test results and to provide the appropriate follow-up communication and care to the patient promptly.

18(6) Each member must establish a reasonable system for communicating test results to his or her patients.

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Creutzfeldt-Jakob Disease
Reminder About Reporting

DIAGNOSTIC SERVICES OF MANITOBA
SERVICES DE DIAGNOSTIC DU MANITOBA
Hôpital St-Boniface Hospital

Department of Pathology
409 Taché Ave, Winnipeg MB Canada R2H 2A6
T. (204) 237-2490 • F. (204) 235-3423

Since the diagnosis of Creutzfeldt-Jakob disease (CJD) can only be made by direct tissue examination, it usually comes to the attention of the autopsy service and neuropathologists at the Health Sciences Centre. Physicians are reminded that by law under The Public Health Act since 1999 that "all cases, including new variant CJD, are reportable by attending health care professional" to the Communicable Disease Control division of Manitoba Public Health (Phone: 204-788-6737, Fax: 204-948-2040). Suspect cases should also be reported to the Canadian Creutzfeldt-Jakob Disease Surveillance System in Ottawa (toll-free: 1-888-489-2999 or email CJDSS@phac-aspc.gc.ca). An autopsy is the only way of verifying the disease. Falsely suspected cases may in fact be rapidly progressive Alzheimer disease or encephalitis. Therefore verification is critical from public health and family health perspectives. The staff of the CJD Surveillance System will contact the family and are typically successful in obtaining permission for the brain-only autopsy. In the rare case where the family refuses an autopsy or the preferred claimant is not available, an autopsy will be performed under The Fatality Inquiries Act. At the time of death, the Office of the Chief Medical Examiner (OCME: 204-945-2088 or via a toll-free call to the MB Government Inquiry line with a request to transfer the call to the OCME: 1-800-282-8069) must be made aware of the suspected diagnosis

Marc Del Bigio, MD FRCPC - Neuropathologist, Diagnostic Services Manitoba

Raymond Rivera, MD FRCPC - Medical Director, Autopsy Services - Diagnostic Services Manitoba

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Diagnostic Services of Manitoba's vision is to deliver a centrally managed diagnostic system for Manitoba that is sustainable, state-of-the-art, cost-effective and known for its high quality and exceptional customer service.
www.dsmanitoba.ca

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Congratulations

Dr. Fred Zeiler – Physician of the Year

– for significant contribution to the practice of medicine and to the community by a member of Doctors Manitoba.

Dr. Davinder Jassal – Scholastic Award

– for scholarly activity in the health professions.

Dr. Murray Enns – Health Administration Award

– for contribution to policy and administration in health care.

Dr. David Rush – Distinguished Service Award

– in recognition of service rendered to patients and the community which have enhanced the image of the physician through devotion to the highest ideals of the medical profession and in the promotion of the art and science of medicine through teaching, writing and administration.

Dr. Mark Prober – Health or Safety Promotion Award

– for contribution toward improving and promoting the health or safety of Manitobans specifically or humanity generally.

Email Address

REMINDER - Please make sure you inform the College if you change your email address. If you do not update your email address you will miss out on important correspondence from the College.

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FROM THE INVESTIGATION COMMITTEE

Billing Tariffs

Physicians have a professional and ethical responsibility to submit accurate and appropriate billing information to Manitoba Health. It is unethical for a physician to request payment for insured services that the physician is not entitled to receive. This can occur when billings are submitted in excess of care given through the use of the wrong billing code. Selecting the correct billing code for a service provided is the sole responsibility of the physician. This necessitates an understanding of the Tariffs and their respective Rules of Application. Physicians are reminded that despite the fact that clinics and physicians often employ clerical support for claim submissions, physicians are personally accountable for selecting the billing tariffs submitted to Manitoba Health on their behalf.

2016-2017 License Fee Renewals

All licence renewals will be online.

Associate Members on the Educational Register will be sent an email notification from the College in May regarding licence renewal. Fees are due by 30 June 2016.

Members on the Manitoba Medical Register, Physician Assistant Register and Clinical Assistant Register will be sent an email notification from the College in July regarding licence renewal. Fees are due by 31 August 2016.

If you do not have a means to renew online, you may call the College to make an appointment to use a College computer to complete your online renewal.

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FROM THE CHILD HEALTH STANDARDS COMMITTEE

Reminder to Physicians Regarding Prompt and Aggressive Management of Sepsis in Children

Several recent cases of sepsis in infants and children have been reviewed by the College of Physicians and Surgeons of Manitoba's Child Health Standards Committee. These reviews have identified a number of management issues and raise several important clinical reminders:

INFANTS LESS THAN 1 MONTH OF AGE

All infants less than one month of age with a fever ≥ 38°C require a full septic work-up including blood, urine (catheter, not bag specimen), and CSF cultures, and should be started on broad-spectrum antibiotics (IV/IM). Note that young infants with sepsis may present with hypothermia and non-specific signs such as lethargy, irritability, poor feeding, apnea/bradycardia, or unexplained jaundice.

INFANTS 1 -3 MONTHS OF AGE

Infants 1-3 months of age with fever who appear unwell require a full septic work-up including blood, urine (catheter), and CSF cultures, and should be started on broad-spectrum antibiotics (IV/IM).

Infants 1-3 months of age with fever who appear well and have no focus of infection identified should be screened for serious bacterial infection. Current guidelines suggest a minimum of: CBC, blood culture, urinalysis and urine culture (catheter). Lumbar puncture should be considered, particularly for infants less than 2 months of age. A number of algorithms have been published that identify infants at low risk for serious bacterial infection and suggest criteria for admission and antibiotics (e.g. Philadelphia, Rochester and Boston criteria). These criteria should not be used for children with a history of prematurity, chronic disease, previous admission, previous infection, or recent/current antibiotic use. Consult a Pediatrician for advice regarding management if you are not familiar with these guidelines. (Biondi and Byington. Evaluation and Management of Febrile, Well-appearing Young Infants. Infect Dis Clin N Am 29 (2015) 575–585).

POSSIBLE SEPSIS OR MENINGITIS

Infants and children presenting with possible sepsis or meningitis require prompt assessment, cultures, and initial IV/IM antibiotics within the first hour if possible, or as soon as sepsis/meningitis is suspected, and prior to transfer to another facility. Do not delay antibiotics if cultures/LP cannot be obtained.

CONSIDER MRSA (methicillin-resistant *Staphylococcus aureus*)

A number of recent cases of fatal MRSA-related sepsis underscore the importance of MRSA coverage (vancomycin if available; otherwise clindamycin) for children with a possible musculoskeletal or skin/soft tissue source or severe sepsis.

Consult the **Pediatric Severe Sepsis Order Sheet** for suggested antimicrobials and doses for various age groups and suspected sources. Request a copy from the HSC Print Shop (204-787-3555) or in urgent situations from the Children's Emergency Department (204-787-4244).

Consult the **Children's Emergency Department (204-787-4244)** or **PICU attending physician on call (204-787-2071)** for transfer and advice regarding sepsis/meningitis management.

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 of 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 as well, with post-test questions, which is eligible for Medscape CME credit:
- http://www.cdc.gov/pcd/issues/2012/12_0071.htm

Physicians are encouraged to go through these learning tools.

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Pediatric Dosing in Resuscitation: The Importance of Weight

Safe medication administration in children requires consideration of the child's weight or body surface area. For most medications, standard adult doses are not used until the child is greater than 12 years of age and the weight is 50kg or more. Always use kilograms (kg) when weighing children and when documenting weight in the medical record.

In resuscitation situations, the child's weight may not be known. Clinicians are encouraged to use a Pediatric Color-Coded Length-Based Resuscitation Tape (e.g. Broselow Tape) to estimate weight and for guidance regarding equipment sizes and medication doses. There are also electronic decision support tools and smartphone applications that may assist in estimating weight; however verify the accuracy of the weight estimation method before using these. Record the actual weight or estimated weight on the resuscitation form.

One of the most commonly used medications in pediatric resuscitation is epinephrine. The correct dose for epinephrine is 0.01 mg/kg (0.1 mL/kg 1:10,000) IV/IO, to a maximum of 1mg. For example, a 5kg infant would receive 0.5ml of 1:10,000 (0.05mg) IV/IO and a 20kg four-year old would receive 2ml (0.2mg).

Reminder cards are available for clinicians and hospitals, including the Pediatric Advanced Life Support (PALS) Pocket Reference Card, laminated PALS Crash Cart Cards, and a PALS poster set. These are available from Laerdal Canada (www.laerdal.ca).

To search for an upcoming PALS course go to: https://resuscitation.heartandstroke.ca.

Dr. Lynne Warda
Medical Consultant
Child Health Standards Committee
College of Physicians & Surgeons of Manitoba

Moving? Retiring?

If you are leaving the province or retiring from practice, By-law #11 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.

You are also required to give timely notice of closing, leaving or moving a medical practice to your patients and other parties as set out in By-Law #11, Standards of Practice Section 64.

Excerpt from By-Law #11

Practice Management: Closing, Leaving or Moving a Medical Practice

A. Notice of Intention to Close, Leave or Move

64(1) A member must give notice of the member's intention to close his or her medical practice, to take a leave of absence, to relocate practice or otherwise cease to practice medicine in Manitoba to:

- *(a) his or her patients or their representatives;*
- *(b) the college;*
- *(c) colleagues (referring and consulting);*
- *(d) Manitoba Health;*
- *(e) any Regional Health Authority in which the member has privileges;*
- *(f) Canadian Medical Protective Association (if a member);*
- *(g) Doctors Manitoba.*

64(2) This section does not apply if the patient records are maintained by a trustee under The Personal Health Information Act who employed, engaged or granted privileges to the member.

64(3) The notice to the patients must include:

- *(a) the date of closure, relocation, absence or cessation of practice;*
- *(b) information about where the patient's records are to be located; and how the records can be transferred to another member or how copies can be obtained; and*
- *(c) particulars of any arrangements for care that have been made for the patients.*

64(4) The member must individually notify (i.e. not through a notice posted in the office) of the closure, relocation, leave of absence or cessation of practice each patient who:

- *(a) has an appointment booked prior to the date of closure, absence or relocation;*
- *(b) calls to arrange an appointment prior to the date of closure, absence or relocation.*

64(5) The notice to the College must include:

- *(a) the date of closure, relocation, absence or cessation of practice;*
- *(b) a forwarding mailing address and contact information for the member; and*
- *(c) if the member is ceasing medical practice in Manitoba, forward all unused Manitoba Prescribing Practices Program (M3P) prescription forms in the possession of the member to the Manitoba Pharmaceutical Association and notify the College when this has been done.*

64(6) Unless a member is leaving a medical practice due to illness or other urgent circumstances, at least 90 days' notice must be provided to each of the persons described in subsection (1).

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FROM THE MATERNAL & PERINATAL HEALTH STANDARDS COMMITTEE

Clindamycin in Pregnancy

Physicians, who practice maternity care, are reminded that for patients allergic to penicillin and found to be colonized with Group B streptococcus bacterium in the anal vaginal tract, sensitivity of the bacterium to clindamycin antibiotic should be documented. While clindamycin and vancomycin are used as alternatives to patients who are allergic to penicillin under these circumstances, it should be reminded that not all Group B streptococcus bacteria are sensitive to clindamycin; hence the importance of obtaining and documenting that the bacterium is sensitive to the antibiotic.

Physicians are also reminded that if the sensitivity to penicillin excludes a previous anaphylactic reaction, consideration may be given to using cefazolin as an alternative antibiotic for Group B streptococcal neonatal sepsis prophylaxis.

Oxytocin Infusion in Umbilical Vein

Following review of management of retained placenta cases after a normal vaginal delivery, it was noted by the Maternal and Perinatal Health Standards Committee of the College that several physicians are attempting to infuse oxytocin into the umbilical vein with the hope that the oxytocin will be delivered to the placental bed and hence help separate the placenta.

Physicians should be reminded that the randomized clinical trials and subsequent meta-analysis failed to show efficacy of this intervention. Physicians are advised to manage the third stage of labour in a standard manner which includes the use of prophylactic oxytocin at the time of birthing of the baby, with or without some uterine massaging.

Should the third stage of labour become prolonged (between 45-60 minutes) or is associated with severe bleeding, physicians should undertake manual removal of the placenta.

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Treatment of Chorioamnionitis in the Intrapartum and Postpartum Period

In the event of a clinical diagnosis of chorioamnionitis, physicians, midwives and nurses are reminded to use a broad spectrum antibiotic for aerobic and anaerobic bacterial coverage (such as cefoxitin); however, given increasing resistance of bacteria to cefoxitin, a preferable alternative is to use multi-agent antibiotic coverage (such as Ceftriaxone with either Metronidazole or Clindamycin). Continuation of antibiotics after delivery may be warranted depending on the severity of the infection.

Urgent Obstetrics Specialist Referrals

Family physicians and midwives are reminded that in the event of difficulty in arranging for a patient to be seen for an urgent consultation by a specific obstetrician of their choice, referrals could be arranged immediately by calling upon the 24 hour obstetric specialist on call at the two tertiary centres, Health Sciences Centre and St. Boniface General Hospital, in Winnipeg. These specialist physicians can be reached by calling the paging services at these two institutions.

St. Boniface General Hospital Paging: 204-237-2053
Health Sciences Centre Paging: 204-787-2071

Dr. Michael Helewa
Medical Consultant
Maternal & Perinatal Health Standards Committee
College of Physicians and Surgeons of Manitoba

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Continuing Professional Development

The College recognizes that it can be challenging for members to meet the annual requirements for Continuing Professional Development. We have particularly had enquiries from physicians who are more isolated, and have difficulty being able to attend educational sessions held in regional centres.

I have some suggestions of accredited programs for family medicine which can be done individually, on a schedule set by the individual, and at very reasonable cost.

The College of Family Physicians of Canada has three offerings:

1. Pearls (paper) and ePearls (electronic)
2. Linking Learning to Practice
3. Self-Learning

Pearls and **Linking Learning to Practice** are both based on questions arising from practice, and have a reflective component which has the participant come back to the question and learning one to three months later to reflect on if or how their practice has changed. Self-Learning is a series of modules of questions which have resources linked to them. This provides for immediate feedback, and learning on-the-spot. Information on all of these programs is available on the College of Family Physicians website, www.cfpc.ca.

The Foundation for Medical Practice Education has collaborated with McMaster University to offer Practice Based Learning. There is a small group format which is widely used. There is also a Practice Based Individual Learning Program. It requires a reflective component after anywhere from one to six months. Paper modules are mailed out to participants four times a year. Modules contain resources pertaining to the clinical topic. Information can be found on the Foundation website at www.fmpe.org.

We hope that our members find this helpful.

Respectfully submitted,
Marilyn Singer MD CCFP
Consultant for Physician Competence

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Meet Your New Councillors

Eastman Electoral District

DR. NADER SHENOUDA, MD BCh

Registered 2006
M.B.B.ch 1987, Egypt;
Internship 1989 Family and ER Medicine residency training 1990-1994;
MPH 1997;
LMCC 2006; CCFP 2011

Attending physician, staff of Family Medicine Department-Mansoura University, Egypt 1994-2006; Visiting professor University of Columbia, MO, USA 2001-2006;

Dr. Shenouda worked as a Family and ER physician in Arborg, Manitoba from 2007-2009 and now works as a Family physician in Oakbank and Staff ER physician in Selkirk.

Winnipeg Electoral District

Dr. CANDACE BRADSHAW, MD CCFP FCFP

Candace was born and raised in Winnipeg. She completed both her MD (1999) and Family Medicine Residency (2001) at the University of Manitoba. Her Mentors and Idols in Family Medicine include Dr Richard Blouw, Dr Alan Katz and Dr Maureen McConnell.

After practising full scope Rural Family Practice for 4 years in Geraldton, Ontario she returned home to Winnipeg in 2005. Candace now co-owns and operates Tuxedo Family Medical Clinic where she practices Family Medicine full time.

Candace is passionate about physician health and well-being. She will promote healthy policies and physician behaviours which in turn lead to better quality care for patients. During her off hours you can find Candace running, spinning and watching her kids - or her Jets - play hockey.

DR. FLORIN PADEANU, MD CCFP

After working as a litigation lawyer for a few years, Dr. Padeanu decided to follow in the footsteps of his parents and become a physician. Dr. Padeanu has now practiced family medicine at his own clinic for over 10 years and he continues to enjoy spending time with his patients, staff and colleagues.

DR. JOSEF SILHA, MD

Dr. Josef Silha is an Endocrinologist working at the Manitoba Clinic. He received his MD in 1998 and PhD in 2004 from Charles University in Prague and subsequently completed clinical training in Internal Medicine and Fellowship in Endocrinology in Winnipeg. Since 2008 he has been practicing in Winnipeg in the area of Endocrinology and Diabetes.

Public Representative

MS PRITI SHAH

Priti Shah is a lawyer, mediator, arbitrator, investigator, facilitator and the owner of PRAXIS Conflict Consulting. She is widely known and highly respected for her work in the area of board governance, risk management and dispute resolution and has personally worked with hundreds of board members from across the country.

Ms Shah has travelled to 56 countries and represented the Government of Canada and the Organization for Democratic Institutions and Human Rights in September 1998 as an observer of the parliamentary elections in Bosnia & Herzegovina. She is committed to international development and travelled to Trinidad to complete her seventh Habitat build. In May 2005, Priti was awarded the Woman Entrepreneur of the Year Award for Contribution to Community from the Women Business Owners of Manitoba.

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Meetings of Council
2015-2016 College Year

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

- Friday, June 17, 2016

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

Officers of the College
2015-2016 College Year

President:	Dr. Alewyn Vorster
President Elect:	Dr. Daniel Lindsay
Past President:	Dr. Brent Kvern
Treasurer:	Dr. Helmut Unruh
Registrar:	Dr. Anna Ziomek
Deputy Registrar:	Dr. Terry Babick

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Councillors

TERM EXPIRING JUNE 2016

Brandon	Dr. Stephen Duncan
Eastman	Dr. Nader Shenouda
Westman	Dr. Alewyn Vorster
Winnipeg	Dr. Heather Domke Dr. Brent Kvern Dr. Michael Boroditsky Dr. Helmut Unruh
University of Manitoba	Dean Brian Postl
Public Councillors	Mr. John Stinson Ms Laurie Read

TERM EXPIRING SEPTEMBER 2016

Associate Members Register	Dr. Boshra Hosseini

TERM EXPIRING JUNE 2018

Central	Dr. Ockie Persson
Interlake	Dr. Daniel Lindsay
Northman	Dr. Hussam Azzam
Parkland	Dr. Elizabeth Senderewich
Winnipeg	Dr. Wayne Manishen Dr. Michael West Dr. Nichole Riese Dr. Eric Sigurdson Dr. David Pinchuk
University of Manitoba	Dr. Ira Ripstein
Public Councillors	Mr. Richard Dawson Mr. Robert Dewar

TERM EXPIRING JUNE 2020

Brandon	Dr. Stephen Duncan
Eastman	Dr. Nader Shenouda
Westman	Dr. Alewyn Vorster
Winnipeg	Dr. Heather Domke Dr. Candace Bradshaw Dr. Florin Padeanu Dr. Josef Silha
Public Councillor	Ms Priti Shah

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INQUIRY:
DR. RAJPAL S. AHLUWALIA

NOTICE: DR. AHLUWALIA FILED A NOTICE OF APPEAL IN THE MANITOBA COURT OF APPEAL PURSUANT TO S. 59.10 OF *THE MEDICAL ACT* ON MARCH 3, 2016 IN WHICH HE APPEALS THE FINDINGS AND ORDER OF THE INQUIRY PANEL SET OUT BELOW.

REASONS FOR DECISION OF THE INQUIRY PANEL
INTRODUCTION AND BACKGROUND

On December 1, 2015, a hearing was convened before an Inquiry Panel (the "Panel") of the College of Physicians and Surgeons of Manitoba (the "College") for the purpose of conducting an inquiry pursuant to Part X of *The Medical Act*, into 12 counts of misconduct against Dr. Rajpal S. Ahluwalia ("Dr. Ahluwalia") as set forth in a Notice of Inquiry dated March 13, 2015.

At the outset of the hearing on December 1, 2015, a motion to amend the Notice of Inquiry was made by counsel for the Investigation Committee of the College with the consent of counsel for Dr. Ahluwalia. The motion sought to "sever" 7 of the 12 counts from the Notice of Inquiry, so that those counts would be dealt with separately from the remaining counts. The motion to amend was granted and an Amended Notice of Inquiry, also dated March 13, 2015 was filed consisting of the five remaining charges, renumbered as counts 1-5.

The Amended Notice of Inquiry charged Dr. Ahluwalia with committing acts of professional misconduct, contravening various provisions of By-Law #1 of the College, Statements 104 and 805 of the College, displaying a lack of knowledge of or a lack of skill and judgment in the practice of medicine, and of demonstrating an unfitness to practice medicine. The Amended Notice of Inquiry alleged that:

> "1. You made false and misleading statements in your written correspondence to the College when you described one or more individuals having reviewed the report of the College's audit of your practice conducted on or about June 27, 2013 ("Audit Report") and/or having participated in the preparation of a report dated August 15, 2013 entitled *Peer Group Audit Statement And Analysis Of The Practice Of Dr. Ahluwalia* ("Peer Group Analysis") thereby committing acts of professional misconduct.
>
> 2. On or about November 27, 2013, during the course of an

interview with the Investigation Chair of the College, you attempted to mislead the College about the involvement of one or more individuals in reviewing the Audit Report and/or having participated in the preparation of the Peer Group Analysis, thereby committing acts of professional misconduct.

3. After installing computer software which complied with College Statement 104 in November 2000 as required by Order of the Manitoba Court of Appeal dated July 13, 1999, you failed to maintain and/or update and/or use that software and/or your medical computer system in a manner which complies with that Order and/or with Statement 104 and/or in a manner which complies with the requirement of trustees of personal health information as set out in The Personal Health Information Act, C.C.S.M. c. P33.5, thereby breaching Statement 104 and/or committing acts of professional misconduct.

4. In respect to Patients B, C, D, E, F, G, H, I, J, K, L, M, N and O, you failed to create and maintain adequate clinical records and/or did not create an accurate or complete medical record in respect of one or more prescriptions, thereby breaching the record keeping requirements of By-Law #1 of the College in effect at the material time and/or Statement 805 of the College and/or committing acts of professional misconduct.

5. By reason of one or more of the foregoing, you have displayed a lack of knowledge of or a lack of skill and judgment in the practice of medicine and/or an unfitness to practice medicine."

In addition to the foregoing, the Amended Notice of Inquiry also contained extensive factual particulars, some of which will be referred to elsewhere in these Reasons.

The hearing proceeded before the Panel on December 1, 2015 in the presence of Dr. Ahluwalia and his counsel, and in the presence of counsel for the Investigation Committee of the College. Dr. Ahluwalia entered a plea of guilty to counts 1-4 as outlined in the Amended Notice of Inquiry, thereby acknowledging that the facts alleged in counts 1-4 of the Amended Notice of Inquiry, including the additional factual particulars, were true and also acknowledging that he was guilty of professional misconduct, and of contravening various provisions of By-Law #1 of the College and of contravening Statements 104 and 805 of the College.

With respect to count 5 of the Amended Notice of Inquiry, Dr. Ahluwalia made no admission, and was therefore deemed by the Panel to enter a plea of not guilty to that count.

Counsel for the Investigation Committee also moved for an order under subsection 56(3) of *The Medical Act* for the non-disclosure of the names of any patients or other third parties referred to in the proceedings. Counsel for Dr. Ahluwalia consented to such an Order. The Panel therefore granted an Order for the non-disclosure of the names of any patients or other third parties specifically referred to during the Hearing, or in any documents filed as exhibits at the hearing.

The Panel reviewed and considered the following documents, all of which were filed as exhibits in the proceedings by consent:

1. The Amended Notice of Inquiry (Exhibit 2); and
2. The Statement as to Agreed Documents (Exhibit 3) and all of the documents referred to therein.

Copies of the documents referred to in the Statement as to Agreed Documents were provided to the Panel in two binders, consisting of approximately 50 tabs. The documents were extensive. In reviewing the documents contained in the two binders, the Panel was cognizant of the following statement contained in the Statement as to Agreed Documents:

> "…the documents are not to be taken as part of the Member's or the Investigation Committee's case. Both the Member and the Investigation Committee may lead evidence to contradict any document in this agreed Book of Documents. The Member and the Investigation Committee may make arguments as to the weight that should be assigned to any document by the Inquiry Panel."

No oral evidence was introduced at the hearing by either the Investigation Committee or by Dr. Ahluwalia. With respect to count 5 in the Amended Notice of Inquiry, it was the position of the Investigation Committee of the College that the evidence in relation to counts 1-4 was sufficient to establish that Dr. Ahluwalia displayed a lack of knowledge of, or a lack of skill and judgment in the practice of medicine and/or that he was unfit to practice medicine, and that a finding of guilt with respect to the other four counts in the Amended Notice of Inquiry was sufficient to establish Dr. Ahluwalia's guilt with respect to the other allegations in count 5. It was the position of Dr. Ahluwalia that neither the evidence with respect to the first four counts, or any finding of guilt with respect to the first four counts was sufficient to establish his guilt with respect to the allegations in count 5 of the Amended Notice of Inquiry.

BACKGROUND

The first two counts of the Amended Notice of Inquiry relate to certain communications from Dr. Ahluwalia to the College.

The College had undertaken an investigation of Dr. Ahluwalia's practice pursuant to Section 45 of *The Medical Act* and had caused a chart audit of Dr. Ahluwalia's practice to be conducted on June 27, 2013. The College wrote to Dr. Ahluwalia by letter dated July 12, 2013, providing him with a copy of the Audit Report (the "Audit Report") and requiring him to respond to the Audit Report and all of the concerns raised in the Audit Report within 30 days. Dr. Ahluwalia's initial written response to the College was dated August 11, 2013. Thereafter an exchange of correspondence occurred between the College and Dr. Ahluwalia, which also included letters from Dr. Ahluwalia dated August 23, 2013, September 6, 2013, November 13, 2013 and November 15, 2013. In the letters written by Dr. Ahluwalia between August 11, 2013 and November 15, 2013 inclusive, he made a series of false and misleading statements to the College, whereby he represented that:

(i) he had provided a copy of the Audit Report to a group of patients and peers including ethicists, psychiatrists, psychologists, general practitioners, surgeons and para-medicals;

(ii) he had engaged independent auditors and was in the middle of "an independent chart audit";

(iii) a document entitled "PEER GROUP AUDIT STATEMENT AND ANALYSIS OF THE PRACTICE OF DR. AHLUWALIA" ("Peer Group Analysis") dated August 15, 2013 which he provided to the College was a report from a panel of his peers, providing their comments on all of the charts which had been reviewed and commented upon in the Audit Report.

All of Dr. Ahluwalia's statements as outlined above were false. He did not provide a copy of the Audit Report to a group of patients and peers, he had not initiated an "independent chart audit" of his practice, and the "Peer Group Analysis" had not been written by a panel of his peers, but in fact had been written entirely by himself. In addition Dr. Ahluwalia in correspondence to the College on November 23, 2013 was non-responsive, evasive and untruthful in responding to requests from the College that he name the purported independent auditors and the authors of the "Peer Group Analysis.

On or about November 27, 2013, Dr. Ahluwalia was interviewed by the Investigation Chair of the College. During that interview Dr. Ahluwalia continued to make false and misleading statements with respect to the involvement of one or more individuals in reviewing the Audit Report and in preparing the "Peer Group Analysis", before ultimately admitting that he was the sole author of the "Peer Group Analysis" and solely responsible for its contents.

The implausibility of the false statements made by Dr. Ahluwalia, both in his correspondence to the College between August 11, 2013 and November 15, 2013, and in his interview with the Investigation Chair on November 27, 2013, was striking, as was his misguided persistence in attempting to have the College accept his statements as factual and accurate, when they were so obviously false and untruthful.

The third count of the Amended Notice of Inquiry relates to Dr. Ahluwalia's failure to comply with College Statement 104 entitled "Medical Computer Systems: Security and Self-Audit". The preamble to Statement 104 states:

> "The Physician is responsible for the safe custody of information contained in the course of patient care in order to fulfill the ethical precept:
>
> > "an ethical physician will keep in confidence information derived from the patient, or from a colleague regarding a patient and divulge it only with the permission of the patient, except when the law requires the physician to do so."
>
> The following minimum guidelines are intended to assist the physician in applying this responsibility to the use of computerized records."

One of the General minimum guidelines in Statement 104 provides that:

> "… 5. The system must have in place a monitoring system which creates an audit trail which both alerts the physician to any appropriate access and identifies how the system was accessed."

Paragraphs 2, 3 and 4 of the minimum guidelines in Statement 104 with respect to Software stipulate that:

> "… 2. All access must be entered onto a permanent file log. The software must be capable of identifying and recording where the access originated and by whom. Where alterations are made to the record, then it must be possible to identify by whom, what was altered, and when the alteration was made.
>
> 3. A test of the system's backup and recovery must be made on a regular basis.
>
> 4. The inventory of all data files must be regularly reviewed and updated. …"

By Order of the Manitoba Court of Appeal dated July 13, 1999, Dr. Ahluwalia was required to install a computer software system which complied with Statement 104. He did so, but failed to maintain or update the system or to utilize it in a manner which complied with the Order of the Court of Appeal, or Statement 104, or with the requirements of trustees of personal health information as set out in *The Personal Health Information Act* C.C.S.M.

A forensic audit of Dr. Ahluwalia's computer and any medical computer system in use on that computer conducted on or about January 25, 2014, found that the requirements of Statement 104 were not being met and/or that the personal health information of his patients was not properly protected. Among others, the following deficiencies were found:

(i) there was no trace of a medical computer system software of any kind on Dr. Ahluwalia's computer;
(ii) Dr. Ahluwalia's patient records were being recorded and stored in Microsoft Excel files in the local C:/ drive of his computer;
(iii) there was no audit trail capacity whatsoever for the patient records created by Dr. Ahluwalia;
(iv) the firewall on his computer was disabled and the anti-virus system was found to be expired and several years out of date;
(v) Dr. Ahluwalia's computer did not contain any trace of software that would indicate that the data on it was being backed up; and
(vi) the operating system on his computer was found to be vulnerable to unauthorized and/or inappropriate access.

The non-compliance by Dr. Ahluwalia with College Statement 104 and the deficiencies found in his computer and in any medical computer system in use on that computer were such that the medical records being maintained by Dr. Ahluwalia could not be relied upon as being comprehensive, accurate, or unaltered.

The fourth count of the Amended Notice of Inquiry relates to a failure on the part of Dr. Ahluwalia to create and maintain adequate clinical records and/or a failure to create an accurate or complete record in respect of one or more prescriptions. The failures and deficiencies on the part of Dr. Ahluwalia as outlined in the fourth count involved fourteen patients over a time period from 2002 to 2015. The fourth count in the Amended Notice of Inquiry also relates to a failure on the part of Dr. Ahluwalia to create any clinical record of his assessment, plan and management in respect of various complaints and diagnosis of five patients in 2013, all of whom were among the fourteen patients otherwise referred to in count 4.

Article 24 of the College's By-Law #1 is entitled "Keeping of Medical Records". It contains the following provisions:

"24.1 Clinical Records

Members in practice shall keep:

(a) Clinical records on every patient which shall include:

(i) patient demographic information, including:

(A) full name as it appears on the patient's health insurance registration card;

(B) current address;

(C) personal health identification number or other unique identifier;

(D) date of birth;

(E) telephone number and any alternate telephone contact numbers; and

(F) next of kin.

(ii) all dates on which the patient was seen and for each visit:

(A) an adequate patient history;

(B) particulars of physical examinations, investigation orders and the results of same;

(C) the diagnosis made (if any);

(D) the treatment prescribed; and

(E) ancillary medical or psychological investigations.

(b) daily diary or appointment sheets showing for each day the names of patients seen or treated or in respect of which some professional service is rendered.

24.2 Legible

All records shall be typed or legibly written and kept in suitable systematic permanent forms such as files, cards, folders or computer disk.

24.3 Computerized Records

Records may be retained in a computerized system only if the system is acceptable to the College. The system must be capable of promptly producing the same printed record as required elsewhere in this Article."

In relation to the fourth count in the Amended Notice of Inquiry, counsel for the Investigation Committee, as part of his submission, made reference to multiple tabs in the two binders comprising the Statement of Agreed Documents, referring to charts and records of particular patients that were generated both before and after the installation by Dr. Ahluwalia of an updated computer program in his computer system. Counsel's purpose in referring to those charts and records was to demonstrate that in several cases the notations were simply verbatim repetitions of notations which had been made with respect to particular patients on previous visits, or that Dr. Ahluwalia had merely "cut and pasted" previous entries with respect to that patient using the computer system to do so.

By way of examples, in some cases, blood pressure readings and pulse rates were identical for one patient over many visits covering an extended period of time. Identical notations relating to a retinal detachment were noted with respect to one patient over many visits. In several cases, follow up appointments were noted at the end of various entries to occur at specific intervals, which, based on a review of subsequent entries, did not occur at those intervals.

As a result of such deficiencies in the charts and records referred to by counsel for the Investigation Committee, it was clear to the Inquiry Panel that the charts were of limited or no value to Dr. Ahluwalia or any other treating physician in providing an accurate record of the types of examinations and tests which had been performed, the diagnosis or assessments which had been made, the treatments, if any, which had been prescribed, or the results of those treatments.

Such deficiencies were widespread and persisted for extended periods of time. The second element of count 4 in the Amended Notice of Inquiry was equally troubling, namely, a complete absence of any clinical record for specific treatments which had been prescribed and billed for by Dr. Ahluwalia.

Having considered the guilty plea of Dr. Ahluwalia to the first four counts of the Amended Notice of Inquiry, and having reviewed the documentation in the two binders comprising the Statement as to Agreed Documents, within the context of the submissions of Counsel for the Investigation Committee of the College and Counsel for Dr. Ahluwalia, and having read and considered Article 24 of the College's By-Law #1 and Statements 104 and 805 of the College, the Panel is satisfied that counts 1-4 of the Amended Notice of Inquiry have been proven. In the result, the Panel hereby makes a formal finding pursuant to Section 59.5 of *The Medical Act* that Dr. Ahluwalia is guilty of professional misconduct and of contravening Article 24 of the College's By-Law #1 and Statements 104 and 805 of the College.

Count 5 in the Amended Notice of Inquiry, to which Dr. Ahluwalia has <u>not</u> pled guilty, alleges that by virtue of all of the allegations in count 1-4, Dr. Ahluwalia has displayed a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

Conduct which is described by phrases such as a "lack of knowledge" or a "lack of skill and judgment" is conduct amounting to incompetence. As noted in Richard Steinecke's text, *A Complete Guide to the Regulated Health Professions Act*, there are normally 3 requirements necessary in order for a finding of incompetence to be made in a disciplinary context:

(i) The conduct must be clinical in nature, in the sense of relating to the practitioner's care of patients;

(ii) The incompetence must relate to an actual deficiency, i.e. either a lack of knowledge of a particular subject, or a lack of skills in a particular area or failure to apply such knowledge or such skills when it was necessary to do so;

(iii) The matter must be serious.

Problems associated with managerial activities or administrative errors, unrelated to patient care, will not support a finding of guilt with respect to a "lack of knowledge" or a "lack of skill and judgment".

However in, *College of Physicians and Surgeons (Ontario) v. Porter, 2002 Carswell Ont. 8816*, a physician was found incompetent, largely as a result of his failure to keep current, complete and accurate patient records. Such a failure was found not to be a mere matter of poor administration, but rather demonstrated a disregard for the welfare of patients.

Notwithstanding the absence of a guilty plea to count 5, the Panel has concluded that the matters alleged in counts 1-4, and particularly the matters alleged in counts 3 and 4 reflect problems which are serious and which relate to proper medical practice and patient care, and not merely managerial or administrative functions.

Therefore the Panel expressly finds that by virtue of the allegations in counts 1-4, which Dr. Ahluwalia has admitted and which have been proven, Dr. Ahluwalia is guilty of displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine and of displaying an unfitness to practice medicine.

DR. AHLUWALIA'S DISCIPLINARY RECORD

All of the above-noted findings and conclusions must be considered in the context of Dr. Ahluwalia's previous disciplinary record with the College.

In the 1990s, Dr. Ahluwalia was cited by the College for professional misconduct and for having demonstrated an unfitness to practice medicine. In those proceedings, Dr. Ahluwalia was charged with dishonesty and a lack of candor in his responses to and communications with the College, including submitting documents purporting to be accurate and original medical records with respect to certain patients, which documents were not what they purported to be, and in fact had been rewritten by Dr. Ahluwalia.

The proceedings by the College against Dr. Ahluwalia in the 1990s had a complex procedural history. It is sufficient for the purposes of these Reasons to state that at that time, a properly constituted Inquiry Panel of the College found that Dr. Ahluwalia was guilty of professional misconduct and had demonstrated an unfitness to practice medicine. The finding was made by that Inquiry Panel that the appropriate penalty was "erasure", i.e. the removal of Dr. Ahluwalia's name from the Medical

Register. On appeal, the Manitoba Court of Appeal upheld the Inquiry Committee's findings of professional misconduct and unfitness to practice medicine, but set aside the order of erasure, substituting a six month suspension and imposing certain conditions, including the installation, on or before July 29, 1999, of computer software in Dr. Ahluwalia's computer system, complying with the College's Statement 104. The Court of Appeal also ordered Dr. Ahluwalia to undergo a program of psychological assessment and treatment as directed by the Executive of the College.

THE OBJECTIVES OF ORDERS UNDER SECTION 59.6 OF *THE MEDICAL ACT*

Pursuant to Section 59 of *The Medical Act*, when an Inquiry Panel of the College has found a member of the College to be guilty of professional misconduct, or of contravening the Code of Conduct or a Statement of the College, or of displaying a lack of knowledge of, or a lack of skill or judgment in the practice of medicine, or of demonstrating an incapacity or unfitness to practice medicine, the Panel may make one or more orders as set forth in Section 59.6(1) of *The Medical Act*. Such orders include, but are not limited to reprimanding the member, suspending the member's license for a specific period of time, suspending the member's license until he or she has completed a specified course of studies or obtained supervised clinical experience, imposing conditions on the member's entitlement to practice medicine, or cancelling one or both of the member's registration and license.

In determining the types of orders to be granted pursuant to Subsection 59.6 of *The Medical Act*, it is useful to consider the objectives of such orders. Those objectives are:

a) the protection of the public. 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) to protect against the betrayal of the public trust in the sense of preventing a loss of faith on the part of the public and 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 to the public;
g) the sentence should be proportionate to the conduct of the physician involved.

THE POSITIONS OF THE PARTIES

The Investigation Committee and Dr. Ahluwalia have starkly different positions as to the type of order which ought to be made pursuant to section 59.6 of *The Medical Act*.

It is the Investigation Committee's position that pursuant to subsection 59.6(1) of *The Medical Act*, Dr. Ahluwalia should be reprimanded (representing a formal denunciation by the College of his conduct) and that both his registration with the College and his license to practice medicine in Manitoba should be cancelled. In addition the Investigation Committee seeks payment from Dr. Ahluwalia in the amount of $35,000 representing a contribution of the costs of these proceedings. It is the understanding of the Inquiry Panel that Dr. Ahluwalia has paid that sum to the College. Finally, the Investigation Committee asks that the Inquiry Panel order that publication be made of the circumstances relevant to its findings herein, pursuant to section 59.9 of *The Medical Act*.

In contrast, Dr. Ahluwalia submits that an appropriate order pursuant to section 59.6 of *The Medical Act* should not include the cancellation of his registration and license. Instead Dr. Ahluwalia and his counsel suggest the following:

a) an order or orders imposing conditions on Dr. Ahluwalia's entitlement to practice medicine such as a requirement that he complete a course of study and/or training in proper charting methods and appropriate electronic record keeping practices;

b) an order prohibiting him from practicing alone and requiring him to undergo a period of supervision lasting between six and nine months including a periodic review by his supervisor of a random selection of Dr. Ahluwalia's charts and records and as a further condition, Dr. Ahluwalia should be obliged to maintain legible transcripts of his patient notes to be transmitted to the College and available for examination by the College at any subsequent time;

c) a fine in an amount to be determined by the Inquiry Panel;

d) publication pursuant to section 59.9 of *The Medical Act*.

ANALYSIS

The College emphasizes that the following factors provide the basis for its position that Dr. Ahluwalia's registration with the College and his licence to practice medicine in Manitoba should be cancelled:

(i) Dr. Ahluwalia is a "repeat offender". The problems which arose in the 1990s, which resulted in Dr. Ahluwalia being found guilty of professional misconduct and of demonstrating an unfitness to practice medicine, and which caused him to be suspended from practice, involved serious deficiencies in his medical records and dishonesty and a lack of candor in his communications with the College. Both of those elements are also involved in these proceedings. In the words of counsel for the Investigation Committee, Dr. Ahluwalia's misconduct was "inexcusable the first time, and incomprehensible the second time";

(ii) Dr. Ahluwalia's conduct in relation to counts 1 and 2 of the Amended Notice of Inquiry (namely his communications with the College in response to the audit of his practice) were premeditated and occurred over an extended period of time (from August 11, 2013 to November 15, 2013). He engaged in a deliberate course of conduct and made multiple false statements with the intention of misleading the College and causing the College to discontinue its investigation. According to counsel for the Investigation Committee, whenever Dr. Ahluwalia was asked challenging questions by the College, he would replace "one lie with another lie";

(iii) The deficiencies in Dr. Ahluwalia's computer software, as outlined in count 3 of the Amended Notice of Inquiry were not only a breach of the College's Statement 104, they were a violation of the Court of Appeal's Order dated July 31, 1999. Therefore Dr. Ahluwalia's conduct demonstrated contempt for both the College's regulatory authority and the Court of Appeal's decision;

(iv) The failure to create and maintain adequate clinical and medical records as referred to in count 4 of the Amended Notice of Inquiry was a flagrant, unjustifiable contravention of Article 24 of the College's By-Law #1 and represented a fundamental disregard of one of the basic elements of providing competent medical care;

(v) The seriousness of Dr. Ahluwalia's recent breaches of various professional standards and the similarity between his most recent misconduct and his misconduct in the 1990s require a robust and significant response from the College both to punish Dr. Ahluwalia's unacceptable behaviour and to protect the public;

(vi) The Orders sought by the Investigation Committee (a reprimand, the cancellation of Dr. Ahluwalia's registration and his license to practice medicine, publication and a payment of costs in the amount of $35,000) are necessary in order to fulfill the objectives of orders under s.59.6 of *The Medical Act*. Any type of order allowing Dr. Ahluwalia to practice medicine, even if subject to significant conditions will be inadequate to fulfill those objectives;

In contrast, Dr. Ahluwalia emphasizes other factors, as summarized below, in support of his position that he should be allowed to continue to practice medicine, subject to significant conditions, and upon publication of the background circumstances and the payment of a fine:

(i) There was no evidence introduced to establish actual harm to any specific patient or patients as a result of the actions of Dr. Ahluwalia;

(ii) Dr. Ahluwalia's guilty plea does not constitute an admission of inadequate patient care. No evidence was introduced to establish any harm to any specific patients, either as a consequence of deficient record keeping or of any other of his actions or omissions;

(iii) Dr. Ahluwalia's false statements, although foolish and inappropriate, did not actually mislead the College or cause it to discontinue its investigation. The College placed no reliance on Dr. Ahluwalia's false statements.

(iv) Immediately upon being provided with the Audit Report by the College in July, 2013, Dr. Ahluwalia indicated a willingness to change his charting and record keeping practices and to work with the College to achieve compliance with the necessary requirements;

(v) His initial false statements to the College were made, in part, because he felt "terrified and

intimidated", as he specifically stated in his letter to the College dated August 22, 2013. His feelings were understandable given the adversarial relationship which had existed with the College throughout the proceedings in the 1990s. Nonetheless, at the conclusion of his interview on November 27, 2013, Dr. Ahluwalia apologized to the Investigation Chair;

(vi) The matters referred to in count 3 of the Amended Notice of Inquiry with respect to the computer software system resulted from a lack of computer skills on Dr. Ahluwalia's part, not a willful breach of the requirements of College Statement 104 or the Court of Appeal's Order of July 13, 1999. The computer software which was initially installed had been compliant with the College's requirements but had degraded over time to the point of non-compliance. However, the deficient computer software has since been replaced by Dr. Ahluwalia and his office is now complying with all applicable requirements;

(vii) There are mitigating circumstances present in this case, including Dr. Ahluwalia's offer to change his charting and record keeping practices, his apology to the Investigation Chair, the replacement of the deficient computer software and computer system, and his guilty plea to the first four counts in the Amended Notice of Inquiry;

(viii) Cancellation of a licence to practice medicine should be reserved for the most serious cases. This case is not as serious as those outlined in the authorities relied upon by the College. An order placing meaningful and thoughtfully considered conditions on Dr. Ahluwalia's entitlement to practice medicine, combined with a fine and publication of the circumstances of this case will properly fulfill all of the objectives of orders pursuant to s.59.6 of *The Medical Act*, including the protection of the public, the punishment of Dr. Ahluwalia and specific and general deterrence.

The Panel has carefully reviewed all of the authorities on sentencing submitted to it by both the Investigation Committee and by Dr. Ahluwalia. Not surprisingly, the facts of the cases submitted by the parties are not identical, or substantially similar to the facts of this case. The Panel recognizes that several of the cases submitted by the Investigation Committee involved various types of incompetence which resulted in actual patient harm (including a patient death in one case) or fraud committed with the intention of realizing a financial benefit for the physician, or fraud in order to cover up a serious error in medical practice. Another case involved misrepresentations made at a discipline hearing which were designed to mislead the adjudicative panel itself. The Panel is aware that this case does not involve those elements.

Conversely, the Panel also recognizes that most, if not all of the cases relied upon by Dr. Ahluwalia involved first offences, whereas Dr. Ahluwalia has been previously convicted of unprofessional conduct and of having demonstrated an unfitness to practice medicine. The Panel also notes that most of the cases submitted by Dr. Ahluwalia featured only one type of misconduct (e.g. false or inadequate charting) not various types of misconduct, such as are present in this case.

Although all of the cases submitted by the parties can be distinguished factually from the present case, there are principles contained in many of the cases submitted by each of the parties, which have been useful to the Panel in reaching its decision.

Counsel for Dr. Ahluwalia placed considerable emphasis in his submissions on the absence of proof of specific patient harm. He properly stressed that Dr. Ahluwalia's guilty plea to counts 1 to 4 in the Amended Notice of Inquiry cannot be construed as an admission that any patient harm resulted from Dr. Ahluwalia's actions. He also correctly stated that the Panel should not speculate and presume that the deficiencies in Dr. Ahluwalia's charts and records must have adversely affected some of his patients. Notwithstanding those useful cautions, the Panel has concluded that the actions and behaviours of Dr. Ahluwalia, as referred to and particularized in counts 1 to 4 are extremely serious.

The false statements to the College in Dr. Ahluwalia's letters from mid-August, 2013 to mid-November, 2013 and his false statements in his interview with the Investigation Chair on November 27, 2013 were intentional, premeditated and occurred over an extended period of time (counts 1 and 2). The Panel is dismayed by the number of misrepresentations made by Dr. Ahluwalia and is particularly alarmed by his authorship of the "Peer Group Analysis", a 21-page document submitted by Dr. Ahluwalia to the College which was entirely false and contrived. The Panel is also deeply troubled by the motivation for his deceit, namely to cause the College to cease its investigation or to fundamentally change the focus of its investigation. It matters not that Dr. Ahluwalia's false statements were so plainly untrue that the College was not in fact misled.

Similarly, Dr. Ahluwalia's deficiencies in his charting and record keeping practices, as particularized in count 4 of the Amended Notice of Inquiry are significant and sobering. Creating and maintaining adequate records is an essential element of providing competent medical care. The type of information required in a clinical record, as outlined in Article 24 of the College's By-Law #1, is necessary, not only for the current treating physician so he or she has an accurate record of the diagnoses and treatments being provided over time, but for any specialist who reviews the records, or another physician who subsequently assumes care of the patient. The College's audit of Dr. Ahluwalia's records, conducted on June 27, 2013 disclosed serious deficiencies. The records were found to have insufficient detail, poor follow up and inadequate documentation of the investigations which had been undertaken. In addition, there were five instances in which Dr. Ahluwalia failed to create any clinical record of his assessment, plan and management of various complaints and diagnoses, although bills were submitted to Manitoba Health with respect to Dr. Ahluwalia's services. There is no suggestion or evidence that Dr. Ahluwalia had submitted false bills. Rather the Panel's concern relates to the fact that no clinical record whatsoever was generated with respect to those matters.

Count 3 in the Amended Notice of Inquiry relates to the serious deficiencies in the software in Dr. Ahluwalia's medical computer system and Dr. Ahluwalia's failure to comply with Statement 104 of the College. Dr. Ahluwalia's counsel sought to minimize the seriousness of this count by pointing out that:

(i) The software, which was initially installed by Dr. Ahluwalia was compliant with Statement 104 and with the Court of Appeal Order dated July 13, 1999;

(ii) The system had degraded over time. Dr. Ahluwalia's own limited computer skills were such that once the degradation had occurred, he was not sufficiently adept to properly deal with or rectify the deteriorating situation;

(iii) When the College intervened, Dr. Ahluwalia promptly took the steps to install new software and/or a new medical computer system in order to comply with all applicable requirements.

The Panel does not regard the significant deficiencies and inadequacies outlined in count 3 as something which can be minimized by reference to Dr. Ahluwalia's limited computer skills. The requirements of Statement 104 are set forth as minimum standards relating to the use of computerized records. The creation and maintenance of medical records are essential features of providing competent medical care. If a physician does not have the requisite computer skills to fulfil the requirements of Statement 104, it is the responsibility of that physician to either acquire those skills personally, or to organize his or her practice in such a way that those skills and resources are available to the practice.

Non-compliance with the requirements of Statement 104 also reflect a seriously inadequate understanding of the reasons underlying those requirements, and the importance of complying with them on a continuous basis.

It is the position of the Investigation Committee that the nature and extent of Dr. Ahluwalia's misconduct is so serious that he is in fact "ungovernable". The Ontario Superior Court of Justice's decision in *Mundulai v. The Law Society of Upper Canada* 2014 OMSC 7208 provides guidance as to the meaning of the concept of "ungovernability". A professional person will be considered "ungovernable" if the nature, duration and repetitive character of the person's misconduct demonstrates an inability on the part of that person to respond appropriately to the authorities who are authorized to regulate the individual's professional activities.

In this case, there are at least 3 factors present which strongly suggest that Dr. Ahluwalia is ungovernable. Those factors are:

(i) Dr. Ahluwalia has engaged in several different types of serious misconduct involving multiple written and oral misrepresentations to the College, a breach of the Statement 104 of the College, and a breach of the Order of the Court of Appeal of July 13, 1999 and serious deficiencies in his clinical and medical record keeping practices.

(ii) His written and oral misrepresentations to the College demonstrate that he is prepared to lie to his governing body in an attempt to avoid the College's reasonable exercise of its regulatory jurisdiction. His breaches of the College's Statement 104 and Article 24 of By-Law #1 establish that he will break reasonable rules and disregard appropriate guidelines. The Investigation Committee asserts that Dr. Ahluwalia has lied to the College on many occasions and breached rules and standards repeatedly. The College therefore has no faith that Dr. Ahluwalia will respond truthfully to future inquiries from the College or that he will practice medicine in accordance with appropriate standards.

(iii) Dr. Ahluwalia committed similar transgressions in the 1990s, which resulted in him being suspended from the practice of medicine after being found guilty of professional misconduct and of demonstrating an unfitness to practice medicine. The similarities between Dr. Ahluwalia's misconduct in the 1990s and the misconduct which has resulted in these proceedings, are powerful indicators that Dr. Ahluwalia lacks insight into the seriousness of his own conduct and the importance of adhering to professional standards set or adopted by the

College to protect the interests of patients and to otherwise protect the public interest.

As a counterpoint to the College's assertion that Dr. Ahluwalia is ungovernable, counsel for Dr. Ahluwalia submits that cancellation of a licence to practice medicine is only appropriate in the most serious cases. Dr. Ahluwalia says that in this case, a fine, publication, and the placement of appropriate conditions on his licence to practice medicine will be sufficient to achieve the objectives of orders under s.59.6 of *The Medical Act*.

Implicit in the position that Dr. Ahluwalia should be entitled to practice medicine, but subject to conditions, is the proposition that Dr. Ahluwalia has significant rehabilitative potential, meaning that with proper remedial training and adequate supervision he will be able to practice medicine safely and competently in accordance with professional standards. Unfortunately there are several reasons why the Board cannot accept that proposition.

Firstly, the current proceedings are the second time Dr. Ahluwalia has been found guilty of professional misconduct and other serious breaches of the standards of the profession. Rehabilitation requires insight into the underlying causes of the problem and Dr. Ahluwalia's present difficulties indicate that he has no such insight.

Secondly, the Panel recognizes that appropriately drafted conditions on a physician's licence to practice medicine can be effective in certain circumstances. By way of example, if a physician has exhibited a lack of skill or judgment in a particular area, remedial training or problem focused supervision can be effective in correcting specific clinical deficiencies. Similarly conditions on a physician's licence to practice can be effective if that physician is suffering from an addiction, because conditions requiring therapy, counselling, and abstinence enforced by testing can meaningfully address the problems associated with the addiction. Conditions will be less effective when the root problems are many and varied, and those problems include issues relating to integrity and honesty, as in the case of Dr. Ahluwalia. Furthermore, the imposition of conditions on Dr. Ahluwalia did not work in relation to the proceedings in the late 1990s. The changes required to his computer system, which were part of the proceedings in the 1990s were allowed to degrade over time, and the program of psychological assessment and treatment, which was also ordered as part of those proceedings, failed to produce the desired results as demonstrated by Dr. Ahluwalia's current difficulties.

Thirdly, there was no specific evidence introduced as part of these proceedings relating to Dr. Ahluwalia's rehabilitative potential in the form of psychological or psychiatric assessments. Nor was a specific supervision plan put forward. As a result, there is no evidence or information upon which the Panel is able to rely to satisfy itself that notwithstanding Dr. Ahluwalia's past record and current problems, he has sufficient rehabilitative potential to warrant allowing him to practice medicine subject to conditions. After careful consideration of the issue of a conditional licence, the Panel is simply not satisfied that any conditions will provide reasonable assurances that Dr. Ahluwalia will practice medicine safely, competently and in accordance with the standards set or adopted by the College.

In reaching its decision with respect to the Order or Orders to be made under s.59.6 of *The Medical Act*, the Panel considered each of the 13 factors referred to in *Jaswal v. Newfoundland (Medical Board) (1996) 42 Admin. L.R. (2nd) 233 (NFLD. Trial Division)* which include, but are not limited to:

a) the nature and gravity of the proven allegations;

b) the age and experience of the offending physician;

c) the previous character of the physician and in particular the presence or absence of any prior complaints or convictions;

d) the presence or absence of any mitigating circumstances;

e) the need to maintain the public's confidence in the integrity of the medical profession; and

f) the range of sentences in other similar cases.

The Panel also recognized that some of the factors mentioned in *Jaswal* involved a consideration of the circumstances of and the impact on the "offended patient" and that in these proceedings, there was no evidence of an "offended patient". The absence of any evidence as to specific harm to a patient is a factor of which the Panel has been acutely aware in reaching its decision.

In weighing the factors articulated in *Jaswal* and in considering the objectives of orders under s.59.6 of *The Medical Act*, the Panel must attempt to balance public rights and the private rights of Dr. Ahluwalia. As noted by James Casey in his text *The Regulation of Professions in Canada*:

> "Given that the primary purpose of the legislation governing professionals is the protection of the public, it follows that the fundamental purpose of sentencing for professional misconduct is also to ensure that the public is protected from acts of professional misconduct."

The Panel recognizes its responsibility to ensure the safety of the public and to issue orders pursuant to s.59.6 of *The Medical Act* which will encourage and enforce the safe and competent practice of medicine. The Panel has been particularly mindful of the following factors:

(i) The seriousness of Dr. Ahluwalia's conduct and behaviour as outlined in the Amended Notice of Inquiry and as proven in these proceedings;

(ii) His multiple misrepresentations and false statements to the College, both orally and in writing, made with the intention of misleading the College, including the preparation of an elaborate "Peer Group Analysis", which was an entirely false and contrived document;

(iii) The nature and extent of the deficiencies in his clinical and medical records which show an alarming disregard of fundamentally important elements for proper medical practice and patient care;

(iv) His breaches of the College's Statement 104 and the Court of Appeal Order of July 13, 1999, which indicate both an inadequate understanding of the reasons underlying those requirements and a disrespect for the regulatory jurisdiction of the College and the authority of the Court of Appeal;

(v) Dr. Ahluwalia's prior disciplinary record;

(vi) The absence of any reliable evidence or information with respect to Dr. Ahluwalia's rehabilitative potential;

(vii) While there are some mitigating circumstances in this case, they are insufficient to negate or counterbalance the seriousness of Dr. Ahluwalia's misconduct.

Given the above noted factors, the Panel has concluded that allowing Dr. Ahluwalia to practice medicine, but subject conditions, does not provide an adequate assurance of patient safety or otherwise protect the public interest. Furthermore, such an order would not enhance the public's faith in the medical profession's ability to regulate itself.

Based on all of the foregoing, the decision of this Panel is to issue an Order pursuant to s.59.6 of *The Medical Act*:

(i) Reprimanding Dr. Ahluwalia;

(ii) Cancelling Dr. Ahluwalia's registration with the College and his licence to practice medicine in Manitoba, the effective date of the cancellation to be as determined by the College;

(iii) Requiring payment from Dr. Ahluwalia of the sum of $35,000 representing a contribution to the costs of the College in relation to these proceedings, (the Panel recognizes this sum has already been paid to the College).

The Panel also issues an Order pursuant to s.59.9 of *The Medical Act* that there shall be publication of the circumstances relevant to the findings made by the Panel and of the Orders of the Panel, including reference to Dr. Ahluwalia's name. The particulars of the publication shall be as determined by the Investigation Committee of the College.

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

WHEREAS Dr. Rajpal s. Ahluwalia (Dr. Ahluwalia), a member of the College of Physicians and Surgeons of Manitoba (the "College") was charged with professional misconduct and with contravening various provisions of By-Law #1 of the College and with contravening Statements 104 and 805 of the College and with displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine, and of demonstrating an unfitness to practice medicine, as more particularly outlined in an Amended Notice of Inquiry dated March 13, 2015;

AND WHEREAS Dr. Ahluwalia was summoned and appeared with counsel before an Inquiry Panel (the "Panel") of the College on December 1, 2015;

AND WHEREAS Dr. Ahluwalia, entered a plea of guilty to counts 1, 2, 3 and 4 in the Amended Notice of Inquiry and was deemed to enter a plea of not-guilty to count 5 in the Amended Notice of Inquiry;

AND WHEREAS, the Panel reviewed all of the exhibits filed, including a Statement as to Agreed Documents and all of the documents referred to therein, and heard submissions from counsel for the Investigation Committee of the College and counsel for Dr. Ahluwalia;

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

1. Pursuant to ss. 56(3) of *The Medical Act*, the identity of all Patients and of other third parties as referred to in the exhibits or otherwise in these proceedings, shall be protected in the record of these proceedings by referring to them in a non-identifying manner.
2. Dr. Ahluwalia is guilty of count 5 in the Amended Notice of Inquiry dated March 13, 2015.
3. Dr. Ahluwalia is hereby reprimanded pursuant to ss. 59.6(1)(a) of *The Medical Act.*
4. Dr. Ahluwalia's registration with the College and his licence to practice medicine in Manitoba is hereby cancelled pursuant to ss. 59.6(1)(g) of *The Medical Act*, the effective date of the cancellation to be as determined by the College.
5. Dr. Ahluwalia shall pay the sum of $35,000.00 representing a contribution to the costs of the investigation and inquiry pursuant to ss. 59.7(1) of *The Medical Act*.
6. There shall be publication of the circumstances relevant to the findings made by the Panel and of the Orders of this Panel, including reference to Dr. Ahluwalia's name, as may be determined by the Investigation Committee of the College pursuant to ss. 59.9 of *The Medical Act*.

Dated this 27th day of January, 2016.

O R D E R

This motion made by the Investigation Committee of the College of Physicians & Surgeons of Manitoba for an Order amending paragraph 4 of the Panel's Order and Resolution and the reasons for same issued on January 27, 2016 to the extent that the paragraph is referenced in the reasons by deleting the words "the effective date of the cancellation to be as determined by the College." was heard this day at the offices of the College of Physicians & Surgeons of Manitoba 1000-1666 Portage Avenue, Winnipeg, Manitoba.

ON READING the Notice of Motion dated February 5, 2016 and on hearing counsel for the Investigation Committee of The College of Physicians & Surgeons of Manitoba and reading the letter from Dr. Ahluwalia's legal counsel to Mr. Blair Graham dated February 10, 2016, Dr. Ahluwalia choosing not to appear at the hearing of this motion:

THE INQUIRY PANEL HEREBY ORDERS THAT:

1. The motion made by the Investigation Committee of the College is granted. As a result, paragraph 4 of the Inquiry Panel's Resolution and Order dated January 27, 2016 and subparagraph (ii) on p. 26 of the Reasons for Decision of the Inquiry Panel, also dated January 27, 2016 are hereby amended by deleting the words "the effective date of the cancellation to be as determined by the College."

DATED this12th day of February, 2016

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