From the College

Publications Mail Agreement #40051985
Return Undeliverable Canadian Addresses to
1000 – 1661 Portage Avenue, Winnipeg, MB R3J 3T7

Volume 43 Number 2 September 2007

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...

In my opinion, these changes came just in time. Over the past several years, there has been a steady increase in the complexity and contentiousness of the problems faced by the College. We are facing significant challenges in serving and providing leadership to Government, the public and our members in many areas. These include professionalism, end of life care, umbrella health legislation, emergency preparedness, registration and its impacts on medical manpower, to name only a few. More are coming. This is all set against a backdrop of legislative changes taking place in Britain and Canada which threaten to limit physicians' ability to regulate ourselves.

I am confident that the College of Physicians and Surgeons is well placed to defend physician self-regulation. However, this is true only as long as Council remains energetic, informed and vigilant. Many of you have strong feelings about how the College should conduct itself. I welcome them, as do all of your Councillors. Please don't hesitate to contact us with your thoughts as to how the College might do better.

Better yet, run for Council! We are always looking for members who have new ideas about how best to serve the public, represent our membership and preserve self-regulation.

Best wishes for a happy and productive Fall.

From the New President

On behalf of Council I would like to thank Dr. Heather Domke for her service as president in the past year. We were fortunate to have a leader who was so dedicated to her task and so inclusive of all points of view. For me personally, it was a great pleasure to learn from her and I am grateful for her generosity of time and insight.

Readers of this newsletter will be aware that your College and Council have changed considerably over recent years. The adoption of Policy Governance has meant a leaner Council whose focus has shifted more towards the larger "Ends" of the College and on making policies to achieve them. We have reduced duplication of effort between College staff and Council. At the same time, the College staff has taken steps to divest itself from responsibilities not felt to be essential to our core functions of registration, standards, and complaints and investigation.

Dr. Andrew MacDiarmid, President

Manitoba Colorectal Cancer Screening Program

The doors of the Manitoba Colorectal Cancer Screening Program are now open! The program office is located within the Misericordia Health Centre. The personnel for the program includes Dr. Ross Stimpson, Medical Lead, Jean Sander, Program Manager and Kim Morency, Health Educator.

Distribution of screening kits commenced in August 2007. During this first phase 25,000 individuals, 50 to 74 years of age, living in the Winnipeg and Assiniboine RHAs will receive a kit, which will include a fecal occult blood test.

For more information, call 788-8635 or 1-866-744-8961.

Standards Committee Confidentiality

Discussions which occur during a standards committee meeting are protected by The Evidence Act of Manitoba. Confidentiality of the discussions is crucial in order to protect the integrity of the review process and to allow open and frank exchange of information and ideas. Circumstances may occur which require some sharing of information when it is deemed that the public may be at some risk.

Bylaw 6**,** Section 5, states the conditions under which information may be disclosed or published. There are many ways that information from the Standards Committee can appropriately be communicated. However, Standards Committee members are reminded that the decision to disclose or publish information is made by the committee, and it is not an option for individual committee members to disclose information independently.

Information that is protected under The Evidence Act includes advice and opinions. It does not include any aspect of the patient's medical chart.

Individuals who believe that the committee is failing to inform or report appropriately are welcome to discuss their concerns with the Deputy Registrar of the College of Physicians and Surgeons of Manitoba, Dr. T. Babick.

Retaining Medical Records

Members of the College are required to keep medical records in accordance with By-Law Number 1 of the CPSM. Guideline 117: *The Physician Medical Record* and Statement 104: *Medical Computer Systems: Security and Self-Audit* were developed in order to assist members in meeting this requirement.

These documents can be accessed on the College's website at www.cpsm.mb.ca.

Disasters and Docs *(Part IV of IV)*

TRACING THE WAY AHEAD
Submitted by Guy Corriveau, Director, Disaster Management, WRHA

THIS IS THE LAST IN A SERIES OF ARTICLES DEALING WITH DISASTER MANAGEMENT AND THE ROLE OF THE PHYSICIAN IN RESPONSE TO AND/OR RECOVERY FROM DISASTER EVENTS.

Involving private practice and primary care physicians, and collaborating with the College of Physicians and Surgeons of Manitoba in Regional Disaster Management are desirable and achievable goals. The Winnipeg Regional Health Authority presentation to the College of Physicians and Surgeons was a first step. This article constitutes the next step of many in encouraging the participation of physicians in coordinated disaster response and recovery operations.

Remaining steps might comprise the following:

- Enabling the physician, when confronted by an extraordinary patient load, to respond in a manner that provides the highest level of appropriate patient care and reduces the burden on the overall Winnipeg Health Region healthcare delivery system.
- Enabling the physician, when confronted by patients in need of isolation to protect the patient and minimize the potential for spreading disease.
- Facilitating the analysis of an influx of patients, the provision of appropriate care, and/or the direction to patients on how to access further care and minimize the transmission of disease.
- Finding ways to reduce the impact on the community and practice during an event that may interrupt delivery of patient care; to sustain business operations for the overall health care capabilities within the community or the larger Winnipeg Health Region; and to minimize fiscal impacts.
- Strengthening relationships with regional public health and primary care programs.
- Maintaining clinic to clinic relations.
- Developing mutual aid agreements.
- Reviewing clinic to hospital referral protocols
- Establishing clinic to regional public health relationships for potential coordination (e.g., for a mass vaccination event).

Last Word

Readiness to provide effective medical care requires effective preparedness for your office and home, including a business emergency plan, home emergency plan, communications plan, and basic supplies. It also requires a means to check on your staff, and a way to let them know if, and how, they can come to work.

You, your family, and your staff must be safe.

Note from the Registrar

Welcome back after an extraordinarily hot summer. There are a number of exciting new issues that your College will be working toward over the next year.

As you know, this is the second year the College has offered on-line renewal of licensure. Many more members opted for this process this year, and we hope that it has made life easier for you. This year the College opted to forego the administration cost of using credit cards in order to encourage members to use this process. During the year, the College will implement a new data management system and over the next several years, it is likely that on-line will become the primary method for licence renewal.

Your College has always been an important participant in the national regulatory organization - the Federation of Medical Regulatory Authorities of Canada (FMRAC). Over the last several years, FMRAC has become a key player in the development of important national medical policy issues. The Executive Director/CEO, Fleur-Ange Lefebvre, Ph.D., was formally with the Canadian Medical Association. Dr. Lefebvre has provided great leadership and vitality to FMRAC, which has worked with Health Canada to develop emergency preparedness proposals, identify the importance of developing the ability to e-prescribe, and been a spokes-unit for important issues related to standards of practice and registration of doctors. At the Annual General Meeting in June 2007, I finished my term on the FMRAC Executive as Past President. Your Deputy Registrar, Dr. Terry Babick, was appointed to the Executive and so Manitoba will still be in a position to influence national policy in the future.

In August, Dean Sandham invited me to participate at the Inaugural Ceremonies for the Medicine I class of the Faculty of Medicine, University of Manitoba. Every year this extraordinary event gives me a chance to welcome new students to the broader practice of medicine for the rest of their lives. At the conclusion of the ceremony, the Dean led the students and all of us in the audience who were physicians in reciting the Hippocratic Oath. It is a moving experience to again enunciate those principles that are thousands of years old and identify why we give our lives to the service of our patients. We all should consider renewing that pledge at regular intervals.

The theme of this Inaugural Address was "*Professionalism*". I recently met with the Board of the Manitoba Medical Association to discuss a number of important issues. One of these was professionalism and the risk to physician self-regulation in Canada. In many of the other countries of the world, including the United Kingdom, Australia, New Zealand and the United States of America, the ability of physicians to influence regulation has been greatly eroded over the past decade. In Canada, we still are permitted by society through Government and The Medical Act to have a College of Physicians and Surgeons which is run by member physicians and where decisions on standards of practice, qualifications and discipline are made by physicians with public representative input. This is a privilege, not an entitlement. Likewise, the practice of medicine is a privilege and not an entitlement. We need to constantly keep this in mind and ensure that our daily actions continue to merit the retention of this privilege. The College Registrars are presently meeting with the Deans of the Faculty of Medicine to identify opportunities for all of us - the MMA, public representatives, Registrars, Deans, Faculty members and physicians in practice, to act as mentors and educators for medical students and residents. By setting responsible examples, we will be able to ensure that the privileges of self-regulation remain with us as physicians into the future.

Since the beginning of 2007, your College has been working with other health regulatory authorities in Manitoba as we look to the development of umbrella health legislation. Ontario, Alberta and British Columbia already have this in place. The principle here is that all health care professions will be established under a single Health Act. That Act will set out primary expectations for registration and licensure, handling of complaints and investigations, standards of practice, and transparency to the public, as well as a set of "reserved acts", the performance of which will be available only to professions included under that Act. Each profession will then have a regulation which will clarify how the main points of the Act will be interpreted for that profession. The purpose is to provide greater transparency for the public to understand how health care professions are regulated and to ensure that certain actions, which may be dangerous to individuals, are performed only by those who are recognized as appropriate and competent to perform them. This will be the first time in decades that all the College regulations and procedures will be reviewed. Certain aspects in other provinces have given rise to questions. I will be closely involved in this over the next months and will be keeping your Council informed. As new items are identified, we will communicate issues to you in the newsletter.

In this newsletter you will see the *Physician Resource Statistics* as at April 30, 2007. We are pleased to note an overall increase in the number of physicians. However, we hear from both the profession and the public that we still need many more physicians in Manitoba in order to provide the level of service which will be needed, particularly as some of us "mature" over the next decade or two.

I encourage any member with questions or comments on any of the above items to contact me by telephone (774-4344) or e-mail (bpope@cpsm.mb.ca) .

Transfer of Patients

Transfer of care of a patient can be a complex interaction between medical personnel. Stabilization of the patient to the extent possible is essential prior to transfer and transport.

The receiving physician must agree to accept the patient prior to transfer. The physician who initiates the transfer must speak with the receiving physician, must communicate the care which the patient has received, and must clearly describe the patient's present status. A written record must be transferred with the patient.

Recommendations for Ordering Diagnostic Imaging Studies

As part of their commitment to patient safety, the WRHA Diagnostic Imaging Program Standards Committee conducts case reviews to determine factors that contribute to occurrences. Recent reviews have demonstrated that there are opportunities for improvement in communication between referring health care providers (including physicians, extended practice registered nurses, and midwives) and DI staff. To this end, the following recommendations were developed in collaboration with Diagnostic Services Manitoba (DSM):

- All emergency and after hours diagnostic imaging requests should include an emergency contact number for the referring care provider and/or pager number to provide a route for urgent contact.
- Requisitions for diagnostic testing should have appropriate and legible clinical information regarding the patient's underlying condition.
- The referring care provider of the diagnostic test should be responsible for viewing or appointing a designate to review the emergency and/or after hours imaging study.
- As there always is a radiologist on call for the WRHA, in those circumstances where the ordering physician or their designate has difficulty interpreting the emergency diagnostic image, that physician can access the radiologist on call for assistance in the interpretation of the exam.
- Outside Winnipeg, if a radiologist on call is available for specific or all diagnostic imaging services provided by the healthcare facility, the ordering physician or designate should access the radiologist on call for assistance in the interpretation of the exam if having difficulty interpreting the emergency diagnostic image. It is out of radiographers' and sonographers' (x-ray and US technologist respectively) scope of practice to discuss preliminary findings with medical or nursing staff other than the reporting radiologists.
- There should be a clear and legible name of the referring care provider ordering the exam and a name of the attending care provider for reporting purposes.
- It should be the ordering care provider's responsibility to contact the patient when the radiologist's report differs from the preliminary report by the ordering care provider.

Need Assistance?

Call PHYSICIANS AT RISK –

Phone 237-8320 (24 hours)

Effective Delivery of Primary Health Care

Submitted by Dr José François and Dr Julie Lévesque, Centre de santé St-Boniface Health Centre

Ensuring effective delivery of primary health care services to patients is an important role of the health care system. Timely access to practitioners is a key feature of quality health care and a difficult goal to achieve. Until one and a half years ago, the way we used to handle scheduling at our community health centre matched the prevailing practice in health care: We maintained a large backlog of future appointments. Patients learned to expect a three- to six-week wait for appointments and dueled with our office staff to be seen for acute care when needed. We developed complex systems for managing the demand for acute care, most of which didn't work very well. Physicians and staff felt overwhelmed as they faced overbooked schedules and frustrated patients.

We knew we needed a better way to schedule our patients and found a solution in "advanced-access" scheduling, also called "open-access" scheduling, which theoretically eliminates the appointment backlog and makes appointments available the same day the patient calls. The principle behind open-access scheduling is to "do today's work today."

In February 2006, our clinic took a leap of faith and became one of the first in this province to adopt advanced access scheduling. Now, a physician's weekly schedule has at least 50% of all appointment slots open for same day appointments, 40% of the slots can be filled within a 4 day window and the remaining 10% of slots can be scheduled ahead of time. When one provider's schedule is full, patients are placed in a colleague's schedule. The transition was not easy, but we can now appreciate the benefits – the number of "no shows" has dropped, the number of effective appointments has increased and staff satisfaction is improved. The process first starts by assessing the demand (number of patients calling for appointments) and calculating the practice's supply (number of appointment slots in the schedule). The goal is to match the supply with the demand. If a physician's panel of patients is too large (ie 6,000 patients), he or she may not be able to meet the demand for appointments and therefore advanced access scheduling would not be feasible without first getting extra help in the office. After this first step has been completed, the practice then needs to reduce its backlog (the so called "appointment debt"). This usually involves seeing more patients each day for a period of 6-8 weeks. In our practice's case, the start of our new scheduling system coincided with the hiring of a new physician who dealt with our practices backlog before taking on new patients of her own.

Once the backlog is dealt with, the practice should be in the position of doing today's work today. The work does not stop here, maintaining the whole process is important – one needs to remember that demand may change over time as can the supply. The practice must make contingency plans to deal with periods of peak demand (ie flu season) or when supply is low (ie a physician on vacation or on leave).

For more information on implementing advanced access scheduling, go the Institute for Health Care Improvement (IHI) at www.ihi.org/IHI/Topics/OfficePractices/Access .

Electronic Printing of Prescriptions

It is commendable that physicians are implementing electronic prescription printing processes in order to improve the quality of text. This contributes to improved patient safety and better patient outcomes.

However, there is concern regarding the quality of printing produced by electronic thermal printers that may be purchased by physicians for use in their offices. Several grades of paper and ink are available and physicians should ensure that they purchase a medical grade printer and paper products. Medical grade equipment assures that the prescription remains legible and does not fade during the seven years that the law requires a prescription be kept.

Congratulations

- To Dr. Frank Plummer who has been awarded the Order of Canada
- To Dr. James Blanchard, of Community Health Sciences, who won the RH Award this year for his research on the characteristics of individuals, communities and large populations, and contributed to the distribution of diseases.
- To Dr. Allan Ranson, a former College Councillor, who has been awarded the Family Physician of the Year Award by the Manitoba Chapter.
- To Dr. Colin Noel, who has been awarded the Award of Excellence from the College of Family Physicians of Canada for his 25 year commitment to an enormous workload of comprehensive patient care.
- To Dr. Michael Penrose, by the College of Family Physicians of Canada, in honour of his 17 year commitment to patients, trainees and the community at large, for exemplifying the principles of family medicine.
- To Dr. Philip Hall, who has been awarded Honorary Membership in the College of Family Physicians of Canada.
- To the winners of the Manitoba Medical Association awards for 2007. They are: Dr. Anthony Miller (Distinguished Service Award), Dr. Lindsay Nicolle (Scholastic Award), Dr. Luis Oppenheimer (Health Administration Award), Dr. Stuart Hampton (Physician of the Year Award) and Dr. Ferdinand Pauls (Dr. Jack Armstrong Humanitarian Award).

Physician Member Wanted for the Engineers' Discipline Committee

The Manitoba Association of Professional Engineers and Geoscientists is requesting the name of a physician to add to the list of possible individuals who might participate on the discipline committee of the Association. If any members are interested, please contact the Registrar for further information at 774-4344.

Items from the Complaints and Investigations Committees

1. Uninsured Services

The Investigation Committee recently reviewed a complaint from a patient from Quebec who was charged a fee equivalent to 2 times the amount payable by Manitoba Health for an insured service (in accordance with the MMA recommendation). It is noted that Quebec is not a participant in the reciprocal billing agreement between the provinces. Quebec residents submit fees paid for uninsured services and the Quebec health plan gives re-imbursement in accordance with the Quebec rates.

Members are reminded that patients must be informed in advance of the specific charges (or range of charges) of all uninsured services to be provided to the patient. Besides posting signs in the clinic area, staff should ensure that patients are aware of the uninsured fees prior to service delivery.

2. Lessons Learned

The Investigation Committee recently considered a complaint against a physician who charged the patient a fee for conversion of a paper medical record to an electronic medical record. As part of its review, the Investigation Committee made inquiries of other Colleges and the MMA, each of which concurred with this College that conversion to electronic records is part of the cost of operating an office and not a service for which a fee may be charged.

Physicians are reminded that it is not appropriate for a patient to be charged for the cost of creating a patient chart, whether that chart be a paper chart or an electronic file.

3. *Confidentiality Within the Office*

The Complaints Committee recently reviewed a patient concern. The patient had attended a physician's office for the first time. The initial discussion between the physician and the patient deteriorated and the discussion became both loud and bad tempered.

The patient was concerned that other patients in the office heard the confrontation and he was humiliated in front of the public.

The Complaints Committee reminds physicians that they must do everything possible to ensure that all confidential communications between patients and physicians or patients and office staff must be conducted out of hearing range of the waiting room and other patients. Physicians are encouraged to remind their staff that confidential information must be kept private under the Personal Health Information Act.

4. Appropriate Information to Accompany Emergency Room Discharge

The Complaints Committee recently reviewed a concern about a patient who was admitted to Emergency overnight and then discharged the next day. The Committee was concerned that the patient was not assessed satisfactorily prior to discharge. The note the next morning was very sketchy.

It is important for members to know that any patient, upon discharge, should be properly re-assessed by the physician at the time of discharge and a clear note written, including discharge instructions, medications and follow-up requirements.

New Application Form for Handi-Transit

In April 2006, City of Winnipeg Council approved a number of changes to the eligibility criteria and registration process for Handi-Transit service.

As part of the changes, the Transit Department has developed a new application form to obtain the information required to assess applicants' transportation needs. An Occupational Therapist will review applications and follow-up as required to determine an applicant's eligibility.

To expedite the process, the new Handi-Transit Application Form (full) is posted on the website at winnipegtransit.com:

- Click on the Handi-Transit link
- Click on the On-Line Application Form link
  Note: An Application for Extension of Temporary Service (short) has been posted.

As of June 18, 2007, Handi-Transit will only accept the new application form. The application form may change slightly as additional information is required. However, the current version will always be available on the website. Completed applications will be accepted by mail or fax.

All current Handi-Transit registrants (except those who require the use a wheelchair or are legally blind) will be required to re-register for Handi-Transit service to ensure they fully meet the eligibility criteria. Registrants will be notified by letter and allow an eight-week window to submit their new application. This will occur gradually over the next 18 months or so.

For more information on Handi-Transit visit the website or telephone 986-5722 or fax 986-6555. You may also write to Unit B, 414 Osborne Street, Winnipeg, MB R3L 2A1.

Physicians Ordering Lab Tests for Themselves & Immediate Family Members

Recently, the Central Standards Committee of the CPSM has been informed that some physicians have been ordering laboratory tests for themselves and for immediate family members. Article 11 of the Code of Conduct states "Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available."

The broad interpretation of the word "treatment" is deemed to include the ordering of laboratory tests and diagnostic imaging.

Members are reminded that the ordering of these procedures for self or immediate family members is a breach of the Code of Conduct and could be deemed to be professional misconduct.

Automated External Defibrillators

In the past, defibrillation was considered exclusively a physician function. However, with advances in technology and training, defibrillation is now broadly available in the public domain.

Automated External Defibrillators (AEDs) are widely available in airports, restaurants, and sports facilities and these machines are operated by non-health care individuals with some life saving training from programs that may or may not include a physician director.

There is a difference in public expectation when a physician has an AED in their office or clinic and when an AED is located in a public access location.

When an AED is located in a physician's office or clinic, it is considered part of a medical process. The physician director of the office or clinic must ensure that staff have appropriate training to use AEDs, there are relevant and up-to-date policies, and the equipment is properly maintained.

Ensure FAX Number is Correct

The College was recently informed that several doctors' offices had sent personal health information in error to a private fax number similar to that of a local clinic.

Members are reminded that, under the *Personal Health Information Act*, they must ensure that fax numbers on all information forwarded to another location is correct.

Reporting Minor Parents

Physicians who provide prenatal or obstetrical care are reminded of a reporting requirement in *The Child and Family Services Act* to report to the Director of Child and Family Services regarding unmarried pregnant children. The requirement is as follows:

Notice to director of birth of child to an unmarried child
9(4) Where a hospital or other institution has received for care during pregnancy or accouchement an unmarried child or a child with respect to whose marriage there exists reasonable doubt, the person in charge of the hospital or other institution shall forthwith notify the director or an agency on a prescribed form; and shall in like manner, on the birth of the child in the hospital or other institution, report the fact to the director forthwith.

After Hours Coverage

In the Spring, the College surveyed all licensed physicians to ask their opinions on after hours call. The response, according to the experts, was much higher than normal. Thanks to all who participated.

The following letter has been prepared by the Working Group:

Dear Members,

As members may recall, the College undertook a survey of all members in January and February 2007 regarding after hours coverage. In total, 2200 surveys were mailed out, and 927 replies were received, a response rate of 42%.

For analysis purposes, physicians were grouped as follows:

- Region
- Area of Practice:
  - Group 1– Family medicine, paediatrics and psychiatry
  - Group 2 – Anesthesia, surgery, ophthalmology, critical care, obstetrics
  - Group 3 – Internal medicine, oncology, ER and hospitalists
  - Group 4 – Lab, radiology, public health, admin, sports medicine and others
- Age
- Gender

The full report of the survey is available on the College's website. However, it is worth highlighting several results. Not surprisingly, 72% of physicians in Brandon and rural communities of more than 5000 people indicated they were part of a call group, compared with 55% of Winnipeg doctors. Of those physicians who do not offer after hours coverage, 20% stated that they recommend patients call Health Links, go to an ER or a WIC, 14% stated that they were not in clinical practice and 13.7% stated that they were hospital/ER/or PCH based.

Only 57% of physicians answered that they were available for a lab to contact them in the event of a critical lab value. 43% are notified when the office next opens.

67% of physicians replied that they agreed with the statement that "physicians involved in direct patient care have a duty and obligation to arrange for 24 hour coverage for patients currently under their primary care".

The After Hours Working Group is committed to working with members towards developing better models for the provision of after hours coverage for patients. We understand the obstacles that face physicians in their daily practices, and recognize the complex interplay of resources, remuneration, access to patient information, and communication that present challenges to providing quality care to our patients in the current medical environment. Over the ensuing months, we will be meeting with stakeholders to attempt to collaborate and develop creative, workable solutions to this issue, that reflect a desire to provide quality care to our patients while recognizing the difficult challenges that physicians face.

We welcome your input. The members of the Working Group include Dr. Will Fleisher, Dr. Andrew McDiarmid, Dr. Kevin Saunders, Dr. Sarah Kredentser and Mr. Bill Shead.

Members who wish to comment may forward their thoughts to the Registrar at bpope@cpsm.mb.ca.

FROM THE COLLEGE
is a publication of

College of Physicians & Surgeons of Manitoba
1000 – 1661 Portage Ave
Winnipeg MB R3J 3T7

Tel: (204) 774-4344; Fax: (204) 774-0750
Internet: www.cpsm.mb.ca

Physician Resource Statistics 2006-2007

The following statistical material provides a measure both of College activity and also the movement of physicians within and through the Medical Register.

Committee Activities
The Councillors of the College make up the governing body and as such met four times last year to consider financial matters and policy issues. They are all expected to serve on at least one College committee.

Numbers Registered
The total number who received initial registration showed an increase of 7. The number of University of Manitoba graduates increased from 30 to 41 but the total number of Canadian graduates decreased from 43 to 31. The number of graduates from Asia remained the same at 40.

Numbers Practising
This year's total shows an increase of 54 physicians.

"Resident Impact" on the Community
Residents in training who are qualified to enter onto the Medical Register may take out a full licence. Those who then choose to confine themselves to the teaching program activities may do so at a reduced licence fee. These "licensable doctors" have traditionally been the source of human resources in Manitoba for vacation relief for community doctors, emergency departments and special care units. Section D of this report shows a slight increase from 2006. The 2007 residents with full licences increased slightly since last year from 33 to 35. The number of resident licences remained the same at 24.

Distribution of Medical Practitioners by Source
The percentage of practising physicians who are Canadian graduates remained relatively the same this year. Percentages over the past five years are 64.8%, 65.1%, 64.7%, 65.6%, and 65.5% (65.1% in 2007). The presence of Canadian graduates in Winnipeg is 74.9% compared to 36.6% in all other areas.

In contrast, graduates from Africa are represented in reverse significance: 3.6% in Winnipeg compared to 35.1% in all other areas. These physicians now form a very important part of rural Manitoba physician numbers (see Table III).

While approximately half of the African graduates in rural Manitoba and Brandon are from South Africa, the remaining half is from other African countries, primarily Egypt.

Specialists
The number of physicians currently enrolled on the Specialist Register has increased by 16 from last year (1089 to 1105). This figure is based on physicians currently residing in the province who are on the Specialist Register.

(A) **MEETINGS**
During the period 1 May 2006 to 30 April 2007, the following meetings were held:

4	Council: 15 June, 15 September, 15 December 2006; 16 March 2007
9	Executive Committee: 16 June, 29 June, 20 July, 30 August, 15 September, 15 December 2006; 22 January, 16 March, 4 April 2007
5	Appeal Committee: 16 June, 15 September 2006; 26 January, 16 March, 18 April 2007
9	Complaints Committee: 13 June, 11 July, 5 September, 10 October, 14 November, 5 December 2006; 23 January, 6 March, 17 April 2007
2	Audit Committee: 31 May; 6 December 2006
0	Inquiry Committee
0	Inquiry Panel
6	Investigation Committee: 7 June, 27 September, 15 December 2006; 17 January, 14 March, 11 April 2007
0	Liaison Committee with M.M.A.
2	Program Review Committee: 10 November 2006; 26 January 2007
5	Standards Committee: 7 June, 5 October, 6 December 2006; 14 February, 4 April 2007
	In addition: 4 meetings of Child Health Standards Committee
	2 meetings of Maternal & Perinatal Health Standards Committee
	27 meetings of Area Standards Committees
42	meetings
33	meetings of subcommittees, and
24	(19) hospital and (5) non-hospital reviews
99	Total

(B) **CERTIFICATES OF REGISTRATION ISSUED**

During the period 1 May 2006 to 30 April 2007, 157 persons were issued registration and a full licence to practise. In total there were 173 certificates of which 15 were for a residency licence. One physician did not practise here.

TABLE I MEDICAL PRACTITIONERS GRANTED REGISTRATION AND FULL LICENCE ANNUALLY IN MANITOBA 1998 - 2007 with Country of Qualification

Year	Man	Can	USA	UK&I	Eur	Asia	Aust	NZ	Afr	C/S Am	Total
1998	26	21	2	3	4	7	1	0	44	2	110
1999	21	27	1	3	1	11	0	0	52	1	117
2000	27	43	0	5	7	11	2	1	48	2	146
2001	16	19	3	1	1	9	1	0	48	0	98
2002	33	25	1	3	2	13	1	0	61	0	139
2003	30	35	0	1	8	12	0	1	45	4	136
2004	28	19	1	2	9	20	0	0	38	4	121
2005	36	33	2	3	6	23	0	0	22	4	129
2006	30	43	0	3	8	40	0	0	26	2	152
2007	41	31	0	8	4	40	1	0	29	3	157
Total (10 Yr)	288	296	10	32	50	186	6	2	413	22	1305
New Practitioners % of Total											
2007	26.1	19.7	0.0	5.1	2.6	25.5	0.6	0	18.5	1.9	100%

Percentages may not be exact due to rounding

(C) **NUMBER OF LICENSED PRACTITIONERS IN MANITOBA AS AT 30 APRIL 2007**

TABLE II NUMBER OF LICENSED MEDICAL PRACTITIONERS IN MANITOBA 1998- 2007

Year	Winnipeg	%	Outside Winnipeg	%	Totals	Net Gain Net Loss(-)
1998	1543	76.5	473	23.5	2016	-19
1999	1539	75.6	498	24.4	2037	21
2000	1554	75.5	504	24.5	2058	21
2001	1560	75.2	514	24.8	2074	16
2002	1592	75.0	530	25.0	2122	48
2003	1618	75.2	534	24.8	2152	30
2004	1626	74.7	550	25.3	2176	24
2005	1640	75.0	546	25.0	2186	10
2006	1663	75.0	555	25.0	2218	32
2007	1688	74.3	584	25.7	2272	54

The total of 2272 includes 35 fully licensed residents. There are no data on how many actually “moonlight”, or to what extent.

The following table shows the possible influence of this resident population on the number in active practice.
(Full Licence: FL; Resident Licence: RL)

	FL		*Subtotal*	*RL*	*Total*
2002	2074	48	2122	26	2148
2003	2106	46	2152	24	2176
2004	2135	41	2176	24	2200
2005	2145	41	2186	21	2207
2006	2185	33	2218	24	2242
2007	2237	35	2272	24	2296

(D) CLINICAL ASSISTANT REGISTER PART 1 (Educational)

Postgraduate physicians in training programs are now referred to as residents. They may be pre-registration (Clinical Assistant Register) or they may have met the registration requirements and are eligible for an independent licence. This latter category of residents may opt to practise only within their residency program (residency licence) or may obtain a full licence.

	2007	**%**
Medical Students	373	
Postgraduate trainees	389	
Total On Clinical Assistant Register	762	92.8
On Residency Licence	24	2.9
Full Licence	35	4.3
TOTAL	**821**	**100.0**

(E) DISTRIBUTION OF PRACTITIONERS

The following tables analyse the composition of the physicians in Manitoba by various breakdowns.

TABLE III
DISTRIBUTION OF MEDICAL PRACTITIONERS BY COUNTRY OF QUALIFICATION
as at 30 April 2007 (as a percentage)

		Winnipeg	**Brandon**	**Rural**	**Residency**
		1688	126	458	24
%	Man	58.6	24.6	29.3	41.7
	Can	16.3	14.3	6.8	25.0
	Total Canada	**74.9**	**38.9**	**36.1**	**66.7**
	USA	0.5	0.0	0.4	0.0
	UK & Irel	6.0	8.7	8.5	4.2
	Eur	4.3	0.8	2.8	4.2
	Asia	8.8	14.3	14.6	16.7
	Aust/NZ	0.5	0.0	0.7	0.0
	Afr	3.6	32.5	35.8	8.3
	S.Am	1.5	4.8	1.1	0.0

Percentages may not be exact due to rounding.

TABLE IV **PERCENTAGE OF MEDICAL PRACTITIONERS IN MANITOBA AS TO COUNTRY OF QUALIFICATION**

	2007
Manitoba Graduates	50.8
Other Canadian Graduates	14.3
TOTAL CANADA	**65.1**
United Kingdom & Ireland	6.6
Asia	10.3
Other	18.0

TABLE V **GEOGRAPHIC DISTRIBUTION OF FEMALE PRACTITIONERS**

	Winnipeg	**Brandon**	**Rural**	**Total**	**Resident Licence**
1982	213	8	44	265	51
2002	444	21	94	559	15
2003	465	29	90	584	8
2004	469	28	110	607	9
2005	492	31	110	633	6
2006	518	33	118	669	7
2007	528	32	128	688	11

30.3% of fully licensed physicians are female, up 19 in actual numbers in the past year. 31.3% of practitioners in Winnipeg are women, 25.4% in Brandon and 27.9% in rural Manitoba. 45.8% of those with a residency licence are female. During the past 25 years there has been an increase of 315 women in Winnipeg, 24 in Brandon and 84 in the remainder of the province.

TABLE VI **AGES OF DOCTORS RESIDING IN MANITOBA AS AT 30 APRIL 2007**

	Winnipeg	**Brandon**	**Rural**	**Total**
Over 70	90 (5.3)	5 (4.0)	16 (3.5)	111 (4.9)
65 -70	93 (5.5)	9 (7.1)	22 (4.8)	124 (5.5)
56 - 64	321 (19.0)	24 (19.0)	53 (11.6)	398 (17.5)
46 - 55	540 (32.0)	41 (32.5)	131 (28.6)	712 (31.3)
36 - 45	453 (26.8)	34 (27.0)	142 (31.0)	629 (27.7)
31 - 35	164 (9.7)	10 (7.9)	82 (17.9)	256 (11.3)
30 or under	27 (1.6)	3 (2.4)	12 (2.6)	42 (1.8)

Percentages (shown in brackets) may not be exact due to rounding

(F) CONTINUING MEDICAL EDUCATION

In 1979 the Council passed a by-law establishing a voluntary standard of continuing medical education with the proviso that members who met that standard would have this acknowledged in the published list of practising physicians. December 1982 was the first time that this by-law became effective.

TABLE VII PERCENTAGE OF PHYSICIANS REPORTING COMPLIANCE WITH CONTINUING MEDICAL EDUCATION STANDARDS FOR THE PERIOD 1 January 2006 to 30 April 2007

	Winnipeg	Brandon	Rural	TOTAL
Total	1688	126	458	2272
70+	84.8%	40.0%	84.2%	82.9
65 - 69	89.7	88.9	84.2	88.7
50 - 64	94.1	90.5	89.3	93.1
35 - 49	91.1	75.9	78.7	87.4
under 35	70.1	66.7	66.2	68.7
All Ages	89.8	79.4	79.9	87.2

(G) **MANPOWER CHANGES from 1 May 2006 to 30 April 2007**

TABLE VIII ADDITIONS AND DELETIONS

A comparison of additions and deletions to the roll of physicians currently resident in Manitoba and licensed to practise: 1 May 2006 to 30 April 2007.

Deletions include deaths, retirements, erasures, and transfers to Residency Licence.

Additions are those entering who initiate a licence to practise and includes those who were previously registered.

ADDITIONS 2006	ADDITIONS 2007		DELETIONS 2007	DELETIONS 2006
		AGE		
30	29	30 or under	8	19
73	96	31 - 35	54	55
79	84	36 - 45	65	60
31	48	46 - 55	42	41
11	13	56 - 64	19	14
7	6	65 - 70	18	14
5	8	over 70	24	22
257	**284**		**230**	**225**
		YEARS SINCE QUALIFICATION		
40	44	5 or less	14	16
81	80	6 - 10	51	64
111	133	11 - 30	106	98
25	27	over 30	59	47
257	**284**		**230**	**225**
		YEARS SINCE REGISTERED IN MANITOBA		
N/A	N/A	5 or less	105	109
		6 - 10	46	41
		11 - 30	42	39
		over 30	37	36
			230	**225**

ADDITIONS 2006	ADDITIONS 2007		DELETIONS 2007	DELETIONS 2006
		PLACE OF QUALIFICATION		
67	87	Manitoba	57	71
6	9	Alberta	10	3
7	7	B.C.	5	5
7	2	Atlantic Provinces	3	5
28	30	Ontario	31	22
4	2	Quebec	1	2
9	6	Saskatchewan	6	4
128	**143**	**TOTAL CANADA**	**113**	**112**
0	1	U.S.A.	0	0
17	18	U.K. & Ireland	29	17
12	6	Europe	9	7
48	56	Asia	29	28
0	2	Aust/N.Z.	1	0
48	51	Africa	42	58
4	7	C/S America	7	3
129	**141**	**TOTAL ALL OTHERS**	**117**	**113**
		TYPE OF PRACTICE		
88	85	Specialist	87	67
169	199	Non-Specialist	143	15
257	**284**		**230**	**225**

DEATHS OR DELETIONS	**2006**	**2007**	
Deaths		6	6
Transferred to Residency Licence	7	7	
Removed from Register/Suspended	4	0	
No Longer Practising/Retired	44	48	
DEPARTURES to: (Total)	163	169	
Atlantic Provinces	5	1	
Quebec		3	3
Ontario		23	33
Saskatchewan	1	2	
Alberta		12	18
British Columbia	23	29	
NWT/NU	0	0	
TOTAL CANADA	66	86	
U.S.A.		15	8
U.K. & Ireland	0	1	
Others/Unknown	82	74	
TOTAL DELETIONS	225	230	

(H) SPECIALIST REGISTER

54There were 1105 specialists enrolled on the Specialist Register as at 30 April 2007.

(I) CERTIFICATES OF PROFESSIONAL CONDUCT (COPC)

During the period 1 May 2006 to 30 April 2007, 314 COPCs were issued. These are usually required for the purposes of obtaining registration in another jurisdiction. The following table indicates the purposes for which the certificates were issued and a comparison with 2006.

Provincial Licensing Bodies:	**2007**	**2006**
British Columbia	60	59
Alberta	42	52
Saskatchewan	10	4
Ontario	70	52
Quebec	0	1
Prince Edward Island	1	1
New Brunswick	1	0
Nova Scotia	4	9
Newfoundland	4	3
Northwest Territories/Nunavut	12	17
Australia & New Zealand	1	9
Overseas	7	2
U.S.A.	25	9
Miscellaneous	17	15
Winnipeg RHA	51	55
Brandon RHA	9	15
TOTALS	**314**	**303**

Notices, etc…

College Council Meetings for 2007 - 2008

- Friday, December 14, 2007
- Friday, March 14, 2008
- Friday, June 30, 2008 (AGM)

All meetings are held in the College of Physicians and Surgeons of Manitoba Boardroom. Members are welcome to attend, however you must register in advance as seating is limited.

Public Forum at Provincial Patient Safety Conference.

We Grieve, We Listen, We Learn *- A Public Forum on Patient Safety*

Wednesday, November 21 1830 hrs – 2000 hrs
Winnipeg Convention Centre
Featuring:
- Mr. John Lewis, Hamilton, Ontario
- Dr. Stavros Prineas, Bathurst, Australia
- Dr. Rob Robson, Winnipeg, Manitoba

This forum provides a voice for patients and families in patient safety initiatives and fosters openness to discuss and learn from adverse events in health care settings.

This forum is free to all who wish to attend. No registration is required

For more information, visit the events section of the Manitoba Institute For Patient Safety website at www.mbips.ca or call 204-927-6477.

Approved Billing Procedure

When physicians wish to recruit a colleague to carry out the practice of medicine in their place and bill in their names, the College must be advised ***in advance*** and approve the specific time interval. Only when written approval is received may a physician act in place of another. Without written approval as a locum tenens, one physician may replace another, but must act and bill independently

Changes of Address

Bylaw #1 requires that all members must notify the College of any change of address within 15 days so that communications can be kept open. The College cannot be responsible for failure to communicate to registrants who have not notified us of address changes.

Accepting Visiting Medical Students for Electives (UG/PG)

Are you considering sponsoring a medical student and/or resident for an elective? ALL visiting medical students and residents must be registered with the University of Manitoba and the College of Physicians and Surgeons of Manitoba. There is a defined process with eligibility criteria that must be met. For more information please contact the appropriate person at the University of Manitoba:

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

11th Annual Bug Day

When:
Tuesday, October 16th, 2007 - During National Infection Control Week

Where:
Health Sciences Centre, U of M Bannatyne Campus,Theatres A, B and
Basic Medical Sciences Building
730 William Avenue, Winnipeg, Manitoba

Objectives:
• Promote infection prevention and control principles and practices
• Promote hand hygiene awareness and safe health practices for the prevention of infection
• Identify emerging pathogens and antimicrobial resistant microorganisms as important issues in the community and healthcare facilities

Who Should Attend?
Any person with an interest in the prevention and control of communicable diseases and health issues in the community or in healthcare settings.

Bug Day will be broadcast through MBTelehealth. To confirm availability at your location, contact your local MB Telehealth Coordinator, or call the Network Scheduler (204) 975-7754, or call MB Telehealth toll free 1-866-667-9891

To learn more about MBTelehealth visit their website at www.mbtelehealth.mb.ca.