From the College

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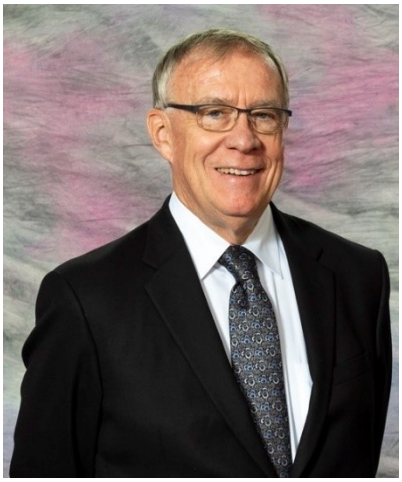
This newsletter is forwarded to every registered member of the College of Physicians & Surgeons of Manitoba. Decisions of the College on matters of standards, amendments to regulations, bylaws, etc., are published in the newsletter. The College therefore expects that all members shall be aware of these matters.

From Your President
DR. ERIC SIGURDSON



Professionalism

Honesty, judgment, reliability, communication, empathy, tolerance for frustration, and commitment to "get it right" are all hallmarks of professionalism. These qualities are applicable to the medical profession and other professions. The citizens of Manitoba have an understanding of professionalism which is conduct that meets an intuitive standard. The public recognizes this quickly when receiving care.

Your Council was most fortunate to discuss professionalism in medicine with Dr. Samia Barakat, recently retired from the University of Manitoba as Associate Dean, Professionalism in the Max Rady College of Medicine. Many of you may have been fortunate to hear her present this topic elsewhere. If so, I expect you will agree that this is highly valuable for all physicians as professionalism is integral to the College's mandate. I would like to highlight a few comments.

Dr. Barakat defined professionalism as "The habitual and judicious use of communications, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served." From her perspective the attributes of professionalism are:

- Knowledgeable, including scientific method and biomedicine
- Skillful, including clinical reasoning skills and communication
- Altruistic, including respect, compassion, honesty
- Dutiful, including population health, advocacy, outreach, health system management

Every physician is required to have a commitment to professionalism, encompassing a responsibility to patients, society, the profession, and to self. Professionalism will change over time and can vary by generation. What an older baby boomer will consider to be professionalism might differ from what a millennial considers professionalism. Professional attire, tattoos, and referring to people by their surnames, as examples, have all altered over time. Some aspects of professionalism such as the need to maintain healthy boundaries, to respect differing cultural perspectives, and to be financial responsibility to a publically funded health system are enduring.

Professionalism is at the core of medicine's contract with society. It assumes physicians will place the interests of patients above our own, even when difficult.

Self-Regulation is key to understanding professionalism. Medicine and its practitioners are granted certain privileges on the understanding that physicians and their organizations will behave in a certain fashion. These organizations are responsible for ensuring that practicing physicians understand their obligations under this Social Contract. Dr. Barakat described the College as the conscience of the profession.

At the College, we often address examples of unprofessional behaviours: misrepresentations, boundary violations, financial violations, and others. At a basic level, the importance of a culture of personal self-regulation and respect can prevent many of these transgressions. Ask this basic question, if you are uncomfortable in discussing a matter with a colleague, then that should be an indicator that something is wrong. For instance, gifts from a patient such as a box of chocolates may be acceptable, but something more substantial, such as a trip with the patient is not.

We are well advised to consider the words of the Canadian Medical Professional Association that as physicians we can take comfort in the knowledge that if we anchor our actions and decisions in Professionalism, our patients, society and the profession will be well served.

All the best
Sincerely
Eric Sigurdson, MD MSc FRCPC
President, CPSM

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Notes from the Registrar

It has been a very busy spring and summer here at the College.

The new member data base (iMIS) has and continues to be a big IT project for staff at the College. The new data base went live on July 16th and although there is still lots of work to do it is going relatively well. We hope to introduce a secure member's portal which will house each member's information on fees, medical corporation, annual reports for renewal, undertakings, status of membership, complaints, etc. We hope to have the portal in place for license renewals in the fall.

The last membership database was 10 years old and no longer supported by IT companies, so it was at the end of its useful life, or even beyond that!

I would like to thank all College staff for the extra time and effort that has been put into this project. I also want to thank you, the members, for being patient with staff as their response times may have been a bit longer than usual due to the extensive testing that was required over that last few months in order for the new member data base to go live in July.

The next IT project will be a new website. Something anyone who has visited the CPSM website recently will agree is much needed.

As you were advised in the June 2018 College Council update the new Standard of Practice for Prescribing Opioids was passed by Council and will be effective September 30, 2018. Staff is working on an implementation plan and we will keep you updated when we have more information to share with you. The comments from the consultation were extremely helpful and many of you will notice changes to the new version reflecting your input. As the Registrar and a practicing physician (ER and hospitalist), I believe the standard falls appropriately in the balance of achieving safe and effective prescribing practices that physicians will be able to follow.

The College's implementation focus will be educational for the purposes of an approach which achieves safe prescribing practices and is not punitive. The intent is to take a "remedial" approach overall, mindful that the threat of serious discipline could lead some physicians to abandon opioid-addicted patients, leaving them to secure opioids from a potentially contaminated street supply.

The next big project will be to bring the College under the Regulated Health Professions Act (RHPA) which we still anticipate will be January 1, 2019. Most of the work on the documents has been completed and preparation by each department is taking place so all is ready for January 1, 2019. With the new RHPA there will be a number of changes in the way the College operates. A chart outlining "RHPA Key Changes for Members" can be found at the end of this newsletter.

Under the RHPA many members will be placed into new classes of membership, though most will remain as full practising members of the College as physicians. Any member whose existing class of membership will change will receive a letter form the College advising them of this change.

Under the RHPA a license will become a certificate of practice, similar to every other regulated health profession. While numerous changes occur at the College level, your practice of medicine will remain pretty much unchanged.

I will continue to keep you updated on happenings at the College but also ask that if there are items you feel are relevant that should be included in the newsletter please let me know. Please feel free to contact me any time at AZiomek@cpsm.mb.ca with any comments or suggestions you may have.

Anna M. Ziomek, MD
Registrar/CEO

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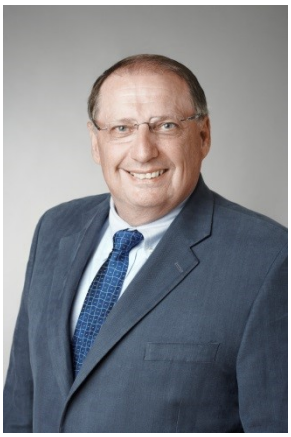
Max Rady College of Medicine, Rady Faculty of Health Sciences



UNIVERSITY OF MANITOBA

Message from
Dr. Brian Postl
Dean, Rady Faculty of Health Sciences &
Vice-Provost (Health Sciences)
University of Manitoba

A couple built their family's home this past June alongside physicians and other health professionals, researchers and students thanks to a continued partnership between the University of Manitoba's Rady Faculty of Health Sciences and Habitat for Humanity Manitoba.

The partner family – parents Leeann and Craig and four children ages 7 to 15 – are involved in sports, community and school activities. The whole family came to Bannatyne Campus June 4 for the kick-off to the 10-day build.

The father expressed that he was "overwhelmed with gratitude" at the kick off and that the home was going to help him and his family prosper.

This is the fourth time the Rady Faculty of Health Sciences is partnering with Habitat to build a home for a family in need and we are proud to be leading the country as a socially accountable faculty. Social responsibility and accountability are core values for our Rady Faculty learners, faculty and staff and we are delighted to be involved in this community project once again.

At the Rady Faculty, we recognize that housing is a social determinant of health and that safe, affordable housing is a "key to health" and leads to better outcomes including improved health and well-being, education success and self-esteem.

This year's partner family, who will experience home ownership for the first time, includes Leeann and Craig and children Jordan, Quinton, Eric and Tierra. Leeann and Craig grew up in Point Douglas, with their families still living in Ebb and Flow and Keeseekoowenin First Nations. Jordan is a very competitive hockey player; Quinton is on a local football team. All the kids like school. Craig recently started a new job working with adults suffering from FASD. Leeann has worked for five years at HeadStart, an Indigenous pre-school program (all her children attended the program) as a family outreach worker and cook.

I am grateful to report that we had 120 volunteers this year from across all colleges in the Rady Faculty. Today, I want to thank all of you: physicians, physician assistants, residents and learners who gave up a day, rolled up their sleeves and came out to help build the Habitat home on Bannatyne campus (which was later moved to its permanent location in the North End.)

I also want to acknowledge the contributions and generosity of individuals as well as many faculty members in the Max Rady College of Medicine who donated through their respective departments.

To date, we have raised nearly $100,000 and are very close to reaching our goal of $120,000.

It's not too late to get involved. In the past, we have asked for physicians to contribute $100 each to help us reach our goal. Every donation helps. If you would like to support our Rady Faculty Habit build, please visit https://www.habitat.mb.ca/get-theme-builds-uofm.cfm to donate on line. If you have any questions regarding fundraising, please contact Vernelle Mirosh, Habitat for Humanity Manitoba at vmirosh@habitat.mb.ca or (204) 235-2407.

Medical Corporation Permit renewals

This is a reminder that your Medical Corporation Permit renewals take place at the same time as your License renewal. Deadline for both your license renewal and your medical corporation renewal is **October 31, 2018**.

You will receive email notification of the renewals in September.

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Manitoba Physician Quality Improvement Program

The College of Physicians and Surgeons of Manitoba (CPSM) is mandated by legislation to supervise the practice of its members. The current Manitoba Physician Achievement Review (MPAR) Program which has been in place since 2010, will be phased out by the end of 2018, in order to implement a more robust review of physicians' practices when the RHPA comes into effect on 1 January 2019.

The purpose of the QI program is to ensure provision of safe medical care to Manitobans. The program will encourage continuing quality improvement activities, and continuing practice improvement for its members. As well, it will provide a new mechanism for the CPSM to interact with members to gather detailed information about their practice, to encourage them to reflect on this information, and to plan their continuing professional development (CPD) around needs they identify in their practice. Over time, this should lead to improved care for their patient populations. Lifelong learning is ideally related to each of our practices, and makes it easier for us to serve our patients and communities.

The goals of the program are:

- to be meaningful to its members and the public
- to be reproducible, and comparable with other programs nationally
- to be educational in nature, collegial and non-invasive
- to promote quality improvement throughout the span of a member's career
- to fulfill the legal and ethical responsibility of the College

The program will operate on a seven-year cycle. All participants will be required to provide in-depth information about their practice, and to provide information about their CPD. It will introduce an element of peer review to Manitoba; other jurisdictions have used peer review for many years. Some participants will undergo offsite chart reviews, multisource feedback, and/or onsite office visits. All participants will be required to identify one or more learning needs, and to develop a plan to address those needs. All participants will receive feedback and practice support resources.

The first group of physicians to participate will be a group of randomly selected family physicians. This will occur in the fall of this year. Feedback from participants and reviewers will be sought for program improvement.

We invite any questions or input that you may have. Please feel free to contact the Quality Improvement Program at quality@cpsm.mb.ca or by phone at 204-774-4344.

Respectfully submitted,
Marilyn Singer MD CCFP
Consultant for Quality Improvement

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What do Physicians Think Makes Them Successful?
Attributes of Commendable Physicians

The College operates the Manitoba Physician Achievement to assess a physician's professional knowledge and skills, communication skills, practice management, and professional ethics. As most of you know, a 360 style survey is undertaken of that physician's colleagues, co-workers, and patients. Those physicians flagged for many commendations by their colleagues are interviewed. They are asked what attributes make them a commendable physician to their colleagues, co-workers, and patients. The following are the attributes that they consider lead to their success:

One Specialist Physician

- Learn from your patients – get feedback
- Pay attention to detail
- Be humane and compassionate
- Be Intentional
- Continually look to improve
- Look after your own wellness
- Take time to explain
- Communicate well
- Take a mindfulness class
- Have an open-door policy with staff, colleagues, and co-workers
- Consult frequently – seek advice

A family practice physician:

- Be a good communicator and spend a lot of time discussing issues with patients ensuring that they understand what is being said
- In interactions with patients, treat all equally and try to relate to patients at their level
- Care about your patients
- Try to keep up to date with medical knowledge
- Respect your patients
- Show the human side of yourself while interacting with patients

Another family practice physician:

- Be a good listener
- Don't limit the number of problems a patient can bring into the office at one visit and extend the office visit if necessary to accommodate the patients
- Take everything seriously
- Do a good history and physical and be diligent in covering all aspects of a patient's health, both physically and socially

Another specialist physician:

- Be humble
- Treat patients with respect
- Not afraid to say, "I don't know" and uses this with both colleagues and patients
- Listen to patients and make an effort to understand where they are coming from. Make an extra effort to appreciate the patient's point of view of any problems they might have
- Believe you are working in a service industry
- If you think you are better that your patients, then you are off to a wrong start

An ER physician:

- Being systematic and organized helps sort out patients effectively and efficiently
- Stress – Manage it. There is only so much that you can do and some things are out of your control, so no need to worry about those things. The other things, sort out.
- Being nice to people and respecting them results in them making an extra effort to do a good job and help you with yours
- List to people and appreciate your thoughts. Nurses will come to you with ideas if you appreciate what they have to say.
- Be thankful for advice and feedback from colleagues. Have a good rapport with hospitalists and their feedback is educational.

Interestingly, none of them mentioned technical skills or intellectual capacity, i.e. medical expert, but this is not a measured factor in the current Manitoba Physicians Achievement Report. Instead, most of the attributes appear to be fundamental characteristics or qualities of good human behaviour. These physicians practice these attributes and behaviours day in and day out, and that is what makes these physicians amongst the most commended in the profession. As we continue our paths to continuous improvement, keep these attributes in mind, along with the points on professionalism from Dr. Barakat mentioned in the first page of this newsletter.

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Participate in Your College!

As a self-governing profession the College needs members to help govern ourselves. Sounds pretty simple – we just need to get you involved! Your involvement is required even more as we transition to *The Regulated Health Professions Act* which reduces the number of Councillors, yet the same, or even more work will be required for College committees and working groups.

There are rights and obligations in self-regulation. This is a privilege shared by all physicians and should be supported by all members of the profession. Continuing and building public trust in the practice of medicine by physicians is achieved partially by monitoring the quality of patient care. The privilege of professional autonomy comes with the responsibility of ensuring the medical profession's house is in order. Most physicians have stated that their involvement with College work has not only made them better physicians but has been a rewarding professional experience. At the College, we believe that many physicians are interested in participating in their College and are willing to devote their time to do so.

Putting your name forward to be elected to Council is only one way to get involved. There are numerous committees all looking for peers to review, audit, and discipline our colleagues and improve and/or regulate our practice of medicine within the province. Here are some examples:

- Standards Committees, including Maternal and Perinatal Health, Child Health, Area Standards, Hospital Standards, Provincial Standards, Program Review Committee (accrediting laboratories and diagnostic imaging), Quality Improvement Committee.
- Quality Improvement Committee is a new committee to guide and oversee the Quality Improvement Program. The QI Program will help physicians to analyze their practices and tailor learning and improvement to the unique needs of their setting and patients.
- Physician Health Committee – works with physicians experiencing health issues to ensure patient safety and their continued ability to practice
- Complaints Committee – reviews complaints about members, meets in panels of three of which one must be a public representative, the panel reviews complaints about members
- Investigations Committee – investigates complaints or referrals from the Registrar and disposes of matters by referring it to the Inquiry Panel, directing no further action, censuring the member, entering into agreements or undertakings by the members regarding their practice of medicine
- Inquiry Panel – acts as a quasi-judicial panel which hears contested disciplinary matters referred from the Investigations Committee. (These hearings may last for multiple days, so a significant time commitment may be required for these Panel members.)
- Audit and Risk Management – Yes, this is the audit, finance, and risk of the College. There is need for a person (either a member or non-member) with significant experience with risk management.
- Working Groups – These are formed on an as-needed basis, dependent upon issues

A principle of self-regulation is that members should be reviewed by their peers. Given the diversity of the membership, that means diversity of:

- Gender, race, age and other personal characteristics
- geography
- area of practice/specialization
- medical school, including international
- experience as a practicing doctor
- and other factors.

All self-regulated profession bodies also have positions for public representatives. All decisions made by the College are to be in the public interest and for the safety of the public – it is not "by the doctors, for the doctors"!

The College pays honoraria which is intended to replace time away from a fee generating practice. Members of Council, most committees, and working groups are entitled to receive honoraria travel time, and reimbursement of expenses in accordance with its Governing Policies.

Feel free to contact the College to ask questions about being active in the self-regulation of our profession. And, if you are interested in participating in the self-regulation of our medical profession in the many capacities other than on Council, please contact the College at TheRegistrar@cpsm.mb.ca, and provide a curriculum vitae/biography, and your areas of interest. We'll keep you in mind for future opportunities.

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Gabapentin, pregabalin and duloxetine listing changes and considerations

Cymbalta® (duloxetine), Lyrica® (pregabalin), and Neurontin® (gabapentin) are now all Part 1 benefits on the Manitoba Drug Benefits and Interchangeability Formulary (Formulary) making them eligible for Pharmacare benefits under all prescribed circumstances. On January 25, 2018, Cymbalta® and generic formulations were moved from a restricted Part 3 listing to a Part 1 benefit on the Formulary; and Lyrica® and generic formulations were added to the Formulary as Part 1 benefits.

Amendments to the Formulary are documented in Bulletins, and may be accessed through the "Information for Health Professionals" page of the Manitoba Health website: https://www.gov.mb.ca/health/pharmacare/healthprofessionals.html.

This change comes amidst reports of gabapentin becoming a significant drug of abuse in recent years. Although therapeutically useful when prescribed appropriately, it is well known that gabapentin, due to its possible psychoactive effects, is commonly diverted and overused along with other prescription drugs such as opioids and benzodiazepines.

It is important to note that there is data suggesting that pregabalin may also have abuse potential, although this has not been a major issue in Manitoba to date. This may be, at least in part, due to this drug's past restricted Part 3 EDS status. Health care practitioners should be alert to the potential abuse or misuse of gabapentin and pregabalin.

The Part 1 listing of duloxetine and pregabalin gives health care providers more options for treatment of pain and pain related conditions. The length of clinical trials associated with these drugs varies from 10 months to greater than 1 year depending on the drug and indication, therefore the use of these drugs for the management of chronic pain conditions must be monitored appropriately and be patient-specific.

Gabapentin is indicated for the management of epilepsy but is commonly used for treatment of neuropathic pain. Gabapentin, duloxetine and pregabalin are all generically available and vary little in price.

These medications have a defined place in therapy, and it is the responsibility of the healthcare professionals caring for these patients to ensure that they are using the best quality evidence currently available in formulating treatment plans. It is important that prescribers become familiar with the indications, dosing, adverse effects and drug interactions for these three drugs. Appropriate monitoring parameters should be considered when starting any of these medications. Practitioners should refer to current literature, drug monographs, guidelines and evidence based reviews such as those provided by the Canadian Agency for Drugs and Technologies in Health (CADTH): https://cadth.ca/evidence-bundles/pain-evidence-bundle/browse-evidence.

Collaborative care is a vital part of health care because it creates better health outcomes for patients. As medication experts, pharmacists are ideally positioned to optimize prescribing by providing suggestions and advice on drug therapy, including:

- dose adjustments for patients with or without renal or hepatic failure,
- suggestions to minimize poly-pharmacy,
- assessment of patient compliance or overuse, and
- monitoring for drug interactions or adverse effects.

Collaboration between all health care practitioners is key to improving patient outcomes and increasing patient safety.

This information was developed by a multidisciplinary ad hoc working group consisting of representatives from the College of Pharmacists of Manitoba, the College of Physicians and Surgeons of Manitoba, the College of Registered Nurses of Manitoba, and the Manitoba Dental Association. Manitoba Health tasked the ad hoc working group with creating a unified and coordinated approach to communications on the use, risks, benefits and monitoring of gabapentin, pregabalin, and duloxetine in prescribing and dispensing.

Jointly prepared by
The College of Physicians & Surgeons of Manitoba
The College of Pharmacists of Manitoba
The College of Registered Nurses of Manitoba
The Manitoba Dental Association

Opioid Replacement Therapy 101 Training Dates

September 13 & 14, 2018 – Winnipeg MB - FULL

November 22 & 23, 2018 – Winnipeg MB - Registration now open

February 28 & March 1, 2019 –Dauphin MB - Registration now open

March 21 & 22, 2019 – The Pas MB - Registration now open

Registration is on a first come first serve basis.

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Medical Marijuana in an Age of Legal Recreational Marijuana

With recreational marijuana becoming legal across Canada this October, the prevalence of marijuana use may increase, and patients may also be more open to discussing with their physicians their use of marijuana. As part of the routine history-taking, physicians should discuss recreational marijuana use with their patients, similar to the manner of discussing alcohol or cigarette smoking.

Although recreational marijuana will be available in government approved retail operations, medical marijuana will still require an authorization and be obtained only through a licensed producer.

As a reminder, the College in its Standards of Practice contains a standard on medical marijuana. These standards are compulsory, not optional. This standard will continue unaltered following the legalization of recreational marijuana.

Marijuana (Cannabis) for Medical Purposes

26(1) Although members may authorize the use of medical marijuana, they are not required to do so if they do not feel it is warranted for a patient.

26(2) Prior to authorizing marijuana for a patient, a member must:

(a) make a conventional diagnosis using the principles of good medical care set out in s. 2 of this by-law;

(b) ensure that other conventional therapies have been tried for the patient's condition;

(c) discuss with the patient all potential risks and benefits and the lack of clear scientific evidence supporting the efficacy of the proposed treatment;

(d) document on the patient record the discussions with the patient and the medical reasons for which the marijuana is authorized.

26(3) A member may not be legally or beneficially involved in any way with a licensed producer and may not directly make any application to become a licensed producer.

26(4) A member must keep a separate log for all authorizations for the use of medical marijuana which must include the following information:

- patient's name;
- patient's personal health identification number;
- condition for which the marijuana was authorized;
- quantity and dosages of marijuana authorized.

The separate record must be available for inspection by the College at any time.

26(5) A member must establish a process to report any misuse or abuse of medical marijuana by the patient.

26(6) The member must not:

(a) authorize marijuana if the member is not the primary treating physician for the condition for which the marijuana is authorized or part of a practice group that is collectively treating the patient for the condition for which the marijuana is being authorized and has shared access to the patient's record;

(b) examine the patient at the premises of a licensed producer or a location provided by or subsidized by a licensed producer;
(c) dispense or provide marijuana to any patient.

Physicians who have a business interest or arrangement with a medical or recreational marijuana corporation may wish to refresh their memory of sections 48-51 "Conflict of Interest Involving Financial or Personal Gain in the Care of a Patient" from the same Standards of Practice to ensure compliance. The Standards of Practice document is found at this link:
http://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/ByLaws/By-Law-11.pdf

Physicians with such a business interest or arrangement may contact the College to discuss compliance with the Standards or contact CMPA.

Manitoba Health & The University of Montreal Awareness Campaign Relating to Opioids

Manitoba Health, in collaboration with researchers at the University of Montreal, will be undertaking a public awareness campaign relating to opioids for the treatment of chronic non-cancer pain. Manitobans who are receiving chronic opioids treatment will be randomized into two time periods to receive education in the mail during the course of the coming year. It is important to note that neither funding or access to medications will be altered for recipients of the public awareness brochure.

Members may be contacted by their patients who receive this communication to discuss their opioid prescriptions.

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Talking About Elder Abuse

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Talking About Elder Abuse

DOC TALK
By Stuart Foxman

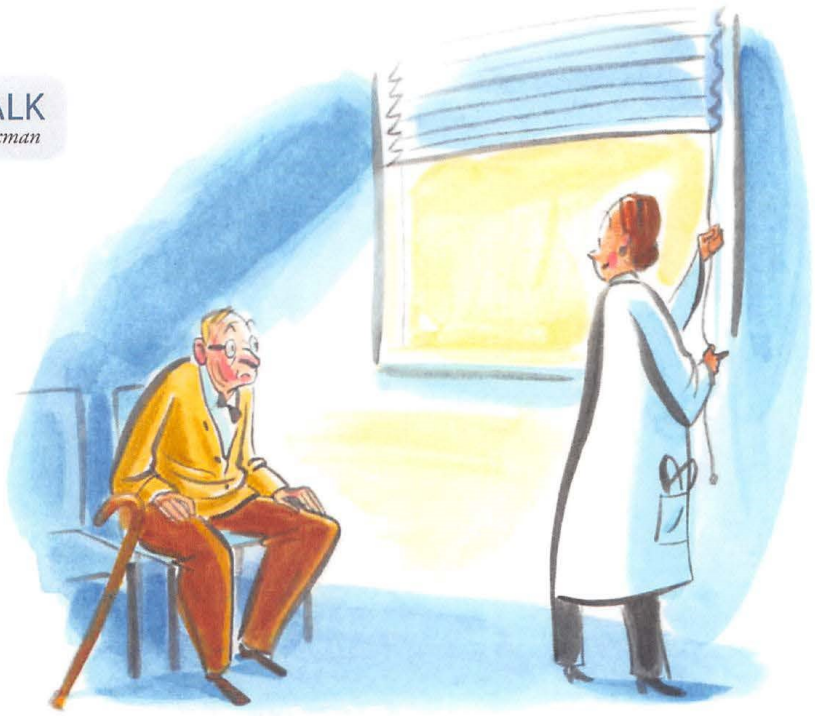

ILLUSTRATION SANDY NICHOLS

Imagine the severity of a condition that can trigger depression and anxiety, cause persistent pain, exacerbate multiple health issues and lead to premature mortality. All of these are potential consequences of elder abuse.

In a 2016 report from Dr. Gregory Taylor, at the time Canada's Chief Public Health Officer, 766,000 older Canadians said they'd experienced abuse or neglect in the past year. That was even higher than the 760,000 who said they'd experienced spousal abuse/conflict in the previous five years.

Some studies put the prevalence of elder abuse as high as 25%. "Very conservatively, 10% of seniors will experience some type of abuse in their lifetimes," says Ms. Maureen Etkin, Executive Director, Elder Abuse Ontario. "It's an epidemic."

Seniors who are abused are often isolated. "The doctor may be the only external professional they see with any measure of privacy," says Ms. Etkin. That gives doctors a critical opportunity to pick up on signs of possible abuse and talk to patients about it.

Awareness is growing, suggests Dr. Mark Yaffe, Department of Family Medicine, McGill University. He devised an Elder Abuse Suspicion Index (EASI) to help doctors explore the topic. As Dr. Yaffe reminds us, elder abuse isn't straightforward. It can present itself in multiple ways, and many symptoms

can be explained by other factors. That makes it even more necessary to probe sensitively, but thoroughly.

Watch for the signs

Start with an understanding of the types of elder abuse. They generally fall into these categories:

- **Physical abuse** – violence and rough treatment that cause injury or discomfort. This can also include over-medicating and inappropriate use of restraints.
- **Psychological/emotional abuse** – acts or treatment that diminishes a sense of identity, dignity and self-worth (e.g., confinement, threats, verbal assault, insults, humiliation, intimidation, excluding competent seniors from decision-making).
- **Sexual abuse** – sexual behaviour directed at an older adult without their full knowledge or consent (e.g., sexual assault, sexual harassment, fondling, sexual comments or jokes).
- **Financial/material abuse** – misusing funds and assets without the person's full knowledge or consent, or not in that person's best interests (e.g., fraud, theft, coercion).
- **Neglect** – withholding basic necessities like food, clothing, shelter, medicine or health care, either intentionally (active neglect) or because of lack of experience, information or ability (passive neglect).

These aren't mutually exclusive. Seniors might experience more than one type of abuse simultaneously. Anyone can be a victim in any setting. The abusers can be friends, neighbours, paid care providers, landlords, anyone in a position of trust or authority and, most often, a family member.

The signs of elder abuse depend on its nature. With physical harm, there may be unexplained injuries, bruising or pain. All abuse can cause changes in mood or behaviour, like fear, sadness, anger, passivity, silence or detachment. Neglect can be manifested by weight loss, bedsores, missing or broken aids (e.g., hearing aids, glasses, dentures, walker), poor mobility, unkempt appearance or poor hygiene.

Doctors can explore and question best when they're alone with the patient, which isn't always simple. Someone being abused may be accompanied to an appointment by their very abuser. That individual may be the one who explains away a suspicious injury, seems to be speaking for the senior, or doesn't want the senior seen in private. Those explanations themselves could be warning signs, says Ms. Etkin.

Go EASI

Doctors needn't be certain of abuse just from seeing signs. How could they be? That's why Dr. Yaffe calls his tool a suspicion index instead of a screening index.

"The purpose is to raise suspicion to the point where you talk to the patient and agree for them to see someone to be assessed at a more comprehensive level," says Dr. Yaffe.

EASI includes six questions. The first is a primer, to get people thinking about their living conditions. The last is for the doctor to answer.

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
4. Has anyone tried to force you to sign papers or to use your money against your will?
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?
6. Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing or medication compliance issues. Did you notice any of these today or in the last 12 months?

A 'yes' response to any of questions 2-6 can ring alarm bells and prompt a conversation. That can be a deli-

Elder abuse happens more often than many people imagine. The victims come from all backgrounds and socio-economic status. Most are mentally competent and don't need constant care.

cate task. The question "Are you being abused?" may be too blunt to pose. And the victim may not use that language to describe the situation. Instead, try questions like "How are you being treated?" "Do you feel safe?" "Do you trust the people around you?" "Have any incidents made you concerned or afraid?"

Still, patients may not always be forthcoming. Many seniors are dependent on the people abusing them. Some might worry about losing their place of living, or retaliation from the abuser. Others might be ashamed. Or wonder if they'll be believed or blamed. All that can shape a conversation too.

A discussion about elder abuse, and how the patient can get help, might have to occur over several appointments. That's one reason to schedule more frequent follow-ups and use the EASI tool again.

Reporting obligations for Ontario doctors aren't the same as those required for suspected child abuse. The duty to report applies only when "they have reasonable grounds to suspect that a resident of a nursing home or retirement home has suffered harm or is at risk of harm due to improper or incompetent treatment or care, unlawful conduct, abuse or neglect."

In those cases, physicians must immediately report their suspicion, and the information upon which it is based, to the Registrar of the Retirement Homes Regulatory Authority, or to the long-term care home director.

Additionally, physicians have a duty to report suspicions of misuse or misappropriation of a resident's money or of funding provided to a licensee.

Even without a formal reporting obligation, Ms. Etkin says doctors need to understand their broader role in the chain of accountability. Do they know enough about elder abuse? How to explore it? Have they trained staff to be aware of signs? Do they have policies to support possible abuse victims?

To fully understand the issue and advise patients, there are important resources to consult and pass along:

- Elder Abuse Ontario: elderabuseontario.com
- Government of Ontario: ontario.ca/page/information-about-elder-abuse
- National Initiative for the Care of the Elderly: nicenet.ca
- Canadian Network for Prevention of Elder Abuse: cnpea.ca
- Seniors Safety Line (24/7 information, referrals and support): 1-866-299-1011

Watch for biases

When seeing older patients, Ms. Etkin cautions against being swayed by biases around the issue, victims or abusers.

Elder abuse happens more often than many people imagine. The victims come from all backgrounds and socio-economic status. Most are mentally competent and don't need constant care. The abuser may be someone the doctor knows too.

A study in 2012 in the *Journal of Elder Abuse & Neglect* looked at perceptions of elder abuse on the part of three professions: physician, nurse and social worker.

Physicians thought that other health-care professionals (and other doctors too) were more likely to see abused and neglected patients. If they saw such patients, they wanted to let social workers address it. But they worried about bringing an outside expert into the relationship, upsetting the patient or labeling suspicion as abuse.

Talking to patients about possible abuse can be difficult. The subject is sensitive. Patients might take offence at the line of enquiry. But this demands attention too.

"Are you going to sit on your hands and say 'Am I going to insult the patient?' In my mind, that's irresponsible," says Dr. Yaffe. "You have to look deeper."

As the above article is from The College of Physicians & Surgeons of Ontario it references Ontario Resources. Below are resources for Elder Abuse in Manitoba.

WRHA Support Services to Seniors: http://www.wrha.mb.ca/community/seniors/abuse-older-adults.php

Senior Abuse Support Line 1-888-896-7183 (24/7, counselling, a partnership between Klinic and A & O support Services for Older Adults)

A & O Support Services for Older Adults (formerly Age and Opportunity) 204-956-6440

In Manitoba, the Protection of Persons in Care Act is to help protect adults from abuse while receiving care in a personal care home, hospital, or other designated facility. Anyone who knows or has reasonable grounds to suspect that a person has, or might be, harmed by physical, sexual, mental, emotional, or financial mistreatment is required by this law to report this.

Email Address

Reminder – A current email address is mandatory under the requirements for licensure and re-licensure. You must inform the College if you change your email address. Changes may be submitted to: registration@cpsm.mb.ca.

Your email will not be made available to the public.

If you do not update your email address you will miss out on important correspondence from the College.

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From the Central Standards Committee

Impact of Peri-Partum Depression on Maternal Mortality in Manitoba

One of the most under-appreciated cause of indirect maternal mortality in the antenatal and postpartum period is maternal depression. Between 1996 and 2013 the Canadian maternal mortality average was 8.8/100,000 births, with a range between 6.1/100,000 to 11.9/100,000 births. In Manitoba, the average maternal mortality is 5.6/100,000 during that period.

MPHSC started collecting maternal deaths related to mental disorders as of 2013, particularly deaths in the postpartum period which were not collected before that date. In the last annual report of the MPHSC of 2017 and summarizing cases from 2014, there were 6 maternity deaths that were brought to the attention of MPHSC. Four were deaths related to de-novo acute or exacerbation of pre-existing depression resulting in self termination of life. Three of those deaths were deemed preventable or theoretically preventable through appropriate identification of signs and symptoms of depression and subsequent timely appropriate management such as, but not restricted to, referral to psychiatry services in Winnipeg.

In 2014 a newsletter item was issued by the College of Physicians and Surgeons of Manitoba on identification and intervention in Post partum depression. Health care workers, specialists and generalist, midwives and nursing are now urged to review this newsletter again.

It should be remembered, that:

1. Peripartum depression is insidious in nature but could be acute in onset especially in patients with no past history of the same.
2. Physicians and maternity health care workers should be attuned to the signs and symptoms of mental disorders. Early recognition, counselling, use of appropriate medications and sequestering expert support, are essential for successful management and prevention of serious consequences.
3. Management may include opportune, prophylactic or timely referral to expertise in mental health. Multidisciplinary approach provides for most comprehensive care to women during that period.
4. Physicians and Health care workers, and particularly in acute situations, have a responsibility to arrange for appropriate referral to a facility or to a specialist expert or an expert team for immediate management. Such a referral should be based on succinct and clear communication with the patient, with her support in a family member or partner, and on verbal and written communication with the receiving institution or expert, to ensure the patient arrives at the facility accepting the referral. Health care workers should assess compliance with proposed treatments and if need be arrange for follow-ups and monitoring.

5. Documentation of such assessments and referrals is essential for future management.
6. Physicians and Health care workers are reminded of the following resources:
   A. Fact sheet for public education on postpartum depression: www.heretohelp.bc.ca/publications/factsheets/postpartum
   B. Culture of Wellbeing: Guide to Mental Health Resources for First Nations, Metis and Inuit People of Winnipeg: www.wrha.mb.ca/aboriginalhealth/services/resources.php
   C. www.postpartum.org
   D. www.postpartum.net
   E. Women's Health Clinic (204) 947 1517
   F. Crisis services: www.gov.mb.ca/healthyliving/mh/crisis.html
   G. For patients:
      Family Doctor Connection Program 204 786 7111
      Mobile Crisis Service 204 940 1781
      Klinic Community Health Centre Crisis line 204 786 8686
      Manitoba Suicide Line 1 877 435 7170

   H. Useful medical literature citations for physicians, midwives and nurses:

Gadot Y., Koren G. The use of Antidepressants in pregnancy: Focus on Maternal Risks. JOGC, 2015; 37(1): 56-63

Ordean A, Wong S, Graves L. Substance use in Pregnancy. SOGC Guideline. JOGC, 2017; 39(10):922-937

Misri S, Swift E. Generalized anxiety disorder and major depressive disorder in pregnant and postpartum women: Maternal quality of life and treatment outcomes. JOGC, 2015 (September): 798-803.

Perinatal Depression: Nursing Best Practice Guideline. Registered Nurses Association of Ontario (2017).
www.RNAO.ca/bestpractices

Dr. Michael Helewa
Medical Consultant

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Monochorionic Diamniotic and Monochorionic Monoamniotic Twin Pregnancies

Twin pregnancies that are diagnosed as being monochorionic diamniotic or monochorionic monoamniotic gestations are known to have an increased risk for congenital anomalies, intrauterine growth restriction of one of the twins, feto-feto transfusion syndromes, cord entanglements (especially in monochorionic monoamniotic twins), abnormal placentation, as well as increased risk of fetal death early in the 3rd trimester. Obstetrician specialists, family physicians and midwives are strongly advised to refer these patients for an early fetal assessment scan as soon as possible after the diagnosis of the monochorionic twins is made. These pregnancies are thereafter placed on an antenatal fetal surveillance program through the fetal assessment units at the tertiary centres in Winnipeg (St. Boniface General Hospital and Health Sciences Centre) with the intention of close monitoring of these fetuses, timely intervention for delivery, and hopefully preventing perinatal morbidity and mortality.

Dr. Michael Helewa
Medical Consultant

Pediatric Sepsis Resources for Physicians

The Child Health Standards Committee published "Reminders to Physicians Regarding Prompt and Aggressive Management of Sepsis in Children" in the May 2016 College newsletter. Since then a number of practice tools have been developed for pediatric sepsis, and are catalogued on the Translating Emergency Knowledge for Kids website (www.trekk.ca).

Most acutely ill and injured children in Canada are managed within emergency departments that are not part of a children's hospital. Difficulties in getting the right resources and training have been cited as barriers to providing the best possible care in these settings. This has resulted in variable levels of emergency care for children within Canada. TREKK is a knowledge mobilization network established to address these critical knowledge gaps and improve emergency care for children across Canada. TREKK is hosted at the University of Manitoba, where there is active outreach to Manitoba emergency departments to improve the care of acutely ill and injured children.

PedsPacs are point-of-care tools published by TREKK. The Sepsis PedsPac includes a Sepsis Algorithm (July 2018), Sepsis Triage Poster and Pocket Card (June 2017), and a Severe Sepsis Order Set (April 2017). These resources can be downloaded on the TREKK website or viewed on the TREKK app.

Consult the HSC 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.

Dr. Lynne Warda
Medical Consultant

Practice Address

Reminder – A current practice address is mandatory under the requirements for licensure and re-licensure. You must inform the College if you change your practice address. Changes may be submitted to: registration@cpsm.mb.ca.

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Congratulations

Dr. Cheryl Rockman-Greenberg has been selected for induction into the Canadian Medical Hall of Fame. Canadian Medical Hall of Fame Laureates are individuals whose contributions to medicine and the health sciences have led to extraordinary improvements in human health. Their work may be a single meritorious contribution or a lifetime of superior accomplishments. Pioneers in their field, they are role models for Canadians and an inspiration to our youth.

We would like to acknowledge and congratulate the Doctors Manitoba Award Recipients as follows:

Distinguished Service Award **- Dr. Amarjit Arneja** - In recognition of service provided to patients and the community which has 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. Jack Armstrong Humanitarian Award **- Dr. Mathen Mathen** - For outstanding contributions by a member or former member of Doctors Manitoba in the service of humanity either within Canada or abroad.

Physician of the Year (Posthumously) **- Dr. Robert Menzies** - For significant contribution to the practice of medicine and to the community by a member of Doctors Manitoba.

Resident of the Year **- Dr. Signy Holmes** - For excellence in academic and clinical training and noteworthy contributions to the resident's home program/specialty or residency program.

Health or Safety Promotion Award **- Dr. James Bolton** - For contribution toward improving and promoting the health or safety of Manitobans specifically or humanity generally.

Health Administration Award **- Dr. Alecs Chochinov** - For contribution to policy and administration in health care.

Scholastic Award **- Dr. John Embil** - For scholarly activity in the health professions.

CMA Honourary Membership Recipients

Congratulations to the following recipients of the 2018 CMA Honourary Memberships for their eminence in medicine, science or humanities, or significant service to the CMA.

- **Dr. Terry Babick**
- **Dr. Kevin Coates**
- **Dr. Savas Menticoglou**
- **Dr. Sunilkumar Patel**

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From the Complaints Committee

Charging for Uninsured Services

Physicians are often asked to complete various documents on behalf of their patients. The College recognizes that this can require significant time and effort and that a reasonable fee may be charged to patients. The CPSM Code of Ethics includes that in determining the fees, physicians should consider both the nature of the service provided and the ability of the patient to pay. This may be especially relevant where the physician is required to complete forms to facilitate patient access to specific programs, including addiction treatment, where the patient has limited financial resources.

Obligation to report

The College relies on its members to report conduct that may compromise the safe practice of medicine in order to fulfil its duty to maintain the standards of practice of medicine. Most members are aware that reporting to the College is necessary if he or she reasonably believes a colleague is unfit to practice, incompetent or unethical, or suffers from a health condition that impairs safe practice. These are detailed in section 39 of The Medical Act and Schedule F, Bylaw 11 of the College. Most members understand this responsibility, but many may have questions about the level of detail they are able to provide to the College under The Personal Health Information Act [PHIA].

The Medical Act and The Personal Health Information Act [clause 22(2)(e)] allow members to provide detailed information to the College for investigative purposes, without the consent of the patient.

If you have a concern which warrants the attention of the College, please provide sufficient detail to enable an appropriate and timely investigation. Along with the name of the physician, please include the details of your concerns, as well as the name of the patient(s) and their demographics, if known. This allows us to access patient records in accordance with the applicable legislation and informs our further actions.

Reporting must be sent to the attention of the Registrar, and contact information is available on the College website.

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Impugning Colleague Reputation Complaints

The Investigation Committee recently reviewed several matters that highlighted the need for physicians to exercise caution in commenting on the care provided by colleagues. Patients and their family members who are seeking answers to their legitimate questions and concerns about the care that was provided will often look to others for an explanation. There are certainly times where fault lies with a physician in relation to a delayed diagnoses or inadequacy of care. In such cases, the College seeks to address those concerns and relies on information provided by patients, their families, or other health care providers, including physicians. That said, the Investigation Committee has noted that patients or their family members have had their concerns about care inappropriately fueled by negative comments reportedly made by another physician who did not know all the relevant facts surrounding the patient's condition or the care provided.

Physicians must recognize their ethical obligation to report patterns of deficiencies in care or serious concerns about another member's competence in accordance with standards of professionalism and must avoid unnecessarily impugning the reputation of a colleague. The Committee was very concerned that physicians reportedly made very negative comments about care that had been provided by a colleague, including perceptions of harm, in circumstances where they should not have done so. It was especially concerning when, based on the Investigation Committee's in-depth reviews of the care provided, the comments were not substantiated.

Physicians who have had limited or subsequent involvement in a patient's care, or who may have a personal relationship with a grieving family, may find themselves in a difficult situation where questions are raised about the care provided. Casual conversation or ill-considered comment from physicians in that situation can have significant and often unintended consequences. As such, physicians are reminded that they must always be cognizant of their role and potential influence on others, particularly vulnerable patients and their families. Professionalism requires that physicians guard against making uninformed or inappropriate comment. In these circumstances it is appropriate to acknowledge and support family members in their quest for answers, but to refrain from judging the care provided by others. This is especially true where only one perspective is known and where there is no appropriate factual foundation for making such judgments. It is also important to carefully consider comments made in relation to another physician's care based on individual opinion in circumstances where more than one approach to care could legitimately be supported.

The ethical practice of medicine includes being honest and open with patients, recognizing their right to know their past and present medical status. When harm occurs to a patient, it must be disclosed in accordance with expected standards of professionalism. The CPSM Standards of the Practice of Medicine (Bylaw #11, section 10) details this principle and provides direction for members who may become aware of potential concerns:

a) Disclosure must occur whether the harm is a result of progression of disease, a complication of care, a failure to follow up, or an adverse event and whether or not the harm was preventable; and
d) Where a member believes another health care provider has caused harm to a patient and has not yet disclosed that harm to the patient, the member must discuss the issue with that health care provider and must encourage that health care provider to disclose the harm. If the other health care provider does not disclose the harm, the member must do so.

It is not always easy for members to identify the appropriate response when patients or their families raise concerns about harm involving the care provided by a colleague. The best approach is a cautious one that considers the context and impact of the comments you make. If you have questions, these can be discussed with the Registrar.

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Meetings of Council
2018-2019 College Year

Council meetings will be held on the following dates:

- September 21, 2018
- December 14, 2018
- March 15, 2019
- June 21, 2019 (Annual General Meeting)

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

Officers of the College
2018-2019 College Year

President:	Dr. Eric Sigurdson
President Elect/Treasurer:	Dr. Ira Ripstein
Past President:	Dr. Alewyn Vorster
Registrar:	Dr. Anna Ziomek
Deputy Registrar:	Dr. Terry Babick

Councillors

TERM EXPIRING SEPTEMBER 2018

Associate Members Register	Dr. Shayne Reitmeier

TERM EXPIRING JUNE 2020

Brandon	Dr. Stephen Duncan
Eastman	Dr. Nader Shenouda
Westman	Dr. Alewyn Vorster
Winnipeg	Dr. Heather Domke Dr. Brent Kvern Dr. Josef Silha Vacant – Bi-Election To be Held
Public Councillor-Elected	Ms Dorothy Albrecht

TERM EXPIRING JUNE 2021

Public Councillor – Government Appointed	Mr. Alan Fineblit
Public Councillor – Government Appointed	Ms Marvelle McPherson

TERM EXPIRING JUNE 2022

Central	Dr. Kevin Convery
Interlake	Dr. Daniel Lindsay
Northman	Dr. Deborah Mabin
Parkland	Dr. Jacobi Elliott
Winnipeg	Dr. Wayne Manishen Dr. Brian Blakley Dr. Heather Smith Dr. Eric Sigurdson Dr. Ravi Kumbharathi
University of Manitoba	Dr. Ira Ripstein
Public Councillor - Elected	Ms Lynnette Magnus, CPA

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RHPA Key Changes for Members of CPSM

(Physicians, Clinical Assistants, Physician Assistants, Trainees)

Medical Act	RHPA	Key Changes
Practice of Medicine		
Medical Act s.2 sets out "persons deemed to be practicing medicine" and "unauthorized practice of medicine" s.5(1)	**Reserved Acts** • actions or clinical procedures that may present a risk of harm to the public unless the provider has the required expertise and training. • Every profession has a list of reserved acts that they may perform and apply specifically to that profession. • The reserved acts that the members of each specific profession may perform are set out in the RHPA regulations for that profession. • Physicians are the only profession entitled to perform **all** reserved acts subject to limitations of competence training etc. **Scope of Practice** –see list of reserved acts set out in *Practice of Medicine Regulation s.3 and also in section 4 of the RHPA at* http://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=r117 *Government information on RHPA & reserved acts:* http://www.gov.mb.ca/health/rhpa/index.html	"Reserved Act" concept is new but it does not fundamentally change what is currently within the practice of medicine. Performance of reserved acts is restricted to specific health professions or specific members within a profession. Although not much change for the practice of medicine, many other professions are gaining increased autonomy and ability to perform certain reserved acts independently that were not previously within their profession's scope of practice. Limitations on physicians performing reserved acts include: • Must be competent, safe, appropriate *See Practice of Medicine Regulation s.6* Specific limitations in these areas: • Methadone Prescribing • M3P triplicate prescribing • Resident prescribing • Prescribing Hearing aids requires a special licence • Compounding, dispensing drugs *See CPSM General Regulation, Part 5*

Medical Act	RHPA	Key Changes
		Both CRNM and CPSM Regulations require that members must comply with any policy respecting the performance of a reserved act that is in place in the "practice setting" where the member will perform the reserved act. **See:** *CRNM General Reg 3.13 and CPSM Standards of Practice Regulation s.6 CPSM General Regulation sections 5.15 through 5.20*
Delegation		
• **Supervision** of residents, students, physician assistants, clinical assistants • **Delegation:** is not defined but generally it is a process whereby an authorized healthcare professional confers the authority to perform a reserved act to someone who is not otherwise authorized to perform the reserved act. • Physicians may delegate performance of certain procedures ordinarily performed only by physicians to a non-physician provided the physician is satisfied the other person is competent to perform the act. The physician remains legally responsible for the performance of the act.	• **Supervision** continues same for students, residents, PAs, CAs. The degree of supervision will depend upon the individual circumstances • **Delegation** permitted by physicians but only as provided in the CPSM regulations • Delegation not required if the profession is authorized under their own regulation to independently perform the act. • Certain reserved acts cannot be delegated, such as making a diagnosis or prescribing a drug. • Some of the reserved acts physicians are authorized to perform are also authorized to be performed by other professions such as nurses. • Therefore, certain professions may now have the ability to independently perform certain acts such as ordering an x-ray within their own scope of practice and do not require a physician's delegation to order that x-ray.	When another health profession is authorized by their own regulation to perform a reserved act, no delegation is required as its within the scope of practice of that other profession.

• Delegations may pertain to an individual patient or to a group of patients such as patients presenting at the ER with chest pain. Nurses may have been delegated certain actions to do immediately upon presentation of a patient with chest pain without a doctor seeing the patient first.		
Council Composition		
• 22 to 24 persons • 4 are public reps	• 16 to 18 persons • 6 are public reps	Smaller Size Increased public representation on Council and Committees Minimum 1/3 public representation
Council meetings		
• Open to members only	• Open to the public and members	More transparency Meetings open to public except *in camera* meetings
Membership Meetings		
Medical Act: • Limited rights • No annual membership meeting • Ability to vote for Council members • Ability to be a member of Council and committees	"Members" include physicians, clinical assistants, physician assistants, assessment candidates and trainees • *RHPA* requires an annual general meeting of "members" • Members vote on bylaws • Members can bring forward their own motions • Right to challenge the actions of Council	RHPA confers increased rights for members New statutory right to annual meeting of members Members approve bylaws of the College except for fee bylaws

Medical Act	RHPA	Key Changes
Registers		
• Manitoba Medical Register (physician) • Educational Register • Clinical Assistant Register • Specialist Register • Medical Corporation Register	• Regulated Member Register (physicians only) • Regulated Associate Member Register • Registrar is required to maintain a "record of health profession corporations) RHPA s.73	RHPA: only 2 registers maintained Medical corporation identified in the public member registers
Classes of Membership		
• As set out in *Medical Act* and *Regulations*	**Regulated Members:** • Full • Provisional • Retired **Regulated Associate Members:** • Assessment • Education • Physician Assistant • Clinical Assistant • Retired	Intent is to more clearly indicate the membership category by class of members Both membership classes have a number of subcategories. See the chart of membership classes and descriptions appended at the end of this document. See details in *CPSM General Regulation sections 3.7 to 3.96* "conditional registration" is changed to "provisional" categories of members
Content of Register		
• Certain information collected by CPSM but is not required to be set out in the register	RHPA: certain information already collected by CPSM now **required** to be noted in register accessible to the public (new): • Date of initial registration and movement to another class • Medical education • Whether has a current certificate of practice • Censure • Voluntary surrender • Undertaking or agreement including if it is given to the Investigation Committee	RHPA • More detailed information now available on the register • Increased transparency

	• Interim suspensions • Cancellation of registration • If member uses a Medical corporation(s)	

Public Access to Information

Information on the public registers is more limited under *The Medical Act* but potentially included information pertaining to ailments, emotional disturbances or addictions suffered by the member	Registers generally contain more publicly accessible information. Certain Information required to be in the Registers is **not** permitted to be publicly available. • RHPA limits public access to information regarding discipline etc. to current year and 10 prior years • Conditions on a member's registration or certificate of practice are public unless the condition pertains to the member's health matters or educational initiatives voluntarily undertaken by a member. • Health Information: Restrictions on publication of physician health information in the discipline context • if conviction at Inquiry on charge that member is suffering from ailment, emotional disturbance or addiction that impairs his or her ability to practice can only publish if CPSM satisfied the public interest in the inquiry finding outweighs the member's privacy interest. *See RHPA s.124(2)(g)* • Censure and voluntary surrender may be public but cannot include information the member suffers from an ailment, emotional disturbance or addiction.	Public access to current conditions on member's ability to practice to be publicly available whether or not the member agreed to the conditions before or after RHPA implementation. More limitations on access to information pertaining to a member's health conditions or addictions Discipline records only publicly available for the current year and the preceding 10 years even if other internet sites may have copies of discipline records older than the past 10 years See *CPSM General Regulation s. 2.6* See *RHPA s. 28(3)*

Application for Registration

• As set out in Medical Act, Regulations and Bylaws	• Required to provide child and adult abuse registry information for registration • Must establish fluency in the English language • CPSM already collecting other information now mandated under RHPA such as: ○ If performing exposure prone procedures and if so has member been advised they have a blood borne disease	• Added requirement to obtain abuse registry information in order to register • Other information now required by statute to be collected that members already provide to CPSM

Medical Act	RHPA	Key Changes
	○ Civil litigation history related to medical practice ○ Outstanding criminal charges and criminal convictions or pleas in any jurisdiction even if pardoned	
Annual Renewal		
Annual renewal of a "licence"	• Now called a "certificate of practice" Disclosure on renewal application same as registration with additional requirements to renew certificate of practice: • Criminal record and abuse registry checks to be provided every number of years as determined by Council • Must provide arrangements for patient record storage • Liability coverage declaration now includes students, PAs and CAs • Must meet required Continuing Professional Development participation	Member now issued a "certificate of practice" not a licence annually Additional disclosure requirements on renewal See *CPSM General Regulation, Part 4* and for CPD requirements *Part 10*
Continuing Competency Programs		
MPAR – Manitoba Physician Achievement Review All physicians, with a few exceptions, are required as part of their continuing professional development to participate in the MPAR program once every seven years since September 2011 MPAR involves completion of a physician practice survey, review by an independent service provider, and feedback to the physician	**Quality Improvement Program** • Mandatory participation for physicians in a newly designed quality improvement program **Continuing Professional Development Programs** • All physicians, clinical assistants and physician assistants must participate in CPD with some limited exceptions See *RHPA s.87* and *CPSM General Regulation, Part 10;* and *Practice of Medicine Regulation, s.16*	MPAR is replaced by a quality improvement program PAs and CAs now required to participate in continuing professional development programs but exempt from the quality improvement program Non-compliance with CPD affects renewal of certificate of practice. If non-compliant registrar may impose conditions or require assessment or examination in order to renew the certificate of practice.

Standards of Practice

Set out in *Bylaw 11 Medical Act*	Set out in RHPA *CPSM Standards of Practice Regulation* – plus Regulation specifically includes by reference, the *CPSM Standards of Practice of Medicine document* See *CPSM Standards of Practice Regulation* s.15	Standards of practice are set out in the *CPSM Standards of Practice Regulation as* well as in a document to be approved by Council called the *CPSM Standards of Practice of Medicine* which is currently substantially similar in content to *CPSM Bylaw 11 under the Medical Act.*

Complaints & Investigation Processes

• Complaints Committee • Investigation Committee • Appeals Committee • Inquiry Committee	RHPA continues Complaints, Investigation, Inquiry and Appeals Committee structures • Mediation an option at Complaints or Investigation stages • Public members selected from a roster maintained by Health Minister • Registrar may dismiss trivial or vexatious complaint, complaint with insufficient or no evidence of conduct sufficient to make a finding. Can appeal to Complaints Committee • Name of Investigator to be supplied to member investigated • Increased powers of investigator • Member must be given opportunity to comment on investigator's report	Member able to comment on investigator's report and to know investigators identity Increased powers for investigators Mediation an option for both Complaints and Investigation Committees

Practice Auditors

• Limited ability to conduct audits	RHPA confers significant new powers on auditors to obtain information and documents	• New powers provided for auditors to perform their work

Medical Act	RHPA	Key Changes
Physician Profiles		
Physician Profile – only for physicians See *Medical Act – Physician Profile Regulation*	Practitioner Profile RHPA - all professions will have profiles	CPSM Profile will now include all practicing: Physicians, Clinical Assistants, Physician Assistants, and Resident Limited members. Profiles will now include: • Whether on specialist register • Criminal convictions in other jurisdictions • Basic qualifications for PAs and Cas • Date of completion of assessment for certain classes of members See *CPSM General Regulation Part 9*
Medical Corporations		
• Must obtain annual "licence" to practise	Must obtain annual "permit" to practise Only Regulated Members i.e. physicians can have a "medical corporation"	No significant changes See *Practice of Medicine Regulation s.14* See *CPSM General Regulation Part 11*
Abandoned Health Records		
• obligations regarding patient records when closing or leaving a practice. See CPSM Bylaw 11, s.67	• In order to obtain a "certificate of practice" and to renew, member must provide evidence the member has made satisfactory arrangements for storage of and access to patient and appointment records • College becomes default custodian of health records if abandoned by a member under new section of RHPA to be proclaimed	CPSM will annually collect information from members on annual renewal as to their record storage plans Potential cost consequences for CPSM (and members) if a member defaults and if CPSM becomes record custodian See *CPSM Standards of Practice Regulation. Part 2 and s.14* See *CPSM General Regulation, s.4.4(1) 7*

What are the types of registration available under the RHPA?

Registration is divided into classes as follows:

Register	Classes		
regulated members (physicians)	full	Practising	
		non-practising	
	provisional	academic	s. 181 faculty
			visiting professor
			post-certification trainee
		specialty practice-limited	
		family practice-limited	
		Manitoba Practice Assessment Program (MPAP) • MPAP is the assessment route to full registration	
		restricted purpose	
		public health officer	
		temporary-locum	
		transitional	
		non-practising	
	retired (physician)		

Register	Classes	
regulated associate members	assessment candidate (physicians)	specialty practice
		family practice
		re-entry to practise
	Educational	medical student
		physician assistant student
		resident
		resident — limited
		external or visiting student
		non-practising
	physician assistant	full
		restricted purpose
		academic — s. 181 faculty
		non-practising
	clinical assistant	Full
		Non-practicing
	retired	physician assistant
		clinical assistant

Cancellation Of Licence and Registration in the Medical Register

Dr. Ramon Eduardo Jovel

IN THE MATTER OF: Section 13(5) of The Medical Act;

AND IN THE MATTER OF: A Notice of Intention to Consider Cancellation Of Licence and Registration in the Medical Register;

AND IN THE MATTER OF: Dr. Ramon Eduardo Jovel, a Member of the College of Physicians and Surgeons of Manitoba.

REASONS FOR DECISION OF COUNCIL

INTRODUCTION

On February 13, 2018, the Registrar of the College of Physicians and Surgeons of Manitoba (the "College") requested that the Executive Committee of the College consider cancelling the licence and registration (the "Registrar's cancellation request") of Dr. Ramon Eduardo Jovel (the "Member"). In so doing, the Registrar had considered the decision of Justice K. Simonsen dated January 31, 2018, in R. v Ramon Eduardo Jovel 2018 MBQB 21 ("Justice Simonsen's decision"), dealing with Dr. Jovel's conviction for sexually assaulting a patient.

The Executive Committee of the College was scheduled to consider the Registrar's cancellation request on March 16, 2018. The March 16, 2018 matter was adjourned.

The matter did not proceed before Executive Committee. Instead, it was determined that the Registrar's cancellation request would be dealt with by the Council of the College ("Council").

On May 31, 20187, the College's President and Chair of Council, Dr. E. Sigurdson, issued a Notice of Intention to Consider Cancellation of Licence and Registration in the Medical Register (the "Notice" - attached as Appendix "A"). The Member and the Registrar were invited to make written submissions in the matter.

The following written submissions were received from the parties:

1. Submission dated May 23, 2018, on behalf of the Member, by legal counsel, Keith Ferbers of MLT Aikins;

2. Submission dated June 1, 2018, on behalf of the Registrar, by legal counsel, Lynne Arnason, which included the following additional material:
   (a) Justice Simonsen's decision.
   (b) The Queen v. Jovel, Queens Bench Criminal Disposition Sheet, January 31, 2018 (the "Certificate of Conviction").
   (c) Tab 3 - Excerpt, The Medical Act (the "Act").
   (d) Tab 4 - Decision of the Executive Committee on Interim Suspension, March 13, 2018.
   (e) Tabs 5 - 9 - Legal decisions.
3. Reply Submission dated June 4, 2018, on behalf of the Member, by his legal counsel.

At a duly constituted meeting of Council held on June 15, 2018, members of Council carefully reviewed the submissions of the parties and associated materials. It is noted that Council members Dr. D. Pinchuk and Mr. A Fineblit did not receive any materials, attend such meeting, nor participate in any way in the matter, including the preparation of this decision.

After careful review and deliberation, on June 15, 2018, Council passed the following resolution:

> "Council, effective immediately, under s. 13(5) of The Medical Act, has canceled the licence and registration of Dr. Ramon Eduardo Jovel who has been convicted by the Court of Queen's Bench on January 31, 2018 of a criminal offence that is relevant to his suitability to practice".
>
> ("Council's Section 13(5) resolution")

By letter dated June 18, 2018, the Registrar communicated Council's Section 13(5) resolution to the Member; indicating that reasons would follow by separate letter as soon as possible.

This serves as the reasons of Council in the matter.

BACKGROUND

On January 31, 2018, Dr. Jovel, a member of the College, was convicted of committing sexual assaults on a patient over a period of more than two years, from about the fall of 1991 to the spring of 1994. As set out in Justice Simonsen's decision, the Member repeatedly touched his patient's vaginal area for a sexual purpose; and on one occasion, the Member rubbed his erect penis against his patient's hip. The findings and reasons underlying the Member's conviction are set out in Justice Simonsen's decision.

The Certificate of Conviction was signed the same date as Justice Simonsen's decision, and additionally stated that the matter was adjourned for sentencing on May 10, 2018. Council was advised within the materials submitted that:

1. The matter came before Justice Simonsen for submissions as to sentencing on May 10, 2018;
2. Sentencing is scheduled to be pronounced by the Court on July 4, 2018;

3. Dr. Jovel intends to appeal his conviction, but must first await the decision of Justice Simonsen as to sentence;
4. By decision of the Registrar dated January 31, 2018, the Member has been suspended from practice on an interim basis, (pursuant to Section 51.1(1) of the Act). On appeal by the Member to the College's Executive Committee, the Registrar's decision was confirmed, by decision dated March 12, 2018, pursuant to Section 51.2(4) of the Act; and
5. The Member has not to date challenged the Executive Committee's Section 51.2(4) decision; although it is noted by Council that the ability of the Member to seek a "stay" of that decision from the Court, under Section 51.2(5) of the Act, is not time-limited.

REASONS FOR DECISION

Subsection 13(5) of The Medical Act provides that:

> "Council may cancel the licence and registration of a member or associate member who has been convicted of an offence that is relevant to his or her suitability to practise, but it must first notify the member or associate member that it intends to do so and give him or her an opportunity to make representations."

Pursuant to Section 13(5) of The Medical Act, to cancel the licence and registration of a member, the following elements must be satisfied:

1. The member must be notified and be given an opportunity to make representations;
2. The member must have been convicted of an offence relevant to the member's suitability to practice; and
3. Council must turn its attention to the matter, and therefore exercise its discretion as to whether to cancel the member's licence and registration.

(collectively "the Section 13(5) test")

There is no issue in this case as to the first and third elements of the Section 13(5) test. The Member raised the issue of the timing involved in considering the second element of the Section 13(5) test; and therefore whether Council should deal with the matter now or alternatively await further proceedings as to the Member's conviction for sexually assaulting his patient.

The ability of Council to cancel a member's licence and registration under Section 13(5) is contained within Part 3 of the Act, dealing with "Registration and Licensing of Members." The procedure that occurred earlier this year, the Member's interim suspension from practice, arose from Part 9 of the Act, dealing with the College's Investigation Committee. The Investigation Committee performs a critical function in relation to the College's overall powers to receive and investigate complaints, hold inquiries, and ultimately to discipline its members (the College's "discipline powers").

The powers of the College dealing with licensure, on the one hand, and its discipline powers on the other hand, are both powers available to be exercised by the College pursuant to its legal duty to regulate the practice of medicine in Manitoba in the public interest. When regulating in

the public interest in a given case, it is not necessary, nor may it be appropriate, for the College to select a single regulatory tool. Such decisions are to be made on a case by case basis, keeping in mind all of the circumstances of a given case.

At the same time, in determining any matter before it under Section 13(5), as in any case where the legal ability of an individual to practice a profession is in question, Council must be mindful of the potential impact of its decision on a member.

As stated by the Registrar in her submission, the issue of suitability to practice is integral to the College's regulatory mandate to protect the public and to maintain the public's confidence in the College's ability to regulate the medical profession. Where, as here, a sexual assault occurs in the course of a patient's medical visits, it necessarily follows that this is "an offence that is relevant to his or her suitability to practise."

In the current case, the Member did not contest, nor properly could he, that at present, the Member is convicted of a criminal offence that is relevant to his suitability to practice. Justice Simonsen's decision and the Certificate of Conviction are conclusive in this regard.

Instead, the Member argued that with the interim suspension in place and the expected appeal of his criminal conviction, Council ought to delay making any decision under Section 13(5) pending sentencing and the exhaustion of any appeals of the criminal conviction. Council declines to postpone its dealing with the matter. All of the elements of the Section 13(5) decision have been satisfied, and it is in the public interest that such decision be made.

The Member also submits that should Council proceed to determine the matter, and decide to cancel the Member's licence and registration, Council should include in its disposition that if the criminal conviction is overturned, the Member's licence and registration will be immediately reinstated. Council declines to include such a provision in its decision.

CONCLUSION

Council is of the view that in this case:

All of the procedural and legal elements of the Section 13(5) test have been satisfied. Council notes in particular that the Notice was given, submissions received and carefully considered, and the Member has been convicted of an offence that is relevant to his suitability to practise. There is no legal nor practical requirement for Council to delay its determination of the Registrar's cancellation request pending the disposition of the Member's appeal of his criminal matters.

Council declines to incorporate into its disposition of this matter any requirement that should the criminal conviction be overturned, the Member's licence and registration is to be reinstated. Should the Member be successful in his appeal(s), he may reapply for licensure under Part 3 of the Act, as in the normal course.

There is no legal requirement for Council to select a single power to regulate in the public interest. Council considers that this is a case for the application of Section 13(5) of the Act, despite the interim suspension of the Member under Part 9 of the Act.

DISPOSITION

Accordingly, Council directs, per its motion passed on June 15, 2018, that effective that date, pursuant to Section 13(5) of The Medical Act, the licence and registration of Dr. Ramon Eduardo Jovel, who has been convicted by the Court of Queen's Bench on January 31, 2018 of a criminal offence that is relevant to his suitability to practice, be and is hereby cancelled.

NOTE

The Medical Act states:

Appeal to court

18(1) A person who is aggrieved by a decision of the council under this Part to refuse registration;

(a) (b) alter or refuse to alter a registration;
(b) refuse to issue or renew a licence;
(c) (c.1) issue or renew a licence on conditions; or
(d) cancel a registration;

may appeal the decision to the court by filing a notice of appeal within 30 days after the day on which the person is notified of the decision.

DATED at Winnipeg, Manitoba, the 22nd day of June 2018