THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

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

IN THIS ISSUE...

Message from the New President

Thank you for the opportunity to represent the physicians and public of Manitoba as your Council President for June 2006-2007. I personally have the deepest respect for the physicians and the profession of Medicine, and I look forward to working with you.

Our Policy Governance has been implemented over the last few years and as the Council and College gained experience we have been able to clarify our Ends (goals) and our means to these Ends in ever-evolving ways.

I would like to thank Dr. Roger Graham for his valuable leadership over the past year as Council President. Together with the Registrar, Dr. Pope and the Deputy and Assistant Registrars, the Council has tackled many important issues of relevance to the medical profession.

With support from the Ministry of Health we have seen the implementation of Physician Profiles and redevelopment of the MANQAP program.

We have reviewed and supported the International Medical Graduates programs, for example by participating in the Western Alliance for the Assessment of International Physicians (WAAIP) process.

The Council has been involved with amendments to *The Medical Act* to include changes to *The Evidence Act* to extend protection for "critical clinical occurrence" reviews, as well as other applications.

Qualifications now includes temporary registration and there was also a regulation change to extend the time to complete the LMCC.

Council will be planning the next year's priorities for the Registrar in September. "Ownership Linkage", an important process of policy governance, will be enhanced.

Outcomes that may be looked at include Continuing Professional Development in the form of revalidation programs, and Emergency Preparedness strategies.

Council welcomes its new members and would like to express its gratitude to those members whose terms finished in June for all their dedicated work throughout the years.

Council plans to become ever more future focused in supporting its function to the public of Manitoba and the medical profession.

Dr. Heather Domke, President

Note from the Outgoing President…

It has been a privilege to serve as President of Council of the College over the last year. This experience allowed a greater appreciation of the challenges constantly bombarding the CPSM staff. Their expertise, commitment and dedication are rarely recognized by physicians in the province. The organization is efficiently managed and demonstrates constant respect for the needs of the public and the profession.

The Council has shown continuous growth in its ability to grasp and apply a Policy Governance model. The Council conscientiously reviews challenging ethical and professional issues, providing direction to the Registrar and his team. The Council has endorsed Continuing Professional Development as a leading issue for the Registrar to develop for the profession. Dr. Pope will keep you informed of the progress in this area.

Thank you to Dr. Pope, the Registrars, the College staff and the Council for this unique experience of my lifetime.

Thank you.
Roger Graham, M.D. FRCPC

Note from the Registrar

The month of June is extraordinarily busy for the College. We receive the College's audited financial statements for the previous year and determine the budget and fee for the renewal process, which takes place over the summer. In addition, the national meeting of the Federation of Medical Regulatory Authorities of Canada (FMRAC) normally occurs the week before the College's AGM. The result is a flurry of activity on both the local and national scene for your registrars and for the President and President-Elect.

This year, the FMRAC AGM topic for the education session was "Emergency Preparedness". It was my privilege to be national president and this topic was my choice. There were 3 major areas of concern for which your College must be prepared. The first is natural disasters, such as the flood of the century, Hurricane Katrina, or the ice storms that occurred in Eastern Canada over the past winters; next, the danger of terrorist attacks and the potential threat identified in Ontario, show that Canadians are by no means immune to this threat; third is the very likely possibility of a serious pandemic in the near future.

Your College must be prepared to deal with any or all of these situations. The State Board of Louisiana had a big problem when their office was flooded during Hurricane Katrina. They were unable to access the building for several months. This meant they were unable to actively confirm whether a physician was licensed when doctors relocated to other states. Likewise, there was no organized process to license new physicians coming into the state to assist during the emergency situation. Fortunately, they had backup information stored with the Federation of State Medical Boards. As a result of this information from the FMRAC meeting, the Colleges across Canada are looking at ensuring safe storage of members' registration data, and backup in the case of a crisis.

It was clear during the SARS outbreak that the ability for offices to function normally may be non-existent in the case of a major pandemic. Therefore, the College will be considering how to function if an influenza pandemic hits Winnipeg and if, as predicted, 50-60% of our staff are ill and unable to come to work. I encourage all physicians to think about this issue and have a plan in place for how you will act when the pandemic arrives. If you work in a wider health care environment, physicians should be asking questions about the emergency plan in the institutions where they are located.

Annual General Meeting: Council held its AGM on June 16, 2006. Several important items were reviewed at that time.

- Annual Fee 2006-2007- This has been set at $1,300.00 per member. The College must have a reserve fund approximately equal to its annual budget. In the past year, your Council directed that the Registrar must put aside 5% of the budget each year to reach the desired amount. The FMRAC has allowed national participation by the Colleges in a liability insurance plan. Savings were significant. Because of the decrease in liability insurance for the College activities this year, the only fee increase necessary was the amount required for this Reserve Fund allocation. We hope to be able to expand these savings programs in the next year.
- Medical Amendments Act – This piece of legislation died on the order table when the legislature was adjourned in June. However, it is likely to be reintroduced in the fall. The Act has a number of important sections which will assist the College in carrying out its business more efficiently. It will also require the publication of an Annual Report similar to those required from other regulatory health authorities. If legislation is reintroduced later in 2006, a newsletter item will update members on its contents.
- International Medical Graduates' Assessment – The College has been part of a working group to the Minister of Health with representation from the Continuing Medical Education Department of the University of Manitoba, the Medical Licensure Program for International Medical Graduates (MLP IMG), Manitoba Health, the Office of Rural and Northern Health, the Regional Health Authorities of Manitoba and Manitoba Health Workforce Planning. There is general approval to move ahead and require a clinical assessment for all International Medical Graduate applicants for the Conditional Register. It is hoped that this will be introduced later in 2006.
- New Councillors – We welcome the new Councillors to the College: Dr. Margaret Burnett (Winnipeg), Dr. Enok Persson (Central), Dr. Dan Lindsay (Interlake) and Dr. Khalid Azzam (Northman).
- Retiring Councillors – Dr. Roger Graham, President, acknowledged and thanked the many retiring Councillors. These are Dr. Ab Alvi (Winnipeg), Dr. Lou Antonissen (Central), Dr. Cary Chapnick (Interlake), Dr. Norman Goldberg (Winnipeg), Dr. June James (Winnipeg), Dr. Maurice Roy (Past President), Dr. Krish Sethi (Northman), Dr. Sat Sharma (Winnipeg), Dr. Eric Stearns (Winnipeg). Their wise advice will be missed.

The next year will be a busy one. Now that Physician Profiling is in place, we will be spending much energy on the introduction of mandatory continuing professional development. This was approved 6 years ago by Council,

but we have not had the legislative changes to permit CPD to be a Standards process. Council's intention is that all licensed members will participate in the CPD program of either the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. There will be much more information available as we move further along in this process.

Finally, the annual physician statistics are included in this newsletter for members' information.

Please enjoy your summer.

Important Notice

The 2006-2007 edition of the ***Winnipeg Medical Directory*** erroneously lists the College's address, telephone number and fax number as the contact information for several physicians.

Please instruct your staff to check carefully before using the physician contact information in the 2006-2007 Directory.

If the Directory lists the College as the physician's location, inquiries should be made of the physician to obtain correct contact information.

Congratulations to….

- Dr. Arnold Naimark, who was named the first President Emeritus of the University of Manitoba at the Medicine Convocation on May 12, 2006;
- Dr. Reeni Soni, who was named one of Winnipeg's Women of Distinction this year;
- Dr. Ian Maxwell, who was named Physician of the Year by the MMA on May 11, 2005;
- Dr. David Mymin, who was awarded the Distinguished Service Award by the MMA on May 11, 2005;
- Dr. Fred Aoki, who was awarded the Scholastic Award by the MMA on May 11, 2005;
- Dr. Homer Janzen, who was awarded the Humanitarian Award by the MMA on May 11, 2005
- Dr. John Foerster, who received the Distinguished Alumni Award of the University of Manitoba Alumni Association on June 21, 2006.

FROM THE COLLEGE
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Lessons Learned…..from the Complaints Committee

1. Timely Pap Tests & Pelvic Exams

On June 8th a 35 year old woman presented to a physician at a walk in clinic complaining of irregular periods with heavy bleeding. No pelvic examination was done. The physician prescribed birth control pills to regulate the patient's periods.

On July 12, the patient presented to her family physician with a complaint of approximately 4 months of abnormal pelvic bleeding, abdominal cramping and increased weight. The patient had not had a complete physical examination, including a pap test, for the past 11 years. The family physician removed a retained tampon, prescribed antibiotics and booked a return appointment for 15 days later. At the return appointment the patient had suprapubic tenderness. No further examination was done as the physician felt the infection had not resolved. The family physician advised the patient to return.

On July 31st the patient attended another physician at a walk-in clinic complaining of irregular periods with heavy bleeding. No pelvic exam was done. Provera was prescribed.

In October the patient returned to her family doctor. She still had heavy bleeding and cramping. She was booked for an ultrasound, but no pelvic exam was done.

On November 10th the patient presented to Emergency at which time a pelvic exam was done and a large tumor was discovered. The cancer had metastasized, and within a short time the patient died.

The Committee reminds the profession that complaint-specific physical examinations must be performed on a timely basis to address the patient's symptoms. The physical setting in which physicians work does not alter this requirement. As well, even if a short appointment is booked, physicians must take the opportunity and make the time to perform the necessary examinations and tests.

2. Facsimile Transmission of Prescriptions

The Manitoba Pharmaceutical Association and the College of Physicians and Surgeons of Manitoba have a joint statement on this subject.

Members should note that a pharmacist may not dispense a prescription received by fax unless the information noted in the statement is included and the required format is used. Otherwise, the pharmacist must wait until the written prescription is in hand.

Statement 804 is included at the end of this newsletter. Please ensure that the information as noted in the enclosed Statement is provided in the required format.

Liability Coverage for Non-Hospital Medical/Surgical Facilities

In its newsletter dated January 1, 2006, the CMPA included a paper entitled *CMPA Assistance to Clinics and Facilities: General Principles.*

Members who own or who are involved with such clinics should review their liability coverage and investigate whether all procedures and treatments at the clinic are covered or whether the liability coverage exists only for the personal coverage of the clinic owner.

Members who own or are responsible for clinics are encouraged to review carefully whether coverage is available for the entire team.

Radiation Doses in Diagnostic Examinations

Most physicians and paramedical personnel could be better informed regarding radiation doses in different radiological exams and the effects of radiation. The relatively small dosage from conventional x-rays versus the relatively large dosage from some CT exams is not widely appreciated. The teratogenic effects and effects of radiation on the fetus are often overestimated, while the carcinogenic effects of radiation are generally underestimated.

Physicians rarely discuss the risks versus benefits of radiological procedures with the patient. X-rays, CT scans, and Nuclear Medicine examinations are requested for a variety of reasons some of which are inappropriate. The inappropriate requests include those demanded by the patient and certain medico-legal situations. The adverse effects of radiation are rare and may not present for many years. This is based on evidence from the atomic bomb survivors in Japan as well as from patients undergoing long term repeated chest fluoroscopies. Radiation induced tumors include Leukemia, Breast, Thyroid, Skin, G.I. and Lung Carcinomas. The mean latent time period for Leukemia is 7 years while the mean time period for solid tumors is 20 years.

The cancer risk from diagnostic radiation cannot be directly measured, but common sense dictates reasonable attempts to minimize the radiation exposure, especially in younger patients or when multiple exposures are likely to occur. Modern diagnostic imaging still represents a major advance in terms of patient care, since the risk from an incorrect diagnosis is far greater than risk from exposure to appropriate diagnostic radiation.

With the advent of multi-detector spiral CT scanners (MDCT), the information obtained has increased dramatically. This has not come without a price as the radiation dose to the patient using this modality has increased as well. On page 24 of this newsletter, you will find a table with estimates of radiation exposures for various exams (data taken from publications of the International Commission on Radiological Protection (ICRP) and the Administration of Radioactive Substances Advisory Committee, National Radiological Protection Board (NRPB), UK). The radiation dose estimates for spiral CT and CT angiography are very dependent on the technique and equipment used. However, the doses quoted conventional CT give a useful guide to the level of potential dose involved.

Can the diagnostic radiation doses in diagnosis be managed without affecting the diagnostic benefit?

Yes. There are several ways to reduce the risks to very low levels while obtaining the beneficial health effects of radiological procedures, far exceeding the health impact of a possible detriment.

There are several strategies that will minimize the risk without sacrificing the valuable information that can be obtained for patients' benefit. One such measure is to ensure the need for the examination before referring a patient to the radiologist or nuclear medicine physician.

Strategies to Reduce Radiation Dosage to Patients

1. Only repeat exams if more information is to be gained.
2. Avoid tests where the outcome, whether positive or negative, will not influence patient management.
3. Provide adequate clinical information so the appropriate exam is performed.
4. Avoid follow up exams at short intervals since there may be significant time delays before clinical changes manifest in images.
5. Use exams which may provide the same information at a lower radiation dose, i.e. conventional radiology, ultrasound, MRI, or Nuclear Medicine instead of CT.
6. Use screening only when approved by national health authorities.

Assessment of the Patient with Altered Level of Consciousness

There have been several incidents recently where acute illness has not been diagnosed and treated in chronic alcohol or solvent abusers. Patient complaints of headache, vision problems and decreased level of alertness are sometimes attributed to substance abuse and patients are sent to "sleep it off". It is important to consider head injury as a possible cause of the symptoms regardless of the individual's inability to relate that an injury has occurred. Physicians are reminded that the patient's condition should be followed up and monitored accordingly.

Pilot Transition Program for Young Adults with Type 1 Diabetes

Starting in January 2006, the Youville Diabetes Centre launched a pilot program for young adults (16-25 years old) with type 1 diabetes.
This program provides integrated care, education and support by a multidisciplinary team consisting of an endocrinologist, certified diabetes educators (nurse and dietitian) and a counsellor.

The primary goals of this program are to keep young adults (YA) engaged with care and education as well as to reduce hospitalizations due to acute complications.

This clinic runs every Thursday evening from 4-8 pm with the endocrinologist on site once monthly. The target populations for this program are:

- YAs who are not accessing any type of diabetes education and/or do not have an endocrinologist
- Graduated clients of Diabetes Education Resource for Children and Adolescents (DER-CA) who have been identified as high risk for drop-out from traditional adult education/care services

Self- referrals and referrals from health or social service providers are accepted.

For more information regarding this program including brochures or posters please contact Michelle or Eleeta at 233-0262.

Disasters and Docs (Part II of IV)

MANAGING DISASTERS

(Submitted by Guy Corriveau, Director, Disaster Management, WRHA)

In answer to typical multi-agency, cross-jurisdictional, and large institutional problems such as non-standard terminology, non-standard and non-integrated communications systems, lack of consolidated actions, lack of designated operations centre facilities, and a requirement for a flexible management structure, the *Incident Command System (ICS)* was born over 30 years ago.

Since then, the ICS has evolved into an effective "all-hazards" disaster management tool. Its successes have resulted directly from applying a common organizational structure, standardized key management principles, Comprehensive Resource Management, and Comprehensive Disaster Management.

The ICS organizational structure is built around five major components, namely, a Command Group with four sections: Planning, Operations, Logistics, and Finance/ Administration. Its foundation applies either when preparing for a major event, managing a response to a major event, or managing the recovery from a major event. The ICS organization expands or contracts to meet the needs of the incident. In a small-scale event, for example, all components may be managed by one person – the Incident Commander.

As an incident grows and expansion of the ICS is required, the Incident Commander will establish Command Staff or Specialist Advisor positions such as Liaison Officer, Security Officer, Safety Officer, Public Information Officer, and/or Medical Health Officer.

ICS is the management structure of choice for Fire, Paramedic, and Police Services across North America and is making headway in public and private sectors. Its use is called for in the National Fire Protection Association Standard 1600 Emergency Management and Business Continuity Programs. In Manitoba, ICS is endorsed by the Department of Labour (Office of the Fire Commissioner) and Manitoba Emergency Measures Organization.

The ICS concept has been approved by Health Services since 1993 and is currently used by Health Authorities in British Columbia, Alberta, and Saskatchewan.

In January 2003, acknowledging the critical importance of coordinating health services responses to and recovery from disaster events within the Winnipeg Health Region, the Winnipeg Regional Health Authority approved a Disaster Management Program *and* adopted ICS as the management structure for use throughout the Winnipeg Health Region. The implementation of a Regional/Corporate ICS, Hospital ICS and Personal Care Home ICS at each facility and a Community ICS for the Community Health Services is currently underway.

In November 2004, Manitoba Health released a policy requiring the use of ICS at each Regional Health Authority throughout the province. Today, the Public Health Agency of Canada is pursuing the development and implementation of a National Health ICS.

This is the second in a series of articles which follow a Winnipeg Regional Health Authority presentation made to the College of Physicians and Surgeons of Manitoba on September 28, 2005 on the topic of Disaster Management.

The previous article, ***Situating Disasters,*** *provided the background and introduced the topic. Subsequent articles will speak to* ***Docs in Disasters*** *broaching the topic of physician roles in Disaster Management and finally* ***Tracing the Way Ahead,*** *proposing a number of suggestions which may help travel the way forward.*

From the Manitoba Institute for Patient Safety….

It's Safe to Ask is a provincial health literacy initiative that supports patients and families in enhancing the safety and quality of their healthcare by becoming active, informed members of their healthcare team. The initiative includes information for providers (physicians, pharmacists, nurses) and patients to make care a more positive experience, and help reduce healthcare errors.

A patient's degree of health literacy has a major impact on their health, and experience of healthcare. Low health literacy puts many Manitobans at a disadvantage. *It's Safe to Ask* encourages people to discuss three questions:

- What is my health problem?
- What do I need to do?
- Why do I need to do this?

Report of Disciplinary Proceedings

INQUIRY: IC04-04-08
DR. JACK RUSEN

On February 27, 2006, Dr. Jack Rusen pled guilty to a charge of professional misconduct. The charge specified that on or about April 2, 2004:

1. Dr. Rusen examined X's breasts in a manner that was not medically indicated for X in that after he examined X's breasts in the supine position, he examined her breasts in the sitting position. After he examined X's breasts in the sitting position, he had X stand and lean over with her arms extended on the examination table while he palpated her breast and then had her turn around and stand with her arms extended on the desk while he palpated her other breast.
2. During portions of Dr. Rusen's physical examination of X, he failed to respect her privacy and/or dignity in that:

a. He examined X's breasts:
   i. without explaining to her why a breast examination was necessary; and
   ii. in circumstances where he ought to have known that she was uncomfortable with having her breasts examined by him.
b. He persisted in teaching X breast self-examination by palpating X's breasts and then instructing her to palpate her breasts while he watched because he believed X did not know how to examine her breasts in circumstances where:
   i. she had advised him that she knew how to examine her own breasts; and
   ii. he ought to have known that she was uncomfortable.
c. While he was examining X's breasts while she was standing with her arms extended on the examination table and/or his desk:
   i. he failed to ensure that she was appropriately draped; and/or
   ii. he palpated her breasts while she had no draping and was wearing only her underpants and socks.
d. He referred to X as "busty".

Dr. Rusen admitted to the particulars set forth in the charge and entered a plea of guilty.

The Investigation Committee of the College and Dr. Rusen made a joint recommendation as to the discipline to be imposed as follows:

1. Dr. Rusen be reprimanded.
2. Dr. Rusen be ordered to pay the costs of the proceedings in the sum of $15,857.56 on or before the date of the Inquiry.
3. There be the usual publication of the facts and disposition, including Dr. Rusen's name.

The Inquiry Panel was advised that Dr. Rusen signed an undertaking pursuant to which he agreed to complete the Boundary Training Program and to only conduct breast and pelvic examinations of patients with a third party attendant present and that the undertaking would take effect upon the joint recommendation being accepted by the Inquiry Panel. The Inquiry Panel concluded that in all of the circumstances, including Dr. Rusen's signed undertaking, the proposed disposition was the appropriate penalty. It therefore accepted the joint recommendation.

INQUIRY: IC03-01-04
DR. NASEER WARRAICH
REASONS FOR DECISION OF INQUIRY PANEL

On February 23, 2006, a hearing was held before an Inquiry Panel of the College to consider a Notice of Inquiry which charged Dr. Naseer Warraich with professional misconduct. Dr. Naseer Warraich entered a plea of guilty to charges of professional misconduct as follows:

1. During the period from in or about April, 2002 until in or about February, 2003, Dr. Warraich counter-signed prescriptions issued by physicians practising in the United States based solely on information he received without direct patient contact and thereby failed to meet an acceptable standard of care and breached Statement 805 and Articles 2, 12 and 45 of the Code of Conduct;
2. During the month of February, 2003, Dr. Warraich practised medicine without professional liability coverage that extended to all areas of his practice in breach of the professional liability coverage requirements of Regulation 25/2003 in that Dr. Warraich had no policy of professional liability insurance that provided coverage for counter-signing prescriptions for patients in the United States;
3. During the period from in or about April, 2002 until in or about February, 2003, in contravention of Article 2 and Article 45 of the Code of Conduct, Dr. Warraich entered into an arrangement with certain pharmacies whereby he counter-signed prescriptions for patients in the United States only when the pharmacy had the patient sign a document which contained, amongst others, terms that released the pharmacy and/or the physician retained by the pharmacy from any liability, claims or causes of action with respect of the use or the application of the medications prescribed.
4. During the course of Dr. Naseer Warraich's practice, he counter-signed prescriptions for animals.
5. During the period from in or about April, 2002 to in or about February, 2003, Dr. Warraich failed to maintain adequate clinical records respecting each of his patients for whom he counter-signed prescriptions issued by physicians practising in the United States and thereby violated Article 29 of By-law No. 1 of the College.
6. During a July 2, 2003 interview with the Investigation Chair of the College, Dr. Warraich made statements that were false or misleading with respect to several aspects of his counter-signing practice. He stated that December, 2002 was the first time that he had ever counter-signed a prescription for anybody. In fact, Dr. Warraich began counter-signing prescriptions in April, 2002. He stated that he had counter-signed prescriptions for a total of three pharmacies. In fact, Dr. Warraich had counter-signed prescriptions for approximately 20 pharmacies. Dr. Warraich stated that he had counter-signed less than 100 prescriptions. In fact, he had counter-signed for several thousand patients. Dr. Warraich understated the number of prescriptions he had counter-signed for Redwood Drugs and for Canadianmedco.com. Dr. Warraich stated that he had spent at least 15 minutes reviewing each patient chart and prescription that he counter-signed. In a March 3, 2004 interview with the Investigation Chair, Dr. Warraich stated that in fact, he had generally spent less time than that and sometimes as little as 20-30 seconds in reviewing each prescription. Dr. Warraich stated that he had discontinued counter-signing prescriptions on February 6 or 7, 2003. In a March 3, 2004 interview with the Investigation Chair, Dr. Warraich stated that in fact, he may have continued counter-signing for a few days after February 6 or 7, 2003.

The parties were unable to agree to a joint recommendation. The Panel heard from counsel for the Investigation Committee and counsel for Dr. Warraich as to the matters to be considered in reaching a decision on penalty.

During determination of the penalty, the Panel reviewed the

details and the range of penalties in nine other cases respecting the counter-signing of prescriptions by Manitoba physicians for American patients. The Panel also reviewed cases involving charges of misleading the Investigation Committee. The Panel reviewed an excerpt from the Regulation of Professions in Canada by James T. Casey on the purpose of sentencing and focused on the following two factors:

a. the need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice of medicine, and
b. the need to maintain the public's confidence in the integrity of the medical profession.

Considering all the facts of the case, the facts of similar cases in Manitoba and the penalties imposed, the Panel orders:

a. a suspension of the licence of Dr. Warraich for a period of two months;
b. that Dr. Warraich pay the costs of the investigation and of the Inquiry Panel in the amount of $16,631.83;
c. publication of the disciplinary report, including the member's name; and
d. that the patients identified in the Amended Notice of Inquiry and the exhibits not be identified by name.

CENSURE: IC05-02-10
DR. CHRISTOPHER EMERY

On February 8, 2006, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee of the College censured Dr. Emery with respect to his failure to report a matter to the College in January 2005 in circumstances where it was mandatory to report.

I. PREAMBLE

The Code of Conduct states:
26.2.3 Every Member or Associate Member must report to the Registrar of the College any other Member or Associate Member whom he/she believes to be unfit to practice, incompetent or unethical.
41 Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege.
43 Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.

Statement 110 on At Risk Colleagues states that in all cases physicians must consider whether reporting to the Registrar of the College is required. It points out that physicians must consider whether the public is at risk due to incompetence, unethical behavior or dishonesty and where the public is at risk, it is the ethical responsibility of each physician to report the colleague to the College.

II. THE RELEVANT FACTS ARE:

1. At all material times Dr. Emery employed Dr. X.
2. On or about October 7, 1999, Dr. Emery was advised that A was making allegations that Dr. X had inappropriately touched a patient. After discussing the allegation with Dr. X, Dr. Emery advised him that he would follow up if there was a formal complaint.
3. When the College became aware of A's allegations, the Investigation Chair of the College telephoned Dr. Emery on October 21, 1999. During the conversation the Investigation Chair advised Dr. Emery that he should have contacted the College with respect to the allegation.
4. On January 30, 2005, Dr. Emery was advised that B was making allegations that Dr. X had inappropriately touched a patient. This allegation was of a substantially similar nature to those made by A in 1999. After discussing the allegation with Dr. X, Dr. Emery did not believe that the alleged event had occurred, and he felt that there was insufficient basis to report the matter at that time.
5. When the College became aware of B's allegations, Dr. Emery was required to respond to the issue of why he had failed to report the recent matter to the College. In an interview with the Investigation Chair, Dr. Emery stated that:

a. Although he acknowledged that the Investigation Chair may have told him in 1999 that he should have reported the 1999 allegation to the College, Dr. Emery now has no recollection of the conversation. Dr. Emery felt that he should have received a letter from the College in 1999 formally reminding him of the ethical obligations of physicians to report to the College.
b. At the time the 2005 allegation came to Dr. Emery's attention, he felt that it was a very spurious allegation and he was not prepared at that time to take action, even taking into account the prior allegation, which he acknowledged was strikingly similar to the 1999 allegation. Dr. Emery felt that the prior allegation had not been proven, and he should not act as though it had been proven.
c. Dr. Emery was aware of the Code of Conduct and Statement 110 of the College, but has become more familiar with them in the past year.
d. In retrospect, Dr. Emery acknowledges that he should have reported the matter to the College when it came to his attention in January 2005.

III. THE INVESTIGATION COMMITTEE NOTED THAT THE OBLIGATION TO REPORT IS NOT PREMISED UPON THE REPORTING PHYSICIAN HAVING PROOF THAT THE ALLEGATIONS ARE TRUE. PHYSICIANS ARE OBLIGED TO REPORT IN ACCORDANCE WITH STATEMENT 110 IN CIRCUMSTANCES WHERE, IF THE ALLEGATIONS ARE TRUE, THE PUBLIC IS AT RISK.

ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. EMERY'S FAILURE TO REPORT A MATTER TO THE COLLEGE IN JANUARY 2005 IN CIRCUMSTANCES WHERE IT WAS MANDATORY TO REPORT.

In addition to appearing before the Investigation Committee to accept the censure, Dr. Emery paid the costs of the investigation in the amount of $1,669.50.

CENSURE: IC04-05-04 & IC04-12-11
DR. KAREN M. MORAN DE MULLER

On December 21, 2005, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Moran de Muller as a record of its disapproval of the deficiencies in her care of two patients.

I. PREAMBLE

Physicians must conduct a physical examination appropriate to the patient's presenting complaint. Subject to the patient's right to decline recommended care, if a particular physical

examination is indicated, it is important that the physician offer that examination to the patient and, if the patient is reluctant to have the examination, convey to the patient the importance of the physical examination. If the examination is refused, the physician should document that refusal.

A medical record is intended to be an account of the patient's medical assessment, investigation and course of treatment. It is an essential component of quality patient care. It is therefore imperative that physicians make prompt, accurate and complete entries in each patient's medical record respecting the care provided.

II. THE RELEVANT FACTS ARE:

A. WITH RESPECT TO PATIENT "Ms A":

1. Ms A, born in 1955, became Dr. Moran de Muller's patient in or around 1995.
2. Ms A's primary complaints were stress and chronic abdominal pain.
3. For the stress, Dr. Moran de Muller provided counseling and prescriptions. She suggested a psychiatric referral, but Ms A declined. From time to time, Dr. Moran de Muller provided her with notes certifying that she was not able to work due to a medical condition, and Dr. Moran de Muller stated that the condition on which she based the certifications was stress. Dr. Moran de Muller's medical record does not reflect any of the discussions that she had with Ms A about the problems that were causing her stress.
4. For the chronic abdominal pain, Dr. Moran de Muller provided prescriptions and in March 2000, made a referral to a gastroenterologist. Following investigations, the gastroenterologist concluded that Ms A had an irritable bowel, aggravated by periods of stress. He recommended a psychiatric evaluation to assist in managing the stress, but Ms A did not attend for this care.
5. During the period from April 1997 to June 2001, Ms A saw Dr. Moran de Muller approximately every 2 months. There are no physical examinations of Ms A documented in the chart during this period of time, despite the fact that Ms A raised with Dr. Moran de Muller her ongoing abdominal symptoms, headaches and other concerns.
6. On June 18, 2001 Dr. Moran de Muller performed a complete physical examination on Ms A. Thereafter, the records do not document any physical examination for the next 18 visits. The first record of a physical examination is on October 2, 2002, when a blood pressure is noted in the records.
7. During the period from October 30, 2000 to December 17, 2002, Ms A attended Dr. Moran de Muller's office on 30 occasions.
8. Dr. Moran de Muller stated that Ms A was advised to book a physical examination and, at one point had booked a physical examination but cancelled it the following day.
9. Dr. Moran de Muller's records for visits made by Ms A in February, March and April of 2002 do not reflect Ms A's status or particulars of her concerns. Dr. Moran de Muller stated that when nothing is written on the chart Ms A was coming in for B12 injections and prescription refills.
10. Dr. Moran de Muller's August 7, 2002 note reflects that Ms A complained of heavier periods for the past year, but her notes do not reflect any further history respecting that complaint and she did not examine Ms A. Dr. Moran de Muller stated that she recommended that Ms A follow up, but there is no record of Dr. Moran de Muller having followed up on this complaint of heavier periods for the past year.
11. Dr. Moran de Muller's notes of Ms A's October 2, 2002 visit to her record Ms A complaining of shortness of breath. Dr. Moran de Muller recorded a blood pressure. Although there is no record of it, Dr. Moran de Muller stated that she listened to Ms A's heart and lungs, and there was no abnormality. A heart tracing and a chest x-ray were ordered.
12. On December 12, 2002, Ms A presented with a complaint of pelvic pain severe enough to keep her awake at night, weight loss and rectal bleeding. Dr. Moran de Muller's chart does not document Ms A's weight. She stated that Ms A would not allow her to weigh her, but Dr. Moran de Muller's record does not reflect this refusal. Dr. Moran de Muller ordered a pelvic ultrasound, and this requisition was sent to St. Boniface Hospital on December 17, 2002. Dr. Moran de Muller stated that she urged Ms A to go to Emergency or to see a gastroenterologist on an urgent basis, but Ms A declined these options. Dr. Moran de Muller's record respecting the December 12th visit does not reflect the referral to the Emergency Department, but does note "see gastro ASAP".
13. Ms A had an appointment scheduled with Dr. Moran de Muller for December 17, 2002.
14. On December 16, 2002, Ms A did attend St. Boniface Hospital Emergency Department. She presented with a temperature of 38.5, a pulse of 140 and a blood pressure of 122/67. The triage nurse documented Ms A having said that she had left lower quadrant pain for months and was awaiting an ultrasound, but wanted another opinion. She was assessed as in no distress and alert, but described her pain as 8 out of 10.
15. A consult to gynecology stated that the lower left quadrant pain started about 2 weeks earlier, and that Ms A had lost 15 – 20 pounds since the summer and was now about 110 pounds. (Ms A was 5'6" tall.) There was a palpable mass in her lower left quadrant. A CT scan showed 2 large ovarian masses at 9.6 cm. on the right and 8 cm. on the left. There was suspicion of further nodules in the omentum and there was a 2 cm. lesion in the liver. The conclusion was that this was suggestive of a bilateral ovarian neoplasm with metastases.
16. After further investigation and surgery, the final diagnosis was poorly differentiated papillary serous carcinoma of the ovary.
17. After Ms A's diagnosis, on January 21, 2003, Dr. Moran de Muller telephoned Ms A's sister who was also Dr. Moran de Muller's patient, and had a discussion with her in which Dr. Moran de Muller referred to Ms A's diagnosis and she inquired about Ms A's status, without the express permission of Ms A.
18. At an interview with the Investigation Chair:

a. Dr. Moran de Muller acknowledged the merit of the Investigation Chair's concern that she had not examined Ms A on numerous occasions when Ms A attended her office. Dr. Moran de Muller stated that she felt she had developed a relationship with Ms A in terms of her sharing her stress issues, and she wanted to continue to provide Ms A with that opportunity to talk about her problems.

b. Dr. Moran de Muller stated that Ms A refused examination on numerous occasions, although this is not documented in the record. She acknowledged the Investigation Chair's concern that although she stated Ms A refused examinations, she continued to provide Ms A with sick notes and medications, and thereby

enabled Ms A to control the relationship.

c. Dr. Moran de Muller acknowledged that it would be difficult for any other physician to understand what had happened with this patient based upon a review of the chart. Dr. Moran de Muller stated that at that time she only documented positive findings, but has since changed her practice so that she uses the SOAP format of record keeping and documents all examinations done.
d. Dr. Moran de Muller agreed with the Investigation Chair that her record does not reflect any of the discussions she had with Ms A about the issues that were causing her stress. She stated that Ms A was concerned that the record might be revealed to others, and therefore Dr. Moran de Muller deliberately did not write down these confidential matters. Dr. Moran De Muller stated that she accepted Ms A's direction not to record confidential matters. She did not document this discussion with Ms A.
e. Dr. Moran de Muller acknowledged having had a conversation with Ms A's sister about Ms A's diagnosis and status, but maintained that her telephone call was for the purpose of giving Ms A's sister permission to leave her practice.

B. WITH RESPECT TO PATIENT "Ms B":

1. Ms B, born in 1967, attended Dr. Moran de Muller as her family physician.
2. On September 18, 2003, Ms B presented with a complaint of a month-long history of constant bleeding (2 pads per day). Ms B stated that she complained of cramps that were gradually worsening, and Dr. Moran de Muller stated that she did not complain of major cramping, but of a pelvic pressure sensation. Ms B stated that she had attempted to arrange an appointment with a gynecologist she had seen in the past, but she was told she needed a referral.
3. At the time of the September 18, 2003 visit, Dr. Moran de Muller was aware that Ms B had a past history of an oophorectomy for a cyst and a successful pregnancy after in vitro fertilization with delivery by Caesarean section.
4. Dr. Moran de Muller's record does not reflect any additional particulars of the bleeding or questions about lifestyle changes that might be pertinent to the complaint. She stated that she usually asks questions of that nature, and she therefore assumed that she did in this case. Ms B does not recall DrMoran de Muller asking her any further questions about the bleeding and stated that she did not ask her about changes in lifestyle that might be pertinent to her complaint.
5. At the September 18, 2003 visit Dr. Moran de Muller agreed to refer Ms B to a gynecologist and she ordered blood work (hemoglobin, an iron level and a Beta HCG) and a pelvic ultrasound.
6. Ms B stated that Dr. Moran de Muller told her that there was no sense in her doing a pelvic examination if Ms B was going to see a gynecologist. Dr. Moran de Muller stated that she "sensed" that Ms B preferred to be examined by the gynecologist and Ms B agreed. Dr. Moran de Muller's record does not reflect any refusal by the patient to be examined, and Ms B denies that Dr. Moran de Muller offered an examination. Ms B stated that, if offered, she would certainly have had the examination. Dr. Moran de Muller's record does not contain any documentation of a refusal of an examination.
7. Dr. Moran de Muller stated that she told Ms B to go to Emergency if her symptoms worsened, but Ms B denies that Dr. Moran de Muller provided her with this advice. Dr. Moran de Muller's record does not have any documentation on this point.
8. The blood work returned with a hemoglobin of 125 and a Ferritin of 45.5. Dr. Moran de Muller cancelled the qualitative Beta HCG in favour of a quantitative Beta HCG, which she stated that she asked to have sent to the gynecologist's office. Dr. Moran de Muller had no record of receiving this result, and nor did the gynecologist.
9. Dr. Moran de Muller's record includes an "urgent" referral for ultrasound at the Misericordia Hospital. She understood this to mean that Ms B would be called for ultrasound within 48 – 72 hours. No ultrasound was performed at Misericordia, within that time frame or at all, and Dr. Moran de Muller did not follow up on the status of the ultrasound.
10. During the period September 25 to 29, 2003, Ms B stated that she contacted the gynecologist's office, and was advised that no referral had been received. Ms B stated that she contacted Dr. Moran de Muller's office and was advised that a referral would be faxed.
11. Dr. Moran de Muller states that a referral to the gynecologist was made on September 18, 2003 and again faxed on September 23, 2003. The gynecologist's office had no record of ever receiving a referral.
12. Ms B states that on September 30, 2003, she contacted Dr. Moran de Muller's office and was advised that the referral had been faxed to the gynecologist on September 23, 2003. She stated that she contacted the gynecologist's office, and was advised that his practice was restricted to pregnancies and hysterectomies. His office arranged an appointment with another gynecologist.
13. On September 30, 2003, Ms B began to hemorrhage and called 911. She was taken to the Emergency Department at Victoria Hospital, where the gynecologist on call arranged an urgent ultrasound. The initial diagnosis was an inevitable abortion for which an urgent D&C was performed. While performing the D&C, the gynecologist diagnosed an ectopic cervical pregnancy. Bleeding could not be controlled, and Ms B required an urgent hysterectomy.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. MORAN DE MULLER'S CARE AND MANAGEMENT OF MS A AND MS B, IN PARTICULAR:

a. Dr. Moran de Muller failed to take or, alternatively, to record an adequate history of Ms A's concerns.
b. Dr. Moran de Muller failed to offer or to conduct physical examinations of Ms A when physical examinations were warranted, particularly on August 7, 2002 and December 12, 2002.
c. Dr. Moran de Muller failed to maintain an adequate medical record with respect to her care of Ms A.
d. On January 21, 2003, Dr. Moran de Muller breached Ms A's confidentiality by having a conversation with Ms A's sister in which she referred to Ms A's diagnosis and inquired about Ms A's status, without the express permission of Ms A.
e. On September 18, 2003, Ms Moran de Muller failed to take or, alternatively, to record an adequate history from Ms B.
f. On September 18, 2003, Dr. Moran de Muller failed to offer or to conduct a physical examination of Ms B when physical examination was warranted.
g. Dr. Moran de Muller failed to maintain an adequate

medical record with respect to her care of Ms B.

In addition to appearing before the Investigation Committee and accepting the Censure, Dr. Moran de Muller paid the costs of the investigation in the amount of $4247.90.

CENSURE: IC04-12-10:
DR. RAJENDRANATH RAMGOOLAM

On April 13, 2006, in accordance with Section 47(1) (c) of The Medical Act, the Investigation Committee censured Dr. Rajendranath Ramgoolam as a record of its disapproval with respect to his care and management of X:

I. PREAMBLE

When a patient presents to a physician with a complaint or symptom, it is the responsibility of the physician to take a thorough history, conduct an appropriate physical examination and implement a plan of investigation and follow-up to diagnose and treat the illness. It is inappropriate to act on impression or assumptions without performing an adequate examination and making adequate investigations in relation to patient complaints.

II. THE RELEVANT FACTS ARE:

1. Dr. Ramgoolam began providing care to X in November of 1999. Dr. Ramgoolam's record documents the following in relation to X:

a. On November 18, 2002 Dr. Ramgoolam diagnosed iron deficiency anemia and he prescribed iron supplements.

b. When Dr. Ramgoolam saw X on October 27, 2003 with respect to his concerns about skin rashes, Dr. Ramgoolam noted that X's complexion was pale and that he was on iron pills. Dr. Ramgoolam's assessment was iron deficiency anemia.

c. On November 17, 2003, X complained of feeling ill for two weeks after a flu shot. Dr. Ramgoolam documented abdominal pain and reassured X that his complaint of abdominal pain was related to coughing. Dr. Ramgoolam diagnosed sinusitis and prescribed antibiotics.

d. On December 18, 2003, X saw Dr. Ramgoolam in relation to a complaint about his ears.

e. On January 5, 2004, X complained of weakness and feeling tired. Dr. Ramgoolam examined X's lungs and heart. X denied depression, but Dr. Ramgoolam noted his belief that X was depressed. Dr. Ramgoolam diagnosed chronic fatigue syndrome and depression. No laboratory investigations were ordered to diagnose the cause of X's fatigue.

f. On January 22, 2004 X consulted Dr. Ramgoolam with respect to eczema.

g. On February 9, 2004, X complained of severe progressive dizziness. Dr. Ramgoolam prescribed Pantoloc and Zithromax. Dr. Ramgoolam did not take a detailed history. He found epigastric tenderness and tender sinuses. No further investigations were planned to explain X's symptoms or physical findings. No diagnosis is recorded.

h. On February 20, 2004 Dr. Ramgoolam prescribed Serc for persistent dizziness. A thorough history was lacking and no examination was done.

i. On March 8, 2004, X complained of diarrhea and abdominal pain. Dr. Ramgoolam noted that X ate a lot of ice cream. No further history was documented and no physical exam was done, except X's ears were syringed. Dr. Ramgoolam queried whether X had lactose intolerance or irritable bowel syndrome. Dr. Ramgoolam diagnosed anemia of chronic disease and queried borderline personality disorder and generalized anxiety disorder with depression, although Dr. Ramgoolam again noted that X denied depression. Dr. Ramgoolam ordered blood work. On March 9, 2004, X's hemoglobin was 131 gm/L.

2. X reported to the College that he complained to Dr. Ramgoolam of stomach pain, diarrhea, and weight loss between November, 2003 and March, 2004, but Dr. Ramgoolam states that X's first complaint of diarrhea was March 8, 2004.

3. X saw a new family physician on April 8, 2004. X complained of explosive diarrhea for months, and stated that he had been told he was lactose intolerant. After examination, investigations and referrals by the new physician, on July 8, 2004, a CT scan showed a large, locally invasive adenocarcinoma of the cecum with liver metastases.

4. In Dr. Ramgoolam's response to the College he stated that:

a. when anemia first appeared, Dr. Ramgoolam did anemia work-up investigations and concluded that X's anemia was secondary to chronic illness (chronic sinusitis and COPD). Dr. Ramgoolam's work-up included performing two sets of occult stools, one in November, 1999 and a second one in November, 2002, both of which were negative. Thereafter Dr. Ramgoolam prescribed iron tablets, which improved X's hemoglobin significantly from 116 to 134 within three months.

b. Dr. Ramgoolam felt that up to the point he prescribed iron tablets, there were no indications, complaints, signs or symptoms, examination or laboratory findings to alert him to investigate X's gastrointestinal system for cancer.

c. Dr. Ramgoolam felt that X's complaints between November, 2003 and April, 2004 were non-specific, ranging from flu-like symptoms after a flu shot, a sinus infection, prostate concerns, fatigue and eczema rash and that X only complained of abdominal pain and diarrhea on March 8, 2004.

5. During an interview at the College, Dr. Ramgoolam acknowledged that:

a. the laboratory investigations were consistent with an iron deficiency anemia, whereas in Dr. Ramgoolam's responses to the College and in his March 8, 2004 note he referred to anemia of chronic disease. In fact, there was never any evidence to support a diagnosis of anemia of chronic disease, and Dr. Ramgoolam was unaware of the cause of iron deficiency anemia. In a further response to the College Dr. Ramgoolam stated that he had been mistaken in his note and in his response to the College.

b. Dr. Ramgoolam did not have a definitive diagnosis as to what was causing the iron deficiency anemia and did not give any thought to further investigation.

c. The psychiatric explanations of the patient's symptoms were based on Dr. Ramgoolam's impressions and no further work up was planned. Dr. Ramgoolam was unable to support his psychiatric diagnoses with any evidence, nor was he able to give the criteria for these diagnoses.

6. At several office visits Dr. Ramgoolam queried various diagnoses, but he did not do any investigations or physical examination which would have assisted in

these diagnoses. Specifically:

a. On January 5, 2004, Dr. Ramgoolam queried depression and/or chronic fatigue syndrome.
b. On February 9, 2004, Dr. Ramgoolam diagnosed X as suffering from chronic sinusitis and Dr. Ramgoolam concluded that X's dizziness was caused by the chronic sinusitis.
c. on February 9, 2004, Dr. Ramgoolam documented epigastric tenderness and prescribe Pantoloc. No adequate history was documented, nor was there any plan for investigation.
d. on March 8, 2004, Dr. Ramgoolam queried borderline personality disorder, generalized anxiety disorder with depression, and lactose intolerance.

7. Although the foregoing diagnoses were Dr. Ramgoolam's impression of X, he had no other work-up planned and there was no physical examination done in relation to these impressions. Nevertheless, there was a lack of further action based on Dr. Ramgoolam's impressions without considering other possibilities.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF HIS MANAGEMENT OF X IN THAT:

a. Dr. Ramgoolam diagnosed iron deficiency anemia without ever determining the cause of that condition, especially in the context of his abdominal complaint, and later incorrectly diagnosed anemia of chronic disease.
b. on January 5, 2004, February 9, 2004 and March 8, 2004, Dr. Ramgoolam acted on assumptions or impressions, without doing an adequate examination and making adequate investigations of X's complaints.

In addition to appearing before the Investigation Chair, Dr. Ramgoolam, paid the costs of the investigation in the amount of $1728.50.

CENSURE: IC04-11-04
DR. M. REIMER

*O*n February 8, 2006, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee of the College censured Dr. Reimer with respect to his care and management of X.

I. PREAMBLE

A physician who issues a prescription to a patient has an obligation to ensure that the medication is an appropriate and safe option for the patient based on current scientific knowledge respecting the medication.

II. THE RELEVANT FACTS ARE:

1. X, born in 1987, presented to Dr. Reimer on August 28, 2003 with a two month history of headaches, photophobia and nausea. According to Dr. Reimer's notes of the visit, she reported having had neck pain for the past week, and more frequent (daily) headaches for the past two weeks. X had been on Amoxil for one week for possible sinusitis, and was taking 3 to 4 tablets of Advil per day. She had taken one Tylenol #3. Dr. Reimer's examination was normal. He gave her a dose of Maxalt 5 mg. with some improvement. Dr. Reimer advised her:
   a. to stop her analgesics and make a headache diary.
   b. to repeat the Maxalt in four hours if her pain recurred.
   c. to see him again on September 2, 2003.
2. At the September 2, 2003 appointment, X reported significant relief with the Maxalt, and she had only a mild, dull headache which seemed to be triggered by hunger. Dr. Reimer felt that no further medications were necessary, and he advised her to return to see him in one month.
3. On September 15, 2003, X saw a colleague in Dr. Reimer's office, due to persistent headaches, who ordered a CBC, a CT scan of the head and sinuses, a TSH, and renal functions. All tests were negative.
4. On September 30, 2003, X returned to see Dr. Reimer, reporting that she had been on Amoxil for 4 days for strep throat, but had a persistent headache and severe sore throat that was not improving. The CT scan had been done the previous day. Dr. Reimer noted very inflamed, enlarged tonsils with a grayish membrane and one small cervical lymph node. Dr. Reimer suspected infectious mononucleosis. This was confirmed with a CBC and Mono-Spot. Since X was having difficulty swallowing pills, Dr. Reimer prescribed a Fentanyl patch, at 25 micrograms per hour.
5. The patch was placed at 11:30 a.m. on October 1, 2003. At 10:45 p.m. on October 1st, X's parents noted that she was vomiting, and she fell asleep after that.
6. On October 2, 2003, X's mother thought X was sleeping, peacefully. However, approximately 1 hour later, X was gasping for breath and could not be woken up.
7. X was taken by ambulance to Hospital. On route, she had a cardiac arrest. The Hospital did regain a pulse and she was taken to Health Sciences Centre on respiration. She never regained consciousness, and died on October 4, 2003.
8. The autopsy report documented the cause of death as likely respiratory depression with vomiting and aspiration, due to transdermal Fentanyl.
9. The drug monograph for Fentanyl states that because serious or life-threatening hypoventilation could occur, contraindications for Duragesic include:
   a. The management of acute or postoperative pain including use in out-patient surgeries.
   b. The management of mild or intermittent pain that can otherwise be managed, and
   c. Opioid-naïve patients.
10. The drug monograph for Fentanyl states:
    "Children – The use of Duragesic in children under 18 years of age is not recommended as efficacy, safety and dosage requirements have not been established fot this patient propulation. Life threatening hypoventilation has been reported in some pediatric patients receiving Duragesic."
11. The drug monograph for Fentanyl contains the following warning:
    "*Duragesic should not be used in the management of acute or postoperative pain since there is no opportunity for dose titration during short-term use and because serious or life-threatening hypoventilation could result. Similarly, Duragesic should not be administered to patients who do not have some degree of tolerance to opioid induced side effects; this contraindication reduces the potential risk of serious or life threatening hypoventilation."*

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL

OF DR. REIMER'S CARE AND MANAGEMENT OF X, IN PARTICULAR:

Dr. Reimer prescribed transdermal fentanyl to X when he ought to have known that it was contra-indicated because she was opioid naïve and she was under the age of 18 years.

In addition to accepting the censure, Dr. Reimer paid the costs of the investigation in the amount of $2,759.50.

CENSURE: IC05-06-09
DR. JAN FREDERICK ENGELBRECHT

On May 4, 2006, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Engelbrecht as a record of its disapproval of the deficiencies in his care of Patient X.

I. PREAMBLE

The primary responsibility for diagnosis and treatment of a patient admitted to hospital belongs to the attending physician. The cornerstone of a physician's assessment is the history and the physical examination. In particular, when a patient's symptoms or course is inconsistent with the initial diagnosis it is incumbent on the attending physician to examine the patient and consider alternate diagnoses.

II. THE RELEVANT FACTS ARE:

1. On April 20, 2004, Dr. Engelbrecht's patient, X fell outside of his office.
2. X complained of pain in his left knee. With X's son, Dr. Engelbrecht helped X to try to stand, but he stated that he was unable to stand on his left leg. Dr. Engelbrecht's examination at that time consisted of lifting X's pant leg and observing an abrasion over his left knee.
3. X was taken by ambulance to the Hospital, where the Emergency Room physician ordered an x-ray of the left knee. The x-ray was normal, but X remained unable to weight bear. The Emergency Room physician kept X in hospital because of the safety issues arising from the fact that he was unable to weight bear. The Emergency Room physician's diagnoses were Parkinsonism and injury to left knee.
4. Dr. Engelbrecht was X's attending physician during his hospitalization which commenced on April 20, 2004 and continued to November 2, 2004 when he died.
5. A nursing note made at 2130 on April 20, 2004 states that X was complaining of pain from his knee to his groin and his left foot was rotated outwards.
6. During the period April 21 to April 27, Dr. Engelbrecht made notes on X on April 21, April 24 and April 28, 2004. Dr. Engelbrecht states that he saw X on other occasions as well, but made no notes at the time of those visits.
7. Throughout the period April 20 to April 27, 2004:

a. Dr. Engelbrecht was aware that X was unable to weight bear.
b. Dr. Engelbrecht was aware that there was swelling and bruising of the left leg, but he attributed this to soft tissue injury of the left leg.
c. Dr. Engelbrecht acknowledges that his only examination of X's left leg was an inspection, and at no time did he palpate or manipulate the leg.

8. In the course of investigating X's other medical problems, a consultant ordered a CT scan, which was reported on April 27, 2004. This scan revealed that X had a broken left hip.
9. In an interview with the College, Dr. Engelbrecht stated:

a. Although it is his usual practice to review nurses' notes, he did not review the entry of April 20, 2004, and was unaware that a nurse had observed and documented external rotation of the left foot. Dr. Engelbrecht believed that in this case he did not read the note because he had personal knowledge of the fall and had spoken with the Emergency Room physician about his findings. Dr. Engelbrecht relied on the assessment of the Emergency Room physician and treated accordingly.
b. At no time before the broken hip was diagnosed did any of the nurses or the physiotherapists draw to Dr. Engelbrecht's attention any concern about the attitude of the left foot.
c. Although the swelling in the left leg was more than Dr. Engelbrecht would have expected from the simple abrasion to the knee that he had observed, Dr. Engelbrecht felt that it was caused by soft tissue injury.
d. By April 26th, X's condition was fluctuating and Dr. Engelbrecht was focusing on addressing X's other health issues.
e. In retrospect, Dr. Engelbrecht acknowledges that:
   i. if he had seen the nurse's note of April 20, 2005 he would have immediately ordered an x-ray of the left hip.
   ii. It is incumbent upon the attending physician to examine the patient when a patient is experiencing ongoing problems which are not consistent with the original diagnosis.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. ENGELBRECHT'S CARE AND MANAGEMENT OF PATIENT X, IN PARTICULAR

Dr. Engelbrecht failed to adequately examine X to determine the cause of his inability to weight bear on his left leg.

In addition to appearing before the Investigation Chair and accepting the Censure, Dr. Engelbrecht paid the costs of the investigation in the amount of $1932.00.

CENSURE: IC04-04-01
DR. JOHN LEONARD WIENS

On June 7, 2006, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Wiens as a record of its disapproval with respect to his care and management of "Mr. X".

I. PREAMBLE

Physicians are often presented with difficult cases where their training and acquired experience is put to the test when managing a patient. Issues of record-keeping, proper assessment, diagnosis and treatment are the same for surgeons, family physicians and other specialties alike.

In the case of orthopedic surgeons, they should possess the requisite knowledge to deal with difficult fractures. In the

event they do not, they must avail themselves of resources available, such as advice from other colleagues, or referral to one who possesses the requisite skills.

II. THE RELEVANT FACTS ARE:

1. On April 24, 2002, Mr. X, then aged 61, fell from a ladder and sustained a comminuted left intra-articular medial tibial plateau fracture, with varus angulation and lateral subluxation of the proximal tibia. He presented to the Emergency Department of the Grace Hospital, where Dr. Wiens was the on-call orthopaedic surgeon.
2. X-rays taken on April 24th confirmed subluxation.
3. On April 24, 2002, Dr. Wiens performed initial reduction of the subluxation with a hematoma block.
4. On April 27, 2002, Dr. Wiens performed surgery on Mr. X. The operative report indicates that Dr. Wiens had difficulty maintaining anatomic position, but he was satisfied after the placement of four cancellous screws. The radiologist's interpretation of the post-operative x-rays was that Dr. Wiens had attained near anatomic position.
5. On May 7, 2002, Mr. X was discharged from hospital.
6. On May 9, 2002, Dr. Wiens saw Mr. X in the cast clinic, and removed his staples.
7. On May 16, 2002, Dr. Wiens saw Mr. X in his clinic, and assessed him as doing well. Dr. Wiens prescribed physiotherapy and range of motion exercises.
8. Mr. X was admitted to Hospital from May 29 to June 15, 2002 for an unrelated serious medical condition. Just before his discharge on June 15, 2002, another x-ray was performed, which revealed that the leg was no longer in anatomical position.
9. Mr. X was admitted to hospital on June 20, 2002 and Dr. Wiens performed a second surgery on June 23, 2002. During this surgery, the screws were removed and then replaced. Two Steinman pins were placed for anatomic reduction. The radiologist's interpretation of the post-operative x-ray was that fragments were near anatomic again.
10. On July 2, 2002, Mr. X was discharged from hospital.
11. On July 7, 2002, Mr. X was admitted with complications from his unrelated medical condition. During this admission, there were concerns of possible infection or a deep vein thrombosis, and, on July 11, 2002, Dr. Wiens opened his cast somewhat for inspection. No signs of infection or deep vein thrombosis were present.
12. At the request of Mr. X's family, Dr. Wiens initiated a consultation for a second opinion. On July 12, 2002, the orthopaedic surgeon who provided the consultation opined that:
    a. a Buttress plate was required in a 61 year old male of this size, who had a comminuted fracture.
    b. The Steinman pins should be removed as they would break away anyway and were not serving any function.
13. After the second opinion was obtained, another orthopaedic surgeon took over Mr. X's management. This surgeon concurred with the opinions of the surgeon who provided the second opinion and, on July 25, 2005, performed surgery to remove the Steinman pins.
14. The College retained two orthopedic surgeons to comment on the management of this man's fracture. They each opined that a Buttress plate was necessary given the severity of the fracture, the size of the patient and the issue of muscle mass contractions inherent with any unstable fracture.
15. In an interview with the Investigation Chair, Dr. Wiens stated that:
    a. this was one of the worst fractures he had seen in some time.
    b. when Mr. X was admitted to Hospital in May, Dr. Wiens was not made aware of his admission.
    c. At the time of his last appointment with Dr. Wiens in the cast clinic, Dr. Wiens advised Mr. X that he wanted to see him again in 4 weeks.
    d. Dr. Wiens did not use a Buttress plate because he felt that he did not need it, as he felt that the fracture was held well with the screws.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. WIENS' CARE AND MANAGEMENT OF MR. X, IN PARTICULAR, inadequate fracture stabilization. Dr. Wiens knew or ought to have known that:

i. for an inherently unstable fracture in a patient of this size a Buttress plate was required to maintain the position of the fracture after reduction.
ii. screws were insufficient to maintain the position of the fracture after reduction.

In addition to appearing before the Investigation Chair and accepting the Censure, Dr. Wiens paid the costs of the investigation in the amount of $2070.95.

CENSURE: IC05-11-03 AND IC06-01-04
DR. MATTHEW HOWARD LAZAR

On June 7, 2006, in accordance with Section 47(1) (c) of The Medical Act, the Investigation Committee censured Dr. Matthew Howard Lazar as a record of its disapproval with respect to his care and management of Baby X:

I. PREAMBLE

Requirements in the Code of Conduct include:

- *Consider first the well-being of the patient.*
- *Provide your patients with the information, alternatives and advice they need to make informed decisions about their medical care, and answer their questions to the best of your ability.*
- *Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.*

Two fundamental ethical principles are:

1. Physicians must be honest and open with their patients, and
2. Patients have a right to know their past and present medical status.

It follows from these principles that when a procedure is performed on the wrong patient, the physician must provide full and frank disclosure to the patient respecting the events.

This case highlights the importance of timely, full and frank disclosure to patients.

II. THE RELEVANT FACTS ARE:

1. On November 8, 2005 Dr. Lazar asked that a particular patient be brought to the procedure room for circumcision, but a different patient (herein referred to as Baby "X") was brought to the procedure room. Dr. Lazar proceeded with the circumcision of Baby X without checking the patient identification.
2. Later that morning, when Dr. Lazar learned of the error, he went to speak with Baby X's parents.
3. Dr. Lazar stated that when he entered the room and told Baby X's parents that he needed to talk to them about circumcision, they indicated that they wished to proceed with circumcision. Baby X's parents deny this occurred. They state that Baby X's mother was undecided, and was particularly concerned about whether her son would experience pain.
4. Baby X's parents and Dr. Lazar agree that in his meeting with Baby X's parents, he did not immediately inform them of the error. Instead, Dr. Lazar discussed with them the pros and cons of circumcision, he provided statistics as to the rate of circumcision, and he provided information to Baby X's parents in response to their questions about the procedure.
5. Baby X's parents state that it was only after this discussion that they decided to proceed with circumcision.
6. Dr. Lazar obtained a consent form for the circumcision and presented it to Baby X's parents for signature.
7. Dr. Lazar then proceeded with circumcision of another patient. Thereafter, he carried Baby X to Baby X's parents and reported to them that it was a perfect circumcision and their baby was fine.
8. Other hospital staff completed a critical clinical occurrence form and notified hospital administration.
9. As a result of discussions between Baby X's parents and another physician who was aware of the error, it became apparent to that physician that Dr. Lazar had not provided full and candid disclosure to Baby X's parents. This was reported to hospital administration.
10. On the afternoon of November 8, 2005, when a member of the hospital administration contacted Dr. Lazar with respect to this matter, Dr. Lazar defended his failure to disclose the error to Baby X's parents on the basis that they wanted the procedure.
11. At the insistence of the hospital administration, Dr. Lazar met with Baby X's parents on the evening of November 8, 2005. At that meeting Dr. Lazar accepted responsibility for what had occurred. Dr. Lazar did apologize for the error in circumcising the wrong baby, but he did not apologize for his failure to immediately disclose the event or for his actions in his meetings with Baby X's parents that morning.
12. At the evening meeting with Baby X's parents, Dr. Lazar did not expressly discuss with them the taking of consent. Dr. Lazar stated that he felt it was implicit in the conversation. Baby X's parents state that it was not until after the evening meeting that they realized the sequence of events, and they felt betrayed by the lack of clear disclosure.
13. Dr. Lazar had a trainee with him at the time of the circumcision who had performed the circumcision of Baby X. Dr. Lazar did not disclose this to hospital administration on November 8, 2005. At no time did he disclose this to Baby X's parents. Baby X's parents learned this fact from hospital administration on November 9, 2005. They state that on learning of this fact, they felt betrayed, and questioned whether they were being told the whole truth of what had occurred. Baby X's parents also state they felt that Dr. Lazar's November 8, 2005 apology was insincere.
14. In an interview with the Investigation Chair Dr. Lazar stated that:
    a. he was upset and flustered when he went to see Baby X's parents.
    b. he was relieved when Baby X's parents stated that they wanted the circumcision done.
    c. he was taking the consent to document the discussion. In retrospect, he felt that it should have been documented in the notes.
    d. he did not reflect upon his own responsibilities as a physician at that time.
    e. he very much regretted the errors he made and he offered his apology to Baby X's parents.

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

1. Dr. Lazar failed to promptly inform Baby X's parents of the error.
2. Dr. Lazar gave Baby X's parents information regarding the pros and cons of circumcision, when he knew or ought to have known that providing this information in the circumstances was misleading to Baby X's parents.
3. Dr. Lazar obtained consent for the procedure but did not report that the procedure had already been done, and thereby misled Baby X's parents.
4. Dr. Lazar presented Baby X to his parents, leaving the impression that the circumcision had just been performed.
5. Dr. Lazar took advantage of the situation for his own purposes, when he knew or ought to have known that Baby X's parents were being manipulated.
6. At the evening meeting with Baby X's parents, Dr. Lazar failed to promptly provide full disclosure of the events.

In addition to appearing before the Investigation Chair, Dr. Lazar paid the costs of the investigation in the amount of $4,676.30.

CENSURE: IC05-12-02
NAME WITHHELD

On June 7, 2006, in accordance with Section 47(1) (c) of The Medical Act, the Investigation Committee censured a physician as a record of its disapproval with respect to the physician's breach of the physician's undertaking to the College.

I. PREAMBLE

An undertaking given by a member of the College to the College is a solemn and express promise by the member. By the undertaking, the member takes upon himself or herself a commitment to the College to adhere to the terms of the undertaking. The College expects any member who signs an undertaking to fully comply with the terms of that undertaking.

II. THE RELEVANT FACTS ARE:

1. In 1999 or 2000, the physician developed an addiction to Fentanyl. Intervention occurred in October 2003,

and the physician entered a treatment program.

2. On February 16, 2004, the physician signed an undertaking to the College in which the physician undertook, amongst other things:
   a. not to consume any of the drugs specified on a schedule to the undertaking; and
   b. to participate in a body fluid monitoring program.
3. The physician returned to work in February 2004, with the support of caregivers and colleagues and in a structured setting.
4. The College received a biochemistry report from a body fluid sample collected on May 11, 2004, which was positive for cannabis, which is one of the drugs specified on the schedule to the undertaking.
5. In the physician's written response to the College and in the physician's interview with the College, the physician acknowledged a breach of the undertaking to the College. The physician explained the personal circumstances in the physician's life at the time, and the physician's current efforts in recovery. The physician was unable to explain the breach of the undertaking other than to state that the disease is characterized by relapses, a relapse had occurred, and the physician believed the physician could move on.
6. The physician continued to work in a restricted practice.
7. On February 8, 2005, the physician self-administered morphine, and subsequently self-reported this event.
8. In the physician's response to the College, the physician indicated that on February 8, 2005 the physician had a very difficult day and should have recognized the vulnerability. The vial of morphine was left out of the drug control zone. The physician took the vial and subsequently self-administered it. The physician attributed this behavior to stressors for which the physician was emotionally ill-prepared. The physician acknowledged that the actions were a further breach of the undertaking to the College.
9. The physician signed an undertaking not to practice, and sought further treatment for addiction. The physician remained out of practice until December 2005, at which point the physician re-entered practice with the support of caregivers and colleagues, in a structured environment and pursuant to an undertaking.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF THE PHYSICIAN'S CONDUCT, IN PARTICULAR THE BREACH OF THE UNDERTAKING TO THE COLLEGE.

In addition to appearing before the Investigation Chair, the physician paid the costs of the investigation in the amount of $2,867.60.

It is the normal practice of the College to publish a member's name who has received a censure. In this case, the Committee received evidence from a specialist in addiction medicine. The Committee concluded that the physician's recovery may be unduly jeopardized by publication of the physician's name, and it would therefore pose an undue risk to the physician's safety to include the physician's name in the publication.

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Request For Applications Pre-Notification - Dr. John Wade Research Award

The Dr. John Wade Research Award, announced at the Inaugural Annual General Meeting of the Manitoba Institute for Patient Safety (MIPS), on November 4, 2005 will be offered as a benefit to Premier Members of MIPS. The CPSM is a Premier Member. The award of $2500 for one year, may be used to support the development of a larger project. MIPS encourages applicants to secure matched funds or in-kind resources.

Applications will be submitted to the MIPS Research Committee through the Premier Member Organization. The MIPS Research Committee will review all proposals and make recommendation to MIPS Board.

The MIPS Board will grant the award to one successful project per year.

The award-recipient will submit a final project report to be reviewed by the MIPS Research Committee, based on an established timeline.

The first call for applications for the Dr. John Wade Research Award will be issued in September, 2006.

Physician Resource Statistics 2006

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 24. The number of University of Manitoba graduates decreased from 36 to 30 and the total number of Canadian graduates increased from 33 to 43. The number of graduates from Asia increased to 40 in 2006 from 23 in 2005.

Numbers Practising
This year's total shows an increase of 32 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 2005. The 2006 residents with full licences decreased since last year from 41 to 33. The number of resident licences increased from 21 to 24.

Distribution of Medical Practitioners by Source
The percentage of practising physicians who are Canadian graduates remained the same this year. Percentages over the past five years are 65.8%, 64.8%, 65.1%, 64.7%, 65.6%, and 65.5%. The presence of Canadian graduates in Winnipeg is 74.7% compared to 37.6% in all other areas.

In contrast, graduates from Africa (primarily South Africa) are represented in reverse significance: 3.5% in Winnipeg compared to 35.8% in all other areas. These physicians now form a very important part of rural Manitoba physician numbers (see Table III).

Specialists
The number of physicians currently enrolled on the Specialist Register has increased by 35 from last year (1054 to 1089). This figure is based on physicians currently residing in the province who are on the Specialist Register.

(A) **MEETINGS**

During the period 1 May 2005 to 30 April 2006, the following meetings were held -

4 Council: 17 June, 31 August, 18 November 2005; 15 February 2006
6 Executive Committee: 18 May, 17 June, 28 September 2005; 25 January, 17 March, 12 April 2006
4 Appeal Committee: 25 May, 21 September, 5 October 2005; 15 February 2006
7 Complaints Committee: 2 August, 20 September, 15 November, 20 December 2005; 7 February, 14 March, 25 April 2006
1 Audit Committee: 2 November 2005
0 Inquiry Committee
0 Inquiry Panel
7 Investigation Committee: 1 June, 13 July, 7 September, 26 October, 21 December 2005; 8 February, 13 April 2006
1 Liaison Committee with M.M.A.: 18 January 2006
3 Program Review Committee: 21 September, 30 November 2005; 1 March 2006
In addition: Meetings of subcommittees on Laboratory Medicine, Nuclear Medicine, Diagnostic Imaging, and Transfusion Medicine Working Group were suspended due to restructuring; 1 meeting of Cytology Working Group
5 Standards Committee: 1 June, 5 October, 7 December 2005; 15 February, 12 April 2006
In addition: 3 meetings of Child Health Standards Committee; 4 meetings of Maternal & Perinatal Health Standards Committee and 20 meetings of Area Standards Committees
38 meetings
28 meetings of subcommittees, and
8 (6) hospital and (2) non-hospital reviews
74

(B) CERTIFICATES OF REGISTRATION ISSUED

During the period 1 May 2005 to 30 April 2006, 152 persons were issued registration and a full licence to practise. In total there were 166 certificates of which 14 were for a residency licence.

TABLE I MEDICAL PRACTITIONERS GRANTED REGISTRATION AND FULL LICENCE ANNUALLY IN MANITOBA 1997 - 2006 with Country of Qualification

Year	*Man*	*Can*	*USA*	*UK&I*	*Eur*	*Asia*	*Aust*	*NZ*	*Afr*	*C/S Am*	*Total*
1997	37	22	1	10	1	7	0	0	33	0	111
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
Total (10 Yr)	284	287	11	34	47	153	5	2	417	19	1259
New Practitioners % of Total											
2006	19.7	28.3	0.0	2	5.3	26.3	0.0	0.0	17.1	1.3	100%

Percentages may not be exact due to rounding

(C) NUMBER OF LICENSED PRACTITIONERS IN MANITOBA AS AT 30 APRIL 2006

TABLE II NUMBER OF LICENSED MEDICAL PRACTITIONERS IN MANITOBA 1997- 2006

Year	Winnipeg	%	Outside Winnipeg	%	Totals	Net Gain Net Loss(-)
1997	1561	76.7	474	23.3	2035	-3
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

The total of 2218 includes 33 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
2001	2034	40	2074	32	2106
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

(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.

	2006	**%**
Medical Students	355	
Postgraduate trainees	365	
Total On Clinical Assistant Register	720	92.7
On Residency Licence	24	3.1
Full Licence	33	4.2
TOTAL	**777**	**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 2006 (as a percentage)

		Winnipeg	**Brandon**	**Rural**	**Residency**
		1663	113	442	24
%	Man	58.1	27.4	29.2	20.8
	Can	16.6	16.8	6.8	37.5
	Total Canada	**74.7**	**44.2**	**36.0**	**58.3**
	USA	0.4	0.0	0.5	4.2
	UK & Irel	6.6	8.9	8.8	0.0
	Eur	4.4	2.7	3.6	4.2
	Asia	8.5	9.7	11.5	29.2
	Aust/NZ	0.4	0.0	0.7	0.0
	Afr	3.5	29.2	37.6	4.2
	S.Am	1.5	5.3	1.4	0.0

Percentages may not be exact due to rounding.

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

	2006
Manitoba Graduates	50.8
Other Canadian Graduates	14.7
TOTAL CANADA	**65.5**
United Kingdom & Ireland	7.1
Asia	9.2
Other	18.2

TABLE V **GEOGRAPHIC DISTRIBUTION OF FEMALE PRACTITIONERS**

	Winnipeg	**Brandon**	**Rural**	**Total**	**Resident Licence**
1982	213	8	44	265	51
2001	432	21	93	546	21
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

30.2% of fully licensed physicians are female, up 36 in actual numbers in the past year. 31.1% of practitioners in Winnipeg are women, 29.2% in Brandon and 26.7% in rural Manitoba. 29.2% of those with a residency licence are female. During the past 24 years there has been an increase of 305 women in Winnipeg, 25 in Brandon and 74 in the remainder of the province.

TABLE VI **AGES OF DOCTORS RESIDING IN MANITOBA AS AT 30 APRIL 2006**

	Winnipeg	**Brandon**	**Rural**	**Total**
Over 70	92 (5.5)	3 (2.7)	14 (3.2)	109 (4.9)
65 -70	92 (5.5)	10 (8.8)	22 (4.9)	124 (5.6)
56 - 64	298 (19.0)	20 (17.7)	52 (11.8)	370 (16.7)
46 - 55	528 (31.8)	35 (31.0)	14 (25.8)	677 (30.5)
36 - 45	483 (29.0)	32 (28.3)	143 (32.4)	658 (29.7)
31 - 35	141 (8.5)	8 (7.1)	81 (18.3)	230 (10.4)
30 or under	29 (1.7)	5 (4.4)	16 (3.6)	50 (2.2)

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 2005 to 30 April 2006

	Winnipeg	Brandon	Rural	TOTAL
Total	1663	113	442	2218
70+	92.2.%	75.0%	64.7%	87.9%
65 - 69	92.6	100.0	89.5	92.7
50 - 64	95.7	86.1	85.5	93.7
35 - 49	91.4	76.4	79.9	88.2
under 35	71.7	77.8	74.1	72.8
All Ages	91.4	81.4	80.1	88.6

(G) **MANPOWER CHANGES from 1 May 2005 to 30 April 2006**

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 2005 to 30 April 2006.

Deletions includes 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			DELETIONS	
2005	**2006**		**2006**	**2005**
		AGE		
22	30	30 or under	19	16
61	73	31 - 35	55	41
85	79	36 - 45	60	58
31	52	46 - 55	41	38
8	11	56 - 64	14	19
2	7	65 - 70	14	12
0	5	over 70	22	15
209	**257**		**225**	**199**
		YEARS SINCE QUALIFICATION		
43	40	5 or less	16	20
53	81	6 - 10	64	39
104	111	11 - 30	98	93
9	25	over 30	47	47
209	**257**		**225**	**199**
		YEARS SINCE REGISTERED IN MANITOBA		
N/A	N/A	5 or less	109	96
		6 - 10	41	30
		11 - 30	39	48
		over 30	36	25
			225	**199**

ADDITIONS 2005	ADDITIONS 2006		DELETIONS 2006	DELETIONS 2005
		PLACE OF QUALIFICATION		
72	67	Manitoba	71	57
11	6	Alberta	3	10
2	7	B.C.	5	3
3	7	Atlantic Provinces	5	2
29	28	Ontario	22	19
2	4	Quebec	2	6
6	9	Saskatchewan	4	4
125	**128**	**TOTAL CANADA**	**112**	**101**
2	0	U.S.A.	0	3
8	17	U.K. & Ireland	17	18
7	12	Europe	7	10
29	48	Asia	28	15
0	0	Aust/N.Z.	0	1
33	48	Africa	58	45
5	4	C/S America	3	6
84	**129**	**TOTAL ALL OTHERS**	**113**	**98**
		TYPE OF PRACTICE		
70	88	Specialist	67	59
139	169	Non-Specialist	158	140
209	**257**		**225**	**199**

DEATHS or DELETIONS	**2005**	**2006**	
Deaths		3	6
Transferred to Residency Licence	6	7	
Removed from Register/Suspended	2	4	
No Longer Practising/Retired	36	44	
DEPARTURES to: (Total)	152	163	
Atlantic Provinces	1	5	
Quebec		4	3
Ontario		33	23
Saskatchewan	5	1	
Alberta		17	12
British Columbia	16	23	
NWT/NU	0	0	
TOTAL CANADA	76	66	
U.S.A.		7	15
U.K. & Ireland	4	0	
Others/Unknown	65	82	
TOTAL DELETIONS	199	225	

(H) **SPECIALIST REGISTER**

There were 1089 specialists enrolled on the Specialist Register as at 30 April 2006.

(I) CERTIFICATES OF PROFESSIONAL CONDUCT (COPC)

During the period 1 May 2005 to 30 April 2006, 303 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 2005.

Provincial Licensing Bodies:	**2006**	**2005**
British Columbia	59	73
Alberta	52	38
Saskatchewan	4	5
Ontario	52	47
Quebec	1	3
Prince Edward Island	1	1
New Brunswick	0	1
Nova Scotia	9	1
Newfoundland	3	2
Northwest Territories/Nunavut	17	7
Australia & New Zealand	9	3
Overseas	2	4
U.S.A.	9	13
Miscellaneous	15	23
WRHA	55	52
BRHA	15	
TOTALS	**303**	**223**

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IT'S THAT TIME AGAIN….

Annual Renewal Notices were Mailed out July 21, 2006.

RENEWAL DEADLINE IS AUGUST 31, 2006.
Penalties will apply to any payments made after August 31st.

NOTE: *You may renew on line this year*. Please refer to the College website www.cpsm.mb.ca and follow the links on the home page for further information.

Notices, etc…

2006-2007 Council Meetings

The dates for the 2006-2007 Council Meetings are as follows:

- Friday, September 15, 2006
- Friday, December 15, 2006
- Friday, March 16, 2007
- Friday, June 15, 2007

All meetings will begin at 9:00 a.m. If you wish to attend a Council meeting, please advise the College at 774-4344, as seating is limited. At that time, please confirm the location for the meeting.

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.

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.

Accepting Visiting Medical Students for Electives (Undergraduate and Postgraduate)

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

MARK YOUR CALENDAR & PLAN TO ATTEND

Manitoba Institute for Patient Safety Conference
Wednesday 25 October 2006
8:00 a.m. to 12:15 p.m.
Delta Hotel, Winnipeg, Manitoba

Officers and Councillors 2006-2007

President:	***Dr. H. Domke***
President Elect:	***Dr. A. MacDiarmid***
Past President:	***Dr. R. Graham***
Treasurer:	***Dr. B. MacKalski***
Investigation Chairman:	***Dr. S. Kredentser***
Registrar:	***Dr. W. Pope***
Deputy Registrar:	***Dr. T. Babick***
Assistant Registrar:	***Dr. A. Ziomek***
Assistant Registra/Legal Counsel:	***Ms. D. Kelly***

Term expiring June 2008

Brandon	***Dr. B. MacKalski***
Eastman	***Dr. B. Kowaluk, Oakbank***
Westman	***Dr. S. Chapman, Neepawa***
Winnipeg	***Dr. A. Arneja***
	Dr. H. Domke
	Dr. S. Kredentser
	Dr. R. Lotocki
University of Manitoba	***Dean D. Sandham***
Public Councillor	***Mr. R. Toews***
Public Councillor	***Mr. W. Crawford***
Clinical Assistant Register	***Mr. Y. Abdulrehman (expires 2006)***

Term expiring June 2010

Central Plains	***Dr. E. Persson, Morden***
Interlake	***Dr. D. Lindsay, Selkirk***
Northman	***Dr. K. Azzam, Thompson***
Parklands	***Dr. D. O'Hagan, Ste. Rose***
Winnipeg	***Dr. M. Burnett***
	Dr A. MacDiarmid
	Dr. R. Onotera
	Dr. K. Saunders
	Dr. R. Suss
University of Manitoba	***Dr. W. Fleisher***
Public Councillor	***Mr. W. Shead***
Public Councillor	***Ms. S. Hrynyk***

Typical effective doses and equivalent periods of natural background radiation from diagnostic medical exposures

See article on page 4

Diagnostic procedure	Typical effective doses (mSv)	Equivalent period of natural background radiation[1]
Limbs & joints (except hip)	< 0.01	< 1.5 days
Teeth (single bitewing)	< 0.01	< 1.5 days
Teeth (panoramic)	0.01	1.5 days
Chest (single PA film)	0.02	3 days
Skull	0.07	11 days
Mammography	0.09	15 days
Cervical spine (neck)	0.08	2 weeks
Hip	0.3	7 weeks
Thoracic spine	0.7	4 months
Pelvis	0.7	4 months
Abdomen	0.7	4 months
Lumbar spine	1.3	7 months
Barium swallow	1.5	8 months
IVU (kidneys and bladder)	2.5	14 months
Barium meal	3	16 months
Barium follow	3	16 months
Barium enema	7	3.2 years
CT head[3]	2	1 year
CT chest	8	3.6 years
CT abdomen/pelvis	10	4.5 years
Lung ventilation (Xe-133)	0.4	2.4 months
Lung perfusion (Tc-99m)	1	6 months
Kidney scan (Tc-99m)	1	6 months
Thyroid scan (Tc-99m)	1	6 months
Bone scan (Tc-99m)	4	2 years
Myocardial imaging (Tc-99m)	4	2 years

1. National average = 2.2mSv per year: regional averages range from 1 - 8 mSv per year.
2. Approximate lifetime risk for patients 16 - 69 years old. For paediatric patients multiply risks by about 2. For geriatric patients divide risks by about 5.
3. CT doses are for conventional CT.

FACSIMILE TRANSMISSION OF PRESCRIPTIONS

(JOINT STATEMENT)

THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
THE MANITOBA PHARMACEUTICAL ASSOCIATION
THE MANITOBA DENTAL ASSOCIATION
THE MANITOBA VETERINARY MEDICAL ASSOCIATION, AND
THE COLLEGE OF REGISTERED NURSES OF MANITOBA

PREAMBLE:

The transmission of a prescription or refill authorization from a prescribing practitioner (which now includes Registered Nurses Extended Practice (RN(EP)) as permitted under the extended practice regulation to *The Registered Nurses Act*), or from a Clinical Assistant (through the delegated function of a medical practitioner) to a pharmacy by facsimile is acceptable when the prescription is in compliance with this joint statement. RNEP's and Clinical Assistants cannot prescribe narcotic, controlled drugs or benzodiazepines.

All prescriptions from facsimile transmission must be entered into the Drug Programs Information Network (DPIN) or they cannot be filled (except for veterinary prescriptions).

PRINCIPLES:

(1) All medications may be prescribed by facsimile transmission excluding those medications requiring a Manitoba Prescribing Practices Program (M3P) prescription (formerly known as a "triplicate" prescription) and sales reportable narcotics for personal care homes (RN(EP)s and Clinical Assistants cannot prescribe narcotics, controlled drugs and benzodiazepines).

(2) The prescription must be sent to the one pharmacy of the patient's choice.

(3) The prescription must be sent from a machine authorized by the practitioner.

(4) The facsimile equipment at the pharmacy must be under the control of the pharmacist so that the transmission is received and only handled by staff in the dispensary in a manner which protects the patient's privacy and the confidential information on the transmission.

(5) The prescription must include the:
- (a) Date
- (b) Surname, initials (or given names) and address of the patient
- (c) Name of the drug or ingredients(s) and strength where applicable
- (d) Quantity of the drug which may be dispensed
- (e) Dosage instructions (and treatment goal and/or diagnosis and/or clinical indications when prescribed by a RNEP or a Clinical Assistant) for use by the patient which shall include a specific frequency or interval between refills, when so required
- (f) Refill authorization where applicable, which shall include the number of refills (and interval between refills, when so required)

(g) Prescribing practitioner's name, address, fax number and telephone number (prescriptions from Clinical Assistants must include this information for the supervising medical practitioner.)
(h) Prescribing practitioner's signature
(i) Time and date of transmission
(j) Name of the pharmacy intended to receive the transmission
(k) Signed certification that:
    i. the prescription represents the original of the prescription drug order,
    ii. the addressee is the only intended recipient and there are no others, and
    iii. the original prescription will be invalidated, securely filed and not transmitted elsewhere at another time.

*Required prescription information and suggest template attached

(6) The pharmacist is responsible for verifying the origin of the transmission, the authenticity of the prescription and, if not known to the pharmacist, the signature of the prescribing practitioner.

(7) The prescription must be retained on permanent quality paper.

(8) Facsimile transmissions may be accepted from a practitioner registered to practice in any province of Canada and in compliance with the Food and Drug Act and the Controlled Drugs and Substances Act. (RN(EP), or similar designation, and Clinical Assistant prescriptions from out of province are cannot be accepted.)

(9) After transmission, the prescribing practitioner or their agent must ensure that the original written prescription has been invalidated, securely filed, retained for a period of at least two years, be available for inspection, and not transmitted elsewhere at another time.

(10) Prescriptions received by facsimile transmission must be appropriately filed at the pharmacy for a period of at least two years and be accessible for validation. It must be handled as the new prescription document hardcopy and filed in sequence by date and number. The entire fax form received should be filed intact as a complete document.

(11) Computer generated prescriptions must comply with College Statement #104 – Medical Computer Systems: Security and Self-Audit.

(12) Pharmacists may transfer prescription copies by facsimile between pharmacies, where not prohibited by federal legislation.

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Revision MPPP/10-00
Revision EXEC/04-06

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

Prescriber Name _____

Registration # _____

Clinic Name _____

Prescriber Address _____

_____

Prescriber Telephone # _____

Prescriber Facsimile Transmission #

_____

Confidential Facsimile to:

Pharmacy Name _____

Pharmacy Fax #_____

Date_____ Time_____

Patient Given and Surname

_____

Patient PHIN _____

Patient DOB_____

Patient Address_____

_____

Rx #1

Refill _____times every _____ days.

Rx #2

Refill _____times every _____days.

Prescriber Name_____
(please print)

Prescriber Signature_____

Prescriber Address_____

_____

Date_____

Prescriber Certification

· This prescription represents the original of the prescription drug order.
· The pharmacy addressee noted above is the only intended recipient and there are no others.
· The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.
· Quantity must be stated in words and numerals

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