From the College

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Volume 51 Number 2 November 2015

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

In this Issue . . . .

From Your President

DR. ALEWYN VORSTER

I hope this letter finds you in good health.

As this is the first letter in my new capacity as your President, I want to start by saying that it is a huge honour and privilege to serve my colleagues and profession in this way. I am humbled and at the same time truly excited by this opportunity.

At the College our timeline is filled with everyday occurrences of regular CPSM business and multiple other matters. 2015/16 will be an extremely busy year at the College as we have several important topics to consider, including:

- In conjunction with government, we are continuing to work on the medicine-specific regulations under *The Regulated Health Professions Act* (RHPA) which will replace *The Medical Act*. Once finalized, the regulations will be sent out for general consultation.

- Standards, Physician Health including Blood Borne Pathogens, Quality of Care and IT are high on our priority list this year.

- Some physicians brought forward issues and concerns respecting the implementation of Statement 190. Several important points were raised, and a working group was established to consider these matters and report to Council. That work is ongoing, and additional consultation is planned. I appreciate that this topic remains on everyone's radar.

- Physician Assisted Dying – At the College we are forging ahead with the development of a whole new end of life choice, which has been mandated by the Supreme Court of Canada, effective February 06, 2016. This being a controversial moral, religious and extremely personal issue for physicians and patients alike, we need to come up with some unique ways to assimilate this individual choice seamlessly into our profession. We do not want to create the supposition that any judgment of either caregiver or patient is at hand when painful choices in individual lives are made.

This thought process has brought me to the all-important concept of RESPECT.

Respect in my opinion is what makes the world go round.

In showing an individual you care about them and respect their opinion, you validate them as a person; whether a patient, a colleague or a fellow human being. If we endeavour not to ever compromise the dignity, values and morals of one another, we establish a connection and commonality with each other even if our beliefs and cultures differ.

Our goals provide a sense of direction and as physicians we are always striving to improve quality of care and competence while realizing we are human and therefore not infallible.

Our chosen profession has bestowed upon us the privilege to be in a position of authority over the health and well-being of our peers and patients. With respectful communication we reach further than the standard into people's personal lives, problems, health and social issues. This immense trust that patients and the public place in us goes hand in hand with a great sense of responsibility and should be treated with the utmost sensitivity and respect, even in cases where it contrasts with our own inherent sets of behaviour or beliefs. We are not here to judge the moral implications or consequences of individual choices, but to enhance care and quality of life.

In our actions and our interactions with others, I think "respect" rises above all other values and models of behaviour. If we respect those around us and respect their individual points of view, I think we can always come up with workable solutions to any challenge. That is what we, at the College, will be investing time and energy into, this year.

Henry Ford said, " Whether you believe you can do a thing or not, you are right ".

So we continue to believe we "can" and are looking forward to an exciting and challenging time ahead.

I hope everyone has had a great summer and that we all continue to appreciate our privileged position in a functional society that is caring toward the rights of the individual. All we need to do is turn on the news to realize how very fortunate we all are.

Sincerely yours
Alewyn Vorster, MBChB CCFP

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Notes from the Registrar

It has been a very busy time here at the College.

Here is an update for you on a number of important and somewhat pressing issues that we are dealing with.

Newsletter Format/Distribution

I want to thank those who provided feedback on the electronic newsletter. Some design changes have been made based on the feedback and I feel the newsletter is more readable in the new format. Distribution of the newsletter electronically is much more economical and past issues are available on the College website. Please feel free to share the link to the newsletter.

On-Line Licence Renewals

Licence renewals are complete for another year. This year the College required mandatory on-line renewal. We received a number of comments and concerns from members regarding the process. We will review them and are working on improving the process for the 2016 – 2017 renewal.

Physician Assisted Dying

As you all know, the Physician Assisted Dying Working Group has provided me with a Draft Statement that has been forwarded via email to all members. A press release was sent out on October 15, 2015 advising the public of the consultation process on the Draft Statement. We have been receiving feedback from both members and the public and encourage you to provide your feedback before November 15, 2015. All feedback will be reviewed. The Working Group will make any changes to the Draft Statement they deem necessary taking into account that feedback. The Draft Statement will then be brought to Council in December.

Statement 190 – Practice Coverage – After Hours and Vacation

The Statement 190 Working Group is preparing a final report that will be brought to Council in December. Council will review the recommendations and decide on the next steps in the consultation process. Watch the website for updates.

Physician Health Committee

Effective January 1, 2016, Council has established a Physician Health Committee as a free-standing committee of Council, independent of Standards Committee. This Committee will operate a Health Program with a strong remedial approach to dealing with physician health issues.

Federation of Medical Regulatory Authorities of Canada (FMRAC)

I, along with some other staff members, attended the FMRAC Annual General Meeting in June. The conference theme this year was Medical Regulatory Authorities' Transparency of Information for the Public and Ensuring Physicians' Continuity of Patient Care.

Email Communication

The College has sent out a number of emails to members notifying you of some important issues. If you have not received these emails, the email address we have on file for you is incorrect. Please make sure if you change your email address you notify the College as we will be using this means of communication more and more as we move forward.

Anna M. Ziomek, MD
Registrar/CEO

Consultation on Draft Statement on PHYSICIAN ASSISTED DYING

On October 15, 2015 all members were emailed a link to an online survey regarding CPSMs Draft Statement on Physician Assisted Dying.

This is a reminder that the deadline for feedback is **November 15, 2015**.

You can complete the online survey, email your comments to PAD@cpsm.mb.ca or send comments via mail to PAD Working Group 1000-1661 Portage Avenue, Winnipeg MB R3J 3T7.

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College of Medicine
Faculty of Health Sciences

UNIVERSITY OF MANITOBA

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

We have very positive news on a number of educational fronts in the College of Medicine, Faculty of Health Sciences that I am happy to share with you this month.

At the undergraduate medical education level, University of Manitoba College of Medicine graduates performed extremely well on the 2014 Medical College of Canada Qualifying Examination (MCCQE), the most recent comprehensive data available for the national exam.

We scored above the mean of first time Canadian Graduates taking the exam in all sections of the exam (Ethical and Legal considerations, Family Medicine, Internal Medicine, Obstetrics / Gynecology, Pediatrics, Psychiatry, Public Health and Surgery) ranking us in the top third of the country's 17 medical schools and in some cases first or second.

Preliminary results from the 2015 MCCQE show we had the highest pass rate in the country. Ninety of 107 of our U of M medical students taking the exam scored above the mean, and one student scored almost 3 standard deviations above the mean.

Our U of M postrgraduate medical education program underwent an accreditation survey visit in February 2014 by the Royal College of Physicians and Surgeons of Canada (RCPSC) and College of Family Physicians of Canada (CFPC).

There were a number of Residency Programs requiring Internal Reviews and several newly established Residency Programs requiring External Reviews by the RCPSC and CFPC. This is part of the accreditation cycle that ensures excellence in our Residency Programs. I want to express my sincere appreciation to our Program Directors, faculty, residents and PARIM executives who have been instrumental in assisting in this important endeavor.

I am happy to report that external reviews have proven to be an excellent opportunity for quality assurance and improvement in our educational environments. Return visits have resulted in positive outcomes and full approval of a number of residency programs until the next accreditation survey.

In late September, our University of Manitoba Faculty of Health Sciences Continuing Professional Development (CPD) programs in Medicine and Dentistry won two national awards of excellence at the national CPD forum in Ottawa.

Casey Hein, director of Continuing Professional Development - Dentistry and Dental Hygiene, and Tanya Walsh, educational specialist, CPD and the CPD teams in Dentistry and Medicine were awarded the 2015 Royal College of Physicians & Surgeons of Canada Accredited CPD Provider Innovation award for the February 2014 Oral Systemic Health Inter-professional Education (IPE) Day. These Awards recognize Accredited CPD Providers for their innovative development and implementation of educational policies or processes; administrative policies; and educational processes, resources or tools.

Dr. Ryan Zarychanski, assistant professor, internal medicine with a clinical specialty in the section of hematology/medical oncology and his partners at Uniting Primary Care and Oncology (UPCON) at CancerCare Manitoba and the CPD Medicine team won the College of Family Physicians of Canada CPD Award for Blood Day for Primary Care, held earlier this year.

Practice Address

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

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Practice Change for Low-Risk Anesthesia Cataract Surgery Patients

March 13, 2015

SCREENING PRACTICE CHANGE: elimination of pre-op medical history and physical

RESEARCH STUDY at Misericordia Health Centre

- Researchers: Drs. Subash Sethi, Lorne Bellan and Andre Jastrzebski
- 3,347 patient participants from May-November 2013
- Goal: reduce surgery wait times to meet nationally-established 16-week benchmark

HYPOTHESIS: cataract surgery patients with lower anesthesia risk could complete a simplified patient questionnaire which would a) more accurately determine anesthesia risk than current questionnaire and b) eliminate the need for pre-op history and physical.

RESULT: Hypothesis confirmed as no significant increase in intra- or post-operative complications without history and physical.

BACKGROUND: research study part of a quality assurance review of the cataract surgery process. Purpose of the study was to see whether preoperative screening for patients undergoing cataract surgery could be significantly simplified, saving both time and money.

Previously all cataract surgery patients were required to complete a 3-page questionnaire, history and physical exam. The 3-page questionnaire was a regional form designed for patients undergoing general anesthesia. Significant advancements in cataract surgery in the last decade allow for majority of cataract cases to be performed under topical anesthetic with sedation, so questionnaire could be simplified.

New questionnaire easily identifies whether more information from a history and physical are necessary before providing anesthesia support during cataract surgery. Only those with higher anesthesia risk now require history and physical.

Pre-op family physician visits for history and physicals identified as causing stress and inconveniencing patients, as well as delaying cataract surgery and adding significant costs to health-care system. Study showed visits unnecessary for low-risk anesthesia patients.
BENEFITS of elimination of pre-op history and physical (unnecessary medical testing for non-complex surgeries):

- Improved patient flow and cataract waitlist times
- Enhanced patient experience
- Annual Manitoba Health cost savings of $360,000 (4,414 fewer physician visits)
- Physician time redirected to more appropriate care

Questions, additional information, copy of study: atoth@misericordia.mb.ca

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eChart Manitoba's five-year journey

Health-care providers have access to more information at their fingertips, thanks to province-wide systems like eChart Manitoba.

eChart provides health-care professionals with a synoptic record of every person in Manitoba, as well as a summary of their health information. Launched in 2010, eChart has since grown significantly in both users and features. Over five years, it has experienced a steady increase in both number of accounts, which currently stands at more than 15,000, and in the number of monthly users, currently over 5,000.

One major difference is that information is now extracted from more sources. In 2010, eChart extracted information from existing repositories like the Manitoba Immunization Monitoring System, Drug Programs Information Network images, Diagnostic Services Manitoba lab information from public and some private labs.

Since then, it has introduced more sources of information such as diagnostic imaging reports and hospital encounters, and has added new test results, such as microbiology.

"One of my biggest wishes after we got the lab work was microbiology. I still remember a two-month-old who came in with a urinary tract infection and, because of eChart, I was able to find test results on a Saturday morning and got her started on antibiotics, which I believe avoided complications for her," said Dr. Tunji Fatoye, a physician at Kildonan Medical Centre, who began using eChart the first year it was released.

In 2012, eChart introduced the Electronic Patient Record (EPR) launch button at St. Boniface Hospital, a feature that many physicians welcomed.

"Launching eChart when you're already logged into the EPR is really good. Anything that speeds our access to the electronic health record is beneficial to us as clinicians," said Dr. Trevor Lee, the new chief medical information officer at Manitoba eHealth. Also an early adopter of eChart, Dr. Lee continues to use the application when he works as a cardiac anesthesiologist at St. Boniface Hospital and Misericordia Health Centre.

Dr. Fatoye was also excited to see the introduction of the launch button for Electronic Medical Records (EMR). "In the first two years [after eChart was introduced], you had to log out of the patient's chart, log onto eChart, type in the Personal Health Identification Number, and then you could view it," he said. "[Now], if I'm in the patient's chart, I just have to drop down, click on eChart, and the patient's eChart profile pops up. That's awesome."

Since its inception, eChart has become increasingly more available to health-care providers, promoting site adoption and benefiting both providers and patients across the province.

“Patients go to the lab that’s convenient for them. So I don’t have to say to my patient who lives in South St. Vital, ‘Go to the Victoria General Hospital or come to Seven Oaks General Hospital.’ I can say, ‘Go to a lab near you’ because I’ll get the results in eChart. That has been a huge help,” said Fatoye.

Both Fatoye and Lee have personally seen the benefits of eChart and hope to see more sites adopt the program in the future.

“It’s a great tool for a summary of health-care information and where a patient has obtained their health-care services in Manitoba,” said Lee. “I see it in the future expanding to having more comprehensive material regarding medical diagnostics tests, and trying to get as many places online as possible that can download the patient data into eChart.”

“I use eChart every day—every single day. Just by talking to colleagues who finally took the plunge and signed up with eChart, they’re beginning to find the value in it,” added Fatoye. “They’re beginning to find that it’s more efficient for them.”

For more information about eChart Manitoba, please visit www.echartmanitoba.ca.

Natasha Woloschuk
Manitoba eHealth

Moving? Retiring?

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

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Prescribing Generic Controlled-Release Oxycodone vs. the Tamper-Resistant Formulation, OxyNEO®

The abuse of prescription drugs, including oxycodone, is a serious and complex problem that negatively impacts Manitobans. These drugs are also needed to help alleviate the suffering of many Manitobans, and have emerged as an important part of pain management protocols under the supervision of health-care professionals. However, prescription narcotic medications are addictive and can be abused (e.g., by smoking, snorting or injecting), and, unfortunately, diverted for illicit use.

Tamper-Resistant Formulations May Reduce Patient Harms and Healthcare Costs

In June 2015, the Canadian Agency for Drugs and Technologies in Health (CADTH) released a report on *Tamper Resistant Oxycodone: A Review of the Clinical and Cost-effectiveness*.

The report indicated that evidence from randomized, controlled trials and observational studies suggest that tamper-resistant oxycodone (e.g., OxyNEO®) has the potential to reduce misuse, abuse and their associated harms. Tamper-resistant oxycodone formulations may also decrease healthcare costs associated with the misuse and abuse of oxycodone. The full report may be accessed at: https://www.cadth.ca/tamper-resistant-oxycodone-review-clinical-evidence-and-cost-effectiveness .

The tamper-resistant version of controlled-release oxycodone, OxyNEO®, has been available in Canada since March 2012. Unlike the available forms of generic oxycodone, this formulation is difficult to crush, limiting its ability to be smoked or snorted. It also forms a thick gel when dissolved in water, making it difficult to inject.

Generic Formulation Not Covered as a Benefit

Manitoba Health, Healthy Living and Seniors currently only lists the tamper resistant formulation, OxyNEO®, on the Manitoba Drug Benefits Formulary. Generic controlled-release oxycodone is not covered as a benefit under the Provincial Drug Program.

In June 2015, Health Canada released draft *Tamper-Resistant Properties of Drugs Regulations* which would require controlled-release oxycodone products sold in Canada to be tamper-resistant, making these prescription drugs more difficult to abuse. This is part of the federal government's comprehensive approach to addressing prescription drug abuse, specifically addressing the risks to public health and safety associated with tampering with prescription drugs for recreational use.

Although OxyNEO® appears to be less likely to be abused than generic oxycodone, patients may still misuse OxyNEO® by obtaining the medication from other prescribers in order to take more than you have prescribed, by asking for prescription renewals before your records indicate the patient should need them, by requesting frequent increases in dose, or by giving or selling the medication to other people. It is important to observe all the usual precautions for prescribing opioids analgesic medications when prescribing OxyNEO®, such as screening patients at high-risk for misuse or abuse, agreeing with the patient on guidelines for taking opioids, having the patient sign a contract detailing these guidelines, and careful periodic assessments of whether the medication is working as intended and whether any adverse side effects are tolerable.

Canadian Opioid Prescribing Guidelines are Available

Guidelines are available to assist physicians in managing patients who are receiving these medications, including the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, published by the National Opioid Use Guideline Group (NOUGG) which can be accessed at: http://nationalpaincentre.mcmaster.ca/opioid/ .

Provincial Drug Programs,
Manitoba Health, Healthy Living and Seniors

REMINDER

Continuing Professional Development (CPD) Requirements

Regulation 25/03 under *The Medical Act* requires all licensed physicians to participate in Continuing Professional Development (CPD) with one of the two national licensing authorities.

Physicians whose 5-year cycle is ending December 31, 2015 are reminded that the minimum number of credits must be met as follows:

CFPC: 250 credits
RCPS: 400 credits

As outlined in Section 13.3 of the Regulation, the Central Standards Committee may refer the member who is not in compliance with the CPD requirement to the Registrar. The Registrar may refer the matter to the Investigation Committee. In addition, any certificate of professional conduct issued by the College in respect of that member must include a statement that the member is not in compliance with the CPD requirement.

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Blood Borne Pathogens

The College has expectations of its members which are intended to safeguard the health of both patients and physicians and to minimize the risk of exposure to blood borne pathogens through the provision of care. The ethical obligations and standards of practice which apply to all members of the College in relation to blood borne pathogens are set out in Statement No. 1580 *Members with Blood Borne Pathogens [Including HBV, HCV and HIV].* The requirements in this Statement reflect the College's mandate to protect the public and its members' ethical obligation to "consider first the well-being of the patient". Members are encouraged to review this Statement in its entirety to ensure that they have a full understanding of and are meeting the requirements. Some of the key requirements are discussed below.

All members are required to take the necessary steps to minimize the transmission of blood borne infections to patients, including conscientious and rigorous adherence to routine practices when they provide care. Members should be immunized for HBV before possible occupational exposure and should have their antibody status assessed and documented after immunization and seek retesting of their serological status following a significant exposure to human blood or other body fluids.

The requirements of the College rely heavily on members both recognizing and meeting their obligations as members of a self-governing profession. Vigorous compliance with the statutory obligation of a member to self-report when he/she is suffering with an illness or a condition that could impact upon the delivery of the safe medical care to patients is essential. It is also essential that members recognize that infection with a blood borne pathogen is such an illness/condition. In addition all members must understand that if they are aware of any other member being positive for a blood borne pathogen, they must report the matter to the Deputy Registrar of a College.

Statement 1580 states that members who are at personal or occupational risk and engaging in exposure prone procedures (EPPs) have an ethical responsibility to be aware of their serological status with respect to blood borne communicable diseases, including HBV, HCV and HIV. EPPs are defined as interventions where there is a risk that injury to the member may result in the exposure of the patients open tissues to blood and body fluids of the member. Having found that physicians were not routinely testing despite their ethical obligation to know their serologic status, the Ontario College now requires its members who perform EPPs to be tested for blood borne pathogens annually and to report if they are infected on their annual renewal form. Those who perform EPPs as a new part of their practice must be tested *before* they commence performing EPPs.

Statement 1580 includes specific requirements of members who are known to have active infection with HBV or HCV or HIV. The requirements of those members include that they **must**:

- consult a physician to receive appropriate medical care and follow-up care; and
- directly or through their treating physician, report to the Deputy Registrar of the College.

Regardless of these requirements, members are reminded that it is always in the best interest of a member to seek medical care immediately upon having becoming aware of his or her illness. There are now very high cure rates of a variety of blood borne pathogens based upon the availability of improved treatments.

The College has a process for confidential review of a member's practice by an Advisory Service Panel ("ASP") comprised of individuals with relevant expertise. The assessment of modifications required to a member's practice must be based upon the test of public protection and reflect the latest scientific information and best practices regarding members who have blood borne pathogens or who are dealing with patients who have blood borne pathogens. Every effort is made to facilitate the infected member's practice, including modifications to the member's practice where necessary to ensure patient safety. Any modifications recommended by the ASP are based on recent scientific, ethical and epidemiological principles.

The Standards Department

Email Address

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

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FROM THE COMPLAINTS COMMITTEE

Opioid Assessment Clinic at Health Sciences Centre

The **Opioid Assessment Clinic (OAC)** at the Health Sciences Centre (HSC) offers consultation services for individuals with opioid use, abuse, or dependence (addiction). The role of the OAC is to provide assessment and treatment recommendations based on individual circumstances. The OAC liaises with the HSC Addictions Unit and community-based treatment programs to assist individuals to coordinate treatment plans.

Physicians who are interested in referring a patient to the OAC are asked to review the OAC's referral information sheet before sending a referral. This information sheet is now posted on the CPSM website under the “Physician Information section "Opioid Assessment Clinic Referral Information Sheet" section.

Need Assistance?

PHYSICIANS AT RISK

Phone 204-237-8320 (24 hours)

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FROM THE INVESTIGATION COMMITTEE

Patients' Right to Complain to The College

The Investigation Committee of the College recently had opportunity to consider whether it was acceptable for a physician to make a financial settlement with a patient contingent on the patient not filing a complaint with the College.

The College points out to all practitioners that the complaints and discipline process of the College is not a civil litigation procedure where matters can be settled by a financial inducement. The purpose of the complaints and investigation process is for the College to investigate whether a physician has provided competent and ethical care. If the patient has not received care in accordance with medical standards, the goal of the process is to ensure patient care of the individual physician and the medical profession improves.

The College is of the view that the physician/patient relationship is a fiduciary one, which requires the physician to place the interest of the patient above his or her own interests and requires scrupulous good faith on the part of the physician when dealing with his or her patients. This means the physician must be open with the patient about his or her care and College processes even if it does not appear to be in the physician's best interests.

The College refers members to article 23A of the Code of Conduct which states

> "When a patient expresses discontent with medical care received from you, the ethical physician will attempt to resolve the issues. If the issues are not resolvable the physician will provide the patient with information about the role of the College and its complaint process. "

Based on the Code of Conduct and the standards of practice expected of the profession, the College states that offering any type of financial incentive in exchange for a patient's agreement not to complain to the College is inappropriate and is outside the standards of the profession.

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Reporting to The College

Physicians are reminded that they are required to notify the College of charges under the *Controlled Drugs and Substances Act* or the *Food and Drugs Act* and any criminal charges, whether in Canada or in another jurisdiction. This information must be provided to the College in writing within thirty days of the charge. The purpose of collecting and reporting this information is to assess whether patient safety is in any way impacted by the pending charge. If a member is uncertain about the responsibility to report, the best course is to call the Registrar for guidance on the reporting requirements.

Snooping in Medical Records

Accessing a patient's medical record without patient consent or other legal authority to access personal health information without consent is a violation of the patient's privacy rights. Recently, concerns have been raised about health professionals, including physicians, using their unique identifier and password to access the electronic medical records of patients not under their care and in circumstances where there is no legal authority for that access. Physicians should be aware of the potentially serious consequences of such actions:

- A breach of a patient's privacy is disrespectful of that patient's rights, and may be harmful to the patient's well-being.
- A patient whose privacy has been breached by a physician may complain to the College.
- A patient whose privacy has been breached may have civil remedies for the intrusion into the patient's privacy.
- Illegally and unethically accessing a patient's record may be harmful to the reputation of the individual physician.
- Physicians snooping in patient records undermines confidence in the profession as a whole.

The Personal Health Information Act is a statutory scheme for protecting personal health information. Physicians are expected to be familiar with and to comply with this legislation, and to adhere to the ethical standard of respect for patients.

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FROM THE CHILD HEALTH STANDARDS COMMITTEE

Child and Family Services *Critical Incident* Reports

The Child and Family Services Act has been amended to require employees and others who work for or provide services to Child and Family Services agencies or authorities to report *critical incidents* that have resulted in the death or serious injury of a child. *Critical incidents* are defined in the legislation to mean an incident that resulted in the death or serious injury of a child in care or who received services from an agency or whose parent or guardian received services from an agency. This term as used in this context should not be confused with a *critical incident* which must be reported under *The Regional Health Authorities Act*.

It is important to note that unless physicians are contracted to provide services for a Child and Family Services authority or agency, physicians do not have a duty to report a *critical incident* pursuant to this amendment. However, the College reminds all physicians that existing obligations to report a child in need of protection and to communicate with the child's guardian about care is not superseded by this new legislated requirement. All existing reporting obligations of physicians under *The Child and Family Services Act* continue and must be met.

An official form entitled *Critical Incident Report* has been created to facilitate reporting. Physicians may be asked by a foster parent or guardian of a child in care to assist with the form by providing information about the death or injury that must be included on the form. Although physicians are not required to complete the form on the foster parent or guardian's behalf, they are expected to assist by providing medical information about the child's death or injury and expected outcome in a timely manner.

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Meetings of Council
2015-2016 College Year

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

- Friday, December 11, 2015
- Friday, March 18, 2016
- Friday, June 17, 2016

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

Officers of the College
2015-2016 College Year

President:	Dr. A. Vorster
President Elect:	Dr. D. Lindsay
Past President:	Dr. B. Kvern
Treasurer:	Dr. H. Unruh
Registrar:	Dr. A. Ziomek
Deputy Registrar:	Dr. T. Babick

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Councillors 2015-2016

TERM EXPIRING SEPTEMBER 2016

Associate Members Register	Dr. B. Hosseini
Brandon	Dr. S. J. Duncan
Eastman	Vacant (Election underway)
Westman	Dr. A. Vorster, Treherne
Winnipeg	Dr. H. Domke Dr. B. Kvern Dr. M. Boroditsky Dr. H. Unruh
University of Manitoba	Dean B. Postl
Public Councillors	Mr. J. Stinson Ms L. Read

Councillors 2015-2016

TERM EXPIRING JUNE 2018

Central	Dr. E. Persson, Morden
Interlake	Dr. D. Lindsay, Selkirk
Northman	Vacant (Election underway)
Parkland	Vacant (Election underway)
Winnipeg	Dr. W. Manishen Dr. M. West Dr. N. Riese Dr. E. Sigurdson Dr. D. Pinchuk
University of Manitoba	Dr. I. Ripstein
Public Councillors	Mr. R. Dawson Mr. R. Dewar

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INQUIRY: IC2134
DR. MARIA LEE WOWK-LITWIN

INTRODUCTION AND BACKGROUND

On June 22, 2015, a hearing was convened before an Inquiry Panel (the "Panel") of the College of Physicians and Surgeons of Manitoba (the "College") for the purpose of conducting an inquiry pursuant to Part X of *The Medical Act*, into charges against Dr. Maria Lee Wowk-Litwin ("Dr. Wowk-Litwin") as set forth in an Amended Notice of Inquiry dated December 5, 2014.

The Amended Notice of Inquiry charged Dr. Wowk-Litwin with committing acts of professional misconduct, contravening Article 6 of the College's Code of Conduct, contravening Statement 169 of the College and displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine. The Amended Notice of Inquiry alleged that:

> "1. On or about October 31, 2012, you did not meet the standard of the profession in attempting endotracheal intubation by way of rapid sequence intubation (RSI) without adequate ancillary equipment being available and/or without a back-up plan, thereby displaying a lack of knowledge of or a lack of skill or judgment in the practice of medicine. …
>
> 2. On or about October 31, 2012, you did not meet the standard of the profession and/or the requirements of Article 6 of the Code of Conduct established pursuant to Article 21.1 of By-Law No. 1 of the College in the manner in which you responded to one or more of your failed attempts to intubate Patient X, thereby displaying a lack of knowledge of or a lack of skill or judgment in the practice of medicine. …
>
> 3. On or about October 31, 2012, following the death of Patient X, you did not meet the standard of the profession when you reported Patient X's death to the Medical Examiner thereby displaying a lack of knowledge of or lack of skill or judgment in the practice of medicine. …
>
> 4. On or about October 31, 2012, following the death of Patient X, you did not provide full and frank disclosure to Patient X's family thereby committing acts of professional misconduct, breaching the requirements of Statement 169 of the College and/or displaying a lack of knowledge of or a lack of skill or judgment in the practice of medicine."

In addition to the foregoing, the Amended Notice of Inquiry also contained additional factual particulars.

The hearing proceeded before the Panel on June 22, 2015, in the presence of Dr. Wowk-Litwin and her counsel, and in the presence of counsel for the Investigation Committee of the College. Dr. Wowk-Litwin, entered a plea of guilty to all of the charges outlined in the Amended Notice of Inquiry, thereby

acknowledging that the facts alleged in the Amended Notice of Inquiry were true and also acknowledging that she was guilty of professional misconduct and of contravening Article 6 of the Code of Conduct, Statement 169 of the College, and of displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

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

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

1. The original Notice of Inquiry (Exhibit 1).
2. A Request for Particulars sought by counsel for Dr. Wowk-Litwin (Exhibit 2).
3. Particulars provided on behalf of the Investigation Committee (Exhibit 3).
4. The Amended Notice of Inquiry (Exhibit 4).
5. A Statement of Agreed Facts, containing 38 paragraphs (Exhibit 5).
6. The Book of Documents (Exhibit 6).
7. The Joint Recommendation As To Penalty (Exhibit 7).

REASONS FOR DECISION

Having considered the guilty plea of Dr. Wowk-Litwin in the context of the above noted exhibits, and the submissions of counsel for the Investigation Committee of the College and counsel for Dr. Wowk-Litwin, the Panel is satisfied that all of the charges set forth in the Amended Notice of Inquiry and the particulars recited therein have been proven. The Panel is also satisfied that the Joint Recommendation As To Penalty is appropriate and ought to be accepted. The Panel's specific reasons for its decision are outlined below.

Background of Dr. Wowk-Litwin

1. Dr. Wowk-Litwin graduated from the Faculty of Medicine, University of Manitoba in 2001. She received her Certification in Family Medicine from the College of Family Physicians of Canada ("CFPC") in July, 2006. She became conditionally registered with the College on February 21, 2006 to provide primary care, no anesthesia. Dr. Wowk-Litwin completed the CFPC Emergency Medical Training Program in March, 2007 and met the requirements for full registration in April, 2007.

2. At all relevant times, Dr. Wowk-Litwin practiced at the same rural hospital in Manitoba, both as a Hospitalist and in the Emergency Department. She began working at that hospital in or about 2007. Prior to that time, she had worked as a Hospitalist and in Emergency Departments in Winnipeg. She left the rural hospital in January, 2013. Dr. Wowk-Litwin began working as a Hospitalist in

Winnipeg in March 2013 and continued to work in that capacity until November 5, 2014. On November 14, 2014, she signed an undertaking with the College to cease practice because of health concerns not directly related to these proceedings. As of the date of the hearing of the Inquiry Panel, June 22, 2015, Dr. Wowk-Litwin was not practising medicine.

Overview of Events Leading to the Charges Against Dr. Wowk-Litwin

3. On October 31, 2012:

(a) At 20:41 Patient X arrived at the Emergency Department of the rural hospital at which Dr. Wowk-Litwin was practicing by ambulance experiencing intermittent chest pain and respiratory distress; and

(b) At 22:12 Patient X was pronounced dead in the trauma room of the ER following Dr. Wowk-Litwin's unsuccessful attempts to intubate him, a successful intubation by the anaesthetist and failed attempts to resuscitate him.

4. At all relevant times, Dr. Wowk-Litwin was on duty in the Emergency Department. There were several nurses on duty at the time, including two nurses, R and C. Patient X was brought in by two EMS personnel, L and G. Nurses R and C and EMS personnel L and G were each involved in X's care before and during X's being intubated and all of them remained in the Emergency Department until after X died. Members of X's family, including his partner, attended the Emergency Department and were with X for much of the time prior to him being sedated for the purposes of intubation. Additional members of X's family were waiting in a room designated for family while X was being intubated and were present following his death.

5. On the basis of information compiled from the hospital record, and interviews with Dr. Wowk-Litwin, the nurses, EMS personnel, and family members of Patient X, the following facts have been established:

(i) Patient X's partner has stated that X returned from a lengthy trucking trip in the United States just before the ambulance was called to take him to hospital. He had driven that day, but he was not feeling well. X was able to drive without difficulty up to and including October 31, but he was having difficulty in performing some of his duties as a truck driver in the weeks preceding his visit to the ER, including walking for more than short distances and carrying bags to and from the truck.

(ii) According to EMS personnel, L and G, X had been alert and able to communicate with them, including during an episode of respiratory distress and tightness in his throat while transferring to the ambulance. His vital signs before and after the episode were stable. During transport, he was on oxygen-3L per min. via nasal prongs and there were no further episodes during transport. He was coded by EMS personnel as non-urgent.

(iii) Upon arrival at the ER, X's care was transferred to the nursing staff and he was put in the trauma room. At this point, Nurse R became the nurse who was primarily responsible for X's care in the ER. The suspected "Acute Coronary Syndrome" (ACS) Chest Pain Protocol was initiated immediately. Patient X's partner and one or more family members were at X's side for much of the time before he was sedated for intubation. X was sedated at 21:40 so that Dr. Wowk-Litwin could perform a rapid sequence intubation (RSI).

(iv) Dr. Wowk-Litwin's decision to intubate Patient X was communicated by Nurse R to Nurse C who thereafter became involved in X's care, including assisting in the preparation for the intubation and assisting with the intubation and resuscitation of X.

(v) Patient X was a large man with a BMI over 50. The EMS personnel and Nurses R and C and X's partner all described X as still verbalizing and alert and oriented right up to the time he was sedated for intubation at 21:40. Neither the EMS personnel nor Nurses R and C shared Dr. Wowk-Litwin's sense of urgency in proceeding to sedate X and to attempt RSI, but all accepted Dr. Wowk-Litwin's decision to proceed as the physician in charge of his care.

(vi) Dr. Wowk-Litwin described Patient X as struggling to maintain his airways and stated that his level of consciousness was deteriorating to the point that he was becoming unresponsive before she made the decision to proceed with RSI on an emergent basis.

(vii) Although there are differences in Dr. Wowk-Litwin's recollection, the recollections of the family and the recollections of the nurses and EMS personnel as to Patient X's level of discomfort, consciousness and the sense of urgency in respect to the timing of the intubation, the following is agreed as to Patient X's condition right up to the time he was sedated for intubation at 21:40:

a) His oxygen SATs were fluctuating between as low as 66% and as high as 100% based on the monitoring equipment readings;

b) Patient X experienced intermittent episodes of very severe chest pain and/or shortness of breath and was having difficulty breathing when he was assessed by Dr. Wowk-Litwin at 21:25;

c) He maintained his gag reflex and did not have an oropharyngeal airway in place;

d) He was not suctioned for and did not have excessive secretions prior to the attempts to intubate.

(viii) Whereas there are differences in the recollection of the nursing staff and Dr. Wowk-Litwin as to whether Dr. Wowk-Litwin requested a CO2 monitor prior to attempting to intubate Patient X and as to whether it would have been available if she requested it, Dr. Wowk-Litwin acknowledges that:

a) She proceeded with the intubation without a back-up plan to address possible complications, including failure to intubate and/or tube misplacement.

b) She proceeded with the intubation without ensuring that the end tidal CO2 monitor was readily available to her if requested.

c) She did not request the CO2 monitor during her attempts to intubate Patient X.

d) The CO2 monitor was available to and used by the anaesthetist on call when the anaesthetist on call successfully intubated Patient X at 22:05.

(ix) The Nursing Reassessments and the Resuscitation Record contained in the hospital records document the following information regarding Patient X's condition and the care provided to him from 21:40 until 22:12 when Patient X was pronounced dead:

Nursing Reassessments:

- 21:40 - Preparing for intubation - Fentanyl 50 mg, Versed 5 mg, Propofol 250 mg, Succynylcholine 150 mg,. IV given, BP recorded as 104/45, pulse 75
- 21:43 - Dr. Wowk attempting to intubate; unsuccessful.
- 21:45 - Attempting intubation again. No. 8 FR ET tube ++ secretions in tube; suction done.
- 21:50 - CPR started. No pulse O2 65% being bagged. Epi 1 mg. I.V. going in, patient pale.
- 21:55 - PEA, CPR held, no pulse, CPR started, Epi 1 mg. I.V. going in - attempting intubation per Dr. Wowk.

Resuscitation Record:

- Initial event date October 31, 2012. Time 2150. Rhythm or diagnosis PEA.
- 21:59 - Rhythm PEA. Pulse no. Treatment Epi 1 mg. I.V. and 20 cc ns flush. Other treatment - intubation being attempted CPR held. I.V. ? to left ACF, ++ suctioning through ET, AE bilat.
- 22:02 - Rhythm PEA. Pulse no. Treatment NS infusing c500cc. Ventilation - bagging. Other treatment CPR started. CPR held. Emesis through ET tube.
- 22:03 - Rhythm PEA. Pulse no. Treatment CPR held. ++ emesis through ET, ++ suctioning, CPR started.
- 22:04 - Treatment Epi 1 mg. I.V. reattempting intubation per on-call anaesthetist.
- 22:05 - PEA and CPR held for intubation. Other treatment - CPR started. Bagging, 8 ET placed, no AU heard. CO2 detector set up and getting CO2 return.
- 22:08 - PEA Pulse and treatment O2 89% bagged. Other treatment CPR stopped and restarted. Held CPR, CPR restarted.
- 22:10 - Rhythm PEA.
- 22:12 - Rhythm PEQA. Pulse none. Other treatment CPR stopped. Time of death 22:12

(x) Dr. Wowk-Litwin acknowledges that after her first attempt to intubate failed, she was quite frustrated and upset with herself. She states that she did not call for help after the failed attempt as she was focused on attempting to get the intubation done and assist the patient. She also states that it was because of her confidence in her ability to intubate that she believed it was more prudent and safer for the patient for her to continue with the intubation rather than wait for assistance.

(xi) Sometime thereafter, Dr. Wowk-Litwin stated she asked for the on-call anaesthetist to be called and that the anaesthetist arrived at around 22:04 hours at which time the anaesthetist listened to X's chest, removed the present tube, suctioned and introduced a new tube successfully ventilating Patient X. Unfortunately, X had been pulseless electrical activity ("PEA") since 21:55 and could not be resuscitated.

(xii) Whereas there are differences in the recollections of those involved in the intubation, the following is admitted by Dr. Wowk-Litwin in respect to the manner in which she responded to one or more of her failed attempts to intubate Patient X:

a) At no time during the attempts to intubate Patient X did Dr. Wowk-Litwin use or request that any of the staff assisting her use an end tidal CO2 monitor to ensure correct tracheal placement on the endotracheal tube;

b) Dr. Wowk-Litwin should have recognized that she had intubated the esophagus sooner than she did;

c) When the nurses initially asked Dr. Wowk-Litwin if she wanted the anaesthetist on call to come in to assist, she initially did not think it would be a problem, but that that she later agreed that the anaesthetist on call should be brought in.

d) Dr. Wowk-Litwin should have sought the assistance of the anaesthetist sooner than she did.

(xiii) After X was declared dead, Dr. Wowk-Litwin reported the death to both the family members of Patient X, who were waiting in a room designated in the ER for family, and to the Medical Examiner, after waiting for and reviewing Patient X's old chart from previous visits to the hospital.

(xiv) Dr. Wowk-Litwin acknowledges that she failed to ensure that the Medical Examiner was aware of her failed attempts to intubate Patient X and that she ought to have advised the Medical Examiner of those facts, so as to ensure that the Medical Examiner had sufficient information to determine the cause and manner of death and/or whether the death warranted investigation, including an autopsy.

(xv) In respect to Dr. Wowk-Litwin's communications with Patient family following his death, Dr. Wowk-Litwin acknowledged that she did not tell them about the failed attempts to intubate X and that she advised them that there would be no autopsy. She did not believe that she had a responsibility to advise the family of the failed attempts to intubate and believed that the decision as to whether there should be an autopsy had been made by the Medical Examiner and that his decision was that no autopsy was required in this case.

6. Prior to the hearing on June 22, 2015, the Panel, with the consent of the Investigation Committee and Dr. Wowk-Litwin received the written opinions of two independent emergency physicians, one engaged as a consultant on behalf of the Investigation Committee and one engaged as a consultant on behalf of Dr. Wowk-Litwin. The Investigation Committee and Dr. Wowk-Litwin agreed that the opinions were provided to the Panel in their entirety on the basis that neither party accepted the premises or factual assumptions of each consultant in their entirety, but that when read together and based on the Statement of Agreed Facts and the admissions of Dr. Wowk-Litwin, the opinions expressed by the consultants provide the necessary foundation for the Panel to accept Dr. Wowk-Litwin's guilty plea.

The Joint Recommendation as to Disposition

This is a tragic and troubling case. Within that context, the Panel's task is to determine the appropriate disposition pursuant to s. 59.6 of *The Medical Act*. The Panel has had the benefit of a Joint Recommendation As To Penalty made by counsel for the Investigation Committee and counsel for Dr. Wowk-Litwin.

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

a. The protection of the public. Orders under s.59.6 of *The Medical Act* are not simply intended to protect the particular patients of the physician involved, but are also intended to protect the public generally by maintaining high standards of competence and professional integrity among physicians;

b. The punishment of the physician involved;

c. Specific deterrence in the sense of preventing the physician involved from committing similar acts of misconduct in the future;

d. General deterrence in the sense of informing and educating the profession generally as to the serious consequences which will result from breaches of recognized standards of competent and ethical practice;

e. To protect against the betrayal of the public trust in the sense of preventing a loss of faith on the part of the public in the medical profession's ability to regulate itself;

f. The rehabilitation of the physician involved in appropriate cases, recognizing that the public good is served by allowing properly trained and educated physicians to provide medical services to the public;

g. The sentence should be proportionate to the conduct of the physician involved.

The Joint Recommendation As To Penalty being made in this case is that:

1. Dr. Wowk-Litwin be reprimanded pursuant to ss.59.6(1)(a) of *The Medical Act*;

2. The following conditions be imposed on Dr. Wowk-Litwin's entitlement to practice medicine pursuant to ss.59.6(1)(e)(vii) of *The Medical Act*:

    a. Dr. Wowk-Litwin shall not be permitted to practice until she satisfactorily completes remedial education and/or training in the following areas as approved by the Investigation Chair:

        i. Ethical communications when delivering bad news to the patients and/or families and ethical and legal requirements surrounding reporting of and handling adverse events to appropriate parties, including administrators and, in the case of death, the Medical Examiner; and

    b. When Dr. Wowk-Litwin resumes practice, she be restricted from performing intubations and be restricted to practicing only at locations and/or in circumstances in which she will not be called upon or expected to perform intubations until she satisfactorily completes remedial education and/or training in the following areas as approved by the Investigation Chair:

        i. Intubation, including decision making surrounding intubation such as when to intubate, assessing difficulty to intubate, anticipating and preparing for complications and performing intubations and including responding to improper tube placement and/or failure to intubate.

    In respect to both of these conditions, the Investigation Chair will have complete authority to:

        1. approve the remedial education and/or training; and

        2. pending satisfactory completion of the remedial education and/or training in intubation, approve Dr. Wowk-Litwin's practice circumstances and/or locations before she commences practicing in any circumstances and/or at any location to ensure that she is practicing at a location and in circumstances in which she will not be called upon or expected to perform intubations; and

        3. receive reports from the provider(s) of the remedial education and/or training; and

        4. release Dr. Wowk-Litwin from these conditions upon being satisfied that she has satisfactorily completed the required remediation.

3. The payment by Dr. Wowk-Litwin of the costs of the Investigation and Inquiry in the agreed amount of $18,000.00, payable in full by Dr. Wowk-Litwin to the College by certified cheque or by a trust cheque from her lawyer's law firm on or before the date of Inquiry, pursuant to ss. 59.7(1) of *The Medical Act*.

4. Publication, including Dr. Wowk-Litwin's name, as determined by the Investigation Committee pursuant to ss.59.9 of *The Medical Act*.

ANALYSIS

The Panel has reviewed the objectives of orders which are granted pursuant to s.59.6 of *The Medical Act*, relative to the Joint Recommendation As To Penalty, to satisfy itself that those objectives will be fulfilled by an acceptance of the Joint Recommendation.

Dr. Wowk-Litwin's actions in relation Patient X caused or contributed to a disastrous and tragic outcome. The Investigation Committee has expressed a justifiable concern that Dr. Wowk-Litwin had an unrealistic and inflated assessment of her own abilities and demonstrated a reluctance to seek assistance which was readily available to her. The Investigation Committee also has expressed great concern about a lack of insight and the failure on the part of Dr. Wowk-Litwin to appreciate the significance of the failed intubations.

On the other hand, there are mitigating circumstances present in this case, which are acknowledged by the Investigation Committee. Significantly Dr. Wowk-Litwin has no prior disciplinary record with the College nor has there been any prior indication of serious issues relating to patient care or competency on the part of Dr. Wowk-Litwin. She has also been cooperative with the Investigation Committee's investigation, and in the context of the facts of this case, she has acknowledged her shortcomings and deficiencies and agreed to a remedial plan. Her guilty plea to the allegations outlined in the Amended Notice of Inquiry has resulted in a sensible and non-contentious outcome to these proceedings.

One of the challenges in determining a fair and reasonable disposition is striking a balance whereby the penalties imposed are neither too harsh, nor to lenient. Dr. Wowk-Litwin is undoubtedly a good candidate for rehabilitation. She has recognized and acknowledged the errors which she made in relation to Patient X and has indicated a willingness to undergo remedial education and/or training in the areas noted in the Joint Recommendation As To Penalty. Rehabilitation is a very important aspect of this case from the perspective of both the Investigation Committee and Dr. Wowk-Litwin.

In practical terms, Dr. Wowk-Litwin has not been practicing medicine for a period of eight months, for reasons not directly related to this case. The Panel accepts the proposition that there is no inherent value in imposing a further period of suspension on Dr. Wowk-Litwin, and that the protection of the public can be effectively accomplished by the imposition of the conditions contemplated by the Joint Recommendation.

There are punitive aspects to the Joint Recommendation made by the parties. A reprimand is a serious and formal denunciation of Dr. Wowk-Litwin's conduct as particularized in the Amended Notice of Inquiry. It is a forceful statement by this Panel of its disapproval of Dr. Wowk-Litwin's conduct. The reprimand, coupled with payment by Dr. Wowk-Litwin of the costs of the Investigation and Inquiry and the publication of a summary of these proceedings and their outcome and of Dr. Wowk-Litwin's name, represent an adequate punishment of Dr. Wowk-Litwin. The reprimand, the payment of costs by Dr. Wowk-Litwin and publication as noted above will specifically deter Dr. Wowk-Litwin from committing similar misconduct in the future.

The publication of these proceedings will also inform and educate the profession generally as to the serious consequences which will result from breaches of recognized standards of competent and ethical practice and will fulfill the objective of general deterrence.

Patient safety and the protection of the public generally will be achieved by the conditions which are recommended pursuant to ss.59.6(1)(e)(vii) of *The Medical Act*. In particular, the requirement that Dr. Wowk-Litwin complete remedial education and/or training in the areas of ethical communications when delivering bad news to patients and fulfilling the ethical and legal requirements surrounding the reporting of and handling adverse events to appropriate parties, including the Medical Examiner and the prohibition against Dr. Wowk-Litwin performing intubations until she satisfactorily completes remedial education and/or training as approved by the Investigation Chair will fulfill the objective of protecting patient safety and the public generally.

The cumulative effect of all the above-noted elements of the Joint Recommendation will prevent a loss of faith on the part of the public in the medical profession's ability to regulate itself, and will provide for the rehabilitation of a physician who still has many years left in her career to serve the public by providing competent medical care.

The Panel has therefore decided that the objectives of an order granted pursuant to s.59.6 of *The Medical Act* will be adequately fulfilled, if the Joint Recommendation of the Investigation Committee and Dr. Wowk-Litwin is accepted. The Panel has been advised that prior to the hearing, Dr. Wowk-Litwin had paid the full costs of the Investigation and Inquiry in the amount of $18,000.

The Panel's decision is therefore is to accept the Joint Recommendation.

Accordingly, the Inquiry Panel orders that:

1. Dr. Wowk-Litwin is hereby reprimanded pursuant to ss. 59.6(1)(a) of *The Medical Act.*

2. The following conditions are hereby imposed on Dr. Wowk-Litwin's entitlement to practice medicine pursuant to ss. 59.6(1)(e)(vii):

    a. Dr. Wowk-Litwin will not be permitted to practice until she satisfactorily completes remedial education and/or training in the following areas as approved by the Investigation Chair:

        i. Ethical communications when delivering bad news to the patients and/or families and ethical and legal requirements surrounding reporting of and handling adverse events to appropriate parties, including administrators and, in the case of death, the Medical Examiner; and

    b. When Dr. Wowk-Litwin resumes practice, she be restricted from performing intubations and be restricted to practicing only at locations and/or in circumstances in which she will not be called upon or expected to perform intubations until she satisfactorily completes remedial education and/or training in the following areas as approved by the

Investigation Chair:

i. Intubation, including decision making surrounding intubation such as when to intubate, assessing difficulty to intubate, anticipating and preparing for complications and performing intubations and including responding to improper tube placement and/or failure to intubate.

In respect to both of these conditions, the Investigation Chair will have complete authority to:

1. approve the remedial education and/or training; and

2. pending satisfactory completion of the remedial education and/or training in intubation, approve Dr. Wowk-Litwin's practice circumstances and/or locations before she commences practicing in any circumstances and/or at any location to ensure that she is practicing at a location and in circumstances in which she will not be called upon or expected to perform intubations; and

3. receive reports from the provider(s) of the remedial education and/or training; and

4. release Dr. Wowk-Litwin from these conditions upon being satisfied that she has satisfactorily completed the required remediation.

3. Dr. Wowk-Litwin shall pay the costs of the Investigation and Inquiry in full in the agreed amount of $18,000.00 pursuant to ss. 59.7(1) of *The Medical Act*.

4. There shall be publication of these proceedings, including Dr. Wowk-Litwin's name, as determined by the Investigation Committee pursuant to ss. 59.9 of *The Medical Act*.

Dated this 14th day of August, 2015.

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