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From the College

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

IN THIS ISSUE...

From the New President

Dr. Roger Graham, President

Thank you for the opportunity to assume the responsibility as President of your Council June 2005-June 2006.

Over the last few years, Council and the College staff have been introduced to and educated on policy governance. The implementation of this model has more clearly defined and enhanced the duties of Council. Ends (outcomes/goals) visioned by Council are efficiently delivered by the CPSM staff under the leadership of the Registrar, Dr. Bill Pope. Through this process, Council focuses on the future direction of the College. Your Council will continue to review and modify Ends.

Council plans to prioritize expected outcomes for the Registrar. These may include a policy on continuing professional development and review of the present evaluation of International Medical Graduates.

The Council supported a survey of the public's awareness, perception and importance of the CPSM. The results were very favourable. The report also provides the Council important information from one of its owners, the public. The process of ownership linkage, a necessary component of policy governance, will be enhanced in the coming year.

The Council, through the new governance model, will continue to be less reactive and more future focused on the College's new role for the public and the profession.

Registrar's Comments

FMRAC

Did you know that there is a national regulatory body coordinating national activities of the Colleges of Physicians and Surgeons in Canada? It is called FMRAC – the Federation of Medical Regulatory Authorities of Canada (formerly FMLAC – Federation of Medical Licensing Authorities of Canada). FMRAC represents all ten provincial regulatory bodies and the territorial licensing organizations to present national issues with a common front. For the last year, the CEO/Executive Director has been Dr. Fleur-Ange Lefebvre, formerly with the Canadian Medical Association. Fleur-Ange has enormous abilities and energy, and the Federation presently has a new lease on life and has been working actively to promote the best interests of the Colleges.

Recently, she coordinated a meeting between the Federation President, Dr. Bob Burns, Registrar in Alberta, herself, and Mr. Ujjal Dosanjh, the Federal Minister of Health, with regard to internet prescribing. The Federation also coordinates an Annual Meeting when all the registrars, presidents and various executive members meet to find out what is happening in the other jurisdictions and what we can use and take from their experiences. As well, at that time, College legal counsel meet to provide advice and support to each other.

At the present time, your Registrar is President of this organization, and was the Chair of the Accreditation and Educational Advisory Committee which appoints representatives to all postgraduate accreditation surveys and has a voting member on the Accreditation Committees of both the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. This is extremely important to ensure that our Colleges are satisfied with the accreditation process carried on for postgraduate medical education. Prior to 1994, the national regulatory authorities were responsible for reviewing and accrediting the interneship process. When that was rolled into the two year entry to practice in 1994, the Federation was given a seat on the Accreditation Committees of the two Colleges. Please be assured that we participate actively on those committees.

At the present time, Federation has a number of important projects which are ongoing. We are looking at a national insurance reciprocal for regulatory authorities in the hope that the skyrocketing liability insurance costs for this College can be contained in the future. The Federation is a co-partner in the development of MINC, the medical information number for Canada, and a National Credentials Verification System. When this is up and running in approximately two years' time, it is hoped that physicians' credentialling information will be easily available and the busy work of one physician moving to another province will be greatly facilitated.

The Federation Executive also meets yearly with the CMPA and CMA Executive Committees and this has produced a facilitative working environment on a number of major issues.

Finally, the Federation has struck a working group under the able chairmanship of Dr. Bryan Ward, Deputy Registrar in Alberta to look for a national approach to revalidation. This will include using the tools that are already in place at the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. They intend to make this revalidation approach educational.

Since your College has already approved mandatory future participation for all Manitoba physicians in these programs, we will be watching the activities of this committee closely.

Please stay tuned – we will keep you up to date of the further activities of FMRAC in the future.

Dr. Bill Pope, Registrar

Serotonin Re-Uptake Inhibitors

The selective serotonin re-uptake inhibitor antidepressants (SSRIs) are widely prescribed psychotropic medications, with demonstrated efficacy in the treatment of major depressive disorder and a number of anxiety disorders in adults.

In recent years attention has been drawn to the occurrence of infrequent but potentially serious psychiatric symptoms such as agitation or suicidal ideation in association with the use of SSRIs. Expert opinions are divided over the question of a causal relationship between SSRI antidepressants and suicidal behaviour.

Agitation and self-harm behaviour are inherent risks in depressive disorders. The risk for these adverse events is highest in the weeks shortly following initiation of treatment for depression. Accordingly, physicians should be aware of the need to monitor patients carefully during antidepressant treatment, particularly in the weeks following initiation of medication or following dosage increases.

Physicians should inform patients about the risks of agitation and suicidal ideation during treatment for depression. Patients should be counselled to contact their physician or utilize emergency resources if worsening suicidal ideation develops.

Elective Undergraduate Medical Students Working with Members

Sometimes medical students will call physicians and ask if they can do an undergraduate elective with them.

Please be aware that if you are agreeable to this, the student should be directed to the Undergraduate Medical Education Office at 789-3568. The individual is Ms. Tara Petrychko.

These individuals must also be registered with the College, but this only occurs after the elective has been arranged through Undergraduate Medical Education.

Congratulations!

- To Dr. Chander Gupta on having received the Order of Manitoba award.
- To Dr. Krish Sethi, College Councillor, who has been designated Physician of the Year by the Manitoba Division of the College of Family Physicians of Canada.
- To the 2005 MMA Awards Winners:
  Dr. Oscar Domke – Physician of the Year Award
  Dr. Henry Friesen – Distinguished Service Award
  Dr. Philip Katz – Scholastic Award
  Dr. Bruce Martin – Administrative Award
  Dr. Gilles Pinette – Health or Safety Promotion Award
- To the following physicians who were inducted as Honorary Members of the Canadian Medical Association: Dr. Robert Abel, Dr. Victor Chernick and Dr. Peter Warner.
- To Dr. Rudy Danzinger, who received the Certificate

of Merit Award from the Canadian Association of Medical Education at their Annual Meeting in 2005.
- To Dr. Estelle Simons, elected President of the American Academy of Allergy, Asthma and Immunology.
- To Drs. David Rush and Ken Van Ameyde, who were elected Clinicians of the Year 2004-2005 by the Graduating Class of Medicine.
- To Drs. Malek Kass and Suma Shastry who were elected the Resident Clinicians of the Year 2004-2005 by the Undergraduate Class.

Consumer Product Safety Program Announces New Toll-Free Number

Every year the CHSC reviews deaths of children related to products such as bath seats, cribs, playpens, riding toys, and window blind cords. These and other serious injuries involving children's products should be reported to Health Canada for further investigation. Health Canada's Consumer Product Safety Program is making it easier for consumers and professionals to report a product-related injury or death, or a safety-related issue with a consumer product. The Program has implemented a new toll-free telephone number available to Canadians. In the past, consumers calling from outside of the Regional Office calling area were charged long distance fees. The new phone service eliminates these costs with one easy to remember toll-free phone number. Calls will be routed to the closest Regional Office.

If you would like to report a product-related injury or death or a safety-related issue with a consumer product, please call 1-866-662-0666. This phone number is accessible only in Canada.

The Program will continue to respond to consumer reports and inquiries received via e-mail and letter mail.

Direct Access to Physiotherapy Services at Workers Compensation Board

The Manitoba Branch of the Canadian Physiotherapy Association, in collaboration with the Workers Compensation Board of Manitoba, has now agreed that injured workers may directly access physiotherapy services for Workers Compensation Board claims. They indicate that this is in no way meant to discourage injured workers from seeing their own physicians, but rather to provide a bridge for the waiting period between the time of injury in an attempt to facilitate timely access to treatment.

The Physiotherapy Act obliges physiotherapists to recommend to a patient that a physician should also be seen if warranted.

Completion of Diagnostic Imaging Requisitions

The Diagnostic Imaging Program Standards Committee of the WRHA conducted an audit of the number of CT exams that were performed for oncology patients within a requested time frame. There were between 93 and 100% of CT exams performed within the requested time frame for the month of June 2004.

The Committee noted that when requesting physicians provided a time frame within which they wished the test to be done and provided information about the patient condition, the process of screening and prioritizing test requests became more manageable for radiologists, who were more likely to be able to accommodate the requesting physician.

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Organ and Tissue Donations

The Human Tissue Act was amended to *The Human Tissue Gift Act* in June 2004. The revised legislation requires hospitals and any other facilities that may be designated by regulation in the future to notify a human tissue gift agency when a patient dies, when a physician determines that death is imminent and inevitable, or when the facility receives a dead body.

The release of information to the Human Tissue Gift Agencies (HTGA) under section 13(1) of the Human Tissue

Gift Act is in accordance with The Personal Health Information Act (PHIA) section 22(2)(O) and the Freedom of Information and the Protection of Privacy Act (FIPPA) section 44(1)(e).

The revised Act identifies three HTGAs: the Lions Eye Bank, the WRHA Tissue Bank Program (currently known as Tissue Bank Manitoba) and the WRHA Organ Donation Program (currently known as Manitoba Transplant Program).

The agency notified is required to determine whether the deceased or dying person made a direction regarding donation of their body or its tissues. If one cannot be found promptly, the agency must decide whether circumstances are appropriate to make a request of the person, or their proxy or nearest relative to donate the body or its tissues. A request must not be made if the agency has reason to believe that the person objected, or would have objected if living, to donation of their body or its tissues. A facility may be asked by the human tissue gift agency to make the request on its behalf.

Reporting requirements differ depending on whether the person is a potential organ or tissue donor. Because when and how to approach next of kin can have a significant impact on obtaining consent, and because donor eligibility criteria change from time to time, the Eye Bank and Tissue Bank Manitoba ask that physicians and RNs not approach families regarding donation unless asked to by a HTGA coordinator. However, if a patient or a family member approaches you about donation, you should call Tissue Bank Manitoba at 940-1750 so that a coordinator can arrange to discuss donation options with them.

The College encourages physicians to make their patients aware of the value of organ and tissue donation and encourage them to share their decision with their families so that timely action can be taken when appropriate.

More detailed information about organ or tissue donation can be found at www.cpsm.mb.ca/faq.

Child Protection and Child Abuse Manual Part I (Background Information for Physicians) and Part II (The Physician's Role) (Revised 2003)

This information is now available. Physicians are encouraged to acquaint themselves with the updated information. Electronic copies of the documents can be obtained at http://www.pacca.mb.ca/publications.html#protection_abuse_manuals.

An additional contact for information about the electronic version is Alana Brownlee at 945-7274 or abrownlee@gov.mb.ca

A limited supply of printed copies is available through the Child Protection Centre at (204) 787-2811 or by fax at (204) 787-2800.

Medication Information Line

The University of Manitoba offers a Medication Information Line to answer questions and concerns from the general public as well as health professionals regarding prescription and non-prescription medications.

Should a physician or a patient wish to use this service, please call 474-6494 Monday to Thursday 9:30 a.m. to 2:30 p.m.

For physicians who wish to place a free poster in your office, please call the University Centre Pharmacy at 474-9323.

Manitoba Prescribing Practices Program (M3P)

Please note that the Manitoba Prescribing Practices Program (M3P) has various methods of ordering M3P prescription pads. They are as follows:

1. By telephone: 772-4984 (same number as before)
2. By fax: 237-3468 (goes directly to Manitoba Pharmaceutical Association), and
3. By e-mail: mppp@mpha.mb.ca

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From the Complaints Committee…

Re Physicians' Responsibility for Informing Patients of Abnormal Test Results

A physician noted an abnormal mammogram report on a patient and was expecting to discuss the results at the patient's next appointment. The patient cancelled the appointment. The physician subsequently left the practice and the patient was not informed of the abnormal mammogram until she returned several months later and met with a new physician who reviewed the chart at that time.

The Complaints Committee reminds members that it is important for physicians to have a method of flagging abnormal results that must be communicated to patients even if scheduled appointments are not kept.

The following *"You Were Asking!"* item was first published in the College newsletter in 1996 and remains very appropriate today.

Q. *The last Disciplinary Report implied we must tell patients the results of all tests that we order. Is this correct?*

A. *No. The Code of Ethics requires that a patient has a right to know why a test is indicated and the right to know the results. This can be accomplished without calling the patient with every test result.*
Some tests used to screen out disease can be dealt with by saying, "We will let you know if there is a problem with the results". You must, of course, set up a mechanism to ensure that you do so.
Other tests clearly may be a source of anxiety to the patient who wishes to be advised regardless of the results. You have two options. You may undertake to advise all patients directly, or you may suggest that the patient follow up by contacting the office. In the latter situation, you must put in p lace a notification for those with abnormal results who fail to call. An example of such a test would be a biopsy.
In the case of consultations, your patients should know the reason for the consultation, what feedback to expect and from whom to expect it.
It is a standard of practice that patients have a right to know why a test is being done and the results. This standard has been reinforced by the courts and should be incorporated into practice. Publication in this newsletter does not create a new expectation.

Re Care Provided by Other Physicians

The Complaints Committee reviewed a case in which a young adult had died of an aggressive cancer. Care had been thorough and appropriate, but the family asked for a review of care when a medical professional (unfamiliar with the full details) suggested that inadequate care had possibly occurred.

The Committee encourages physicians to avoid judgmental remarks about the care provided by other physicians, particularly when accurate information about past events is not available.

Manitoba Health Appeal Board Brochures

The Manitoba Health Appeal Board is an agency through which patients may appeal the government's refusal to cover certain health care costs. They have recently developed a new brochure to explain what they do and how to access them.

Members wishing information or hoping to direct patients may contact the Manitoba Health Appeal Board by e-mail at ***www.gov.mb.ca/health/appealboard*** or by telephone (788-6704) or by writing to 4012 – 300 Carlton Street, Winnipeg, Manitoba R3B 3M9.

Statement 807 - Dispensing Physicians

Statement 807, "Dispensing Physicians" is a joint statement of the Manitoba Pharmaceutical Association and of the College of Physicians and Surgeons of Manitoba.

This statement, developed within the legislative framework of the Pharmaceutical Act, supports physicians and pharmacists in providing safe, quality care to patients in rural Manitoba in situations where there may not be pharmacist services available.

Under the model outlined in the statement, each dispensing physician has a working relationship with a pharmacist. Coordinating medication distribution processes through a pharmacy permits tracking of usage, supports quality assurance, and provides better access to drug information for physicians and patients.

Please refer to the CPSM website or contact the College for a copy of the Statement.

Report of Disciplinary Proceedings

CENSURE: IC03-02-03
DR. ALAN RICH

On January 17, 2005, in accordance with Section 47(1) (c) of The Medical Act, the Investigation Committee censured Dr. Rich as a record of its disapproval with respect to his conduct:

I. PREAMBLE

Physicians should have an adequate tracking system to determine if patients have received follow-up in accordance with the physician's management plan. Subject to the patient's right to decline recommended care, if a particular test is indicated, it is important that the result is obtained. Where a physician obtains an abnormal test result, the physician is responsible to convey that result to the patient and to recommend appropriate follow-up.

In a diabetic patient, an abnormal renal function and proteinuria should be regularly monitored and a timely referral made to a nephrologist. Hypertension should be aggressively managed, and if an ace inhibitor is prescribed to control the hypertension, it may aggravate renal failure and must therefore be closely monitored.

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:

1. The patient, ("X"), born in 1947, was a known diabetic. When Dr. Rich first saw X on October 25, 1999, his blood pressure was elevated (162/80) and his blood sugar was 17.6. Dr. Rich's note includes: "Needs to look after his diabetes".
2. X saw Dr. Rich on October 28, 1999, January 18, 2000 and March 12, 2000 for unrelated problems. On March 22, 2000, X's blood pressure was 140/75.
3. On August 8, 2000 X's blood pressure was 150/80. Diagnostic tests which were ordered that day showed a urea of 9.0 and a Hgb A1C of 8.4.
4. Dr. Rich discussed these results with X on October 10, 2000, and ordered further tests, which showed a creatinine of 205, urea of 10.5 and Hgb of 131. On October 10, 2000, X's blood pressure was 186/96. Dr. Rich prescribed Monopril, at a dose of 10 – 20 mg PO od. His note included: "confirm protein loss from diabetes" and his impression included "diabetes with hypertension and early renal problems". The record indicates that X was asked to return the next week. X next attended on December 20, 2000.
5. On December 20, 2000 X's blood pressure was 188/92 and Dr. Rich prescribed Hydrodiuril, 25 mg. The note of X's visit includes: "definitely has renal disease secondary to diabetes" and Dr. Rich's impression includes: "diabetes with renal disease". The note indicates that X was asked to return in the new year. X next attended on February 14, 2001.
6. In February 2001, X developed retinopathy while on vacation. He sought out and consulted ophthalmologists in this regard. At a February 14, 2001 visit, X advised Dr. Rich that he had discontinued his medication while he was on vacation, and had just started it again. His blood pressure was recorded as 178/93 – 169/96 – 168/88.
7. X saw Dr. Rich for a series of appointments at which his blood pressure was recorded as follows:
   - February 21, 2001 – 170/92 – 172/86
   - March 13, 2001 – 154/82
   - April 14, 2001 – 180/90
   - August 3, 2001 – 164/88
   - September 10, 2001 – 190/92
8. On September 24, 2001, X's blood pressure was 170/108. The note states that he went off all medication but insulin when the eye problems developed. Congestive heart failure was noted at this visit and Dr. Rich prescribed Lasix. Dr. Rich ordered tests which showed an elevated urea of 24.7.
9. On October 3, 2001, X's blood pressure was 200/100 – 180/80.
10. Another doctor changed X's medication to Vasotec on October 19, 2001.
11. On October 30, 2001, X's blood pressure was 182/88. Dr. Rich prescribed Vasotec and Lasix.
12. On November 22, 2001, X's blood pressure was 196/110 – 186/92 and Dr. Rich prescribed Vaseretic. Dr. Rich ordered tests, and results showed a creatinine of 812, Hgb of 86 and urea of 26.3.
13. On November 29, 2001, X's blood pressure was 189/96 and Dr. Rich prescribed Altace. The note includes "going towards renal failure" and Dr. Rich noted his intent to refer the patient to a nephrologist.
14. By letter dated December 3, 2001, Dr. Rich referred X to a nephrologist.
15. X attended at the Nephrology Department of St. Boniface Hospital in January 2002, at which time he was diagnosed with end stage renal disease.
16. In response to the questions of testing at regular intervals and follow-up Dr. Rich stated that:
    a. his usual practice is to provide diabetes patients with a requisition for blood work that should be repeated at regular intervals for up to a year and he believes that he would have provided this to the patient. There is no record that repeat testing was ever performed on the patient at the intervals requested.
    b. he had no system in place in his office to enable him to know whether a test that he ordered had in fact been completed and the results reported to him. Consequently, he was unable to say whether the patient actually had repeat tests.
    c. his standard practice is to remind patients to attend for tests and he believes that he would have addressed that with the patient.
    d. he felt that the patient was non-compliant with his recommendations with respect to his own care. However, he did acknowledge that he could have been more aggressive with him and could have referred him to a nephrologist sooner.
17. The consultant retained by the College opined that:
    a. X's hypertension was not managed to acceptable standards. He stated: "Follow up seems to have been quite frequent, but the increase in hypertension was not recognized to be possibly related to a decrease in renal function, as follow up renal function was not evaluated closely. This despite the use of NSAID's, and ACE inhibitors, which are known to affect renal function, the former of which may also increase blood pressure."
    b. The consult with nephrology should have been initiated in October 2000.
    c. It was inappropriate to prescribe NSAID's without knowing X's renal function, knowing that he had been a diabetic for some years. Prescribing ACE inhibition, while very appropriate for hypertension in diabetes, was also not accompanied by close observation of kidney function.

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

a. He failed to take adequate steps for follow up on X's proteinuria and abnormal renal function.
b. He failed to aggressively manage X's hypertension when he obviously had renal disease.
c. He prescribed medication known to possibly aggravate renal failure, but he did not closely monitor renal function.
d. He failed to maintain an adequate medical record with respect to his care of X.

In addition to appearing before the Investigation Committee, Dr. Rich paid the costs of the investigation in the amount of $2,530.60.

INQUIRY: IC03-09-02
NAME WITHHELD

On January 25, 2005 a physician pled guilty to a charge of professional misconduct in that he violated appropriate boundaries with a patient ("X") and thereby violated his ethical obligations to her.

Initially, the physician provided episodic care to X. Later, he encountered her in a work setting. Ultimately, he became her regular family physician, and continued as such for approximately 7 months. His services to X included an intimate examination in that at the time of X's last office visit to him, the physician provided a pelvic examination, including a pap test.
Around the time of this last office visit, the physician became aware that he was attracted to X, and understood that he could not continue the physician/patient relationship due to that attraction. Within a week of that last office visit, the physician encountered X outside of his office, and during their discussion declared his attraction to her. X responded by declaring her attraction to the physician. On that day, there was physical contact between them, including embracing and kissing. Within 3 days, the relationship progressed to sexual intimacy.

The physician arranged for X to see another family physician. The personal relationship between the physician and X continued.

The physician self-reported to the College. Thereafter, the physician obtained counseling, and sought the input of psychiatrists with respect to the matter, as he wished to act professionally and to continue the personal relationship. The psychiatrists opined that the physician acted in contravention of the College guidelines by proceeding too rapidly and failing to recognize that the influences related to a pre-existing physician/patient relationship do not vanish instantly upon declaring its termination. The psychiatrists noted that X was actually much more emotionally vulnerable than the physician appreciated. However, the psychiatrists felt that the inappropriate influence of the physician/patient relationship was relatively minor and had diluted with the passage of time.

The College obtained expert opinion that concurred with the conclusion of the physician's psychiatric consultants on the nature of the boundary violation. However, the opinion provided to the College also pointed out that the influence of the physician/patient relationship occurs at the outset of the relationship, and potential "dilution" with the passage of time was irrelevant.

The College and the physician made a joint recommendation as to the discipline to be imposed as follows:

1. The physician's licence is suspended for a minimum period of six months.
2. The physician's licence will remain suspended until he has undergone an assessment by an individual or program acceptable to the College, (herein "the assessor") for the following purposes:
   i. to establish an understanding of why the physician violated boundaries;
   ii. to determine the risk of further boundary violations by the physician and what, if any, terms and conditions the assessor recommends should apply to the physician's practice to minimize that risk;
   iii. to determine what, if any, remediation plan the assessor recommends the physician should follow either before returning to practice or while he practices medicine.

The assessment will proceed in accordance with the terms of the physician's undertaking to the College, setting forth details of the process.

3. If the assessor opines that a problem exists such that the physician should undergo specified remediation before re-entering practice, the physician's licence will remain suspended until such time as he has demonstrated to the satisfaction of the assessor that any such problem has been overcome.
4. If the assessor opines that a problem exists such that the physician should undergo specified remediation while he practises medicine, the physician's licence will be issued subject to the term and condition that he comply with all aspects of the remediation plan stipulated by the assessor, within such time frame as may be fixed by the assessor.
5. If the assessor opines that a problem exists such that terms and conditions should apply to the physician's practice of medicine to minimize the risk of further boundary violations, the physician's licence will be issued subject to such terms and conditions.
6. The physician will pay costs of $7,935.46 to the College on or before the date of the Inquiry.
7. There will be publication of the facts and disposition, which will not include the physician's name.

Factors relevant to the penalty include:

i. deviation from the obligation of physicians to maintain appropriate boundaries. X appears to have been much more emotionally vulnerable and fragile than the physician appreciated and, in any event, maintenance of appropriate boundaries is the responsibility of the physician.
ii. There was no evidence of conscious manipulation by the physician of X for his own needs. However, the assessment of the physician's personality and psychological adjustment will address the question of potential risk to the public of further boundary violations.
iii. The physician had no disciplinary history with the College.
iv. The physician took steps to obtain his own treatment under the care of a psychiatrist.
v. The physician was cooperative in the College investigation.
vi. Following the College involvement, the physician sought the advice of experts to assist him in addressing the matter, and accepted the advice of the experts in having a period of no contact with X.
vii. The physician and X have stated that they are in a committed personal relationship, and X is adamant that she makes no complaint with respect to the actions of the physician.

The Investigation Committee emphasized that it was only prepared to recommend publication without the physician's name because the Committee was persuaded that there was a serious potential of harm to the innocent children if the physician's name was publicized. The Investigation Committee also emphasized that this was based upon the peculiar facts of this case and is not intended to detract from its general policy of publication including the physician's name.

The Inquiry Panel concluded that in all of the circumstances the joint recommendation was appropriate and accepted it.

CENSURE: IC03-05-04
DR. LAVERNE JANZEN

On February 17, 2005, in accordance with Section 47(1)(c) of The Medical Act, the Investigation Committee of the College censured Dr. Laverne Janzen with respect to providing care to a family member beyond that of a minor or emergent nature.

I. PREAMBLE

The Code of Conduct states:

Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available; there should be no fee for such treatment.

"Emergency" is well understood by physicians to pertain only to those conditions that are a potential threat to life, limb or function, requiring rapid medical intervention or delegated acts.

A family member may have:

- serious medical conditions,
- a history of life-threatening illness, or
- a history of refusal to seek appropriate health care services,

all of which may put the family member at increased risk. However, if the individual does not require rapid medical intervention (or delegated acts) to save life, limb, or function, it is not an emergency.

It is the responsibility of the physician to establish and to maintain boundaries which limit the treatment of family members to minor care or truly emergent services.

II. THE RELEVANT FACTS ARE:

1. Dr. Janzen's prescribing to a member of her immediate family (herein "X") first came to the attention of the College after she issued a prescription which appeared to be for a very large amount of medication. The prescription was acknowledged to be an error. In November, 2002, the Medical Consultant to the Manitoba Prescribing Practices Program stated to Dr. Janzen that it was inappropriate to prescribe this medication to a family member.
2. On May 8, 2003, in an interview with the Investigation Chair, Dr. Janzen acknowledged that she had permitted X to continue to obtain medication on the basis of refills of prescriptions issued by her.
3. On the point of prescribing the medication to a member of her immediate family, Dr. Janzen explained X's multiple medical issues. She stated that she researched the issue and determined that X should take a particular medication. Dr. Janzen stated that she was unable to find another physician comfortable prescribing the medication to X for X's particular symptoms, and so she began prescribing, and also began monitoring for side effects of the medication.
4. By letter dated May 14, 2003, Dr. Janzen stated that she would not prescribe for X or remain involved in X's care.
5. DPIN searches revealed:
   a. Dr. Janzen first provided to X a prescription for this medication in June 2001, and continued prescribing this medication to X until 2003.
   b. In addition to the medication referred to above, Dr. Janzen wrote several other prescriptions for X, including sleeping aids.
   c. X was continuing to obtain medication based upon refills of prescriptions signed by Dr. Janzen.
6. On May 23, 2003, upon the direction of the Investigation Chair, Dr. Janzen cancelled refills of the prescriptions issued by her to X.
7. By letter dated July 4, 2003, Dr. Janzen stated that she and X were searching for a "suitable" family physician for X, which she defined to be one that understands the complexity of X's medical conditions and is comfortable with prescribing and monitoring the medication she had initiated for X.
8. In response to the point that she was acting as X's

family physician, Dr. Janzen provided explanations for the other medications she had prescribed. She stated that she had attempted to refer X to a specialist, but X had refused to attend. Dr. Janzen attempted to characterize these services as emergency services, stating that X's past history put X in a "life-long emergency state".

9. A further DPIN check revealed that effective June, 2003, other physicians were issuing prescriptions for X.
10. Dr. Janzen later advised that, upon reflection, she acknowledged that the care provided to X was not emergent care within the meaning of that term in the Code of Conduct.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. JANZEN'S ACTIONS RELATED TO PROVIDING CARE TO A FAMILY MEMBER BEYOND THAT OF A MINOR OR EMERGENCY NATURE AS FOLLOWS:

1. Dr. Janzen acknowledged having initiated medication for X in June 2001 and having initiated further medication for X in April 2002, and continued prescribing these medications or allowing X to obtain refills based on her authorizations until May 2003.
2. When confronted with the fact that her prescriptions to X amounted to providing care to a family member beyond minor or emergency care, Dr. Janzen initially attempted to justify her actions by characterizing X as being in a "life-long emergency state". Later, upon reflection, she acknowledged that the care she was providing to X was not emergent care.

In addition to appearing before the Investigation Committee to accept the censure, Dr. Janzen paid the costs of the investigation in the amount of $1,311.60.

CENSURE: IC03-10-08:
DR. MURRAY L.T. HOY

On May 12, 2005, in accordance with Section 47(1) (c) of The Medical Act, the Investigation Committee censured Dr. Murray Hoy as a record of its disapproval with respect to his conduct:

- in counter-signing prescriptions for American patients in violation of College Statement 805,
- in practising without ensuring that he had professional liability insurance coverage that extended to all areas of his practice as required by Regulation 25/03,
- in failing to maintain medical records with respect to his counter-signing practice in breach of Article 29 of By-Law No. 1 of the College.

I. PREAMBLE

In or about February 2002, the College published in its newsletter the full text of Statement 805 on prescribing practices as follows:

> "Prescribing of medications by physicians based solely on information received without direct patient contact fails to meet an acceptable standard of care and is outside the bounds of professional conduct. There is no direct patient contact when the physician relies upon a mailed, faxed or an electronic medical questionnaire or telephone advice to the physician."*

Counter-signing a prescription without direct patient contact fails to meet an acceptable standard of care and is outside the bounds of professional conduct.

In order to meet an acceptable standard of practice, the physician must demonstrate that there has been:

1. a documented patient evaluation by the Manitoba physician signing the prescription, including history and physical examination, adequate to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indications;
2. sufficient direct dialogue between the Manitoba physician and patient regarding treatment options and the risks and benefits of treatment(s);
3. a review of the course and efficacy of treatment to assess therapeutic outcome, and
4. maintenance of a contemporaneous medical record that is easily available to the Manitoba physician, the patient, and the patient's other health care professionals.

*An exception exists for physicians who are fulfilling responsibility as part of a call group."

Statements of the College represent the formal position of the College on a topic, and members of the College are expected to comply with Statements. Members of the College are also expected to be aware of all items published in the College newsletter.

Article 12 of the Code of Conduct provides

> "12. 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."

In the absence of direct contact with the patient, the physician has no direct knowledge of whether the patient has received information regarding the medication from the originating physician and it is not possible for the physician to obtain the informed consent of the patient in accordance with the requirements of Article 12 of the Code of Conduct.

Pursuant to Regulation 25/03, physicians are required to possess and maintain professional liability coverage that extends to all areas of the physician's practice, through either or both of membership in the Canadian Medical Protective Association and a policy of professional liability insurance that meets the requirements stipulated in Regulation 25/03.

Article 29 of By-Law No. 1 of the College requires members to maintain medical records on every patient.

II. THE RELEVANT FACTS ARE:

1. In or about July 2003, Dr. Hoy entered an arrangement

with a pharmacy that he would counter-sign prescriptions for American patients who were customers of that pharmacy.

2. Subsequently, he entered similar arrangements with at least thirteen additional pharmacies to counter-sign prescriptions for American patients who were the customers of those pharmacies.
3. Although the precise arrangements varied slightly from pharmacy to pharmacy, generally Dr. Hoy received from the pharmacy the patients' prescriptions and patient information forms. Dr. Hoy reviewed these documents and, if the prescription was acceptable to him, he counter-signed the prescriptions.
4. Dr. Hoy had no direct patient contact with the patients before counter-signing the prescriptions.
5. Upon receipt of correspondence from the College questioning his counter-signing practice, Dr. Hoy ceased counter-signing using his Manitoba licence, but continued to counter-sign using his Nunavut license. Dr. Hoy's explanation for not immediately ceasing counter-signing or taking appropriate steps to ensure that the pharmacy did not use his counter-signed prescriptions for any renewals or refills was that:
   a. Based on advice from pharmacies, Dr. Hoy understood that this was justifiable given the "virtual" nature of the business.
   b. Dr. Hoy understood he was bound by contractual arrangements with one or more of the pharmacies to continue to counter-sign until a replacement physician was hired, and was faced with civil litigation if he did not meet this commitment.
6. In his response to the College, Dr. Hoy stated that:
   a. He was not aware of the College's position on counter-signing prescriptions without direct patient contact until December 2003 when he received the College's letter questioning his role in counter-signing prescriptions.
   b. For the reasons set forth above, he continued to counter-sign prescriptions using his Nunavut licence until mid-January 2004. Dr. Hoy has not counter-signed prescriptions since that time.
   c. He had not seen the items published in the College newsletter respecting Statement 805.
   d. He acknowledged having breached Statement 805.
   e. He understands the College's concern that counter-signing prescriptions without direct patient contact fails to meet an acceptable standard of care.
   f. On reflection, he accepts the validity of the College's position, and accepts responsibility for his actions in failing to meet an acceptable standard of care when he counter-signed prescriptions without direct patient contact.
   g. At all material times he had CMPA coverage, and thought that this would provide him with liability coverage for counter-signing. However, he made no inquiries of CMPA in this regard. He now understands that CMPA is not prepared to provide coverage for counter-signing for American patients.
   h. Dr. Hoy has no medical records with respect to any of the patients for whom he counter-signed prescriptions, having either destroyed or returned to the respective pharmacies all of the material provided to him by the pharmacies.
   i. He has not counter-signed prescriptions since January 2004.

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

1. Counter-signing prescriptions for American patients in violation of Statement 805 of the College and in violation of the requirements of the Code of Conduct.
2. Practising without professional liability insurance coverage that extended to all areas of his practice in violation of Regulation 25/03.
3. Failing to maintain patient records in accordance with the requirements of By-Law No. 1 of the College.

In addition to appearing before the Investigation Chair, Dr. Hoy paid the costs of the investigation in the amount of $3,570.00.

Physician Resource Statistics

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 three times last year to consider financial matters and policy issues. They are all expected to serve on at least one College committee. In 2004, Council repealed the Qualifications and Legislation and Ethics Committees because they were not legislated committees. They have been replaced by Working Groups appointed by the Registrar.

Numbers Registered

The total number who received initial registration showed a decrease of 7. The number of University of Manitoba graduates increased to 36 from 30 and the total number of Canadian graduates increased to 33 from 19. The total number of African graduates has decreased from 38 to 22, in percentages from 31.4% in 2004 to 17% in 2005. The number of graduates from Asia increased to 23 in 2005 from 20 in 2004.

Numbers Practising

This year's total shows an increase of 10 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 decrease from 2004. The pool has been dropping steadily -- in 1998 it totalled 83 with 50 holding full licences. The 2005 residents with full licences remained the same as last year at 41 and the number of resident licences decreased from 24 to 21.

Distribution of Medical Practitioners by Source

The percentage of practising physicians who are Canadian graduates shows a slight decrease over the past five years (65.8%, 64.8%, 65.1%, 64.7%, 65.6%). The presence of Canadian graduates in Winnipeg is 74.9% compared to 37.5% in all other areas.

In contrast, graduates from Africa (primarily South Africa) are represented in reverse significance: 3.4% in Winnipeg compared to 39% 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 18 from last year (1036 to 1054). This figure is based on physicians currently residing in the province who are on the Specialist Register.

(A) **MEETINGS**

During the period 1 May 2004 to 30 April 2005, the following meetings were held -

3 Council: 18 June, 17 November 2004; 18 February 2005

5 Executive Committee: 2 June, 18 June, 15 September, 17 November 2004; 19 January 2005

6 Appeal Committee: 9 June, 15 September, 1 December 2004; 16 February, 9 March (2 panels) 2005

8 Complaints Committee: 22 June, 24 August, 21 September, 9 November, 21 December 2004; 1 February, 15 March, 26 April 2005

1 Finance Committee: 26 May 2004

1 Audit Committee: 3 November 2004

0 Inquiry Committee

2 Inquiry Panel: 20 May 2004; 25 January 2005

6 Investigation Committee: 14 July, 8 September, 27 October, 15 December 2004; 17 February, 6 April 2005

0 Legislation & Ethics Committee: committee repealed June 2004

0 Liaison Committee with M.M.A.

3 Program Review Committee: 22 September, 1 December 2004, 9 March 2005
In addition: 1 meeting of the Subcommittee on Laboratory Medicine
0 meeting of the Subcommittee on Nuclear Medicine
0 meeting of the Subcommittee on Diagnostic Imaging
0 meeting of Transfusion Medicine Working Group
1 meeting of Cytology Working Group
1 meeting of the Prescribing Practices Advisory Committee

1 Qualifications Committee: 19 May 2004; committee repealed June 2004

4 Standards Committee: 9 June, 6 October, 15 December 2004; 20 April 2005
In addition: (1 meeting of the Clinical Privileges Panel - panel disbanded June 2004
4 meetings of Child Health Standards Committee
4 meetings of Maternal & Perinatal Health Standards Committee
18 meetings of Area Standards Committees)

40 meetings
3 meetings of subcommittees, and
16 (12) hospital and (4) non-hospital reviews

(B) CERTIFICATES OF REGISTRATION ISSUED

During the period 1 May 2004 to 30 April 2005, 129 persons were issued registration and a full licence to practise. In total there were 142 certificates of which 13 were for a residency licence.

TABLE I MEDICAL PRACTITIONERS GRANTED REGISTRATION AND FULL LICENCE ANNUALLY IN MANITOBA 1996 - 2005 with Country of Qualification

Year	*Man*	*Can*	*USA*	*UK&I*	*Eur*	*Asia*	*Aust*	*NZ*	*Afr*	*C/S Am*	*Total*
1996	26	24	3	8	4	8	0	0	26	2	101
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
Total (10 Yr)	280	268	14	39	43	121	5	2	417	19	1208
New Practitioners % of Total 2005	27.9	25.6	1.6	2.3	4.7	17.8	0.0	0.0	17.0	3.1	100%

Percentages may not be exact due to rounding

(C) NUMBER OF LICENSED PRACTITIONERS IN MANITOBA AS AT 30 APRIL 2005

TABLE II NUMBER OF LICENSED MEDICAL PRACTITIONERS IN MANITOBA 1996- 2005

Year	Winnipeg	%	Outside Winnipeg	%	Totals	Net Gain Net Loss(-)
1996	1577	77.4	461	22.6	2038	-75
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

The total of 2186 includes 41 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*
2000	2016	42	2058	23	2081
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

(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.

	2005	**%**
Medical Students	349	
Postgraduate trainees	348	
Total On Clinical Assistant Register	697	91.8
On Residency Licence	21	2.8
Full Licence	41	5.4
TOTAL	**759**	**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 2005 (as a percentage)

		Winnipeg	**Brandon**	**Rural**	**Residency**
		1640	112	434	21
%	Man	59.1	29.5	29.7	23.8
	Can	15.8	15.2	6.0	42.9
	Total Canada	**74.9**	**44.7**	**35.7**	**66.7**
	USA	0.4	0.0	0.5	0.0
	UK & Irel	6.8	8.9	8.5	0.0
	Eur	4.1	5.4	3.5	9.5
	Asia	8.5	7.1	8.1	19.0
	Aust/NZ	0.4	0.0	0.7	0.0
	Afr	3.4	29.5	41.5	4.8
	S.Am	1.5	4.5	1.6	0.0

Percentages may not be exact due to rounding.

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

	2005
Manitoba Graduates	51.7
Other Canadian Graduates	13.8
TOTAL CANADA	**65.5**
United Kingdom & Ireland	7.2
Asia	8.4
Other	18.9

TABLE V **GEOGRAPHIC DISTRIBUTION OF FEMALE PRACTITIONERS**

	Winnipeg	**Brandon**	**Rural**	**Total**	**Resident Licence**
1982	213	8	44	265	51
2000	429	20	90	539	13
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

29% of fully licensed physicians are female, up 26 in actual numbers in the past year. 30% of practitioners in Winnipeg are women, 27.8% in Brandon and 25.3% in rural Manitoba. 28.6% of those with a residency licence are female. During the past 23 years there has been an increase of 279 women in Winnipeg, 23 in Brandon and 66 in the remainder of the province.

TABLE VI **AGES OF DOCTORS RESIDING IN MANITOBA AS AT 30 APRIL 2005**

	Winnipeg	**Brandon**	**Rural**	**Total**
Over 70	95 (5.8)	4 (3.6)	12 (2.8)	111 (5.1)
65 -70	92 (5.6)	8 (7.1)	17 (3.9)	117 (5.4)
56 - 64	283 (17.3)	19 (17.0)	47 (10.8)	349 (16.0)
46 - 55	504 (30.7)	34 (30.4)	109 (25.1)	647 (29.6)
36 - 45	480 (29.3)	32 (28.6)	142 (32.7)	654 (29.9)
31 - 35	152 (9.3)	11 (9.8)	77 (17.7)	240 (10.9)
30 or under	34 (2.1)	4 (3.6)	30 (6.9)	68 (3.1)

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 2004 to 30 April 2005

	Winnipeg	Brandon	Rural	TOTAL
Total	1640	112	434	2186
70+	88.8.%	50.0%	69.2%	85.5%
65 - 69	92.5	100.0	93.8	93.3
50 - 64	96.1	94.3	87.5	94.6
35 - 49	91.9	67.7	78.4	88.7
under 35	71.0	69.2	76.6	73.0
All Ages	91.3	83.9	80.6	88.8

(G) **MANPOWER CHANGES from 1 May 2004 to 30 April 2005**

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 2004 to 30 April 2005.

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 2004	ADDITIONS 2005		DELETIONS 2005	DELETIONS 2004
AGE				
38	22	30 or under	16	24
74	61	31 - 35	41	45
60	85	36 - 45	58	64
28	31	46 - 55	38	34
10	8	56 - 64	19	7
3	2	65 - 70	12	3
3	0	over 70	15	15
216	**209**		**199**	**192**
		YEARS SINCE QUALIFICATION		
52	43	5 or less	20	20
69	53	6 - 10	39	58
81	104	11 - 30	93	89
14	9	Over 30	47	25
216	**209**		**199**	**192**
		YEARS SINCE REGISTERED IN MANITOBA		
N/A	N/A	5 or less	96	99
		6 - 10	30	32
	11 - 30	48	43	
	Over 30	25	18	
		199	**192**	

ADDITIONS			*DELETIONS*	
2004	**2005**		**2005**	**2004**
		PLACE OF QUALIFICATION		
73	72	Manitoba	57	55
6	11	Alberta	10	11
1	2	B.C.	3	6
3	3	Atlantic Provinces	2	5
21	29	Ontario	19	19
4	2	Quebec	6	5
4	6	Saskatchewan	4	3
112	**125**	**TOTAL CANADA**	**101**	**104**
1	2	U.S.A.	3	1
6	8	U.K. & Ireland	18	9
9	7	Europe	10	2
26	29	Asia	15	16
0	0	Aust/N.Z.	1	0
58	33	Africa	45	59
4	5	C/S America	6	1
104	**84**	**TOTAL ALL OTHERS**	**98**	**88**
		TYPE OF PRACTICE		
48	70	Specialist	59	54
168	139	Non-Specialist	140	138
216	**209**		**199**	**192**

DEATHS or DELETIONS	**2005**	**2004**
Deaths	3	3
Transferred to Residency Licence	6	5
Removed from Register/Suspended	2	0
No Longer Practising/Retired	36	26
DEPARTURES to: (Total)	152	158
Atlantic Provinces	1	6
Quebec	4	2
Ontario	33	18
Saskatchewan	5	1
Alberta	17	12
British Columbia	16	14
NWT/NU	0	2
TOTAL CANADA	76	55
U.S.A.	7	14
U.K. & Ireland	4	3
Others/Unknown	65	86
TOTAL DELETIONS	199	192

(H) SPECIALIST REGISTER

There were 1054 specialists enrolled on the Specialist Register as at 30 April 2005.

(I) CERTIFICATES OF PROFESSIONAL CONDUCT (COPC)

During the period 1 May 2004 to 30 April 2005, 223 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 2004.

Provincial Licensing Bodies:	**2005**	**2004**
British Columbia	73	41
Alberta	38	36
Saskatchewan	5	8
Ontario	47	51
Quebec	3	6
Prince Edward Island	1	5
New Brunswick	1	0
Nova Scotia	1	6
Newfoundland	2	1
Northwest Territories/Nunavut	7	13
Australia & New Zealand	3	7
Overseas	4	11
U.S.A.	13	25
Miscellaneous	23	10
WRHA	52	65
TOTALS	**223**	**285**

Notices, etc…

Mark Your Calendar and Plan to Attend:

Advancing Quality in the Name of Patient Safety: Leading us To Excellence

When: Friday, November 4, 2005
Where: Winnipeg Convention Centre
Winnipeg, Manitoba

For further information, contact Strauss Communications at 947-9766.

Council Meeting Dates for 2005-2006

The Council will be meeting on the following dates during the 2005-2006 College year:

- Friday, November 18, 2005
- Friday, March 17, 2006
- Friday, June 16, 2006.

These meetings will be held at the Clarion Hotel beginning at 9:00 a.m. Members of the College who are interested in attending the meeting as observers are asked to notify the College at 774-4344 for registration. Registration is necessary because seating is limited.

Approved Billing Procedure

When physicians wish to recruit a colleague to carry out the practice of medicine in their place and bill in their names, the College must be advised ***in advance*** and approve the specific time interval. Only when written approval is received may a physician act in place of another.

Without written approval as a locum tenens, one physician may replace another, but must act and bill independently.

Changes of Address

Occasionally a doctor has failed to receive communications from the College because of a change of address which has not been given to us. All members must notify the College, even by telephone, of any change of address so that communications can be kept open. Please note that the College Bylaws require notification within 15 days. The College cannot be responsible for failure to communicate to registrants who have not notified us of address changes, or the results of such failures.

Moving? Retiring?

If you are leaving the province or retiring from practice, By-law #1 requires that you advise where your records will be stored, so that we may note it on your file and advise interested parties. The By-Law requires that any member who has not practised in the province for a period in excess of two years without the permission of Council shall, in accordance with section 16(1) of The Medical Act, be struck from the Register. The effective date of erasure shall be two years after that member's cessation of practice.

Officers and Councillors 2005-2006

President:	Dr. R. Graham
President Elect:	Dr. H. Domke
Past President:	Dr. M. Roy
Treasurer:	Dr. B. MacKalski
Investigation Chairman:	Dr. L. Antonissen
Registrar:	Dr. W. Pope
Deputy Registrar:	Dr. T. Babick
Assistant Registrar:	Dr. A. Ziomek
Assistant Registrar:	Ms. D. Kelly
Chair of Council:	Dr. R. Graham

Term expiring June 2006

Central Plains	Dr. L. Antonissen, Portage
Interlake	Dr. C. Chapnick, Gimli
Interlake	Dr. R. Graham, Selkirk
Northman	Dr. K. Sethi, Flin Flon
Parklands	Dr. D. O'Hagan, Ste.Rose
Winnipeg	Dr. A. Alvi
	Dr. N. Goldberg
	Dr. J. James
	Dr. A. MacDiarmid
	Dr. S. Sharma
	Dr. R. Onotera
	Dr. K. Saunders
	Dr. S. Sharma
	Dr. E. Stearns
	Dr. R. Suss
University of Manitoba	Dr. W. Fleisher
Public Councillor	Mr. W. Shead
Public Councillor	Ms. S. Hrynyk

Term expiring June 2008

Brandon	Dr. B. MacKalski
Eastman	Dr. B. Kowaluk, Oakbank
Northman	Dr. N. Nwebube, Thompson
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 (expires 2006)	Mr. Y. Abdulrehman