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 YOUR NEW PRESIDENT DR. DANIEL LINDSAY

"I am a Doctor, Trust Me"

Something remarkable happened in Canada 146 years ago. Shortly after the creation of the Canadian Federation, the Canadian Medical Association (CMA) was formed. Its first President was a physician by the name of Sir Charles Tupper. He was subsequently to become Canada's sixth Prime Minister. As a founding member of Confederation, he understood the moral and legislative responsibility of government to protect its citizens from harm. The creation of professional organizations such as the CMA emerged within the context of the requirement for licensing and regulations in the newly minted Dominion. Sir Charles Tupper and the other one hundred and twenty-seven physicians of the CMA were

convinced that they had the knowledge, skills and wisdom to regulate themselves. The premise was, and remains, that the practice of medicine is complex, thus making direct regulation by government and non-professionals difficult. It is within this historical and philosophical context that the provincial governments have empowered physicians to enter into a social contract with our patients.

Social contracts are a compromise. Patients relinquish some freedoms but benefit in the knowledge that they will receive competent professional care from a licensed physician. The legislation that governs this social contract is ever evolving and the newest iteration is the Regulated Health Professions Act (RHPA). The social contract, however, remains the same; decisions made must always be in the patient's best interest. We as doctors are provided the privilege to determine who can join the profession through controlling licensure, certification, and registration. It is the expectation of government, acting as the patient's agent, that the decisions made by a regulatory body, such as The College of Physicians and Surgeons will always be in the best interest of the patient. It is this expectation that engenders trust in physicians.

"Trust me, I am a physician".

I recently met one of my colleagues who, knowing that I was a College Councilor, stated that he thought that: "The tail was wagging the dog" and that "The College regulations and oversight had become onerous". I have since reflected upon this observation.

Our College Council is currently comprised of sixteen elected physicians, two faculty physicians and four public representatives. In Canada the regulatory authorities have maintained their leadership role but are under increasing pressure to adapt and ensure the competency of physicians.

The question of self-regulation became controversial in Britain, particularly after the Harold Shipman inquiry in 2006 when the CEO, Finlay Scott stated that: "self-regulation has served patients in the public well but is no longer credible". The General Medical Council (GMC) of Britain under the British Medical Act "functions to protect, promote and maintain the health and safety of the public". The GMC has since lost its senior role in regulating physicians in Britain and physicians have lost their majority on the Council of the GMC. In Canada the Colleges continue to provide guidance in an environment of ever expanding knowledge and skills and maintain their senior leadership role that was embodied in the original social contract. It is we physicians who are the signatories to the social contract and as such must hold the College responsible to uphold and maintain the ideals originally conceived and created by our forbearers such as Sir Charles Tupper. I would imagine that Sir Charles Tupper would say that physicians and not government are half of the physician-patient relationship. Ultimately, licensing, credentialing, competency assessment and standards are our responsibility and privilege. Remembering this, please read and understand carefully the implications of the newly drafted and soon to be circulated medical by-laws that are to be reviewed by the College of Physicians and Surgeons of Manitoba as well as Doctors Manitoba. You have Councillors who represent you; get to know them. They are your College resource; give them your ideas and your wisdom which will be incorporated into good governance.

Recently another colleague, when being interviewed for the position of Chair of the Department of Family Practice, was light heartedly asked if the university and in turn the profession should provide a warranty on physicians. He replied "Yes". This answer comprises one of the responses that when made collectively represents the responsibility that we have if we are to retain our status as a trusted self-regulating profession.

The College remains relevant and credible if the statement: "We are doctors, trust us" is affirmed by our patients.

Sincerely yours
Daniel J. Lindsay, MD FRCPC

NOTES FROM THE REGISTRAR

Fellow Members of the College,

Welcome to our new members. This is the busiest time of the year for the Qualifications Division of the College. Nearly eight hundred members of the educational register are licensed at this time. Manitoba, like many other provinces, registers and licenses all undergraduate medical students. In particular we welcome the new Medicine 1 class and I look forward to meeting with you at the inaugural ceremonies in August. As well there are many new residents. Nearly seventy percent of the graduating students in the medicine class of 2013 have chosen to remain in this province for postgraduate training. Congratulations. You have made a wise choice. In addition we welcome those who come from other provinces into residency positions. We especially welcome those international medical graduates who were successful in the CaRMS match this year. As well there are new physicians from other jurisdictions who are joining us here. Welcome to a beautiful prairie summer.

With that introduction, I encourage everyone to consider carefully the comments by your President, Dr. Dan Lindsay, which open this newsletter. Dr. Lindsay notes the importance of professional regulation in medicine. Indeed, the Medical Act was one of the first pieces of legislation enacted in the province of Manitoba after we entered Confederation in 1870. The College has been in operation for over one hundred twenty-five years reviewing, licensing, and regulating physicians in this province. Dr. Lindsay identifies the social contract that has always existed between the people of Manitoba and licensed physicians. As doctors, we are granted extraordinary privileges. First of all, we may intrude into the minds and bodies of our patients to a greater extent than anyone else in society is permitted to do. Second, we are granted the privilege of deciding who may be a physician and of issuing that registration and license to practice. Third, it is we as physicians who have the privilege of reviewing concerns about practise and complaints raised by patients and then determining the outcome of those concerns. It is only the College that can make a decision regarding a physician's right to practise medicine. Finally, the people of Manitoba through the government have set up the College of Physicians and Surgeons of Manitoba, a physician organization, to ensure that the enormous privileges we are granted are not abused but rather that we carry out the expectations of society and always make decisions that are in the best interest of the patient. We can only do that if we remain competent and respectful of our patients.

Every province has a College of Physicians and Surgeons. Of greater interest is that at the present time, each of those Colleges has a CEO, a Registrar, who is a licensed physician in that province. Furthermore, all the Colleges' Councils are composed, by government legislation, of a majority of physicians. As Dr. Lindsay has noted, this is not the case in many other countries in the developed world.

We all recognize that the only stability in our lives these days is constant change. Your College and Council spend much time at their meetings deliberating how to be proactive in this process and ensure that we are sufficiently trusted to retain the leadership role your College presently occupies in medical regulation in this province. Your Council, composed of elected members, balances all these expectations along with physicians' need to be able to practise medicine without being impaired by bureaucracy.

Remember, YOU ARE THE COLLEGE.

On another note, a number of important issues are moving forward:

1. The Regulated Health Professions Act
   You have been hearing about this act for some years now. We expect that it will be fully operational in September, 2014. However, a new Code of Conduct and a document called the "Standards of Practice", which incorporates some aspects of previous Statements, has been approved by Council. As well, Statements and Guidelines will now be called "Practice Directions". Following the September Council meeting, these three documents will be made available on the web site and will be sent to other Colleges of Physicians and Surgeons in Canada and other health regulatory authorities in Manitoba for further comment. I strongly

encourage each of you to review these documents and comment back to us. The final draft will be presented to Council for approval in December, 2013. As well, the Registration Regulation is being revised to make it more up-to-date and useful. In particular, the Faculty of Medicine at the University of Manitoba has had significant input into these regulations.

The final draft of the medicine part of the RHPA will be available on the web site prior to its becoming law. Future newsletters will identify this as well.

2. The Agreement on Internal Trade
   This is generally present now in Canada. Any physician who is fully registered in a Canadian jurisdiction is now eligible for full registration in any other Canadian jurisdiction as a physician. This will make labour mobility much easier in the future.

3. Fairness Commissioner Review of the CPSM
   The Fairness Commissioner has completed her first review of our College with regard to registration. She will be posting the report on her web site and when that occurs, it will also be uploaded onto the College's web site. We have had some very useful discussions. She suggests that our registration web site be improved and easier to use, and the qualification staff are working very hard to ensure that happens. We have also met with her and with Dr. Ian Bowmer, the CEO of the Medical Council of Canada with regard to the Evaluating Examination and the QE1. The Fairness Commissioner is responsible for ensuring that our College does treat fairly all those who are applying for registration particularly those from outside Canada.

4. Annual Renewals
   It's that time of year again. Please remember that we must have your renewal by August 31, 2013.

5. Provincial Medical Leadership Council
   The three College Registrars sit on this body along with the Chief Medical Officers of the regions and representatives from Cancer Care Manitoba and DSM. The work in progress is to define privileging requirements both for initial registration and on-going privileging for all health institutions throughout the province. This will ensure consistency for all.

All of us at the College hope that you enjoy a sunny, warm, relatively mosquito free summer.

William D.B. Pope
Registrar/CEO

FACULTY OF MEDICINE UP-DATE

The University of Manitoba Faculty of Medicine convocation was held May 16 on Bannatyne Campus. Degrees were conferred on 105 medical school graduates: 56 females and 49 males, including four Aboriginal students and 26 with rural attributes which include rural roots, rural work experience or rural volunteer experience.

Exceptional graduates included the Faculty's first deaf student Megan Jack; Brett Houston, who helped solve a blood mystery during her B.Sc. (Med) summer research program; Tito Daodu, an inspiration to youth from West Broadway whom she mentored; and Donna Neufeld, a 48-year-old mom of four who showed perseverance at achieving her dream of becoming a physician and intends to practice Family Medicine in a rural Manitoba community.

Elder Harry Bone, BA received an Honorary Doctor of Laws from the U of M at convocation. He has worked tirelessly and quietly throughout his life to bolster Indigenous rights. He serves as a source of inspiration to the Faculty of Medicine, which shares his goal of improving the lives of Indigenous peoples by respecting their individual and collective rights.

We have been working closely with the Province of Manitoba to expand our distributed medical education sites. The Manitoba government announced in early May, 15 new medical residency positions including eight new Family Medicine residencies in rural Manitoba in Brandon, Morden/Winkler and Steinbach.

This followed recommendations from the Brandon Medical Education Study announced last summer by Advanced Education and Literacy Minister Erin Selby and Health Minister Theresa Oswald.

The study recommended focusing first on post-graduate medical training in Brandon and other rural communities by creating more medical residencies.

In addition to these new positions, we currently offer nine residency positions in our Family Medicine Rural Stream in Dauphin and Brandon and 15 residency spaces in our Family Medicine Northern/Remote Stream.

The Brandon Medical Education Study also recommended creating community campuses with clinical teaching units for third and fourth-year medical students interested in rural practice.

To that end, I have appointed an Associate Dean, Dr. Charles Penner, and Assistant Dean, Dr. Joanne Maier, of the Brandon Satellite Program, Faculty of Medicine, University of Manitoba. They are both based in Brandon.

Lastly, if you work around HSC, you may have noticed a house being built on McDermot Ave. in one of our parking lots! We are the first Faculty of Medicine in Canada to partner with Habitat for Humanity to build a home for a family in need. During the two-week build, we had more than 125 student, faculty and staff volunteers on the build. Thanks to everyone who volunteered and supported the build through donations to make it such a success! The home will be moved in August to its permanent location in East Kildonan and the family of six is expected to move in late fall.

Brian Postl MD, Dean
Faculty of Medicine, University of Manitoba

UNIVERSITY OF MANITOBA

Codeine Use in Pediatric Patients

Codeine is a weak opioid that is used to treat mild to moderate pain in both children and adults. Recently, the WRHA Child Health Pharmacotherapy Subcommittee recommended removing codeine and codeine-containing products from the hospital formulary following increasing safety concerns regarding the use of codeine, particularly in children. At this point, removal of codeine from pediatric patient care areas is voluntary, as the committee needs to work with various stakeholders prior to any formal implementation.

The Issue

Codeine requires metabolism by the CYP2D6 liver enzyme into its active form, morphine, in order to provide analgesia. CYP2D6 displays significant genetic polymorphism; up to 10% of the population are poor metabolizers of codeine, while ultra-rapid metabolizers occur in 0.5 to 1% of Chinese, Japanese and Hispanic patients, 1 to 10% of Caucasian patients, 3% of African American patients, and 16 to 28% of North African, Ethiopian, and Arab patients.(1)

A “normal” metabolizer converts approximately 10% of a dose of codeine into active morphine. Poor metabolizers will create little, if any, morphine and thus will experience minimal analgesia. Rapid or ultra-rapid metabolizers can produce 50 – 75% more morphine than a “normal” metabolizer, which can lead to significant side effects, including respiratory depression and death.(2-5) These effects are related to both dose and duration of codeine use.

The same effect is seen in mothers who breastfeed their infants; in nursing mothers who are ultra-rapid metabolizers, morphine levels are much higher in breast milk, which has led to apneas and death in newborns.(6)

Genetic polymorphism is unpredictable and therefore it is very difficult to know how patients will respond to codeine.

The Literature

More Codeine Fatalities After Tonsillectomy in North American Children – Kelly et al, Pediatrics 2012 (3)

- Three case reports of North American children (2 in Canada) who were prescribed age/weight appropriate doses of codeine post-op tonsillectomy.
- Two children died and one required resuscitation, mechanical ventilation and naloxone.

Is maternal opioid use hazardous to breast-fed infants? – Hendrickson and McKeown, Clinical Toxicology 2012(6)

- 6 case reports involving breastfeeding mothers who used codeine and their infants.
- Infants experienced apneas, bradycardia, sedation and death.

Health Canada also published an advisory statement in 2008 which warns health care providers and the public about the risks of codeine use in breastfeeding mothers. (1) More recently, Health Canada released a recommendation that codeine and codeine-containing products should not be used in children less than 12 years of age. (7)

Therapeutic Alternatives

Given the variable metabolism and subsequent safety concerns with codeine, the following oral analgesics are recommended for pediatric patients:

1) For mild to moderate pain:
   a. Acetaminophen 10 – 15 mg/kg/dose PO q4-6h PRN (do not exceed 5 doses/day; adult maximum dose 4 g/day)
   b. Ibuprofen 4 – 10 mg/kg/dose PO q6-8h PRN (max: 40 mg/kg/day; adult maximum dose 3.2 g/day)

2) For moderate to severe pain:
   a. Morphine (immediate release) 0.1-0.2 mg/kg/dose PO q4-6h PRN (can increase to a maximum of 0.5 mg/kg/dose; usual maximum adult dose for opioid naive patients 30 mg q4h)
   b. Hydromorphone (immediate release) 0.03-0.08 mg/kg/dose every 3-4 hours as needed (up to 2 mg/dose for opioid naïve patients).

Scheduled analgesia as opposed to "as needed" analgesia is suggested to control pain as recommended by the World Health Organization. (8)

Common Misconceptions

1) Morphine is more dangerous than codeine.
   a. **False.** Morphine is a much more predictable and reliable analgesic without genetic variability in its metabolism. Codeine metabolism is varied and hence a less safe alternative.

2) Codeine has fewer side effects than morphine.
   a. **False.** Codeine has the same side effect profile as all opioid analgesics.(9) Poor metabolizers are at an increased disadvantage; they experience the same side effects without the analgesia.

3) Morphine is too hard to prescribe and too hard for families to acquire in the community.
   a. **False.** Morphine is a common narcotic and is available in numerous dosage forms (multiple tablet strengths, as well as 2 commercially available oral solutions). Community pharmacists are able to assist patients with any questions or concerns they have regarding the use of this medication.

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WRHA Child Health Pharmacotherapy Subcommittee

Availability of Codeine & Codeine-Containing Products at Winnipeg Children's Hospital

In light of growing safety concerns regarding the use of codeine, particularly in younger children, the WRHA Child Health Pharmacotherapy Subcommittee has been working towards removing codeine and codeine-containing products (eg. Tylenol with codeine elixir, Tylenol No. 3) from the Pediatric Formulary. However, we acknowledge that there are areas where this would result in a significant practice change, and we need to work with several stakeholders prior to implementing any formal plans. At the same time, recognizing the potential patient safety concerns, there are some areas that wish to proceed with this initiative as soon as possible.

We have developed a document outlining the safety concerns regarding the use of codeine, as well as some information about alternative analgesic options. We hope that this information is helpful for those areas wishing to proceed with this initiative in advance of a more formalized plan. See also the recent Health Canada warning regarding the use of codeine-containing products in children; new product labeling will indicate that these medications are no longer recommended in children less than 12 years of age (http://www.healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2013/33915a-eng.php#issue-problem)

Should you have any questions about this issue or would like more information regarding implementation of this initiative, please contact Brendon Mitchell, Regional Pharmacy Manager at bmitchell2@exchange.hsc.mb.ca.

WRHA Child Health Pharmacotherapy Subcommittee

Crossing the Border with Electronic Devices

Do you carry an electronic device when crossing the border? If you do, you need to think about more than roaming and long-distance charges. Be cautious of what information on the device might be disclosed to border authorities.

We all carry electronic devices of some type, be it laptops, tablets, iPads, iPhones, BlackBerries, cellphones and so on. All of these devices are capable of storing large amounts of information. This is of special concern when you use the electronic device for work—in addition to any personal information, the device likely contains confidential work information, and possibly personal health information and personal

information that we are required by law to keep confidential.

Also of concern are storage media like CDs and USB drives—especially if you are taking information to a conference or a meeting. These media may store other unrelated information as well. Be aware that border authorities of all countries (including Canada) reserve the right to take your electronic device and to review the data on it. This includes emails, text messages, telephone numbers called, contact lists, photos and documents. They may keep your device for the purpose of downloading data for further review, and some countries may even take the opportunity to install tracking software.

What can you do?

1. First, always remember that border authorities are authorized by law to inspect your electronic device. Therefore, always comply with the law and with the authorities' demands for your device.

2. If you are planning to cross a border, take a moment to reflect on the electronic devices you have with you and whether you really need to take them into another country. This is especially important for work-related electronic devices—is the use you plan to make of them worth the risk of information on the devices being disclosed to border authorities? For example, if you are not planning to incur roaming charges, do you need your work BlackBerry with you on a weekend trip to Fargo? Could you take the USB key off your keychain and leave it at home?

3. Reflect on the data contained in the device. Is it highly sensitive? Could it be viewed by law enforcement authorities as possibly illegal? Is it something that you would find personally embarrassing if others saw it? The border is not the right time to assert that your iPad contains personal health information—perhaps you should have thought of that before you left home.

4. If you are taking a device across the border, especially a storage device such as a CD or USB key, see what data can be deleted first. That way, you minimize the information that could be exposed.

5. In the unlikely event that border authorities take temporary possession of your device and you lose sight of it for any period of time, don't turn it back on until you have first confirmed that nothing was installed by those authorities.

We all take devices across the border. We need to be mindful of the risks and take appropriate steps to protect any sensitive information on those devices.

For more information, contact Manitoba eHealth at manitoba-ehealth communications@manitoba-ehealth.ca.

Manitoba eHealth
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ADVANCED MATERNAL AGE

In 2011, the SOGC and CCMG jointly published a clinical practice guideline stating that:

- Maternal age alone is a poor minimum standard for prenatal screening for aneuploidy, and it should not be used as a basis for recommending invasive testing when non-invasive prenatal screening for aneuploidy is available.
- All pregnant women in Canada, regardless of age, should be offered, through an informed counselling process, the option of a prenatal screening test for the most common clinically significant fetal aneuploidies in addition to a second trimester ultrasound for dating, assessment of fetal anatomy, and detection of multiples.

In light of this, the Program of Genetics and Metabolism will no longer be accepting referrals for Advanced Maternal Age (AMA) as the sole indication. It is felt that these services can be more appropriately offered through a patient's primary care physician, obstetrician/gynecologist or midwife at their first prenatal visit.

First trimester nuchal translucency ultrasounds will still be available to women ≥35 years of age at delivery. These can be ordered directly through

your office for eligible patients. Both Women's Hospital and St Boniface Hospital Fetal Assessment Units have appropriately trained staff to provide these ultrasounds.

Positive Maternal Serum Screen results should still be referred to Genetics for follow up as done previously. Referral forms can be obtained from the genetics and metabolism program website http://www.wrha.mb.ca/prog/genetics/.

Bernie Chodirker MD, FCCMG, FRCPC
Medical Geneticist
WRHA Program in Genetics and Metabolism

Hemoglobinopathy Screening

In 2008, the SOGC recommended that carrier screening for thalassemia and hemoglobinopathies should be offered to a woman if she and/or her partner are identified as belonging to an ethnic population whose members are at higher risk of being carriers. Ideally, this screening should be done pre-conceptionally or as early as possible in the pregnancy. From a practical view, any woman of reproductive age who is not Japanese, Korean, Caucasian of Northern European ancestry, First Nations, or Inuit should be screened. A hemoglobinopathy investigation should be sent using a special requisition available from DSM (https://apps.sbgh.mb.ca/labmanualviewer/index.do). This test will include a CBC, ferritin and hemoglobin electrophoresis. If the woman is found to be a carrier, then a referral to genetics and metabolism is indicated. Referral forms can be obtained from the genetics and metabolism program website http://www.wrha.mb.ca/prog/genetics/.

Bernie Chodirker MD, FCCMG, FRCPC
Medical Geneticist
WRHA Program in Genetics and Metabolism

Electronic Progress

The College is moving towards being more accessible electronically and creating processes for electronic interaction.

1. On-line licence renewal is now available.
2. For the upcoming 2014 election voting will be conducted electronically. As a result, all members are required to provide the College with a current email address.
3. In the fall of 2014 registration should also be available on-line.

Seat Belt & Helmet Exemptions

It has been brought to the attention of the Registrar that some members continue to provide exemptions for seat belt and helmet use to their patients. Members are reminded of the College's statement with respect to seat belt and helmet exemptions. Statement #156 states that despite the fact that a physician may legally write an exemption for a certificate, the College of Physicians and Surgeons states that there are no medical conditions that justify exemptions from using a seat belt or a helmet and therefore no seat belt or helmet exemption should be issued.

Access to Records under the Missing Persons Act

On May 29, 2013 the *Missing Persons Act* came into effect in Manitoba. This new Act allows police to obtain certain information about a person who is missing for the purpose of trying to locate that person. The information which must be made available to police may include personal health information about the person.

Under the Act, police may either apply for a Record Access Order or, in an emergency, the police may make an Emergency Demand seeking this

information directly to any person. The Record Access Order is an Order made by the court. The Emergency Demand can only be made by the police when they believe the missing person may be at imminent risk of serious bodily harm or death and they are unable to obtain the Order in a timely basis.

Under a Record Access Order the police may obtain access to "records containing personal health information". Under an Emergency Demand police may obtain "records containing personal health information to the extent that the records might indicate if the missing person has recently been admitted to a hospital and, if the records do so indicate, which hospital and the date and time of, and the reason for, admission".

The records obtained by the police may only be used by them and disclosed by them in accordance with the requirements under the *Personal Health Information Act*. Any person providing this information to the police is protected from liability in respect of anything done in good faith under the Act.

Should any of our members have any questions regarding this matter please contact the College for further information or guidance.

CAN CLINICAL ASSISTANTS AND PHYSICIAN ASSISTANTS PRESCRIBE DRUGS AND ORDER DIAGNOSTIC TESTS?

Yes they can! They are permitted to issue prescriptions and order diagnostic tests subject to the limits imposed on them by their supervising physicians and their practice descriptions. The authority and limitations are set out in Manitoba Regulation 183/99, the Clinical Assistants and Physicians Assistants regulation. The sections pertaining to this question are quoted below.

16(1) "A clinical assistant (Cl.A)or a physician assistant (PA) may issue prescriptions only for medications which the supervising physician has determined the assistant is qualified to prescribe in accordance with the practice description approved by the council."

16(2) "A prescription issued by a clinical assistant or a physician assistant must include the name of the supervising physician and the name and designation – either "PA" or "Cl. A" – of the assistant."

16(3) "The Council may require an applicant for registration as a clinical assistant or a physician assistant to document adequate training and experience in pharmacology commensurate with the practice description and require the applicant to pass a pharmacological examination."

7(1) "A supervising physician shall not delegate to a clinical assistant or a physician assistant a duty or responsibility for which the assistant is not adequately trained."

7(2) "A supervising physician shall not delegate to a clinical assistant or a physician assistant a duty or responsibility the supervising physician is not competent to perform himself or herself."

7(3) "A supervising physician shall not permit a clinical assistant or a physician assistant to provide medical services in an area of practice in which the supervising physician does not provide services."

14(1) "A clinical assistant or physician assistant shall not perform medical services unless they are included in the practice description approved by the council."

CONGRATULATIONS

CONGRATULATIONS TO THE FOLLOWING PHYSICIANS WHO RECEIVED THE ORDER OF MANITOBA

- ***Dr. Francis Patrick Doyle*** – During a five-decade career as a physician, Dr. Doyle has contributed to improvements in health care in Manitoba and across Canada. He was instrumental in creating an entire health-care industry in Ste. Anne including a hospital, a pharmacy and a personal care home. Dr. Doyle was a member of the Manitoba Hospital Commission and president of the College of Physicians and Surgeons of Manitoba and is a senior member of the Canadian Medical Association. He served as chair of the St. Boniface Hospital board from 1978 to 1988. He is also a member of the Order of Canada.

- ***Dr. Tse Li Luk*** – Dr. Luk is a family physician and award-winning photographer whose professional and volunteer work is highly valued in the Chinese-Canadian community and the community-at-large. He was president of medical staff in Vita before joining the Misericordia and Victoria hospitals in Winnipeg in 1997. He is a partner in the Linden Ridge Medical Clinic, a lecturer at the University of Manitoba and on staff at the Pan Am Clinic's Pain Clinic. He also owns a photography gallery and donates his time, expertise and photographs to many community and charitable organizations. His work has been exhibited in Canada and abroad and has been presented to The Queen.

- ***Dr. Allan Ronald*** – Dr. Ronald is professor emeritus in the faculty of medicine at the University of Manitoba and was head of the university's department of internal medicine and physician-in-chief at the Health Sciences Centre. He is internationally respected, particularly in his pioneering work with HIV-AIDS in Africa and under his leadership, the U of M became the pre-eminent national centre for research and training in that field. In 1980, he helped found the U of M/University of Nairobi world Health Organization Research and Training Program in Sexually Transmitted Diseases, which became an epicenter for research on HIV-AIDS in East Africa. In 1987, he convinced the City of Winnipeg to donate land to build the National Virology Lab which has been essential to the control of epidemics and other diseases. He is currently an advisor to the International Centre for Infectious Diseases and an officer in the Order of Canada.

CONGRATULATIONS TO THE FOLLOWING PHYSICIANS WHO WERE HONOURED BY DOCTORS MANITOBA AT ITS AGM IN MAY 2013:

- ***Dr. Brent Schacter*** – Distinguished Service Award - In recognition of service rendered to patients and the community which have enhanced the image of the physician through devotion to the highest ideals of the medical profession.
- ***Dr. James Blanchard*** – Scholastic Award – For scholarly activity in the health profession.
- ***Dr. Catherine Cook*** – Health Administration Award – For contribution to policy and administration in health care.
- ***Dr. Denis Fortier*** – Physician of the Year – For significant contribution to the practice of medicine and to the community by a member of Doctors Manitoba.
- ***Dr. Jack Armstrong*** – Humanitarian Award – For outstanding contributions by a member or former member of Doctors Manitoba in the service of humanity either in Canada or abroad.

FROM THE INVESTIGATION COMMITTEE:

Recently the Investigation Committee reviewed a case where a patient had an extensive soft tissue infection of the hand. A repair was undertaken in the Emergency Room under local anaesthetic. The anaesthetic was infiltrated directly into the hand. Consent was obtained, but the repair was extremely painful and it was acknowledged by the physician administering the anaesthetic that such repairs are commonly painful given that it is very difficult to adequately anaesthetize in that manner. The physician felt that other anaesthetic options such as a regional or general anaesthetic would have delayed treatment and introduced additional risks and that these were unacceptable under the circumstances.

The Investigation Committee was not convinced that a regional block could not have been achieved by an anaesthetist on call within a reasonable time frame. The Committee did recognize that it was possible that had an anaesthetist been called, the anaesthetist might have been unable to provide the block in a timely manner. The Committee encourages members of the profession to consider alternatives to local anaesthesia when it is expected that local anaesthesia will be inadequate. If it proves impossible to obtain an alternative anaesthetic in a timely manner, this should be explained to the patient and documented in the chart.

From the Complaints Committee:

Reminder: Manitoba Vital Statistics Agency requires that all physicians complete the "Registration of Death" form in a clear, legible manner and that these completed forms be returned to the Agency within 48 hours as stipulated in *The Vital Statistics Act*. Please note that the Agency is unable to register the death without this document. Should you require information on the proper completion of these forms, you are encouraged to contact the Agency at 204-945-3701 or via email to dirvitalstats@gov.mb.ca and a guidebook will be forwarded to you.

From the Standards Committee:

Lethal Consequences from the Recreational Use of the Antidepressant Bupropion (Wellbutrin®, Zyban®)

The Office of the Chief Coroner of Ontario is aware of at least 6 cases in which the recreational use of Bupropion by inhalation or injection was a causative factor in the death. In these cases, Bupropion was injected or inhaled alone or in combination with other illicit or prescribed drugs. Injection use may be associated with significant tissue necrosis at the injection site, leading to death in some cases.

Physicians should be aware of the potential for recreational use of Bupropion via inhalation or injection when considering prescribing this medication, and when treating patients presenting with complications of use via these atypical routes.

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

The Central Standards Committee reminds members that this guideline, which contains comprehensive and current information regarding the use of opioids to patients with chronic non-cancer pain safely and effectively, also contains a section on managing misuse and addiction. The guideline can be accessed at http://nationalpaincentre.mcmaster.ca/opioid/documents.html

From the Child Health Standards Committee

Item Correction January 2013 Newsletter

Severe Combined Immunodeficiency (SCIDS)

The incidence of SCIDS is higher among Athabascan-speaking Native Americans, including Navajo and Apache Indians from the southwestern US and Dene Indians from the Northwest Territories. In Manitoba and Saskatchewan, a number of cases of SCIDS have been identified in Northern Cree families, in particular Norway House and South Indian Lake.

Lynne Warda, MD, FRCPC
Medical Consultant
Child Health Standards Committee (CHSC)

MEETINGS OF COUNCIL FOR THE 2013-2014 COLLEGE YEAR

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

- Friday, September 13th, 2013
- Friday, December 13th, 2013
- Friday, March 14, 2014
- Wednesday, June 4, 2014

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

REMINDERS FROM COUNCIL

Licence Renewal – On-line licence renewal is now available at https://renewals.cpsm.mb.ca.

Final Due Date for Licence Renewal

August 31, 2013.

If you have not received your licence renewal form please contact the College: renewals@cpsm.mb.ca

Electronic Voting – You are required to provide a current email address for upcoming electronic voting. Please ensure you include your email address on your licence renewal form.

OFFICERS AND COUNCILLORS 2013-2014

President:	Dr. D. Lindsay
President Elect:	Dr. B.Kvern
Past President:	Dr. B. Kowaluk
Treasurer:	Dr. A. Vorster
Investigation Chair:	Dr. A. MacDiarmid
Registrar:	Dr. W. Pope
Deputy Registrar:	Dr. T. Babick
Assistant Registrar:	Dr. A. Ziomek

TERM EXPIRING JUNE 2013

Associate Members Register (exp. Sept. 2013)	Dr. E. Cohen

TERM EXPIRING JUNE 2014

Central	Dr. E. Persson, Morden
Interlake	Dr. D. Lindsay, Selkirk
Northman	Dr. H. Tassi, Thompson
Parkland	Dr. J. Elliott, Grandview
Winnipeg	Dr. M. Burnett
	Dr. A. MacDiarmid
	Dr. R. Onotera
	Dr. B.T. Henderson
	Dr. W. Manishen
University of Manitoba	Dr. I. Ripstein
Public Councillor	Mr. R. Dawson
Public Councillor	Mr. R. Dewar

TERM EXPIRING JUNE 2016

Brandon	Dr. S. J. Duncan
Eastman	Dr. K. Bullock Pries
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 Councillor	Dr. E. Boldt
Public Councillor	Ms L. Read

PHYSICIAN RESOURCE STATISTICS 2013

(A) MEETINGS

During the period 1 May 2012 to 30 April 2013, the following meetings were held -

4 Council: 1 June, 14 September, 14 December 2012; 15 March 2013

3 Executive Committee: 14 May, 1 June, 14 December 2012

3 Appeal Committee: 14 September, 23 November 2012; 15 March 2013

7 Complaints Committee: 15 May, 26 June, 21 August, 25 September, 23 October, 20 November 2012; 15 January, 5 March, 23 April 2013

2 Audit Committee: 2 June 2012, 9 November 2012

0 Inquiry Committee

6 Inquiry Panel: 23 May, 8 June, 11 September, 14 September 2012; 19 March, 25 April 2013

5 Investigation Committee: 30 May, 12 September, 5 December 2012; 20 February, 24 April 2013

4 Program Review Committee: 28 May, 10 September, 10 December 2012; 25 February 2013

4 Standards Committee: 13 June, 21 September 2012; 1 February, 5 April 2013

In addition: 3 meetings of Child Health Standards Committee
1 meeting of Maternal & Perinatal Health Standards Committee
12 meetings of Area Standards Committees
5 meetings of the Physician Practice Enhancement Committee

38 meetings

21 meetings of subcommittees, and

2 non-hospital reviews

61 TOTAL

(B) CERTIFICATES OF REGISTRATION ISSUED

During the period 1 May 2012 to 30 April 2013, 171 persons were issued registration and a full licence to practise. In total there were 184 certificates issued of which 11 were for a resident licence. Two physicians did not practise here.

TABLE I MEDICAL PRACTITIONERS GRANTED REGISTRATION AND FULL LICENCE ANNUALLY IN MANITOBA 2004 - 2013 with Country of Qualification

Year	*Man*	*Can*	*USA*	*UK&I*	*Eur*	*Asia*	*Aust*	*NZ*	*Afr*	*C/S Am*	*Total*
2004	28	19	1	2	9	20	0	0	38	4	121
2005	36	33	2	3	6	23	0	0	22	4	129
2006	30	43	0	3	8	40	0	0	26	2	152
2007	41	31	0	8	4	40	1	0	29	3	157
2008	45	48	2	7	8	40	0	0	25	6	181
2009	49	26	2	5	2	28	1	0	20	2	135
2010	33	30	1	7	10	46	1	0	22	3	153
2011	56	42	6	5	10	39	2	1	21	7	189
2012	39	30	2	3	8	24	2	0	20	5	133
2013	61	42	2	4	9	28	3	1	15	6	171
Total (10 Yr)	418	344	18	47	74	328	10	2	238	42	1521
New Practitioners % of Total											
2013	35.7	24.6	1.2	2.3	5.3	16.4	1.7	0.6	8.8	3.5	100%

Percentages may not be exact due to rounding

(C) NUMBER OF LICENSED PRACTITIONERS IN MANITOBA AS AT 30 APRIL 2013

TABLE II NUMBER OF LICENSED MEDICAL PRACTITIONERS IN MANITOBA 2004-2013

Year	Winnipeg	%	Outside Winnipeg	%	Totals	Net Gain Net Loss(-)
2004	1626	74.7	550	25.3	2176	24
2005	1640	75.0	546	25.0	2186	10
2006	1663	75.0	555	25.0	2218	32
2007	1688	74.3	584	25.7	2272	54
2008	1722	74.1	603	25.9	2325	53
2009	1788	75.1	594	24.9	2382	57
2010	1839	77.1	576	22.9	2415	33
2011	1870	75.7	602	24.3	2472	57
2012	1931	76.1	607	23.9	2538	66
2013	1979	76.1	620	23.9	2599	61

The total of 2599 includes 61 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*
2009	2345 37	2382	22	2404
2010	2386 56	2442	19	2461
2011	2456 46	2502	22	2524
2012	2475 63	2538	20	2558
2013	2538 61	2599	19	2618

(D) EDUCATIONAL REGISTER

Postgraduate physicians in training programs are now referred to as residents. They may be pre-registration (Educational 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 (resident licence) or may obtain a full licence.

	2013	**%**
Medical Students	441	
Physician Assistant Students	25	
Postgraduate trainees	467	
Total on Educational Register	933	92.0
On Resident Licence	19	2.0
Full Licence	61	6.0
TOTAL	1013	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 2013 (as a percentage)

		Winnipeg	Brandon	Rural	Resident
		1979	133	487	19
%	Man	56.1	22.6	32.7	31.6
	Can	16.8	14.3	6.0	52.6
	Total Canada	72.9	36.9	38.7	84.2
	USA	0.8	0.8	0.4	0.0
	UK & Irel	4.4	6.0	5.5	0.0
	Eur	4.1	1.5	2.9	0.0
	Asia	11.8	33.8	34.7	10.5
	Aust/NZ	0.4	0.8	0.6	0.0
	Afr	3.8	15.8	15.0	5.3
	S.Am	1.9	4.5	2.3	0.0

Percentages may not be exact due to rounding.

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

	2013
Manitoba Graduates	50.0
Other Canadian Graduates	14.6
TOTAL CANADA	**64.6**
United Kingdom & Ireland	4.7
Asia	17.2
Other	13.5

TABLE V **GEOGRAPHIC DISTRIBUTION OF FEMALE PRACTITIONERS**

	Winnipeg	**Brandon**	**Rural**	**Total**	**Resident Licence**
1982	213	8	44	265	51
2013	657	35	173	865	10

33.3% of fully licensed physicians are female. 33.7% of practitioners in Winnipeg are women, 27.3% in Brandon and 33.1% in rural Manitoba. 52.6% of those with a residency licence are female. During the past 31 years there has been an increase of 444 women in Winnipeg, 27 in Brandon and 129 in the remainder of the province.

TABLE VI **AGES OF DOCTORS RESIDING IN MANITOBA AS AT 30 APRIL 2013**

	Winnipeg	Brandon	Rural	Total
Over 70	110 (5.6)	8 (6.0)	17 (3.5)	135 (5.2)
65 -70	168 (8.5)	12 (9.0)	24 (4.9)	204 (7.9)
56 - 64	430 (21.7)	23 (17.3)	94 (19.3)	547 (21.1)
46 - 55	542 (27.4)	49 (36.8)	146 (30.0)	737 (28.4)
36 - 45	539 (27.2)	30 (22.6)	154 (31.6)	723 (27.8)
31 - 35	163 (8.2)	10 (7.5)	42 (8.6)	215 (8.3)
30 or under	27 (1.4)	1 (0.8)	10 (2.1)	38 (1.5)

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

(F) MANPOWER CHANGES from 1 May 2012 to 30 April 2013

TABLE VII **ADDITIONS AND DELETIONS**

Deletions include deaths, retirements, erasures, and transfers to Residency Licence.
Additions are those entering who initiate a licence to practise and includes those who were previously registered.

ADDITIONS 2012		DELETIONS 2013
	AGE	
25	30 or under	1
68	31 - 35	22
65	36 - 45	40
16	46 - 55	16
6	56 - 64	16
2	65 – 70	14
1	over 70	13
183		**122**
	YEARS SINCE QUALIFICATION	
57	5 or less	6
63	6 - 10	27
61	11 - 30	51
8	over 30	38
183		**122**
	YEARS SINCE REGISTERED IN MANITOBA	
165	5 or less	48
9	6 - 10	24
10	11 - 30	21
2	over 30	29
183		**122**

PLACE OF QUALIFICATION

70	Manitoba	30
41	Canada	26
2	USA	4
5	UK & Ireland	11
7	Europe	6
31	Asia	32
4	Australia/New Zealand	2
17	Africa	10
6	C/S America	1
183		**122**

DEATHS or DELETIONS 2013

Deaths	4
Transferred to Residency Licence	1
Removed from Register/Suspended	0
No Longer Practising/Retired	19
DEPARTURES to: (Total)	98
Atlantic Provinces	0
Quebec	0
Ontario	22
Saskatchewan	1
Alberta	7
British Columbia	9
NWT/NU	0
TOTAL CANADA	39
U.S.A.	2
U.K. & Ireland	1
Others/Unknown	56

(G) SPECIALIST REGISTER

There were 1282 specialists enrolled on the Specialist Register as at 30 April 2013.

(H) CERTIFICATES OF PROFESSIONAL CONDUCT (COPC)

During the period 1 May 2012 to 30 April 2013, 531 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 2012.

Provincial Licensing Bodies:	**2013**	**2012**
British Columbia	114	92
Alberta	86	85
Saskatchewan	26	25
Ontario	103	102
Quebec	1	5
Prince Edward Island	1	2
New Brunswick	2	3
Nova Scotia	10	14
Newfoundland/Labrador	0	10
Northwest Territories/Nunavut	12	16
Yukon	2	0
Australia & New Zealand	5	12
Overseas/Other	7	8
U.S.A.	25	37
WRHA	65	56
CFPC	72	86
TOTALS	**531**	**553**