THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

From the College

Canada Post Publication

Publication Agreement #40051985

Volume 40 Number 1 May 2004

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...

The Physician's Role in Moving Primary Health Care Forward

Have you wondered how changes in primary health care might affect your future practice?

To answer this question, an evening is planned for Tuesday, May 18, 2004 at the Winnipeg Convention Centre in conjunction with the national Primary Health Care Conference, "Moving Primary Health Care Forward: Many Successes - More To Do".

The planners for this national three day conference wanted to ensure that Manitoba physicians and conference participants would have an opportunity to contribute to this national dialogue by addressing the Physician's Role. Acknowledging that many physicians are unable to commit the time to participate in a three day meeting, a special evening presentation is being offered, with no registration fee, to Manitoba physicians. Study credits for the CFPC are being requested. Expert speakers will address the rationale for new primary health care practices and the national perspective; provincial and municipal programs will be described; disease specific models will be presented; and a physician and nurse practitioner from the United Kingdom will share their experiences.

Plan to attend at **6:00 pm to 9:00 pm**. Light refreshments will be provided. The evening is hosted by the Faculty of Medicine.

We do request you register your intention to attend by contacting Bev Smith at the MMA; email bsmith@mma.mb.ca; fax 985-5844; phone; (204) 985-5856 or 1 888 322-4242.

If you are interested in attending the entire conference, which includes international and national experts (Terry Tafoya, Charles Boelen, Roy Romanow, Michael Rachlis, Rex Murphy, Ruth Wilson) and more than 25 selected concurrent sessions describing a full range of primary health care programs, contact the web site at www.phcconference.ca.

The conference is a joint initiative of Manitoba Health, Saskatchewan Health and Health Canada.

Congratulations!

To Dr. Roger Graham on being elected President-Elect to the College. Dr. Graham has served on several College committees since 1998, including Legislation & Ethics Committee, Chair of Qualifications Committee and is the current Chair of Finance Committee.

He will assume the post of President for the year 2005-06 at the Annual Meeting in June of 2005.

Dr. Graham is a practising psychiatrist at the Selkirk Mental Health Centre.

President's Message

In our last newsletter, issues of concern regarding after hours coverage were addressed. Your Executive has asked

for wider consultation prior to initiating a policy statement. We hope to work with the WRHA and MMA to develop a more effective plan for after hours coverage that ensures that patients are not put at risk. As a prelude to this, we would encourage all physicians to closely examine their provisions for after hours coverage and to consider how they might create specific arrangements with other groups to provide coverage for those situations delineated in the last newsletter. Our consultation process will look at assisting physicians in achieving this goal. We would also encourage physicians to ensure that their patients are aware of the arrangements for after hours coverage in their practice, and are educated on appropriate use of the system.

The College has continued to be very active in the patient safety movement in Manitoba. Our Disclosure of Harm policy requires physicians to promptly inform patients of any harm that may have occurred in the course of that patient's medical care. Manitoba is one of the few provinces with such a statement. Critical Incident Reporting is now mandatory. In partnership with Manitoba Health, College of Registered Nurses, the Manitoba Pharmaceutical Association, the WRHA and the CPSM, four symposia on Patient Safety have been held for health care providers in the province. Data on patient safety suggests that most "errors" are the result of systemic problems, and preventing future problems can best occur by developing a culture of disclosure and improvement, rather than blame. This does not absolve a physician from personal accountability in situations of deliberate professional misconduct, unsafe practice, or declining competence. However, the College's role in protecting the public is not necessarily best achieved by blaming one person, but may, in some circumstances, be better achieved by addressing the systemic failures in ensuring patient safety. For the majority of practising physicians who make errors or omissions in the course of practice, the goal should be that problems are identified, remediation obtained, and the physician remains in practice.

Drs. Pope, Roy and I travelled to Morden in February for our second "President's Tour", and had an informative and productive meeting with approximately 20 area physicians. Our thanks to Dr. Bob Menzies for organizing the event and thanks to all the physicians who attended.

This past year has been a very challenging one for the College. There have been a number of "crisis" issues that have required urgent attention. The Registrars and staff of the College have worked tirelessly to ensure that standards of care remain appropriate in Manitoba, Manitobans continue to receive quality medical care, physicians have a resource for their concerns, and our profession continues to be self-regulated. Our human resources have been stretched to the limit. As we approach our budget preparation time, we will have difficult decisions to make regarding the services we provide at the current level of fees. If we wish to maintain the same level of service or improve on the functioning of the College, our dues will likely require an increase.

PIPEDA

As you know, on January 1, 2004, most organizations that collect, use or disclose personal information in the course of their commercial activities became subject to the Personal Information Protection and Electronic Documents Act ("PIPEDA").

In an effort to address some of the concerns about the implications of PIPEDA for the health care sector, Industry Canada has published three series of Questions and Answers as part of its "PIPEDA Awareness Raising Tools (PARTs) Initiative for the Health Sector". The series of Questions and Answers provides information on several issues such as the extent to which PIPEDA applies in the health care sector, the additional responsibilities that physicians have as a result of PIPEDA and the anticipated impact upon the relationship between physicians and their patients.

For information on Industry Canada's interpretation of the implications of PIPEDA for the health care sector, you are encouraged to access PARTs at the Industry Canada website – www.strategis.ic.gc.ca. This website also contains sample posters and brochures that you can use to help in meeting the requirements of PIPEDA. You may also wish to access the Privacy Commissioner's website at www.privcom.gc.ca. This website contains a variety of tools to assist in understanding PIPEDA and facilitating compliance.

Employment Insurance (EI) Compassionate Care Benefits

Physicians should be aware that there is a new Employment Insurance Compassionate Care Benefit.

Workers eligible for Employment Insurance (EI) will be entitled to up to six weeks of compassionate care benefits to care for a spouse or common-law partner, a parent, spouse or common-law partner of a parent, a child, or a child of the spouse or common-law partner.

A medical certificate from a physician will be required to obtain this new benefit.

Further information is available on the HRDC website at www.hrdc-drhc.gc.ca.

Information for Physicians

Referring Patients for Nuclear Medicine Procedures

Two Nuclear medicine procedures, Perfusion Lung Scanning and Blood Volume Studies, require the intravenous injection of minute quantities of radioactively labeled human albumin. Patients presenting to the Nuclear Medicine departments will be given an information sheet explaining that the procedure requires the use of small quantities of the blood material albumin. If a patient refuses the test for this or any other reason, the referring physician will be notified.

A copy of the information sheet may be obtained from any of the Nuclear Medicine departments or clinics in the city.

The next article outlines the information sheet.

Information Sheet for Patients Who are to Undergo Nuclear Medicine Perfusion Lung Scan and Nuclear Medicine Blood Volume Study

The following is a copy of the information sheet to be presented to patients prior to undergoing the two above-noted tests:

"Your doctor has requested that you have a procedure called a lung scan performed.

This involves injecting a very small amount of Albumin, a material derived from blood. Precautions have been taken to ensure that the material is sterile (contains no known virus or other infectious agent). We know of no cases of disease transmission from a lung scan.

Your doctor has sent you for this test to assist in making an accurate diagnosis. It is felt that the danger of not making a correct diagnosis is much greater than any theoretical risk associated with the use of this material.

If you have any concerns regarding this test, please do not hesitate to discuss them with the Nuclear Medicine technologist."

Occupational Health

Physicians and Patient Info

Members should note that Guideline #117, The Physician Medical Record, has been amended to include information about a patient's occupational health record. The following information was approved:

- "Occupational health records must be kept separately from general medical records in order to ensure the integrity of the occupational health record.
- Occupational health records must continue under the authority of the Occupational Health Physician and must be transferred only to a named successor.
- Information from an occupational health record must be released to the employer or other third party only with the express consent of the patient, except where the release is necessary to protect the employee or other employees, or pursuant to other exemptions contained in *The Personal Health Information Act.* The Occupational Health Physician is advised to strongly encourage the employer to document and distribute to employees personnel policies describing the circumstances in which information contained in occupational health records will be released to the employer or other third parties without the consent of the employee.
- Information from an occupational health record may only be transferred to a general medical record with the patient's consent."

Members should note that the last bullet applies even when the same physician is both attending and occupational health physician. ***Actual patient authorization should be obtained before a physician transfers information from an occupational health record to a general medical record.***

Lessons Learned….from the Complaints Committee

1. An elderly male patient died of recurrent Staph. aureus infection. The Committee felt it would have been better to use higher doses of antibiotics over an extended treatment period, and to screen for recurrent sepsis with early blood cultures. Especially with elderly, frail, or diabetic patients, family doctors should consider the need for advice from internal medicine or infectious disease specialists.

2. The Complaints Committee reviews 15-20 letters of complaint each month because doctors have not sent in insurance or health forms for patients. This may result in financial distress for the patient, and involves time and inconvenience for the College staff.

Please….return these forms in a timely fashion!

Your College Employees

STANDARDS

The Standards Committee and the employees who work in the Standards area of the College are responsible for the supervision of the practice of medicine by members of the College. They may review members' practice and the professional competence of any member, either on the direction of Council or on their own initiative. The Standards Committee may advise Council to recommend that a member of the College serve a period of refresher training. Standards also oversees the Maternal/Child Health Standards Committees, rural hospital reviews and the Clinical Privileges Program, although the latter will be returned to the Regional Health Authorities of Manitoba on June 30, 2004.

Dr. Terry Babick, Deputy Registrar, joined the College in 1999 as the Complaints consultant and has now been Deputy Registrar for nearly two years. He is responsible for all aspects of the Standards area of the College. In addition, Dr. Babick chairs an ad hoc Bloodborne Pathogens Committee that is responsible for advising on appropriate aspects and principles of sero-positivity for Bloodborne pathogens in the physician and other health care workers.

Ms. Joan Blakley, RN, has been the Manager of Standards for the past two years. She came to the CPSM from the College of Registered Nurses of Manitoba where she performed a similar function. As well as her overall responsibility for Standards, she is the primary coordinator for rural hospital reviews, a responsibility for which she is well prepared as she performed that function previously for the CRNM.

Ms. Diane Kennett, is the senior administrative assistant in the department and performs a wide variety of important functions. She is well acquainted with the area, having worked at the College for many years.

Dr. Valerie St. John joined us two years ago. She has been instrumental in reviewing the Clinical Privileges Panel documentation and in providing physician leadership on hospital reviews.

Dr. Eric Stearns is the medical consultant to the Maternal and Perinatal Health Standards Committee. Dr. Jim Carson is the medical consultant to the Child Health Standards Committee. Both physicians are dedicated to improving the timelines and relevance of standards activities through special topic audits while maintaining the meticulous accuracy and comprehensiveness of retrospective data collection and reporting for their respective areas.

Ms. Joyce Still is the administrative assistant working with the Maternal/Child Health standards programs. She has been with the College for three and one-half years. She brings a tremendous enthusiasm and interest to this important area.

Ms. Gladys Thompson is the administrative assistant responsible for the Clinical Privileges Panel. Over the past years, she worked first with Dr. Bob Walker and now with Dr. St. John and is a familiar voice to administrators and Chiefs of Staff in rural Manitoba when they call to ask for advice on the privileging of their physicians.

The Standards section of the College occupies a significant portion of our time, effort and resources, and is crucial to the education of physicians in a non-threatening environment.

Wellbutrin/Zyban….Another Reminder - 1 Drug – 2 Names

(previously printed in "From the College" in 1999)

The Manitoba Pharmaceutical Association has asked us again to remind members that the drug, Buproprion is presently marketed under two different trade names. Wellbutrin SR is available in 100 mg. and 150 mg. strengths. It is intended as an anti-depressant medication. Manitoba Pharmacare will cover the cost of this drug only if the physician attests that it "meets EDS (exception drug status)" criteria.

Zyban is produced in 150 mg. (SR) quantities. It is intended to be used to assist with smoking cessation. It is not covered by the provincial Pharmacare or other third party payment plans.

Please keep this in mind when prescribing these medications.

Note from the Registrar

The new year continues to be full and interesting for your College. The following issues are presently receiving special attention:

- The Manitoba Government has announced the long awaited review of the Personal Health Information Act (PHIA). Your College has responded in conjunction with the other health regulatory bodies about issues raised by members over the time the Act has been law. The government has also invited presentations which will take place later in the spring.

- As noted elsewhere in this newsletter, the Law Reform Commission suggested that our draft guideline on Withholding or Withdrawing Life Support be adopted provincially as the standard. We will be requesting wide consultation from the profession to determine the final format of the statement. Please consider submitting a comment.

- The government has directed that we begin the formal implementation of physician profiles. We'll keep you up to date as this progresses over the next months.

-

Who Should Authorize Consent for Medical Treatment?

The Law Reform Commission is reviewing the existing law and practice respecting substitute consent for medical treatment, and will be considering whether to recommend legislation authorizing substitute consent for medical treatment.

If you wish to provide any comments to the Law Reform Commission in this regard, please make your comments in writing to the Law Reform Commission, 1210 – 405 Broadway, Winnipeg, Manitoba R3C 3L6.

From the Clinical Practice Guideline (CPG) Offices

Physicians and facilities using the College Guideline and Statement Binders are reminded of the importance of ensuring that the contents are current and updated. If a physician or facility does not subscribe to the Guideline and Statement Update Service and does not therefore receive regular notification of deletions or copies of new and revised documents, they may be using binders which could potentially contain documents which are out of date and/or deleted.

To ensure that the contents of binders are kept up to date, please check the "*What's New*" feature on the College website **www.cpsm.mb.ca** on a regular basis or call the CPG Offices at 774-4458 to subscribe to the update service.

Need Assistance?

PHYSICIANS-AT-RISK
Phone 237-8320 (24 hours)

Report of Disciplinary Proceedings

CENSURE: IC03-02-02
Dr. E. HERSHFIELD

On March 25, 2004, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Hershfield as a record of its disapproval of the deficiencies in his care and management of a patient and his alteration of the patient's medical records. Censure creates a discipline record which may be considered in the future by the Investigation Committee or an Inquiry Panel when determining the action to be taken following an investigation or hearing.

I. PREAMBLE

When a patient presents with complaints, the physician has a responsibility to take a history from the patient, examine the patient, make appropriate investigations, establish a differential diagnosis and a working diagnosis and develop a plan of management. In a teaching hospital, the attending physician has the responsibility to review the information obtained, the diagnoses made, and the management plan developed by the house staff, and to ensure that it is appropriate.

When evidence emerges which is contrary to the initial working diagnosis or management plan, the physician has a responsibility to reassess the patient and make changes as appropriate. This includes, for example, radiology reports which contradict what the physician sees or understands, or failure of the patient to respond to the management plan.

Where appropriate, physicians are responsible to arrange suitable follow-up for their patients.

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.

When an alteration is to be made to the medical record, it must be made in such a manner as to identify who made the alteration, what was altered, what the record stated before the alteration was made and when the alteration was made.

II. THE RELEVANT FACTS ARE:

1. On February 19, 2002, Mr. "A", aged 57, attended St. Boniface Hospital. He had a subacute respiratory illness spanning two to three months, including cough, purulent sputum production, hemoptysis, progressive dyspnoea and weight loss. He had a significant smoking history. Mr. A was found to have a low grade temperature, reduced air entry to the left chest and coarse wheezes and crackles in the right chest. There was mild leukocytosis with left shift and spirometric evidence of an obstructive pattern and perhaps a restrictive component.
2. A chest x-ray taken February 19, 2002 revealed volume loss in the left lung with subtle left hilar prominence and patchy widespread left air space disease.
3. The attending physician's differential diagnosis for Mr. A was tuberculosis, lung cancer, and pneumonia.
4. Due to the possibility of tuberculosis, St. Boniface wished to transfer Mr. A to Health Sciences Centre where there is an isolation ward. Dr. Hershfield was consulted and agreed to accept Mr. A as a patient.
5. On February 20, 2002, Mr. A was transferred to the Health Sciences Centre and admitted under Dr. Hershfield. The resident who saw Mr. A documented a differential diagnosis of tuberculosis, lung cancer and pneumonia.
6. Dr. Hershfield stated that he first saw and examined Mr. A on February 21, 2002. By the time he saw Mr. A, the results of the sputum sample taken at St. Boniface were available and were negative for TB and for tumor cells. He decided to treat Mr. A as a pneumonia.
7. On February 21, 2002, Dr. Hershfield made an entry in Mr. A's chart "see admission note". In an interview with the Investigation Chair, he stated that this meant

that he had read and agreed with the admission note created by the resident.

8. On February 22, 2003, Mr. A had a further chest x-ray. Since the requisition for that x-ray was destroyed, it is not clear who completed the requisition. However, the clinical history recorded on the radiologist's report is "pneumonectomy" and the provisional diagnosis is "follow-up". The radiologist's interpretation of the x-ray was:
   "The left hemithorax is uniformally (sic) opaque with left ward shift of the mediastinal structures and heart. These findings are consistent with a previous pneumonectomy. No other abnormality is identified apart from an occasional healed rib fracture on the right."
9. Dr. Hershfield stated that he saw Mr. A on February 25th and discussed this x-ray with Mr. A. Mr. A said that he had had no surgery. On examination, there was no scar. Dr. Hershfield regarded the documentation of the pneumonectomy as an error, but did not speak to the radiologist about this error.
10. Dr. Hershfield stated that, upon his own review of the February 20th x-ray, he felt that Mr. A had a pneumonia. He continued to treat Mr. A for pneumonia.
11. Health Sciences Centre records document that the chest x-ray taken at St. Boniface on February 19th arrived at Health Sciences Centre on February 26th and was returned to St. Boniface on February 27th, 2002.
12. On February 28, 2002, Dr. Hershfield entered a progress note on Mr. A's chart. The note states "Much improved. To have chest x-ray to see about ~~pleural effusion~~ infiltrates".
13. Mr. A had a repeat x-ray on March 1, 2002. On the radiology report, the clinical history is "pneumonia" and there is no provisional diagnosis. The radiologist compared this film to the previous film. The report states:
   "Note is again made of uniform opacity of the left hemithorax with left ward shift of the heart and mediastinal structures consistent with a previous left sided pneumonectomy…"
14. Dr. Hershfield stated that upon his own review of the x-rays, he felt that there was a resolving pneumonia and discharged Mr. A, with instructions given to Mr. A and the ward clerk for follow-up in 6 – 8 weeks.
15. The ward clerk denies having received instructions respecting Mr. A's discharge. She states that she does not receive verbal orders from Dr. Hershfield or any other physician with regard to discharge instructions. There is no documentation of instructions to the patient in relation to follow-up, and the patient did not attend for any follow-up.
16. On March 2, 2002, Mr. A was discharged from the hospital.
17. There was no follow-up by Dr. Hershfield upon receipt of the radiology report of the March 2, 2002 x-ray. In an interview with the Investigation Chair, he acknowledged that, in retrospect, he should have followed up upon receipt of the radiology report, but stated that, at the time, his narrow view of the patient's condition prevailed.
18. On May 7, 2002, Dr. Hershfield dictated a case summary through the central dictation system of the Health Sciences Centre. The summary states:
   "This patient was admitted in transfer from St. Boniface Hospital where he had been admitted because of cough and sputum production. The question of tuberculosis was raised by chest x-ray which showed a uniform opacity in the left hemi-thorax. He was bronchoscoped. No endobronchial lesion was seen and bronchial washing was negative. His pO_2 on room air was 63 and pCO_2 of 57. It was felt that he had a respiratory infection treated with antibiotics and did well. He improved while in hospital and was to be followed in the Outpatient Department."
19. The final diagnosis was documented as pneumonia in the left lower lobe.
20. In June 2002, Mr. A presented to the Health Sciences Centre Emergency Department with complaints of shortness of breath and coughing up blood. A chest x-ray queried a lung collapse vs. lung pneumonectomy. A CT scan was done and indicated a complete left lung collapse with an underlying tumor.
21. Mr. A raised concerns about the care Dr. Hershfield had provided to him. The Health Sciences Centre patient representative asked that he respond to Mr. A's concerns.
22. Some time after August 13, 2002, Dr. Hershfield made 4 changes to the medical record:
    a. He removed the case summary he had dictated in May 2002,
    b. He inserted on the chart a two page, undated document entitled "discharge summary".
    c. He added to the chart a note dated February 25, 2002, which reads: "Note is made of x-ray report of Feb. 22/02 suggesting that a L pneumonectomy has been performed. Discussed with pt. who says he has never had surgery to chest – no scars present."
    d. He made an alteration to the February 28th note to cross out the words "pleural effusion".
23. In response to questions about these alterations to the record, Dr. Hershfield stated that:
    a. He did re-dictate the discharge summary because on review it had gross inaccuracies, particularly with respect to reference to the bronchosocopy. He assumed that the errors arose because he was dictating a number of charts at one time and became confused as to which patient had a bronchoscopy. These inaccuracies had slipped by his review before the document was placed on the chart. When he reviewed the chart in response to the request from the patient representative, he realized that the summary was in error. At that time he dictated a new summary, which was typed by his secretary and which was a fuller discharge summary than the one originally presented.
    b. He removed the original discharge summary to dictate the new one and forgot to put the original summary back on the chart. He acknowledged that this was the wrong thing to do, but indicated that at the time he thought it was the right thing to do, as he was unaware of the proper procedure for changing or adding things to a chart. His impression was that he could make the changes in the way he did, and he was unaware that he was required to notify medical records of the change.
    c. He did add the note of February 25, 2002 to better reflect the condition of the patient at the time. This

was added at the time Mr. A complained and he realized that he had not made a note respecting the discussion with Mr. A about the pneumonectomy issue. He stated that making the note when he did was undoubtedly the wrong thing to do, but it seemed that it would more clearly define the patient's ongoing care.

d. He did not recall making the alteration to the February 28, 2002 note. However, he accepted responsibility for the change.

III. FACTORS TAKEN INTO ACCOUNT

1. Due to the state of his health at the time this matter came to the attention of the Investigation Committee, Mr. A's recollection of events was unreliable, and he was therefore unable to assist the Committee in its investigation of the matter.
2. The Investigation Committee accepted Dr. Hershfield's explanation that the alterations were made in an attempt to remedy the deficiencies in the record rather than in an attempt to mislead, fabricate or deny the history of the treatment he provided to Mr. A.
3. Dr. Hershfield stated that this was an isolated incident of alteration of a medical record.
4. The Investigation Committee noted that Dr. Hershfield has practiced medicine in Manitoba for 40 years and had no prior discipline record with the College.

IV. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. HERSHFIELD'S CARE AND MANAGEMENT OF MR. A AND HIS ALTERATION OF HIS MEDICAL RECORDS, IN PARTICULAR:

1. Dr. Hershfield's care and management of Mr. A was deficient in the following ways:
   a. further investigation in the form of a CT scan of the chest and/or bronchoscopy was indicated, particularly since the differential diagnosis included malignancy.
   b. There was no evidence to indicate efforts at arranging follow-up.
   c. His interpretation of the x-rays was incorrect. There is no evidence of improvement radiologically on the final film prior to discharge. The left lung remained completely opaque with markedly reduced volume, and in fact was worse than the February 19th x-ray taken at St. Boniface Hospital.
2. Dr. Hershfield failed to make proper records of his management of Mr. A, including:
   a. Failure to create an accurate discharge summary upon his discharge.
   b. Failure to document discharge instructions provided to Mr. A.
3. Dr. Hershfield altered the medical record with respect to Mr. A, in that some time after August 13, 2002,
   a. he removed the May 7, 2002 case summary and substituted a two page, undated document entitled "discharge summary".
   b. he added to the chart a progress note dated February 25, 2002.
   c. he made an alteration to the February 28, 2002 note to cross out two words in that note.

Dr. Hershfield did not make the said alterations in such a manner as to identify what was altered, what the record stated before the alterations were made and when the alterations were made.

In addition to appearing before the Investigation Committee and accepting the Censure, Dr. Hershfield paid the costs of the investigation in the amount of $8,716.47.

CENSURE: IC02-12-05
DR. M.I. HUSSAIN

On March 25, 2004, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Hussain as a record of its disapproval of the deficiencies in his care of a patient. Censure creates a discipline record which may be considered in the future by the Investigation Committee or an Inquiry Panel when determining the action to be taken following an investigation or hearing.

I. PREAMBLE

A physician who accepts a patient for endoscopy and who is not assuming responsibility for management of the patient's condition following endoscopy is responsible for appropriate communication to the referring physician so as to facilitate the proper management of the patient on an ongoing basis. Thus, for example, when a consultant physician has provided a diagnosis to a referring physician based upon clinical examination and endoscopic examination and later receives a pathology report not supportive of that diagnosis, it is incumbent upon the consultant physician to communicate the histological results to the referring physician. Whether taking into account those histological results would alter the course of treatment or the eventual outcome does not diminish the obligation to communicate the results. The consultant physician has a professional obligation to communicate the results.

II. THE RELEVANT FACTS ARE:

1. Mrs. "A", aged 84, was admitted to the Beausejour Hospital by her family physician on March 6, 2002 with a history of nausea and vomiting for about 1 ½ months. On admission her white count was 11.8, hemoglobin 122, platelets 276, sugars and electrolytes normal and urinalysis unremarkable. During the course of her admission the nausea and vomiting subsided and she improved to the point where she appeared to be ready for discharge. However, she developed large amounts of melena stool and bright red blood. By March 12, 2002, she had three positive laboratory results of occult blood.
2. On March 12, 2002, Mrs. A's family physician consulted Dr. Hussain, requesting an esophago-gastroduodenoscopy for further work-up. In his referral letter, the family physician noted that Mrs. A had a history of hypothyroidism, hypertension, bilateral macular degeneration and left breast cancer.
3. Dr. Hussain saw Mrs. A on March 13, 2002. His history and physical examination noted that Mrs. A presented with melena stool. There appeared to be an enlargement of her liver. There were no other palpable

masses. Dr. Hussain's impression was recorded as "Upper G.I. bleed of undetermined etiology."

4. Dr. Hussain proceeded with an esophagogastroduodenoscopy on March 13, 2002. His pre-operative diagnosis was stated to be "gastric cancer". His operative report documents that the clinical picture was one of antral gastric cancer with evidence of marked rugosity of the gastric mucosa with hypertrophic rugae. Two photographs were taken and several tissue samples were taken for biopsy.
5. On March 13, 2002, Dr. Hussain contacted Mrs. A's family physician to advise that he was of the opinion that Mrs. A had antral gastric cancer, which was inoperable. He advised the family physician that he felt palliative care was appropriate for Mrs. A.
6. Based upon Dr. Hussain's advice, the family physician informed Mrs. A and her family that she had a stomach cancer that was inoperable. He offered to refer her for further testing to determine whether the cancer had spread, but she declined further testing.
7. After discussion with Mrs. A and her family, the family physician withdrew her oral medications (including active anti-ulcer treatment), withdrew IV fluid support, and Mrs. A was provided with comfort care until her death on April 8, 2002.
8. The tissue samples were sent by Selkirk Hospital to Health Sciences Centre. The requisition for these tissue samples did not include reference to the family physician and therefore the pathology report was addressed to Dr. Hussain and was not copied to the family physician.
9. On March 19, 2002, the pathology report issued with respect to the tissue samples taken by Dr. Hussain at the time of surgery. The diagnosis was "Stomach, biopsy: Consistent with chronic gastritis, ulceration and intestinal metaplasia. Malignancy is not identified in multiple sections."
10. Dr. Hussain advised that:
    a. He received the surgical pathology report on March 21, 2002 and had an opportunity to review it either that day or shortly thereafter.
    b. At the time, he did not take note that the family physician was not listed to receive a copy of the surgical pathology report.
    c. In his view, the diagnosis of antral gastric cancer was correct based upon his clinical findings and, in his experience, such biopsies may be falsely negative for malignancy.
    d. He did not believe that the treatment plan for Mrs. A would have been altered had he advised the family physician of the results of the surgical pathology report.

11. On receipt of the pathology report, Dr. Hussain did not contact the family physician or Mrs. A to advise of its contents.
12. In his response, he was unable to say why he did not communicate the contents of the pathology report to Mrs. A or her family physician so that they might take that into account in the ongoing management of her condition.

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

Dr. Hussain failed to communicate the results of the March 19, 2002 pathology report to Mrs. A or her family physician, who was responsible for the ongoing management of her condition, with the result that the family physician continued to treat Mrs. A without the benefit of knowing the contents of the pathology report.

In addition to appearing before the Investigation Committee and accepting the Censure, Dr. Hussain paid the costs of the investigation in the amount of $1,960.60.

CENSURE: IC02-08-07: DR. NEVILLE S. WILSON

On March 25, 2004, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Wilson as a record of its disapproval of the deficiencies in his care of three patients. Censure creates a discipline record which may be considered in the future by the Investigation Committee or an Inquiry Panel when determining the action to be taken following an investigation or hearing.

I. PREAMBLE

Physicians have a responsibility to be knowledgeable in the fields in which they choose to practice. If a physician is practicing and a situation presents itself in which the physician is unfamiliar with current therapy, or insecure in his/her findings, it is incumbent upon the physician to seek out other opinions or advice. The urgency with which this is done depends upon the potential consequences of delay for the particular problem of the particular patient.

II. THE RELEVANT FACTS ARE:

A. With respect to Mr. "X":

1. On October 27, 2001 Mr. X sustained a right thumb laceration. The laceration went through the joint, but did not sever the thumb completely. All vital structures were damaged, including the bone of the phalanx. The thumb remained attached by a small bridge of tissue, described as being on the ulnar side.
2. Mr. X promptly presented to the Hospital where Dr. Wilson assessed him. Mr. X was offered amputation, but refused. Dr. Wilson's assessment was that there was a minimal chance of maintaining the viable distal portion, but Mr. X requested an attempt.
3. Dr. Wilson apposed the distal portion by suturing it under a ring block. He prescribed Cloxacillin and Flagyl and advised Mr. X to follow up in 24 hours. Mr. X was discharged home.
4. On October 28, 2001 when Mr. X presented, the distal thumb had gray cyanotic tissue. He was referred to a surgeon the following day.
5. On October 29th, the surgeon saw Mr. X. The surgeon advised Dr. Wilson that he believed the flap was viable and that he would explore the thumb surgically to see if

the IP joint was salvageable. A week later, necrotic tissue was excised, and both the extensor and flexor tendons were repaired. Ultimately, Mr. X had further surgery and in the result had a radial artery based flap graft to the thumb.

6. In response to the concern that Dr. Wilson did not immediately refer Mr. X to a plastic surgeon, he stated that he saw it as a futile effort because it was the weekend and it takes at least thirty minutes to establish contact with a specialist. Dr. Wilson advised the College that he contacted a general surgeon on October 27, 2001 and arranged the appointment for October 29, 2001.
7. Dr. Wilson stated that his plan was to perform a primary repair while the tissues were viable and contact a surgeon for follow-up and secondary repair of the tendons at a later stage.

B. With Respect to Mr. "Y":

8. On August 12, 2002, Mr. Y, aged 63, presented to Dr. Wilson with a dull frontal headache associated with nausea. Dr. Wilson recorded "headache – frontal with nausea. No vomiting" and "long history of headaches, sometimes acute". He also recorded a previous accident with back and neck injury. Neurologic examination, including fundoscopy, was normal. Dr. Wilson documented that his blood pressure was 130/80, his heart rate was 76, there was no marked meningismis, he was tender C6-7, there was a somewhat decreased range of motion in the neck and ++ tenderness in the lumbar area. Dr. Wilson's assessment was acute or chronic headache and he queried migraine and intracranial bleed. His plan was to admit Mr. Y for investigations including lumbar puncture. At the hospital, Mr. Y was given Toradol and Gravol. The hospital record documents that Mr. Y wanted to go home. He went home with a prescription for Ponstan and advice to return if the headaches increased.
9. Although Mr. Y had had severe headaches in the past, there was no past history of frequent visits to seek medical treatment for severe headache. The records document that his August 12th attendance upon Dr. Wilson was his second visit for such treatment in 5 years.
10. Mr. Y returned to the hospital on August 14, 2002 with what he described as a headache with pain of ten on a scale of one to ten, ten being the worst. There were no abnormal neurologic signs at that time. The hospital record documents a family history of cerebral aneurysms. At 1400, Dr. WIson gave a telephone order:
    a. to admit Mr. Y to the Hospital for observation,
    b. to give him Demerol, 75 mg. and Gravol, 50 mg. I.M. and to repeat prn.
    c. to do an EKG and to do blood work, including CEA and thyroid studies.
11. Dr. Wilson saw Mr. Y at 2200 on August 14th and noted that:
    a. Mr. Y was feeling better, and asking for another Demerol injection. His headache was less, his temperature was up, but coming down, and there was no nausea or vomiting.
    b. he had moderate neck stiffness and difficulty in leg raising due to a previous injury.
    c. if the elevated temperature persisted, Dr. Wilson planned to do a lumbar puncture the next day. He ordered CBC and blood cultures. Demerol 100 mg., Gravol 30 mg. (IM) and Tylenol #3, 2 tabs (p.o.) were continued as required for pain control.
12. On August 15, Mr. Y had a dull headache. Dr. Wilson's plan was to await blood cultures and discharge Mr. Y, depending on the blood results and how he was feeling.
13. According to the nurses' notes, on August 15, Mr. Y reported his headache was much improved – "almost nil". He was discharged at 1345 hours.
14. On August 16, Mr. Y was readmitted with a throbbing headache, nausea, vomiting, unable to keep water down. He was given Demerol and Gravol.
15. On August 16, at 1430 hours, Dr. Wilson made an order to give Demerol 100 mg. and Gravol 50 mg. IM, stat.
16. On August 16 at 1700 hours Dr. Wilson noted that Mr. Y was feeling better, his examination was negative and the blood cultures were negative. Dr. Wilson's plan was to have him stay on Tylenol #3 until he was discharged on Saturday, after assessment by the on-call physician.
17. On August 17 the on-call physician noted that Mr. Y had classical subarachnoid hemorrhage symptoms. He transferred Mr. Y to Health Sciences Centre by ambulance, to be seen by a neurosurgeon as an emergency.
18. At the Health Sciences Centre, the CT scan showed ruptured subarachnoid hemorrhage. Mr. Y underwent surgical repair.
19. In his response, Dr. Wilson acknowledged having missed the diagnosis of subarachnoid hemorrhage until 5 days after the event. He agreed that a CT scan should have been ordered earlier. Dr. Wilson indicated that he was thrown off track by the history of chronic headaches with severe exacerbations. He stated that the presentation was not classical because Mr. Y did not experience an acute headache while straining or standing, the headache was frontal, not occipital and it was not associated with vomiting. It was not different than some of the headaches that the patient had experienced previously.

C. With respect to Ms "Z":

20. On September 23, 2000, Ms Z, aged 62, presented to the Hospital with a 3 day history of left-sided chest pain, squeezing pain to her jaws, throat and left arm. She described her pain scale as 7 out of 10. There was no shortness of breath or diaphoresis. She was anxious. Ms Z was given nitrospray and the pain eased and she was less anxious.
21. Ms Z had a history of interior myocardial infarction in 1988. She was a smoker and tried to continue to smoke in the hospital. Medications prior to admission included: Nitropatch 0.2, Diltiazen 240 mgs., ASA 325 mgs., Ativan l mg., Eltroxin 150 mcg., Risperodol 1 mg. and Luvox 50 mgs. taken daily. Her blood pressure was 149/76, pulse 66/minute, normal heart sounds, lung fields were clear.
22. Dr. Wilson was notified of Ms Z's attendance. He instructed the nurses to keep Ms Z until the next day.

An EKG was done stat. No blood work was ordered.

23. While waiting for the EKG, the pain in the throat and chest increased. Nitrospray was repeated and the pain started to ease.
24. The EKG recorded small Q waves in leads II, III and aVF. T waves were inverted in leads III and aVF. These findings were consistent with the myocardial infarction in the past. There was normal R wave progression V1 to V6 in the precordial leads. There was a slight ST segment elevation recorded in leads V2 to V5, especially in V4.
25. Dr. Wilson was notified regarding the EKG result and made aware of the chest pain. He ordered a nitro patch 0.2.
26. At 1615 enzymes were ordered. At 1650 blood work was ordered for the morning.
27. Dr. Wilson was telephoned with the lab work. An INR was ordered. The nurses were advised to start the patient on Heparin and transfer her to another Hospital by ambulance.
28. At the second Hospital, Dr. Wilson saw Ms Z at 2130 on September 23rd. He noted that the EKG showed increased ST changes. On examination there was no pericardial friction rub. Dr. Wilson queried inferior myocardial infarction. He also noted that there was increased CKMB. His plan was to treat Ms Z with Morphine, Heparin and oxygen, as well as continuing her medications at home with the addition of a nitropatch. The labs were to be repeated on Sunday morning. Dr. Wilson advised Ms Z not to smoke and to have strict bed rest.
29. On Sunday morning, Dr. Wilson's assessment was ? ischemia, ? infarct. He noted anterolateral ischemia with ST elevation. His plan was to continue Heparin.
30. The EKG taken that day showed loss of R wave voltage in all the precordial leads, most marked in V3 and V4, with a significant Q wave in V2. More ST segment elevation occurred in V2 to V6 with terminal T wave inversion in these leads.
31. Between 0640 and 0840 on Monday, September 25, Ms Z required six injections of Morphine for left chest pain.
32. Dr. Wilson became aware of the morphine dosages at rounds on Monday morning at approximately 0815 hours, but he took no steps to actively treat Ms Z at that time. He noted that there was central chest pain requiring Morphine. There was still an ST elevation. On examination, there was no pericardial friction rub. At 0900 hours, he telephoned her treating physician to report her condition and arrange for transfer back to the first Hospital.
33. At the patient's request, she was transferred back to the first Hospital. Dr. Wilson's diagnosis at this time was still ?inferior myocardial infarction, ?pericarditis. His plan was to continue with incremental Morphine and Heparin.
34. The patient was transferred to the first Hospital on September 25th. Later that day, another physician found the patient to be in cardiogenic shock following an anterior acute myocardial infarction and she was transferred to the Health Sciences Centre.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. WILSON'S CARE AND MANAGEMENT OF MR. X, MR. Y, AND MS Z, IN PARTICULAR:

1. *With respect to Dr. Wilson's management of Mr. X:*

   i. Mr. X should not have offered Mr. X an amputation. In the management of hand injuries, digits must only be shortened as a last option, particularly when the thumb or index fingers are involved, in order to maintain as normal a "pinch" function as possible.
   ii. Dr. Wilson should have immediately referred Mr. X to a tertiary care hospital. Both digital arteries had been damaged, and the thumb had no chance of surviving unless the blood supply was restored. The appropriate treatment (including a neurovascular reanastamosis and reanastamosing tendons and bone) would best be done at a tertiary care hospital, where the blood supply and other vital structures could have been repaired at one primary operation. The shorter time period between the injury and the reanastamosis, the better the result. Access to a tertiary care hospital was easily available to Dr. Wilson and it was his responsibility to send Mr. X to such a facility. If plastic surgery could not be readily reached, he should have made the referral to the Emergency Department of a tertiary care hospital for assessment and ongoing management.
2. With respect to Dr. Wilson's management of Mr. Y:
   i. Acute in onset and severe headaches are a grave concern. On August 12th, Dr. Wilson documented "no marked meningismus. Tender "C6-7", which suggests that there was some evidence of neck stiffness.
   ii. His initial impression on August 14th included the appropriate diagnosis, and yet he did nothing to investigate this possibility over the course of several days. As a result of the failure to appropriately investigate, the diagnosis was missed.
   iii. By the time he reassessed Mr. Y on August 14th at 2200 hours, moderate terminal neck stiffness was present. This in a patient who was suffering what the patient described as a headache with pain of ten on a scale of one to ten should have concerned him enough to at least seek a telephone consultation with an appropriate consultant.
3. With respect to Ms Z:
   i. The EKG findings at admission in a patient with chest pain and elevated cardiac enzymes warranted a repeat tracing within hours or transfer to a centre capable of thrombolytic therapy. Instead of taking this action, Dr. Wilson treated Ms Z as though she had only unstable angina.
   ii. Dr. Wilson failed to aggressively treat Ms Z. Because the occlusion was not relieved, extensive muscle damage occurred. The EKG taken the day after admission suggests the patient had a rather extensive anterior-septal infarction with extension to involve the lateral wall. Even at this relatively late stage of infarction, aggressive treatment may have save some myocardial muscle. Had cardiac muscle damage been prevented, the cardiogenic shock the patient suffered on September 25, 2000 would have been avoided.
   iii. Dr. Wilson's records suggest that he thought Ms Z might be having pericarditis. Heparin is contraindicated in a patient with pericarditis.

In addition to appearing before the Investigation Committee and accepting the Censure, Dr. Wilson paid the costs of the investigation in the amount of $3,340.00.

Notices, etc…

Annual Council Meeting

The Annual Meeting of the College of Physicians and Surgeons of Manitoba will be held on Friday, June 18, 2004 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 fo registration. Registration is necessary because seating is limited.

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 the College. All members must notify the College in writing of any change of address. Please note that the College By-Law requires 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.

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.

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 to advise interested parties. The By-Law requires that a member who has not practised in the province for a period in excess of 2 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 2004-2005

President:	*Dr. M. Roy*
President Elect:	*Dr. R. Graham*
Past President	*Dr. S. Kredentser*
Treasurer	*Dr. R.. Graham*
Investigation Chairman:	*Dr. R. Menzies*
Registrar:	*Dr. W. Pope*
Deputy Registrar:	*Dr. T. Babick*
Assistant Registrar:	*Ms. D. Kelly*
Chair of Council:	*Dr. G. Bristow*

Term expiring June 2004

Brandon	*Dr. G. Lindsay*
Pembina	*Dr. R. Menzies, Morden*
Southeast	*Dr. M. Roy, Ste. Anne*
Thompson	*Dr. G. Anid*
Westman	*Dr. R. Sangster, Baldur*
Yellowhead	*Dr. A. Ranson, Hamiota*
Winnipeg	*Dr. A. Arneja*
	Dr. M. Burnett
	Dr. H. Domke
	Dr. S. Kredentser
	Dr. R. Lotocki
	Dr. W. Manishen
	Dr. J. Ritchie
	Dr. M. Singer
University of Manitoba	*Dr. B. Hennen*
Public Councillor	*Canon J. Caird*
Public Councillor	*Mr. W. Crawford*
Clinical Assistant Register	*Dr. D. Henry*

Term expiring June 2006

Brandon	*Dr. B. MacKalski*
Central Plains	*Dr. L. Antonissen, Portage*
Interlake	*Dr. C. Chapnick, Gimli*
Norman	*Dr. K. Sethi, Flin Flon*
Northeast	*Dr. R. Graham, Selkirk*
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. E. Stearns
	Dr. R. Suss
University of Manitoba	*Dr. R. Danzinger*
Public Councillor	*Mr. W. Shead*
Public Councillor	*Ms. S. Hrynyk*