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...

The President's Message

The New Year has arrived and with it new and diverse issues and opportunities. Increasingly the College must respond to legislation, public expectations, limited health human resources and the political climate. The paucity of medical manpower, the crisis of the lack of rural practitioners, the requirements to assure competent care, and the expectations of accountability and transparency are the challenges of the hour. The past six months have been busy and exciting for Councillors and College staff. I highlight several developments.

To focus on our mandate and to ensure fiscal responsibility and effective resource management, Council has recommended the discontinuation of the Hospital Review program. Facilities are now reviewed by the CCHSA. Therefore, the Hospital Review Program became redundant.

There is a new statement "Discrimination in Access to Physicians". This statement was reviewed by the Manitoba Medical Association and concerns were addressed and incorporated into the final document.

Physicians are required by law to provide medical service without discrimination in accordance with the Human Rights Code. Recognizing the profession's collective responsibility to serve the public, the statement serves as the framework for ethical behaviour regarding the acceptance or refusal of new patients. I encourage all members to become familiar with the statement.

The Qualifications Blue Sky Working Group continues to meet regarding issues related to qualifications and the licensure of specialists and generalists. We are most grateful for the assistance of Dr. Sandham, Dean of the University of Manitoba Medical School, and Dr Heather Dean, Associate Dean. It is hoped that the University will be able to develop tools which may also be used as part of a Continuing Professional Development process.

Perhaps the most important issue for physicians is the Agreement on Internal Trade (AIT), which will come into effect on April 1, 2009. The intent of the AIT is to enable any individual registered to practise a profession in one province to be registered in other provinces in that same profession. Through the AIT, governments are committed to eliminate barriers. While this is a positive concept that will allow greater portability in our profession, potential challenges for Manitoba will be the retention of physicians, especially in the rural areas. This is a huge issue which requires forward, creative solutions.

We are certainly living in "interesting times". I thank you again for the privilege of being permitted to serve the citizens of our province, and you, the members of the medical profession.

May I take this opportunity to wish all of you a Happy New Year!

Dr. Barbara A. MacKalski

President-Elect Election Results

Congratulations to Dr. Roger Suss, who was elected President-elect at the recent election on December 17, 2008.

Dr. Suss has sat on various College committees since 2002 and is currently the Chair of the Audit Committee and the

Standards Committee, and is also a member of the Executive Committee. He will assume the office of President-Elect in June 2009.

Notes from the Registrar

Welcome to nearly the end of the first decade of the third millennium. Doesn't that sound like the future?!

As I review the issues faced by the College at this time, it is important to reiterate that many of them will, in fact, have a major effect on the future practise of medicine in Manitoba for the next decades. Your President has identified several of these in her column. In particular, they are:

1. *Labour Mobility – Agreement on Internal Trade*

On December 5, 2008, the Labour and Competitiveness Ministers across the country met and signed this agreement. It will be ratified by the Premiers and the Prime Minister early in 2009. It will require that all provinces introduce easy mobility for all professionals and trades across provincial borders. This means that, at the present time, any physician who is licensed in one province or territory may apply for and must be accepted for registration/licensure in any other province or territory in Canada. We have now received a copy of the document. There are many questions which arise from it, which must still be clarified.

There are two areas of immediate concern. The first relates to ensuring that any physician who comes into the province provides information to assure us of fitness to practise. The second relates to the requirement that may be introduced for those who are presently under terms and conditions from the jurisdiction they are leaving.

2. *Health Profession Regulatory Reform Initiative*

This is the formal title for the proposed umbrella health legislation which will put all Manitoba health professions under a single Act. We expect to receive further information on this early in the New Year, and legislation may be introduced in the spring. Once that information is available, it will be placed on the College website for members to see and respond back to us. There has already been significant discussion about the Complaints/Investigations section and the reserved acts. The latter are those acts which only a member of a regulated health profession may perform (eg. prescribing of medications). Stay tuned!

3. *Regulations for Nurse Practitioners, Optometrists and Podiatrists*

As you know, the College was involved in the development of the regulation for the RN[EP] [nurse practitioner] over the past few years. The committee met again recently to review the regulation. In addition, we have requests from Optometry and Podiatry to be involved in the development of the regulations for their new Acts. The College appreciates the opportunity to be involved and make our support and concerns known to these professions as they develop a broader scope of independent practice.

4. *Hospital Review Program*

After several decades of doing rural hospital reviews on a five year cycle, Council voted at its meeting on December 12th to cease the program as of December 31st. Although we thought the program had its uses, the College had no authority to carry out the reviews. There were times when significant suggestions were not or could not be followed up. Furthermore, the call on the College resources was extensive. Accreditation Canada now reviews most of these hospitals. Some hospitals looked forward to the reviews and comments, while others clearly considered it an imposition. The introduction of Regional Health Authorities also provided a framework for hospitals to be more tightly controlled by the regions. No longer do they operate as independent facilities, which was the reason the program was introduced in the first place. The Standards Department resources can now be used to develop the Continuing Professional Development program, which the College will be bringing in over the next two years. The College will still carry out a hospital review if so invited by the region or the province.

5. *Continuing Professional Development*

Nearly six years ago, Council agreed that a formalized CPD program should be developed for this College. In 2007, The Medical Act was amended to permit this to happen. Dr. Terry Babick Deputy Registrar, and Dr. Anna Ziomek, Assistant Registrar, are working together to develop this program for the doctors of Manitoba. The program will be coordinated by Dr. Babick through Standards as the intent is that it will be primarily educational. To view other models, Drs. Babick and Ziomek have visited the Colleges of Alberta, Ontario and Nova Scotia, who have already developed useful programs. Future newsletters will contain more details as they are finalized.

On behalf of all those here at the College, I wish you the very best for 2009. Once again, we are living in "interesting times"!

Statement on Access to Physicians

Council approved this statement, which is mandatory practice, in the fall. It is being circulated with this newsletter to all physicians for information and review. As the President notes in her comments, the statement was circulated widely and was supported by the Manitoba Medical Association.

Addendum to Previous Item on "Release of Information by Physicians"

Further to the item "The Privilege of Privilege" in our last newsletter, I was contacted by the Chief Occupational Medical Officer (COMO), who works for the Workplace Safety and Health Division of the Manitoba Department of Labour and Immigration. He reminds fellow physicians that under the authority of the COMO, there is authority for the COMO to "*notwithstanding the provisions of any other Act, request and receive medical information from any physician or health care facility involved in the diagnosis and treatment of a person who became ill or injured while employed at a workplace or while being otherwise engaged as a worker*".

Communication from Winnipeg Hospitals to Rural Facilities

There are many concerns noted about referring physicians' difficulties getting information about their patients from Winnipeg hospitals. Dr. Brock Wright, CMO for the WRHA, has provided the following information about patient information:

1. Referring physicians are always entitled to receive information about their patient's stay in the receiving hospital. However, if the doctor dictating the discharge summary does not request a copy be sent to the referring physician, it won't happen. If the referring physician later requests a copy it will be provided without patient consent.
2. A referring hospital (as opposed to a referring physician) may request information about a patient without patient consent if it is for review by a standards committee.
3. If a test result, such as a Pathology report, is received after the discharge summary is sent, a referring physician may request a copy. This will be provided without patient consent.
4. Finally, changes to *PHIA* legislation are expected shortly and the WRHA will be launching new educational sessions for staff. This will help to clear up misunderstandings staff may have about *PHIA*. *PHIA* should not (and is not) an impediment to the ability to provide information to referring physicians.

The CPSM reminds physicians that when dictating discharge summaries, they should request a copy of the discharge summary be sent to the referring physician and/or referring hospital. To complete a review of patient care, Standards Committees may, through their hospitals' Medical Records Departments, request information about a patient, so that a review of patient care can be completed. Standards Committees are advised to refer the matter to the CPSM Central Standards Department when there are concerns about care provided in facilities elsewhere.

If physicians are having difficulty obtaining the information they need about their referred patients, they should first seek assistance from the site Health Information Services Directors who are also the site *PHIA* Privacy Officers. If resolution with the site contact is not forthcoming, physicians should contact Evelyn Fondse, Regional Director, Health Information Services, WRHA Phone: (204) 926-7832; Fax: (204) 947-9964

Congratulations to…

- Dr. Harvey Chochinov, Distinguished Professor of Psychiatry, Community Health Sciences & Family Medicine and Canada Research Chair in Palliative Care. He was recently awarded the O. Harold Warowick prize of the National Cancer Institute of Canada for excellence in cancer research and making a significant contribution in the area of palliative care.
- Dr. Sarah Kredentser, GFT & Preceptor, Department of Family Medicine, Kildonan Medical Centre, who was elected President of the College of Family Physicians of Canada at its recent Annual Meeting.

Oxycontin Abuse: "Hillbilly Heroin" Hits Manitoba

Over the last two years there has been a dramatic increase in the abuse of Oxycontin within Manitoba.

Oxycontin has replaced Morphine and Dilaudid as the opiate of choice on the street. It has become the most common drug used amongst clients requesting treatment at the methadone clinic. Of great concern is the change in demography of patients presenting for help with Oxycontin addiction.

It is no longer an issue presenting amongst clients with a long history of alcohol and drug dependence and involvement in street drug use. Oxycontin has become a "party drug" amongst younger suburban adults (ages 15-25). Unfortunately, these young people are very quickly becoming addicted to this substance and often do not realize the intensity of treatment required to stop using opiods.

Physicians should be alert to the following issues:

1. The following signs of Oxycontin use may be problematic:
   - frequent refill of the prescription early.
   - request for that drug specifically
   - use in excess of what you would expect for the physical condition (especially 40 mg and 80 mg tablets).
2. Patients may request help in which case it is advisable to refer them to an addiction counselling service.
3. A trial of tapering Oxycontin is reasonable with strict conditions – frequent dispensing of the medication from the pharmacy (daily dispensing is recommended unless a family member is involved to control the medication – just write "daily dispensing" on the triplicate prescription) and a time limited trial with the agreement that if no progress is being made, the patient will access more intensive treatment e.g. residential rehabilitation program or methadone maintenance program.

For further information about this or consultation, please contact Dr. M. Fisher (944-6309) or Dr. L. Lee (787-3730).

Closing a Practice

When a physician's practice is closed, there are a number of important responsibilities. College Statement 172 "Permanent Closure of a Medical Practice" outlines the responsibilities. There are many reasons why a physician may close a practice, including personal health concerns, retirement, a change in pattern of practice or a relocation. A practice may also close as a result of the death of a physician.

All physicians should be prepared for the need to close a practice and have plans in place to address the responsibilities outlined in the Statement.

From the Complaints/ Investigation Committees

- ***Monitoring Patients on Coumadin***

The Investigation Committee recently reviewed the care provided to a very elderly patient with multiple co-morbidities. The patient was on Coumadin, developed an infection, and was then prescribed Septra by the same physician. That physician did not order INR monitoring.

The Committee reminds physicians that INR monitoring of a patient on Coumadin is important when any change or addition to medication occurs that could potentially interact with Coumadin.

The Committee also reminds physicians to be very careful when assessing the indications for Coumadin in elderly patients with co-morbid conditions, and weighing the perceived benefits against the potential for harm.

- ***Adhering to CDA Guidelines for the Management of Diabetes***

The Investigation Committee recently reviewed two cases where review of physician charts indicated inadequate adherence to the Canadian Diabetes Association (CDA) guidelines for the management of diabetes. These included monitoring of hemoglobin A1C, monitoring for proteinuria and ophthalmologic screening, among others.

The College reminds all physicians of the importance of adhering to the CDA guidelines.

The CDA guidelines can be accessed through the website at www.diabetes.ca/cpg2003.

- ***Missed Appointments***

At a recent Complaints Committee meeting, the Committee reviewed a case where a patient was charged for a number of missed appointments. The letter advising the patient of her missed appointments was dated two days prior to her scheduled appointment. The physician cancelled the patient's appointment and said it would be re-booked once the invoice was paid.

When the patient arrived for her appointment, the patient was unaware that it had been cancelled because the patient had not received the physician's letter.

The Complaints Committee supported the decision to charge a patient for missed appointments, but said the patient should have been given time to address the issue of paying the fee, or, at the very least, provided sufficient notice about the appointment cancellation.

The Complaints Committee reminds members that:

- Physicians have the right to charge a reasonable remuneration for no-show appointments.
- The physician's office should have a policy for fee collection that must be made known to the patient in a timely fashion.
- The physician is responsible for the staff and must ensure reasonable communication with patients for the collection of such a fee.
- Physicians must exercise reasonable judgment with due consideration for patients' circumstances in the provision of medical care.
- Repeated patient disregard of office policy/procedure or expectations after due notice may result in a patient being dismissed from a practice in accordance with the existing College statement.

Diagnostic Imaging Requirements: Intravenous Contrast for Patients with Decreased Renal Function

Radiographic contrast agents have been known to cause acute renal failure and reduction in serum creatinine clearance. As such, it is important to identify and manage patients "at risk" for possible renal complications from intravenous contrast radiological exams.

Ordering physicians must provide serum creatinine levels when ordering a contrast media diagnostic imaging exam on the following "at risk" patients:

Age 65+
Insulin dependant Diabetes
Transplant recipients
Non-insulin dependant Diabetes
Collagen Vascular Disease
Paraproteinemia Syndrome
Hypertension Heart Disease
Family history of renal failure
History of renal disease/impairment
Patients taking Metformin
Patients taking Interleukin, NSAIDS

The referring physician should consider stopping NSAIDS, ace inhibitors any other nephrotoxic medication prior to contrast media imaging examinations.

If there is no renal failure, serum creatinine should be tested within 90 days of contrast media exam date; patients with known elevation in serum creatinine must be tested within 30 days of the contrast media exam.

For patients taking metformin:

Diagnostic imaging departments must be made aware of any patients who are taking Metformin. Serum creatinine levels of these patients will determine whether the intravenous contrast procedure will be done.

- Patients taking metformin must have their level tested within 30 days of contrast media exam date;
- Metformin must be stopped for 48 hours following contrast injection;
- A post contrast media serum creatinine level must be obtained by the ordering physician to ensure adequate renal function prior to re-initiating metformin.

Note: Lactic acidosis can result from patients taking Metformin. However, this rare complication occurs only if the contrast medium causes renal failure and the patient continues to take metformin in the presence of renal failure.

Stay tuned:

An estimation of Glomerular Filtration Rate, (eGFR) may supplant the current standard of practice of utilizing absolute serum creatinine levels as the preferred determinant. The St. Boniface General Hospital Diagnostic Imaging Department is currently beta testing eGFR as a pre-contrast media process. Clinical investigations for adopting this as a universal standard are currently under review.

Referrals to Emergency Departments

Primary care physicians often refer patients from their offices to the Emergency Department for further evaluation and/or treatment. Normally, these physicians notify the Emergency Department in advance. However, unless specific arrangements have been made with a consultant, these patients are triaged in the same manner as self-referred patients and often endure the same lengthy waiting times. Unfortunately, these referred patients are under the misunderstanding that, because their physician sent them in and called ahead, they will be seen more quickly and be able to jump the waiting room queue. Understandably, these patients who have a false expectation about how quickly they will receive medical care are more likely to be frustrated and angry and to complain.

Referring physicians are encouraged to advise their patients they will still be triaged like other patients and may have a lengthy wait before they are seen by an Emergency Physician.

Members' Reporting Responsibilities to the College

Physicians who are members of the College have legal and ethical reporting responsibilities to the College. These obligations are set out in s.39 of *The Medical Act*, the Code of Conduct and Statement 110. Essentially, every member who reasonably believes that another member is unfit to practise, incompetent, or unethical; or suffers from a mental or physical disorder or illness that may affect his or her fitness to practise, and continues to practise despite having been counselled not to; **must** disclose that belief to the Registrar, along with the name of the member and particulars. *The Medical Act* provides statutory protection from liability on the part of a member making such a report, unless it is proved that the disclosure was made maliciously.

It should be noted that Statement 110 elaborates on the statutory duty to report, requiring that physicians consider whether the public is at risk due to incompetence, unethical behavior or dishonesty on the part of the physician whose conduct is of concern. In any circumstance where the public is at risk by the actions of a colleague, it is the ethical responsibility of each physician to report the colleague to the College. Specific examples of mandatory reporting include where a colleague is not compliant with intervention attempts or intervention cannot be implemented in a timely manner and where the behaviour involves sexual misconduct with a patient.

Physicians are reminded that the obligation to report colleagues to the College is not limited to information about a colleague obtained in the course of clinical practice. Members who are involved with Committees and/or organizations come into possession of information respecting the conduct of individual physicians in the course of fulfilling their duties as members of those Committees or organizations. If any information respecting the conduct of a physician is received by a member such that the member reasonably believes that his/her statutory and/or ethical obligation to report the physician pursuant to *The Medical Act*, the Code of Conduct or Statement 110 has arisen, the physician should consider raising the issue with the Chair/Head of the Committee/Organization and/or contact the Registrar to ensure that appropriate steps are taken and the member's obligations met.

Notice of Disciplinary Proceedings

CENSURE: IC07-12-04
DR. KENNETH BRUCE WHITE

On December 17, 2008, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee of the College censured Dr. White with respect to his falsification of a Controlled Drugs and Substances record, and his failure to properly record on patient records medication administered to patients.

I. PREAMBLE

A Controlled Drugs and Substances Record is intended to be an accurate and complete account of controlled drugs and substances provided to a physician for use in patient care. It is an important component of systems for tracking controlled drugs and substances and thereby minimizing the opportunity for abuse of controlled drugs and substances entrusted to physicians for use in patient care. It is therefore imperative that physicians make prompt, accurate and complete entries in these records.

II. THE RELEVANT FACTS ARE:

1. At all material times, Dr. White practised pursuant to an undertaking given by him to the College which stipulated that:
   a. he was required to sign opiates out of the hospital's pyxis system;
   b. he was required to dispose of any wastage in standard fashion in the company of a witness, and
   c. all opiate handling had to be in accordance with institutional protocols of the facility in which he practised.

2. Each time Dr. White received opiates for patient care, he was required to complete and submit to the Regional Health Authority a Controlled Drugs and Substances Record accounting for all of the controlled drugs and substances in his possession, whether administered to patients, wasted, or returned to the hospital pharmacy.

3. On December 10, 2007, Dr. White was issued controlled drugs and substances for the purposes of providing those medications to patients. His schedule that day included starting epidurals, doing epidural top-ups, providing nerve blocks and providing anaesthesia to patients in the operating room.

4. On December 10, 2007, Dr. White submitted a Controlled Drugs and Substances Record which reported having administered 250 mcg. of Fentanyl to each of patients "Jones" and "Smith".

5. Dr. White's Controlled Drugs and Substances records for December 10, 2007 and December 12, 2007 showed 600 mg. of Demerol administered to specific patients.

6. On reconciliation of Dr. White's submitted Controlled Drugs and Substances Record for December 10, 2007 and December 12, 2007, the Regional Health Authority:
   a. was unable to identify patients "Jones" and "Smith";
   b. noted that the medical records of the patients Dr. White documented on the Controlled Drugs and Substances record as having received Demerol did not include documentation of Dr. White administering Demerol to the patients.

7. On December 14, 2007 the Health Authority confronted Dr. White with the discrepancies.

8. Dr. White acknowledged having created fictitious patients (i.e. "Jones" and "Smith") to attempt to hide the discrepancy between the amount of Fentanyl in his possession and the Fentanyl usage documented in his Controlled Drugs and Substances Record for December 10, 2007. Dr. White stated that the Demerol was in fact administered to patients and that the patient records were incomplete.

9. In Dr. White's meeting with the Investigation Chair:
   a. he disclosed personal circumstances that impacted upon his work performance at the material time, and he provided information as to steps taken by him to address those circumstances.
   b. he denied that he had used the Fentanyl and/or Demerol himself,
   c. he was unable to account for the Fentanyl documented as given to "Jones" and "Smith";
   d. he stated that he had administered the Demerol to patients, but failed to record that in their individual patient records, and
   e. he acknowledged that his behaviour in creating fictitious patients was unethical and unconscionable behaviour.

10. On December 14, 2007 Dr. White ceased practice. He later re-entered practice pursuant to an undertaking that restricts his practice to have no access to narcotics.

III. OTHER CONSIDERATIONS

1. The Investigation Committee took into account:
   a. Dr. White's personal health status.
   b. Dr. White's discipline history with the College, namely a censure for breach of an undertaking given to the College.

2. In deciding that Dr. White's name should be published, the Committee noted that although his personal health status is a private matter, his behaviour in creating fictitious patients was clearly unethical and a serious breach of the trust placed in physicians. Although Dr. White's illness factored in his behaviour, the interests of the public in disclosure outweigh his privacy interest.

IV. ON THESE FACTS, the Investigation Committee records its disapproval of Dr. White's falsification of medical records, in particular, the controlled drug and substances record completed by him on December 10, 2007 and Dr. White's failure to properly record on the patients' records medication (Demerol) that he administered to the patients.

In addition to appearing before the Investigation Committee to accept the censure, Dr. White paid the costs of the investigation in the amount of $2,542.50.

Notices, etc…

Accepting Visiting Medical Students for Electives *(UG/PG)*

Are you considering sponsoring a medical student and/or resident for an elective? ALL visiting medical students and residents must be registered with the University of Manitoba and the College of Physicians and Surgeons of Manitoba. There is a defined process with eligibility criteria that must be met. For more information please contact the appropriate person at the University of Manitoba:

Undergraduate Medical Students:
Ms. Tara Petrychko; Tel: (204) 977-5675
Email: petrych@ms.umanitoba.ca
Residents (Postgraduates)
Ms. Laura Kryger; Tel: (204) 789-3453
Email: krygerl@cc.umanitoba.ca
Website:
http://www.umanitoba.ca/faculties/medicine/education/index.html

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Moving? Retiring?...What you Need to Know

If you are leaving the province or retiring from practice, the By-law requires that you advise where your records will be stored, so that we may note it on your file and advise interested parties.

By-Law #1 requires that any member who has not practised in the province for a period in excess of two years without the permission of Council shall, in accordance with section 16(1) of The Medical Act, be struck from the Register. The effective date of erasure shall be two years after that member's cessation of practice

Changes of Address

Bylaw #1 requires that all Members must notify the College of any change of address within 15 days so that communications can be kept open.

The College cannot be responsible for failure to communicate to registrants who have not notified us of address changes.