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...

Message from the President

The Council has been very busy over the summer and fall of 2006. With the reduction in Council size, some Councillors have had to do double duty committee work. My thanks for all their participation. The College has a knowledgeable and vocal Council this year.

Council has endorsed the new International Medical Graduate Program. This program is a process whereby coordinated efforts between the College, Manitoba Health and the University will support a clinical on-site IMG assessment and mentoring process. The aim is to provide quality care to Manitobans through recruitment and retention initiatives.

Over the last few years, Council has been reviewing and debating After Hours Call issues. In 2006, Council approved the development of a questionnaire that would be sent to Manitoba physicians. The intent of the questionnaire is to ascertain the "after hours" practice of physicians. This questionnaire has now been completed and is included in this package. The information gathered will be reviewed by Council and will assist in the formation of a new statement. Council hopes that you will take the time to complete the questionnaire.

In December, Council received information regarding Regulated Health Profession Legislation, commonly known as Umbrella Legislation. The legislation is in the process of development and is intended to improve public accountability, improve public protection and remove barriers to interdisciplinary practice. The government has initially requested input from the College in two areas. These are: (a) review of the complaints/investigation/ disciplinary processes and (b) specifications of reserved acts.

At its September meeting, Council reviewed new government legislation regarding prescribing abilities for pharmacists and met with the Registrar of the Manitoba Pharmaceutical Association (soon to be the College of Pharmacists of Manitoba). The intent of the legislation is to allow collaborative approaches with pharmacists and the health care team.

Other upcoming issues for the Council may include a review of the draft of the working group's paper on "Withholding and Withdrawing Life-Sustaining Treatment".

There will be many important decisions to be made. Please be informed. Councillors and the Registrars are available to provide information and receive comments.

On behalf of Council, I wish you a joyous and peaceful 2007.

Comments from the Registrar

Some of our members suggest that the College and the Registrars live in an ivory tower and have little awareness of the daily realities of a physician's life. I would challenge such a suggestion.

Although it is some years since your Registrar "passed gas" as an anaesthesiologist, he did spend 20 years on the front line at the Health Sciences Centre. I can assure you that those experiences remain with me to this very day. All the

other physicians who work at the College as registrars or who provide advice as consultants, as well as all your physician councillors, have active busy practices. This ensures that any issue with which they must deal reflects their present understanding of the practice of medicine today in the Province of Manitoba. Moreover, a number of important items that will strongly influence the profession in the future are ongoing. These include:

- The Registrar attends the monthly Medical Executive Committee Meetings of the Winnipeg Regional Health Authority to ensure that the College is aware of important issues within the WRHA and can provide College perspective on its future plans.
- Dr. Anna Ziomek, Assistant Registrar for Qualifications, attends the every-other-month meeting of the Chief Medical Officers of the Regional Health Authorities of Manitoba and provides College input. These meetings are hosted in the College boardroom.
- Drs. Pope and Ziomek met with the First Nations and Inuit Health Branch senior team for Manitoba in the fall to encourage an ongoing and seamless continuity of care in northern communities.
- Either Dr. Pope or Dr. Ziomek has attended weekly meetings of the University of Manitoba's Development Committee for a new International Medical Graduate Assessment Process for family medicine. This was approved by Council in September and the first individuals will enter the assessment process in February 2007. The previous "CAPE" assessment, which, although useful, did not include live patients, has been replaced by a 3 month clinical on-site assessment in a rural site. Success in this process will be mandatory for any conditional registrant in family practice who is not a Canadian or U.S. trained family physician or eligible to sit the certification exam of the College of Family Physicians of Canada. The process will also support the conditional registrants to ensure successful entry into practice.
- The Faculty of Medicine has created a committee to design a Physician Assistant training program for the University of Manitoba. Dr. Pope and Dr. Ziomek have been key members of this working group. Manitoba is the only province in Canada with a regulation that permits physician assistants (Clinical Assistant Register part 2). Without these individuals, many of the WRHA programs would not have been able to provide the degree of patient care presently offered.
- In October, the Registrar attended the AGM of the Medical Council of Canada. The MCC Board consists of 2 nominees from each regulatory authority (one of whom must be the Registrar) and one from each medical school. This was the last meeting for Dr. Gary Lindsay, who served with distinction and was President of the Medical Council of Canada two years ago. His replacement is Dr. Bob Menzies, a rural family physician from Morden. The Medical Council of Canada is responsible for the creation of the Evaluating and Qualifying Exams which permit physicians to enter into the practice of medicine in Canada. The Registrar also finished a 4 year term as Chair of the committee to nominate members of the Test Committees.
- Dr. Pope and the Assistant Registrar, Ms. Kelly, have been attending meetings with the Legislative Unit of Manitoba Health. Government has announced its intention to create health professions legislation for Manitoba (umbrella legislation), which will be a significant change for this province. Members are encouraged to review the article in this newsletter.
- The College is a founding member of the Manitoba Institute for Patient Safety. Our nominee to the Board is Ms. Joan Blakley, Standards Manager for the CPSM. The MIPS recently introduced "It's Safe to Ask", an important program to encourage patients to ask questions about their care. At the recent public introduction of this program, the Deputy Registrar, Dr. Terry Babick, spoke from the point of view of a family physician and was warmly received.
- On January 8, 2007, the Registrar attended a meeting in Ottawa of the registrars, the Medical Council of Canada, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. The meeting was intended to look at the harmonization of assessment and certification processes across the country. The Province of Quebec will be condensing its certification exams into a single process in the near future that will combine the Medical Council of Canada, the College des Medicins du Quebec, and the College of Family Physicians of Canada certification processes. It is hoped these meetings will continue and expand to other provinces in the future.
- On January 23/24, Dr. Pope and Dr. Babick attended with the other provincial registrars in Ottawa at the request of Dr. David Butler-Jones, Chief Medical Officer of Health for Canada, to discuss national approaches to emergency preparedness.

These are just some of the external issues in which your Registrars are involved, as well as carrying out their daily responsibilities. I will continue to keep members updated on these issues in future newsletters.

Like the President, I wish you all a very healthy and happy 2007. As this newsletter is prepared, the external temperature is -26 degrees Celsius. These wishes also include the hope that we all stay warm!

Disasters and Docs (Part III of IV)

DOCS IN DISASTERS
Submitted by Guy Corriveau, Director, Disaster Management, WRHA

Consider the possibility of any one of the following scenarios[1]:

- A flood destroys your office…
- A new patient presents with a strange rash…
- A cloud forms over the city and people are having difficulty breathing and ten of your "reactive airway disease" patients show-up at the office requesting treatment…
- Two days ago a patient presented with flu-like symptoms and today four of your staff call in sick with similar symptoms…
- An explosion rocks your office. Glass has shattered into your waiting room, patients have been thrown to the floor, equipment and pharmaceuticals have fallen from their shelves. Your phone is not working. You realize that a bus has crashed into your office building and there are 20 passengers on board with 15 of them suffering moderate injuries. The bus driver is pleading for your help…

[1] With permission, Paul Penn, EnMagine Inc., http://www.hazmatforhealthcare.org, January 2006.

- A disaster wipes out the community in which you practise…
- "Rabbititus" has broken out throughout the Winnipeg Health Region. This disease, previously only associated with celluloid characters, has jumped species and is now affecting humans. Symptoms include a coated tongue and seeing spots. Patients' conditions deteriorate rapidly…

Now consider what your role as a physician may be in responding to and recovering from any one of those events. In certain circumstances, you may be the "first contact" with the patient, and your actions will contribute to the outcome. In other circumstances, you may be contacted directly by other involved agencies, and the media. In any case, you may initially discuss the incident with the Winnipeg Regional Health Authority (Liaison Officer, EMS Liaison, Primary Care Program, Public Health Program, etc.). If the event is communicable, your appraisal to pre-hospital EMS (through WRHA EMS Liaison) may prevent responders from being unnecessarily exposed. The Medical Officer of Health may close and isolate your office and demand patient records be provided.

In other cases, where an event may escalate and become widespread, all physicians may have difficulty getting to the office, obtaining supplies and pharmaceuticals, and accessing the hospital(s) where they may have visiting privileges. If the event is a mass casualty incident, you may not have a hospital to which to send your patients.

If you are working outside your normal practice area network, you may have to go through a credentialing process.

Practice in the disaster environment, therefore, may force "new" duties. Is there a possibility you may assume an Incident Command System (ICS) role as Planning Chief? Operations Chief? Medical Officer (Command)? Medical Staff Leader (Planning)? Medical Care Director (Operations)?

Practising in a disaster environment will certainly impose challenges, both for diagnosis and treatment. Moreover, ethical and practical questions will arise, as will the need to clarify College statements, duties, ethical and personal obligations, liabilities and remuneration.

If you have patients currently in the hospital(s) where you have privileges, the beds they occupy may be desperately needed. You may have to "clear the hospital," effect early discharge, postpone elective surgery, etc. For those who can't be discharged, you may have to arrange patient care needs in person. There may also be a degradation of care (or nicely phrased: "an altered standard of care"). Unlike emergency medicine where there are few resources for few patients, disaster medicine will impose many patients on the same number of limited resources. It is NOT "business as usual."

This is the third in a series of articles which follow a Winnipeg Regional Health Authority presentation made to the College on September 28, 2005 on the topic of Disaster Management. Previous articles: ***Situating Disasters*** *provided the background and introduced the topic; and* ***Managing Disasters*** *described a standardized management structure. The last articles in the series* ***Tracing the Way Ahead*** *will propose a number of suggestions which may help travel the way ahead.*

The Physician Integrated Network (PIN) Initiative

One of Manitoba Health's strategic priorities is the need to address primary care renewal. Under the guidance of an Advisory Committee, with representation from the Manitoba Medical Association, the University of Manitoba, the College of Registered Nurses and the College of Physicians and Surgeons of Manitoba, the Winnipeg and Assiniboine Regional Health Authorities and other primary care stakeholders, Manitoba Health has embarked on an initiative which involves the development of the Physician Integrated Network (PIN).

The Physician Integrated Network initiative will address the following objectives:

- to improve access to primary care;
- to improve primary care providers' access to and use of information;
- to improve the working environment for all primary care providers, and
- to demonstrate high quality primary care with a specific focus on chronic disease.

In early June 2006, applications of interest were invited from group practice sites interested in actively participating in the development and implementation of the PIN initiative. There are four group practices participating as demonstration sites: Brandon Clinic Medical Corporation, Agassiz Medical Centre in Morden, Dr. C.W. Wiebe Medical Centre in Winkler, and Assiniboine Clinic in Winnipeg. The PIN Initiative is now well underway, working directly with the four demonstration sites in developing strategies to meet the objectives of the initiative.

A PIN Workshop was held on November 17, 2006 with representation from each of the demonstration sites, other interested family medicine group practices, Manitoba Health, the Regional Health Authorities where each of the demonstration sites are located, and the Manitoba Medical Association. The objectives of the workshop were:

- to provide an opportunity to begin the development of a PIN Network;
- to identify potential activities for each objective;
- to identify the opportunities and requirements to achieve the potential activities for each objective;
- to identify barriers to achieving the identified activities for each objective.

Feedback from the day was positive and indicated an interest and need to begin specific planning for each of the demonstration sites. Several key themes that emerged from the working day were:

- an interest in the use of additional primary care providers (multidisciplinary teams);
- the need to understand delegation of functions and liability issues associated with the use of additional primary care providers;
- the need to develop funding supports such as:
  - flexibility as each site has different characteristics and needs, and
  - the need to focus on the intended outcomes of the objectives, namely access, quality of care and healthy work lives.

The PIN Resource Team is now working with representatives from the demonstration sites to

collaboratively establish demonstration site deliverables. Guided by the PIN Advisory Committee, other work currently underway by the PIN Resource Team includes:

- an Environmental scan/study of Quality Based Funding Models by Dr. Dominika Wranik, (Ph.D Health Economics);
- refining of the Evaluation Plan with key indicators;
- collection of EMR data to determine each clinic's core patient population profile;
- organizing planning sessions with PIN site representatives to obtain input into the evolving PIN strategies;
- organizing a second PIN Workshop on March 16, 2007 for demonstration sites and key stakeholders.

PIN will continue to provide updates on the Initiative through the CPSM newsletter as significant milestones are reached in the initiative. These will also be posted on the PIN website at www.gov.mb.ca/health/phc/pin.html.

Questions can be directed to:

Physician Integrated Network Initiative
1027A-300 Carlton Street
Winnipeg MB
R3B 3M9

Phone (204) 786-7112
Fax (204) 775-7536
Email: pin@gov.mb.ca

The Auditor Committee Needs You…

We are looking for physicians who have an interest in promoting quality medical care. The CPSM Auditor Committee members participate in a variety of activities including:

- peer chart audits
- interactive peer chart audits
- hospital reviews in rural Manitoba
- review of non-hospital medical/surgical facilities
- document development – statements, policies.

If you are interested and wish to be considered for inclusion in any of the above activities, please send a letter briefly outlining your area of experience and in which activity you wish to participate.

If you have any questions, please contact Joan Blakley at 774-4344, ext. 114.

Manitoba Health Professions Legislation on the Horizon

The Manitoba Government has begun consultation that will lead to a new legislative framework for Manitoba's 19 regulated health professions. The legislation, sometimes referred to as umbrella legislation, will bring all of the health professions under a common, modern Act with consistent processes and mechanisms. Key elements of the legislation are expected to include:

- common structure, composition, governance and public representation provisions for regulatory bodies
- common complaints, discipline and appeals processes and
- common bylaw-making powers and public accountability provisions.

While the common framework applies to each profession, a unique regulation would apply to each to address issues like unique practices or reserved or controlled acts or activities and title protection. Government has made a strong commitment to self-regulation and indicated that the regulatory bodies will continue to have the primary responsibility for regulating the respective professions and setting out the parameters for practice. Self-regulation in the public interest will remain the mandate of the health profession regulatory bodies.

At its December meeting, Council directed that the involvement by the Registrars in this legislation change is the number one priority for the upcoming year. We will keep you informed over the next months.

WRHA Breast Health Centre New Resources for Physicians Now Available

The WRHA Breast Health Centre (BHC) offers timely diagnosis for women and men who have breast problems or signs and symptoms of breast cancer. The BHC coordinates clinical assessment, diagnostic testing, education and support through a variety of specialized services and programs.

To understand how the work-up and evaluation of patients is generally managed, three sources have been developed for your information and use:

- revised BHC referral Form
- 3 algorithms for work-up and evaluation of patients
- clinical pearls for breast cancer management.

The Breast Health Centre is continually looking for ways to expedite the diagnostic process and support our referring community. The BHC looks forward to hearing from you if you have any questions or concerns.

Phone (204) 235-3906
Fax (204) 231-3783
Toll Free in Manitoba: 1-888-501-5219

U of M Medical Class of 2006 Valedictory Addresses

The following two talks were presented at the Faculty of Medicine Convocation in June 2006. The Registrar attended and was greatly impressed at the thoughtful and intelligent comments made. The two articles are reproduced below.

The first address is by Jason Tapper, MD

I would first like to express how honoured I am to be representing our class as one of this year's co-valedictorians.

It seems like yesterday, in this very atrium, four years ago, we were all standing in line waiting to sign up for orientation. There we were ninety excited, eager and nervous strangers about to start down the long road to becoming physicians. Being the friendly guy that I am, I introduced myself to the person behind me…he was a lawyer. Then the person in front of me…she was an Olympic Athlete and there I was…I made balloon animals for a living. It sounds like the beginning of a bad joke: A lawyer, an Olympian and a Balloon Artist are standing in line about to enter medical school. The point is that we all have varied backgrounds with a multitude of diverse experiences. We have all taken different paths to get to this day and it is what makes our class so unique.

While sitting through countless lectures and reading pages upon pages of medical text, it can be difficult to remember the ideals we had when we first entered medical school…to become caring and humane physicians who would always help those in need. Despite the workload thrust upon us, our class has truly embodied this altruistic spirit. Whether we were starting initiatives to raise thousands of pounds of food for Winnipeg Harvest, handing out candy to children at the Children's Hospital for Halloween or helping a fellow medical student going through difficult times, our class has always stepped forward. As we leave behind our lives as medical students we must always remember these ideals, as they will not only make us better physicians but better people.

As we end one journey and begin another, we must give thanks to those who have helped us accomplish this feat. To the many doctors and residents who have guided us by passing on both knowledge and wisdom…we thank you. To the office staff who would always go above and beyond to try to make the past four years run smoothly…we thank you. And most importantly to those of you sitting in the audience today, without your endless support and words of encouragement we would not be here today…we thank you.

To my fellow graduates: As we go our separate ways and enter the world as residents, even though we are entering different disciplines and some will be living in different cities, I implore you to look back at the past four years and cherish the friendships and camaraderie that have been forged. We entered this atrium as strangers and are now leaving it as both colleagues and most importantly friends.

The following is the address presented by Phil Dawe, MD

I would first like to echo Jason's sentiments regarding the honour and privilege I feel to speak on behalf of the class.

During his inaugural address in 1961, American President John F. Kennedy said *"Ask not what your country can do for you, but what you can do for your country"*.

I fear that as inspiring as these words may have been 45 years ago, they would likely be received with no shortage of cynicism today.

You may quite rightly be asking yourselves what, if anything, this has to do with our convocation ceremonies. And I can assure you I'm getting there. I simply think we have become increasingly selfish as a society, and I think we can be better than that. And at this important milestone, we, the Medicine Class of 2006, just may be in a position to buck that trend.

I don't mean to digress from our accomplishments; these were four tremendously challenging years whose completion is worthy of praise. I simply ask that we, as a class, look beyond that for a moment and take pause to reflect on a few points.

Let's first reflect on our vast support systems of family and friends, classmates included, who have steered us through the challenges of medical school. I'm sure I'm not unique in feeling particularly indebted to my parents for their belief in me, and to my partner for seeing me through this period.

Next, I say to us all - Let's be leaders! We're a well-trained, bright and charismatic lot. Let's use these resources to provide great care for and to advocate for our patients, to make positive changes in our communities and to teach and inspire the next generation of physicians and allied professionals. Each of us can make a difference. And remember that good leaders are also good followers.

Let's remember how thrilled we were the day we found out we were accepted into medical school. Remember how privileged we are to have this opportunity to practice the art and science of medicine. And in exchange for this gift, let's ourselves be generous. Let's be generous with our time and our consideration. Let's be generous with our respect for our colleagues and for our patients and finally let's be generous with our expertise. Let's do all these things and when people say 'doctor' before our names, let them say it willingly and with respect and not out of obligation.

In that spirit, I leave you with a quote from Lieutenant-Colonel John McCrae, who is widely known as the author of *In Flanders Fields*. He was also a physician.

"What I spent, I had; what I saved, I lost; what I gave, I have. It will be in your power every day to store up for yourselves treasures that will come back to you in the consciousness of duty well done, of kind acts performed, things that having given away freely you yet possess."

Important Reminder …. College/MMA Joint Statement on Seatbelt/Helmet Exemptions

BACKGROUND:

The Highway Traffic Act provides for an exemption from the mandatory use of seatbelts or a helmet assembly. The exemption applies to a person who holds a certificate signed by a qualified medical practitioner certifying that the person is, during the period stated in the certificate, unable for medical reasons to wear a seatbelt or a helmet assembly and who, on request made by a peace officer, produces the certificate.

The literature confirming the reduction in morbidity and mortality by the use of seatbelts and helmets, alone and in combination with other safety measures, is overwhelming.

Using a motor vehicle for transport without using a seatbelt creates predictable risks for the unbelted individual and for others using the roads. Using an alternative form of transportation is preferable to using a motor vehicle for transport without using a seatbelt.

Physicians who issue exemption certificates should be aware of their potential liability in the event of injury or death arising from the non-use of the seatbelt or helmet assembly. The Canadian Medical Protective Association advises:

> *"A physician's best protection against any potential litigation is to give careful consideration to the matter, ensuring that his/her decision and reasons for granting the certificate are documented and of a nature that he/she can expect agreement about them from among the majority of his/her confreres. As can happen when a physician grants a certificate of any kind, that physician may be called upon later to justify that decision".*

SCOPE:

This Statement applies to all physicians.

REQUIREMENTS:

1. Reconfiguration of the seatbelt, the use of padding, or other accommodations are available and acceptable alternatives to non-use of a seatbelt or a helmet assembly. There are **NO** medical conditions that justify exemptions from using a seatbelt or a helmet assembly.
2. Despite the fact that a physician may still legally write an exemption certificate, the Manitoba Medical Association and the College of Physicians and Surgeons state that **NO** seatbelt or helmet exemption should be issued.

A statement is a formal position of the College with which members shall comply.

Lessons Learned… From the Complaints Committee…

Wait Times for Scheduled Appointments

In recent months, a number of patients have brought forth complaints regarding waiting times for scheduled appointments.

Patient complaints most often describe occasions when multiple patients are booked for the same time slot - for example, several morning patients being told to arrive at 9:00 a.m. (One patient described attending for a scheduled appointment only to find the office closed, with no notice or explanation on the door). A seriously disabled patient describes having specifically notified the physician's office of his inability to endure a long waiting time due to his physical condition, and yet was left waiting for more than two hours.

Both the Complaints and Investigation Committees have identified these situations as demonstrating disrespectful behaviour. While there are certainly some situations where unforeseen circumstances create a longer wait, inappropriate booking has become the norm in some practices. Physicians are reminded to schedule appointments taking into account the realistic time requirement for the appointment.

Physicians can access information on a variety of different booking strategies through MD Solutions.

Physicians' Electronic Equipment Purchases

Physicians are advised to thoroughly research purchases of medical computer systems including hardware, antivirus and anti-spyware software, firewalls, and remote access capabilities. Several problems have been reported to CPSM recently that raise concerns about available products that may not necessarily meet legal requirements.

Watch the CPSM website for information regarding questions to ask:

- when you are selecting an IT specialist to assist you in setting up and managing data hardware and security,
- about hardware and software products that you are considering for purchase.

New Link on our Website

Recently the College has added a new link to its website. This link is entitled "Events". If you have any upcoming events you would like to have published on the CPSM website, please call Susan Wiebe at the College offices.

Re-Entry Specialty Residency

Training for Physicians in Practice in MB

The Division of Postgraduate Medical Education (PGME) of the Faculty of Medicine, University of Manitoba wishes to announce the availability of residency training positions (for re-entry physicians) for July 1, 2007.

A variety of specialty areas of training will be considered by PGME based on the candidate's potential preference and availability of training positions. Priority will be given to Family/General Practice physicians who wish to obtain a primary specialty recognized by the Royal College of Physicians and Surgeons of Canada. Partial residency positions will not be considered. All applicants **MUST** fulfill the following criteria:

- Must be fully licensed to practise medicine in the Province of Manitoba;
- Must have been practising medicine in Manitoba for at least one year;
- Must be willing to be interviewed by a PGME Re-Entry Committee;
- Must provide a Certificate of Professional Conduct from the College of Physicians and Surgeons of Manitoba.

The potentially successful candidate will be required to enter into a return-of-service agreement to practise within Manitoba on a year-for-year basis following completion of his/her residency training.

The University of Manitoba encourages applications from qualified women and men, including members of visible minorities, Aboriginal peoples, and persons with disabilities. This notice is directed to Canadian citizens and permanent residents who hold a full licence (not conditional) to practise medicine in Manitoba. Further information may be obtained by contacting Ms Laura Kryger at krygerl@cc.umanitoba.ca

Please submit a personal letter indicating your area of interest, updated curriculum vitae, original transcripts, and three current letters of reference to:

Dr. Ira Ripstein, Associate Dean, PGME
University of Manitoba, Faculty of Medicine
260 Brodie Centre, 727 McDermot Avenue
Winnipeg, MB R3E 3P5

Closing date for applications is February 15, 2007.

Animal-Sourced Insulin Still Available

With advances in recombinant and biosynthetic human insulin production, the demand for animal insulins has declined. This has led to concerns about the availability of animal-sourced insulin for some Canadian patients. Although the majority of patients with diabetes now use human insulin, there remain a small number of patients who cannot manage their disease with biosynthetic insulins and are concerned over the availability of animal-sourced insulin for the future.

The Health Products and Food Branch of Health Canada recently wrote to the Registrar to say that, despite these concerns, physicians should be aware that animal-sourced insulins are still available for Canadian patients.

The Use of ACE Inhibitors During Pregnancy

Health Canada is advising women not to use blood pressure medication known as ACE (angiotensin-converting enzyme) inhibitors during pregnancy due to the risk of birth defects. These drugs are used alone or with other medicines to treat high blood pressure in adults.

A recent study in the *New England Journal of Medicine* suggests that ACE inhibitors may be associated with an increased risk of birth defects when used in the first three months of pregnancy.

There are many Health Canada-approved drugs to treat high blood pressure that do not contain ACE inhibitors. Women with high blood pressure who are pregnant, or who plan to become pregnant, should discuss the use of an appropriate blood pressure drug with their physician.

All ACE inhibitors approved by Health Canada already include warnings in the labelling information against use of these products during pregnancy. Even before the study, it was known that taking ACE inhibitors during the last six months of pregnancy can harm an unborn child.

ACE inhibitors include:

- Quinapril HCI
- Ramipril
- Captopril
- Perindopril Erbumine and Perindopril Arginine
- Cilazapril Monohydrate
- Benazepril HCI
- Trandolapril
- Fosinopril Sodium
- Enalaprilat

Drugs containing ACE inhibitors include:

- Quinapril HCI - Hydrochlorothiazide
- Perindopril Erbumine - Indapamide
- Cilazapril Monohydrate - Hydrochlorothiazide
- Lisinopril - Hydrochlorothiazide
- Enalapril Maleate - Hydrochlorothiazide
- Trandolapril - Verapamil Hydrochloride

Health Canada recommends that:

- Women who are pregnant should not take any of the above drugs.
- Women who are taking any of the above drugs should tell their doctors if they are planning to become pregnant.
- Women who are taking any of the above drugs and are pregnant should contact their physician for advice.

Consumers requiring more information about this advisory can contact Health Canada Public Inquiries at (613) 957-2991, or toll free at 1-866-225-0709.

To report a suspected adverse reaction, contact the Canadian Adverse Drug Reaction Monitoring Program by telephone at 1-866-234-2345 or by fax at 1-866-678-6789.

Draining Ears – Drops or Oral Antibiotics?

How do you treat a draining ear? Although some physicians seem uncertain, the issues are not complex. The two main causes of otorrhea are:

1. External Otitis (OE), that is infection of the skin of the external ear canal with intact tympanic membrane and,

2. Chronic Suppurative Otitis Media (CSOM): This is also called Chronic Otitis Media (COM). The clinical definition of COM or CSOM is an ear with a tympanic membrane perforation that may drain intermittently.

Whether the cause is OE or COM, the most important part of treatment is topical otic antibiotics/steroid ear drops. The second part of treatment is cleaning of the ear canal.

For both diseases, the causative organisms are usually gram negative so an aminoglycoside is appropriate if the tympanic membrane is intact. If there is a perforation, the ototoxicity of aminoglycosides should be avoided by using one of the fluouroquinolone drops such as Ciprofloxacin. Inclusion of a steroid in the drops is very helpful.

Topical therapy exposures the bacteria to concentrations of antibiotic that far exceed the minimal inhibitory concentration (MIC) so swabs for culture and sensitivity are usually not relevant.

Systemic antibiotics might be considered if there is cellulitis around the ear or in the presence of complications. Amoxicillin, the standard for otitis media, is ***not*** indicated for OE or COM.

The use of drops as opposed to systemic antibiotics for draining ears has been supported by multiple papers in the literature and at least two Cochrane reviews. In addition, it makes sense!

Submitted by Dr. Brian Blakley, MD, PhD, FRCSC, FACS

FROM THE COLLEGE
is a publication of

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Report of Disciplinary Proceedings

CENSURE: IC06-03-02:
DR. MOHAMED IKRAMULLA HUSSAIN

On September 27, 2006, in accordance with Section 47(1)(c) of The Medical Act, the Investigation Committee censured Dr. Mohamed Ikramulla Hussain as a record of its disapproval with respect to his care and management of X:

I. PREAMBLE

The standard of care for a physician providing post-operative care to a patient includes the ability to recognize and to appropriately manage septic shock and hemodynamic compromise. A failure to recognize and to appropriately manage these conditions may place a patient at significant risk.

II. THE RELEVANT FACTS ARE:

1. On January 25, 2005, Dr. Hussain performed a right hemicolectomy and ileotransverse colostomy on X.
2. Initially, X's course was unremarkable, but by January 29 2006, he began to show signs of deterioration in his condition. Specifically, the nurses' notes indicate that he became increasingly restless and required more analgesics.
3. On January 30, 2005, at 1530 the nurses noted an oxygen saturation of 84% on room air, with a temperature of 38.9. At 1625, the nurses noted X was tachypneic and febrile. At this time, the nurses telephoned Dr. Hussain to advise of X's condition. Dr. Hussain ordered Ativan, 1 mg. Q4 to 6 h prn.
4. On January 30, 2005, at 1700, the nurses recorded X's vital signs as pulse of 140 – 180; blood pressure of 109/58 and oxygen saturation of 81% on 3 litres nasal prongs. X was noted to be confused. At 1900 the nurses recorded that X was restless and diaphoretic.
5. On January 30, 2005, at 2010, the nurses recorded X's vital signs as pulse of 150 - 180, blood pressure of 102/50, oxygen saturation of 79% on 10 litres non-rebreath, and temperature of 38.5 degrees. The nurses called Dr. Hussain and he came to assess X.
6. In Dr. Hussain's January 30, 2005, 2215 progress note, he documented that X was restless and anxious, hyperventilating, with abdomen distended. Dr. Hussain noted a temperature of 39 degrees, but noted no other vital signs. Dr. Hussain documented a plan to add Gentamycin and to drain an abscess in the morning.
7. Three more sets of vital signs for X were documented between 2030 on January 30 and 0440 on January 31. Oxygen saturation remained low on high rates of supplemental oxygen, and by 0440 oxygen saturation was 71 – 73% on 15 litres non-rebreath. Pulse rates remained elevated and by 0440 the pulse rate was 151. Blood pressure readings were either not obtainable or low, and by 0440 the reading was 80/48. Respiratory rates were elevated, first at 36 per minute, then 48 per minute and, by 0440, 52 per minute. At 0440, the nurses called Dr. Hussain again to inform him of the patient's condition. Dr. Hussain ordered an increase in the intravenous rate to 150 cc per hour.
8. At 0455 on January 31, 2005, X was catheterized, and there was no urine output for a 6 hour period.
9. At 0726, Dr. Hussain reassessed X and made arrangements to transfer him to Health Sciences Centre.

Dr. Hussain ordered the intravenous rate to be increased to 250 cc per hour.

10. Before transfer, at 0730, X's vital signs were pulse of 148, blood pressure of 85/56 and respiratory rate of 53. A bolus of 600 cc of normal saline was infused en route to Health Sciences Centre.
11. At Health Sciences Centre X suffered a cardiac arrest and was resuscitated.
12. In an interview with the investigator respecting this matter, Dr. Hussain pointed out that X was immunocompromised from prolonged illness and prolonged use of steroids. Dr. Hussain stated that at the material times, he knew X was septic, but he did not think X was in septic shock. However, Dr. Hussain acknowledged that there was a delay in the treatment of this patient's septic shock.

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

1. By the time Dr. Hussain assessed X on January 30, 2005 at 2200, X was exhibiting clear signs of shock. He had low oxygen saturation, elevated pulse rate, low blood pressure, and was restless and confused. Dr. Hussain did not make the diagnosis at that time and he did not take adequate steps to treat the patient, and he thereby breached the standard of care.
2. When Dr. Hussain was called by the nurses at 0440 on January 31, 2005, he again did not make the diagnosis and he did not take adequate steps to treat the patient and he thereby breached the standard of care.
3. The interventions that Dr. Hussain ordered, namely increasing the intravenous rate to 150 cc per hour at 0440 and to 250 cc per hour at 0726, were inadequate to treat the patient's serious medical condition, with the result that X was transferred by ambulance in an unstable condition, and Dr. Hussain thereby breached the standard of care.

In addition to appearing before the Investigation Chair, Dr. Hussain paid the costs of the investigation in the amount of $2057.00.

Notices, etc…

Approved Billing Procedure

When physicians wish to recruit a colleague to carry out the practice of medicine in their place and bill in their names, the College must be advised ***in advance*** and approve the specific time interval. Only when written approval is received may a physician act in place of another. Without written approval as a locum tenens, one physician may replace another, but must act and bill independently

Changes of Address

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.

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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