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.

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FROM YOUR PRESIDENT DR. BRENT KVERN

The first quarter of 2015 has been quite busy for us here at the CPSM. In addition to the regular functions of the College, two issues have taken much time and energy: (1) the follow-up to Statement 190 (After-hours and Vacation Coverage), and (2) getting ready to implement the organizational structural changes that will be brought about when the *Regulated Health Professions Act's* (RHPA) components relating to medicine are enacted by government.

First of all, if you were one of the many physician-members who gave feedback to the College regarding Statement 190 earlier this year, thank you. This issue generated one of the largest physician-member feedback responses ever. As a result, the registrar (Dr. Ziomek), the President-Elect (Dr. Vorster), and I attended several meetings and educational sessions. A special meeting of Council occurred on February 9, 2015 where Council supported a motion to defer the implementation of Statement 190. The Registrar has formed a special working-group to recommend how the multiple concerns that were identified can be addressed and how physician-members can best be supported as we move forward to implement this statement.

Currently, Council is working to understand how the RHPA fundamentally changes many aspects of the CPSM. The issues are complex in that there are expectations and regulations affecting the CPSM laid out in the general RHPA itself (already proclaimed by government) and in the portions of the RHPA specific to medicine (not yet enacted by government). There are three aspects of the RHPA that have specific impact on the practice of medicine in Manitoba: the Regulations, the Standards of Practice, and the Code of Ethics. The Standards of Practice and the Code of Ethics have already been sent out for public consultation and we are very close to being able to send out the Regulations for public consultation. Once the Regulations have been commented upon and the comments reviewed, Council, in September 2015, will vote to support or reject the Regulations and if supported, the Government will then enact that portion of the legislation (likely by the fall or winter of 2015).

There are many issues within the RHPA that will affect all members, including, but not limited to:

- Changes to the size of Council (from 23 members down to 16 members),
- Make up of Council (from 4 public representatives in a 23 member Council to 6 public representatives in a 16 member Council),
- Modifications to the various classes of registration with the College,
- Having a "certificate of practice" instead of a "licence",
- Which information must be published about all members, including changes to complaints, disciplinary findings and any conditions of practice. There will be a much great emphasis on transparency and openness.
- The requirement to have some form of continuing competency assessment programming. Enforcement will become enabled (i.e. the member must meet the continuing competency requirements and if he or she fails to do so, the Registrar may impose conditions on the certificate of practice or may require the member to complete any examinations, training or education the Registrar considers necessary).

As you can see, there is no shortage of work. I welcome any feedback or comments via the President's email at President@cpsm.mb.ca. (I apologize for not writing back individually to all who submitted comments regarding Statement 190, but the volume was very large. However, all comments were read, analyzed and grouped into themes that will be used to inform the work of the Registrar's special working group.)

Regarding things upcoming and on the horizon, two key issues are: (1) ensuring the CPSM has a clear understanding of and approach to physician-assisted death (aka practitioner-hastened dying), and (2) reinvigorating the role of Standards Committees.

Sincerely yours
Brent Kvern, MD

NOTES FROM THE REGISTRAR

It has been six months since I took over the role of Registrar/CEO at the College and it has been a very busy time.

On a personal note, I would like to thank all those individuals (too many to name) who have helped me transition into my new role.

I have learnt a great deal and have much more to learn. Your advice and support has been invaluable. My hope at the College is that we will continue to improve in our activities through better relationships with our members while always remembering the College is responsible for the maintenance of standards of medical practice through the administration of *The Medical Act* which includes The Code of Ethics.

Here is an update for you on a number of important and somewhat pressing issues that we are dealing with.

Dr. Lindy Lee

Dr. Lee was a Medical Consultant with the College of Physicians and Surgeons of Manitoba. She passed away in November 2014. She worked tirelessly with great enthusiasm and passion to educate physicians regarding issues of substance abuse. Lindy supported innumerable patients in their journey to recovery from addition. She was a true leader, a champion for work in addiction medicine. The initiatives she undertook in helping establish the methadone and prescribing review programs at CPSM continues to evolve and is seen as innovative and very effective. Lindy is sorely missed by both patients and colleagues.

The Regulated Health Professions Act (RHPA)

The College has been working with government on the regulations for the RHPA for some time now. Council reviewed a draft at the March meeting; a number of issues for discussion were identified to government. Once these are settled the regulation will go out for a sixty day consultation. Members will be given the opportunity to provide feedback to CPSM. Feedback will be considered and incorporated where appropriate. The regulation will go back to Council for approval and subsequently back to government for proclamation.

Statement 190 – Practice Coverage – After Hours and Vacation

A working group has been struck to explore and address concerns related to the recent release of Statement 190 in the context of recognizing that the ultimate goal of Statement 190 is improved patient care vis a vis continuity and access. The group met in May and is scheduled to meet again in July. Updates will be sent out when available and also published in the next newsletter. Continuity of care will also be discussed at the national level at the Federation of Medical Regulatory Authorities of Canada Annual General meeting in June.

Physician Assisted Death

With the Supreme Court's decision (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do) striking down the *Criminal Code* provisions that prohibit physician-assisted death for a competent adult who clearly consents to the termination of his/her life **and** has a grievous and irremediable medical condition that causes enduring suffering that is intolerable to that individual, the College is in the process of striking a working group to consider the issue of Physician Assisted Death. The Working Group will provide the Registrar with advice as to appropriate recommendations to make to Council regarding the College's role in establishing new and/or adapting existing ethical and/or clinical standards of the profession. The working group is schedule to meet in June 2015.

Email Communication

I would like to advise all members that the College is moving towards communicating more with our members and will be doing so via email. I remind you that you must keep your email address current with the College so you do not miss any communications.

2015 Licence Renewals

I would like to remind members that this year all licence renewals are required to be completed on-line. A valid email address is required to renew.

Federation of Medical Regulatory Authorities of Canada (FMRAC)

I, along with some other staff members, will be attending the FMRAC Annual General Meeting in June. The conference theme this year is Medical Regulatory Authorities' Transparency of Information and their Role in Ensuring Physicians' Continuity of Patient Care.

Anna M. Ziomek, MD
Registrar/CEO

College of Medicine Faculty of Health Sciences Update

The University of Manitoba's new Faculty of Health Sciences -comprised of the Colleges of Medicine, Dentistry, Nursing, Pharmacy and Rehabilitation Sciences- is now in place and we are excited about the opportunities for inter-disciplinary collaboration among health professions in education, research, clinical practice and community engagement as well as the benefits of one, unified voice with government, health regions and our partners.

The new academic structure of the Faculty of Health Sciences (FHS) includes four vice-deans: Dr. Peter Nickerson (Research); Dr. Christine Ateah (Education); Dr. Cathy Cook (Indigenous) and Dr. Sara Israels (Academic Affairs).

Our new Faculty will enhance our research competitiveness with the federal granting agencies by promoting team-based approaches in the clinical, biomedical and community health sciences and creating new possibilities for inter-disciplinary, and multi-site research endeavours.

Community engagement and supporting pipeline programs to encourage under-represented populations to consider careers in the health professions are key priorities. A harmonized approach to outreach activities in the new Faculty will range from service/advocacy in the community to service learning, student clinical placements and service delivery opportunities.

Finally, Interprofessional Education (IPE) is an important, and strategic, new target for our dual-campus Faculty of Health Sciences. IPE, a teaching philosophy to promote collaborative care, will give FHS students opportunities to learn about, with and from one another across the continuum of education. It's not a stand-alone curriculum; IPE opportunities will be developed and integrated in the way we teach at all levels across the Faculty.

When students from different colleges learn and train together in IPE pods and groups, I predict the result will be graduates–and health-care practitioners-who are not siloed and guilded, but take care of patients as a team which will lead to improved health care for Manitobans.

We, as physicians -in a hospital, clinic or operating room -will no longer be the primary decision makers. Increasingly, we will be both expected to, and will function, as but one member of a health care team. This is a positive evolution that will ultimately benefit patient care.

Brian Postl, MD FRCPC
Vice-Provost (Health Sciences)
Dean, Faculty of Health Sciences,
University of Manitoba

UNIVERSITY OF MANITOBA

2015 Licence Renewal

Start date for Renewals
July 15, 2015

This is a reminder to all members that ALL licence renewals will be done on-line this year. If you do not have a means to renew on-line you may call the College to make an appointment to use a College computer to complete your on-line renewal.

NOTICE TO THE PROFESSION

With the increased use of electronic medical records, the College has observed that some physicians are using the EMR templates in an unacceptable manner.

The College is aware of situations where misleading and unreliable information has become part of the permanent record. This has resulted largely from the use of templates where irrelevant material has not been deleted from prepopulated templates or where entries have been cut and pasted from prior entries.

The College is gravely concerned that this may lead to significant patient harm.

Article 24 of By-Law No. 1 states in part:

24.1 Clinical Records

Members in practice shall keep:

- *a) Clinical records on every patient which shall include:*
  - *i. all dates on which the patient was seen and for each visit:*
    - *A. an adequate patient history;*
    - *B. particulars of physical examinations, investigation orders and the results of same;*
    - *C. the diagnosis made (if any);*
    - *D. the treatment prescribed; and*
    - *E. ancillary medical or psychological investigations.*

While a template can assist a physician in creating a complete and accurate record of each patient visit, it is essential that physicians adhere to the practices of good medical record keeping when using templates. Note that:

1. It is unacceptable to use a template which is a clone of a record from a previous appointment. The note of each office visit must accurately reflect the patient's history, investigations done, physical examination, assessment and treatment plan for that visit.
2. Prepopulated entries in any field are unacceptable. As an example, while it may be a useful cue to list items for review in the EMR template, it is <u>unacceptable</u> to prepopulate the response. Any questions not actually asked must be deleted. Likewise, while it is acceptable to list the anticipated physical exam, it is <u>unacceptable</u> to prepopulate the anticipated finding. Any part of the examination listed, but not done, <u>must</u> be deleted.
3. The use of templates may lead to a less than fulsome consideration of the patient's condition. A template cannot substitute for the individual physician's judgment based on the subjective complaints of the patient and the physician's objective assessment and investigations.

Dr. Karen Bullock-Pries
Investigation Committee Chair

Undergraduate Medical Education Requirements

It has come to the attention of the College that a number of external visiting students have been permitted to attend practising physicians' offices without formal approval by the Division of Undergraduate Medical Education at the College of Medicine, University of Manitoba.

If students are NOT registered with the University they are not on the Educational Register at the CPSM and do not have any affiliation with the University of Manitoba or the College of Physicians & Surgeons of Manitoba. Therefore they cannot receive any formal credit for the completed rotations. The preceptors and these students are at significant risk as the students are unlicensed and probably uninsured. In Manitoba *The Medical Act* mandates all medical students and residents to be licensed. Failure to be licensed during an elective may remain on their permanent record with the CPSM.

While the CPSM understands that the preceptor physicians are providing this opportunity in good faith, it does not meet the requirements set out by the University nor the CPSM. Preceptors are advised to check with students that they have accepted and if they are not registered with the University of Manitoba, please contact electivesugme@umanitoba.ca.

Dr. Ira Ripstein
Associate Dean UGME

Statement 138 – Observing Physicians in a Clinical Setting

Please be aware of Statement 138 where it states:

> "The College expects that when IMGs observe physicians, they will only observe clinical practice. Observation is not intended to provide IMGs with an opportunity to contribute to the delivery of care, or to perform any service for which the physician will, or could be remunerated."

Some physicians are providing the International Medical Graduates with letters of reference which suggest the IMGs are involved in the provision of clinical care. Allowing IMGs (when in the observer role) to provide care contravenes Statement 138.

Moving? Retiring?

If you are leaving the province or retiring from practice, By-law #1 requires that you advise the College where your records will be stored. This is so we can make note of it on your file to advise interested parties.

The Medical Examiner's Corner

The CPSM continues to attend Medical Examiner's Meetings in order to review deaths involving polypharmacy. The College provides information to individual practitioners regarding their patients reviewed at these meetings. These letters are meant to be informative as well as educational in nature.

All physicians need to be aware of the risks of opioid and benzodiazepine prescribing. The College reviews approximately 8-10 deaths per month in which prescription opioids are implicated. All opioids, including codeine, are implicated in these deaths. Prescription benzodiazepines are often a contributory factor.

In the past 5 months (Dec, 2014 – April, 2015) The College has reviewed the following deaths:

1. Fourteen deaths in which the individual's **own prescribed opioids** were implicated.
2. Twenty-two deaths in which **diverted** (street acquired/purchased or from family/friends) prescription opioids were implicated.

The above mentioned deaths included:

Five deaths due to prescription fentanyl (4 as a result of diverted fentanyl patches and 1 as a result of the individual's own medication).

Eight deaths due to methadone (2 as a result of the individual's own prescription and 6 as a result of diverted methadone).

One death due to meperidine (Demerol – diverted).

3. One heroin death was recorded (not included in above numbers - since an illegal opioid, not available by prescription).

During our review the following was also noted:

a) Several deaths involved polypharmacy where all prescriptions were written by a single physician.

b) Several deaths involved multiple medications (including more than one benzodiazepine at a time) prescribed to the same patient by different physicians and filled at multiple different pharmacies. Physicians are encouraged to utilize DPIN or *e*-Chart in their practices to improve patient safety.

c) Other categories of prescription medications commonly implicated in overdose deaths were: SSRI's, Tricyclics and antipsychotics such as quetiapine.

Physicians are reminded to review the Canadian Guidelines for Opioid Use in Chronic Non-Cancer Pain. This is the standard which the College of Physicians and Surgeons of Manitoba expects you to adhere to. There is also an excellent web site that provides more detailed information for each recommendation.
See
http://nationalpaincentre.mcmaster.ca/opioid/

Marina Reinecke MD
Medical Consultant

Manitoba Public Insurance | **Societe d'assurance publique du Manitoba**

Information on Medical Standards for Driving for Health Care Professionals:

Information on Medical Standards for Driving for Health Care Professionals:

In Manitoba, physicians are required by law to report drivers with a medical condition that may affect their ability to safely operate a motor vehicle, pursuant to section 157(1) of ***The Highway Traffic Act*** (HTA). In support of this reporting requirement, Manitoba Public Insurance (MPI) is pleased to announce a new section within the Driver Licensing area of their corporate website, named **Medical Conditions and Driving for Health Care Professionals.**

http://www.mpi.mb.ca/en/DL/DL/MedCondAndDrivingForHealthCareProf/Pages/Driving-Fitness-Overview.aspx

This new section, and accompanying web pages, has been developed as a comprehensive resource specifically for health care professionals. It explains your role in identifying and referring patients with cognitive and/or physical impairments that may impact driving ability. It contains information on processes and the various driver assessments used by MPI to determine whether an individual with a cognitive and/or physical impairment is safe to drive. It also includes a link to the recently revised CCMTA Medical Standards for Driving, **along with** links to frequently used forms such as a 'Report to Registrar form' (***which can be printed and completed***), and samples of the 'Driver Medical Examination Report' and the 'Report of Visual Examination' for your reference.

Please note this is a private area of MPI's website which can only be accessed through the link provided. Should you leave this section of the website to access other material within MPI's public website, you may only re-enter this site through the link provided.

STATUTORY REPORTING REQUIREMENTS

REMINDER TO MEMBERS

The following four *Acts* are among those presently requiring mandatory reporting. Members should note this information.

AVIATION SAFETY

The Aeronautics Act requires physicians to report pilots and other classifications of holders of Canadian Aviation licences who have a condition which is likely to constitute a hazard to aviation safety. In essence, a mandatory consultation is required with the regional Aviation Medical Officer when, in your professional opinion, such a likely hazard may exist.

The Canadian Medical Association has developed a guideline with respect to conditions which should be considered under these provisions. Section 6.5 of the *Act*
http://laws-lois.justice.gc.ca/eng/acts/A-2/

RAILWAY SAFETY

The Railway Safety Act has mandatory reporting respecting personnel with "safety critical" positions. The *Act* requires physicians to report to the worker and the employer if the worker is found to have a medical condition that may "reasonably pose a threat to railway safety". Section 35 of the *Act*
http://laws-lois.justice.gc.ca/eng/acts/r-4.2/

Guidelines have been developed by specialists to clarify the rules and to outline reportable conditions. The guidelines are available through the Canadian Medical Association.

PROTECTION FOR PERSONS IN CARE

The Protection for Persons in Care Act contains mandatory reporting provisions. The *Act* creates an obligation to report where a person "has a reasonable basis to believe that a patient is, or is likely to be, abused". The duty applies even if the information on which the person's belief is based is confidential and its disclosure is restricted by legislation or otherwise.

"Patient" is defined to mean an adult resident, inpatient or other person receiving care in a health facility, excluding vulnerable persons within the meaning of ***The Vulnerable Persons Living with a Mental Disability Act.*** Hospitals and personal care homes are included in the definition of "health facility".

"Abuse" is defined to mean "mistreatment whether physical, sexual, mental, emotional, financial or a combination that is reasonably likely to cause death or that causes or is reasonably likely to cause serious physical or psychological harm to a person, or significant loss to the person's property."
http://web2.gov.mb.ca/laws/statutes/ccsm/p144e.php

Further information is available from Manitoba Health, at 204-788-6366 or 1-866-440-6366, or on the web-site at
www.gov.mb.ca/health/protection.

Congratulations

The following physicians have been honoured by Doctors Manitoba:

Dr. Johan du Plooy – Physician of the Year - Dr. du Plooy received the physician of the year award in recognition of his compassionate care to all of his patients. Dr. du Plooy works full time in oncology at the Western Manitoba Cancer Centre in Brandon.

Dr. William Pope – Health Administration Award – Dr. William (Bill) Pope is being recognized for his career as a physician in health administration. Dr. Pope was the Registrar of the College of Physicians & Surgeons of Manitoba from 1999 until his retirement in December 2014.

Dr. Jitender Sareen – Scholastic Award
Dr. Sareen received the Doctors Manitoba Scholastic Award for his many scholarly achievements over the years including recognition of his work in the areas of military mental health, indigenous suicide and homelessness.

Dr. Estelle Simons – Distinguished Service Award – Dr. Simons has earned the Doctors Manitoba Distinguished Service Award for her many years of dedicated service including investigation of medications for allergic diseases.

Dr. John Embil – Health or Safety Promotion Award – Dr. Embil received the Health or Safety Promotion Award for his commitment to infection prevention and control, as well as his research on diabetic foot care and blastomycosis.

MEDICAL-LEGAL PROTECTION WHEN PROVIDING MEDICAL CARE OR ADVICE TO OUTSIDE OF PROVINCE PATIENTS

Members should be aware of certain issues when providing medical care or advice to patients located outside the province or when they are providing consultation for patients outside of the province.

The requirements of the Medical Regulatory Authorities vary from jurisdiction to jurisdiction with respect to licensing requirements. A member who is providing tele-medicine should check with the province or territory where the patient is located to see whether there is a requirement for the member to have registration and licensure in that province or territory where that patient lives. It is important that the physician not be practising without a licence in that jurisdiction.

The second issue is ensuring appropriate CMPA medical-legal protection. CPSM has been informed by CMPA that it "expects members to pay membership fees in relation to the region/province where the patient lives." This is to ensure that the physician has medical-legal protection where the patient lives because if any legal action is initiated, it is likely to be initiated in that province.

Therefore anybody practising tele-medicine should check with the jurisdiction where the patient lives to ensure they have the appropriate licence and medical-legal protection.

Marvin Giesbrecht
Legal Counsel, CPSM

PREVENTION OF NEEDLESTICK INJURY IN MEDICAL WORKPLACES

It is important to understand your legal requirements for the use of needles in medical workplaces, as found in *The Workplace Safety and Health Act*, section 45.1. When hollow-bore or intravenous needles are used in a medical workplace, employers must ensure workers use **safety-engineered needles** and that they are trained in procedures and practices relating to the safe use of safety-engineered needles.

If it is not possible to use safety-engineered needles at a medical workplace, the employer must ensure workers are trained in procedures and practices relating to the safe use of hollow-bore or intravenous needles.

Where workers are at risk of sustaining a needlestick injury, the employer must provide procedures to be followed in the event of an injury. These procedures must include instructions for the worker who has suffered the injury. All workers should also receive training on these policies and procedures.

Additionally, employers must ensure that all needlestick injuries are investigated and a report prepared per 2.9(1) of MR 217/06.

Definitions:

"**medical workplace**" includes:

a) a hospital, a personal care home, a psychiatric facility, a medical clinic, a medical laboratory, a community health centre and CancerCare Manitoba;

b) a physician's office;

c) if prescribed by regulation, a registered dentist's office;

d) an ambulance as defined in *The Ambulance Services Act*; and

e) any other workplace where physical or mental health treatment or care is provided to a person.

"**needlestick injury**" is an injury caused by a hollow-bore or intravenous needle puncturing a person's skin or mucous membrane.

"**safety-engineered needle**" includes a shielded needle device, a retractable needle system and a needleless device.

For information on sharps safety and how to prevent needlestick injury, see:

Routine Practices and Additional Precautions: Preventing the Transmission of Infection in Health Care, Manitoba Healthy Living and Seniors.

http://www.gov.mb.ca/health/publichealth/cdc/docs/ipc/rpap.pdf

For information about legal requirements and enforcement visit:
www.gov.mb.ca/labour/safety

Prevention resources available at:
www.safemanitoba.com

Denise Koh, BSc, MD, CCFP, MPH, FRCPC
Medical Officer of Health
Manitoba Labour and Immigration
Labour Programs -Workplace Safety and Health

ADULT AND CHILD ABUSE REGISTRY SELF CHECKS ONLINE

You can now apply for self-checks online for Manitoba government's Adult Abuse Registry (AAR) and Child Abuse Registry (CAR).

There is one application for both registries. It is an easy and secure way to send personal information and payment. The application form (e-form) and instructions are available at http://manitoba.ca/fs/abuseregistries.html

For more information contact:

Adult Abuse Registry	Child Abuse Registry
Ph 204-948-4934	Ph 204-945-6967
Email: aar@gov.mb.ca	Email: car@gov.mb.ca

Email Address

If you change your email address please make sure you inform the College. In the last several months we have being sending out email correspondence to our members and a number of the email addresses on file are incorrect. If you do not update your email address you will miss out on important correspondence from the College.

Improving the Safety of Prescriptions

There's no doubt that medication is a key part of healthcare today, and drugs to treat mental health conditions play a particularly important role. In Manitoba, they account for one in every four dollars spent on prescriptions. For common conditions like anxiety, depression and insomnia, medications can be very helpful, but they can also be potentially harmful. In 2011, Manitoba Health, Healthy Living and Seniors launched an experimental program to reduce potentially inappropriate prescribing - IMPR$_x$OVE (Improving Medication Prescribing and Outcomes Via Medical Education). A report by the Manitoba Centre for Health Policy (MCHP) presents the first evaluation of the IMPR$_x$OVE program (the full report is available at http://mchp-appserv.cpe.umanitoba.ca/reference//ImproveRx_report_website.pdf).

IMPR$_x$OVE uses an "audit and feedback" method, which has been shown to be an effective way to change prescribing.

Using the Drug Program Information Network (DPIN) data, every month the sale of all prescription drugs in the province for the previous 90 days are reviewed electronically to look for patterns that might be unsafe or not recommended (the audit). The program targeted fifteen Quality Indicators (QIs) that looked for four kinds of patterns:

- Patients who receive multiple medications of the same type.
- Prescriptions at a higher than recommended dose for an extended period of time.
- Patients who receive the same type of medication from more than one doctor.
- Patients who don't refill a prescription within 30 days of the end of the first prescription for that medication.

When one of these patterns is noted for the drugs being monitored, an educational letter is mailed to the prescribing physician (the feedback). The letter alerts the doctor to the potential concern that has been flagged and identifies the specific patient, so their chart can be consulted to determine whether the prescription is appropriate, or whether there was a good reason for using it in this case. The letter also summarizes the current evidence about the issue and suggests other approaches to consider. The decision about whether or not to change their treatment is left up to each doctor.

IMPR$_x$OVE has so far focused on drugs often used in mental health treatments, such as antidepressants, anti-insomnia medications, benzodiazepines (generally prescribed for anxiety or insomnia), antipsychotics, and opioids (painkillers). The provincial government worked with leading physicians on advisory panels to determine the specific drugs and prescribing patterns that the program should monitor and to craft the feedback information.

At the start, the program operated similarly to a randomized controlled trial.

Family physicians, psychiatrists, and pediatricians in active practice were randomly divided into two groups. For over a year, an intervention group received the feedback letters while the other group (the controls) did not. If the rate of events of potentially inappropriate prescribing for the intervention doctors decreased significantly more than for the control group, then the program was effective. The analyses presented in the Table show that IMPR$_x$OVE was effective for the most commonly occurring QIs, while some QIs did not happen often enough to even evaluate ('Insufficient Data').

Lessons learned

A program like IMPR$_x$OVE is most likely to show measurable change when three factors are in place:

- The specific prescribing scenarios being monitored are fairly common.
- The objective is to reduce certain types of prescribing (rather than increase).
- Addressing the problem is within the control of a single prescriber.

Interestingly, where the program was effective, the positive changes did not come only from doctors who had the most room for improvement at the start of the program (i.e., those with high rates of QI events). Even the doctors who were already doing a good job at following the current evidence had lower rates of QI events by the end of the program.

Quality Indicators	Frequency of QI Events	Intervention Effect
Primary		
Multiple Benzodiazepines for youth	Low	Insufficient data
Multiple Benzodiazepines for adults	High	Significant
Multiple Benzodiazepines for older adults	Moderate	Significant
Long-acting benzodiazepines for older adults	High	Significant
High-dose benzodiazepines for youth	Low	Insufficient data
High-dose benzodiazepines for adults	Moderate	No change
Anti-insomnia agents for adults	High	Significant
Anti-insomnia agents for older adults	Moderate	Significant
Secondary		
Five or more Psychotropics for adults	Moderate	No change
Multiple SSRIs for adults	Low	Insufficient data
Multiple SSRIs for older adults	Low	Insufficient data
Multiple prescribers of opioids for adults	Moderate	No change
Multiple prescribers of opioids for older adults	Low	No change
Failure to refill antidepressants	High	No change
Failure to refill antipsychotics	Low	No change

High frequency: greater than 13,000

Moderate: between 1,000-13,000

Low: less than 1,000

With this information, some indicators have since been altered. Others may be added, and the program may be expanded to monitor prescribing for other kinds of health conditions. As IMPR$_x$OVE evolves, it will continue to build on the key principles it was designed around: providing feedback to doctors that presents clinical evidence in an easy-to-read format, is specific to their patients, and provides information which they can reflect upon to make improvements in their practice.

Dan Chateau
Manitoba Centre for Health Policy

FROM THE COMPLAINTS COMMITTEE

Consider Alternatives to Talwin

In August, 2014, the College newsletter noted that at the College AGM in June 2014, Council passed a motion recommending to Manitoba Health that Talwin no longer be prescribed or dispensed in Manitoba. In April, 2014, Council of the College of Pharmacists of Manitoba's supported a similar philosophy.

At its meeting in November, 2014, the Manitoba Monitoring Drug Review Committee (MMDRC) which has membership from this College, recommended zero (0) tolerance for the prescribing of Talwin. At that November meeting, 4 physicians were identified in Manitoba who had prescribed Talwin in 2013. Members should be aware that the government is taking steps to remove Talwin from the Formulary. If physicians are currently prescribing it, they should consider alternative pharmacologic options.

Dr. Garth Campbell
Medical Consultant

Practice Address

It is important that if you are changing your practice location you must notify the College immediately so your Physician Profile can be updated and current. You can email your change of location to cpsm@cpsm.mb.ca.

FROM THE INVESTIGATION COMMITTEE

"Lessons Learned"

Physicians are reminded that prescriptions should be legible to pharmacists, not only as to drug and dosing instructions, but also with respect to the name of the prescriber. If your signature is not clearly legible, there should be an alternate way for the pharmacist to identify your name. This could be as simple as printing your name under your signature. Alternatively, if clinics use printed pads with multiple physician names, the name of the prescriber could be circled.

Notifying the Emergency Department

The Investigation Committee has reviewed cases where there was inadequate communication between the referring physician and the Emergency Department. Members are reminded that physicians have a duty to contact the Emergency Department when they send a patient for any reason.

FROM THE CENTRAL STANDARDS COMMITTEE

Electronic Medical Record Systems (EMR)

Despite the adoption by physicians of electronic medical record systems (EMR), Standards auditors frequently note that problem lists and medication records are not being entered in the available data entry fields. Physicians should ensure that they understand how to enter and maintain these lists and should seek help from their EMR vendor if difficulties are encountered. This information should be readily displayed when opening patient files (electronic or paper), to permit auditors and other health care providers to ensure provision of high quality care.

Critical Lab Results and Emergency Contact Numbers

The College stresses to physicians the importance of keeping their emergency contact information current so that Laboratory Medical Directors are able to contact them when faced with critical lab results after hours. We ask that you please ensure that:

1) accurate emergency contact information is recorded on all CPSM license applications;
2) the CPSM is notified with updated contact information when you make changes;
3) your emergency contact information is made available to laboratories and diagnostic imaging facilities which your patients would normally attend;
4) your office staff ensures that patients' phone numbers are recorded on all lab requisitions.

We commend you for being available to receive critical results on your patients.

Physician Health Program

As a physician community we have many members who are able to contribute substantially despite personal medical problems. We value them and want them to be able to continue their professional contributions to the best of their abilities. The College has an important role to play in ensuring that this happens in a way that does not pose a risk to the safety of the public.

In order to fulfill this function the College needs to know about the significant medical problems of its members. Members are required to report their own medical problems to the College if those problems interfere with, did interfere with, or may interfere with, their ability to practice - including taking time away from practice for health reasons. This is particularly important when the health problem is a mental illness or potentially transmissible infection. Not all significant health problems require a member to have an undertaking (limitation on practice), but all require the member to report them to the College so that the College is aware of the problem. This requirement comes into effect when the problem occurs, or at least before a return to practice, but there are questions on the annual licence renewal form which serve as a reminder of this duty. Failure to report a significant medical problem can result in disciplinary action in some circumstances. College staff are available to answer questions if members are unsure about whether their

medical problem requires them to report it. Members also have a duty to watch out for one another. Members must report their fellow member if that member is continuing to practise despite the evident negative impact of a medical condition.

At the Physician Health Committee we are proud of our members who have bravely faced their illnesses and made the most of their lives, and we wish to continue to assist them in continuing their medical careers.

Roger Süss
Physician Health Committee Chair

Need Assistance?

PHYSICIANS AT RISK

Phone 204-237-8320 (24 hours)

MEETINGS OF COUNCIL FOR THE 2014-2015 COLLEGE YEAR

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

- Wednesday, June 24, 2015

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

OFFICERS AND COUNCILLORS 2014-2015

President:	Dr. B. Kvern
President Elect:	Dr. A. Vorster
Past President:	Dr. D. Lindsay
Treasurer:	Dr. H. Unruh
Investigation Chair:	Dr. K. Bullock Pries
Registrar:	Dr. A. Ziomek
Deputy Registrar:	Dr. T. Babick

TERM EXPIRING SEPTEMBER 2015

Associate Members Register	Mr. I. Jones

TERM EXPIRING JUNE 2016

Brandon	Dr. S. J. Duncan
Eastman	Dr. K. Bullock Pries, Steinbach
Westman	Dr. A. Vorster, Treherne
Winnipeg	Dr. H. Domke
	Dr. B. Kvern
	Dr. M. Boroditsky
	Dr. H. Unruh
University of Manitoba	Dean B. Postl
Public Councillor	Dr. E. Boldt
Public Councillor	Ms L. Read

TERM EXPIRING JUNE 2018

Central	Dr. E. Persson, Morden
Interlake	Dr. D. Lindsay, Selkirk
Northman	Dr. H. Tassi, Thompson
Parkland	Dr. J. Elliott, Grandview
Winnipeg	Dr. W. Manishen
	Dr. M. West
	Dr. N. Riese
	Dr. E. Sigurdson
	Dr. D. Pinchuk
University of Manitoba	Dr. I. Ripstein
Public Councillor	Mr. R. Dawson
Public Councillor	Mr. R. Dewar

CENSURE: IC1983
DR. LEONARD ELIA LOCKMAN

On May 6, 2015 in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Lockman as a record of its disapproval of the deficiencies in his conduct. Censure creates a disciplinary 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

Before referring a patient to the Emergency Department of a hospital for care, it is incumbent upon a family physician who sees the patient in his or her office to assess the acuity of the patient's condition through appropriate history-taking, physical examination and investigations. No patient should be referred from the family physician's office to an Emergency Department when the patient's acuity does not warrant urgent or emergent intervention.

Medical records must accurately reflect the interaction between the physician and the patient and must document all relevant history, physical examination, the physician's assessment, any treatment provided and the physician's plan.

II. THE RELEVANT FACTS ARE:

The Committee assessed the facts as follows:

1. At all material times, Dr. Lockman practised family medicine at his own clinic, St. Vital Family Medical Clinic.

2. During the period between September 2011 and March 2012, Dr. Lockman saw 8 patients, the identities of whom are known to him, in his capacity as their family physician and 2 patients, the identifies of whom are known to him, as patients who attended Dr. Lockman from time to time for episodic care.

3. In each of these patient visits, Dr. Lockman's record:

    a. Documents the patient's entrance complaint, but does not always document relevant details.

    b. Does not document any examination of the patient and instead records "exam not necessary acc to patient".

    c. Documents Dr. Lockman's plan as "Refer St. Boniface ER STAT".

4. Each of the ten patients subsequently attended at the St. Boniface Hospital Emergency Department in relation to the same complaint which the patient had presented to Dr. Lockman in his office, where:
    a. In six of the ten cases, the Emergency Department physician elicited relevant history beyond that which Dr. Lockman recorded in his office record.
    b. Each of the ten patients consented to an appropriate physical examination.
    c. In each of the ten cases, the Emergency Department physician conducted a physical examination which could have been performed by Dr. Lockman in his office.
    d. In six of the cases, the Emergency Department physician ordered investigations which could have been ordered by Dr. Lockman.
    e. In one case, the Emergency Department physician initiated a referral for specialist consultation which could have been made by Dr. Lockman.
    f. Eight of the cases were triaged as Level 4 (less urgent) or Level 5 (non-urgent).

5. Three patients stated to the College that they did not decline a physical examination by Dr. Lockman on the visits in question, and one of these patients stated to the College that a physical examination had in fact occurred.

6. In none of the cases that Dr. Lockman referred, did he provide to the Emergency Department a detailed summary of the information relevant to the referral.

7. The Investigation Committee obtained the opinion of an independent family physician. This consultant opined that in each of the ten cases referred to above, Dr. Lockman's management and documentation fell below the standard of the profession based upon:
    a. Dr. Lockman's minimal histories recorded,
    b. Dr. Lockman's failure to conduct an appropriate physical examination of the patient,
    c. Dr. Lockman's referral of the patient to St. Boniface Hospital Emergency Department when the patient's acuity did not warrant urgent or emergent intervention, and
    d. Dr. Lockman's referral of the patient to an Emergency Department without providing adequate verbal or written information to the Emergency Department physician about the patient.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. LOCKMAN'S CONDUCT IN:

1. Failure to meet the standard of the profession when referring his patients to the Emergency Department for care in that he referred one or more patients to the Emergency Department:
    a. without taking an adequate history and without performing an adequate physical examination or an adequate assessment of the patient to determine if the patient's acuity warranted emergent or urgent intervention.
    b. without adequate written or verbal communication to the Emergency Department physician about the patient's condition, Dr. Lockman's diagnosis or differential diagnosis and the reason for the referral.
2. Documenting that one or more of Dr. Lockman's patients had declined a physical examination when one or more of the patients state that they did not decline an examination.

Dr. Lockman paid the costs of the investigation in the amount of $20,000.00.