December Council Meeting

Wednesday, December 9th, 2020 | 8:00 a.m. |

AGENDA

Time		Item		Page Number
5 min	8:00 am	1.	Opening Remarks	-
0 min	8:05 am	2.	Agenda – Approval	-
		3.	Call for Conflict of Interest	
		4.	In Camera (if needed)	-
5 min	8:05 am	5.	Council Meeting Minutes – For Approval – i. September 25th, 2020 Council Minutes	3
30 min	8:10 am	6.	Accredited Facilities Bylaw – For Approval	9
20 min	8:40 am	7.	Terms of Reference - Standard of Practice for Office Based Procedures Working Group – For Approval	87
20 min	9:00 am	8.	Maintaining Boundaries Standard of Practice – Consultation Feedback – For Information	91
5 min	9:20 am	9.	Additional Specialist Fields of Practice for Assessment – For Approval	107
10 min	9:25 am	10.	Age Triggered Quality Audit Policy – For Approval	110
5 min	9:35 am	11.	Strategic Organizational Priorities Progress Tracking - For Information	113
30 min	9:40 am	12.	COVID-19 Update and Discussion – For Information	115
20 min	10:10 am	13.	--Break--	
15 min	10:30 am	14.	Election of President Elect – For Approval	116
15 min	10:45 am	15.	Quality Department Launch - Information – For Information	119

15 min	**11:00 am**	**16.**	**Complaints/IC Alternative Dispute Resolution – For Information**	**128**
10 min	**11:15 am**	**17.**	**CEO/Registrar's Report**	**130**
15 min	**11:25 am**	**18.**	**Committee Reports (written, questions taken) – For Information** **i. Executive Committee** **ii. Audit & Risk Management Committee** **iii. Complaints Committee** **iv. Investigation Committee** **v. Program Review Committee** **vi. Quality Improvement Committee** **vii. Central Standards Committee**	**133**
15 min	**11:40 pm**	**19.**	**Review of Self-Evaluation of Governance Process – In Camera**	**139**
3 hrs 40 min			**Estimated time of sessions**	

Meeting of Council - September 25, 2020

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on Friday, September 25, 2020 via ZOOM videoconference.

1. CALL TO ORDER

The meeting was called to order at 08:00 a.m. by the Chair of the meeting, Dr. Ira Ripstein.

COUNCILLORS:
Ms Leslie Agger, Public Councillor
Ms Dorothy Albrecht, Public Councillor
Dr. Brian Blakley, Winnipeg
Dr. Kevin Convery, Morden
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor
Dr. Ravi Kumbharathi, Winnipeg
Dr. Daniel Lindsay, Selkirk
Dr. Wayne Manishen, Winnipeg
Dr. Norman McLean, Winnipeg
Dr. Audrey Nguyen, Assoc. Member
Dr. Charles Penner, Brandon
Ms Leanne Penny, Public Councillor
Dr. Brian Postl, Winnipeg
Dr. Ira Ripstein, Winnipeg
Dr. Mary Jane Seager, Winnipeg
Dr. Nader Shenouda, Oakbank
Dr. Eric Sigurdson, Winnipeg
Dr. Heather Smith, Winnipeg
Dr. Brett Stacey, Flin Flon
Dr. Roger Süss, Winnipeg
Dr. Anna Ziomek, Registrar

REGRETS:
Ms Lynette Magnus, Public Councillor
Ms Marvelle McPherson, Public Councillor

MEMBERS:
Dr. Brent Kvern, Winnipeg (8:25*)

(*) departed the meeting

STAFF:
Dr. Ainslie Mihalchuk, Assistant Registrar
Dr. Karen Bullock Pries, Assistant Registrar
Ms Kathy Kalinowsky, General Counsel
Mr. Dave Rubel, Chief Operating Officer
Dr. Garth Campbell, Medical Consultant
Dr. Marilyn Singer, Quality Improvement Director
Ms Karen Sorenson, Executive Assistant
Ms Lynne Leah, Executive Assistant
Ms Lynne Arnason, Legal Counsel (9:40*)
Mr. Jeremy de Jong, Legal Counsel (10:20*)

2. ADOPTION OF AGENDA

IT WAS MOVED BY DR. ROGER SÜSS, SECONDED BY DR. BRIAN BLAKLEY:
CARRIED:

That the agenda be approved as presented.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

Dr. Ira Ripstein called for any conflicts of interest to be declared. There being none, the meeting proceeded. Similarly, there was no request for an in-camera session.

4. ADOPTION OF MINUTES

IT WAS MOVED BY DR. ERIC SIGURDSON, SECONDED BY DR. CHARLES PENNER:
CARRIED

- That the minutes of the June 19, 2020 meeting be accepted as presented.

5. STANDARD OF PRACTICE FOR AUTHORIZING MEDICAL CANNABIS – APPROVAL

A CPSM Strategic Organizational Priority is to review and revise the Standard of Practice to Authorize Cannabis for Medical Purposes. The draft Standard was distributed to the members, public, and stakeholders for consultation from June 26, 2020 to July 31, 2020. Feedback was provided from a wide variety of individuals and organizations.

The Working Group met to review the feedback and make amendments based upon the feedback. The Working Group recommends that Council approve the revised Standard of Practice to Authorize Cannabis for Medical Purposes. Council considered it was in the public interest to adopt the new draft Standard which provides further direction. A "Contextual Information & Resources" document will provide further assistance to the medical profession & does not require Council approval.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. ERIC SIGURDSON:
CARRIED

Council approves the Standard of Practice for Authorizing Medical Cannabis be added to the Standards of Practice of Medicine to be effective on November 1, 2020.

6. DRAFT STANDARD OF PRACTICE FOR MAINTAINING BOUNDARIES – SEXUAL INVOVEMENT WITH A PATIENT – APPROVAL FOR CONSULTATION

A CPSM Strategic Organizational Priority is to review Maintaining Boundaries – Sexual Involvement with a Patient Standard of Practice. The Working Group prepared and presented a report and a draft Standard of Practice for Maintaining Boundaries – Sexual Involvement with a Patient to Council for approval for consultation. The consultation period is to be for 60 days given the complexity and sensitivity of the subject matter as well as the widespread consultation sought.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. ERIC SIGURDSON that:
CARRIED

Council approves the draft Standard of Practice for Maintaining Boundaries – Sexual Involvement with a Patient for distribution and consultation with the membership, stakeholders, and patients.

7. STANDARD OF PRACTICE FOR PRESCRIBING BENZODIAZEPINES AND Z-DRUGS – FOR APPROVAL

Council approved distributing the draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs to the membership and public for consultation purposes on March 13, 2020. The feedback was reviewed and discussed by Council.

The Standard was revised to address many aspects of the feedback. The Standard was also revised to prepare a supporting document entitled "Contextual Information and Resources", which does not require Council approval but will assist the members in providing good medical care to patients in prescribing these drugs. Council considered patient safety requires the adoption of this Standard of Practice and adoption by the profession will contribute to good medical care.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. ROGER SÜSS that:
CARRIED

Council approves the Standard of Practice for Prescribing Benzodiazepines and Z-Drugs be added as Schedule N to the Standards of Practice of Medicine to be effective on November 1, 2020.

Council also approves the recommendation to the Monitored Drug Review Committee, that Alprazolam be removed from the Manitoba Drug Benefits and Interchangeability Formulary.

8. STANDARD OF PRACTICE FOR VIRTUAL MEDICINE WORKING GROUP TERMS OF REFERENCE

The Terms of Reference for the Virtual Medicine Working Group were reviewed. The new updated Standard is to reflect the changes and experiences gained by the several months of extensive use of virtual medicine by the profession during the COVID-19 pandemic. This is important and timely as crucial elements of practicing medicine changed very significantly during this pandemic, recognizing virtual care, new technologies, and new prescribing practices.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. ERIC SIGURDSON that:
The Terms of Reference for the Standard of Practice for Virtual Medicine Working Group be approved as presented.

There was discussion that Doctors Manitoba not be included in the Terms of Reference due to a conflict of interest.

IT WAS MOVED BY DR. BRIAN POSTL, SECONDED BY DR. AUDREY NGUYEN that:

The motion be amended by removing Doctors Manitoba from the Terms of Reference.

CARRIED with 5 opposed and 16 in favour.

9. STANDARD OF PRACTICE FOR PATIENT RECORDS WORKING GROUP TERMS OF REFERENCE

The Terms of Reference for the Patient Records Working Group were reviewed. The Working Group is to develop a draft CPSM Standard of Practice for Patient Records that will be circulated to the members, stakeholders, and the public in spring 2021 and finalized for implementation in 2021.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. BRIAN BLAKLEY that:
The Terms of Reference for the Standard of Practice for Patient Records Working Group be approved as presented.

There was discussion that Doctors Manitoba, Shared Health and Health Seniors and Active Living not be included in the Terms of Reference due to a conflict of interest.

IT WAS MOVED BY DR. ROGER SÜSS, SECONDED BY DR. BRIAN POSTL that:

The motion be amended by removing Doctors Manitoba, Shared Health and Health Seniors and Active Living from the Terms of Reference.

CARRIED with 2 opposed and 19 in favour.

10. STANDARD OF PRACTICE FOR DUTY TO REPORT WORKING GROUP TERMS OF REFERENCE

The Terms of Reference for the Duty to Report Working Group were reviewed. The current duty to report provisions are scattered throughout the Standards of Practice and legislation and includes duties to report another member and self-reporting to CPSM. There are also statutory requirements for a wide variety of reporting of patients.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. ERIC SIGURDSON that:
CARRIED

The Terms of Reference for the Standard of Practice for Duty to Report Working Group be approved as presented.

11. ACCREDITED FACILITIES CRITERIA

The Report and Recommendations of the Accredited Facilities Criteria Working Group were distributed for consultation with the members, stakeholders, and public in the spring. The Working Group continues to meet to finalize its recommendations from the feedback.

12. STRATEGIC ORGANIZATIONAL PRIORITIES UPDATE

Councillors were presented with a brief synopsis and discussed the strategic organizational priorities and progress. Some of the Priorities are "on hold" until FMRAC provides a framework or national level agreement and direction. Other priorities are being worked on.

13. CENTRAL STANDARDS BYLAW AMENDMENT

The Central Standards Bylaw sets out the grounds for the Committee to refer a matter to the Registrar for further action. The following amendments will assist the Central Standards Committee to ensure the high practice standards required of all members are adhered to.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. ROGER SÜSS that:
CARRIED

The Central Standards Bylaw section 14 be amended by

- Adding section g. "In the opinion of Central Standards, the member's standard of care may pose a risk to patient safety."
- In section f. replacing "the public" with "patient safety".

14. CEO/REGISTRAR'S REPORT

Dr. Ziomek provided Council with a written report for information outlining the matters currently being dealt with at the College. Dr. Ziomek spoke verbally to this report and answered the questions presented by the Councillors, including about COVID-19.

15. COMMITTEE REPORTS

The following Reports were presented to Council for information:

- Executive Committee
- Audit & Risk Management Committee
- Complaints Committee
- Investigation Committee
- Program Review Committee
- Quality Improvement Committee
- Standards Committee

16. IN CAMERA SESSION

An in-camera session was held, and the President advised that nothing be recorded in the minutes.

There being no further business, the meeting ended at 12: 05 p.m.

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Dr. I Ripstein, President

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Dr. A. Ziomek, Registrar

COUNCIL MEETING – DECEMBER 9, 2020

NOTICE OF MOTION FOR APPROVAL

TITLE: Accredited Facilities Bylaw Amendments

BACKGROUND

A Review of the Criteria for Facilities that require CPSM accreditation is a Strategic Organizational Priority set by Council. CPSM has the statutory power to make bylaws accrediting facilities and the diagnostic or treatment procedures that may be performed at a facility. As per the legislation, this applies to any facility in which a registrant performs or causes to be performed diagnostic or treatment services, such as a non-hospital medical or surgical facility or a nuclear medicine facility, other than a hospital of health care facility operated by the government.

Currently the Accredited Facilities Bylaw Part B requires accreditation of non-hospital surgical facilities that:

i) utilize procedural sedation or local, regional, or general anesthesia provided that the standard of care requires monitoring of vital signs or;
ii) any other procedure the Committee directs.

Council had not directed any further procedures requiring CPSM accreditation.

In June, Council reviewed the initial recommendations of the Working Group and approved their distribution for consultation. Council reviewed the feedback from the consultation in September. The Working Group met twice to review the feedback provided by the consultation.

The feedback provided some unique perspectives that helped inform the Working Group. Especially helpful was the input from those physicians working in the current accredited facilities. Also, Dr. Mihalchuk was able to participate in a full day Ontario and Western provinces virtual conference amongst the regulatory colleges to discuss accredited facilities. CPSM was able to utilize their collective experiences to improve the accredited facilities regulation in several ways. The Working Group also recommended the Bylaw be re-written to improve procedures and enhance patient safety. This has been done.

The Working Group has met and provided their final recommendation to approve the attached Accredited Facilities Bylaw amendments.

Attached is a copy of the Summary of Feedback and two copies of the Accredited Facilities Bylaw, one is a clean copy and one is a tracked changes copy.

To assist you in reviewing the changes, below are the main changes to the Accredited Facilities Bylaw recommended by the Working Group:

Main Changes to the Accredited Facilities Bylaw

1 – Criteria for Accreditation by CPSM

The current criteria for accreditation is only for facilities engaging in procedures that require procedural sedation. The new criteria is:

13.1. Part B of this Bylaw applies to all non-hospital medical or surgical facilities, subject to section 183 of the RHPA, and not included in Part A of this Bylaw. All non-hospital medical or surgical facilities in which procedures that have a sufficient risk of potential harm to a patient must apply for, obtain, and maintain accreditation from CPSM prior to providing any such diagnostic or treatment services or procedures.

13.2. The criteria for assessing sufficient risk of potential harm to a patient include:
- *13.2.1. Level of anesthesia and/or sedation*
- *13.2.2. Need for medical device reprocessing (infection risk)*
- *13.2.3. Complexity of procedure and risk of complications*

2 – Procedures With Anesthesia and Certain Sedation to Require Accreditation by CPSM

Rather than just the current procedural anesthesia, this has been expanded to include other forms of anesthesia:

13.1.1. Any procedure that is carried out or should be carried out in accordance with generally accepted standards of care with the concurrent use of procedural or oral sedation including for patient comfort (pain and/or anxiety); See definitions of procedural and oral sedation in Article 13.

13.1.2. Any procedure that requires general anaesthesia, See definition of general anaesthesia; or

*"**Oral sedation**" means an altered state or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained. This is specific to the use of oral medication alone. An example may include oral dosing of opioids and/or benzodiazepines that produce the above states.*

***"procedural sedation"** means an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained, and*

- *i. includes, but is not limited to, the use of any IV or intra-muscular agent for this purpose; and*
- *ii. requires the monitoring of vital signs,*

but does not include the use of oral pre-medication alone or in combination with local anaesthesia. No distinction is made between light and deep procedural sedation for credentialing or monitoring purposes.

3 – Deep, Major, and Complicated Procedures to Require Accreditation by CPSM

This section is all new.

13.3.3.i. deep, major, and complicated procedures that may require more resources than are commonly available in a medical office. Surgeons should make decisions as to the appropriate location for these surgical procedures in accordance with the resources necessary for unexpected complications and with generally accepted standards of care. These procedures may include:

13.3.3.i.a. resection of a deep, major or complicated lesion;

13.3.3.i.b. surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal organs, and other life-threatening complications or requiring sterile precautions to prevent blood borne deep closed cavity or implant-related infections;

4 – Specific Procedures to Require Accreditation by CPSM

This section is all new.

13.3.3.ii. flexible endoscopic evaluation of the gastrointestinal or genitourinary tract;
13.3.3.iii. assisted reproduction technology, uterine evacuation procedures, and hysteroscopy;
13.3.3.iv. cataracts and retinal procedures;
13.3.3.v. Lasik therapeutic procedures;
13.3.3.vi. the use of drugs by injection which are intended or may induce a major nerve block or spinal, epidural or intravenous regional block;
13.3.3.vii. any tumescent liposuction procedure involving the administration of dilute local anesthesia;
13.3.3.viii. hair transplantation;
13.3.3.ix. venous sclerotherapy;
13.3.3.x. hyperbaric oxygen therapy;
13.3.3.xi. hemodialysis; or
13.3.3.xii. any procedure that the Committee directs, which must be performed in an approved, non-hospital medical or surgical facility, in order to meet the minimum acceptable standard of care for that procedure.

5 – Insertion of a New Provision for Standard of Care

22.1. An accredited facility and those members performing procedures must meet appropriate standards for the quality and safety of those treatments and procedures performed in that facility. To receive and maintain accredited status, a facility must:

22.1.1. demonstrate compliance with appropriate standards for quality and safety of treatments and procedures performed;

22.1.2. provide patient care in a manner consistent with good medical care as defined in the CPSM Standards of Practice Regulation and elaborated on in the Standards of Practice, Practice Directions, and Code of Ethics and Professionalism; and

22.1.3. engage in ongoing processes of self-review and quality improvement.

6 – Facility Accreditation Process

Article 15 sets out the process and rules for applying and receiving accreditation of an accredited facility.

7 – New Manner to Grant Privileges

Privileges can be granted by the Medical Director of an Accredited Facility if the privileges are the same as the member holds in Shared Health or a Regional Health Authority.

If the member does not hold privileges at either, then Shared Health will be asked to undertake an assessment of the member's competence and then CPSM's Program Review Committee will decide. The Working Group considered Shared Health to be the provincial body with the most knowledge to assess credentials, and CPSM did not have this expertise to perform such an in-depth assessment. See Article 21.

8 – Rules for Anesthesia and Other Patient Care Expanded

The Working Group originally recommended only those patients with ASA I and II have procedures performed in accredited facilities, and not those at ASA III as is permitted currently.

Several accredited facilities provided feedback advising of their extensive experience in providing safe care to ASA III patients, particularly those patients who due to obesity would be ASA III. Excluding ASA III patients would be particularly problematic for the Lasik clinics, and other eye procedures, where there is limited capacity in the hospitals for many eye procedures and many insured services for eyes are undertaken by contract with the health authority to be performed in an accredited facility. Assisted reproductive technologies are not provided in hospitals in Manitoba and excluding ASA III patients would mean many would not have access to this treatment in the province.

In the interest of patient safety, certain procedures could be limited to ASA I and II patients at facilities as part of the accreditation approval process of that facility.

Accordingly, the Working Group considered it appropriate for anesthesia risk level III patients to continue to undergo procedures in CPSM accredited facilities on an overall basis.

Anesthetic Care

23..1. All patients proposed to undergo anaesthesia in a facility must be assigned an American Society of Anaesthesia risk score and only patients with ASA I, II and III Risk scores may have a procedure performed unless otherwise indicated in the accreditation approval.

9 – Anesthesiology in Dental Clinics

CPSM members provide anesthesiology services in dental clinics for dentists performing dental surgery. These dental clinics are not CPSM accredited facilities, but they are accredited by the Manitoba Dental Association. A CPSM registered anesthesiologist accompanies the Manitoba Dental Association on its accreditation inspections and audits and plays a formal role in their accreditation process. The bylaw is recommended to include the provisions that CPSM members providing anesthesiology services for dentists must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association. See Article 13.4

10 – Day Procedures

The Working Group considered it important that the accredited facilities be confined to day surgeries and not become full hospitals as they cannot provide full hospital care.

23.3. A member shall not perform a procedure in an accredited facility unless the procedure is one that should safely allow the discharge of a patient from medical care in the facility within 23 hours of the day cycle (no overnight).

11 – Role of Medical Director

The role of the medical director was clarified and expanded to ensure one member was responsible for the accredited facility.

25.1 The facility shall appoint a medical director, who is a member acceptable to the committee, and who must:

25.1.1 enforce the standards of care in the facility, which include the safe and effective care of patients in the facility;

25.1.2 be responsible for the administration of the facility; and

25.1.3 provide required reporting to CPSM.

See Article 25 for the detailed list of the roles and responsibilities of the medical director under these three categories.

12 - Annual Reporting Requirements

The annual reporting requirements were enhanced and streamlined to provide value and concentrate on patient safety. Many of these requirements are now comparable to other jurisdictions and enhance the value of regulating the accredited facilities. See Article 27.

PUBLIC INTEREST RATIONALE

"A College must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest." s. 10(1) RHPA

All priorities are firmly within the public interest by improving patient safety by fulfilling CPSM's mandate and enhancing the quality of care by physicians. Each priority has its own public interest rationale.

The first decision of the Working Group was to require accreditation based on procedures that have a sufficient risk of potential harm to a patient. The second decision was to define sufficient risk of potential harm to a patient as being based upon the level of anesthesia/sedation, medical device reprocessing (infection risk), and complexity of procedure and risk of complications. The third decision was to list the actual procedures. Each decision is based on risk of potential harm to a patient which ensures public interest (patient safety) is paramount in decision-making.

Other decisions such as who can perform these procedures (granting privileges) ensures that those in the province most knowledgeable with both the procedures and with the required knowledge, skills, and judgment exercise the greatest power (through Shared Health granting privileges or making an assessment for CPSM's Program Review Committee). This heightens patient safety by having only those duly qualified by an external expert body perform such procedures.

The number of facilities performing procedures of an elevated risk and therefore requiring accreditation and regulation will increase, thereby enhancing patient safety.

IMPLEMENTATION DATE:

At this point CPSM is unaware as to how many facilities might require accreditation. Currently there are ten accredited facilities.

If approved by Council, CPSM will send a notice to the profession to advise them of the new accreditation requirements if they are performing any of these procedures outside of a hospital or Government owned and operated facility (or facility already accredited) and to apply for accreditation. CPSM will then spread out the process of granting accreditations over the next couple of years. CPSM will also ask these questions upon the on-line renewal of registration in 2021 to ensure all members understand the requirements for accreditation for certain procedures.

A transitional clause is included in the bylaw to permit time for every facility to become accredited.

31.2 To permit the orderly accreditation of new facilities under Article 14 effective the date of the Annual General Meeting, June 9, 2021, members must not perform these procedures at a facility unless the facility:

31.2.1 has applied for accreditation by December 1, 2021,

31.2.2 has been granted at least conditional or full accreditation by December 1, 2022,

31.2.3 is actively working on obtaining full accreditation as determined by the Committee, and

31.2.4 is seeking to comply with all requirements of this Part of the Bylaw as if it were a fully accredited facility.

31.3 The Committee may determine whether the facility is compliant with the provisions in 31.2.3 and 31.2.4.

Any change to the Bylaw requires ratification by the membership at the Annual General Meeting. This will be included in the June 2021 AGM.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 9, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

The Attached Accredited Facility Bylaw be approved effective the date of the Annual General Meeting on June 9, 2021.

1000 – 1661 Portage Avenue
Winnipeg, Manitoba R3J 3T7
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Accredited Facilities Bylaw

(Under Section 183 of The Regulated Health Professions Act)

The College of Physicians and Surgeons of Manitoba

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba on November 22, 2018 repealing and replacing Bylaw #3 and 3D under The Medical Act)

Effective Date January 1, 2019

~~Table of~~ Contents

Preamble

Prior to making this Bylaw, the Minister must be provided with a copy of the proposed Bylaw for review and Council must review and consider any comments made, pursuant to s. 183 of the RHPA.

PART A – DIAGNOSTIC FACILITIES

Application of this Part

Article 1 - Definitions

1.1. In Part A of Bylaw:

1.1.1. "**accreditation**" means a review process conducted by ~~CPSM~~the College to determine whether the facility being reviewed meets the standards specified by ~~CPSM~~the College.

1.1.2. **"anatomic pathology laboratory"** means a place where human surgical tissue biopsies and specimens, cytological specimens and autopsies are examined for diagnostic purposes.

1.1.3. **"certificate of accreditation"** means a certificate issued under this ~~Part of the~~ Bylaw.

1.1.4. **"clinical pathology laboratory"** means a place where diagnostic testing is performed on human samples including the disciplines of chemistry, hematology, transfusion medicine, cytology, immunology, microbiology, virology, histology or pathology.

1.1.5. **"Committee"** means the Program Review Committee of ~~CPSM~~the College.

1.1.6. **"diagnostic imaging facility"** means a place where imaging techniques are used for diagnostic purposes including radiography, ultrasound, computed tomography, magnetic resonance imaging, fluoroscopy, mammography or nuclear medicine.

1.1.7. **"facility"** means a place or a vehicle, whether privately owned or affiliated with or administered by a hospital or other health facility, which is principally equipped to perform a procedure normally performed in an anatomic pathology laboratory, a clinical pathology laboratory, a diagnostic imaging facility~~,~~ or a patient service centre. A clinical pathology laboratory facility may be comprised of a primary location, which is its laboratory, and one or more patient service centres.

1.1.8. **"facility director"** means a physician appointed as director of a facility in accordance with this ~~Part of the~~ Bylaw and ~~whose credentials are acceptable to the Committee and~~ is synonymous with the term "medical director" used in section 183(3) of the RHPA.

1.1.9. **"patient service centre"** means a location for the collection and/or testing of specimens of blood and of body fluids for the purpose of testing in an accredited laboratory.

1.1.10. **"physician office laboratory"** means a physician's office where specimens are collected and tested by the physician or a laboratory technician/assistant qualified by training from an accredited medical laboratory technician/assistant training program and is certified or eligible for certification with the Canadian Society of Medical Laboratory Science for the diagnosis of the physician's own patients.

1.1.11. **"standards"** means the standards approved by Council for facilities.

1.1.12. **"vehicle"** means a device in, upon or by which diagnostic equipment is transported upon a roadway and which is:

1.1.12.a. used primarily for the purpose of offering diagnostic services; and

1.1.12.b. has the approval of the Government of Manitoba to offer diagnostic services in Manitoba but does not include an emergency vehicle as defined in *The Highway Traffic Act*.

1.1. In this Bylaw, words and phrases defined in *The RHPA* have the same meaning as in the *RHPA*.

Article 2 ~~– Application of this Part~~

~~Part A of this Bylaw applies as follows:~~

~~2.1. Pursuant to *The Regulated Health Professions Act (RHPA), ss* 183(1)[1], to all diagnostic facilities in Manitoba which are principally equipped to perform a procedure normally performed in an anatomic pathology laboratory, clinical pathology laboratory, diagnostic imaging facility, and patient service centre, in which services are performed by members of CPSM, other than those under the jurisdiction of the provincial or municipal~~

[1] ~~183(1) This section applies to any facility in which a member performs or causes to be performed diagnostic or treatment services, such as a non-hospital medical or surgical facility or a nuclear medicine facility, other than~~
~~(a) a facility that is designated as a hospital under *The Health Services Insurance Act;*~~
~~(b) a hospital or health care facility operated by the government, the government of Canada or a municipal government; and~~
~~(c) a facility or class of facility exempted by regulation from the application of this section.~~

governments and those designated as hospitals under *The Health Services Insurance Act,* and a facility or class of facilities exempted by Regulation from the application of s.183(1) of the *RHPA.*

2.2. Pursuant to *s.183(15)*[2] *of the RHPA* and pursuant to the Service Purchase Agreement made between the College of Physicians and Surgeons of Manitoba and the Government of Manitoba governing diagnostic facilities, to those diagnostic facilities falling within the jurisdiction of the Government of Manitoba as specified in the Service Purchase Agreement.

2.3. Pursuant to s.12.3(1) (d) of the *CPSM General Regulation* this does not apply to a facility operated by the Canadian Blood Services, CancerCare Manitoba, St. Amant Inc., or Mount Carmel Clinic unless it is part of the Service Purchase Agreement referred to above.

Article 3 - Facility Accreditation

2.1. A facility is required to obtain accreditation before it offers any services to the public.

2.2. Accreditation of a facility must be:
- 2.2.1. except in the case of a vehicle, for a specific address or addresses.
- 2.2.2. for the fixed period of time determined by the Committee, to a maximum of 5 years.
- 2.2.3. for the procedures specified with the certificate of accreditation.

2.3. In the case of a vehicle, the facility must provide a current mailing address for the owner and the operator of the service.

2.4. Prerequisites to full accreditation of a facility pursuant to this By-law are:
- 2.4.1. compliance with the relevant standards; and
- 2.4.2. appointment of a facility director acceptable to the Committee.

2.5. The Committee must establish and make available on request:
- 2.5.1. standards for each type of facility.
- 2.5.2. the accreditation process for each type of facility.
- 2.5.3. the Committee's policies governing the accreditation process for each type of facility.

2.6. Applications for accreditation of a facility must be made to the Committee by the facility director, on the forms prescribed by the Committee, and must contain the information required by the Committee.

[2] 183(15) The council may enter into agreements with the government, the government of Canada or a municipal government to make this section applicable to any facility or any part of a facility that falls within that government's jurisdiction.

~~**Accreditation Process**~~

~~2.7. The accreditation process will include:~~

~~15.1.1 completion of a pre-inspection questionnaire by the Facility Director;~~

~~15.1.2 an inspection by one or more persons, with knowledge in the facility's work, designated by the Committee;~~

~~15.1.3 review of the facility's compliance with standards;~~

~~2.8. On completion of the accreditation process, the Committee may:~~

~~3.8.1 grant full accreditation and issue a certificate of accreditation to a facility if the Committee is satisfied that the facility has met all the requirements of Part A of this Bylaw and there are no identified deficiencies;~~

~~3.8.2 grant conditional accreditation to a facility with identified deficiencies and specifying the date it will expire if the identified deficiencies are not corrected;~~

~~2.9.~~2.7. Facility director and personnel who are subject to the accreditation process must cooperate fully, which includes but is not limited to:

2.7.1. permitting inspectors to enter the facility and inspect the premises and all diagnostic equipment located therein.

2.7.2. permitting inspectors to inspect all records pertaining to the provision of services and providing copies of the same if so requested.

2.7.3. providing requested samples or copies of any material, specimen, radiological image or product originating from the diagnostic service.

2.7.4. answering questions posed by the inspectors as to the procedures or standards of performance relating to examinations/procedures performed.

~~3.8.3 deny accreditation pending correction of identified deficiencies in accordance with s. 183(7) of the RHPA; or~~

~~3.8.4 withdraw any existing accreditation.~~

~~2.10.~~2.8. Where an inspection is conducted as part of the accreditation process, and deficiencies are observed, the Committee must issue a report of the inspection and must provide a copy of the report to the applicant.

Full Accreditation

~~2.11.~~2.9. Where a facility fully complies with the relevant standards, the Committee will grant full accreditation and will specify with the certificate of accreditation the procedures for which the facility is accredited.

Accreditation Not Granted

~~2.12.~~2.10. Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to the Executive Committee.

Conditional Accreditation

~~2.13.~~2.11. Where a facility does not fully comply with the relevant standards, but the Committee is of the opinion that it is in the public interest to permit the facility to operate while it corrects specified deficiencies, the Committee may grant conditional accreditation.

~~2.14.~~2.12. Where conditional accreditation is granted, the Committee must:

~~2.14.1.~~2.12.1. provide written notice of its decision and the reasons therefor and the information on the right of appeal to the Executive Committee.

~~2.14.2.~~2.12.2. state in its decision a fixed deadline for the facility to comply with all relevant standards and for the facility director to provide written confirmation of compliance to the Committee.

~~2.14.3.~~2.12.3. state in its decision whether a follow-up inspection must occur before full accreditation may be granted.

~~2.15.~~2.13. The Committee may extend the deadline for compliance with standards fixed pursuant to Article ~~3~~2.10 if, in its sole discretion, the Committee deems it appropriate to do so.

~~2.16.~~2.14. Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:

~~Extend conditional accreditation~~

~~2.16.1.~~2.14.1. direct an inspection.

~~2.16.2.~~2.14.2. withdraw the conditional accreditation and if the facility is publicly owned, report the matter to government with the request that the government require the facility to cease operation.

~~2.17.~~2.15. If the Committee is of the opinion that it is unsafe for the facility ~~is unsafe~~to provide services, it must ~~request~~direct the Registrar to notify the public of the deficiencies and ~~prohibit members from using~~to require that physicians not use the diagnostic facility.

Accreditation Status Review

~~2.18.~~2.16. Accreditation status may be reviewed at the discretion of the Committee.

Temporary Accreditation

~~2.19.~~2.17. Temporary accreditation may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.

~~**Role of Facility Director During Accreditation**~~

~~2.19.1.~~2.1.1. ~~Facility director and personnel who are subject to the accreditation process must cooperate fully, which includes but is not limited to:permitting inspectors to enter the facility and inspect the premises and all diagnostic equipment located therein.~~

~~2.19.2.~~2.1.1. ~~permitting inspectors to inspect all records pertaining to the provision of services and providing copies of the same if so requested.~~

~~2.19.3.~~2.1.1. ~~providing requested samples or copies of any material, specimen, radiological image or product originating from the diagnostic service.~~

~~2.19.4.~~2.1.1. ~~answering questions posed by the inspectors as to the procedures or standards of performance relating to examinations/procedures performed.~~

Article ~~4~~3 – Maintenance of Accreditation

3.1. In order to maintain accreditation, a facility must:
- 3.1.1. comply with the relevant standards.
- 3.1.2. perform only the procedures permitted pursuant to the facility's certificate of accreditation.
- 3.1.3. at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect.
- 3.1.4. cooperate with and participate in the inspection process approved by the Committee for its type of facility.

3.2. During the currency of a full or conditional accreditation the Committee may direct an inspection for the purpose of monitoring compliance, if the Committee is of the opinion that:
- 3.2.1. a facility may not meet the relevant standards ~~and~~ or practice.
- 3.2.2. an inspection would be in the public's best interest.

Article 4 – Variance of Accreditation

4.1. A facility may apply at any time to vary its accreditation.

Article 5 – Renewal of Accreditation

5.1. In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation.

Article 6 – ~~Variance or Withdrawal~~Cancellation of Accreditation

~~6.1 A facility may apply at any time to vary its accreditation.~~

~~6.2 If the Committee is of the opinion that the facility may be unsafe, the Committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the Committee deems appropriate in the circumstances, including withdrawing accreditation and if the facility is publicly owned, report the matter to government with the recommendation that the government require the facility to cease operation. If the Committee is of the opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit members from using the facility.~~

6.1. Where a facility is no longer providing patient services, the Committee may ~~withdraw~~cancel the facility's accreditation.

6.2. Council may ~~withdraw~~cancel accreditation in accordance with The ~~RHPA~~Regulated Health Professions Act.

Article 7 – Facility Director

7.1. A facility must have a facility director.

7.2. A facility director must be a physician whose credentials are acceptable to the Committee.

7.3. The Committee must establish and make available on request the qualifications for facility directors in each type of facility.

7.4. The facility director is responsible for granting privileges to any physician who wishes to work for the facility and notifying the Committee of the physicians who are granted privileges. Before granting privileges to any physician a facility director must:

7.4.1. define in writing the qualifications and competencies required in order to obtain privileges in each field of practice.

7.4.2. obtain written confirmation that the applicant is registered and licensed to practice medicine in Manitoba.

7.4.3. obtain full particulars of the applicant's education, training, competencies and experience.
7.4.4. take reasonable steps to ensure that the applicant has the education, training competencies and experience required, and that the applicant is otherwise a suitable candidate for privileges.

7.5. Within one year of first granting privileges to a physician, the facility director must review that physician's privileges. Thereafter, privileges must be reviewed by the facility director at least every two years.

7.6. Before granting renewal of privileges or extending the existing privileges of any physician, the facility director must take reasonable steps to ensure that the physician has the education, training, competencies and experience required for each field of practice for which he or she is seeking privileges within the facility.

7.7. The facility director must have effective control of and be responsible for the safe operation and administration of the facility, the supervision of all professional, technical and administrative activities of the facility, and for compliance with this Bylaw and with the relevant standards established by the Committee.

7.8. Without limiting the generality of the foregoing, the facility director must:

7.8.1. have access to all records and documents relating to the operation of the facility and the procedures performed therein.
7.8.2. communicate with any facility under his/her direction a minimum of once per year.
7.8.3. ensure that quality management system requirements and improvement programs are in place.
7.8.4. ensure that the facility has current up to date policies and manuals as required by the standards for that facility.
7.8.5. ensure that complete and accurate patient records and documentation relating to the operation of the facility and procedures performed are kept.
7.8.6. ensure that no procedure is carried out in the facility unless it is permitted by the certificate of accreditation.
7.8.7. ensure that technologists have the qualifications as provided by training from an accredited:
7.8.7.a. medical laboratory training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.
7.8.7.b. medical radiology technology training program and are certified or eligible for certification with the Canadian Association of Medical Radiology Technologists.
7.8.8. ensure that medical laboratory technologists who are required to perform x-ray examinations and medical radiology technologists who are required to perform laboratory testing have graduated from a cross-training program.

7.8.9. ensure that laboratory technicians/assistants have the qualifications as provided by training from an accredited medical laboratory technician/assistant training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.

7.8.10. ensure that persons who provide services to the facility maintain competence to perform the procedures for which the facility is accredited.

7.8.11. ensure that work referred out of the facility is performed by persons with appropriate qualifications and competence to perform the work.

7.8.12. promptly notify ~~CPSM~~the College of any change in the ownership or directorship of the facility.

7.8.13. promptly notify ~~CPSM~~the College if the facility is no longer providing patient services.

7.8.14. where applicable, be available for consultation with referring physicians.

7.8.15. promptly notify the Committee if there is a major change in the following:

7.8.15.a. equipment.

7.8.15.b. the accredited list of diagnostic imaging examinations, laboratory or transfusion medicine tests, or blood and blood products dispensed.

7.8.16. Ensure that the duties and responsibilities of all personnel are written and understood;

7.8.17. Ensure adequate quality assurance and improvement programs are in place

7.9. The facility director must submit to ~~CPSM~~the College such information as required by the Committee.

Article 8 - Appeal

8.1. The facility or a ~~member may appeal any~~physician who has been adversely affected by a decision of the Committee ~~to~~may appeal the ~~Executive~~decision of the Committee ~~pursuant to sections 183 and 38 of the RHPA~~. The appeal must be made by filing a written notice of appeal with the ~~Registrar~~Council within ~~thirty calendar~~30 days ~~of being informed of~~after the person receives notice of the decision. The notice of appeal must specify the reasons for the appeal.

Article 9 - Fees

9.1. A privately-owned facility ~~shall~~must pay all expenses, charges and fees incurred by ~~CPSM~~the College in ~~respect of~~relation to the accreditation or inspection of ~~the~~that facility ~~and the administration of Part A of this Bylaw~~.

Article 10 – Physician Office Laboratory

10.1. Physicians must not operate a physician office laboratory without first obtaining the written approval of ~~CPSM~~the College.

10.2. The Committee may direct the inspection of any facility where physician office laboratory procedures are performed.

Article 11 - Standing

11.1 Revoked

Article 12 - Transition

12.1. A facility that holds accreditation at the time this Bylaw comes into force continues to hold that accreditation status under this Bylaw in accordance with the terms of that accreditation.

12.2. A facility which has not undergone the accreditation process will be notified in writing by ~~CPSM~~the College that it is exempt from the requirement of accreditation set forth in this Bylaw until the inspection process for that facility is complete and a report is issued, but the facility must cooperate with ~~CPSM~~the College for the timely completion of its accreditation process in accordance with this Bylaw.

12.3. A physician who holds a facility directorship at the time this Bylaw comes into force continues to hold that status under this Bylaw.

PART B – NON-HOSPITAL SURGICAL FACILITIES

Article ~~12~~13 - Application of this Part

13.1 Subject to section 183 of the RHPA and Article 13.3 of this Bylaw, Part B of this Bylaw applies to all non-hospital medical/surgical facilities that carry out diagnostic and treatment procedures.

13.2 Subject to Article 13.3, Part B of this Bylaw applies to the following procedures:

13.2.1 Any procedure that is carried out with the concurrent use of:

13.2.1.1 procedural sedation, or

13.2.1.2 local, regional or general anesthesia,

provided that the standard of care requires monitoring of vital signs as a result of the administration of the drug to induce sedation or anesthesia;

13.2.2 Any procedure that the Committee directs must be performed in an approved non-hospital surgical/medical facility in order to meet the minimum acceptable standard of care for that procedure.

13.3 This Part of the Bylaw does not apply to any facility which is wholly owned and operated by a Regional Health Authority.

Article 14 - Definitions

14.1. In Part B of this Bylaw:

“accreditation” means ~~a review process conducted by CPSM to determine whether the facility being reviewed meets the requirements specified~~the approval granted by ~~CPSM~~the College to a non-hospital medical/ surgical facility to carry out certain diagnostic and/or treatment procedures.

"certificate of accreditation" means a certificate issued ~~under this Part of the Bylaw.~~to a non-hospital medical/surgical facility by the committee of the College certifying that it has received accreditation.

"committee" means the ~~Program Review~~ committee of ~~CPSM~~the College responsible for the administration of this Part only of the Bylaw.

“direct or indirect financial interest” means any interest owned by a member, by individuals connected by blood relationship, marriage or adoption to a member, by any corporation, proprietorship, partnership, society, business, association, joint venture, group or syndicate in which a member or any individual connected by blood relationship, marriage or adoption to a member have any interest.

"director" means a physician who is appointed the director of a non-hospital medical/surgical facility.

"facility" means a non-hospital medical/surgical facility for the purposes of Part B of this Bylaw.

“general anaesthesia” means a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently, or to respond purposefully to physical stimulation or verbal command, produced by pharmacologic or non-pharmacologic methods, alone or in combination.

“hospital” means a hospital under *The Hospitals Act* ~~or the *Regional Health Authorities (Health System Governance and Accountability) Act* when proclaimed~~ with an operational Emergency ~~or Urgent Care~~ Department.

~~**"medical director"** means a physician appointed as director of a facility in accordance with this Part of the Bylaw and whose credentials are acceptable to the Committee and is synonymous with the term "medical director" used in section 183(3) of the RHPA.~~

~~"**oral sedation**" means an altered state or depressed state of awareness or perception of pain brought about by pharmacologic agents and with is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained. This is specific to the use of oral medication alone. An example may include oral dosing of opioids and/or benzodiazepines that produce the above states.~~

"privileges" means the authority to admit and treat patients at a facility.

"procedural sedation" means an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained, and

i. includes, but is not limited to, the use of any IV ~~or intra-muscular~~ agent for this purpose; and
ii. requires the monitoring of vital signs,

but does not include the use of oral pre-medication alone or in combination with local anaesthesia. No distinction is made between light and deep procedural sedation for credentialing or monitoring purposes.

"procedure" means the diagnostic and treatment procedures, both medical and surgical, as approved by the committee to be carried out in a facility.

~~Article 13 - Application of this Part – Procedures Requiring Accreditation~~

~~13.1. Part B of this Bylaw applies to all non-hospital medical or surgical facilities, subject to section 183 of the RHPA, and not included in Part A of this Bylaw. All non-hospital medical or surgical facilities in which procedures that have a sufficient risk of potential harm to a patient must apply for, obtain, and maintain accreditation from CPSM prior to providing any such diagnostic or treatment services or procedures.~~

~~13.2. The criteria for assessing sufficient risk of potential harm to a patient include:~~
~~13.2.1. Level of anesthesia and/or sedation~~
~~13.2.2. Need for medical device reprocessing (infection risk)~~
~~13.2.3. Complexity of procedure and risk of complications~~

~~13.3. The following procedures have a sufficient risk of potential harm to the patient to require accreditation:~~
~~13.3.1. Any procedure that is carried out or should be carried out in accordance with generally accepted standards of care with the concurrent use of procedural or oral~~

sedation including for patient comfort (pain and/or anxiety); See definitions of procedural and oral sedation in Article 13.

13.3.2. Any procedure that requires general anaesthesia, See definition of general anaesthesia; or

13.3.3. Procedures involving:

13.3.3.i. deep, major, and complicated procedures that may require more resources than are commonly available in a medical office. Surgeons should make decisions as to the appropriate location for these surgical procedures in accordance with the resources necessary for unexpected complications and with generally accepted standards of care. These procedures may include:

13.3.3.i.a. resection of a deep, major or complicated lesion;

13.3.3.i.b. surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal organs, and other life-threatening complications or requiring sterile precautions to prevent blood borne deep closed cavity or implant-related infections;

13.3.3.ii. flexible endoscopic evaluation of the gastrointestinal or genitourinary tract;

13.3.3.iii. assisted reproduction technology, uterine evacuation procedures, and hysteroscopy;

13.3.3.iv. cataracts and retinal procedures;

13.3.3.v. Lasik therapeutic procedures;

13.3.3.vi. the use of drugs by injection which are intended or may induce a major nerve block or spinal, epidural or intravenous regional block;

13.3.3.vii. any tumescent liposuction procedure involving the administration of dilute local anesthesia;

13.3.3.viii. hair transplantation;

13.3.3.ix. venous sclerotherapy;

13.3.3.x. hyperbaric oxygen therapy;

13.3.3.xi. hemodialysis; or

13.3.3.xii. any procedure that the Committee directs, which must be performed in an approved, non-hospital medical or surgical facility, in order to meet the minimum acceptable standard of care for that procedure.

13.4. CPSM members providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.

13.5. This Part of the Bylaw does not apply to any hospital or health care facility operated by a health authority or the Governments of Canada, Manitoba, or any municipality.

~~Article 14 - Members Must not Work in Non-Accredited Facilities~~

~~14.1. A member must not perform or cause to be performed any procedure in a facility that requires accreditation under this Part, but is not accredited, in accordance with s. 183(14) of the RHPA and in accordance with the transition provisions in Article 29.~~

~~14.2. A facility is required to obtain accreditation before it offers any services to the public.~~

Article 15 - Facility Accreditation

15.1 ~~The medical director of~~ A facility seeking accreditation must:

~~15.1.4~~15.1.1 apply on the form prescribed by the committee, specifying the procedures for which accreditation is sought~~.~~;

~~15.1 The medical director must agree to pay the fee charged for the inspection and accreditation process even if the accreditation is not completed or granted.~~

~~**Accreditation Process**~~

15.1.2 provide full and complete details of the facility's ownership, the facility's administration and a list of all members who wish to have privileges to carry out procedures at the facility, including but not limited to: the names of the director(s) and owner(s) of the facility, including any members who have direct or indirect financial interest in the facility, and a medical corporation has a direct or indirect financial interest, the names of the medical corporation's officers and directors;

15.1.3 provide the name of the facility director, a written outline of his or her duties and responsibilities, an outline of the facility's administration, and an organization chart; and

15.1.4 submit the application form, signed by the director, and supporting documents to the committee with the prescribed fee for the application and inspection processes.

15.2 The accreditation process will include:

15.2.1 completion of a pre-~~inspection~~visit questionnaire ~~by the medical director;~~;

15.2.2 an on-site inspection by one or more members, with expertise in the appropriate area of medical practice, designated by the committee;

15.2.3 review of the facility's compliance with ~~requirements including CPSM and medical or other~~the College's standards; and

15.2.4 ~~CPSM~~ providing the Minister with a copy of each application and report as required by section 183(17) of the RHPA.

15.3 In circumstances which the committee deems appropriate, provisional approval may be granted for the operation of a facility pending the completion of the accreditation process.

~~15.3~~15.4 On completion of the accreditation process, the committee may:

~~15.3.1~~15.4.1 grant full accreditation and issue a certificate of accreditation to a facility if the committee is satisfied that the facility has met all of the requirements of Part B of this Bylaw and there are no identified deficiencies~~;~~.

~~15.3.2~~15.4.2 grant conditional accreditation to a facility with identified deficiencies and issue a conditional certificate of accreditation specifying the date it will expire if the identified deficiencies are not corrected~~;~~.

~~15.3.3~~15.4.3 deny accreditation pending correction of identified deficiencies in accordance with s. ~~not grant accreditation pending correction of identified deficiencies in accordance with s.~~ 183(7) of the RHPA~~; or~~.

~~15.4.1 withdraw any existing accreditation.~~

~~15.2 Where an inspection is conducted as part of the accreditation process, and deficiencies are observed, the Committee must issue a report of the inspection and must provide a copy of the report to the applicant.~~

~~**Full Accreditation**~~

~~15.3 Where a facility fully complies with the relevant requirements, the Committee will grant full accreditation and will specify with the certificate of accreditation the procedures for which the facility is accredited.~~

~~**Accreditation Not Granted**~~

~~15.4 Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to the Executive Committee.~~

~~**Conditional Accreditation**~~

~~15.5 In circumstances where a facility does not comply fully with all requirements for accreditation, and if the Committee deems it adequate for patient safety, conditional approval may be granted for the operation of a facility pending the completion of the accreditation process or while it corrects specified deficiencies.~~

~~15.6~~ Where conditional accreditation is granted, the ~~Committee must:~~

~~15.9.1 provide written notice of its decision and the reasons therefor and the information on the right of appeal to the Executive Committee.~~

~~15.9.2 state in its decision a fixed deadline for the facility to comply with all relevant standards and for the medical director to provide written confirmation of compliance to the Committee.~~

~~15.9.3 state in its decision whether a follow up inspection must occur before full accreditation may be granted.~~

~~15.4~~15.5 ~~Where conditional accreditation is granted, the medical~~ director must provide a written response to each deficiency within the time specified by the committee, and a follow-up inspection may occur, if the committee so directs. Full accreditation will only be granted when identified deficiencies have been corrected to the satisfaction of the committee.

15.6 A certificate of accreditation will be issued by the committee for a period not to exceed five years.

15.7 Each certificate of accreditation must append a schedule of procedures approved for the facility.

15.8 Where a facility is no longer ~~The~~ being used for the procedures set out in Article 15.7, the committee may ~~extend the deadline for compliance with~~ revoke the facility's certificate of accreditation.

~~15.5~~15.9 If the committee is of the opinion that a facility is not meeting the requirements ~~if, in its sole discretion,~~of Part B of this Bylaw or is unsafe, the committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the committee deems ~~it~~ appropriate ~~to do so~~ in the circumstances. Where the committee is of the opinion that a facility does not meet the required standards, the committee must report the matter pursuant to s. 183(9) of *The Regulated Health Professions Act*.

~~15.7 Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:~~
~~15.12.1 extend conditional accreditation;~~
~~15.12.2 direct an inspection;~~
~~15.12.3 withdraw the conditional accreditations.~~

~~**Temporary Accreditation**~~

~~15.8 Temporary accreditation may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.~~

~~**Term of Accreditation and Renewal**~~

~~15.9 Accreditation of a facility must be for the fixed period of time determined by the Committee, to a maximum of five years.~~

~~15.6~~15.10 In order to renew a certificate of accreditation, ~~a~~the facility must ~~re-~~apply for renewal of accreditation at least six months prior to the ~~expiration~~ date ~~of~~ the ~~existing~~certificate of accreditation~~.~~ is to expire. The re-accreditation process will follow the same procedure as required for accreditation. Where an application to renew is pending, the ~~Committee may continue the~~ facility's accreditation continues until a decision is made on the renewal application.

~~Article 16 - Maintenance of Accreditation~~

15.11 The facility must inform the committee of any changes in the information provided in its application for accreditation within 15 days of the date of the change.

Article 16 - Hospital Agreement

Every facility must have

~~16.1 In order to maintain accreditation,~~ a ~~facility must:~~

~~16.1.1 comply~~written agreement with ~~the relevant requirements;~~

~~16.1.2 perform only the procedures permitted~~a hospital or a Regional Health Authority pursuant to ~~the facility's certificate of accreditation;~~

~~16.1.3 at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of~~which the ~~Committee's intention~~hospital or the Regional Health Authority agrees to provide emergency treatment if a patient has to ~~inspect; and~~

~~16.1.4 cooperate with and participate in the inspection process approved by~~ be transferred from the ~~Committee for its type of facility.~~

~~16.2 During the currency of a full or conditional accreditation the Committee may direct an inspection for the purpose of monitoring compliance, if the Committee is of the opinion that:~~

16.1. ~~a~~ facility ~~may not meet the requirements, standards of practice, or other standards for public safety and~~.

~~16.2.1 an inspection would be in the public's best interest.~~

Article 17 ~~– Renewal of Accreditation~~

~~18.1 In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation.~~

~~Article 18 – Variance or Withdrawal of Accreditation~~

~~17.1. A facility may apply at any time to vary its accreditation.~~

~~17.2. If the Committee is of the opinion that the facility may be unsafe, the Committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the Committee deems appropriate in the circumstances, including withdrawing accreditation and ordering it to cease operation. If the Committee is of the opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit members from using the facility.~~

~~17.3. Where a facility is no longer~~ ~~providing patient services, the Committee may withdraw the facility's accreditation.~~

~~17.4. Council may withdraw accreditation in accordance with the RHPA.~~

~~Article 19~~ - Approved Procedures

~~17.5.~~17.1. Each certificate of accreditation must include a schedule listing the procedures which have been approved for the facility, and the names of the members who have been given privileges to perform the procedures at the facility.

~~17.6.~~17.2. The schedule of procedures may be amended from time to time upon the application of the facility and the approval of the committee.

~~17.7.~~17.3. Only those procedures which are approved by the committee and set out in the schedule to the facility's certificate of accreditation may be performed in the facility~~.~~

Article 18 - Privileges

~~19.1.~~ A facility ~~Where a facility is no longer being used for the procedures set out in Article 13, the Medical Director must inform the Assistant Registrar. The Committee may withdraw the facility's certificate of accreditation.~~

~~Article 20 – Health Authority Agreement~~

~~16.2. Every facility must have a written agreement with a health authority pursuant to which the health authority agrees to provide emergency treatment if a patient has to be transferred from the facility.~~

~~Article 21 - Privileges~~

~~21.1. A member must have privileges at an accredited facility prior to performing any of the services and procedures listed in Part B;~~

~~21.2. The Medical Director must only grant and renew privileges for a member to perform procedures in an accredited facility if the Medical Director is satisfied that:~~
~~21.2.1. the applicant is a suitable and competent candidate~~
~~21.2.2. the treatment services and procedures are within the privileges requested and within the knowledge, skill, and judgment of the applicant and~~

18.1 ~~those privileges are the same as granted~~must not grant privileges to a member unless:
18.1.1 the member qualifies for privileges in accordance with this Part of the Bylaw, or
18.1.2 the member's application for privileges is expressly approved by ~~Shared Health~~the College.

18.2 An applicant seeking privileges at a facility must:
18.2.1 apply in writing to the director,
18.2.2 provide to the director:
~~18.1.1.a~~18.2.2.a a description of any privileges currently held in a hospital or a Regional Health Authority ~~or are recommended through the Shared Health credentialing process and those privileges are and remain~~ in ~~good standing.~~the city or the municipality where the facility is located; and

18.2.2.b ~~Where~~a letter from the ~~member does not have Shared Health~~hospital or Regional Health Authority confirming the privileges ~~the Medical Director must only provide~~held and the good standing of the applicant.

18.3 Provided that:
18.3.1 the applicant complies with the requirements of Article 18.2,
~~21.3.~~ the privileges ~~for a specific facility if the Committee has already granted privileges under the following process:~~
~~21.3.1. utilize the established Shared Health credentialing process to assess applicants using established specialty groups;~~
~~18.1.2~~18.3.2 ~~implement a non-refundable assessment fee paid to Shared Health~~sought by the applicant are no greater than those the applicant holds at a hospital or the Regional Health Authority ~~payable by~~in the ~~member seeking credentials for~~municipality or the ~~credentialing process;~~city where the facility is located,
~~18.1.3~~18.3.3 ~~seek and obtain an assessment from Shared Health regarding~~ the ~~granting of~~director is satisfied that the applicant is a suitable candidate for the privileges~~,~~ requested, and ~~then~~
~~18.1.4~~18.3.4 the ~~Committee shall decide whether to~~director may grant privileges~~.~~ to the applicant.

~~21.4.~~ Within 15 ~~calendar~~ days of granting ~~or renewing~~ privileges pursuant to Article 18.2, the ~~Medical~~ director must provide, to the ~~Assistant Registrar with the~~College, particulars of the privileges granted in the facility~~.~~
and, upon request by the College, a copy of the correspondence from the hospital or the Regional Health Authority referred to

~~21.5. Any member who performs services and procedures without obtaining privileges in the facility and any Medical Director who permits a member to perform services and procedures without privileges in the facility may be found guilty of professional misconduct.~~

~~18.2~~18.4 Article ~~22 - Standard of Care~~18.2(b)(ii).

18.5 ~~An accredited facility and those members performing procedures must meet appropriate standards for the quality and safety of those treatments and~~ A member seeking privileges who does not hold the same or similar privileges in a hospital or a Regional Health Authority in the municipality or the city where the facility is located must provide to the director:

18.5.1 details of the same or similar privileges, if any, currently held in other facilities;

~~22.1.~~ numbers of procedures performed ~~in that facility. To receive and maintain accredited status, a facility must:~~

~~18.2.1~~18.5.2 ~~demonstrate compliance with appropriate standards for quality and safety~~during the past year similar to those for which he/she is seeking privileges and the name(s) of ~~treatments and procedures~~the facilities in which they were performed;

~~22.1.1. provide patient care in a manner consistent with good medical care as defined in the CPSM Standards of Practice Regulation and elaborated on in the Standards of Practice, Practice Directions, and Code of Ethics and Professionalism; and~~

~~22.1.2. engage in ongoing processes of self-review and quality improvement.~~

18.5.3 any other relevant past experience; and

18.5.4 the names of two referees who can be consulted as to the skill and judgment of the member to perform such procedures.

18.6 For any application made pursuant to Article 18.5, the director must forward to the College:

18.6.1 a copy of the application,

18.6.2 the director's assessment of the suitability of the applicant for the privileges requested, and

18.6.3 a letter from the Regional Health Authority or an appropriate hospital located in the municipality or city in which the facility is located confirming that patients treated by the applicant at the facility shall be treated and admitted to a hospital, as necessary, under the care of members who have appropriate credentials and privileges.

18.7 In considering an application made pursuant to Article 18.5, the committee may request such further or other information as it deems necessary to assess the application.

18.7.1 The committee may grant privileges to a member who does not have the same or similar privileges at a hospital or a Regional Health Authority in the municipality or the city in which the facility is located only on the following conditions:

18.7.1.a the member shall be subject to a periodic review conducted by the director and/or any other person(s) deemed appropriate by the committee, to ensure maintenance of competence of the procedures he or she performs; and

18.7.1.b where applicable, a process for reviewing pathology reports shall be established and followed by the facility.

18.8 Any member who performs procedures without obtaining privileges in the facility and any director who permits a member to perform procedures without obtaining privileges in the facility may be found guilty of professional misconduct.

Article ~~23~~19 - Patient Care

~~23.1. Anesthetic Care~~

19.1 In a facility:

19.1.1 All patients proposed to undergo ~~anesthesia~~anaesthesia in a facility must be assigned an American Society of Anaesthesia risk score ~~and~~ .

~~19.1.1~~19.1.2 Only patients with ASA I, II and III Risk scores may have a procedure performed ~~unless otherwise indicated in the accreditation approval.~~.

~~19.1.2~~19.1.3 General anaesthesia must not be given to infants under the age of twenty-four months.

~~19.1.3~~19.1.4 A patient who receives general anaesthesia or procedural sedation should only leave the facility in the care of an adult.

~~19.1.4~~19.1.5 Procedural sedation must be administered by or under the direct supervision of a member with appropriate training acceptable to ~~CPSM~~the College to provide procedural sedation.

~~19.1.5~~19.1.6 A patient who receives procedural sedation must be attended by a registered nurse or a member who is not assisting in the surgical procedure and who is trained to monitor patients under procedural sedation.

19.1.7 All personnel who administer anaesthesia, major regional block or procedural sedation or who monitor the recovery of patients who receive anaesthesia, major regional block or procedural sedation must maintain a current certificate of proficiency in basic cardiopulmonary resuscitation.

~~19.1.6~~19.1.8 There must be at least two personnel who are certified in basic cardiopulmonary resuscitation within the facility while patients are receiving care.

~~19.1.7~~19.1.9 All equipment for the administration of anaesthetics must be readily available, clean and properly maintained.

19.2 A member ~~who has been granted privileges~~ must:

19.2.1 be in the room at all material times during the performance of a procedure in the facility.

19.2.2 ensure that following any procedure~~,~~ patients receive an adequate recovery period under supervision before leaving the facility.

19.2.3 be responsible for the post-operative care of the patient within the facility.

19.2.4 ensure qualified support staff are be on duty during and after a procedure in the facility.

19.2.5 maintain accurate information concerning the medical condition of patients in a clinical record which meets the expected standards of medical record-keeping, including documentation related to the informed consent of the patient for the procedure(s) performed in a facility.

19.2.6 perform procedures in a facility only if the facility ~~is~~has adequately equipped and ~~has~~ maintained operating and post-operative rooms and all equipment is safe, well maintained and compliant with applicable federal, provincial, and municipal legislation.

~~23.2. A member shall not perform~~ A procedure ~~in an accredited facility unless the procedure is one that should safely allow the discharge of a patient from medical care in the facility~~ within ~~23 hours of~~the cranium, the thorax, or the abdomen and major joint surgery may be performed, assisted or provided in a facility only where the ~~day cycle (no overnight).~~

~~Article 24 - Infection Control~~

~~22.1 A facility must:~~

~~22.1.1 use sterilization techniques,~~

~~22.1.2~~22.1.1 ~~store medical and dental supplies, and~~

~~22.1.3 use waste handling and disposal procedures~~

~~consistent with the standards applicable~~committee has given its written authorization to ~~hospitals.~~

19.3 ~~A facility must comply with all guidelines~~ ~~CPSM may require~~ the facility to ~~comply with to meet best practices on infection control practices in a facility setting, including~~perform the procedure, which authorization may include conditions or restrictions specified by the ~~Ontario Public Health~~ ~~Infection Prevention and Control for Clinical Office Practice.~~ committee.

Article ~~25 - Medical~~20 - Facility Director

20.1 The facility shall appoint a ~~medical~~facility director, who is a member acceptable to the committee, and who must:

20.1.1 be responsible for the administration of the facility;

~~20.1.1~~20.1.2 enforce the standards of care in the facility, which include the safe and effective care of patients in the facility;

~~25.1.1 be responsible for the administration of the facility; and~~

~~25.1.2 provide required reporting to CPSM.~~

~~25.2 In enforcing the standards of care in the facility which includes the safe and effective care of patients, the medical director must ensure that:~~

~~25.2.1 procedures and equipment are appropriate and safe;~~

~~25.2.2 procedures are performed in accordance with current good medical care and practice;~~

~~25.2.3 sufficient numbers of appropriately trained personnel are present during procedures;~~

~~25.2.4 procedures approved by the Committee as set out in the certificate of accreditation are only performed at the facility by members with privileges;~~

~~25.2.5 persons who provide services to the facility have appropriate qualifications and maintain competence to perform the procedures for which the facility is accredited;~~

~~25.2.6 members with privileges have current basic life support skills and other skills appropriate to the clinical settings (such as advanced cardiac support, pediatric advanced life support, and airway management skills);~~

~~25.2.7 all direct patient care personnel have life support skills and there must be two such qualified personnel present at any time patients are receiving care;~~

~~25.2.8 adequate quality assurance and improvement programs, including the monitoring of infection and medical complication rates, are in place.~~

~~25.3 In being responsible for the administration of the facility, the medical director must:~~

~~20.1.2~~20.1.3 have access to all records and documents relating to the operation of the facility and the procedures performed therein;

~~20.1.3~~20.1.4 develop appropriate and up-to-date policy and procedure manuals, including acceptable staff health policies;

~~20.1.4~~20.1.5 ensure the duties and responsibilities of all personnel are written and understood;

20.1.6 ensure the requirements for granting privileges are met and the necessary approvals are obtained;

20.1.7 ensure sufficient numbers of appropriately trained personnel are present during procedures;

20.1.8 ensure procedures and equipment are appropriate and safe;

20.1.9 ensure agreements are in place for the emergency transfer and admission of patients as required herein;

~~20.1.5~~20.1.10 ensure complete and accurate confidential patient records and documentation relating to the operation of the facility and procedures performed are kept ~~current and up to date~~;

20.1.11 ensure adequate quality assurance and improvement programs, including the ~~requirements for granting privileges~~monitoring of infection and medical complication rates, are ~~met with necessary approvals and~~ in place;

20.1.12 ensure only those eligible procedures which are approved by the committee as set out in the certificate of accreditation are performed at the facility by members; and

~~20.1.6~~20.1.13 ensure complete records are kept of all members who obtain privileges at the facility, including their applications~~;~~ and to make such records available to the committee or its designates on request.

~~20.1.7~~20.1.14 ensure documentation, fees and a complete reporting of all required information to ~~CPSM~~the College is submitted ~~when and as required;~~.

~~25.3.1 meet annually with each member~~ensure that persons who ~~has privileges~~provide services to ~~review those privileges~~the vacility have appropriate qualifications and ~~document the review; and~~

~~25.3.2 attend at~~maintain competence to perform the procedures for which the facility ~~at least one day per month or more if prescribed by the Committee to inspect the facility, and meet with other staff to review operations, the facility, standards, and quality assurance;~~

~~25.4 In providing required reporting to CPSM, the medical director must:~~

~~20.1.8~~20.1.15 ~~Ensure that the Assistant Registrar~~ is ~~notified within one working day of becoming aware of any of the following circumstances and provide a report within two weeks of any of the following:~~accredited;

~~25.4.1.i death that occurs within 10 days of the procedure;~~

~~25.4.1.ii transfers from the facility to a hospital regardless of whether or not the patient was admitted;~~

~~25.4.1.iii unexpected admission to hospital within 10 days of a procedure performed;~~

~~25.4.1.iv clusters of infections among patients treated in the facility; or~~

~~25.4.1.v procedure performed on wrong patient, side, or site or wrong procedure; or~~

~~25.4.1.vi any other major adverse event.~~

~~20.1.9~~20.1.16 promptly notify the ~~Assistant Registrar~~College of any change in ownership of the facility ~~within one month;~~ ;

~~20.1.10~~20.1.17 promptly notify the ~~Assistant Registrar~~College if the facility is no longer providing patient services ~~within one month;~~ ;

~~20.1.11~~20.1.18 promptly notify the ~~Assistant Registrar~~College if there is a major change in equipment or ~~renovations to the facility or~~ the accredited list of procedures ~~within ten days; and~~.

~~25.4.2 advise the Assistant Registrar of resignation, revocation, suspension, or restriction of privileges of staff immediately.~~

Article ~~26~~21 - Audit and Quality Control

21.1 All certificates of accreditation are subject to the following conditions:

21.1.1 All procedures and all clinical records must comply with the requirements of standards of care set by ~~CPSM.~~ the College.

21.1.2 Quality assurance and improvement programs are in place sufficient to demonstrate that standards of patient care set by ~~CPSM and required for good medical care~~the College are met in the facility.

~~Article 27 - Annual Report~~

21.1.3 ~~The medical~~At least annually the director must review the facility's quality assurance and improvement programs ~~at least annually~~.

21.1.4 Within 30 days of each calendar year end, the ~~medical director~~facility must forward an annual report ~~in the prescribed form~~ to the ~~Assistant Registrar~~ College outlining:

21.1.4.a the ~~exact~~ number and types of procedures performed in the facility;

21.1.4.b the ~~exact~~ number and type of adverse outcomes ~~and events~~, including infections and complications, arising from procedures done in the facility;

~~27.2.1 exact number of events such as needlestick, incomplete sterilization, breaks in technique, medication errors, each of which must be investigated and documented;~~

21.1.4.c ~~assurance that quality assurance and~~ quality improvement program initiatives in the facility ~~sufficient to demonstrate the standards of care set by CPSM and required for good medical care;~~; and

21.1.4.d the number of transfers to hospital from the facility.

Article 22 - Infection Control

22.1 A facility must:

22.1.1 use sterilization techniques,

22.1.2 store medical and dental supplies, and

22.1.3 use waste handling and disposal procedures

consistent with the standards applicable to infection control and waste handling and disposal in a hospital.

~~27.2.2~~ A facility must comply with all guidelines ~~list of members with privileges and health care staff~~

~~27.2.3 List of members whose privileges were not renewed, or suspended, or revoked with details;~~

~~27.1. Included with the annual report, the medical director must review, sign, and return to the Assistant Registrar an annual declaration in a form prescribed by the Committee confirming that they are aware of their responsibilities as set out in law, this Bylaw, Standards of Practice, and Practice Directions.~~

22.2 the College may require the facility to comply with to meet best practices on the subject of infection control practices in a facility setting.

Article 23 - Appeal

23.1 The facility or a member may appeal any decision of the committee to the Executive Committee pursuant to sections 183 and 38 of the RHPA by filing a Notice of Appeal with the Registrar within thirty days of being informed of the decision.

Article 24~~28~~ - Inspections and Audits

24.1 At any time and ~~without notice~~at the cost of the facility, a facility is subject to on-site inspection ~~and audits~~ by members ~~or other persons with expertise (the latter~~ designated by the ~~Assistant Registrar)~~committee to conduct inspections ~~and audits, including, but not limited to if there is:~~.

~~28.1.1. a change in or addition to procedures offered at the facility;~~
~~28.1.2. renovations in the facility;~~
~~28.1.3. an adverse event;~~
~~28.1.4. a possible failure to comply with this Bylaw or the approval accreditation;~~
~~28.1.5. a possible failure to meet appropriate standards;~~
~~28.1.6. a possible risk to patient care and safety.~~

~~28.2. The facility will be required to pay the costs of any such inspection/audit and any required follow-up expenses.~~

24.2 If access to the facility for any inspection is refused, the committee may take such action it deems necessary including, suspending, revoking or amending the facility's certificate of accreditation.

24.3 The Committee may appoint an investigator with powers under s. 183(6) of the RHPA.

Article ~~29 - Appeal~~

~~23.1 The facility or a member may appeal any decision of the Committee to the Executive Committee pursuant to sections 183 and 38 of the RHPA by filing a written notice of appeal with the Registrar within thirty calendar days of being informed of the decision. The notice of appeal must specify the reasons for the appeal.~~

~~Article 30~~25 - Administration Fees for Facilities

25.1 The facility shall pay all expenses, charges and fees ~~incurred by CPSM~~including any licence fees imposed by the committee, in respect of the ~~accreditation or inspection of the facility and the~~ administration of Part B of this Bylaw.

Article ~~31~~26 – Transition

~~26.1~~ All accreditations and approvals of facilities, procedures, ~~medical~~facility directors, conditions~~, and privileges~~ granted at the time this Bylaw comes into force continues to be valid.

~~26.2 To permit the orderly accreditation of new facilities under Article 14 effective the date of the Annual General Meeting, June 9, 2021, members must not perform these procedures at a facility unless the facility:~~

~~24.2.1 has applied for accreditation by December 1, 2021,~~

~~24.2.2 has been granted at least conditional or full accreditation by December 1, 2022,~~

~~24.2.3 is actively working on obtaining full accreditation as determined by the Committee, and~~

~~24.2.4 is seeking to comply with all requirements of this Part of the Bylaw as if it were a fully accredited facility.~~

~~26.3~~26.1 ~~The Committee may determine whether the facility is compliant with the provisions in 31.2.3 and 31.2.4.~~

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Accredited Facilities Bylaw

(Under Section 183 of *The Regulated Health Professions Act*)

The College of Physicians and Surgeons of Manitoba

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba on November 22, 2018 repealing and replacing Bylaw #3 and 3D under The Medical Act)

Effective Date January 1, 2019

Table of Contents

Preamble

Prior to making this Bylaw, the Minister must be provided with a copy of the proposed Bylaw for review and Council must review and consider any comments made, pursuant to s. 183 of the RHPA.

PART A – DIAGNOSTIC FACILITIES

Article 1 - Definitions

1.1. In Part A of Bylaw:

1.1.1. "**accreditation**" means a review process conducted by CPSM to determine whether the facility being reviewed meets the standards specified by CPSM.

1.1.2. **"anatomic pathology laboratory"** means a place where human surgical tissue biopsies and specimens, cytological specimens and autopsies are examined for diagnostic purposes.

1.1.3. **"certificate of accreditation"** means a certificate issued under this Part of the Bylaw.

1.1.4. **"clinical pathology laboratory"** means a place where diagnostic testing is performed on human samples including the disciplines of chemistry, hematology, transfusion medicine, cytology, immunology, microbiology, virology, histology or pathology.

1.1.5. **"Committee"** means the Program Review Committee of CPSM.

1.1.6. **"diagnostic imaging facility"** means a place where imaging techniques are used for diagnostic purposes including radiography, ultrasound, computed tomography, magnetic resonance imaging, fluoroscopy, mammography or nuclear medicine.

1.1.7. **"facility"** means a place or a vehicle, whether privately owned or affiliated with or administered by a hospital or other health facility, which is principally equipped to perform a procedure normally performed in an anatomic pathology laboratory, a clinical pathology laboratory, a diagnostic imaging facility, or a patient service centre. A clinical pathology laboratory facility may be comprised of a primary location, which is its laboratory, and one or more patient service centres.

1.1.8. **"Facility Director"** means a physician appointed as director of a facility in accordance with this Part of the Bylaw and whose credentials are acceptable to the Committee and is synonymous with the term "medical director" used in section 183(3) of the RHPA.

1.1.9. **"patient service centre"** means a location for the collection and/or testing of specimens of blood and of body fluids for the purpose of testing in an accredited laboratory.

1.1.10. **"physician office laboratory"** means a physician's office where specimens are collected and tested by the physician or a laboratory technician/assistant qualified by training from an accredited medical laboratory technician/assistant training program and is certified or eligible for certification with the Canadian Society of Medical Laboratory Science for the diagnosis of the physician's own patients.

1.1.11. **"standards"** means the standards approved by Council for facilities.

1.1.12. **"vehicle"** means a device in, upon or by which diagnostic equipment is transported upon a roadway and which is:

1.1.12.i. used primarily for the purpose of offering diagnostic services; and

1.1.12.ii. has the approval of the Government of Manitoba to offer diagnostic services in Manitoba but does not include an emergency vehicle as defined in *The Highway Traffic Act*.

1.2. In this Bylaw, words and phrases defined in *The RHPA* have the same meaning as in the *RHPA*.

Article 2 - Application of this Part

Part A of this Bylaw applies as follows:

2.1. Pursuant to *The Regulated Health Professions Act (RHPA),* ss 183(1)[1], to all diagnostic facilities in Manitoba which are principally equipped to perform a procedure normally performed in an anatomic pathology laboratory, clinical pathology laboratory, diagnostic imaging facility, and patient service centre, in which services are performed by members of CPSM, other than those under the jurisdiction of the provincial or municipal governments and those designated as hospitals under *The Health Services Insurance Act,* and a facility or class of facilities exempted by Regulation from the application of s.183(1) of the *RHPA*.

[1] 183(1) This section applies to any facility in which a member performs or causes to be performed diagnostic or treatment services, such as a non-hospital medical or surgical facility or a nuclear medicine facility, other than
(a) a facility that is designated as a hospital under *The Health Services Insurance Act*;
(b) a hospital or health care facility operated by the government, the government of Canada or a municipal government; and
(c) a facility or class of facility exempted by regulation from the application of this section.

2.2. Pursuant to *s.183(15)*[2] *of the RHPA* and pursuant to the Service Purchase Agreement made between the College of Physicians and Surgeons of Manitoba and the Government of Manitoba governing diagnostic facilities, to those diagnostic facilities falling within the jurisdiction of the Government of Manitoba as specified in the Service Purchase Agreement.

2.3. Pursuant to s.12.3(1) (d) of the *CPSM General Regulation* this does not apply to a facility operated by the Canadian Blood Services, CancerCare Manitoba, St. Amant Inc., or Mount Carmel Clinic unless it is part of the Service Purchase Agreement referred to above.

Article 3 - Facility Accreditation

3.1. A facility is required to obtain accreditation before it offers any services to the public.

3.2. Accreditation of a facility must be:
- 3.2.1. except in the case of a vehicle, for a specific address or addresses.
- 3.2.2. for the fixed period of time determined by the Committee, to a maximum of 5 years.
- 3.2.3. for the procedures specified with the certificate of accreditation.

3.3. In the case of a vehicle, the facility must provide a current mailing address for the owner and the operator of the service.

3.4. Prerequisites to full accreditation of a facility pursuant to this By-law are:
- 3.4.1. compliance with the relevant standards; and
- 3.4.2. appointment of a Facility Director acceptable to the Committee.

3.5. The Committee must establish and make available on request:
- 3.5.1. standards for each type of facility.
- 3.5.2. the accreditation process for each type of facility.
- 3.5.3. the Committee's policies governing the accreditation process for each type of facility.

3.6. Applications for accreditation of a facility must be made to the Committee by the Facility Director, on the forms prescribed by the Committee, and must contain the information required by the Committee.

[2] 183(15) The council may enter into agreements with the government, the government of Canada or a municipal government to make this section applicable to any facility or any part of a facility that falls within that government's jurisdiction.

Accreditation Process

3.7. The accreditation process will include:
- 3.7.1 completion of a pre-inspection questionnaire by the Facility Director;
- 3.7.2 an inspection by one or more persons, with knowledge in the facility's work, designated by the Committee;
- 3.7.3 review of the facility's compliance with standards;

3.8. On completion of the accreditation process, the Committee may:
- 3.8.1 grant full accreditation and issue a certificate of accreditation to a facility if the Committee is satisfied that the facility has met all the requirements of Part A of this Bylaw and there are no identified deficiencies;
- 3.8.2 grant conditional accreditation to a facility with identified deficiencies and specifying the date it will expire if the identified deficiencies are not corrected;
- 3.8.3 deny accreditation pending correction of identified deficiencies in accordance with s. 183(7) of the RHPA; or
- 3.8.4 withdraw any existing accreditation.

3.9. Where an inspection is conducted as part of the accreditation process, and deficiencies are observed, the Committee must issue a report of the inspection and must provide a copy of the report to the applicant.

Full Accreditation

3.10. Where a facility fully complies with the relevant standards, the Committee will grant full accreditation and will specify with the certificate of accreditation the procedures for which the facility is accredited.

Accreditation Not Granted

3.11. Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to the Executive Committee.

Conditional Accreditation

3.12. Where a facility does not fully comply with the relevant standards, but the Committee is of the opinion that it is in the public interest to permit the facility to operate while it corrects specified deficiencies, the Committee may grant conditional accreditation.

3.13. Where conditional accreditation is granted, the Committee must:
- 3.13.1. provide written notice of its decision and the reasons therefor and the information on the right of appeal to the Executive Committee.

3.13.2. state in its decision a fixed deadline for the facility to comply with all relevant standards and for the Facility Director to provide written confirmation of compliance to the Committee.
3.13.3. state in its decision whether a follow-up inspection must occur before full accreditation may be granted.

3.14. The Committee may extend the deadline for compliance with standards fixed pursuant to Article 3.10 if, in its sole discretion, the Committee deems it appropriate to do so.

3.15. Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:
3.15.1. Extend conditional accreditation
3.15.2. direct an inspection.
3.15.3. withdraw the conditional accreditation and if the facility is publicly owned, report the matter to government with the request that the government require the facility to cease operation.

3.16. If the Committee is of the opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit members from using the facility.

Accreditation Status Review

3.17. Accreditation status may be reviewed at the discretion of the Committee.

Temporary Accreditation

3.18. Temporary accreditation may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.

Role of Facility Director During Accreditation

3.19. Facility Director and personnel who are subject to the accreditation process must cooperate fully, which includes but is not limited to:
3.19.1. permitting inspectors to enter the facility and inspect the premises and all diagnostic equipment located therein.
3.19.2. permitting inspectors to inspect all records pertaining to the provision of services and providing copies of the same if so requested.
3.19.3. providing requested samples or copies of any material, specimen, radiological image or product originating from the diagnostic service.
3.19.4. answering questions posed by the inspectors as to the procedures or standards of performance relating to examinations/procedures performed.

Article 4 – Maintenance of Accreditation

4.1. In order to maintain accreditation, a facility must:
- 4.1.1. comply with the relevant standards.
- 4.1.2. perform only the procedures permitted pursuant to the facility's certificate of accreditation.
- 4.1.3. at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect.
- 4.1.4. cooperate with and participate in the inspection process approved by the Committee for its type of facility.

4.2. During the currency of a full or conditional accreditation the Committee may direct an inspection for the purpose of monitoring compliance, if the Committee is of the opinion that:
- 4.2.1. a facility may not meet the relevant standards and
- 4.2.2. an inspection would be in the public's best interest.

Article 5 – Renewal of Accreditation

5.1. In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation.

Article 6 – Variance or Withdrawal of Accreditation

6.1 A facility may apply at any time to vary its accreditation.

6.2 If the Committee is of the opinion that the facility may be unsafe, the Committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the Committee deems appropriate in the circumstances, including withdrawing accreditation and if the facility is publicly owned, report the matter to government with the recommendation that the government require the facility to cease operation. If the Committee is of the opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit members from using the facility.

6.3 Where a facility is no longer providing patient services, the Committee may withdraw the facility's accreditation

6.4 Council may withdraw accreditation in accordance with the RHPA

Article 7 – Facility Director

7.1. A facility must have a Facility Director.

7.2. A Facility Director must be a physician whose credentials are acceptable to the Committee.

7.3. The Committee must establish and make available on request the qualifications for Facility Directors in each type of facility.

7.4. The Facility Director is responsible for granting privileges to any physician who wishes to work for the facility and notifying the Committee of the physicians who are granted privileges. Before granting privileges to any physician a Facility Director must:

7.4.1. define in writing the qualifications and competencies required in order to obtain privileges in each field of practice.

7.4.2. obtain written confirmation that the applicant is registered and licensed to practice medicine in Manitoba.

7.4.3. obtain full particulars of the applicant's education, training, competencies and experience.

7.4.4. take reasonable steps to ensure that the applicant has the education, training competencies and experience required, and that the applicant is otherwise a suitable candidate for privileges.

7.5. Within one year of first granting privileges to a physician, the Facility Director must review that physician's privileges. Thereafter, privileges must be reviewed by the Facility Director at least every two years.

7.6. Before granting renewal of privileges or extending the existing privileges of any physician, the Facility Director must take reasonable steps to ensure that the physician has the education, training, competencies and experience required for each field of practice for which he or she is seeking privileges within the facility.

7.7. The Facility Director must have effective control of and be responsible for the safe operation and administration of the facility, the supervision of all professional, technical and administrative activities of the facility, and for compliance with this Bylaw and with the relevant standards established by the Committee.

7.8. Without limiting the generality of the foregoing, the Facility Director must:

7.8.1. have access to all records and documents relating to the operation of the facility and the procedures performed therein.

7.8.2. communicate with any facility under his/her direction a minimum of once per year.

7.8.3. ensure that quality management system requirements and improvement programs are in place.

7.8.4. ensure that the facility has current up to date policies and manuals as required by the standards for that facility.

7.8.5. ensure that complete and accurate patient records and documentation relating to the operation of the facility and procedures performed are kept.

7.8.6. ensure that no procedure is carried out in the facility unless it is permitted by the certificate of accreditation.

7.8.7. ensure that technologists have the qualifications as provided by training from an accredited:

7.8.7.i. medical laboratory training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.

7.8.7.ii. medical radiology technology training program and are certified or eligible for certification with the Canadian Association of Medical Radiology Technologists.

7.8.8. ensure that medical laboratory technologists who are required to perform x-ray examinations and medical radiology technologists who are required to perform laboratory testing have graduated from a cross-training program.

7.8.9. ensure that laboratory technicians/assistants have the qualifications as provided by training from an accredited medical laboratory technician/assistant training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.

7.8.10. ensure that persons who provide services to the facility maintain competence to perform the procedures for which the facility is accredited.

7.8.11. ensure that work referred out of the facility is performed by persons with appropriate qualifications and competence to perform the work.

7.8.12. promptly notify CPSM of any change in the ownership or directorship of the facility.

7.8.13. promptly notify CPSM if the facility is no longer providing patient services.

7.8.14. where applicable, be available for consultation with referring physicians.

7.8.15. promptly notify the Committee if there is a major change in the following:

7.8.15.i. equipment.

7.8.15.ii. the accredited list of diagnostic imaging examinations, laboratory or transfusion medicine tests, or blood and blood products dispensed.

7.8.16. ensure that the duties and responsibilities of all personnel are written and understood;

7.8.17. ensure adequate quality assurance and improvement programs are in place

7.9. The Facility Director must submit to CPSM such information as required by the Committee.

Article 8 - Appeal

8.1. The facility or a member may appeal any decision of the Committee to the Executive Committee pursuant to sections 183 and 38 of the RHPA by filing a written notice of appeal with the Registrar within thirty calendar days of being informed of the decision. The notice of appeal must specify the reasons for the appeal.

Article 9 - Fees

9.1. A privately-owned facility shall pay all expenses, charges and fees incurred by CPSM in respect of the accreditation or inspection of the facility and the administration of Part A of this Bylaw.

Article 10 – Physician Office Laboratory

10.1. Physicians must not operate a physician office laboratory without first obtaining the written approval of CPSM.

10.2. The Committee may direct the inspection of any facility where physician office laboratory procedures are performed.

Article 11 - Transition

11.1. A facility that holds accreditation at the time this Bylaw comes into force continues to hold that accreditation status under this Bylaw in accordance with the terms of that accreditation.

11.2. A facility which has not undergone the accreditation process will be notified in writing by CPSM that it is exempt from the requirement of accreditation set forth in this Bylaw until the inspection process for that facility is complete and a report is issued, but the facility must cooperate with CPSM for the timely completion of its accreditation process in accordance with this Bylaw.

11.3. A physician who holds a Facility Directorship at the time this Bylaw comes into force continues to hold that status under this Bylaw.

PART B – NON-HOSPITAL SURGICAL FACILITIES

Article 12 - Definitions

12.1. In Part B of this Bylaw:

“accreditation” means a review process conducted by CPSM to determine whether the facility being reviewed meets the requirements specified by CPSM.

"certificate of accreditation" means a certificate issued under this Part of the Bylaw.

"Committee" means the Program Review Committee of CPSM.

“direct or indirect financial interest” means any interest owned by a member, by individuals connected by blood relationship, marriage or adoption to a member, by any corporation, proprietorship, partnership, society, business, association, joint venture, group or syndicate in which a member or any individual connected by blood relationship, marriage or adoption to a member have any interest.

"facility" means a non-hospital medical/surgical facility for the purposes of Part B of this Bylaw.

“general anaesthesia” means a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently, or to respond purposefully to physical stimulation or verbal command, produced by pharmacologic or non-pharmacologic methods, alone or in combination.

“hospital” means a hospital under *The Hospitals Act* or the *Regional Health Authorities (Health System Governance and Accountability) Act* when proclaimed with an operational Emergency or Urgent Care Department.

"medical director" means a physician appointed as director of a facility in accordance with this Part of the Bylaw and whose credentials are acceptable to the Committee and is synonymous with the term “medical director” used in section 183(3) of the RHPA.

“**oral sedation**” means an altered state or depressed state of awareness or perception of pain brought about by pharmacologic agents and with is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained. This is specific to the use of oral medication alone. An example may include oral dosing of opioids and/or benzodiazepines that produce the above states.

"privileges" means the authority to admit and treat patients at a facility.

“procedural sedation” means an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained, and

i. includes, but is not limited to, the use of any IV or intra-muscular agent for this purpose; and
ii. requires the monitoring of vital signs,

but does not include the use of oral pre-medication alone or in combination with local anaesthesia. No distinction is made between light and deep procedural sedation for credentialing or monitoring purposes.

"procedure" means the diagnostic and treatment procedures, both medical and surgical, as approved by the Committee to be carried out in a facility.

Article 13 - Application of this Part – Procedures Requiring Accreditation

13.1. Part B of this Bylaw applies to all non-hospital medical or surgical facilities, subject to section 183 of the RHPA, and not included in Part A of this Bylaw. All non-hospital medical or surgical facilities in which procedures that have a sufficient risk of potential harm to a patient must apply for, obtain, and maintain accreditation from CPSM prior to providing any such diagnostic or treatment services or procedures.

13.2. The criteria for assessing sufficient risk of potential harm to a patient include:
- 13.2.1. Level of anesthesia and/or sedation
- 13.2.2. Need for medical device reprocessing (infection risk)
- 13.2.3. Complexity of procedure and risk of complications

13.3. The following procedures have a sufficient risk of potential harm to the patient to require accreditation:
- 13.3.1. Any procedure that is carried out or should be carried out in accordance with generally accepted standards of care with the concurrent use of procedural or oral sedation including for patient comfort (pain and/or anxiety); See definitions of procedural and oral sedation in Article 13.
- 13.3.2. Any procedure that requires general anaesthesia, See definition of general anaesthesia; or
- 13.3.3. Procedures involving:
  - 13.3.3.i. deep, major, and complicated procedures that may require more resources than are commonly available in a medical office. Surgeons should make decisions as to the appropriate location for these surgical procedures in accordance with the resources necessary for unexpected complications and with generally accepted standards of care. These procedures may include:
    - 13.3.3.i.a. resection of a deep, major or complicated lesion;
    - 13.3.3.i.b. surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal organs, and other life-threatening complications or requiring sterile precautions to prevent blood borne deep closed cavity or implant-related infections;
  - 13.3.3.ii. flexible endoscopic evaluation of the gastrointestinal or genitourinary tract;
  - 13.3.3.iii. assisted reproduction technology, uterine evacuation procedures, and hysteroscopy;
  - 13.3.3.iv. cataracts and retinal procedures;
  - 13.3.3.v. Lasik therapeutic procedures;
  - 13.3.3.vi. the use of drugs by injection which are intended or may induce a major nerve block or spinal, epidural or intravenous regional block;

13.3.3.vii. any tumescent liposuction procedure involving the administration of dilute local anesthesia;
13.3.3.viii. hair transplantation;
13.3.3.ix. venous sclerotherapy;
13.3.3.x. hyperbaric oxygen therapy;
13.3.3.xi. hemodialysis; or
13.3.3.xii. any procedure that the Committee directs, which must be performed in an approved, non-hospital medical or surgical facility, in order to meet the minimum acceptable standard of care for that procedure.

13.4. CPSM members providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.

13.5. This Part of the Bylaw does not apply to any hospital or health care facility operated by a health authority or the Governments of Canada, Manitoba, or any municipality.

Article 14 - Members Must not Work in Non-Accredited Facilities

14.1. A member must not perform or cause to be performed any procedure in a facility that requires accreditation under this Part, but is not accredited, in accordance with s. 183(14) of the RHPA and in accordance with the transition provisions in Article 29.

14.2. A facility is required to obtain accreditation before it offers any services to the public.

Article 15 - Facility Accreditation

15.1 The medical director of a facility seeking accreditation must apply on the form prescribed by the Committee, specifying the procedures for which accreditation is sought.

15.2 The medical director must agree to pay the fee charged for the inspection and accreditation process even if the accreditation is not completed or granted.

Accreditation Process

15.3 The accreditation process will include:
15.3.1 completion of a pre-inspection questionnaire by the medical director;
15.3.2 an inspection by one or more members, with expertise in the appropriate area of medical practice, designated by the Committee;
15.3.3 review of the facility's compliance with requirements including CPSM and medical or other standards; and
15.3.4 CPSM providing the Minister with a copy of each application and report as required by section 183(17) of the RHPA.

15.4 On completion of the accreditation process, the Committee may:
- 15.4.1 grant full accreditation and issue a certificate of accreditation to a facility if the Committee is satisfied that the facility has met all of the requirements of Part B of this Bylaw and there are no identified deficiencies;
- 15.4.2 grant conditional accreditation to a facility with identified deficiencies and specifying the date it will expire if the identified deficiencies are not corrected;
- 15.4.3 not grant accreditation pending correction of identified deficiencies in accordance with s. 183(7) of the RHPA; or
- 15.4.4 withdraw any existing accreditation.

15.5 Where an inspection is conducted as part of the accreditation process, and deficiencies are observed, the Committee must issue a report of the inspection and must provide a copy of the report to the applicant.

Full Accreditation

15.6 Where a facility fully complies with the relevant requirements, the Committee will grant full accreditation and will specify with the certificate of accreditation the procedures for which the facility is accredited.

Accreditation Not Granted

15.7 Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to the Executive Committee.

Conditional Accreditation

15.8 In circumstances where a facility does not comply fully with all requirements for accreditation, and if the Committee deems it adequate for patient safety, conditional approval may be granted for the operation of a facility pending the completion of the accreditation process or while it corrects specified deficiencies.

15.9 Where conditional accreditation is granted, the Committee must:
- 15.9.1 provide written notice of its decision and the reasons therefor and the information on the right of appeal to the Executive Committee.
- 15.9.2 state in its decision a fixed deadline for the facility to comply with all relevant standards and for the medical director to provide written confirmation of compliance to the Committee.
- 15.9.3 state in its decision whether a follow-up inspection must occur before full accreditation may be granted.

15.10 Where conditional accreditation is granted, the medical director must provide a written response to each deficiency within the time specified by the Committee, and a follow-up

inspection may occur, if the Committee so directs. Full accreditation will only be granted when identified deficiencies have been corrected to the satisfaction of the Committee.

15.11 The Committee may extend the deadline for compliance with requirements if, in its sole discretion, the Committee deems it appropriate to do so.

15.12 Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:
- 15.12.1 extend conditional accreditation;
- 15.12.2 direct an inspection;
- 15.12.3 withdraw the conditional accreditations.

Temporary Accreditation

15.13 Temporary accreditation may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.

Term of Accreditation and Renewal

15.14 Accreditation of a facility must be for the fixed period of time determined by the Committee, to a maximum of five years.

15.15 In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation. The re-accreditation process will follow the same procedure as required for accreditation. Where an application to renew is pending, the Committee may continue the facility's accreditation until a decision is made on the renewal application.

Article 16 - Maintenance of Accreditation

16.1 In order to maintain accreditation, a facility must:
- 16.1.1 comply with the relevant requirements;
- 16.1.2 perform only the procedures permitted pursuant to the facility's certificate of accreditation;
- 16.1.3 at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect; and
- 16.1.4 cooperate with and participate in the inspection process approved by the Committee for its type of facility.

16.2 During the currency of a full or conditional accreditation the Committee may direct an inspection for the purpose of monitoring compliance, if the Committee is of the opinion that:

16.2.1 a facility may not meet the requirements, standards of practice, or other standards for public safety and.

16.2.2 an inspection would be in the public's best interest.

Article 17 – Renewal of Accreditation

17.1 In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation.

Article 18 – Variance or Withdrawal of Accreditation

18.1. A facility may apply at any time to vary its accreditation.

18.2. If the Committee is of the opinion that the facility may be unsafe, the Committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the Committee deems appropriate in the circumstances, including withdrawing accreditation and ordering it to cease operation. If the Committee is of the opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit members from using the facility.

18.3. Where a facility is no longer providing patient services, the Committee may withdraw the facility's accreditation.

18.4. Council may withdraw accreditation in accordance with the RHPA.

Article 19 - Approved Procedures

19.1. Each certificate of accreditation must include a schedule listing the procedures which have been approved for the facility, and the names of the members who have been given privileges to perform the procedures at the facility.

19.2. The schedule of procedures may be amended from time to time upon the application of the facility and the approval of the Committee.

19.3. Only those procedures which are approved by the Committee and set out in the schedule to the facility's certificate of accreditation may be performed in the facility.

19.4. Where a facility is no longer being used for the procedures set out in Article 13, the Medical Director must inform the Assistant Registrar. The Committee may withdraw the facility's certificate of accreditation.

Article 20 – Health Authority Agreement

20.1. Every facility must have a written agreement with a health authority pursuant to which the health authority agrees to provide emergency treatment if a patient has to be transferred from the facility.

Article 21 - Privileges

21.1. A member must have privileges at an accredited facility prior to performing any of the services and procedures listed in Part B;

21.2. The Medical Director must only grant and renew privileges for a member to perform procedures in an accredited facility if the Medical Director is satisfied that:
- 21.2.1. the applicant is a suitable and competent candidate
- 21.2.2. the treatment services and procedures are within the privileges requested and within the knowledge, skill, and judgment of the applicant and
- 21.2.3. those privileges are the same as granted by Shared Health or a Regional Health Authority or are recommended through the Shared Health credentialing process and those privileges are and remain in good standing.

21.3. Where the member does not have Shared Health or Regional Health Authority privileges the Medical Director must only provide privileges for a specific facility if the Committee has already granted privileges under the following process:
- 21.3.1. utilize the established Shared Health credentialing process to assess applicants using established specialty groups;
- 21.3.2. implement a non-refundable assessment fee paid to Shared Health or the Regional Health Authority payable by the member seeking credentials for the credentialing process;
- 21.3.3. seek and obtain an assessment from Shared Health regarding the granting of privileges; and then
- 21.3.4. the Committee shall decide whether to grant privileges.

21.4. Within 15 calendar days of granting or renewing privileges the Medical Director must provide the Assistant Registrar with the particulars of the privileges granted in the facility.

21.5. Any member who performs services and procedures without obtaining privileges in the facility and any Medical Director who permits a member to perform services and procedures without privileges in the facility may be found guilty of professional misconduct.

Article 22 - Standard of Care

22.1. An accredited facility and those members performing procedures must meet appropriate standards for the quality and safety of those treatments and procedures performed in that facility. To receive and maintain accredited status, a facility must:

22.1.1. demonstrate compliance with appropriate standards for quality and safety of treatments and procedures performed;

22.1.2. provide patient care in a manner consistent with good medical care as defined in the CPSM Standards of Practice Regulation and elaborated on in the Standards of Practice, Practice Directions, and Code of Ethics and Professionalism; and

22.1.3. engage in ongoing processes of self-review and quality improvement.

Article 23 - Patient Care

23.1. Anesthetic Care

23.1.1. All patients proposed to undergo anesthesia in a facility must be assigned an American Society of Anaesthesia risk score and only patients with ASA I, II and III Risk scores may have a procedure performed unless otherwise indicated in the accreditation approval.

23.1.2. General anaesthesia must not be given to infants under the age of twenty-four months.

23.1.3. A patient who receives general anaesthesia or procedural sedation should only leave the facility in the care of an adult.

23.1.4. Procedural sedation must be administered by or under the direct supervision of a member with appropriate training acceptable to CPSM to provide procedural sedation.

23.1.5. A patient who receives procedural sedation must be attended by a registered nurse or a member who is not assisting in the surgical procedure and who is trained to monitor patients under procedural sedation.

23.1.6. There must be at least two personnel who are certified in basic cardiopulmonary resuscitation within the facility while patients are receiving care.

23.1.7. All equipment for the administration of anaesthetics must be readily available, clean and properly maintained.

23.2. A member who has been granted privileges must:

23.2.1. be in the room at all material times during the performance of a procedure in the facility.

23.2.2. ensure that following any procedure, patients receive an adequate recovery period under supervision before leaving the facility.

23.2.3. be responsible for the post-operative care of the patient within the facility.

23.2.4. ensure qualified support staff are on duty during and after a procedure in the facility.

23.2.5. maintain accurate information concerning the medical condition of patients in a clinical record which meets the expected standards of medical record-keeping,

including documentation related to the informed consent of the patient for the procedure(s) performed in a facility.

23.2.6. perform procedures in a facility only if the facility is adequately equipped and has maintained operating and post-operative rooms and all equipment is safe, well maintained and compliant with applicable federal, provincial, and municipal legislation.

23.3. A member shall not perform a procedure in an accredited facility unless the procedure is one that should safely allow the discharge of a patient from medical care in the facility within 23 hours of the day cycle (no overnight).

Article 24 - Infection Control

24.1 A facility must:

24.1.1 use sterilization techniques,

24.1.2 store medical and dental supplies, and

24.1.3 use waste handling and disposal procedures

consistent with the standards applicable to hospitals.

24.2 A facility must comply with all guidelines CPSM may require the facility to comply with to meet best practices on infection control practices in a facility setting, including the Ontario Public Health Infection Prevention and Control for Clinical Office Practice.

Article 25 - Medical Director

25.1 The facility shall appoint a medical director, who is a member acceptable to the Committee, and who must:

25.1.1 enforce the standards of care in the facility, which include the safe and effective care of patients in the facility;

25.1.2 be responsible for the administration of the facility; and

25.1.3 provide required reporting to CPSM.

25.2 In enforcing the standards of care in the facility which includes the safe and effective care of patients, the medical director must ensure that:

25.2.1 procedures and equipment are appropriate and safe;

25.2.2 procedures are performed in accordance with current good medical care and practice;

25.2.3 sufficient numbers of appropriately trained personnel are present during procedures;

25.2.4 procedures approved by the Committee as set out in the certificate of accreditation are only performed at the facility by members with privileges;

25.2.5 persons who provide services to the facility have appropriate qualifications and maintain competence to perform the procedures for which the facility is accredited;

25.2.6 members with privileges have current basic life support skills and other skills appropriate to the clinical settings (such as advanced cardiac support, pediatric advanced life support, and airway management skills);

25.2.7 all direct patient care personnel have life support skills and there must be two such qualified personnel present at any time patients are receiving care;

25.2.8 adequate quality assurance and improvement programs, including the monitoring of infection and medical complication rates, are in place.

25.3 In being responsible for the administration of the facility, the medical director must:

25.3.1 have access to all records and documents relating to the operation of the facility and the procedures performed therein;

25.3.2 develop appropriate and up-to-date policy and procedure manuals, including acceptable staff health policies;

25.3.3 ensure the duties and responsibilities of all personnel are written and understood;

25.3.4 ensure complete and accurate confidential patient records and documentation relating to the operation of the facility and procedures performed are kept current and up to date;

25.3.5 ensure the requirements for granting privileges are met with necessary approvals and complete records kept of all members who obtain privileges at the facility, including their applications;

25.3.6 ensure documentation, fees and a complete reporting of all required information to CPSM is submitted when and as required;

25.3.7 meet annually with each member who has privileges to review those privileges and document the review; and

25.3.8 attend at the facility at least one day per month or more if prescribed by the Committee to inspect the facility, and meet with other staff to review operations, the facility, standards, and quality assurance;

25.4 In providing required reporting to CPSM, the medical director must:

25.4.1 Ensure that the Assistant Registrar is notified within one working day of becoming aware of any of the following circumstances and provide a report within two weeks of any of the following:

25.4.1.i death that occurs within 10 days of the procedure;

25.4.1.ii transfers from the facility to a hospital regardless of whether or not the patient was admitted;

25.4.1.iii unexpected admission to hospital within 10 days of a procedure performed;

25.4.1.iv clusters of infections among patients treated in the facility; or

25.4.1.v procedure performed on wrong patient, side, or site or wrong procedure; or

25.4.1.vi any other major adverse event.

25.4.2 notify the Assistant Registrar of any change in ownership of the facility within one month;
25.4.3 promptly notify the Assistant Registrar if the facility is no longer providing patient services within one month;
25.4.4 promptly notify the Assistant Registrar if there is a major change in equipment or renovations to the facility or the accredited list of procedures within ten days; and
25.4.5 advise the Assistant Registrar of resignation, revocation, suspension, or restriction of privileges of staff immediately.

Article 26 - Audit and Quality Control

26.1 All certificates of accreditation are subject to the following conditions:
26.1.1 all procedures and all clinical records must comply with the requirements of standards of care set by CPSM.
26.1.2 quality assurance and improvement programs are in place sufficient to demonstrate that standards of care set by CPSM and required for good medical care are met in the facility.

Article 27 - Annual Report

27.1. The medical director must review the facility's quality assurance and improvement programs at least annually.

27.2. Within 30 days of each calendar year end, the medical director must forward an annual report in the prescribed form to the Assistant Registrar outlining:
27.2.1 the exact number and types of procedures performed in the facility;
27.2.2 the exact number and type of adverse outcomes and events, including infections and complications, arising from procedures done in the facility;
27.2.3 exact number of events such as needlestick, incomplete sterilization, breaks in technique, medication errors, each of which must be investigated and documented;
27.2.4 assurance that quality assurance and quality improvement program initiatives in the facility sufficient to demonstrate the standards of care set by CPSM and required for good medical care;
27.2.5 the number of transfers to hospital from the facility
27.2.6 list of members with privileges and health care staff
27.2.7 List of members whose privileges were not renewed, or suspended, or revoked with details;

27.3. Included with the annual report, the medical director must review, sign, and return to the Assistant Registrar an annual declaration in a form prescribed by the Committee confirming that they are aware of their responsibilities as set out in law, this Bylaw, Standards of Practice, and Practice Directions.

Article 28 - Inspections and Audits

28.1. At any time and without notice, a facility is subject to inspection and audits by members or other persons with expertise (the latter designated by the Assistant Registrar) to conduct inspections and audits, including, but not limited to if there is:
- 28.1.1. a change in or addition to procedures offered at the facility;
- 28.1.2. renovations in the facility;
- 28.1.3. an adverse event;
- 28.1.4. a possible failure to comply with this Bylaw or the approval accreditation;
- 28.1.5. a possible failure to meet appropriate standards;
- 28.1.6. a possible risk to patient care and safety.

28.2. The facility will be required to pay the costs of any such inspection/audit and any required follow-up expenses.

28.3. If access to the facility for any inspection is refused, the Committee may take such action it deems necessary including, suspending, revoking or amending the facility's certificate of accreditation.

28.4. The Committee may appoint an investigator with powers under s. 183(6) of the RHPA.

Article 29 - Appeal

29.1 The facility or a member may appeal any decision of the Committee to the Executive Committee pursuant to sections 183 and 38 of the RHPA by filing a written notice of appeal with the Registrar within thirty calendar days of being informed of the decision. The notice of appeal must specify the reasons for the appeal.

Article 30 - Administration Fees for Facilities

30.1 The facility shall pay all expenses, charges and fees incurred by CPSM in respect of the accreditation or inspection of the facility and the administration of Part B of this Bylaw.

Article 31 – Transition

31.1 All accreditations and approvals of facilities, procedures, medical directors, conditions, and privileges granted at the time this Bylaw comes into force continues to be valid.

31.2 To permit the orderly accreditation of new facilities under Article 14 effective the date of the Annual General Meeting, June 9, 2021, members must not perform these procedures at a facility unless the facility:

31.2.1 has applied for accreditation by December 1, 2021,

31.2.2 has been granted at least conditional or full accreditation by December 1, 2022,

31.2.3 is actively working on obtaining full accreditation as determined by the Committee, and

31.2.4 is seeking to comply with all requirements of this Part of the Bylaw as if it were a fully accredited facility.

31.3 The Committee may determine whether the facility is compliant with the provisions in 31.2.3 and 31.2.4.

ACCREDITED FACILITIES

SUMMARY OF FEEDBACK

There were 9 submissions of feedback, six from those physicians whom currently perform procedures in and/or own an accredited facility.

1 – ASA 3 Patients Not Being Permitted in Accredited Facilities

- Heartland Fertility Clinic – this would severely interfere with the ability of ASA 3 women from receiving fertility treatment. In 24 years there has not been a complication with conscious sedation and egg retrievals. Requests an exemption from this prohibition.
- Eye Surgery - A high proportion of eye surgery, especially cataract surgery, patients are ASA 3. At Western Surgical Centre there is always an anesthetist present compared to Misericordia where there is an anesthetist assistant present and one anesthetist for 3-4 rooms. If an adverse event occurs in either facility, a transfer to a hospital is required. Restricting ASA3 patients to Misericordia will increase waiting times.
- Lasik – Lasik is not available in hospitals and Manitoba Health covers cost if medically necessary.
- Skin Cancer – Excision of skin cancer lesions may occur safely in accredited facilities for ASA 3 patients.

2 – Cardiac Exercise Stress Testing be Included as an Accredited Facility

- Included in some other jurisdictions. Inherently risky patients with high risk outcomes if adverse event occurs.
- See Cardiologist's comments

3 – Privileges

- Concerns expressed by process if Shared Health does not grant privileges for certain procedures since no Shared Health facility does that procedure.
- Renewing privileges annual is excessive paperwork and could be done if there is a change in privileges instead.

4 – Inapplicability to Non-CPSM Regulated providers

- Requiring high standards of accreditation for physicians for procedures (filler, injectables, laser) but not others does not overall advance patient safety. Can other regulators become involved? Registered nurses, Dental, Pharmacy.
- Some procedures are undertaken by unregulated providers, so Government should step in.

- Oral Surgery/Dental offices has CPSM registered anesthesiologists involved, so CPSM should regulate this aspect of these clinics.

5 – Lumps and Bumps Surgery

- These are common and low morbidity so does not need to be regulated, but guidelines for sterilization requirements, pathology specimens, etc are worthwhile
- Carpal tunnel surgery, trigger finger, dupuytrens surgery (no major nerve block and no sedation of any kind) are often done in an office setting and should not require accreditation
- An exhaustive list of procedures undertaken without being in an accredited facility should be included

6 – Competence of Practitioners

- Specialists moving into areas of other specialists (ie plastic surgery) creates patient safety issues due to lack of competence (ie, OB/GYN doing cosmetic surgery procedures on genitals)
- Peers must determine privileges (OB/GYN wishing to do breast augmentation must be reviewed by both OB/GYN and Plastic Surgery)
- Canadian based competence is required
- Week-end courses are not sufficient to ensure competence

7 – Credentials

- Members to only utilize appropriate credentials
- Advertising of appropriate credentials to be mandatory

8 – Plastic Surgery

- Plastic surgery did not have representation on the Working Group but should have for the Practice Directions.

9 – Inspections

- An inspection includes a detailed facility review which is significant effort. A site visit or dialogue may be more appropriate, especially if there is a critical incident, it should occur immediately.

10 – Medical Director

- Having the medical director responsible for ensuring that procedures are in accordance with current accepted medical practice implies a specific knowledge and judgment in fields of practice other than their own and is too onerous and not possible if multiple scopes of practice/specialties.
- Only CPSM members can run accredited facilities

11 – Cosmetic Procedures

- Several concerns were expressed about cosmetic procedures performed by non-specialists

12 – Multi-Level Approach to Regulation of Accredited Facilities

- Level 1 – clinic performing injections and minor procedures such as skin biopsies and non-laser light based treatments. A steam steriliser and/or disposable instruments are minimal requirements. No sedation.
- Level 2 – More invasive procedures with local and oral sedation available if required, but no IV meds and no inhalation anaesthetics. CPSM monitoring of sterile equipment semi-annually. Laser use permitted if trained and certified operators.
- Level 3 – the current accredited facilities. All standards to be met for invasive deep surgical procedures under general anesthesia.

13 - Government of Manitoba

- Does not have any fundamental concerns
- Requests list of areas not accredited
- Requests confirmation that laboratories and radiology facilities will still require accreditation
- requests whether amendments to the regulations are required for exemption
- Continuous monitoring of performance and improvement with solid clear indicators continue to be a key element in a governance approach to quality and patient safety

14 – CPSA (Alberta)

- Thorough, adds clarity to the expectations of accredited facilities

The College of Physicians & Surgeons of Manitoba

Bylaw Changes Non-Hospital Surgical Facilities

Current State

- Existing criteria for accreditation of NHSF
  - Use of procedural sedation or general anesthesia

- 10 facilities province-wide
- 5 year cycle of accreditation
- Cost recovery model

Need for Change

- Jurisdictional Scan of other Canadian Regulators; CPSM **under-regulating**
- **Increased use of NSHF** for services previously provided in hospitals (transformation)
- **Risk to the public**
- Concerns from **practicing physicians** (e.g. colonoscopies, cosmetic procedures)
- CPSM Council made Accredited Facilities a **strategic priority**

Process for Change

- CPSM Council approved **working group** to review existing Bylaw for enhancements and expanded scope
- **Jurisdictional scan** of Canadian Regulators
- Working group made **recommendations**
- Approved by Council for **consultation**
- Consultation Summer 2020
- Revisions and Final Bylaw **for approval in Dec 2020**

Recommendations

1) Accreditation should be determined by:
   - **risk of potential harm to the patient**

2) Criteria to assess risk of potential harm:
   - **Level of anesthesia and/or sedation**
   - Need for medical device reprocessing **(infection risk)**
   - **Complexity of procedure and risk of complications**

Recommendations

3) Create a **list of procedures** posing sufficient risk of harm:

- Procedural or oral sedation
- General anesthesia
- Deep, major and complicated procedures
- GI and GU flexible endoscopy
- Assisted reproductive technologies, uterine evacuation and hysteroscopy
- Cataracts and retinal procedures
- Lasik
- Major nerve blocks (spinal, epidural, or IV regional)
- Tumescent liposuction with dilute local anesthesia
- Hair Transplant
- Venous Sclerotherapy
- Hyperbaric Oxygen Therapy
- Hemodialysis
- Any additional procedure directed by the committee that must be done in an approved NHSF to meet the standard of care

Recommendations

4) **Enhanced privileging** including for sole practitioner/owners and new medical staff using provincial specialty credentialing committees if regional privileges have not been obtained

5) Strengthen the role of **Medical Director** with enhanced reporting requirements

Recommendations

6) Create **Standards of Practice** for office-based procedures and stress testing

7) Conduct a **general re-write of the Bylaw** for Accredited Facilities

Part A – Lab and Diagnostics

Part B – Non-Hospital Surgical Facilities

- Make it easier to read, align Part A and Part B to support parallel processes, enhanced reporting and safety provisions

Medical Director

- Enhancements to the role include:
  - Explicit role in **quality and safety** within the facility
  - Ensuring **qualifications and privileging** of medical staff
  - Enhanced clarity and expectations around **reporting adverse events and outcomes**
  - Increased requirement to be **present on-site** within the NHSF
  - Initiating an **annual declaration** form to acknowledge acceptance and understanding of duties and responsibilities

New Standard of Practice

- **Performing Office Based-Procedures**
  - Vasectomy
  - Male Circumcision
  - Cosmetic/Aesthetic Procedures
    - Injectable neuromodulators and fillers
  - Stem Cell Injections
  - Platelet Rich Plasma Injection
  - Use of Laser Devices
- In the process of forming a **working group** to assist in developing the standard of practice

New Standard of Practice

- **Exercise Stress Testing**
  - To be drafted from the Cardiac Care Network document "**Standards for the Provision of Electrocardiography (ECG)-Based Diagnostic Testing in Ontario**"
  - Pending consultation with local experts

Future State and Impact

- NHSF Team preparing to implement
- Improved NHSF practices and procedures **aligned with MANQAP**
- Unclear how many more facilities will need accreditation
- Continue with **5 year cycle** of accreditation with cost recovery
- Better regulation of cosmetic industry (MDs)
- Overall enhanced **safety for the public**

Article 29 – Transition

- All accreditations and approvals of facilities, procedures, medical directors, conditions, and privileges **granted at the time this Bylaw comes into force continues to be valid.**

- To permit the orderly accreditation of new facilities under Article 14 effective the **date of the Annual General Meeting, June 9, 2021**, members must not perform these procedures at a facility unless the facility:
  - has **applied for accreditation by December 1, 2021**,
  - has been **granted at least conditional or full accreditation by December 1, 2022,**
  - is actively working on obtaining full accreditation as determined by the Committee, and
  - **is seeking to comply with all requirements of this Part of the Bylaw as if it were a fully accredited facility.**

- The Committee may determine whether the facility is compliant with the provisions in 31.2.3 and 31.2.4.

» Questions?

COUNCIL MEETING – DECEMBER 9, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT: Standard of Practice for Office Based Procedures

BACKGROUND

The Accredited Facilities Working Group provided a recommendation for a Practice Direction on Office Based Procedures to be implemented. Certain procedures performed in a physician's office pose a higher risk to patient safety, yet do not meet the threshold for accreditation. These procedures are usually not medically required and many physicians performing these procedures are financially incentivized, thereby providing further rationale for regulatory rules to govern these practices.

The procedures already identified are cosmetic/aesthetic, platelet rich plasma, peripheral stem cells, lasers, vasectomy, and male circumcision. Other procedures may be identified by the Working Group.

If the Terms of Reference for the Working Group are approved by Council in December, the Working Group can commence in January. This will be added as a Strategic Organizational Priority separate from the Accredited Facilities Criteria. There is capacity within CPSM to undertake this priority.

See attached Terms of Reference.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 9, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

The Standard of Practice for Office Based Procedures Working Group Terms of Reference be approved as presented.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

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STANDARD OF PRACTICE FOR OFFICE BASED PROCEDURES
Terms of Reference
CPSM Working Group

Section 1: Background

There is a need for the College of Physicians and Surgeons of Manitoba to have a Standard of Practice to establish minimum practice requirements for those members conducting more complicated medical procedures in their offices. The Accredited Facilities Working Group recommended to Council that CPSM create a Standard of Practice for Office Based Procedures. These procedures pose a higher risk to patient safety yet do not meet the threshold for accreditation.

In general, these procedures are usually not performed for medical purposes. Furthermore, many physicians performing these procedures are financially incentivized. This provides further rationale for regulatory rules for these procedures.

Section 2: Purpose

The purpose of the Working Group is to develop a draft CPSM Standard of Practice for Office Based Procedures that will be circulated to members, stakeholders, and the public in spring 2021 and finalized for implementation in 2021. This Standard of Practice will be used to promote the current best practices and ensuring patient safety.

Risk of potential harm to a patient may include:

- Level of anesthesia and/or sedation
- Need for medical device reprocessing (infection risk)
- Complexity of procedure and risk of complications

Whereas the above criteria are used to determine the procedures requiring accreditation, certain procedures may not reach the threshold for accreditation, yet the risk to patient safety requires rules for minimum practice requirements to be followed by all practitioners performing these procedures in their physician offices. This Standard of Practice also applies to facilities under the Accredited Facilities Bylaw. It will not apply to procedures performed in hospitals or facilities owned by a regional health authority of the Governments of Canada, Manitoba, or a Municipality.

This Standard is intended to apply to the office-based provision of both insured and non-insured procedures that are reserved acts for the practice of medicine under the RHPA. Examples of such procedures include, but are not limited to:

1. Vasectomy;
2. Male circumcision; (for female see Standard of Practice prohibiting female genital cutting/mutilation)
3. Cosmetic/aesthetic procedures which may include, but are not limited to:
    a. Application of laser energy and light-based therapies;
    b. Soft tissue augmentation - injection of dermal fillers;
    c. Botulinum toxin/Neuromodulators – injectable;
    d. Venous sclerotherapy that is small superficial vessel injections.
4. Procedures aimed at the treatment of pathology may include, but are not limited to:
    a. Peripheral stem cell injection as approved by Health Canada; and
    b. Platelet rich plasma injection as approved by Health Canada;
5. Lasers, including Lasik
6. And any other procedures the Working Group considers appropriate for patient safety.

Section 3: Roles, Functions, and Accountabilities

The following are the roles, functions, and accountabilities of the Working Group:

- To make recommendations to CPSM Council on office based procedures.
- To develop a Standard of Practice on Office Based Procedures which will be circulated to members, stakeholders, and the public for consultation and review the results of that consultation process.
- To finalize a Standard of Practice for Office Base Procedures.

Section 4: Chair and Membership

4.1 Chair

The Committee will be chaired by XXX.

4.2 Membership

Working Group Membership is to include representatives from:

- CPSM Council
- Family Medicine
- Specialists (plastic surgery, dermatology)
- College of Registered Nurses of Manitoba
- And any other representative the Chair considers appropriate

Members of the Working Group may include practitioners who perform or are knowledgeable about the following procedures:

- Vasectomy
- Male circumcision
- Cosmetic/aesthetic procedures
- Peripheral stem cell injection
- Platelet rich plasma therapy
- Venous sclerotherapy
- Laser usage

Section 5: Communication and Meetings

5.1 Meetings

Meetings will be held every month or at a frequency determined by the Working Group. Administrative support will be provided by CPSM.

5.2 Records of Discussion and Decisions

A record of Discussion/Decision will be produced following each meeting.

Section 6: Accountability and Reporting

The Working Group shall prepare a recommended Standard of Practice for Office Based Procedures.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – DECEMBER 9, 2020

FOR INFORMATION

SUBJECT: Standard of Practice Maintaining Boundaries Consultation Feedback

BACKGROUND

In September, Council approved the distribution of the Working Group's Report and Draft Standard of Practice to members, the public, and stakeholders for consultation feedback. The consultation period is 60 days, running from October 16 to December 16, 2020. The consultation period will still be open at the date of Council's December meeting. In the New Year, the Working Group will be re-convened to consider the feedback and provide its recommendations to Council.

There have been few comments to date. An advertisement has appeared twice in the Winnipeg Free Press.

Attached are the comments received.

Standard of Practice for Sexual Boundaries with Patients, Former Patients & Interdependent Persons consultation comments

Comments
CPSM Member Feedback
Seems pretty straight forward. If a patient is a FORMER patient with no ongoing plan for a therapeutic relationship, it should be OK to have a romantic relationship. Probably means that the person can never see the MD as a patient ever again though Questions: -if a family MD starts dating someone -incidentally they realize the person they are dating has a sibling/parent under their care – what do they do then? Just comments
I find the former patient clause too persecutory to medical staff. If you have seen a patient in clinic for a brief time period, and then legitimately transfer them to another physician with no outstanding testing, labs, prescriptions, they should be a truly "former patient." There should not be a problem seeking a personal relationship with former patients, granted that you also do not have a relationship with their family members. The entire notion of former is just that- no ongoing professional relationship. By that reasoning a member should be able to pursue a relationship with that individual. The wording about the former patient is too harsh and too restrictive.
I do Pediatric Urology. I perform many genital exams in prepubertal and post-pubertal patients, some who DO NOT want their parents in the room (or a chaperone) during their exam. Based on this, I have the following comments/questions as these rules would not necessarily apply to children. 4.2.5.ii (I am okay this wording if my assumptions are correct) I assume the level of autonomy I provide with having the patient expose their genitals themselves (ie lower their pants) is age/maturity dependant 4.2.5.iii (I am okay with this wording if my assumptions are correct) I'm not sure if there is a definition of "adequate draping", but I am assuming that if the clothes that remain on the patient (such as pants pulled down) provides the same coverage that a sheet would, this is acceptable 4.2.5.v (I accept the first half. I take issue with the second half). I always offer/recommend for the patient's caregiver/chaperone/companion to stay in the room during the genital exam, but they often choose to be alone, and are also not wanting any other chaperone in the room. If I don't have any concerns about my safety (physical or legal), I proceed with the companion (if one came) just outside the room with the door unlocked. Some of these patients might even refuse a physical exam if it meant having someone else in the room. I feel this satisfies the first line: "offering a chaperone". However, it does not meet the second line: "not proceeding in the absence of a chaperone". This second line indicates that the patient does not have a choice in the matter and a chaperone MUST be present. Was this the intent?

4.2.5.xii (I would like this clarified to only apply to post-pubertal patients)
I have issues with excess glove use. I do not believe that examination of male genitalia in a prepubertal boy requires the wearing of gloves provided proper hand hygiene is used and there are no concerns regarding infection

Thank you for the opportunity to comment. Please let me know if you request further clarification

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I hope that the college will take into account the potential social difficulties of a single physician working in a small community where it is likely that the physician will by necessity have a professional interaction with almost everyone in that community

---

I'm a male rural GP practicing family medicine and ER.

I was pleased with most of the document, the prohibitions on sexual contact are straightforward and logical.

However, I have several concerns with the standard of practice as it is written and how it will hinder the efficient provision of routine care. I'm also not sure that it strikes the right balance between protecting the public from sexual predators and protecting physicians from false allegations.

A member must limit physical examinations of their patient to what is clinically indicated and such that it only includes that to which the patient has provided their informed consent. In this context, prohibited conduct may include, but is not limited to one or more of the following:
Must informed consent be documented for each examination? Typically in an encounter consent is implied when the patient removes their clothing and climbs upon the exam table. The statement "may include" makes it very hard to interpret the list below. Most of the points are clear-cut and unacceptable, while others are quite vague.

4.2.5.i. not providing privacy while the patient is undressing or dressing;
This is very non-specific. Am I to leave the room any time a patient removes any clothing? This is not at all practical with the time constraints we currently work under. With male patients I routinely ask for shirts and pants to be removed without leaving the room, no one has ever objected to this. For female patients I will leave and return with a chaperone once the patient has changed for breast and gential exams, but not for exposing legs, abdomen, feet, etc.

4.2.5.ii. assisting with undressing or dressing, unless the patient is having difficulty and expressly consents to such assistance;
This statement also lacks clarity. Does this include such things as lifting a shirt to expose the abdomen, or lifting the shirt in the back for auscultation of the lungs, or lifting a pant leg to look at the leg, or removing socks/shoes to examine the feet?

4.2.5.iii. providing inadequate draping;
Where is "adequate draping" defined?

4.2.5.iv. not offering the presence of a chaperone/attendant before conducting a sensitive examination or proceeding with a sensitive examination in the absence of a chaperone/attendant;

I have never offered a male patient a chaperone, is this a new mandate? If so, will I need to document "refused chaperone" with every DRE? Is signage offering a chaperone upon request adequate, or do I need to document verbal consent to omit a chaperone for every examination I perform? I generally only have female chaperones available, as females make up the vast majority of both nursing and medical reception workforces. Do I need to offer males a male chaperone? Conversely, if I find myself in the unusual situation of an ER shift with all male nurses, is offering a second male presence to a female patient considered adequate for a chaperone?
Also, who is defining "sensitive examination". Does the college define it, or is it whatever that patient considers sensitive? Is this only breast/genital/anal, or might a cardiac auscultation on a woman wearing a bra be considered sensitive?
Chaperones are very time consuming, not just for solo practitioners. I work in a large clinic, but we do not have a trained chaperone available at all times, depending on the circumstances either a nurse or medical receptionist is used. To achieve the standard of offering every patient a chaperone, we would need to hire more staff.
At what age is the parent no longer adequate as a chaperone? Obviously for a DRE in a constipated infant there would be no need for a chaperone, but at some point before adulthood a chaperone would be necessary for breast/genital/anal exams, the standard makes no mention of this.

With regards to chaperones in general the statement does not discuss what to do if the patient refuses a chaperone but I as a physician want one. Am I able to refuse to perform an examination even if medically indicated? It is my nearly universal practice to have a chaperone present for any exam of a female involving the breasts or genitals for my own medico legal protection, the only exception being elderly patients I know well and trust.

It is discussed in some detail in the working group document, but how will the College establish whether an offence has occurred "on the balance of probabilities"? The nature of medicine frequently requires private one-on-one encounters in closed rooms, with only the physician and patient. Suppose a patient alleges groping occurred during a visit for URTI, the physician denies it, and the medical record reflects a typical URTI encounter. How will this be adjudicated? Obviously one cannot have a chaperone present for every moment of every encounter.
In my practice, especially in the ER, I encounter many patients who are less than truthful for any number of reasons. Under-reporting drug and alcohol use, malingering for disability benefits, reporting factitious overdoses to enter the sick role, stories of "lost" opioid prescriptions, etc. These same patients are also more likely to leave angry with me for not providing them with the drugs they seek, or the admission they want, the forms they want signed, the unnecessary imaging they request. This mix of a revenge motive and willingness to make false reports is very concerning if the standard is "balance of probabilities" versus "beyond a reasonable doubt". Given the severity of the potential penalties, I do not think this is a reasonable burden of proof. Under these terms any disgruntled patient merely needs to allege sexual misconduct to cause enormous personal and professional damage to the physician.

Also, in my experience, female physicians use chaperones at a far lower rate than male physicians. Are male, female and non-binary physicians all held to the same standard with respect to chaperones? Is the entire profession expected to offer a chaperone to all patients regardless of the patient and provider's gender? If the patient declines, is every note expected to document that?

How does our standard on chaperones compare with others in the RHPA? I have almost never seen nurses request a chaperone for inserting a catheter, changing a diaper, inserting an enema. Likewise, ECG technicians routinely expose women's breasts while applying leads with no specific draping. Ultrasound technicians routinely perform invasive pelvic ultrasounds one on one with patients.

I hope the standard can be revised to offer clear guidance on what constitutes a sensitive exam, when a chaperone is required, whether the gender of the patient/provider matters, what documentation is required around sensitive exams and consent.

Doctors and patients, as all people, are damaged at some level. Someone said recently that surviving medical school would be sufficient to qualify as having suffered PTSD. A study measuring cortisol levels prior to staring year one, and at the end of year one showed reduction in serum cortisol in medical students.
Doctor- doctor relationships- how are they viewed? We often ask those close to us for advice, and when the partner is a doctor, do we still ask, or do we shut them out from their field of interest when we have symptoms?
How much doctoring do you have to do in order to be considered to have had a power relationship with another person? Your groundskeeper, housekeeper, chauffeur, parent of a patient, child of a patient who has attended visits, and "seen" you as a doctor? Tom Cruise' latest relationship was clearly of a devoted fan (power imbalance, like yeah!), and we know how that turned out.

Perhaps doctors should apply for the privilege of having a relationship with an ex-patient, former patient, anyone with whom they had a relationship involving their profession as a doctor prior to starting the relationship. Then they can get the all clear in advance. Just a thought, because after the fact, and making rules to excuse or punish each eventuality could be daunting to the extreme.

High school sweetheart, apart for years, one becomes a doctor, they see each other in ER, where the doctor sews up a laceration. Off limits? Off limits if the laceration is in a socially sensitive anatomic location, vs OK if on an arm? Where do you start or stop?

In applying for employment with the College, [redacted] had to list all the doctors in Manitoba he knew in order to have no conflict of interest should those doctors require legal attention from the College.
As an example of a pre-emptory declaration, a physician wishing to engage in an intimate relationship with a fellow staff person, a junior staff person, a nurse, orderly or otherwise could apply to the College in an application that would list the current relationship, and the intended relationship. I am confident a score sheet of sorts could be set up with diminishing score points over time of no contact between applicants in order for the applicant to gain a sense of the safe zone, the cautionary zone, and the danger zone.
In the safe zone, the applicant could proceed on the basis of the score alone, the score, and the details of the test as part of their College file, and not reviewed until such time as a potential problem arose. In the cautionary zone, a conversation with the Registrar to clarify details would be engaged, with a determination of safe or danger zone applied. The danger zone is self explanatory, and if pursued as a challenge by the doctor, would require a more formal hearing to move someone in the danger zone to the safe zone, if the circumstances were that expultatory, even if the score was more alarming. Otherwise a red zone score would serve as a complete stop and desist order, "Do not pass Go, Do not collect $200.00".

The upshot of the guidelines is essentially the above, although not formalized in a questionnaire type format, which I think would add validity, and a numerical framework. If the number assigned to a particular relationship is considered disproportionate by the majority of physicians, then it can be

adjusted. If the specialty bears a weight on the number for the relationship, for example a radiologist and a patient, then that can be modified as well. If the patient is a minor, has a cognitive, or language barrier, the answers can have modifying variance to them, up or down, depending on the circumstances.
Countertransference, the rescuer, the enabler, the voyeur, whatever the nature of the driving force in initiating a relationship, from either direction, patient to doctor or vice versa is always in play, and cannot be readily enumerated until the relationship has developed for some time. At the least, one can say that due diligence was applied at the outset.

In medical school a more senior student pursued a more junior, and very young student until he had conquered her, at which point he soon lost interest, and moved on. Appropriate? She was a willing participant. She succumbed to his seduction, both were adults, although she just barely, and I anticipate she learned more than he. She was not his first, but he was hers.

I am a strong believer in strict boundaries, don't misinterpret. Years ago a serial sexual offender was not outed, or reprimanded formally, other than to lose access through the teaching program to the young victims they preyed on. If guidelines are prepared, and if criminal acts are committed, it is my hope that the powers that be do not protect the abuser under the guise of "it would be a shame to lose a doctor of such skills early in their career." The abused were talked into not laying charges out of some sort of pity for the abuser as a fellow physician.
The advantage of the scoring system is that a physician pursuing a relationship that scored in the red zone would be aware of the consequence at the outset, so as not to mount some sort of defense of ignorance when confronted.

Even if the College does not establish a formal scoring system, each act has a sense of revulsion towards it, and reflecting the severity of the variance is part of what guidelines are meant to do. Acts that are described as in the Criminal Act do not need to be addressed by the College, unless to state that the College will not play a role in thwarting a physician from being charged with a criminal act regarding a physician and person claiming they were the subject of a criminal act. If a doctor can hide behind the College to protect themselves from criminal charges, then we have certainly lost our way.

Someone prepared a score of losses and changes that, if experienced within a 12 month span, would increase their likelihood of experiencing depression. I am suggesting a similar comparative scoring system for doctors and would be intimate partners.

This is an impressive document and the report of the Working Group identifies extraordinary work in its creation.
Although one of the cases noted was as an interaction with a learner, I didn't see that area as specifically considered. I realize that the Rady Faculty has a number of policies and that the CPSM will be working with them. I applaud that decision and encourage the CPSM to include some of the Faculties work in our published material.

Has the working group considered raising the issue of our being using being a physician to approach non-patients – whether as a fellow health care provider or in the community. We do say that a doctor is always a doctor, no matter where we are or what our involvement outside a practice setting. Perhaps that could be enlarged.

4.2.5.iv. I must say having practice for over 20 yrs as a female physician and I have never offered a chaperone for any genital exams or for full skin examinations. So I would be guilty of this. How many cases of inappropriate touching during an exam by a female doctor to a patient have occurred in Canada? I must say, I have no intentions of ever inappropriately touching any patient. But I have not offered a chaperone for 20 yrs. I would be curious to know how many female doctors do this for every exam? I know that I have not been offered one with my female doctors. This is a double standard I realize but I think stats would bear out the differences in the issue. I know that you would not like to separate female from male doctors but there is a big statistical difference. If I were a male physician , I would offer or even insist on having one in the room but with female doctors, there is a big difference and luckily for the better. I do skin exams all day so I guess now I have to offer a chaperone which will take more time explaining of course and slow down the already busy day. Obviously if they had requested one, I would have complied but I understand that pts may not have courage to request. But it is a lot of wasted time for 99.9% of female doctors. I think the pendulum has swung the other way for most doctors where I am even so careful where I stand during surgery to make sure I am not touching the bed and inadvertently touching the patients body while standing for surgery, not resting my instruments on the chest as we frequently did. I worry during a skin check even touching a body part now and how that is perceived, even just an arm or a leg - which I do all the time because touch is important for skin lesions. Obviously I dont do it in a creepy way x 20 yrs as I have never had a compaint but I still worry. I obviously provide gowns and sheets and start with them. Otherwise I think it is a good document. Sad that we have to have this in our society though but if the stats are so unfavourable to one sex, should we have different guidelines for male and female physicians?
I fully support this proposition.
Public Feedback
Stakeholders
Having reviewed this document, I feel it to be very comprehensive and as such do not have any suggestions for additions or changes. I would say however, that it has brought to light that although our profession has never had to investigate a sexual boundaries infraction, that we should have a

similar policy in place. I would like to thank all those involved in the production of this document for their hard work and diligence as I am sure that, once ratified, it will provide a basis for many professional boards to update their own policies.

I am a Policy and Practice Consultant for the CLPNM and have been working on this draft document to address Boundaries with our registrars. Sexual Misconduct is a section in the draft document that I would like to contribute to the conversation.

College of Licensed Practical Nurses of Manitoba
Boundaries
Draft Outline of the Practice Direction

Purpose:
The purpose of this practice direction is to provide the nurse, employers, and the public with information regarding Professional Boundaries of the CLPNM registrants.

Introduction:
The core of nursing is the therapeutic nurse-client relationship. Professional Boundaries create the framework for the therapeutic relationship. The nurse establishes and maintains this key relationship by using nursing knowledge and skills, as well as applying caring attitudes and behaviors. Therapeutic nursing service contributes to client's health and well-being. The relationship is based on trust, respect, empathy, and professional intimacy, and requires appropriate use of the power inherent in the caregiver's role.

The Nurse-Client Relationship:
This relationship contributes to the client's health outcomes and healing, and is fundamentally for providing safe, competent, compassionate, and ethical nursing care.
Nurse-client relationship consists of four (five) components that are always present, regardless of the length of the relationship:

- Trust
- Respect
- Empathy
- Power

The nurse is responsible for maintaining healthy professional boundaries, not the client:
While each therapeutic nurse-client relationship is unique, every relationship sits on a continuum of professional behavior and has a beginning, middle and an end. This continuum places under-involvement at one end and over-involvement at the other.

CONTINUUM OF PROFESSIONAL BEHAVIOR

Under involvement----------Therapeutic Relationship----------Over-involvement

Under-involvement:
When a nurse is under-involved (e.g. avoids a client) the therapeutic nurse-client relationship can be damaged causing repercussions for a client's health and well-being. Avoiding client interactions can occur when a client exhibits undesirable behavior. The nurse-client relationship can be affected on two levels. Firstly, by avoiding a client, a nurse may just focus on the 'task' associated with providing minimal care rather than dealing with the issue that makes them feel uncomfortable. When a nurse avoids a client, they are putting their own needs ahead of the client's. Secondly, avoidance can raise the potential for substandard care. Avoidance can lead to neglect, which is a boundary violation.

Over-Involvement:
Over-involvement refers to unnecessary focus and excludes instances when a client's needs are higher than other clients because of increased complexity. Over-involvement can affect the recovery of other clients. For example, when a nurse spends more time with one client than another, the neglected clients may feel their health is not important to the nurse causing them to refrain from seeking assistance.
Developing a personal or romantic relationship is clearly over-involvement and can result in not only a breach of trust but is both a boundary crossing and boundary violation.

Therapeutic Relationships:
A therapeutic relationship is a planned, goal-directed, and contractual connection between a nurse and a client for the purpose of providing care to the client to meet the client's therapeutic needs. Nurses maintain appropriate professional boundaries and ensure their relationships are always for the benefit of the client.

Professional boundaries in the nurse-client therapeutic relationship:
Professional boundaries are the spaces between the nurse's power and a client's vulnerability. Boundaries separate the therapeutic behavior of the nurse from any behavior which well-intended or not, could lessen the benefit of care to a client. Professional boundaries need to be established and maintained both on duty and off duty when a nurse-client relationship begins.
Healthy professional boundaries protect the nurse-client relationship and allow respect for both parties. Nurses recognize the importance of protecting clients' dignity, autonomy, and privacy. The nurse is a professional with certain obligations and rights and trusted to recognize the power differential. The nurse-client relationship has the power to heal and the power to harm clients.
Appendix A illustrates therapeutic and non-professional relationship differences.
Boundary Crossing:
Boundary crossings are brief excursions across boundaries that may be inadvertent or even purposeful if done to meet a client's specific therapeutic need. Nurses should return to established boundaries and evaluate the crossing for potential client consequences and implications as these actions and behaviors deviate from established professional boundaries and this conduct could result in boundary violation. Even when the action or behavior seems appropriate, it is not acceptable when it benefits the nurse's personal needs over the need of the client.

Boundary Violations:
Boundary violations occur when the client's needs are no longer the focus of the therapeutic relationship. An act or behavior becomes unacceptable because the outcome benefits the nurse over the needs of the client. These behaviors move the nature of the relationship from therapeutic and professional to personal, breaching the limits of safe therapeutic environment.
Boundary violations can result when the nurse confuses their own needs with those of the client. Nurses may not recognize their own boundaries or have not understood the client's boundaries. Boundary violations can cause distress that the client may not recognize but can cause harm. How the client perceives the behavior matters, not the intention of the behavior
The following activities are boundary violations:

- Accepting and giving gifts
- Borrowing or attempting to borrow money form a client
- Self-Disclosure
- Commencing a social relationship with a client or former client
- Romantic or sexual relationships with clients or former clients

- Engaging with clients or former clients on social media platforms (see Social Medial Practice guideline)
- Marketing products to clients to promote their personal business
- Influencing a client to write or change their will or power of attorney so the nurse will benefit
- Providing care beyond one's job
- Providing care to family and friends
- Neglect
- Failure to demonstrate sensitivity to religious, spiritual and cultural beliefs and values

(The above topics will be expanded on)

Warning signs/Red flags:
Signs of Over-involvement:

- Discussing personal issues with a client
- Thinking about a client in a personal way as opposed to being concerned about the client's progress
- Engaging in behaviors that could reasonably be interpreted as flirting
- Keeping secrets with a client or for a client
- Changing client assignments to ensure contact with client
- Believing that you are the only one that understands or can help the client
- Spending more time with the client than is necessary
- Speaking poorly about colleagues or your employment setting with the client and/or family
- Showing favoritism
- Meeting client in settings other than care area or when you are at work

PROFESSIONAL BOUNDARY
THINKING TOOL

WHO-> Ask
Who will benefit ---------- IF "me" ----------Abstain
From this? Whose ---------- If "not Sure" ----------Consult
Needs will be met?
If Client
WHY? ASK
Will my action/behavior -------If "no" ----------Abstain
Contribute to the therapeutic ----If "not sure"----------Consult
Nurse-client relationship?
IF Yes
What? ASK
Is my actions/behavior ----------If "no"----------Abstain
Consistent with the plan ---------If "not Sure" ----------Consult
Of care for the client and
Am I comfortable?
IF Yes
HOW? ASK
Is this action/behavior --------If "no" ----------Abstain
Something I would want --------if 'NOT sure"----------Consult
Colleagues to know I had

Engaged in with a client?
IF YES
PROCEED

Nurses in Dule Role:
A dule role is a situation where a nurse is required to provide professional care to a client who is also a family member, friend or have business relationship with. This is likely to happen in small communities. The best course of action in this situation is to make every effort to transfer the care of the family member or friend to another appropriate care provider. If this is not possible, the nurse should set very clear boundaries with the client to make sure they understand that even if the nurse is a family member or friend providing care, they are doing so in the role of a professional nurse.

Act Early:
When you have concerns about the professional boundaries of a colleague, your first concern is protecting the client. The following actions keep the client and the nurse safe from harm:

- Determine the facts to avoid hasty judgement. Focus on the client's welfare when assessing the facts and get each party's point of view, particularly the client's perception. Wherever possible, discuss your concerns with the nurse involved.
- If you are unable to speak with the nurse directly, speak to their immediate supervisor. Explain your reasons for concern and keep to observable facts and the impact on client care. Follow appropriate employer requirements for reporting observed incidents of boundary violations, including adequate documentation.
- Stat the actions you expect will occur to resolve the situation. If discussion confirms your concerns about a risk of potential boundary violation, offer your support to get you colleague assistance or help within the practice setting. CLPNM Practice Consultants can also provide confidential consultation on how to proceed.
- Ensure that the clients, families, or other health-care professionals are aware of resources if they have any concerns regarding therapeutic nurse-client relationships.
- Do not allow a problem situation to persist uncorrected. Discuss the concerns about the individual's conduct with CLPNM. Early intervention prevents client harm and protects the nurse's professional status.
- If the situation is not resolved, farther actions may include filling out a complaint letter describing the concerns to the next level or the highest level of authority in the agency or reporting the matter to the College.

Other - Staff

Thank you for the opportunity to share feedback on the proposed standard of practice.

RE: Section 4 (Sexual Boundary Violations – the Spectrum of Prohibited Conduct): While I recognize that the list is not exhaustive, would the Working Group consider adding: "encouraging the masturbation of a member by the patient"? This would spell out more clearly (as does 4.1.2.v.) that not only is the act itself prohibited but the encouragement of the act is also prohibited.

RE: Section 7 (Psychotherapeutic Relationships): I am curious about the omission of interdependent persons in this section. Depending on the circumstances that lead a patient to seek therapeutic

counselling or treatment, the therapeutic relationship may involve discussion of the patients' relationships with those with whom he or she is interdependent (for example, a minor who is attending therapy and discusses his/her relationship with his/her parent with a member). In that context, the member may be privy to information about the patient's interdependent relationships that can create a power imbalance (in the event that a member should seek a sexual relationship/contact with an interdependent person). Perhaps there should be limits noted around a member's sexual contact with persons who are interdependent with the patient (or at least the statement that sexual contact is discouraged with persons who are interdependent with the patient). One possible typo: Section 1.6 should likely read "complements", rather than "compliments".

CMPA.ACPM
Empowering better healthcare
Pour l'avancement des soins de santé

November 24, 2020

Via email: TheRegistrar@cpsm.mb.ca

Dr. Anna M. Ziomek
Registrar/CEO
College of Physicians & Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg, MB R3J 3T7

Dear Dr. Ziomek:

Re: Standard of Practice for Sexual Boundaries with Patients, Former Patients and Interdependent Persons

The Canadian Medical Protective Association (CMPA) appreciates the opportunity to provide feedback to the College regarding the draft *Standard of Practice for Sexual Boundaries with Patients, Former Patients and Interdependent Persons*.

As you know, the CMPA delivers efficient, high-quality physician-to-physician advice and assistance in medical-legal matters, including the provision of appropriate compensation to patients injured by negligent medical care. Our evidence-based products and services enhance the safety of medical care, reducing unnecessary harm and costs. As Canada's largest physician organization and with the support of our over 100,000 physician members, the CMPA collaborates, advocates and effects positive change on important healthcare and medical-legal issues.

The CMPA appreciates the College's efforts to comprehensively address sexual boundary violations. We support the implementation of appropriate measures to ensure that sexual boundary violations are properly investigated and adjudicated in a way that protects patients and properly deals with those found to have committed these violations. We are hopeful the following comments will assist in clearly articulating physicians' obligations and the College's expectations.

Proportionate Sanctions

As recognized in the *Sexual Boundaries Working Group Report to Council*, Manitoba currently does not have sexual abuse legislation. The College is therefore not bound by any requirements with respect to mandatory sanctions for sexual boundary violation findings.

With this in mind, it is appropriate that the College refrained from adopting mandatory minimum penalties or permanent revocation for sexual boundary violation findings. The CMPA is supportive of the approach proposed in the draft *Standard* of determining the appropriate penalty based on

the unique circumstances of each case. This is consistent with the fact that not all sexual boundary violations are the same. Some violations, such as ill-advised comments or miscommunication about a clinical examination, are considered less serious compared to overt sexual abuse of a patient. The penalties for the range of misconduct in this area must be proportional and reflect the seriousness of the finding.

For example, the CMPA advocates in less egregious cases that it is appropriate to consider a preventative strategy involving remediation and educational programs focused on clearly defined boundaries designed to reduce the risk of recurrence. An important and necessary part of any process for addressing sexual boundary complaints is improved education focused on prevention.

Proportionate sanctions that reflect the relevant circumstances of individual cases promote fairness in accordance with the principles of natural justice without undermining the public policy objectives behind penalties for sexual misconduct by physicians. Proportionate penalties also help to restore confidence amongst the public and profession that these complaints are being addressed in a balanced and appropriate way. On the other hand, disproportionate sanctions that are too blunt create fear and anxiety for the profession and do not promote a clearer understanding of evolving professional boundaries.

Definition of Patient

In light of the devastating consequences to a physician's career and reputation resulting from a sexual boundary violation finding, it is essential that the *Standard* clearly describe who is considered a "patient" in this context. In this regard, the draft *Standard* should more clearly address how it is intended to apply with respect to former patients and individuals with whom the physician has a pre-existing relationship.

Former Patient

It would be beneficial if the draft *Standard* indicated how the factors listed in section 3.2.3 will be weighed in determining whether a "reasonable period" has elapsed after the last patient encounter ends and before sexual contact or interaction with a former patient is initiated.

Unlike the approach in some other jurisdictions, the draft *Standard* does not articulate a specific time that must elapse prior to the commencement of any sexual relationship with a patient (*e.g.* one year from when the individual ceased to be the physician's patient). Rather, the member must satisfy the College "that a 'reasonable period' has elapsed in accordance with section 3(b) above[1] before engaging in what is otherwise prohibited conduct as defined in this Standard of Practice with a patient".

The CMPA recognizes that not all physician-patient relationships result in the same degree of vulnerability for all patients. Therefore, it may not be reasonable to broadly impose a specified period for when an individual is no longer considered a patient. On the other hand, without this specificity, it may be challenging for physicians to gauge whether a sufficient amount of time has elapsed such that there is no longer an inherent power imbalance.

[1] We presume the fact that the draft *Standard* does not include a section 3(b) that this is a typographical error. Section 3.2.3.sets out the factors that are relevant in determining what is considered a "reasonable period".

A physician's consideration and application of the factors identified in the *Standard* could differ from that of the College. Although section 6.3 suggests physicians can contact the Registrar to ensure they fully understand the risks prior to engaging in sexual contact or interactions with a former patient, we expect many physicians will not be comfortable doing so. It would be preferable if the *Standard* more clearly defined what the College considers a "reasonable period".

Pre-Existing Relationships

The CMPA recommends that the *Standard* specify that an individual is not considered a "patient" where the physician has a pre-existing sexual relationship with the individual.

Other Colleges have created exceptions for pre-existing relationships. For example, the Colleges in Alberta and Nova Scotia adopted exceptions similar to those of the College of Physicians and Surgeons of Ontario, which state:

> A person is not a physician's patient if all of the following conditions are met: (a) There is a sexual relationship between the person and the physician at the time the health care service is provided to the person; (b) The health care service provided by the physician to the person was done due to an emergency or was minor in nature; and (c) The physician has taken reasonable steps to transfer the person's care, or there is no reasonable opportunity to transfer care.

It is equally important that the *Standard* specify that where a physician provides medical treatment to such persons beyond any specified conditions (*e.g*. not in an emergency), this would not constitute a sexual boundary violation, but instead would be considered non-sexual professional misconduct (*e.g.* "conduct unbecoming a member").

Persons Interdependent with Patient

Given the potentially significant consequences for physicians, this section of the *Standard* should be particularly clear, certain and capable of application by more clearly defining the instances in which a sexual relationship with these individuals will be considered inappropriate.

Although section 5.2 lists the factors that physicians should consider in determining whether sexual contact or interaction with these persons would be considered a boundary violation, it is not expressly stated how the factors should be weighed. For example, what if the care provided was minor and episodic, but the degree of reliance by the patient on the person is high? It is also unclear how those factors might affect the College's determination as to whether misconduct has occurred.

References to CMPA

We appreciate that section 6.3 of the draft *Standard* encourages physicians to contact the CMPA for advice in relation to engaging in sexual relationships with former patients. We would be grateful if the reference to "professional indemnity insurer" was removed in relation to the CMPA.

As the College is aware, the CMPA is a mutual-defence organization, not an insurer. We do not provide "insurance" to physician members. To better reflect the nature of the CMPA's assistance, we request that this statement in the *Standard* be amended to refer to "professional liability provider".

To further assist physicians obtain the advice required in these challenging circumstances, the College may also consider referencing in the *Standard* the following CMPA publications related to sexual boundaries:

- *Good Practices Guide, Maintaining Appropriate Boundaries*
- *Criminal and sexual impropriety matters*
- *Recognizing boundary issues*
- *Is it time to rethink your use of chaperones?*

We hope these comments will be helpful to the College in finalizing the draft *Standard*.

Yours sincerely,

Dr. Lisa Calder, MD, MSc, FRCPC
Chief Executive Officer/Executive Director

LAC/ml

Cc. cpsmsopboundaries@cpsm.mb.ca
Dr. M. Cohen

COUNCIL MEETING – DECEMBER 9, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT: Additional Specialist Field of Practice for Assessment

BACKGROUND:

1. Physicians who are eligible for conditional registration with CPSM must undergo an assessment acceptable to Council, unless the physician is exempted by reason of one of the statutory exemptions from assessment.

   Assessments for specialists are provided through the Faculty of Medicine at the University of Manitoba. Since the Faculty is unable to offer assessments in all specialties, the Practice Direction for Qualifications and Registration sets out the specific specialist fields of practice which are eligible for conditional registration and temporary registration and permits Council to add specific fields of practice pursuant to CPSM General Regulation Section 3.38(b)

   CPSM has been approached by the University in the attached letter to request the addition of Dermatology. If Council approves the addition of Dermatology to the Speciality Field of Practice for Assessment, a physician can be referred to the University's Division of Continuing Professional Development for an assessment.

2. Specialty Practice Assessments may also be approved for the purposes of CPSM General Regulation s. 3.16(1)(g)(i) and include the University, Royal College. In some very rare instances, there may be candidates that could be assessed but there might be other provisions that may preclude such as assessment, even though it might not have been the intention to block such a specialty practice assessment.

   In these very unusual cases, it is recommended that the Registrar have the discretion in exceptional circumstances to approve an assessment that is satisfactory to the Registrar and deemed equivalent to the regular assessments. There would also be the safety check of having two other practicing specialists endorse the assessment.

PUBLIC INTEREST RATIONALE:

"A college must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest." S. 10(1) RHPA

Dermatology is a specialty with very lengthy waiting periods for consults, with no residency program in Manitoba. In very rare situations where applicants do not qualify under the regular rules for specialty practice assessments, applicants will be able to be assessed to determine if they can become full practicing specialists. The assessment would then determine their competency and ensure their knowledge, skill, and judgment are to the required level to ensure patient safety. Only if successful in the assessment would the applicant then be able to practice unsupervised as a full member.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 9, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

1. Dermatology be added to the Qualifications and Registration Practice Direction, section 2.15, as a Specialist Field Practice for Assessment for the purposes of CPSM General Regulation section 3.38(b) and

2. Section 2.2.2 of the Qualifications and Registration Practice Direction be amended by adding: “section 2.2.2.g. in exceptional circumstances, an assessment that is satisfactory to the Registrar, is deemed equivalent to the above assessments by the Registrar, and is endorsed by two other Manitoba specialists practicing in the same area of practice.”

University of Manitoba | Rady Faculty of Health Sciences

Max Rady College of Medicine

International Medical Graduate Program
260 Brodie Centre
727 McDermot Avenue
Winnipeg, Manitoba R3E 3P5

Phone: 204-975-7757
Fax: 204-789-3911

November 5, 2020

Dr. Anna Ziomek
College of Physicians and Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg, MB R3J 3T7

Re: Practice Ready Assessment - Specialty Practice (PRA-SP) in Dermatology

I would like to report that Dr. Marni Wiseman, with the Section of Dermatology, has confirmed their commitment to participate in the PRA-SP effective immediately.

I would therefore like to officially request that the College add Dermatology to the Approved Fields of Specialty Practice for Assessment for the Purposes of CPSM General Regulation Section 3.38(b).

Please let me know if you require any additional information or documentation to process this request.

Yours sincerely,

Martina Reslerova, MD, PhD, FRCPC
Director,
International Medical Graduate Program

MR/cc

cc: Dr. Marni Wiseman, Section Head, Dermatology

COUNCIL MEETING – DECEMBER 9, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT: Policy - Elderly Physician Audit

BACKGROUND

The elderly physician audit program was launched in 1991. The policy requires updating. CPSM has the inherent jurisdiction to conduct audits on any of its members to ensure competence, though the broad parameters and authority for the Elderly Physician Audit program should be contained in a new policy.

Attached is an Elderly Physicians Audit Policy recommended by the Central Standards Committee, to Council for approval. It is a high level policy establishing the authority for the elderly physician audit and its applicability. A further document establishing processes, policies, and procedures will be developed for the Central Standards Committee. That subsequent document need not be approved by Council as the Committee can establish its own policies and procedures.

See attached policy.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 9, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

The attached Elderly Physician Audit Policy of Council be approved.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

POLICY

Age Triggered Quality Audit

Initial Approval: December 9, 2020 **Effective Date: December 9, 2020**

1. Establishment

1.1. An Age Triggered Quality Audit Program is established by Council and administered by the Central Standards Committee.

2. Authority

2.1. The Central Standards Committee is responsible for supervising the practice of medicine by CPSM members and may review the professional competence of a member in accordance with s. 182(1) of the *Regulated Health Professions Act*.

3. Physician Risk Factors

3.1. The hallmark study on age as a physician risk factor, "The Epidemiology of Competence: Aging as a Risk to Competence in Practising Physicians" summarizes the evidence for the impact of age on six associations:

- 3.1.1. Physical performance
- 3.1.2. Cognitive performance
- 3.1.3. Psychological wellness
- 3.1.4. Clinical knowledge or performance
- 3.1.5. Patient safety
- 3.1.6. Medico-legal implications/repercussions

3.2. The study concludes advancing age negatively impacts the individual's competence in practicing medicine. This has been supported by the Federation of Medical Regulators in Canada *Framework on a Regulatory Approach to Physicians with Health Condition and Potential Impact on Performance and Patient Safety* which recommended, "All Medical Regulatory Authorities consider age as a screen for potential risk to competence and patient safety."

4. Application and Purpose

4.1. Upon reaching age 75, every member registered to practice medicine (full and associate members, physicians, clinical assistants, and physician assistants) must participate in an audit performed for the purposes of determining their professional competence.

4.2. The applicable age for the Age Triggered Quality Audit will decrease to age 70 by no later than 2030, to be implemented at the discretion of the Central Standards Committee.

5. Administration

5.1. The Central Standards Committee must administer the Age Triggered Quality Audit Program in accordance with the Central Standards Bylaw and CPSM Governance Policy – Central Standards Committee Terms of Reference.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING –DECEMBER 9, 2020

ITEM FOR INFORMATION

SUBJECT:

Strategic Organizational Priorities Update

BACKGROUND:

A Progress Tracking Document for the Strategic Organizational Priorities is attached.

The Strategic Organizational Priorities for Virtual Medicine, Patient Records, and Duty to Report are marked as "On Track" as all working groups have commenced and are meeting virtually. Included is the new Strategic Organizational Priority: Office Based Procedures. This has been added as a result of the Accredited Facilities Criteria Working Group recommendation and the Terms of Reference are included in this Council meeting's agenda. Council is being asked at this meeting to approve the amended Accredited Facilities Bylaw. If not approved the progress tracking chart will be amended.

Some of the Priorities are "on hold" until FMRAC provides a framework or national level agreement and direction.

PUBLIC INTEREST RATIONALE

"A College must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest." s. 10(1) RHPA

All priorities are firmly within the public interest by improving patient safety by fulfilling CPSM's mandate and enhancing the quality of care by physicians. Each priority has its own public interest rationale.

CPSM
ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	FMRAC Working Group	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Benzodizaepine Prescribing Standard of Practice		Sep-19	Sep-20	Started Oct 2019	Mar-20	May-20	Sep-20	Nov-20	Achieved	Approved/Nov 1 implementation
Cannabis Authorization Standard of Practice		Sep-19	Sep-20	Started Nov 2019	Sep-20	July/August 2020	Sep-20	Nov-20	Achieved	Approved/Nov 1 implementation
Streamlined Registration - Fast Track Application	FMRAC-Started								Not Started	
Streamlined Registration - Portable Licence	FMRAC-Started								Not Started	Amendments to Acts Required in many jurisdictions
Artificial Intelligence	FMRAC-Started								Not Started	
Telemedicine Across Jurisdictions	FMRAC-Started								Not Started	
Maintaining Boundaries - Sexual Involvement with a Patient		Sep-19		Started Sept 2019	Sep-20	Oct-20	Dec-20	Dec-20	Delayed	In consultation until Dec 16
Accredited Facilities Criteria		Sep-19		Started Oct 2019	Jun-20	July/August 2020	Sep-20	Jan-21	Delayed	Further review by the WG - Expected for Council in Dec 20
Virtual Medicine within Manitoba - Standard of Practice		Sep-20	Jun-21		Mar 21	May 21	Sep 21	Sep 21	On Track	TofR Approved by Council 9/25
Patient Records - Standard of Practice		Sep-20	Mar 21		Dec 20	Jan 21	Mar 21	Apr 21	On Track	TofR Approved by Council 9/25
Duty to Report - Standard of Practice		Sep-20	Jun-21		Mar 21	May 21	Sep 21	Sep 21	On Track	TofR Approved by Council 9/25
Office Based Procedures - Standard of Practice		Jan-21			Jun 21	Jul 21	Sep 21	Oct 21	Not Started	
Standards of Practice Ongoing Review - 4 Year Cycle		Jan-20	Dec-24						On Track	

Last revised: Nov 4, 2020

COUNCIL MEETING – DECEMBER 9, 2020

FOR INFORMATION

SUBJECT: COVID-19 Pandemic Update

BACKGROUND:

As the regulator of the profession, CPSM has been careful to maintain its independent regulatory role and not engage in advocacy on behalf of physicians and other members – which is very ably carried out by Doctors Manitoba. The Registrar has participated in several conversations and meetings with Shared Health and others on regulatory matters, including the standard of care during a pandemic, duty to provide care, and withdrawing and withholding medical care.

CPSM issued a direction to the profession in the recent Code Red advising they must refrain from providing care that is not medically indicated (e.g. aesthetic services, non-insured procedures).

CPSM staff are once again working at home, though a few individuals come into the office on a rotating occasional basis, including the Registrar. The experience gained in March during the first COVID-19 wave made this a very smooth transition. Committees and Working Groups have met virtually and been productive in performing and completing their tasks. The Inquiry Committee proceeded with hearings in person until recently.

It is expected there will be a further discussion on COVID-19 at the Council meeting.

COUNCIL MEETING – DECEMBER 9, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT: CPSM President-Elect Position

BACKGROUND

The nominating and election of the President-Elect are scheduled to occur in the December Council meeting. The Executive Committee is to recommend to Council at least one nominee for the position of President-Elect. That President-Elect would take office in June 2021 after Dr. Ripstein steps down as President and Dr. Elliott as the current President-Elect takes the office of President from June 2021 to June 2023. The President-Elect as chosen by Council will serve in that office from June 2021 to June 2023 and as President from June 2023 to June 2025.

These are the relevant provisions from the Affairs of the College Bylaw:

Appointment of President-Elect

39. The President-Elect must be appointed from Councillors who are regulated members according to the following process:
    a. Commencing in 2018, in every second year, the Executive Committee must present a report to Council prior to December, recommending at least one nominee for the office of President-Elect.
    b. In each year when appointment to the office of President-Elect is required, the Executive Committee's report must be included in the agenda material distributed to Councillors in advance of the December Council meeting.
    c. At the December Council meeting, the Chair must ask for nominations from the floor for the office of President-Elect, provided that only Councillors present (either in person or through electronic means) are eligible to nominate from the floor, and that a Councillor may nominate himself or herself as a candidate for President-Elect.
    d. If more than one candidate is nominated for President-Elect, the Registrar must conduct an election by Councillors according to the following process:
        i. No later than the first Wednesday following the December Council meeting, provide to each Councillor:
            1. a form of ballot that lists the names in alphabetical order of all candidates nominated;
            2. voting instructions, including the date and time by which votes must be received by the Registrar; and
            3. such other material as may be required.
        ii. Upon receipt of a vote, the Registrar must be satisfied that it is the vote of a Councillor entitled to vote.

iii. The candidate for whom the highest number of votes is cast will be appointed as President-Elect.
iv. In the event of a tie vote, the President shall cast the deciding vote.
v. Any of the candidates for President-Elect may be present at the counting of the ballots.
vi. The Registrar must resolve any dispute or irregularity with respect to any nomination, ballot or election.

Attached is a list of Councillors and their terms.

The Executive Committee is nominating Dr. Heather Smith to be the President-Elect. Dr. Ripstein and Dr. Elliott will speak to this nomination. Any other councillor can nominate another Councillor, including themselves, who is a physician. There will be an opportunity to do so at the December meeting.

There are two options for motions, depending if any other names are nominated.

MOTION (if only one nomination)

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 9, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

Dr. Heather Smith be approved as President-Elect of CPSM Council for a two-year term commencing June 2021, immediately following the 2020/21 Annual General Meeting.

OR

MOTION (if two or more nominations)

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 9, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

An election be held for the position of President-Elect of CPSM Council for a two-year term commencing June 2021, immediately following the 2020/21 Annual General Meeting between the nominated candidates, Dr. Heather Smith and _____, in accordance with Article 39 of the Affairs of the College Bylaw.

Councillor Term Listing

Council Members	Yrs	# of Terms	1996 - 2000	2000 - 2004	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	Start Date	End Date	Comments
Public Representatives																													
Agger, Leslie	1	1																								8-Jul-19	19-Jun-23	CPSM Appointed
Albrecht, Dorothy	2	1																								23-Jul-18	19-Jun-24	CPSM Appointed
Magnus, Lynette	2	1																								16-Jun-18	15-Jun-22	CPSM Appointed
McPherson, Marvelle	3	1																								13-Apr-17	28-Feb-21	Government Appointed
Fineblit, Allan	3	1																								30-Mar-17	28-Feb-21	Government Appointed
Penny, Leanne	2	1																								17-Dec-19	16-Dec-21	Government Appointed
Councillors																												
McLean, Norman		1																								19-Jun-20	19-Jun-24	
Seager, Mary Jane		1																								19-Jun-20	19-Jun-24	
Suss, Dr. Roger	2	2																								19-Jun-20	19-Jun-24	
Penner, Charles		1																								19-Jun-20	19-Jun-24	
Shenouda, Dr. Nader	4	2																								6-Jan-16	19-Jun-22	\
Convery, Dr. Kevin	2	1																								15-Jun-18	15-Jun-22	/ June 2022 - 2 positions transition to 1
Blakley, Dr. Brian	2	1																								15-Jun-18	15-Jun-22	\
Manishen, Dr. Wayne	10	3																				X				15-Jun-10	15-Jun-22	\
Sigurdson, Dr. Eric (PP)	5	2																								15-Jun-14	15-Jun-22	\ June 2022 - 5 positions transition to 2
Kumbharathi, Dr. Ravi	2	1																								15-Jun-18	15-Jun-22	/
Smith, Dr. Heather	1	1																								15-Jun-18	15-Jun-22	/
Elliott, Dr. Jacobi (PE)	1	1																								15-Jun-18	15-Jun-22	\
Lindsay, Dr. Daniel	14	4																				X				15-Jun-06	15-Jun-22	\ June 2022 - 3 positions transition to 1
Stacey, Dr. Brett	1	1																								1-Nov-19	15-Jun-22	/
Associate Member																												
Nguyen, Audrey	1	1																								19-Jun-20	19-Jun-21	Yearly Elected
University Appointed (Yearly)																												
Postl, Dr. Brian	10	11																				X				15-Jun-10	19-Jun-21	\ June 2020 - 2 positions transition to 1
Ripstein, Dr. Ira (P)	10	11																					X			15-Jun-10	19-Jun-21	/ Past President completes term
as of February 19, 2020																												

Red and dark black lines indicate election years

X means member has completed 12 years of service and is not eligible to run for Council that year

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – DECEMBER 9, 2020

FOR INFORMATION

SUBJECT: CPSM Quality Department Launch

BACKGROUND

Dr. Ainslie Mihalchuk has been the Assistant Registrar since January this year. She will present the attached power point deck on restructuring those areas of CPSM addressing the quality of medical practice (other than Complaints and Investigations).

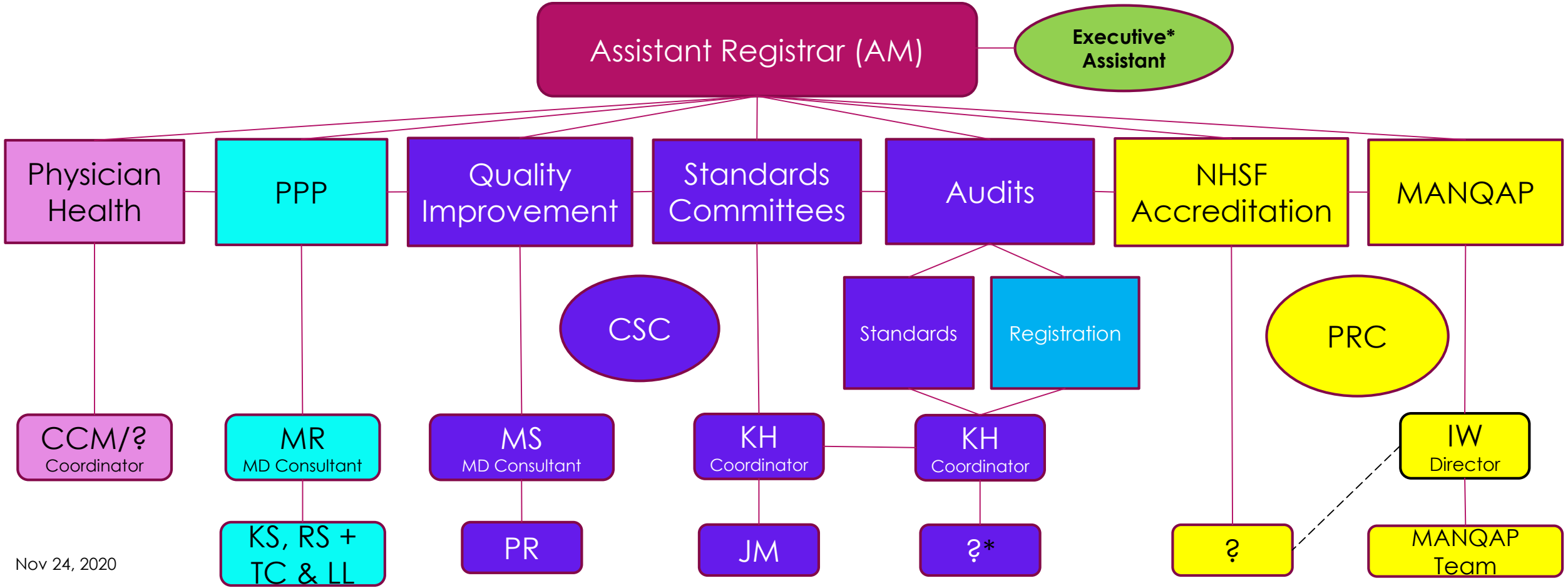

CPSM Quality Department
AT THE INTERFACE OF PRACTICE AND PATIENT SAFETY

Time to Rebrand and Grow

- Jan 2020 Department of Standards - in need of a refresh
- Recent opportunities have prompted a revisioning of our scope, identity and future direction for growth
- The team will expand
- The impact on regulation will be more significant
- The Quality Department will become data and outcome focused

CPSM Quality Department

At the interface of practice and patient safety



Key Changes: **Prescribing Practices Program**

- **New affiliation** with The Quality Department and other internal programs like Quality Improvement and Standards Audits
- **Common purpose with education and supporting practice change** in key areas linked to patient safety (opioids, benzodiazepines & Z-drugs)
- Core element of **patient safety in practice**
- Value of **enhanced working relationships between internal teams** with sharing of knowledge and expertise
- Enhanced **reporting of outcomes**

Key Changes: **Standards**

- **Standards Committees**
  - **Execution of key deliverables** from enhancements to standards processes and practices for all committees
  - Support for **transition to new standards model provincially** with relationship between Shared Health and CPSM – Bill 10
  - Increased **support and communication** between CPSM and Standards Committees
  - Improvements in **reporting and outcome measurements**

Key Changes: **Audits**

- **Audits**
  - Enhanced focus on **continuous quality improvement and engagement of members in ongoing learning**
  - **Continue with Standards Audits:**
    - Evidence-Act Protection
    - Chief Medical Examiner
    - Age-Triggered Quality Audit
    - For Cause Audits
    - CPD Audits
  - **Addition of Registration Audits**:
    - Quality Monitoring audits
    - Provisional Registration
    - Physician Assistants
  - Opportunity to **standardize processes** across all audit types

Key Changes: **MANQAP and NHSF**

- Leveraging **staff knowledge and expertise** to create efficiencies
- **Standardizing processes and reporting** for both accreditation of lab/diagnostic and clinical facilities
- Improvements in quality of NHSF accreditation process to align with **implementation of the new By-Law for Accredited Facilities**
- Alignment of areas reporting to **Program Review Committee**

Key Benefits

- Single home for audits outside of Complaints/Investigations
- Benefit of 3+ physicians to support and consult on the work within the department
- Standardized approaches and coordination of audits
- Aligns all of quality within one area including registration audits
- Alignment of NHSF and MANQAP including consistent approaches and processes
- Increased focus on improving care – and measuring outcomes to demonstrate impact
- Opportunity to engage staff in the new vision

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – DECEMBER 9, 2020

FOR INFORMATION

SUBJECT: Complaints/Investigations Alternative Dispute Resolution

BACKGROUND

Under the Regulated Health Professions Act, the Complaints or Investigation Committee can resolve a matter by mediation. Several provinces currently use some sort of alternative dispute process, although the legislated rules vary.

Dr. Garth Campbell has taken preliminary mediation training. He is aware of the ability to use the mediation/alternative dispute pathway for complaints that arise, but at this time has found limited opportunity for doing so.

Standard Process

For context, our current complaints process primarily involves the review of documents that are submitted:

- the letter of complaint
- the response of the physician to the complaint
- the complainant's comments on the physician's response
- the medical consultant's review of the medical record

The Complaints Committee reviews the documents and considers the Medical Consultant's comments. They discuss the issues and arrive at a decision that is communicated to the complainant through a letter of decision. The process often results in the loss of the physician – patient relationship if it had remained intact to that point.

While we do not collect official feedback, a recent study out of Australia (who has a similar document driven committee process) identified significant concerns from all parties with respect to the resolution of matters. This includes that complainants find the process of submitting documents without human contact to be frustrating, physicians find the process stressful especially when long periods pass without communication and both parties are often dissatisfied with the outcomes.

The CPSM has employed a social worker since August 2020 and she is contacting many complainants, allowing them to voice their concerns and ask questions about the process. Informal feedback has been encouraging and the department is extremely satisfied with this addition to the process.

Alternative Dispute Process

In an alternative dispute resolution, the complainant and the physician agree to pursue a facilitated discussion and arrive at a resolution without the involvement of the Committee. Goals of resolution are established at the outset. Rather than a true mediation process, it involves a "shuttle diplomacy" where the facilitator goes back and forth between the parties addressing their concerns.

To implement this approach, the resolution must be satisfactory to the complainant, the physician and CPSM or it flows back through the usual process where a Committee would determine the outcome.

Considerations for CPSM

The Complaints and Investigation Department is very interested in adopting this option and is gathering information to better understand the requirements. The College in Ontario has successfully used this approach to resolve what are considered low risk concerns. The majority of complaints they receive fall into this category. Alberta also has an alternative pathway and further information is being sought about the specifics of their process.

The CPSO and CPSA have refined their processes over time and have provided useful feedback about important considerations. This includes:

- This works best when
    - the risk to public safety is considered low based on the identified complaint
    - the physician does not have a significant past complaint history
    - the complainant is motivated to have the physician learn from the experience versus disciplinary action (many people who complain to CPSM express a desire that "this" not happen to someone else.)
- The facilitator plays a crucial role and it is imperative to employ the right person – someone who can build rapport on both sides and understand "systems" issues. The CPSO primarily uses nurses and this is considered a good choice if we were to adopt this system.
- It is often very resource intense and can involve multiple meetings. If the process breaks down, the complaint reverts into the standard pathway. When this is successful, there is less need for the Committees.
- Medical consultants continue to review and analyze care where applicable but provide the information to the facilitator for use in the process.
- Where information/explanation is required by the complainant, the facilitator can review the medical record with the physician and then spend time explaining it to the complainant.
- Where miscommunication was a factor, the parties have a chance to hear the other's perspective and address the impact.
- The impact on a Certificate of Professional Conduct needs to be determined.

Registrar's/CEO's Report

Media

The media has inquired several times on the role of physicians in authorizing medical cannabis to be grown rather than purchased from a licensed producer or dispenser. The Registrar, President, and General Counsel also met with Mr. Kevin Lamoureux and Ms Raquel Dancho, federal politicians, at their request to discuss this matter and the proliferation of grow-ops in their ridings.

The media has published articles on two physicians in Manitoba who have written notices on social media or posted in their clinic questioning the wearing of masks during COVID and vaccinations for COVID and other public health directives.

All news media covered the conviction of Dr. Ravesh for sexually assaulting patients during medical encounters. A hearing for revocation of Dr. Revesh's medical registration is scheduled for January 2021.

Certificate of Practice Renewals

A preamble to the personal health information questions was included to provide context and examples of reportable conditions. Questions were reworded to be specific to report blood-borne pathogens; Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) or Human Immunodeficiency Virus (HIV) under a separate question. This reduced the number of inquiries to CPSM and reporting under the incorrect questions.

Completed Renewals (Physicians, Clinical/Physician Assistants)	3282
Not Renewed at time of Report	125
Total	**3407**
Completed Medical Corporation Renewals	2093
Medical Corp. Not Renewed at time of Report	63
Total	**2156**

Emergency Registration – s.56 Regulated Health Professions Act.

Seven physicians were registered in the Provisional Restricted Purpose Class – Emergency Registration under s.56 of the RHPA. All 7 physicians were approved to provide services at the Maples Surgical Centre for the period 28 September 2020 to 17 March 2021.

COVID Registration

With the postponement of the Medical Council and certifying examinations, the 2020 cohort of residents were issued provisional registration. All were required to have a practice supervisor but the reporting requirements were exempted for this group. For comparison purposes, last year for the period 15 May 2019 to 31 August 2019, registrations were issued in the following membership classes: educational – resident (135); full (74); provisional (10). This year the numbers are: educational resident (172); full (33); provisional (51). While the difference in the total number from 2019 (380) to 2020 (380) is 9, the categories of membership shifted from full to provisional and educational.

Exams/Qualifications

The College of Family Physicians of Canada forwarded an update on November 24, 2020. Here is an excerpt from their update.

Please note the following decisions regarding the Certification Examination in Family Medicine for the year 2021:

- *For candidates **writing the Certification exam in Family Medicine for the first time in 2021**, the Simulated Office Oral (SOO) component is cancelled and certification decisions will be based on successfully passing the Short Answer Management Problem (SAMP) component only. (This is the same as 2020.)*
- *For candidates who **currently have a Fail-standing from a previous SAMP component**, or who receive a Fail-standing from the October 2020 administration when the results are released in December 2020, the CFPC will only require the SAMP component of the exam to be re-taken in 2021, and if successful then certification will be awarded. This is updated information from what was previously communicated.*
- *For those who **currently have a Fail-standing on the SOO component** of the exam and need to repeat it to achieve certification, we will be offering a special virtual administration of the SOO component in the spring of 2021. We will share further details shortly regarding this special administration that only applies to this select group.*

The Royal College of Physicians and Surgeons of Canada sent an update on October 1, 2020. Here is an excerpt from their update.

NEW DATE: Registration deadline for 2021 primary exams - Upon receiving their ruling letter, candidates must register by Dec. 4, 2020 for 2021 primary exams.

WHERE: 2021 candidates have two options for the written exam, one virtual option for applied/oral

Written exams - For all 2021 written exams, candidates have two options: to write online or in-person at one of our 17 Canadian exam centres. The decision to write online or in-person will have to be made in advance of the exam delivery.

Applied/oral exams - All applied/oral exams will be delivered virtually. The candidate and examiner will interact on a virtual platform. More information on virtual applied exams will be shared via email and on our website in early November 2020.

CPSM Personnel

To fulfill its mandate CPSM has recently hired several individuals, including a lawyer to work in Complaints/Investigations and a Coordinator for the Prescribing Practices Program. CPSM will also be hiring a Communications Officer and an Administrative Assistant for the Assistant Registrar in Quality.

Office Premises

The current CPSM office lease at 1661 Portage Avenue will expire in July 2021. In regard to this, the current lease indicated intent must be made with the current landlord by October 31, 2020 as to the decision to renew.

To facilitate this process, CPSM engaged a commercial real estate agent who was critical to assist CPSM to negotiate the transaction on our behalf whether a renewal, new lease or relocation. After much evaluation and assessment of alternatives, CPSM entered an "Offer to Lease" with the current landlord several weeks ago and is in the process of signing the final lease agreement.

Electronic Document Records Management System (EDRMS)

The CPSM EDRMS Project – now formally named the "DOCing Station" continues. The consulting partner Gravity Union has been working with the CPSM pilot departments of Complaints & Investigations – Quality Improvement and IT. The project is being rolled out across all departments of CPSM in an effort to reduce the volume of paper while introducing the electronic capture of all information content at CPSM. Benefits anticipated include:

- Reduced manual effort through streamlined business processes
- Faster and more accurate retrieval of documents
- Greater security and access control over sensitive information; comprehensive audit trails

A timeline for transition of all CPSM departments and support services has been developed toward a completion date of April 2021.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – DECEMBER 9, 2020

ITEM FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The full Executive Committee met on November 9, 2020. Most of the matters dealt with by the Executive Committee are included on the agenda for this meeting of Council, so will not be reiterated.

Appointment of substitute member to the Central Standards Committee

Two members indicated a conflict of interest with one item on the CSC agenda. To obtain quorum, a substitute member needed to be appointed by the Executive Committee in accordance with s. 4.3.1.e of the Governance Policy. This was done electronically on November 3, 2020.

AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

1. **Independent Auditor's 2021 Audit Plan**
   - The independent auditing firm Deloitte presented their annual Audit Plan for the upcoming audit of CPSM's Financial Statements for the fiscal year 2020-21.
   - An Audit Report and the CPSM Annual Financial Statements will be presented to Council at the AGM June 9, 2021.
2. **October 31, 2018 Quarterly Financial Statements**
   - Management presented the October 31, 2020 quarterly financial statements of CPSM.
   - At the end of the 2nd quarter CPSM had posted a surplus of $320,000, which is an increase from the original budget of $31,000.
   - This positive variance has resulted from lower than anticipated expenses for this period due to the timing of when these expenditures will actually be realized.
3. **Investment portfolio update**
   - The Committee received an overview and update of the CPSM investment portfolio.
   - Letters of Compliance with the approved investment policies of CPSM were received by CIBC Private Wealth Management regarding CPSM investment portfolio.
4. **Information Technology update**
   - The committee received an IT update from management which included a summary of the significant activities being undertaken to increase the efficiency and effectiveness of the current CPSM IT infrastructure environment.
   - Included in these projects is the implementation of an Electronic Document Records Management System (EDRMS) that will move CPSM into a completely "paperless" environment by April 30, 2021.

Respectfully submitted,
Dr. Jacobi Elliott
Chair, Audit & Risk Management Committee

PROGRAM REVIEW COMMITTEE REPORT:

MANQAP adapted rapidly to the Covid-19 Pandemic and continues to work with stakeholders and clients to ensure that standards are maintained. MANQAP is performing on-site inspections where it is safe to do so and will be using remote inspections as a temporary measure when necessary. MANQAP continues to address the public's concerns regarding patient service centres. There have been numerous complaints from the public and some physicians regarding patient services centres. MANQAP has investigated and required remediation of problems as far as is possible within the limits of the Accredited Facilities Bylaw and existing standards. Facility information and monitoring also continues to be collected via annual reports.

The Non-Hospital Medical/Surgical Facilities Program conducted two facility inspections in 2020. The first facility to be inspected was granted full five-year accreditation and the other facility is pending but is expected to be accredited for a full five years following a decision from the upcoming Program Review Committee meeting in November 2020.

Respectfully submitted,
Dr. Wayne Manishen
Chair, Program Review Committee

COMPLAINTS COMMITTEE REPORT:

COMPLAINTS RECEIVED BETWEEN - 01-MAY-2020 AND 24-NOV-2020

Complaint Received	Total Cases
May/2020	9
June/2020	5
July/2020	10
August/2020	16
September/2020	10
October/2020	17
November/2020	3
Grand Total	70

Length of time required to acknowledge complaints received
between 01-May-2020 and 24-Nov-2020

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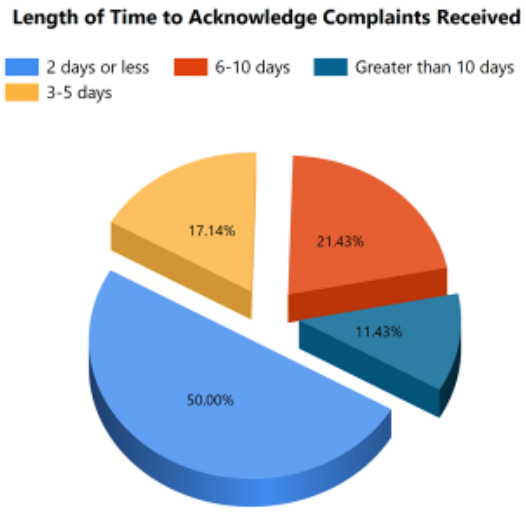
Page 1 of 3

Complaints Acknowledge In	Total Cases
2 days or less	35
3-5 days	12
6-10 days	15
Greater than 10 days	8
Total number of complaints cases in time period:	70



Length of time required to resolve complaints for cases closed between
01-May-2020 and 24-Nov-2020

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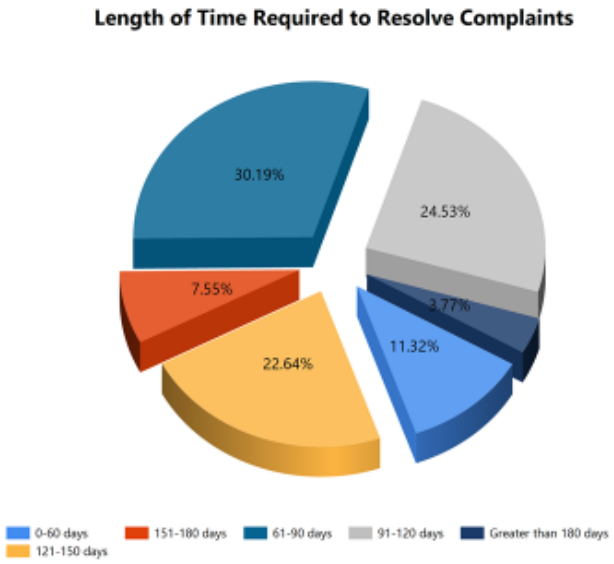
Page 1 of 3

Complaints Cases with	Total
0-60 days	6
61-90 days	16
91-120 days	13
121-150 days	12
151-180 days	4
Greater than 180 days	2
	53



Respectfully submitted,
Dr. Heather Smith
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

Since the September report, the Investigation Committee has been meeting virtually on a monthly basis to expedite resolution of outstanding files. Since September, 14 new investigations files have been opened and 19 have been closed. A smaller number of matters are heard at each meeting, allowing for robust discussion. Although only one public representative is required, the Committee has had the benefit of two public representatives at each of the meetings and their input has been insightful and greatly appreciated.

Our Public Support Advisor (a social worker) began work in our department in mid-August. Her work has improved communication with complainants and allows us to more fully address their relevant concerns, help them understand our process and direct them to other applicable resources.

Interviews of physicians and complainants have been done virtually since March. This has had the unexpected benefit of convenience and cost savings in that meetings can be more easily fit into schedules and we routinely tape the interviews rather than pay a court reporter. We are planning for upcoming Inquiry Hearings to proceed virtually and are aware that Colleges in other provinces have successfully done the same.

A new lawyer has been hired to assist with the work of the department and she is expected to take on the bulk of work for the multiple Inquiry Hearings expected to commence in 2021. This will eliminate the need to hire external counsel to do this work.

We continue to value the work of the staff in the department and appreciate their flexibility in being able to adapt processes to allow for work to continue during the pandemic.

Respectfully submitted,
Dr. Nader Shenouda
Chair, Investigations Committee

QUALITY IMPROVEMENT COMMITTEE REPORT:

The Quality Improvement Program activities resumed after a pause in the spring related to the COVID-19 pandemic. The program re-engaged with participants in early June. Participants were offered the option of resuming their program activity at that point or deferring to the fall. A cohort had been launched January 2020, comprising 159 participants. The participants from January 2019 to June 2020 had all been family physicians. We began involving specialists in the program in June 2020, beginning with psychiatry and general surgery. Members were offered the option of participating then or in the fall. Uptake was low, so the full cohorts were launched in October, as well as the first cohort for pediatrics. Dr Singer presented to the Department of Pediatrics Grand Rounds on September 24, 2020. She will be presenting to Internal Medicine Grand Rounds on December 8th, in anticipation of launching an Internal Medicine cohort in 2021.

The program is showing sensitivity and flexibility during these extraordinary times and accommodates reasonable requests from members for extensions or deferrals. Most participants to date have been able to complete their process.

As a reminder, some participants undergo an off-site chart review (normally done at the CPSM offices), multisource feedback, and/or an on-site office visit. The processes for these functions have been reviewed in light of the pandemic, and alternate means of providing the reviews in a remote manner have been developed, so that the program can remain operational through the next year.

The deferral rate to date is 32% in 2020, with most now falling into the category of unable to assess. These are participants who have a narrower scope of practice. The QI program is working to broaden the cadre of reviewers such that we will be able to address this group more fully. From what we see trending in the recent assessment category, we expect the overall deferral rate to reduce significantly in 2021.

Of the total participants, 8 files have been/are being brought forward to the QI Committee regarding concerns around practice deficiencies. Outcome details are as follows:

- 3 – Closed
- 4 – Pending remediation/follow-up review
- 1 – Referred to Central Standard Committee

Below is a summary of initiations/participants/completions for the 2019 and 2020 cohorts:

QI PARTICIPANTS

YEAR	INITIATED	PARTICIPATED	COMPLETED
2019	294	194	194
JANUARY 2020	157	88	63
OCTOBER 2020	95	In progress	TBA

In the January 2020 cohort, 41 participants were deferred. 28 of those participants chose to participate in the fall cohort, therefore, they are included in the current cohort of 95 who are moving through the process.

Based on chart reviews completed to date, it appears that medical record keeping is a challenging area of practice for some physicians and that there is a need for refresher training in medical record keeping. The University of Manitoba has offered a renewed version of a medical record keeping course. It is anticipated that this will be available on an ongoing basis.

Feedback from participants has largely been positive, including the feedback gathered via an anonymous online survey. Suggestions for program improvement continue to be collated and incorporated where reasonable and feasible.

All participants are required to submit an Action Plan for improvement as the concluding activity of their participation. They are contacted via email after one year to solicit feedback as to the success or challenges of realizing their plan. Most participants complete the plan in a thoughtful and reflective manner. The one-year feedback reveals honesty about accomplishments achieved and

barriers encountered. COVID-19 affected the plans of many, and members found that they made many unanticipated changes to their processes and procedures related to this, such as incorporating virtual visits.

The QI Program has received CPD accreditation by both the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. Both have granted the program the highest credit level available of 3 credits per hour MainPro+ and Section 3 Assessment credits respectively.

Respectfully submitted,
Dr. Christine Polimeni
Chair, Quality Improvement Committee

STANDARDS COMMITTEE REPORT:

The Central Standards Committee (CSC) has had one meeting since September. Of note the committee is forming a working group to establish instructions for its subcommittees with the goals of clarifying expectations regarding operational processes and reporting measures. The CSC hopes to have a quantitative report for Council of the number of audits performed/cases reviewed, in which areas of practice, and educational measures taken in response, by June 2021.

Respectfully submitted,
Dr. Roger Suss
Chair, Central Standards Committee

SELF-EVALUATION OF COUNCIL

The CPSM is interested in your feedback regarding your experience at the Council meeting. The results of this evaluation will be used to improve the experience of members and to inform the planning of future meetings.

	Strongly Disagree	Neutral	Strongly Agree	Comments
How well has Council done its job?				
1. The meeting agenda topics were appropriate and aligned with the mandate of the College and Council.	1	2	3	
2. I was satisfied with what Council accomplished during today's meeting.	1	2	3	
3. Council has fulfilled its mandate to serve and protect the public interest	1	2	3	
4. The background materials provided me with adequate information to prepare for the meeting and contribute to the discussions.	1	2	3	
How well has Council conducted itself?				
5. When I speak, I feel listened to and my comments are valued.	1	2	3	
6. Members treated each other with respect and courtesy.	1	2	3	
7. Members came to the meeting prepared to contribute to the discussions.	1	2	3	
8. We were proactive.	1	2	3	

Feedback to the President				
9. The President/Chair gained consensus in a respectful and engaging manner.	1	2	3	
10. The President/Chair ensured that all members had an opportunity to voice his/her opinions during the meeting.	1	2	3	
11. The President/Chair summarized discussion points in order to facilitate decision-making and the decision was clear.	1	2	3	
Feedback to CEO/Staff				
12. Council has provided appropriate and adequate feedback and information to the CEO	1	2	3	
My performance as an individual Councillor				
13. I read the minutes, reports and other materials in advance so that I am able to actively participate in discussion and decision-	1	2	3	
14. When I have a different opinion than the majority, I raise it.	1	2	3	
15. I support Council's decisions once they are made even if I do not agree with them.	1	2	3	
Other				
16. Things that I think Council should start doing during meetings:				
17. Things that I think Council should stop doing during meetings:				