September Council Meeting

Friday, September 25th, 2020 | 8:00 a.m.
Virtual Meeting
1661 Portage Avenue

Time		Item		Page Number
5 min	8:00 am	**1.**	Opening Remarks	---
0 min	8:05 am	**2.**	Agenda - Approval Call for any Conflicts of Interest	---
0 min	8:05 am	**3.**	Approval – Minutes June 2020 Council Meeting	**2**
30 min	8:05 am	**4.**	Standard of Practice for Authorizing Medical Cannabis – For Approval	**7**
75 min	8:35 am	**5.**	Maintaining Boundaries – For Approval	**43**
20 min	9:50 am	**6.**	Standard of Practice for Prescribing Benzodiazepines and Z-Drugs – For Approval	**86**
10 min	10:10 am	**7.**	Standards of Practice – Virtual Medicine - Terms of Reference – For Approval	**104**
15 min	10:20am	**8.**	Break	
10 min	10:35 am	**9.**	Standards of Practice – Patient Records – Terms of Reference – for Approval	**109**
10 min	10:40 am	**10.**	Standards of Practice – Duty to Report – Terms of Reference – for Approval	**115**
15 min	10:55 am	**11.**	Accredited Facilities Criteria – For Information	**119**
5 min	11:10 am	**12.**	Strategic Organizational Priorities – For Information	**136**
0 min	11:15 am	**13.**	Central Standards Bylaw Amendment – For Approval	**138**
20 min	11:15 am	**14.**	Registrar/CEO's Report – For Information	**140**
15 min	11:35 am	**15.**	Items for Information: i. Committee Reports – For Information	**146**
25 min	11:50 am	**16.**	In Camera i. Evaluating Governance Process ii. Other Matters	**150**
0 min	12:15 pm	**17.**	End Meeting	

Meeting of Council, June 19, 2020

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on Friday, June 19, 2020 at the College offices, 1000-1661 Portage Avenue, Winnipeg, Manitoba.

1. CALL TO ORDER

The meeting was called to order at 10:15 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 (12 noon*)
Dr. Daniel Lindsay, Selkirk
Dr. Audrey Nguyen, Assoc. Member
Ms Lynette Magnus, Public Councillor (11:10 am*)
Dr. Wayne Manishen, Winnipeg
Dr. Norman McLean, Winnipeg
Ms Marvelle McPherson, Public Councillor
Dr. Charles Penner, West
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

MEMBERS:
Dr. Heather Domke
Dr. S. Jay Duncan (till 12:50 pm*)
Dr. Brent Kvern, Winnipeg (12 noon*)
Dr. Clara Wiess

(*) 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 Erin Wilcosh, Administrative Assistant

2. ADOPTION OF AGENDA

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

That the agenda be approved as presented.

Dr. Ira Ripstein welcomed the new council members Dr. Norman McLean, Dr. Charles Penner, Dr. Mary-Jane Seager and as the new Associate Member, Dr. Audrey Nguyen.

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. JACOBI ELLIOTT, SECONDED BY DR. ROGER SÜSS:
CARRIED

- That the minutes of the March 13, 2020 meeting be accepted as presented.

5. STANDARD OF PRACTICE FOR AUTHORIZING MEDICAL CANNABIS – APPROVAL FOR CONSULTATION

At its June 2019 meeting, Council directed the Registrar to establish a Working Group to develop a Standard of Practice for the Authorizing Medical Cannabis. The Working Group composed of practitioners encompassing diverse practices and specialties submitted its draft Standard of Practice to Council. This Standard will set CPSM's minimum requirements for all physicians authorizing medical cannabis and ensure authorizing when clinically indicated for good patient care.

The Working Group recommended that Council approve the draft Standard of Practice for Authorizing Medical Cannabis for distribution and consultation with the membership and stakeholders.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. MARY-JANE SEAGER:
CARRIED

That the draft Standard of Practice for Authorizing Medical Cannabis be approved and distributed for consultation with the membership and stakeholders.

6. ACCREDITED FACILITIES CRITERIA – APPROVAL FOR CONSULTATION

At its June 2019 meeting, Council directed the Registrar to establish a Working Group to provide recommendations and criteria for determining which non-hospital medical or surgical facilities should be accredited to ensure patient safety. The Working Group provided a report to Council.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. CHARLES PENNER that:
CARRIED

Council approves the recommendations of the Accredited Facilities Working Group for distribution and consultation with the membership, stakeholders, and the Minister.

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

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 Working Group will meet to review the feedback and will make revisions as required. It is intended that Council review the new and revised Standard of Practice for Prescribing Benzodiazepines and Z-Drugs in its September meeting.

8. STRATEGIC ORGANIZATIONAL AND OPERATIONAL PRIORITIES UPDATE

Councillors were presented with a brief synopsis and discussed the strategic organizational issues identified, and progress of the following:

i. Streamlined Registration
ii. Telemedicine
iii. Artificial Intelligence & The Practice of Medicine
iv. Continuity of Care - After Hours Coverage
v. Maintaining Boundaries – Sexual Involvement with a Patient
vi. Governance Review
vii. Standards of Practice of Medicine Document Review/Update

Council was presented with some updates on the following strategic operational priorities:

i. Electronic Document & Records Management System
ii. Information Technology Strategic Roadmap
iii. CPSM Physician Portal IT Development
iv. 1661 Portage Avenue Lease Renewal
v. FIRMS College-Wide Risk Assessment
vi. Standards Department Review
vii. Streamlined Registration
viii. Patient Assistance and Mediation in Complaints/Investigations
ix. Complaints and Investigations Streamlining

Duty to Report, Patient Records & Virtual Medicine are three major reviews of the current Standards of Practice requiring Working Groups, which Council also directed the Registrar to proceed with. Virtual Medicine was seen a particularly important and timely given the move to virtual medicine by many members during the COVID-19 pandemic.

9. AUDIT & RISK MANAGEMENT COMMITTEE TERMS OF REFERENCE

CPSM Management recognized that there were several important gaps within the current Terms of Reference. An in-depth review of the Terms of Reference was conducted to identify these gaps and opportunities for improvement.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. WAYNE MANISHEN that:
CARRIED

Council approve the changes as recommended by the Audit & Risk Management Committee

10. CPSM 2020-2021 OPERATING BUDGET

The CPSM 2020-2021 Statements of Operation were presented by nature of expense such as employee costs, committee meetings and office expenses as well as by core function and by Department.

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

That the 2020-2021 Annual Operating Budget be approved as presented.

11. APPOINTMENT TO COMMITTEES AND PUBLIC REPRESENTATIVES TO COUNCIL

The Executive Committee is responsible for making a recommendation to Council for Committee membership.

Ms Dorothy Albrecht was appointed by Council in July 2018 to replace a public representative who resigned part way through their appointment. Ms. Albrecht's term ended June 2020. Ms. Albrecht indicated her willingness to continue to serve.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. BRIAN POSTL that:
CARRIED

Council approve Ms. Dorothy Albrecht be appointed as a public representative on Council for a four-year term and that membership in Committees be appointed as recommended at the Executive Committee meeting on May 29, 2020.

12. 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. CPSM's response to leadership in the COVID-19 pandemic was discussed.

13. FOR INFORMATION

The following Reports were presented to Council for information:

- Meeting Dates
- Attendance Record

14. 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 2: 05 p.m.

_____

Dr. I Ripstein, President

_____

Dr. A. Ziomek, Registrar

COUNCIL MEETING – SEPTEMBER 25, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Standard of Practice for Authorizing Medical Cannabis

BACKGROUND:

A CPSM Strategic Organizational Priority is to review and revise the Standard of Practice to Authorize Cannabis for Medical Purposes. In its June meeting, Council reviewed the recommended draft Standard prepared by the Working Group. At that same meeting, Council approved distributing the draft Standard to the members, public, and stakeholders for consultation. A consultation was undertaken from June 26, 2020 to July 31, 2020. Feedback was provided from a wide variety of individuals and organizations. A number of changes were made to the Standard as a result of the feedback and are listed below as Direction of the Working Group. Also included is a copy of the draft Standard with red line changes to incorporate the feedback from the consultation.

STATISTICS

CPSM received 25 responses:

- MDs: 13
- Public Persons: 4
- Government: 1
- CMPA: 1
- Other Regulators: 2
- Doctors Manitoba: 2
- Member of Parliament: 1
- Other Organizations: 1

SUMMARY AND THEMES OF FEEDBACK, INCLUDING DIRECTION TAKEN BY THE WORKING GROUP

1 – Need to Keep a Separate Log for Cannabis Authorizations Unnecessary

- Can search easily in EMR, so unnecessary
- Difficult to configure EMR
- How to log in hospital? PCH?
- Why different need to log than a prescription?

Direction by Working Group – eliminate this provision.

2 – Naming Licensed Producer

- Physician may not know who the licensed producer is and this is a patient choice
- Federal framework set up to let the patient choose and not have the physician involved in choosing the producer
- Could lead to undue influence by producers on physicians

Direction by Working Group – Eliminate this provision.

3– Physicians have No Obligation or Mandated Requirement to Authorize

Direction by Working Group: Not Necessary

4 – Opposition to Cannabis for Medical Purposes

- Don't support medical cannabis even though it is a legal regimen established by Government through Health Canada
- No scientific support for medical cannabis

Direction by Working Group: Not Necessary to include. This is a statutory scheme established by Parliament for doctors to adhere to.

5 – Impairment

- Impairment by medical cannabis may lead to impaired driving charges and other legal sanctions
- Treat other impairing drugs (Benzodiazepines/Z-Drugs/Opioids) the same

Direction by Working Group: Not necessary to Add "and legal sanctions due to impairment" to the following "Advise patients that cannabis may cause impairment, including advising the patient of the dangers associated with driving *and legal sanctions due to impairment*, operating heavy machinery, performing safety sensitive tasks, and providing child or elder care while impaired."

Direction of Working Group: Recommend to Registrar that the Duty to Report Standard of Practice be Reviewed and Updated

6 – Billing for Completion of Form

- Remove the prohibition on charging patients for completing the form for authorization
- Doctors Manitoba takes the position that the completion of the medical cannabis form is an uninsured service and physicians should be entitled to bill privately for the completion of the Medical Document Authorization arguing that
    - It is not a prescription
    - Additional duties required beyond prescription writing and no tariff for these additional duties
    - Fewer MB physicians will authorize cannabis due to the additional duties with no compensation which will hurt patient care

A CPSM legal opinion concludes that:

- The distinguishing factors between a traditional prescription and the Medical Document Authorization are not sufficiently significant so as to justify a fee for completing the Medical Document.
- The completion of the form is incidental to the overall patient visit which is an insured service. The additional obligations listed by Doctors Manitoba are more appropriately categorized as part of the overall visit, which is an insured service, and constitute required aspect of good medical care under the Standards of Practice and Regulations.

Direction by Working Group: Retain this provision and expand upon it for clarity to prevent possible misconceptions that may lead to erroneous double billing.

7 – Relations with Industry

- Prohibition on legally or beneficially involved with licensed producer
    - too broad and could extend to ownership of shares through mutual funds
    - extends to business relationships doctors have with pharmacists that dispense
- Prohibition on having a clinical encounter with patients at the same premises as a dispenser precludes medical clinics in pharmacies that dispense

Direction by Working Group: Revise Standard to clarify that a medical encounter can occur in medical clinics located within pharmacies that are licensed dispensers.

8 – Sativex® and nabilone are Prescribed Medicines approved by Health Canada; CBD Oil is also Cannabis

Direction by Working Group: Insert this in the Standard

9 – Clarification on Authorizing Growing Cannabis (the physician does not authorize the number of plants, but instead authorizes the grams of dried cannabis to be consumed per day)

- The physician's role is generally limited to providing the patient with a medical authorization document that indicates the daily quantity of dried cannabis that they authorize for the patient. The patient can then obtain cannabis by:
    - Submitting the medical authorization document straight to a licensed commercial producer;
    - Registering with Health Canada to produce a limited amount of cannabis for their own medical purposes;
    - Designating someone else to produce it for them; or
    - Purchase it from authorized retail outlets or online sales

  Health Canada (not the physician) then decides whether the patient is authorized to grow cannabis for personal medical needs.

Direction by Working Group: Eliminate the references to growing in the Standard for accuracy. Insert the above explanation in the Contextual Information document.

10 – Grow Ops in Residential Areas Allegedly have Medical Authorizations for Plants

- This issue will be referred to the Registrar for determination if Manitoba physicians are authorizing appropriate amounts
- The President, Registrar, and General Counsel met with two Members of Parliament to discuss the issue of grow ops and medical authorizations

11 – Contextual Information is very helpful

Direction of Working Group: Add further resources to the Contextual Information document to assist physicians.

MEDICAL DOCUMENT TO AUTHORIZE MEDICAL CANNABIS

For your information, we have attached a copy of the Health Canada medical document authorizing the patient's use of medical cannabis. This medical document is to be completed by the physician – whether the patient chooses to purchase from a licensed dispenser or to grow their own with a Health Canada registration certificate.

RECOMMENDATION OF THE WORKING GROUP

The Working Group met throughout the summer to review the feedback and make amendments based upon the feedback and further reflection. The Working Group is now in a position to recommend that Council approve the revised Standard of Practice to Authorize Cannabis for Medical Purposes.

The Working Group also recommended the Standard of Practice on the Duty to Report be reviewed and updated. (Note – this is on the schedule for review already).

Strategy for and Date of Implementation

Working with Health Canada, CPSM will prepare a list of cannabis authorizations by Manitoba physicians. Those physicians authorizing very high amounts will be contacted by CPSM to participate in a review. Under that review, the CPSM and physician will discuss the nature of their practice, the patient(s), authorizing practices, options, etc.

The recommended effective date for implementation is October 1, 2020. If Council approves this Standard of Practice, a notification will be sent to members and stakeholders.

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

Cannabis is unique compared to medications prescribed by physicians. It is now available recreationally in stores. There is limited good-quality evidence to support cannabis use for most medical conditions, yet a legal regime establishes the ability for medical practitioners to authorize it. There are no uniform titration and dosage schedules, no standardized THC:CBD ratios, dispensers may provide variable products, and patients may have extremely strong expectations of its almost mythical healing powers for many diverse conditions.

In the age of recreational cannabis, there is still a need for medical cannabis. First, there is clinical evidence demonstrating the efficacy of cannabis for some medical conditions and those patients should have access to a medical source no different than other drugs. Second, while available recreationally, many patients may obtain reimbursement from insurance or other organizations if authorized by a physician.

These unique factors necessitate an updated Standard to ensure patient safety and the integrity of medical cannabis authorized by members. This Standard seeks to provide the rules around authorizing cannabis for medical purposes in a manner that addresses the need for patients to obtain this unique substance for medical and not recreational purposes.

The conditions where cannabis is most commonly authorized remain sources of debate in medical circles. Physicians must consider multiple factors when authorizing medical cannabis. Good clinical

judgment and an evidence-based approach remain key to safe and appropriate authorization. This Standard will set CPSM's minimum requirements for all physicians authorizing medical cannabis and ensure authorizing when clinically indicated for good patient care.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

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

Medical Document Authorizing the use of Cannabis for Medical Purposes under the Access to Cannabis for Medical Purposes Regulations

Help on accessing alternative formats, such as Portable Document Format (PDF), Microsoft Word and PowerPoint (PPT) files, can be obtained in the alternate format help section.

For related information, please see Health Canada's Information for Health Care Practitioners.

This document may be completed by the applicant's health care practitioner as defined in the Access to Cannabis for Medical Purposes Regulations (ACMPR). A health care practitioner includes medical practitioners and nurse practitioners. In order to be eligible to provide a medical document, the health care practitioner must have the applicant for the medical document under their professional treatment. Regardless of whether or not this form is used, the medical document must contain all of the required information, (see in particular s. 8 of the ACMPR).

Your health care practitioner may use this form to provide you authorization to use cannabis for medical purposes. Your health care practitioner may use a different form, but the required information as per section 8 of the ACMPR (outlined below) must be included.

Access via Health Canada licensed producers: Should you choose to access cannabis from a licensed producer, this form must be sent directly to the licensed producer of your choice. You may choose any licensed producer who is authorized to sell to registered clients. Please see the Health Canada website for a list of licensed producers. Should you wish to switch from one Health Canada licensed producer to another a new medical document will be required as licensed producers are required to keep the original medical document on file.

Access via production for own medical purposes: Should you choose to produce your own cannabis, or designate someone to produce it for you, the original of this document must be sent to Health Canada with your Registration Application Form.

Patient's Given Name and Surname: _____

Patient's Date of Birth (DD/MM/YYYY): _____

Daily quantity of dried marihuana to be used by the patient: _____ grams / day

The period of use is _____ day(s) or _____ week(s) or _____ month(s).

Note: The period of use cannot exceed one year

Health care practitioner's given name and surname: _____

Profession: _____

Health care practitioner's business address:

_____

Full business address of the location at which the patient consulted the health care practitioner (if different than above):

Phone Number:

Fax Number (if applicable):

Email Address (if applicable):

Province(s) Authorized to Practice in:

Health Care Practitioner's Licence number:

By signing this document, the health care practitioner is attesting that the information contained in this document is correct and complete.

Health Care Practitioner's Signature: _____

Date Signed (DD/MM/YYYY):

Important Note for Authorizing Health Care Practitioner

If the patient chooses to produce cannabis for their own medical purposes or you are not submitting this document via secure fax do not initial the box below.

If your patient chooses to access cannabis for medical purposes via a licensed producer, this medical document can be submitted from the health care practitioner's office to the licensed producer by secure fax. If you choose to submit the medical document by secure fax, initial the statement below to acknowledge agreement.

I, the health care practitioner, acknowledge that the faxed medical document is now the original medical document and that I have retained a copy of this document for my records only.

Initial here:

DRAFT FOR COUNCIL - FINAL

STANDARD OF PRACTICE FOR AUTHORIZING CANNABIS FOR MEDICAL PURPOSES

This Standard articulates the standard of practice and ethical requirements for all members using their clinical skill, knowledge, and judgment in authorizing cannabis for medical purposes. This Standard does not apply to prescribing nabilone and Sativex®. This Standard does apply to all other cannabinoids and derivatives including oils.

Members are expected to educate themselves on authorizing medical cannabis, including clinical pharmacology, dosing, potential therapeutic uses, warnings, adverse effects and toxicity.

There is useful information in Health Canada's 2018 'Information for Health Care Professionals – Cannabis (marihuana, marijuana) and the Cannabinoids': https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/information-medical-practitioners/information-health-care-professionals-cannabis-cannabinoids.html - and in the College of Family Physicians of Canada's 2018 'Simplified Guideline for Prescribing Medical Cannabinoids in Primary Care: https://www.cfp.ca/content/cfp/64/2/111.full.pdf Members are also expected to educate themselves respecting legal requirements for authorizing medical cannabis under the federal *Cannabis Act* and Regulations.

1. Every member is professionally responsible for each medical cannabis authorization they provide to a patient. In deciding whether to authorize medical cannabis, each member must exercise the level of clinical judgment expected by the profession.

2. A member must only authorize medical cannabis:
    a. for a patient under their professional treatment; and
    b. when the medical cannabis authorized is required for the condition for which the patient is receiving treatment.

3. Prior to authorizing cannabis for medical purposes, a member must:
    a. make a diagnosis using the principles of good medical care set out in Part 2 of the Standards of Practice of Medicine;
    b. ensure that other conventional therapies have been tried or considered for the patient's diagnosis;
    c. advise the patient as to material risks and benefits and the level of scientific evidence supporting the efficacy of the proposed treatment;
    d. discuss any other drug use, including recreational cannabis use and the risk for diversion;
    e. advise that cannabis may cause impairment, including advising the patient of the dangers associated with driving, operating heavy machinery, performing safety sensitive tasks, and providing child or elder care while impaired[1]; and
    f. establish a plan for follow up and management.

[1] Members are reminded that they must be aware of and comply with statutory reporting duties in the context of disease or disability, including a treatment regime, that is expected to cause impairment to any relevant authorities (e.g. the Registrar of Motor Vehicles).

4. In authorizing cannabis for medical purposes, a member must:
    a. document on the patient record how the requirements of section 3 of this Standard are satisfied, including notation of:
        i. relevant discussions with the patient,
        ii. the clinical reasons for which the medical cannabis is authorized, and
        iii. the rationale for the amount authorized; and
    b. make reasonable efforts to communicate with other health care providers involved in the patient's care, including the patient's primary health care provider, as appropriate, and document same.

5. A member who authorizes medical cannabis must not:
    a. be legally or beneficially involved with a licensed producer/dispenser other than for the purpose of providing expert opinion, independent and impartial education, or conducting clinical research approved by an ethics board;
    b. be a licensed producer/dispenser;
    c. have a clinical encounter with patients at the same premises of any licensed producer/dispenser unless the medical clinic is located within a pharmacy that is a licensed dispenser; or
    d. otherwise contravene the Conflict of Interest provisions in the Standards of Practice of Medicine.

6. A member must not under any circumstances dispense or provide medical cannabis to any patient.

7. A member who is treating a patient admitted in a health care facility, or resident in a personal care home, and who also has privileges therein, may order that the patient may use medical cannabis if the member is satisfied that:
    a. the patient has previously been provided with an authorization to obtain cannabis for medical purposes by another member that continues in effect;
    b. the order is limited to the amount of cannabis needed for the period of admission or residency; and
    c. medical cannabis is required to ensure continuity of care respecting the diagnosis for which medical cannabis was authorized.

8. A member who is treating a patient admitted in a health care facility or resident in personal care home must comply with all sections of this Standard in order to authorize medical cannabis, including where a prior authorization has expired.

9. A fee must not be charged for completing a form for authorizing medical cannabis or for any activities associated with completing the authorization, including assessing the patient, reviewing the patient's chart, educating or informing the patient about the risks or benefits of cannabis, or confirming the validity of the authorization in accordance with the Cannabis Regulation.

Contextual Information and Resources for Standard of Practice for Authorizing Cannabis for Medical Purposes

Background

Cannabis is unique compared to medications prescribed by physicians. Consider the following: it is now available recreationally in stores. There is limited good-quality evidence to support cannabis use for most medical conditions, yet a legal regime establishes the ability for medical practitioners to authorize it. There are no uniform titration and dosage schedules, no standardized THC:CBD ratios, dispensers may provide variable products, and patients may have strong expectations of its almost mythical healing powers for many diverse conditions.

In the age of recreational cannabis, many might ask why is there a need for medical cannabis? First, there is clinical evidence demonstrating the efficacy of cannabis for certain medical conditions and those patients should have access to a medical source no different than other drugs. Second, while available recreationally, many patients may obtain reimbursement from insurance or other organizations. In 2019/20 Veterans Affairs Canada spent $85 million on medical cannabis.

Ethical requirements

- Authorizing a patient's use of cannabis for medical purposes is a clinical decision and is comparable to prescribing a medication.

- Members may be presented with belief systems and great expectations of some patients for the alleged healing powers of cannabis. Members must always determine the strict clinical need and evidence for medical cannabis, balanced against the known harms and risks, as compared to patients' legally obtaining recreational cannabis.

- Members who authorize medical cannabis should be aware of the role industry may play from time to time in promoting cannabis for health and wellness.

Legal framework

- Medical cannabis is authorized not prescribed.

- There is limited good-quality evidence to support cannabis use for most medical conditions, yet the federal *Cannabis Act* and Regulations have established a process by which health care practitioners can authorize medical cannabis. As a result, patients determined to have a medical need can access a legal source of authorized cannabis.

- It is important to note in this regard that only persons over 19 years can legally purchase recreational cannabis in Manitoba. Individuals of any age can receive a medical authorization that would permit them to obtain cannabis.

- In authorizing cannabis for medical purposes, the federal *Cannabis Act* and Regulations must be complied with by members.

Available evidence

- Non-pharmacological interventions such as cognitive behavioural therapy and brief behavioural interventions have proven benefit in treating many conditions for which medical cannabis may be authorized.

- The 2018 Health Canada document has excellent information on medical cannabis for physicians and should be consulted prior to authorizing cannabis. https://www.canada.ca/content/dam/hc-sc/documents/services/drugs-medication/cannabis/information-medical-practitioners/information-health-care-professionals-cannabis-cannabinoids-eng.pdf

- Clinical recommendations for the use of certain cannabinoids may change rapidly as the pace and scope of research may expand now that cannabis is legal in Canada and several US states. Currently (2018 review) there is medical evidence as set out in the above Health Canada source that certain cannabinoids *may* be beneficial for only a small number of indications.
    - Palliative care
    - Chronic neuropathic pain
    - Nausea and vomiting due to chemotherapy
    - Seizures
    - Tremors, spasticity, and inflammation in multiple sclerosis
    - Stimulation of appetite in patients with severe weight loss due to HIV/AIDS and possibly cancer.

- There is evidence that the risks of medical cannabis are numerous and include, but are not limited to, the following mental health illnesses as set out in the above Health Canada source:
    - anxiety,
    - PTSD,
    - depression,
    - bipolar,
    - schizophrenia,
    - psychosis,
    - suicidal ideation, suicide attempts and mortality, and
    - amotivational syndrome.

- Other adverse effects include the potential for
    - diminished cognition, psychomotor performance, and driving,
    - hyperemesis syndrome, and
    - carcinogenesis and mutagenesis of cannabis smoke.

- The risk of cannabis on developing brains (i.e., under the age of 25 years) is supported by clear medical evidence. The risks, harms, and benefits of cannabis in the elderly are not well established.

- More research is needed to characterize the mental health impact of medical cannabis. High-quality trials of long-term exposure are required to further characterize safety issues related to the use of medical cannabinoids.

Dosage and active ingredients

- Cannabis has many aspects that do not fit well with the traditional medical model for drug prescribing. Uniform dosing and titration schedules have not been established. The cannabis product itself can vary significantly by producer making its effect unpredictable and unreliable. The user is likely exposed to a product that may have varying ratios and amounts of THC and CBD cannabis components, even within the same strain and same producer. Thus, the cannabis effect may be highly and unexpectedly variable. Not only does this contribute to the difficulty in patients receiving precise doses but dispensers are not obligated to provide the cannabis product strength (e.g. CBD-prominent, CBD-THC-balanced, THC-prominent) recommended or authorized by the member.

The Authorization

- The physician's role is generally limited to providing the patient a medical authorization document that indicates the daily quantity of dried cannabis that they authorize for the patient. The patient can then obtain medical cannabis by:
    - Submitting the medical authorization document straight to a licensed commercial producer;
    - Registering with Health Canada to produce a limited amount of cannabis for their own medical purposes;
    - Designating someone else to produce it for them; or
    - Purchase it from authorized retail outlets or online sales

  Health Canada (not the physician) decides whether the patient is authorized to grow cannabis for personal medical needs or have someone else grow it on their behalf.

Drug Program Information Network (DPIN)

- Health Canada indicates:

  > Cannabis is not an approved therapeutic product, unless a specific cannabis product has been issued a drug identification number (DIN) and a notice of compliance (NOC).

- Accordingly, medical cannabis, which is not deemed to be a drug by Health Canada, can be authorized but not prescribed, and **is not recorded in DPIN**.

- Sativex® and nabilone have been issued a drug identification number by Health Canada. Both are included in the DPIN and DPIN should be checked for active prescriptions as a means of managing total CBD and THC dosages.

Fees

- Providing an authorization for medical cannabis is similar to providing a prescription and requires the same standard of care including medical documentation and assessing and educating the patient. The appropriate billing for a visit is an insured service and may be submitted to Manitoba Health as per the physician billing guide.
- No separate fee should be charged to the patient just as no separate fee is charged for a prescription. This includes no fees for completing a form for authorizing medical cannabis or any activities associated with completing the authorization, including assessing the patient, reviewing the patient's chart, educating or informing the patient about the risks or benefits of cannabis, or confirming the validity of the authorization in accordance with the Cannabis Regulation.

Suggested Resources

In addition to these two resources contained in the Standard of Practice, below are further resources.

- Health Canada's 2018 'Information for Health Care Professionals – Cannabis (marihuana, marijuana) and the Cannabinoids'
- The College of Family Physicians of Canada's 2018 'Simplified Guideline for Prescribing Medical Cannabinoids in Primary Care'.

Information for Health Care Practitioners - Medical Use of Cannabis is the Health Canada website that provides information about the use of cannabis for medical purposes (for example, pharmacology, potential therapeutic uses, contraindications, adverse reactions, etc.) and resources including scientific and medical information to help you in discussions with your patients.

Access to Cannabis for Medical Purposes Regulations – Daily Amount Fact Sheet (Dosage) is dosing information from Health Canada.

Authorizing Dried Cannabis (Medical Marijuana) for Chronic Pain or Anxiety: Preliminary Guidance from The College of Family Physicians of Canada provides helpful guidance on these two diagnoses.

Medical Document Authorizing the Use of Cannabis for Medical Purposes by Health Canada is the document that must be completed by the physician to authorize cannabis for medical purposes.

Cannabis Use During Pregnancy is the statement by The Society of Obstetricians and Gynaecologists of Canada.

Standard of Practice for Authorizing Cannabis for Medical Purposes consultation comments

Comments from CPSM Members
Overall, this looks good. My main objection/question would be Article 7 "A member must keep a separate log for all authorizations cannabis for medical purposes separate from the patient's chart. The log must include patient's name, PHIN, quantity and dosages, and name of licensed producer or grower. This log must be available for inspection by the College at any time. " Given the utility of the EMR, why is a separate log required? I can search and print all of my cannabis authorizations from the EMR using a search tool within a few minutes, to provide this to the CPSM. I agree that a standard needs to be met, but making it more complicated and problematic, will reduce an MD's willingness to authorize cannabis for a legitimate request.
Thank you for the opportunity to respond to the draft SOP concerning authorization of cannabis The current structure and legislation for provision of medical cannabis was driven more by a political rather than a medical agenda. This largely occurred due to pressure put on the government and VAC by individuals and organizations that came to believe that cannabis is an effective and safe treatment for many conditions including Post Traumatic Stress Disorder. This well intended position led to a demand for funding and access to this purported beneficial and (at the time) illegal treatment modality. Since legalization of recreational cannabis, access is no longer a barrier to "therapeutic" use of cannabis the only remaining issue is that of funding. In my humble opinion this is no longer a medical issue at all but rather a matter of policy and contract between the funder (VAC and other health insurance plans) and the subscriber / patient. In my opinion the funding and access mechanism should now be no different than it is for other non-prescription agents such as nutraceuticals and OTC's. Under that system the physician may or may not play a role in advising and recommending but not in authorizing, monitoring use and generally accepting responsibility for use of a substances that as the Contextual Information Document correctly points out has very little in the way of quality control or standardization and is supplied directly by commercial entities. This should strictly be a consumer / supplier transaction with the supplier assuming all of the inherent liability issues rather than the physician who has no ability to monitor or control product potency (dosing) and use. Having said all of that, I am quite aware that my position unlikely to be adopted and under the circumstances I think the Draft POS is reasonable with one exception. I would like to see a statement clearly indicating that the physician has no obligation or mandated requirement to provide a medical authorization for cannabis to a patient requesting one.
Item 3e of the draft standard refers to cautioning the patient about the impairment that might be caused by cannabis and the effect on a number of activities, including driving, where the impairment may lead to adverse outcomes. I would recommend that there be a further comment about the federal and provincial impaired driving legislation and the fact that an individual legally impaired by cannabis can be charged even if the cannabis is prescribed (ie having a prescription for cannabis does not protect a driver from legal

sanctions). The same principle applies to any other prescribed medication (eg opioids, benzodiazepines) that might cause a driver to be impaired. Neil Swirsky, Medical Advisor, Manitoba Public Insurance, Driver Fitness Division
I would clarify in the preamble that cannabis includes any kind of CBD oil, as some people think they are distinct
Although I don't partake ,I have no concern with recreational cannabis, my opinion is that it it is less harmful than other legal recreational drugs (alcohol) Despite pressure from users I feel strongly that physicians should limit prescriptions to those conditions that are known to have benefit This should be amended as pier reviewed evidence emerges. I think that conditions that are known to worsen with cannabis should be listed as contraindications. I also think there should be a functional endpoint. For palliative patients it may be simply nausea control but for most patients it should be something tangible, return to work, reduction of other meds etc. A patient who is happy to sit on the couch stoned on cannabis is not in my opinion a positive outcome!
I would appreciate a clause in the cannabinoid documents about physicians who feel they do not want to prescribe marijuana on ethical grounds. A clause and liability protection that states we are not obligated to provide such a service, if we can refer a patient to an expert in that field. I have no intention of prescribing marijuana to patients at this time. I do not feel that it is necessary when the other medications we have currently can control pain and anxiety, and there is so little randomized control trials on the benefits of this drug. This is coupled with the inherent risks of this drug that are known, not the least of which is impaired driving, potentiating schizophrenia and in the case of smoking marijuana, lung disease.
I have authorized the use of CBD products as a consultant to another physician. The Standard is not clear enough to permit that pattern to continue. I have been asked, usually for pain management consultation, and most of the patients have already used and found their dose of CBD the tis effective for their needs. Some of the patients I advise to try other therapies before going to CBD options, based on their history, physical and laboratory findings. In my own practice, the number of patients that responded to CBD for pain is < 10%. The response of some of those people has been remarkably effective. One patient went from T#3 to CBD oils and was able to ditch his cane, regain sexual function, and was really thrilled, even though the difference in cost was substantive. My experience is that CBD is useful for few patients, but can be really effective for those individuals. I don't authorize for anyone under 18, and prefer patients to be >25. My follow-up as a consultant is limited, but for those patients who basically need a renewal authorization rather than a full on start to finish initiation of CBD products, the follow-up is basically happened already in terms of dose titration and combinations. I try to use oils as much as possible.

The inclusion of not being able to charge for form completion is really out of place. I understand the problems that have occurred in the past with egregious fees, and next to no medical expertise used. The challenge is that the College stipulating which form completions can or cannot be charged to the patient opens up an entire range of issues regarding forms requested by patients. The patient cost of form completion is a non-covered service, not addressed by MHSC, a general framework is provided by Doctors Manitoba, but the patient can choose a physician who has a fee structure that suits them. Having to inform the patient of Doctors Manitoba's suggested fees, along with the individual doctor's fees could be suitable for any form completion, not just the CBD authorization ones, if the College would support the opinion of Doctors Manitoba in regard to fee structures.

Getting involved in the financial aspect of providing patient services has never been part of the College's mandate. I do not see that topic included in any of the legislation or the College's own stated mandates. To make a rule in order to avoid a possible bruha affects everyone who is trying to do an honest job, and punishes everyone who is working hard to make their practice economically viable. I think that honest work should be paid an honest wage. Completing paper work requested by the patient is a service that is not covered by Manitoba Health. It should be up to the patient to pay for the service they are requesting. If the College makes completing one form a forced gratis event, it is only a question of time before patients demand ALL their forms be completed for no remuneration. What possible reason could the College offer at that time? Why is one form acceptable to receive remuneration and not another? If someone is significantly overcharging, as in a multiple of Doctors Manitoba's suggested fees, that physician should be identified, and charged as such. The news of one conviction would appreciably diminish the likelihood of overcharging again.

Suggested update: Any fees charged to the patient for completion of CBD authorization forms should be comparative to fees charged for form completion of similar time consumption. - or something akin to that. That way Doctors Manitoba does not need to be mentioned, but a limit on form fees is stated in the Standard.

I have read the draft which a reasonable one.

However, I cannot understand the need for separate log of authorization.

In the era of digital integrated medical chart system where we can keep a records of anything, why do we need a log separate from patient chart which may get lost or not available to other health care providers in the same institution?

I have read through the Contextual Information and the Draft Standard of Practice regarding Authorizing Cannabis for Medical Purposes, and I have the following question:

Item #7 says we are to keep a log, separate from the patient's chart of all the authorizations for cannabis for medical purposes we do. What would this look like? Would a file with copies of the forms filled out for each patient be sufficient? Sort of like the MP3 rxs?

Overall this looks good.

I have the following concerns/questions:

#5a - 5. A member who authorizes medical cannabis must not: a. be legally or beneficially involved with a licensed producer/dispenser other than for the purpose of providing expert opinion, independent and impartial education, or conducting clinical research approved by an ethics board;

This is so broadly written as to potentially include shareholders in publicly traded companies. As the market cap of companies such as Canopy and Aurora grows, many physicians will own shares, knowingly or through managed funds. I assume this level of involvement/benefit from Cannabis companies is acceptable?

#9 - 9. A member who is treating a patient admitted in a health care facility or resident in personal care home must comply with all sections of this Standard in order to authorize medical cannabis, including where a prior authorization has expired.

I assume this only applies when the physician is actually writing an authorization, rather than an order "may use own Cannabis". If one needs to re-litigate the patient's entire chronic pain history, all treatments tried, review evidence base, then document it all simply to continue the home dose of Cannabis in hospital this seems excessive.

I have reviewed a number of articles on this topic. Much like a lot of other physicians. But I do not consider myself an expert. However I do have some observations...

I would point out that cannabis is a herbal product with hundreds of isolated components in any preparation. There are a number of different psychoactive derivatives. The components of interest are typically psychoactive.

There are many listed studies of this herbal product spectrum.

With variable actual component content in different studies.

There is clearly a lack of robust scientific studies supporting any effectiveness for legitimate medical indications. For example even regarding positive analgesic effect.

A drug psychoactive effect is not one of them. As well my observation is that many individuals even professionals are convinced about this products effectiveness without actual supporting evidence. Cannabis can be obtained legally for its recreational psycho active effects.

Having an insurance company pay for your psychoactive drug use is an example of secondary gain.
I would also advise that when speaking about cannabis to call it cannabis.

There is no Scientific support for a medical version as per medical cannabis.

All that putting medical in front , is legitimize third party payment as a product with doctors supporting its use as medical.

We must be very careful to divest our profession from products that clearly are not “medical”.

We took ethanol off of hospital formularies because we didn’t think it was medical anymore.

Also in the sixties doctors appeared in some cigarette advertising “medical” tobacco smoking for nausea in pregnancy.

The public still looks up to the medical profession. As of the present there is no robust support for the medical in medical cannabis.

Please call it cannabis to start.

If you want to prove that it has medically proven benefits please prove it with reproducible robust scientific study.

Preamble: The CPSM struggles with integrating legal marijuana into our evidence-based paradigm that we are comfortable with. Our pharmaceutical world has placebo-controlled double-blind studies that evaluate very specific doses of individual chemicals, the results of which we use in our evidence-based decisions. A marijuana plant will not care whether the percentage of THC is consistent across the product line to make us comfortable. The myriad of patients who present with a myriad of subjective issues, and experience a myriad of subjective/qualitative benefits, will never fit into our quantitative evidence-based world. I feel the angst experienced at the College is secondary to this "reality". If a patient says that CBD gives them a benefit, I am uncomfortable telling them that they are wrong because I do not have an evidence-based study to back them up. My thoughts on the draft flow from this position.

Section 2-(b)- replace required with reasonable

Section 3-(c)- the use of the word "all" is unreasonable as is the expectation that scientific evidence will be available concerning a qualitative/subjective issue. Studies are not, nor will they be, available to a satisfactory degree.

3-(e)- my understanding is that there is the expectation that if a physician authorizes cannabis, they must notify MPI in a similar fashion as physicians notify (or do not notify) MPI when they prescribe lorazepam or Percocet. I agree with the requirement to notify MPI if I am prescribing or authorizing a medication that works "from the neck up". However, our expectations should be universal across all pharmaceuticals and we are currently only singling out marijuana. As well, if we expect MPI notification with cannabis authorization, it should be in large font and bolded within the draft, and not a small print footnote. We subjected a member through a complaint on this issue, so please let us make sure everyone knows what we are expecting. As well, taking same stance on all other psychoactive medications is a logical next step and if we do not, why not. This appears to be a double standard secondary to our discomfort.

Section 4-(b)- "make reasonable efforts" is pretty good, but I will suggest using the word "consider". The patient may not want the authorizing physician to communicate with their FP and the presence of "make reasonable efforts" shackles the physician to la to communicate. A discussion should occur on this topic with the patient and then consent, if provided, would then allow communication to occur when appropriate.

Section 5-(c)- this appears to be a double standard as physicians are increasingly practising within pharmacies probably with incentives (low overheads) and side deals. I would question the justification of this expectation as it does not seem fair.

Section 7- "a member must keep a separate log for all authorizations cannabis for medical purposes separate from the patient's chart". The wording is awkward.

Also, within section 7, the log requires the name of licensed producer or grower. At the time of authorization, I would think the only way the physician can know this answer is to direct the Rx to be filled at a specific site (which should not be allowed). If the patient returns to the authorizing physician a second time then the MD can fill in that space but after the fact. The patient may also not return. Again, it is a double standard compared to the regular world of pharmaceuticals and pharmacies and therefore feels unreasonable. The patient has the right to go wherever they want, and the government is required to regulate the available dispensaries so why should we care where the authorization is filled.

Section 8- if I read this correctly only a physician with privileges at a specific PCH can authorize medical cannabis at that site. If there is at least one physician at every PCH that is comfortable with authorizing cannabis for themselves and their colleagues, then my concern is moot. My concern will be for the patient who has been on medical cannabis from the community who is then paneled and placed. If their community physician cannot continue their authorization, and their new PCH physician will not authorize, the patient will be disadvantaged. There will be increasing numbers of these patients (those using a cannabis product either privately or with physician authorization) being paneled and placed as the baby boomer generation gets older. If we are providing patient centred care, we should ensure their cannabis authorization continues in their new and last home. Not ensuring this feels like punishment.

Section 10- I claim ignorance in knowing what a cannabis authorization looks like, but if it is significantly more complex than writing a simple prescription, this may be an unreasonable position for the College to take from a business perspective. Doctors Manitoba can arrive at a fair value for completing any form which then gives us guidance if physicians charge too much (just like with other forms).

I appreciate the College's angst. If we accept that medical cannabis is here to stay, we should not develop double standards and threatening expectations, but rather trust our members "to do the right thing". If we do not want physicians to authorize it, we should say so clearly.

Thank you for the opportunity to share my thoughts,

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the reason Veterans Affairs Canada spends $75,000,000 a year on cannabis is because to many veterans with PTSD it is the difference between living as a recluse [with intolerable symptoms, especially rage and paranoia, but also the other well known symptoms of PTSD.] and living as a family member with friends and avocational pursuits.

i don't understand why Canadian physicians who are advising about cannabis do not seem to have studied the scientific literature in other countries, especially Israel.

yes caution is necessary lest deleterious effects are perpetrated, but the emphasis on these is out of balance with the evidence from and especially the experiences of doctors such as myself who work with war veterans suffering from unimaginable psychological pain.

i do not want to sound like a fervent advocate for marijuana, but i am alarmed that a negative view of cannabis (some of it perhaps published in the days of Reefer Madness with the scientific dubiousness of that era)....

i have prescribed medical-grade cannabis to approximately 70 veterans with PTSD.
they have been referred to me by Veterans Alliance Canada Inc. since 2017. I invite every one of them to phone or email me 24/7, and at least once-a-year follow-up. these veterans are very knowledgeable, often to a meticulous extent, about the chemistry, botany and vehicles of medicating.

if i quote what the veterans have said about the renewal of their will to live and the diminishing physical and mental pain (includes discontinuing oxycontin, tylenol-3, alcohol and ineffectual antidepressants) i am sure you would discount the validity of this letter.

Please take what i have written here seriously, if not to diminish the stigma of cannabis, at least to start looking beyond Canadian borders to nations that are advanced in their efforts to prescribe cannabis judiciously and optimistically.

Members of the Public

Response to Standards of Practice for Authorizing Cannabis for Medical Purposes & Standards of Practice of Medicine for Authorizing Cannabis

I found the information in the Contextual Information for Standard of Practice for Authorizing Cannabis for Medical Purposes to be extremely helpful and informative.
I particularly liked the way it was spelled out from ethical, legal, and available evidence, clinical recommendations and links.
The information would be helpful to the public, the practitioners that are able to authorize it and the physicians whose patients are using it
Again the College is to be commended for taking the initiative in the interest of safe patient care.
I believe there is a need for education of the public as today you hear more and more people, especially those with chronic pain and/or the elderly who are resorting to edibles, creams, oils, etc.
Is this something the College can do or at least ask Government to do - just wondering.
To the College itself - keep up the good work and thanks.

Three of these grow ops are across the street from me. So, as people are selling their large bungalows, this group swoops in to pay top dollar for these homes that in months, will be damaged from humidity and mould. In turn, this is bringing down our neighborhood's desirability and value. Not to mention our safety! This is leading to other neighbours considering selling their homes as well.!

There are various cars coming and going all day and loading and unloading.

Manitoba Justice has been investigating these homes and can find nothing that goes against the federal government's legal license criteria. This includes that it is perfectly acceptable to be grown in a residential area and that due to privacy laws, that the prescriptions are not allowed to be cross referenced with the number of plants that are being grown in the home. Since the prescriptions aren't

allowed to be requested for review, there is no way to find out who the doctors are so they can be taken to task.

It appears that the laws are totally in the side of the criminals and we have absolutely no choices as we watch our neighbourhood deteriorate.

If there are any other thoughts on which you would like some feedback, please let me know!

My name is EK. I am a resident of the Garden City neighbourhood in Winnipeg. My family and I have been impacted by the presence of 6 large scale cannabis medicinal grow ops within 300 metres of my home.

There is a community petition with 140 signatures gathered the old school way of going door to door in the midst of a pandemic. There was a community meeting with MP Raquel Dancho, MLA Shannon Martin, MLA Andrew Micklefield and City Councillor Devi Sharma. and 40 members of my neighbourhood. We had to cap the attendance due to COVID precautions. My community is angered by the threat to public safety, loss of community, and decline of property values due to the presence of these industrial scale medicinal grow-ops. many people shared the stories of how their lives have been negatively impacted by the grow-ops.

Marijuana is legal, and I am not going to debate that. I do take exception with the excessive limits that the health Canada medicinal licence allows. How anyone can consume 30 grams of cannabis a day, and how up to 4 licences can be located within one home is inexplicable. What is scary is health Canada has been issuing licences to individuals for up to 150 grams a day. Plus why is production permitted in residentially zoned residential neighbourhoods. Medicinal grow-ops require industrial level of hydro, and water, use of extreme heat and harmful chemicals. A medicinal grow-op is 24 times more likely to catch fire than a non grow-op. A 2016 report in Surrey, BC on the hazards of medicinal grow-ops found that all 314 residences had problems including; mould, dangerous wiring, and holes in fire break walls. On April 8, 2018 a tragic fire in Surrey, BC killed 2 people and injured 2 more in a house fire caused by the heating equipment that was used to dry 188 cannabis plants.

My community has identified 30 homes that have been purchased in the last 3 years for the sole purchase of cannabis production. The purchases of these 30 homes have used the services of 2 realtors to purchase these homes.I have searched the titles of 6 of these homes and found that they were substantially financed by 4 different credit unions. When I contacted these credit unions, they had no idea that they had financed industrial level medicinal grow-ops. They credit unions are left with 2 options. Call in the mortgage and face substantial losses on resale, or allow them to operate (and collct the mortgage payment) and destroy the security (the home) and the community around it. Mortgage fraud has been committed and it is likely inadequate insurance exists on these homes as well. These homes are all substantially financed. Of the 6 homes searched, they were purchased for 2.4 million dollars with cumulative mortgages in excess of 2.8 million. This is mortgage fraud - period.

On June 12, 2020 a medicinal grow op on Celina Cove in Winnipeg was broken into by 3 criminals. Their intent was to steal the medicinal cannabis inside the home. The invaders tied and bound the 2 occupants of the home at the time and then tried to make off with the cannabis. They were apprehended by the city of Winnipeg Police chopper. The residents around this home felt violated and unsafe. What if the invading criminals picked the wrong home what then?

Another concern is the stench that comes from these large scale operations. It is unbearable and reduces the enjoyment of our properties. Why do the right of criminals, trump the rights of citizens? Why was the public not consulted? The city of Winnipeg does not allow citizens to own pigs as pets, yet a medicinal licence using industrial level toxic chemicals, home destroying heat and humidity is allowed to continue, does this make sense?

Worst of all, these 6 homes in my neighbourhood are all vacant. They are not used to live in. Instead they are industrial work sites. Instead of housing other families that continue to the fabric of the neighbourhood, they become vacant structures that will lead to decay and destruction of a proud and determined neighbourhood. Recently a young family was looking to purchase a home on Ambassador Row. Instead it was purchased by the operators of a medicinal grow-op. Instead of bringing new life, and new activity to the neighbourhood, the home is now an industrial production site with heavy traffic especially on weekends. The inground pool in the backyard, isn't even being used, and security cameras and hydroponic lights surround the property. The address is 139 Ambassador Row. I suggest your committee go by on a Friday night to see for yourself. Plus there are 3 other medicinal grow-ops on the street. Another home at 111 Ambassador Row was home to a young family with triplet children aged 2. When the home next door at 107 Ambassador was purchased and turned into a grow-op, they were frightened and put their home up for sale. The next day the grow op next door came over, looked at the home and bought it. There are now 2 in a row!

If the College must place a limit on the number of plants on a licence, I suggest the maximum limit be set at 20 plants. I do understand some people especially chronic pain sufferers require cannabis to help with their ailments. A maximum limit of 20 plants should be adequate.I would further argue that those prescriptions be issued my Manitoba doctors, not out of province doctors. Secondly, the licence cannot be permitted in a residentially zoned neighbourhood. Homes are for residents, not industrial production sites. They belong in industrially zoned areas in buildings with proper industrial level scrubbers and ventilation.

If desired, I would be delighted to speak with your organization. I can be reached at 204-.

I have enjoyed living in the Garden City neighbourhood in Winnipeg over the past 30 years. However, an issue has arisen in the past year or so where several cannabis grow ups have surfaced in various homes within the Garden City area. One of our neighbours has led an effort to investigate and address this issue including organizing a meeting of representatives from all three levels of government to discuss. That meeting took place last week where over 35 folks from the community discussed and aired their concerns about these residential grow ups.

The initial indicator that helps us identify these homes as grow ups is the odour that resonates from them. As well, these homes are typically poorly maintained from the outside (i.e. poorly cared home exterior, little or no landscaping) and do not always appear to be occupied or lived in. Some of the risk factors that we are concerned about relating to grow ups are as follows:

1. Bad Odour that impacts on our enjoyment when outdoors
2. Commercial activity taking place in a residential neighbourhood with respect to the sale of cannabis
3. Possible criminal/illegal activity and other security issues relating to unoccupied homes and the nature of the high value plants that are grown within the homes
4. The exterior conditions of the house and property reflect poorly on the neighbourhood

5. The production process requires commercial grade ventilation, humidity control and a substantial amount of electrical power. Residential homes are not built to the standard to safely grow large quantities of marijuana resulting in extensive damage to the property.
6. Adverse impact on property values

My understanding of how these grow ups become authorized is by patients initially obtaining authorized doses/quantities of cannabis from their physicians for the purpose of medicinal use. These authorizations are presented to Health Canada, which is the governing authority that administers the approval of licenses to the public for growing the cannabis plants for medicinal use. Once the license is obtained, the individuals who are licensed can harvest the authorized quantities of plants. If the authorization is for large quantities of cannabis, the licensee can harvest a large number of plants, which can be resold to third parties; in effect becoming a grow up operation. The setting up of large grow ups in residential neighborhoods was never the intention of the program, which is to allow individuals to grow cannabis for medicinal purposes for their own use.

The reason why I am providing feedback to CPSM on this issue, is that there is concern that physicians are authorizing large quantities/doses of cannabis for medicinal purposes to their patients, which is above and beyond the normal or typical amount that individuals would require over a specified period of time. These authorizations can result in Health Canada granting applicants a license to produce a hundred or more plants in their homes which could not possibly be used by the patient who has been granted the licenses. I do not have any evidence to support this scenario but it certainly a potential causal factor to residences being turned into commercial production sites for cannabis.

I do not know if there is any limitation on how much a physician can authorize for a patient at any one time. If no limits are in place, then this in itself is problematic and if possible, CPSM should consider establishing some guidelines on what amounts can be authorized by physicians for their patients.

In addition, my understanding is that physicians who authorize the use of cannabis for their patients are required to maintain separate records of these authorizations. I would assume that this information can be periodically reviewed by CPSM if an issue arises about certain physicians who are authorizing large quantities of cannabis to their patients. If not already taking place, consideration should be given to implementing some level of monitoring of these authorizations to identify those physicians who are authorizing excessive quantities to their patients in relation to what is considered to be reasonable limits on cannabis quantities being authorized.

Thank you for establishing a process for public feedback on the cannabis issue as it pertains to CPSM.

Licences to grow medical marijuana have been issued to individuals , who are using the licences to protect themselves from the police , as they buy bungalows in residential areas to grow large number of plants , while never living at those houses . The marijuana being produced is most definitely for sale and not for medical reasons . Some review of different grow ops , you'll find the individuals are connected , by real estate agent , doctor , mortgage broker , etc . The detrimental affect on our neighborhoods needs to be stopped . These grow ops smell like a skunk and are a huge annoyance , not to mention the enormous loss in value to our homes , for being in neighborhoods with (medical) marijuana grow ops .
I hereby submit the following few ideas for consideration :
-To receive a medical marijuana grow license , it must be signed/approved by **two** doctors (from unrelated offices) that have both thoroughly assessed your need for medical marijuana by **in person examinations** .

-All doctors should be limited to approving a maximum of **3 licenses in a 36-month period** , to eliminate certain corrupt doctors from likely fraudulently approving numerous requests potentially just for money .
-No house should have multiple grow licenses ever .
- No license is valid if the licensee is not residing at that residence .
- No residential medical marijuana license will be for more than 12 plants .
Many other areas need to be pursued such as : immigration (in Winnipeg ; extra attention to Asians) , real estate agents , CRA , financial lenders , hydro , environmental (air quality) , Police Service determination of violations of licenses or criminal activity (ie: growing only for the purpose of selling) , etc .
Thanks .

Stakeholders

Manitoba Health, Seniors & Active Living

Cannabis:

- You will be aware that the proposed Standards of Practice and Contextual information document must uphold the principles of The Canada Health Act, and the requirements of provincial legislation and regulations, and specifically The Smoking and Vapour Products Control Act.
- Preliminary review of the documents indicate alignment with the aforementioned legislation. We have noted the following for your consideration:
    - In the document titled, "Contextual information for Standard of Practice for Authorizing Cannabis for Medical Purposes", the CPSM should consider including reference to existing cannabinoid treatments that have been available in Canada for many years – Sativex and Nabilone. Both of these products have been issued Notice of Compliance by Health Canada and are prescribed medicines.
    - The standards should remind prescribers to check DPIN for active prescriptions for either of these products as a means of managing total CBD and THC dosages.
- Manitoba Health, Seniors and Active Living (MHSAL) is responsible for health system policy, funding, and oversight activities respecting Manitoba's health system. Shared Health (SH) is responsible for leading health system clinical governance and planning in Manitoba. If not already, we recommend you discuss these documents with leadership within SH to facilitate clinical planning and alignment.

CMPA
The Canadian Medical Protective Association (CMPA) appreciates the opportunity to provide comments as part of the consultation on the draft updates to the "Standard of Practice for Authorizing Cannabis for Medical Purposes".
As Canada's largest physician organization, the CMPA delivers 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.
Upon review of the draft Standard, we identified one aspect that would benefit from further clarity to ensure consistency with the *Cannabis Regulations*.
As currently written, paragraphs 3(d) and 4 (a)(iii) of the draft Standard suggest that physicians can authorize a patient to grow medical cannabis. However, a physician's role under the *Cannabis*

Regulations is generally limited to providing the patient with a medical document that indicates the daily quantity of dried cannabis that they authorize for the patient. The *Cannabis Regulations* do not allow physicians to authorize patients to grow cannabis. Once a physician provides the medical document, the patient can then obtain cannabis, either directly from a federally licensed seller, by registering with Health Canada to produce cannabis for their own medical purposes, or by designating someone to produce it for them. It is Health Canada (not the physician) that decides whether the patient is authorized to grow cannabis for personal medical needs. We encourage the College to amend the language in the draft Standard so that it accurately reflects the requirements under the *Cannabis Regulations*. To reduce their medical-legal risk, it is important that physicians have a clear understanding of their obligations in relation to authorizing cannabis for medical purposes. I trust that these comments will be of assistance to the College in finalizing the draft Standard.
On behalf of CPSA, thank you for the opportunity to read your draft standard and provide feedback. Overall, the documents look good and covers the bases well. With respect to clause 7, the idea of having a separate record is useful from an awareness perspective for the prescriber and makes it easy should CPSM need to follow-up. It might add to administrative burden at the clinic, but has its advantages from a regulatory perspective. How long the records need to be maintained isn't addressed in the documents; CPSM may want to consider including an item to add to the companion resource. If you have any other questions or require additional information, please let me know how I may be of assistance.

Other Regulated Health Profession

Thank you for providing us with the opportunity to provide feedback on your standard of practice for authorizing cannabis for medical purposes.

We noted the following statement on page 2 of the contextual information:

It is important to note in this regard that only persons over 18 years can legally purchase recreational cannabis in Manitoba. Individuals of any age can receive a medical authorization that would permit them to obtain cannabis.

However, the webpage for Cannabis in Manitoba states the legal age for accessing non-medical cannabis in Manitoba is 19+.
We have no further comments on this standard.

Doctors Manitoba Response

Re: Medical Cannabis

We appreciate the opportunity to provide this submission on behalf of the members of Doctors Manitoba.

The authorization of medical cannabis is an emerging issue. We appreciate the College's efforts to update and clarify existing direction by the proposed Standard of Practice.

We expect that some of our mutual members may provide comments and suggestions respecting the clinical aspects of the proposed Standard of Practice.

For our part, we will restrict our comments to two areas:

1. Paragraph 7 of the proposed Standard of Practice, requiring physicians to log the name of the "licensed producer or grower"; and
2. Paragraph 10 of the proposed Standard of Practice, imposing a new requirement that "a fee must not be charged for completing a form for authorizing medical cannabis".

Paragraph 7
It is our position that requiring a physician to log the name of the "licensed producer or grower" is cumbersome for the physician, does not accord with the federal framework, and does not advance (and may in fact be against) the public interest.

We agree with the College's general position that physicians must be entirely independent of from the medical cannabis "industry" – producers and suppliers.

That goal appears to be reflected in the federal framework: a patient has the choice of licensed producers and can forward the authorization form to their choice. Patients may change producers or suppliers if they wish, provided that they obtain a new authorization form.

The federal authorization form found at https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/dhp-mps/alt_formats/pdf/marihuana/info/med-eng.pdf states as follows:

"Access via Health Canada licensed producers: Should you choose to access cannabis from a licensed producer, this form must be sent directly to the licensed producer of your choice. You may choose any licensed producer who is authorized to sell to registered clients. Please see the Health Canada website for a list of licensed producers. Should you wish to switch from one Health Canada licensed producer to another a new medical document will be required as licensed producers are required to keep the original medical document on file."

The federal framework does not require nor even suggest that physicians should document a particular producer. The obligation to retain records is placed squarely on the producer, as only the original authorization form provided by the physician is sufficient.

We would suggest that the proposed obligation would not advance the public interest. If anything, requiring the physician to confirm the name of a licensed producer at the time the authorization form is provided would make it more likely that the medical cannabis industry would attempt to influence physicians.

If a patient chooses to switch producers, a new authorization form is required. The patient may not attend upon the same Manitoba physician, making it even less likely that logging the licensed producer has any benefit to the public interest.

Finally, the College has taken the position that the authorization form shares some of the same properties as a prescription. No one has suggested that physicians should be required to log where a prescription is to be filled.

We submit that this requirement should be deleted from Paragraph 7.

Paragraph 10
It is our position that the completion of the medical cannabis form is an uninsured service. Physicians should be entitled to bill patients for completing the form.

The form authorizing the use of medical cannabis by a patient is not a prescription. The balance of the proposed Standard of Practice makes it quite clear that while the authorization form shares some of the same properties as a prescription, it is indeed quite different.

Both the existing and the proposed Standard of Practice allow the authorization form to be issued only where a physician has taken on responsibilities beyond those required to write a prescription. Some of these responsibilities are expected and inherent, such as the obligation of physicians to educate themselves on the clinical and legal aspects of authorizing medical cannabis. However, the full impact of these additional requirements is considerable.

These additional requirements include, but are not limited to:

- Ensuring that other conventional therapies have been tried or considered for the patient's diagnosis;
- In addition to advising the patient of all material risks and benefits of medical cannabis, the "level of scientific evidence supporting the efficacy of the proposed treatment";
- Advising the patient of the risk for diversion of authorized medical cannabis;
- Documenting on the patient record how all of the requirements have been satisfied, including relevant discussions with the patient, the clinical reasons for which the medical cannabis is authorized, and the rationale for the amount authorized, including if authorizing the patient to grow;
- Keeping a separate log for all authorizations including the patient's name, PHIN, quantity and doses, and name of the licensed producer or grower (as discussed above), which must be available for inspection by the College at any time.

The Physicians' Manual contains no special tariff for meeting these obligations, which go far beyond those for prescribing medication. While that alone may not be a concern for the College, the Physicians' Manual also contains no tariff for providing the authorization form, meaning that it is an uninsured service.

Section 47(1) of the Standards of Practice allows a physician to charge a "reasonable fee" when performing a health service that is not insured by the provincial fee schedule. Patients are already well protected by the requirements for physicians providing uninsured services, as set out in Section 8 of the Regulation, and the balance of Section 47 of the Standard of Practice.

We acknowledge there is not a uniform practice across Canada. Slightly more than half of jurisdictions, including Manitoba, have no language in their regulatory standards which would prevent billing the authorization form as an uninsured service.

If the proposed Standard of Practice is adopted, there would not be another regulator in Canada with more provisions in its standards differentiating the authorization form from a prescription, yet insisting both should be treated in the same manner for billing purposes.

If the proposed Standard of Practice is adopted, we anticipate that fewer Manitoba physicians will choose to take on the considerable additional responsibilities required to provide an authorization form. This will have a negative and unintended effect on patient safety.

As the Contextual Information issued by the College correctly notes, our members "may be presented with belief systems and great expectations of some patients for the alleged healing powers of cannabis".

Some members are already reporting that Manitobans who wish to use medical cannabis may seek out a different health care professional, or may even be directed to a health care practitioner outside of Manitoba to request the authorization form. Some may ignore a health care professional entirely, and attend at a retail store to buy a product which is legal to purchase and consume. It is difficult to see how this would be in the best interests of Manitobans.

It should be up to the physician, and not the College in its role as the regulator, to determine whether a physician charges a patient a fee for completing the authorization form for medical cannabis.

We submit that all of Paragraph 10 of the Standard should be deleted.

Thank you for the opportunity to provide this submission. If you require any clarification or further information, please contact us.

MP Raquel Dancho

I am writing to you on behalf of the residents of Kildonan—St. Paul regarding the Standard of Practice for Authorizing Cannabis for Medical Purposes and Accredited Facilities Bylaw public consultation by The College of Physicians and Surgeons of Manitoba (CPSM). I am also requesting a formal meeting with you in the coming weeks to discuss and relay directly concerns I have heard from community members on the issue outlined below.

I attended a forum in Garden City on July 28, 2020 with approximately 40 area residents, who are concerned about large cannabis cultivation operations in residential areas of Winnipeg. Garden City families and seniors highlighted dozens of homes known to have hundreds of marijuana plants each in their neighbourhood. These large home cultivation operations have negatively affected their quality of life, including the presence of a strong odour when plants are ready to be harvested. Other concerns highlighted include a decline in home values, security risks and the potential for home invasions due to surplus cannabis being made available for sale outside of the legal market.

Media reports have indicated that primary care physicians have been asked by patients to prescribe up to 100 grams of dried cannabis per day. This far exceeds 1-3 grams of dried cannabis per day reported in clinical studies and patient usage surveys cited by Health Canada in their Access to Cannabis for Medical

Purposes Regulations - Daily Amount Fact Sheet (Dosage) Information for Health Care Practitioners. Health Canada's reference Calculator for the production of a limited amount of cannabis for medical purposes highlights the effect of this discrepancy: a prescription of 100 grams of dried cannabis per day can result in an individual receiving authorization from Health Canada to grow over 450 marijuana plants through home cultivation. Whereas if an upper limit of 3 grams of dried cannabis per day were to be utilized, only 15 plants would be approved by Health Canada for home cultivation, an adequate amount of cannabis for personal use according to Health Canada Survey data.

Further, Health Canada allows for up to four medical cannabis licenses at one non-commercial location. This could result in the cultivation of hundreds marijuana plants in a single residential home as has been reported in the Garden City area at over a dozen locations.

On behalf of Kildonan—St. Paul residents, I respectfully request that CPSM Council set an upper limit for dried cannabis prescriptions written by physicians licensed in the Province of Manitoba. This limit should be based on peer-reviewed clinical studies, Health Canada dosage surveys and set in consultation with the appropriate provincial stakeholders. I would ask that consideration be given for an interim cannabis prescription limit during this process.

Doctors Manitoba Second submission

We are writing to you today respecting the submission made by MP Raquel Dancho dated July 30, 2020.

We have already provided a submission on behalf of Doctors Manitoba, and we appreciate that the window for making submissions has closed. However, we believe that the letter from Ms Dancho does require a response, which we ask the College to receive as information.

Doctors Manitoba does not accept the implication that home cultivation of cannabis in the Garden City area is related to any unreasonable practices by Manitoba physicians. Further, Doctors Manitoba does not believe that the letter provides any reason for further regulation by the College beyond the proposed Standard.

We state as follows:

1. Doctors Manitoba does not discount the concerns about cannabis raised in the letter. While there is a diversity of opinion among our members about the benefits of medical cannabis, there is widespread acceptance that cannabis can pose certain risks and should only be authorized where medically appropriate and in appropriate quantities. Further, Doctors Manitoba agrees that the cultivation of cannabis in a residence could have serious health consequences for residents, and may damage the residence.
2. As noted in our submission, Doctors Manitoba agrees with the large majority of the requirements set out in the proposed Standard. Our concerns are limited to two narrow areas which we canvassed in some detail in our submission.
3. We do not doubt that Ms Dancho's constituents have expressed concern about home cultivation of cannabis, or "grow ops". However, there is no evidence presented to support the implication that these grow ops have resulted from authorizations for medical cannabis issued by Manitoba physicians.
4. Ms Dancho's letter refers to unspecified "media reports", from unspecified locations, alleging that patients are asking physicians for the authorization of large daily amounts (up to 100 grams) of

cannabis. There is no evidence presented that any Manitoba physician has agreed to authorize any such amounts of cannabis.

5. Home cultivation is illegal in Manitoba, except as allowed by the application process through Health Canada. Legal home cultivation requires not only an authorization, but also a Registration Certificate from Health Canada which can be requested through an application process. Manitoba physicians play no role in this process once an authorization has been provided. More details can be found at https://www.canada.ca/en/health-canada/services/registering-produce-cannabis-own-medical-purposes.html#a2a.
6. Manitoba physicians are not the only health care professionals who can authorize medical cannabis. Under the federal Cannabis Regulations, a "health care practitioner" is defined as a medical practitioner or a nurse practitioner who "is not restricted, under the laws of the province in which they practise, from authorizing the use of cannabis." We have been made aware that some patients seeking an authorization for medical cannabis may be directed to physicians or others practicing outside of Manitoba.

Concerns about grow ops should be reported to the police, and/or the Public Safety Investigations Unit at (204) 945-3475. Information about The Safer Communities and Neighbourhoods Act, the provincial law authorizing civil remedies to close grow ops and other activities, can be found at https://www.gov.mb.ca/justice/commsafe/scna.html .

Concerns about the licencing of home cultivation of medical cannabis should properly be addressed to Health Canada.

Manitoba physicians who choose to authorize medical cannabis will continue to be informed by the latest clinical advice, and are agreeable to meeting the additional requirements in the proposed Standard, subject to the concerns in our submission. There are no reasons to impose further obligations on physicians, to try to solve what appears to be a criminal problem.

We ask the Council to take this into consideration in their deliberations.

DRAFT FOR COUNCIL - FINAL

STANDARD OF PRACTICE FOR AUTHORIZING CANNABIS FOR MEDICAL PURPOSES

This Standard articulates the standard of practice and ethical requirements for all members using their clinical skill, knowledge, and judgment in authorizing cannabis for medical purposes. This Standard does not apply to prescribing Nabilone and Sativex. This Standard does apply to all other cannabinoids and derivatives including oils.

Members are expected to educate themselves on authorizing medical cannabis, including clinical pharmacology, dosing, potential therapeutic uses, warnings, adverse effects and toxicity.

There is useful information in Health Canada's 2018 'Information for Health Care Professionals – Cannabis (marihuana, marijuana) and the Cannabinoids': https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/information-medical-practitioners/information-health-care-professionals-cannabis-cannabinoids.html - and in the College of Family Physicians of Canada's 2018 'Simplified Guideline for Prescribing Medical Cannabinoids in Primary Care: https://www.cfp.ca/content/cfp/64/2/111.full.pdf Members are also expected to educate themselves respecting legal requirements for authorizing medical cannabis under the federal *Cannabis Act* and Regulations.

1. Every member is professionally responsible for each medical cannabis authorization they provide to a patient. In deciding whether to authorize medical cannabis, each member must exercise the level of clinical judgment expected by the profession.

2. A member must only authorize medical cannabis:
    a. for a patient under their professional treatment; and
    b. when the medical cannabis authorized is required for the condition for which the patient is receiving treatment.

3. Prior to authorizing cannabis for medical purposes, a member must:
    a. make a diagnosis using the principles of good medical care set out in Part 2 of the Standards of Practice of Medicine;
    b. ensure that other conventional therapies have been tried or considered for the patient's diagnosis;
    c. advise the patient as to ~~all~~ material risks and benefits and the level of scientific evidence supporting the efficacy of the proposed treatment;
    d. discuss any other drug use, including recreational cannabis use and the risk for diversion~~, particularly if authorizing growth~~;
    e. advise that cannabis may cause impairment, including advising the patient of the dangers associated with driving, operating heavy machinery, performing safety sensitive tasks, and providing child or elder care while impaired[1]; and

[1] Members are reminded that they must be aware of and comply with statutory reporting duties in the context of disease or disability, including a treatment regime, that is expected to cause impairment to any relevant authorities (e.g. the Registrar of Motor Vehicles).

f. establish a plan for follow up and management.

4. In authorizing cannabis for medical purposes, a member must:
   a. document on the patient record how the requirements of section 3 of this Standard are satisfied, including notation of:
      i. relevant discussions with the patient,
      ii. the clinical reasons for which the medical cannabis is authorized, and
      iii. the rationale for the amount authorized~~, including if authorizing the patient to grow~~; and
   b. make reasonable efforts to communicate with other health care providers~~members~~ involved in the patient's care, including the patient's primary health care provider, as appropriate, and document same.

5. A member who authorizes medical cannabis must not:
   a. be legally or beneficially involved with a licensed producer/dispenser other than for the purpose of providing expert opinion, independent and impartial education, or conducting clinical research approved by an ethics board;
   b. be a licensed producer/dispenser;
   c. have a clinical encounter with patients at the same premises of any licensed producer/dispenser unless the medical clinic is located within a pharmacy that is a licensed dispenser; or
   d. otherwise contravene the Conflict of Interest provisions in the Standards of Practice of Medicine.

6. A member must not under any circumstances dispense or provide medical cannabis to any patient.

~~7. A member must keep a separate log for all authorizations cannabis for medical purposes separate from the patient's chart. The log must include patient's name, PHIN, quantity and dosages, and name of licensed producer or grower. This log must be available for inspection by the College at any time.~~

~~8.~~7. A member who is treating a patient admitted in a health care facility, or resident in a personal care home, and who also has privileges therein, may order that the patient may use medical cannabis if the member is satisfied that:
   a. the patient has previously been provided with an authorization to obtain cannabis for medical purposes by another member that continues in effect;
   b. the order is limited to the amount of cannabis needed for the period of admission or residency; and
   c. medical cannabis is required to ensure continuity of care respecting the diagnosis for which medical cannabis was authorized.

DRAFT FOR COUNCIL - FINAL

~~9.~~8. A member who is treating a patient admitted in a health care facility or resident in personal care home must comply with all sections of this Standard in order to authorize medical cannabis, including where a prior authorization has expired.

~~10.~~9. A fee must not be charged for completing a form for authorizing medical cannabis or for any activities associated with completing the authorization, including assessing the patient, reviewing the patient's chart, educating or informing the patient about the risks or benefits of cannabis, or confirming the validity of the authorization in accordance with the Cannabis Regulation.

COUNCIL MEETING – SEPTEMBER 25, 2020

NOTICE OF MOTION

SUBJECT:

Maintaining Boundaries – Sexual Involvement with a Patient

Council approved as a Strategic Organizational Priority to review Maintaining Boundaries – Sexual Involvement with a Patient. Council approved the Terms of Reference for the Working Group in 2019. The Working Group has met and prepared the attached Report and Recommendations for Council to consider. Also included is a recommended draft Standard of Practice.

It is anticipated that this Report and Recommendations will lead to much discussion.

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

Maintaining boundaries and sexual involvement with a patient strikes at the ethical core of public protection and patient safety. The unique nature of the relationship between patients and physicians is the foundation for prohibiting sexual contact and sexualized interactions between physicians and their patients, and strictly limiting sexual contact and sexualized interactions with former patients and persons who are interdependent with a member's patient. Sexual impropriety is treated as a very serious failure to maintain boundaries and the severity of the misconduct is assessed along a continuum. All allegations of sexual impropriety are investigated vigourously and prosecuted if the standard for referral to Inquiry is met with the primary focus being the public interest and protection of patients.

The sections within the recommended draft Standard of Practice entitled "Purpose" and "Foundation of the Relationship" describe the public interest rationale for a need for a Standard and the recommended revisions.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

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

SEXUAL BOUNDARIES WORKING GROUP

REPORT TO COUNCIL – SEPTEMBER 2020

Table of Contents

APPENDICES

I. INTRODUCTION

In June 2019, Council approved a strategic organizational priority of reviewing the law, policies, and procedures of the College for addressing matters of maintaining sexual boundaries with a patient. Council also passed a motion to establish a Working Group to undertake this review. In doing so, it recognized the College's mandate to protect patients and ensure that they have access to medical care without encountering inappropriate sexual comments or any type of sexualized physical contact, ranging from an otherwise legitimate examination conducted in an inappropriate manner to abuse or assault.

In September 2019, Council established a Working Group chaired by Mr. Allan Fineblit, with representation from the College's physician members from various practice settings and others with expertise in psychology, sexual assault crisis response and ethics.

This report reflects the efforts of the Working Group and sets out its recommendations to Council.

II. MANDATE

The Terms of Reference of the Working Group are attached as Appendix 1. The essential role of the Working Group was identified as including:

- making recommendations to Council on whether there is a need to revise the Standards of Practice on Boundary Violations, and if so, then make such recommendations.
- Considering whether:
    - the College is regulating boundary violations by its members within its legislated duty to serve the public interest;
    - legislative amendments should be recommended to Council for discussion with Government;
    - policies and practices of the College in addressing boundary violations are appropriate and to make recommendations to address any deficiencies/concerns are identified.
    - In the context of the movement towards mandatory minimum penalties in other jurisdictions, consider and make recommendations as to whether the College should move towards minimum penalties and, if so, how that could be achieved.

III. COMPOSITION

Sal	First	Last	Organization
Mr.	Allan	Fineblit	CPSM - Public Rep - CHAIR
Dr.	Ira	Ripstein	CPSM – President (ex officio)
Ms	Leslie	Agger	CPSM Council - Public Representative
Dr.	Bonnie	Cham	Medical Director Clinical Ethics
Dr.	Heather	Domke	CPSM Councillor
Dr.	Jacobi	Elliott	CPSM - President-Elect
Dr.	Yvette	Emerson	Emergency Department Selkirk Hosp
Dr.	Valerie	Holms	Psychological Association of Manitoba
Dr.	Shayne	Reitmeier	Portage Clinic
Dr.	Carol	Scurfield	Women's Health Clinic
	STAFF		
Dr.	Ainslie	Mihalchuk	CPSM - Assistant Registrar
Dr.	Karen	Bullock Pries	CPSM – Assistant Registrar and Director Complaints/IC
Ms	Lynne	Arnason	CPSM - General Counsel
Ms	Meredith	McLeod	CPSM – Coordinator of Complaints IC - Admin

Although not members of the working group, several staff members were involved to provide guidance as to standards and processes. Lynne Arnason also provided background information and advice about legal issues and was primarily responsible for drafting the Standard of Practice and this Report. Meredith McLeod coordinated and provided administrative support for the meetings.

IV. PROCESS

The Group met as a whole 5 times between October and February. In between meetings, the members were provided with material which they reviewed for discussion at each following meeting. At its last meeting in February the Working Group reached consensus on all outstanding discussion items and was to meet in March to begin preparation of this report. The March meeting was cancelled due to COVID 19. The Group has not met in person or virtually as a whole since then. Instead, a draft of this Report and the attached Standard of Practice was circulated. Feedback was obtained through electronic communications and incorporated into the final documents.

At its first meeting, Dr. Bullock Pries and Ms Arnason presented a review of the College's historical and current approach to sexual misconduct allegations from 2006 to the present. Materials were distributed describing policies and practices in other Canadian and international jurisdictions. The Group also developed a work plan which it based loosely on the following list of issues for consideration:

1. Review of Standards of Practice on Boundary Violations

    a. Is there a need for change and making recommendations? Are the current Standards of Practice for maintaining boundaries with current and former patients and/or patients with whom a physician has a psychotherapeutic relationship adequate? Consider the following:
        i. existing and alternative definitions and use of the following terms:
            - Patient
            - Former patient
            - professional boundaries;
            - examples of sexualized interactions;
            - sexual misconduct
            - sexual abuse
        ii. mandatory reporting obligations of fellow members and other regulated health professionals.
        iii. interim orders/suspension of practice pending final outcome of investigation or inquiry as means of protecting the public
            - suspension of practice
            - conditions on practice
                i. chaperones
                ii. supervision
                iii. impact on reputation of the member given allegation not yet proven

2. Review of Existing Policies and Practices

    a. Assessing existing policies and practices of the College in addressing boundary violations and identifying appropriate recommendations
        i. INVESTIGATIONS
            1. Identifying best practices in relation to investigation of allegations of boundary violations/sexual misconduct:
                - Should investigators be specifically trained in conducting such investigations?
                - What training is available?
                - The trauma informed investigations
            2. What support should be provided to complainants before, during and/or after a disciplinary hearing of allegations of sexual misconduct?
                - Independent legal representation
                - Counselling – psychological/psychiatric
                - Other representatives of the College who are not involved in the investigation or prosecution?
                - Patient advocate or facilitator

ii. INQUIRIES
    1. Should there be specific Panels with expertise in addressing sexual misconduct to hear cases involving such allegations? What training is available?
    2. Should we have gender diversity requirements for Panels who hear cases involving sexual misconduct?

iii. DISPOSITIONS / OUTCOMES
    1. Specifically consider the movement towards minimum penalties in other jurisdictions and make recommendations as to whether the CPSM should move towards minimum penalties and, if so, how that could be achieved.
    2. What is the appropriate approach to penalty determination following a finding of a significant sexual boundary violation?
        - Are presumptive penalties possible and/or appropriate?
        - Should the government of Manitoba be approached to pass legislation imposing minimal penalties for serious allegations of sexual misconduct?
        - Should the penalty for a "consensual" sexual relationship with a patient be considered using different principles than "non-consensual" sexual touching of a patient, particularly outside of the clinical setting?
        - Is there a place for remedial approach in relation to allegations of sexual misconduct?
        - What forms of assessment should be required to inform decisions whether a physician is safe to see patients and on what conditions?

b. What are appropriate restrictions before and after conviction?
    i. Are gender restrictions appropriate?
    ii. Chaperones
        1. What is the evidence with respect to the effectiveness of a chaperone (practice monitor) requirement?
        2. Should we require chaperone training?
        3. How do we monitor?
        4. Who pays?
    iii. PREVENTION
        1. Are there education programs which should be considered in relation to educating physicians as a means of preventing boundary violations
        2. What educational endeavours can educate BOTH our members and the public about the following issues relating to sensitive examinations:

- Proper gowning for patients.
- What constitutes a normal exam?
- When might sensitive exams be indicated?
- Proper opportunity to request a chaperone?
- Chaperone education.

3. Consideration of the Tools Available To Address Any Deficiencies/Concerns That Are Identified
    a. COUNCIL
        i. Amendment to existing by-laws, standards of practice and practice
        ii. Recommending legislative amendments to Government.
    b. THE REGISTRAR
        i. Allocation of resources
        ii. Internal policies and practices

    c. GOVERNMENT
        i. Legislative solutions
        ii. Funding source

    d. OTHER HEALTH CARE PROFESSIONAL GOVERNING BODIES & ORGANIZATIONS
        i. CRNM and other health care professional regulatory bodies in Manitoba
        ii. FMRAC
        iii. OTHER MEDICAL REGULATORY AUTHORITIES IN OTHER PROVINCES
        iv. CMPA

    e. EDUCATIONAL RESOURCES
        i. RADY COLLEGE OF MEDICINE
        ii. FEDERATION OF MEDICAL AUTHORITIES

The remainder of the Group's meetings involved a review of and detailed discussion about the various topics. The primary focus of the Group was on the Standard of Practice and the appropriate approach to penalty for sexual boundary violations. It also considered the other matters and formed recommendations in relation to them.

V. MATERIALS REVIEWED

1. Terms of Reference
2. Guidance for Setting Priorities and Developing an Action Plan – prepared by Lynne Arnason for this Working Group
3. CPSM Standard of Practice

4. IC Policy - Standard Approach for Cases of Physician, Patient Sexual Relationships – Former Version under *The Medical Act* – Under Review since enactment of RHPA
5. Independent Review of Sexual Misconduct Processes at the College of Physicians and Surgeons of Nova Scotia – June 2019
6. Standards & Policies from Other Jurisdictions:
    a. Standard of Practice – Boundary Violations: Sexual – College of Physicians and Surgeons of Alberta
    b. Guideline: Sexual Boundaries in the Doctor-Patient Relationship – Medical Board of Australia
    c. Practice Standard – Boundary Violations in the Patient-Physician Relationship – College of Physicians and Surgeons of British Columbia
    d. Professional Boundaries for Therapeutic Relationships – College of Registered Nurses of Manitoba
    e. Maintaining a Professional Boundary Between You and Your Patient – General Medical Council (UK)
    f. Intimate examinations and chaperones – General Medical Council (UK)
    g. Sexual behavior and your duty to report colleagues – General Medical Council (UK)
    h. Policy – Maintaining Appropriate Boundaries and Preventing Sexual Abuse – College of Physicians and Surgeons of Ontario
    i. Policy – Sexual Boundaries – Working Draft approved in principle in October 2019 - College of Physicians and Surgeons of Saskatchewan
7. Penalties for Sexual Misconduct / Abuse in other Provinces - prepared by Lynne M. Arnason - November 2019
8. Some of The Pros & Cons of Sentencing Options – prepared by Alan Fineblit and Lynne Arnason for this Working Group
9. The Impact of Trauma on Adult Sexual Assault Victims - Report Submitted to Justice Canada by Dr. Lori Haskell, C. Psych. And Dr. Melanie Randall
10. Policies / Standards approved since last meeting – but distributed for information and review:
    a. CPSNS - Professional Standards and Guidelines Regarding Sexual Misconduct by Physicians – approved March 2020
    b. CPSS – Policy – Sexual Boundaries – Amended March 2020

VI. DISCUSSION – STANDARDS OF PRACTICE

A. CURRENT STANDARDS IN OTHER JURISDICTIONS

The Group reviewed several examples of standards from other medical regulatory authorities in significant detail. This provided the members with important insight into various approaches in general and with very specific examples of content that they either

endorsed or rejected for various reasons. This Report will not review each standard in detail. Its focus is the general approaches in the standards that were reviewed and their impact on the Group's recommendations.

The standards in several provinces distinguish between sexual misconduct versus sexual abuse of a patient/former patient. Colleges or provincial governments have determined what the specific consequence will be to a member who is convicted of committing an act in that category. Alberta is one such example where, if a member is found guilty of sexual abuse, the penalty following a conviction is permanent loss of licensure. It defines these categories of conduct as follows:

- **Sexual abuse** – includes intercourse, genital to genital/oral/anal contact, masturbation in their presence, touching of a sexual nature of a patient's genitals, anus, breasts or buttocks.
- **Sexual misconduct** – any incident or repeated incidents of unwelcome conduct, behavior or remarks of a sexual nature that would cause offence, humiliation or adversely affect the patient's health and wellbeing.

Other provinces that use these or similar categories as giving rise to specific consequences include Ontario and Prince Edward Island and now to a certain extent Saskatchewan. For the most part, sexual abuse is defined in relation to behaviour on the part of the member involving a current patient to include sexual intercourse and other physical sexual relations including genital to genital, genital to anal, oral to genital, or oral to anal contact, masturbation by or of either party.

Sexual contact with former patients is also prohibited in these provinces, but for how long after the member/patient relationship ends that prohibition applies varies. For example, in Alberta the period is one year. In 2017, Ontario expanded its definition of patient to include "an individual who was a member's patient within one year or such longer period of time as may be prescribed from the date on which the individual ceased to be the member's patient".

The standard in BC is similar to Manitoba's current standard in many respects. It has a practice standard entitled Boundary Violations in the Patient-Physician Relationship which approaches sexual misconduct as a boundary violation. It provides examples of what physicians must do to maintain appropriate sexual boundaries. It states that termination of a professional relationship in order to pursue a personal or intimate relationship is considered unethical, but does not otherwise address former patients. Financial and social boundaries are addressed in the same document. There are no predetermined consequences for certain acts or categories of acts.

The general approach in Australia and the UK is similar to that taken in BC, Nova Scotia and Manitoba, although each have their own unique characteristics.

In the UK, the standard is essentially that a member must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them. The UK's General Medical Council publishes a guidance document that

explains what types of conduct is prohibited. It strongly discourages relationships with former patients and expressly states that it is not possible to specify a length of time after which it would be acceptable to begin a relationship with a former patient. It provides guidance as to the relevant factors to consider. It states that members who are not sure whether they are (or could be seen to be) abusing their professional position should seek advice about their situation from an impartial colleague, their defence body (equivalent to CMPA) or their medical association.

The approach in Australia is similar but particularly well reflected in its guidelines which describe a spectrum of behaviours that constitute breaching sexual boundaries. In relation to former patients, it states that it may be unethical and unprofessional for a doctor to engage in a sexual relationship with a former patient and identifies factors which make it unethical. The Group found its guidance document to be excellent in terms of its explanation of the range of conduct that constitutes conduct that breaches the standard.

The newly adopted standard in Nova Scotia, which is based on the recommendations of the Independent Review uses terms such as sexual abuse and sexual misconduct. It also incorporates sexual abuse into its definition of sexual misconduct, which it clearly states is prohibited. It also describes certain acts as "sexualized conduct" and includes such conduct in the definition of sexual misconduct. The document which combines the standard and guidelines does not set out any predetermined consequence but makes clear what the College will normally seek as a penalty for certain acts of sexual misconduct. More will be said on this later when addressing penalties for sexual boundary violations.

B. CURRENT STANDARD IN MANITOBA

The Current standard in Manitoba is incorporated into By-law 11 as part of the College's Standards of Practice of Medicine as sections F, G and H:

F. Maintaining Boundaries: Current Patients

8(1) A member must maintain appropriate professional boundaries in any interaction with a current patient. Examples of prohibited conduct include:

(a) initiating any form of sexual advance toward a patient;
(b) responding sexually to advances made by a patient; and
(c) not taking appropriate steps to respect the patient's privacy and dignity when conducting or offering to conduct a physical examination.

8(2) A member must not sexualize any interaction with a current patient. Inappropriate member-patient interactions of a sexual nature encompass a spectrum of behaviours, which may include:

(a) providing inadequate draping;

(b) not providing privacy while the patient is undressing or dressing;
(c) not offering the presence of a chaperone during a sensitive examination;
(d) being judgmental of a patient's sexual orientation or activities;
(e) sexualizing comments, gesture or tone of voice;
(f) requesting details of a sexual history when not medically indicated;
(g) not obtaining informed consent for intimate or sensitive examinations;
(h) using unorthodox examination techniques including inappropriate touching of the breasts, genitalia, or anus;
(i) sexualizing body contact, including kissing, hugging or fondling. This does not prohibit hugging in appropriate circumstances where there is no sexual aspect to the physical contact;
(j) socializing with a patient in the context of developing an intimate relationship;
(k) making member-patient sexual contact;
(l) scheduling appointments for examinations outside normal office hours.

This list is not exhaustive.

G. Maintaining Boundaries: Former Patients

9(1) Since the member-patient relationship is a fiduciary relationship and the characteristics of such a relationship may extend beyond the point in time when the member-patient relationship ends, a member must not initiate any form of sexual advance toward a former patient where there is a risk of power imbalance from the former member/patient relationship.
9(2) Where there is no continuing power imbalance, a member must not have any sexual or intimate involvement with the former patient for a period of time after the last member-patient encounter. The period of time depends on the nature and extent of the member-patient relationship.

H. Maintaining Boundaries: Psychotherapeutic Relationship

10 A member who has had a psychotherapeutic relationship with a patient must not engage in a sexual or intimate relationship with that patient at any time during or after the psychotherapeutic relationship.

C. RECOMMENDATIONS FOR THE STANDARD OF PRACTICE FOR MANITOBA

The Working Group carefully reviewed the existing Standard of Practice in Manitoba and reviewed several standards and guidelines from other jurisdictions. It identified some weaknesses and concerns with the current standard and recommended the express rejection of or adoption of certain features in the standards and guidelines from other jurisdictions.

1. The existing Standard did not provide the necessary context for members to fully understand the reasons for strict prohibitions on boundary violations with current patients or the reasons that relationships with former patients are problematic. The concept of a fiduciary relationship may not be understood by all if that language is used without more explanation and context.
2. The Standard was helpful in providing some examples, but the Group wanted to ensure that the Standard recognized that there are many shades of gray in relation to maintaining boundaries and that black and white categories and exhaustive lists of specific acts in specific categories for which there were mandatory penalties attached should be avoided. It recommended approaching boundary violations as being on a continuum and offering examples of prohibited conduct as opposed to exhaustive lists in specific categories drawing predetermined consequences.
3. The sexual abuse / sexual misconduct categorization was expressly rejected. The need for care in the use of labels was recognized as important. Not everyone who commits a boundary violation should be painted with the same brush.
4. Many liked the Australian document and adopted several of the recommendations of the Review done in Nova Scotia.
5. The Alberta and Ontario approaches to penalty which are the result of a legislative approach imposed on the Colleges in those provinces was rejected as the approaches do not recognize the need for a nuanced approach to a very serious and complicated set of concerns. There was a real sense that many cases would never be addressed because of challenges of prosecuting difficult cases and there being no incentive for members to cooperate as they have everything to lose if found guilty.
6. The Group felt that the standard of practice for sexual boundary violations should be a stand-alone document as a schedule forming part of the Standards of Practice bylaw and not a small section within the other more routine standards.
7. The definitions of patient and former patients were important and should be very clear. One of the keys to successful compliance generally is clarity as to what is permitted and not permitted and with whom.
8. An absolute prohibition on a sexual relationship with a former patient, other than for those which involve a significant psychotherapeutic relationship with that patient, was rejected as was setting a defined period of time for the prohibition to extend after a person is no longer a patient (such as one year). The Group

favoured a flexible approach with clear criteria. This conclusion was reached after much debate over the prohibition on relationships with former patients in the rural setting and the need to show some flexibility yet maintain adequate protection from the abuse of the power differential by a member pursuing a sexual relationship with a former patient in any setting. The group rejected the prohibition on ending a doctor patient relationship for the aim of starting a sexual relationship or a one year waiting period and asked for a more nuanced approach.

9. The group favoured inclusion of significant limitations on sexual relationships on those who are interdependent with a member's patient, such as the parent of a child patient. All recognized the vulnerability and the need for some protections.
10. The issues of chaperones and attendants for sensitive examinations such as genital/rectal/breast examinations was discussed at length. There was a need identified to develop a more clear and comprehensive approach to the issue. The Group did not develop a specific Standard of Practice or Practice Direction recognizing that requiring a chaperone or attendant in all circumstances had been rejected because of the difficulties it presents for sole practitioners and the complex nature of gender issues and properly trained chaperones/attendants. It determined that the failure to offer a chaperone should be a factor in this Standard and suggested that Council provide direction as to whether it was appropriate to establish more clear requirements as they relate to chaperones. Some of the issues highlighted for determination are discussed further at page 23 of this report.
11. The standard should address social media.
12. The Group was strongly in favour of the College / Registrar being a resource to go to for advice, input , or direction. This was considered particularly important for members considering a sexual relationship with a former patient. It feels that otherwise it could be perceived as setting members up for failure with a "gotcha" approach if they made uninformed decisions. It was determined that internal processes should be developed to avoid the pitfalls of the College providing input, including limiting such involvement to the Registrar as opposed to staff members and that the input should be limited to when a member is considering entering into a sexual relationship with a former patient as opposed to a member who may already be violating boundaries.

Based on the input and direction of the Working Group, a draft Standard of Practice was drafted, a copy of which is attached as Appendix 2. The Working Group recommends that the Standard of Practice attached as Appendix 2 be accepted by Council to be circulated for consultation with a view to it replacing the existing Standard of Practice following changes that may arise from the consultation process.

VII. DISCUSSION PENALTY / DISPOSITION

A. APPROACHES TO PENALTY

The approach taken to penalty varies significantly across Canada. There are essentially three different approaches taken:

1. **Mandated Minimum Penalties**
   The Group considered the approach taken in Alberta and Ontario where revocation of a member's licence is the mandatory penalty for committing sexual assault. In Alberta revocation is permanent. In Ontario, the member cannot apply for reinstatement for five years.

2. **Full Sentencing Discretion**
   The penalty is determined by the Inquiry Panel that hears the matter and determines the appropriate penalty based on the proven allegations and the evidence, the orders available to it in the governing legislation and in accordance with well established legal principles of sentencing. This approach is taken in several provinces, including Manitoba, BC and Nova Scotia.

3. **Presumptive Penalties**
   This approach stipulates penalties that should be imposed in the absence of extraordinary circumstances. They are intended to act as a guide as to what the consequences of a particular act will be both for the entity imposing the penalty and for the persons who may be subject to such penalties. The only province taking this approach is Saskatchewan.

1. Mandatory Minimum Penalties

In some provinces (Alberta, Ontario, Quebec and Prince Edward Island) the legislature has established mandatory revocation of the licences for members convicted of "sexual abuse" as that term is defined in that province's legislation.

In all but Alberta, where the revocation following conviction for sexual abuse is permanent, members can apply for reinstatement of their licence after 5 years. In Quebec, any form of sexual misconduct results in a period of revocation for five years unless a shorter period is justified in the circumstances, plus a fine of between $2,500 and $62,500.

Each of these jurisdictions have also defined "sexual misconduct" which usually involves making inappropriate gestures or remarks of a sexual nature for which the penalty is less severe. Penalties vary but include mandatory suspension of the member's licence for a defined period to be determined by the Panel who decides the matter.

2. Discretionary Penalties

The following information is from some provinces with discretionary penalties.

British Columbia

There is no legislation in place in British Columbia addressing sexual misconduct by physicians. The BC College advises that the most likely outcome for a sexual boundary violation is a suspension of up to two years, transfer to the disciplined class of registration, multidisciplinary assessment, and enduring practice conditions as directed by registrar staff or the Board. Completion of their boundary professionalism course is indicated. The BC College has a request for a change to the legislation under consideration, to be considered by the Board.

Newfoundland and Labrador

The information from the CPSNL was that recent penalty decisions for a "consensual sexual relationship" with a patient have included the following:

1) 19-24 months suspension
2) Boundary course (if re-licensed)
3) Chaperone for 1 year (if re-licensed)
4) Costs
5) Publication

The CPSNL had no current initiative to review this situation. There is no pending legislation.

New Brunswick

The CPSNB advised that, in December 2017, Dr. H was suspended for 18 months as a result of a "consensual sexual involvement" with a patient extending over 3 years. If he took an ethics and boundaries course acceptable to the College that suspension would be reduced to 12 months. Members of the community launched a petition asking that the suspension not be imposed.

Nova Scotia

There is no legislation in Nova Scotia directly addressing sexual misconduct by physicians. When the Group was first considering this issue there had not been any recent penalty decisions related to sexual abuse, so it was uncertain what approach would be taken to imposing penalty in such a situation.

Shortly before the Working Group was formed, an independent legal review of the CPSNS's approach to addressing sexual misconduct had been conducted by the Canadian Centre for Legal Innovation in Sexual Assault Response (CCLISAR). The CCLISAR's comprehensive report was shared with the Working Group and it was considered to be very relevant, informative and helpful.

In March 2020, the CPSNS adopted its Professional Standards and Guidelines Regarding Sexual Misconduct by Physicians. That document sets out both standards and guidelines regarding sexual misconduct and was informed by the independent review. The following section from that document reflects the CPSNS approach to penalty.

> *5.0 College's Approach to Complaints Alleging Sexualized Conduct*
>
> 5.1 The College recognizes the authority of the Investigation Committee and the Hearing Committee under the *Medical Act* to make findings and to determine the disposition of matters brought before them. As a party in a proceeding under the *Medical Act*, the College will take the following positions:
>
> > 5.1.1 Sexual misconduct involving a current patient or a vulnerable former patient constitutes professional misconduct[9] within the meaning of the *Medical Act;*
> >
> > 5.1.2 Sexualized conduct by a physician with a former patient that runs contrary to Article 3.2 also constitutes professional misconduct within the meaning of the *Medical Act;*
> >
> > 5.1.3 Sexualized conduct by a physician that is entirely unconnected to the physician's medical practice, his or her status as a physician, or the medical profession may constitute "conduct unbecoming"[10] as defined in the *Medical Act*, if the sexualized conduct tends to bring discredit upon the medical profession;
> >
> > 5.1.4 Where there is a finding of either professional misconduct or conduct unbecoming that constitutes sexual abuse, the College will seek the revocation of the physician's licence.
> >
> > 5.1.5 Where there is a finding of professional misconduct or conduct unbecoming arising from a finding of sexual misconduct that does not constitute sexual abuse, the College will seek a licensing sanction against the physician. The licensing sanction will be commensurate with the relevant circumstances. A licensing sanction creates a disciplinary record for the physician, and can include one or more of a reprimand, conditions or

restrictions, periods of suspension from practice, or a revocation of the physician's licence.

5.1.6 Where an intimate medical examination or procedure is clinically indicated but is performed contrary to acceptable standards in a manner that does not constitute sexual misconduct, the College will consider whether to address the actions of the physician as "incompetence" as defined in the *Medical Act*,[11] or as a matter that should lead to a non-disciplinary outcome such as advice, remedial education or a caution.

5.1.7 Where there is any other finding of a breach of these Standards, the College will seek a disposition that is commensurate with the relevant circumstances.

3. Presumptive Penalties

Saskatchewan

In March 2020, the Council of the CPSS approved a policy which includes the adoption of a presumptive penalty of revocation and no ability to apply for reinstatement for 5 years for its members convicted of sexual abuse. It is the only jurisdiction in Canada to take this approach.

Key elements of the CPSS policy in this regard include the following:

- There is a "presumptive penalty" of revocation of the licence of a member convicted of the most serious forms of sexual misconduct, including any of the following:
    a) sexual intercourse between a regulated member and a patient of that regulated member;
    b) genital to genital, genital to anal, oral to genital, or oral to anal contact between a regulated member and a patient of that regulated member;
    c) masturbation of a regulated member by, or in the presence of, a patient of that regulated member;
    d) masturbation of a regulated member's patient by that regulated member;
    e) encouraging a regulated member's patient to masturbate in the presence of that regulated member;
    f) touching of a sexual nature of a patient's genitals, anus, breasts or buttocks by a regulated member.

- The presumptive penalty for such sexual misconduct will include the following:
  a) An inability to apply for restoration for a minimum period of three years;
  b) A requirement that before applying for restoration, the member must provide a satisfactory report from a professional person, persons or organization chosen by the Council which attests that the member has undertaken counseling at the member's expense for sexual misconduct, has gained insight into the matter and has achieved a measure of rehabilitation which protects the public from risk of future harm from the regulated member.
- The adoption of such a "presumptive penalty" does not bind the Council to impose that penalty, and there may be extraordinary circumstances in which that penalty may not be appropriate.
- The Council may:
  a) consider whether any additional conditions should be imposed as a precondition for the regulated member to apply for restoration; and/or
  b) impose a longer or shorter period of ineligibility to apply for restoration.
- In considering whether the Council should impose a period of ineligibility of more than three years, a significant factor should be the degree of vulnerability of the patient in the relationship with the physician. Among the factors which may justify a more significant period of ineligibility to apply for restoration are the following:
  a) If the physician has provided psychiatric treatment to the patient (including psychotherapy);
  b) If the patient has a mental health disorder;
  c) If the conduct may reasonably be regarded as a criminal sexual offence.

B. CURRENT MANITOBA APPROACH

The approach of this College is based on the following principles:

- All allegations of sexual impropriety are investigated vigorously and prosecuted if the standard for referral to inquiry is met with the primary focus being the public interest and protection.
- Sexual impropriety is treated as a very serious failure to maintain boundaries and the severity of the conduct is assessed along a continuum.
- Penalties imposed must be consistent with previously decided cases involving similar circumstances.
- Conduct is not categorized by the nature of the act and there are no fixed penalties associated with any particular conduct and, in seeking penalty, the Investigation Committee considers the individual circumstances of each case with a focus on the College's public protection mandate in determining the penalty/orders it seeks to address the misconduct.

The following is an overview of the outcomes for matters involving sexual allegations based on shared insight from the perspective of the people who investigate and prosecute cases involving sexual allegation. The information below was presented by Dr. Bullock Pries. It represents an analysis of the allegations of sexual abuse & sexual misconduct reviewed by the CPSM from 2006 through 2018.

Between 2006 and 2018 there were 54 boundary violation allegations considered in the Complaints & Investigation Department. If the allegations were divided into the categories used by other jurisdictions (sexual abuse vs misconduct) the matters would have been categorized as 45 allegations of sexual abuse and 9 of sexual misconduct. Of the 45 sexual abuse allegations, 8 involved a sexual relationship with a patient, 34 were inappropriate breast/pelvic examinations and 3 were other (assault, masturbation etc.)

In terms of penalties for sexual boundary violations, it has been a number of years since a member has been disciplined for what some describe as a "consensual sexual relationship" with either a patient or former patient. Based on past cases, the most likely penalty if that was to occur would be revocation unless there is an assessment supporting the potential of remediation for the physician. If there is an assessment indicating potential remediation, there would likely be an indefinite suspension, with a minimum period of suspension measured in years, until a multidisciplinary assessment and report supporting re-entry is received. There are usually fairly strict conditions on re-entry.

A summary of the cases for which members have been convicted of boundary violations in the past twenty years follows. The names of the physicians have been omitted due to statutory restrictions on publication of disciplinary action on the internet.

> *Dr. 1* (2018) Dr. 1 pleaded guilty to misconduct which went far beyond transmitting an extraordinary number of salacious and manifestly unprofessional and inappropriate text messages to his was 17-year-old patient. He also committed other serious boundary violations in relation to Patient A, such as meeting her outside of the Clinic for personal reasons on at least five occasions, giving her a series of expensive gifts and offering to loan her $4,000.00 to assist in the purchase of a car. Dr. 1 also inappropriately prescribed of various medications. Dr. 1 was suspended for a period of 12 months and was only allowed to return subject to very strict conditions, including supervision and a chaperone being present for every encounter with a female patient, counselling, etc. None of his chaperone and supervision requirements were removed.
>
> *Dr. 2* (2018) involved inappropriate relationships with two individuals, in each of which there were isolated instances of <u>non-consensual</u> sexual touching. The context for both was predominantly a physician-learner relationship, though each case had a physician-patient aspect. A joint recommendation for an indefinite suspension was accepted. Consideration was given to Dr. 2's having been out of

practice for 3 years in determining penalty, which included a minimum 6-month period of suspension and indefinite suspension pending a satisfactory fitness to practice assessment. In 2019, Dr. 2 unsuccessfully applied to the Inquiry Panel to have the conditions on his return to practice altered and to allow him to return. He has yet to return to practice. If that occurs, his return will be graduated and supervised.

Dr. 3 (2012) involved a consensual sexual relationship with two patients. In each case, Dr. 3 also engaged in inappropriate prescribing of drugs of potential abuse. Based on a joint recommendation that recognized Dr. 3 had been out of practice for a period of 2 years prior to penalty being imposed, he was suspended for a minimum of 6 months and indefinitely pending a satisfactory fitness to practice assessment. Dr. 3's return to practice, if that occurs, would be graduated and supervised. Dr. 3 has yet to return to practice.

Dr. 4 (2010) involved a consensual sexual relationship with two patients. In each case, Dr. 4 also engaged in inappropriate prescribing of drugs of potential abuse. Revocation was jointly recommended. Dr. 4 has thrice unsuccessfully applied for reinstatement. He has consistently been found to have failed to demonstrate adequate rehabilitation.

Note: Because of the relatively few cases involving conviction for sexual boundary violations, the following two cases have been included to provide as much meaningful background as possible. The names of the members have been excluded as the matters are more than 10 years old and the RHPA includes limitations on publication of such matters.

Re Dr. X (2004) involved a consensual sexual relation with an extremely vulnerable patient. Sexual intercourse did not occur until after the active patient care relationship had concluded. Dr. X's licence was revoked. He was reinstated in December 2004 with strict conditions and supervision. Monitoring is ongoing.

Re Y (2003) involved a consensual sexual relation with a patient over an extend period and other instances of professional misconduct related to boundary issues. Dr. Y's licence was revoked in 2003. He was reinstated in 2007 on strict conditions and supervision. Monitoring is ongoing.

There is no pending legislation nor has there been any indication of there being any legislation introduced in Manitoba to restrict the College in the approach it takes to these cases.

C. RECOMMENDED APPROACH TO PENALTY / DISPOSITION

The Working Group was specifically asked to consider and make recommendations as to whether the College should move towards minimum penalties and, if so, how that could be achieved. It also considered the approach taken in Saskatchewan where the CPSS has adopted presumptive penalties for certain acts of sexual misconduct.

It is important to understand who makes decisions as to what is an appropriate penalty for sexual boundary violations and the context in which those decisions are made. In Manitoba, *The Regulated Health Professions Act* requires that, if an Inquiry Panel makes findings that a member has committed certain acts, such as professional misconduct or demonstrating a lack of care, skill and judgment in the practice of medicine, it is then tasked with addressing those findings by making appropriate orders. The orders a Panel makes are set out in the RHPA and include measures that are generally considered punitive and others that are remedial in nature. Revocation of a member's licence is the most serious order available to a Panel. Suspensions can vary in length and can be linked to certain things occurring such as treatment or remediation. Those orders are often referred to as the penalty.

In the context of allegations involving sexual boundary violations, it is important to note that there are many complicated steps that must be completed before a penalty hearing and all of these steps are dictated by the College's legislative requirements and administrative legal requirements of fairness. The Working Group noted that in order to understand penalties and determine the best approach to take, it is essential to understand the process. For that reason, the following information is provided so that Council has the necessary context.

- When the College receives a complaint or is made aware of allegations for sexual boundary violations from another source such as a physician to whom a patient reports the allegations about a member, the matter is reviewed on an urgent basis.

- All serious allegations of sexual impropriety are referred directly to the Investigation Committee as opposed to being dealt with by the Complaints Committee as a first step;

- The allegations will be investigated thoroughly and as quickly as possible an assessment is made as to whether there is a need to take interim action to protect the public pending a final disposition of the matter. This will usually involve the following:
    - consideration of interim suspension or restrictions such as mandatory chaperones, supervision, etc. while the investigation proceeds;
    - review of the written allegations of the patient and written response of the member;
    - interviews with the patient and the physician;
    - review of medical records;

- where the physician cooperates, information from a psychiatric/boundary assessment;
- interviews of any other parties with relevant knowledge such as a chaperone, other health care provider, family member or friend
- collection and review of other relevant documents
- consultations with expert consultants in appropriate cases.

- The Investigator will prepare a report and the member will have an opportunity to respond to that report. The matter will then be considered by the Investigation Committee;

- If the Investigation Committee has determined that the concerns are very serious and remedial efforts alone are not appropriate or sufficient, or the member does not agree to conditions on their practice, the Committee will consider issuing charges of professional misconduct to be referred to the Inquiry Committee to conduct a hearing. It is up to the Investigation Committee to determine if the allegations are serious enough to warrant charges of misconduct, whether there is sufficient evidence to establish that the charges could successfully be proven (based on a balance of probabilities), and whether it is in the public interest to do so. All cases involving serious allegations of sexual boundary violations will be referred to inquiry where the threshold for referral is met.

- When a matter is referred to Inquiry, a hearing of the allegations against the member are determined by a Panel at a hearing. It usually takes place at the College and is similar to a trial, but less formal and subject to different rules. Lawyers representing the Investigation Committee present their case to a panel of 3 (2 doctors and one public representative). The member is usually represented by their own lawyer. The panel is provided with independent legal advice and that lawyer sits through the entire hearing and assists with the decision making process and writing of the decision after the hearing concludes.

- Like a trial, the member can plead guilty or not guilty to all, or some of, the charges. In addition, the member may admit some or all of the facts underlying the allegations. If the member acknowledges the conduct and pleads guilty to the charges, the hearing consists of reviewing evidence compiled in an Agreed Statement of Facts. If the member and the College agree on a recommended penalty, this is offered to the panel for their consideration as a Joint Recommendation as to penalty. Every effort is made to reach agreement where possible. This usually involves compromise by both sides, but ensures that the essential allegations are proven and made public without the necessity of a lengthy contested hearing, the result of which could be that the allegations are not proven and there is no publication as required by the RHPA. Where witnesses are reluctant to testify or there are issues with proving a case, negotiated resolutions are a particularly important way that some action can be taken to protect the public through a negotiated resolution, recognizing that if the member is acquitted on all charges, there is no penalty or publication of the hearing. In

such cases the hearing is often only one day, and the panel takes time to consider the issues and recommendations before issuing its report with reasons.

- If the member pleads not guilty to the charges, a longer hearing is necessary. Evidence is presented and witnesses testify and are cross examined. A court reporter records the process. The hearing can take several days or even several weeks if the issues are complex and no agreements on evidence can be reached. At the conclusion of the hearing, the panel considers the evidence and issues their notice of decision. If there is a finding of guilt, there will be a further hearing to consider arguments about the applicable penalty and costs. If not, that concludes the matter.

The Working Group was satisfied early on in its review of available options that mandatory minimum sentences and permanent revocation in particular was not an appropriate option. It rejected the approach for several important reasons, including the following:

1. Not all cases are the same. The individual circumstances are important.
2. The risks of an "all or nothing" approach to hearings where a member has nothing to lose by vigorously defending the charges are too great. This is particularly so given:
    a. the challenges of prosecuting cases involving sexual boundary violations where the case often turns on credibility in the classic "he said/she said" scenario;
    b. the reluctance of many victims to participate fully in the process, including testifying and being subject to cross-examination.
3. There are so many nuances in each case and those nuances need to be considered at all levels, including the final penalty.
4. Despite impressions based on media reporting, when the Group analyzed the penalties in the cases in this jurisdiction for the past decade, it realized that they generally were reasonable and served the public protection, deterrent and other sentencing goals.
5. Mandatory penalties are often seen as arbitrary and unfair. The Supreme Court of Canada has struck them down in the criminal context for that reason.

The Group was quite interested in the approach taken in Saskatchewan and considered full sentencing discretion left with the Panel to presumptive penalties from a pros/con perspective as set out below:

<u>Full sentencing discretion</u>

Pros:

- It allows panels to choose the right penalty for the specific facts presented;
- It increases the chances that the case can be settled because the CPSM lawyer has freedom to negotiate. (Consider the Dr. 1 case and protecting the 17 year old patient from testifying)

- This means the patient is forced to testify less often and reduces the likelihood of an acquittal on a technical issue or because a witness does not perform as expected. This is important because if the physician is not convicted, the CPSM can do nothing and the name of the physician is not published;
- It allows for the integration of creative resolutions that specifically address the physician's issues. Many of these cannot be imposed by a panel as a penalty but are available if the parties agree.
- Some of the creative solutions ensure that the Investigation Committee, which has full knowledge of the circumstances, can maintain control over if and when the physician returns to practice (for example – consider the case of Dr. 2 summarized above)

Cons:

- Opens the door to a penalty that is inappropriate because a hearing panel departs from precedent. (Keep in mind that most panel members have limited experience and training with cases of this kind). Training should address the concern;
- May put the CPSM at risk of public criticism or political intervention if the penalty is seen as inadequate (unless the penalty is revocation, this is often the case);
- Could result in more variation in sentencing (2 similar cases have different outcomes)
- Could result in reduced penalties simply because they are available and the lawyer for the physician will press hard for a reduced penalty (this is less likely with a presumptive penalty).

<u>Presumptive penalty</u>

Pros:

- It has the potential to create more consistency in penalties;
- It simplifies the role of hearing panels;
- In rare cases which are not difficult to prove, it may provide greater assurance that the presumed penalty is imposed, but it may also unduly shift the focus very early in the investigation on penalty.
- It may make it less likely that there will be public criticism of a penalty.

Cons:

- It makes it more difficult to resolve cases, particularly those cases which are difficult to prove;
- It makes the process more difficult for patients who may need to give evidence and be cross examined;
- It reduces the ability to tailor a disposition to the unique circumstance of that particular matter.
- It introduces legal issues as to the impact they have on a Panel's discretion to determine the appropriate penalty.

After much discussion, the Group unanimously favoured maintaining a full sentencing discretion approach to penalty.

VIII. CHAPERONES / OBSERVERS

The Group grappled with the difficult issue of chaperones and observers and recognized that the approach to chaperones and observers in Canada, the UK and Australia and New Zealand varies. That said, in most jurisdictions the use of chaperones is strongly recommended but not required. Some require that a chaperone be offered and set out a process for when it is refused. The CPSA has developed a training course for chaperones to help them understand the roles and responsibilities of a chaperone which is available to any of the physician's office staff.

Council should be aware that the College communicated to the profession what it considered to be best practices for the use of chaperones in a newsletter article in 2014:

1. The presence of a chaperone should be explained to the patient before the examination takes place. Notices in the waiting room and in the examination rooms may be helpful.
2. The chaperone must be properly trained to recognize what constitutes a proper examination, to recognize and deal with patient discomfort, and to know what to do during a sensitive examination.
3. The chaperone should be capable of supporting and reassuring a patient as necessary, and may assist with aspects of the examination, for example providing lubricant or gloves for the physician
4. The chaperone should not be a member of the patient's family, although the patient may wish to have a family member present in addition to the chaperone.
5. The identity of the chaperone should be recorded in the medical record.

Remember that a patient always has the right to request a chaperone be present for any examination.

The Working Group considered a number of issues surrounding the use of chaperones/ observers, including the following:

1. Concerns about the challenges a mandatory requirement of a chaperone being present for all intimate examinations presents for solo practitioners and some practice settings. In such circumstances a family member or receptionist may be available, but it is unlikely that someone who has received specialized training would be available.

2. Linking chaperone requirements to a specific gender of patient is very problematic in relation to patients who identify outside of the gender binary on which traditional requirements have been based.
3. Some patients may prefer not to have a chaperone/observer present.
4. In the private practice setting, there should be someone available to act as a chaperone for the benefit of both the patient and the member and the patient must be advised when the member requires that a chaperone be present and consent in advance of the examination taking place in the presence of the chaperone.
5. Some physician members have observed that most female patients prefer a female chaperone.
6. Where a chaperone is mandated because of specific concerns about a member, the chaperone should be aware of the issues and have had training to provide a greater assurance that examinations will be conducted appropriately.

The consensus of the Group was:

1. The College should not mandate that chaperones be present for all intimate examinations (genital/rectal/breast) but should make clear to its members that chaperones should be offered to all patients before an intimate examination is initiated. It did not determine whether offering a chaperone should be mandatory but is strongly of the view that the College should set out its expectations surrounding the use of chaperones more clearly.
2. In situations where chaperones are required by the College, there should be vetting and training. It recognized that for members who have committed sexual boundary violations, having a chaperone may not be adequate to protect the patient.
3. The Group determined that the failure to offer a chaperone should be a factor in the College's Standard of Practice; and
4. Recognizing that requiring a chaperone or attendant in all circumstances had been rejected because of the difficulties it presents for solo practitioners and the complex nature of gender issues and properly trained chaperones/attendants, the Working Group recognized the need for the College to establish a process that would facilitate a more comprehensive review of this important aspect of providing good medical care. The Group recommends that:
    a. Failure to offer a chaperone should be a factor in this Standard; and
    b. Council should provide specific direction to establish more clear requirements as they relate to chaperones and observers and whether a specific Practice Direction or Standard of Practice should be developed.
    c. At a minimum, an updated indication of best practices should be circulated to the profession.

IX. COLLEGE PROCESS FOR COMPLAINTS INVOLVING SEXUAL BOUNDARY VIOLATIONS

Some of the initiatives already underway in the Complaints and Investigation Department, including the following were discussed by the Working Group:

1. Staffing and Training
    a. The Department is actively pursuing training for staff in the trauma informed approach to investigating and prosecuting cases involving sexual boundary violations. They have already been doing some reading and are planning for training from experts in the field. This training will include key staff members.
    b. Training will also be required of all potential panel members. In addition, specialized training, including the trauma informed approach will be required of potential Inquiry Panel members. The Group endorses that there should be education on what a trauma informed approach is and that an expert in the field should do this training. It also recommended that only Inquiry Committee members who have completed this training should sit on Panels which hear matters involving sexual boundary violations.
    c. The Department has hired a Social Worker whose primary role is to provide ongoing direction and support to complainants as they navigate/move through the College's complaints and investigations process. While not acting as a counsellor, this person will have personal contact with complainants to assist them as needed and as appropriate and will provide particular support and ongoing contact with complainants alleging sexual boundary violations. The Working Group endorses this initiative.
2. Updating and creating separate information sheets for patients with complaints involving sexual boundary violations.
    a. The Group supports developing a brochure (web and paper) specifically dealing with sexual boundaries setting out in plain language what the rules are, what patients' rights are and what they should do if they have a concern about a sexual boundary violation. The Group made the following specific suggestions which have been passed on to those who are working on this project:
        i. It was noted that the document says that the complaint may end the doctor/patient relationship and the patient may have to find a new physician. This is concerning and the Group is of the view that the College should offer some assistance in finding these people new physicians. It was also noted that this may not be possible.

ii. The Group referenced the Nova Scotia trauma informed model and reiterated that there should be a different form for these types of issues that is more supportive than what currently exists.
iii. The suggestion was made that the form should perhaps provide some detail about the kinds of complaints that are boundary violations.
iv. The need to identify an appropriate terminology to describe those who complain was discussed. It was suggested that consideration be given to not using "complainant" but that care also be taken to avoid gender specific pronouns
v. One member commented on question 7 on the current form in that it allows people to feel a sense of justice and wondered about the possibility of a form to be filled out at the end of the process (i.e. an exit interview)

3. Supports to complainants and members throughout the process
   a. The Group was informed that the College has supported a couple of complainants by paying for some counselling for a limited period of time. The Group endorses this approach and recommends that it be continued.
   b. Staff also informed the Group that funding for independent legal counsel has been provided to patients whose records regarding psychiatric counselling were sought by the accused member. It also endorses this approach and recommends that it be continued.
   c. Supports for members accused of sexual boundary violations was also discussed by the Group. It was noted that Doctors Manitoba has programs available to its members. The Group was assured that the College takes this concern very seriously and puts all members in touch with MD Care and/or Physicians At Risk and encourages treatment. The Investigation Committee usually relies on CMPA to help physicians access these resources. In appropriate cases, the member is referred to the College's Physician Health Program. It was noted that the College always warns the physician's counsel when the publication is going up as the College is always worried about the ramifications for physicians and the incredible stress this puts on them.

X. THE HEARING PROCESS

The Group considered several specific aspects of the hearing process:

1. Publication Bans

The Group was advised that normally hearings are open but that there is a ban on publication of the identity of the patient both during and after the hearing. Decisions are

always published without identifying the patient. The member's name is always included if there are findings made against the member, but the legislation requires that the members name not be published if the member is not convicted. It was noted that members have a huge fear of their names being published and that was an important deterrent.

No changes to the current approach is recommended.

2. Open versus Closed Hearings

The RHPA requires that a hearing must be open to the public unless otherwise ordered by the Panel hearing the matter. It allows for a **request for an order that a hearing be private or that a person be identified only by initials**. The panel may make such an order on the request of the investigated member or the college, or on the panel's own initiative, but only if the panel is satisfied that:

a) matters involving public security may be disclosed;
b) financial, personal or other matters may be disclosed that are of such a nature that the desirability of avoiding public disclosure of those matters outweighs the desirability of adhering to the principle that meetings be open to the public;
c) a person involved in a civil or criminal proceeding may be prejudiced; or
d) a person's safety may be jeopardized.

Some members of the Group favoured the Nova Scotia recommendation that the hearing be "closed", but recognized the need for the member and complainant to have support with them.

Legal counsel advised that there is rarely media present at a hearing and that the Investigation Committee goes to great lengths to protect the identity and privacy of complaints and their families. Orders are sought and usually granted with the consent of the member. This has not been an issue of concern in Manitoba.

The Group recommends that the current approach be maintained.

3. Victim Impact Statements

The Working Group endorsed the use of victim impact statements and feels that all patients who wish to file one should be provided with the opportunity to do so. It recognized that care should be taken in terms of their use.

4. Options on Testifying

The Group's discussion was focused on the possibility of offering complainants with alternatives if they are uncomfortable testifying and being in the same room as the accused member. It concluded that counsel prosecuting the case should be encouraged to be sensitive to those

who are uncomfortable testifying and consider, where appropriate, proposing alternative approaches to the hearing panel that might increase patient comfort. These might include the use of video testimony or screening devices.

5. Cross-examination by self-represented members

While most physicians are represented by counsel at hearings, in the rare instance when they are self represented, the Group was of the view that it is inappropriate to permit the accused member to personally cross examine the complainant. It recommends that should that situation arise, counsel prosecuting the case seek an order from the Panel requiring the physician to retain someone else to conduct the cross examination.

6. Consultation with the complainant before reaching agreed resolution

The Group recognizes that complainants cannot direct how a particular case is prosecuted or its outcome. That said, it also recognizes that they have an important role in the proceedings and their interest in the outcome must be respected. As such, it recommends that complainants generally be advised of and asked for their input when major decisions that impact their participation in the process or the outcome are made, recognizing there are limited circumstances when it is neither possible nor advisable to involve the complainant in such decisions, such as where the complainant has serious mental health issues and consultation might be harmful.

XI. EDUCATION AND RESOURCES

The Group recommends that there be training and education for all members as to what is a boundary violation, other than the obvious. It encourages the College to be proactive and reach out to the Rady College of Medicine in relation to education and training of physicians. It also encourages to provide educational materials and resources on the College's website

The Group recognized the educational value of every decision of an Inquiry Panel. The Group suggested that information about each published decision should be accompanied with an explanation of it at a grade 6 reading level to ensure that it is understood by not only members of the profession but also members of the public.

XII. SUMMARY OF RECOMMENDATIONS

1. The Standard of Practice attached as Appendix 2 be accepted by Council to be circulated for consultation with a view to it replacing the existing Standard of Practice following changes that may arise from the consultation process.

2. The College should continue to follow the full sentencing discretion approach to penalty, recognizing the authority of the Investigation Committee to oversee investigations and prosecutions of cases involving sexual boundary violations and individual Inquiry Panels under the RHPA to make findings and to determine the disposition of matters brought before them.

3. The Investigation Committee should consider developing clear policies or guidelines as to appropriate considerations in relation to penalty for boundary violations involving sexual contact with patients and sexualized interactions with patients, and former patients. For example, it may wish to consider that, absent extraordinary circumstances, the Investigation Committee which oversees the prosecution of the matter involving sexual intercourse or other sexual contact with a current patient will seek revocation of the member's licence. Extraordinary circumstances may include such things as reluctance or limitations on the ability of the patient/victim to fully participate in the hearing process and the availability of other means to achieve an appropriate level of public protection.

4. The College should educate and train its staff employed in the Complaints and Investigation Department and potential panel members on the trauma informed approach to investigating and prosecuting allegations involving sexual boundary violations. An expert in the field should do this training. Only Inquiry Committee members who have completed this training should sit on Panels which hear matters involving sexual boundary violations.

5. The Working Group endorses the hiring of a Social Worker whose primary role is to provide ongoing direction and support to complainants as they navigate/move through the College's complaints and investigations process who will provide particular support and ongoing contact with complainants alleging sexual boundary violations.

6. New materials should be developed which include a specific form and brochure (web and paper) specifically dealing with sexual boundaries setting out in plain language what the rules are, what patients' rights are and what they should do if they have a concern about a sexual boundary violation.

7. The College should build on training for medical students on boundary issues by working with the Rady College of Medicine. It should also consider offering CPD sessions and publish educational materials with useful practical guidance, tips and FAQs.

APPENDIX 1

CPSM Working Group
Terms of Reference:
Boundary Violations, Sexual Involvement with a Patient

Initial Approval: September 13, 2019

Section 1: Background

As societal values evolve, the College of Physicians and Surgeons must reconsider whether the public interest and patient safety are being served with the appropriate standards of practice and procedures regarding boundary violations – sexual involvement with a patient. CPSM Council passed a motion in June 2019 to establish a Working Group to review this issue.

Section 2: Purpose

The purpose of the Working Group is to review and determine the appropriate standards of practice and procedures regarding boundary violations – sexual involvement with a patient, whether sexual misconduct or sexual abuse. The Working Group should consider whether changes and/or amendments are to be recommended to Council. These recommendations are to be provided to Council in fall 2020.

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 whether there is a need to revise the Standards of Practice on Boundary Violations, and if so, then make such recommendations.
- To consider whether the College is regulating boundary violations by its members within its legislated duty to serve the public interest:

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

- To consider whether legislative amendments should be recommended to Council for discussion with Government.
- To consider whether policies and practices of the College in addressing boundary violations are appropriate and make recommendations to address any deficiencies/concerns are identified

- To specifically consider the movement towards minimum penalties in other jurisdictions and make recommendations as to whether the CPSM should move towards minimum penalties and, if so, how that could be achieved.

Section 4: Chair and Membership and External Resources

4.1 Chair

The Committee will be chaired by Mr. Allan Fineblit.

4.2 Membership

Working Group Membership is to include diverse representatives from:

- CPSM (President, President Elect, Registrar and Assistant Registrar)
- Members of CPSM, including an ethicist
- Psychological Association of Manitoba
- Klinic Community Health Centre
- Women's Health Clinic
- Physician and Public Representatives from CPSM Council

4.3 External Resources

Recognizing the wide societal importance of this issue and legal matters involving such cases, the Working Group may seek advice from a Crown Attorney (or former Crown Attorney) to assist on the criminal and evidentiary aspects of sexual assault and abuse cases.

The Working Group may seek the advice from a psychiatrist specializing in boundary violations of regulated health care professionals to ensure that the Working Group are knowledgeable about the psychiatric rationale for such behaviour and current treatment for physician offenders.

Other sources identified by the Working Group or its Chair and as approved by the Registrar.

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 the College. Meetings will also be attended by the both the Director and General Counsel of Complaints and Investigation, who will also coordinate administrative support for the Working Group

5.2 Records of Discussion and Decisions

A record of Discussion/Decision will be produced following each meeting and circulated to the member of the Working Group, preferably two weeks after the meeting.

Section 6: Accountability and Reporting

The Working Group shall prepare a report to CPSM Council recommending:

- Any need to revise the Standards of Practice on Boundary Violations, and if so, then make such recommendations.
- Any need to recommend legislative amendments.
- Any need to revise the practices of the College in addressing boundary violations more appropriately.

At all times it is paramount for the Working Group to consider whether the CPSM is regulating boundary violations by its members within its legislated duty to serve and protect the public interest and in accordance with its other legislative and common law obligations to both the public and its members.

APPENDIX 2

SCHEDULE N

SEXUAL BOUNDARIES WITH PATIENTS, FORMER PATIENTS AND INTERDEPENDENT PERSONS

1. Purpose

This standard or practice:

(a) sets out the mandatory requirements of members for establishing and maintaining appropriate boundaries with their patients, former patients and persons who are interdependent with their patients;

(b) prohibits sexual contact and sexualized interactions of any kind between members and their patients;

(c) identifies the spectrum of conduct and behaviours which are considered to be sexual contact and sexual interactions;

(d) strictly limits sexual contact and sexualized interactions with former patients and persons who are interdependent with a member's patient;

(e) provides important context for understanding what is required of members to maintain strict sexual boundaries with their patients, former patients and persons who are interdependent with their patients; and

(f) compliments all other relevant standards of practice and the *CMA Code of Ethics and Professionalism*.

2. Foundation of the relationship

The unique nature of the relationship between patients and the people from whom they seek medical care is the foundation for prohibiting sexual contact and sexualized interactions between a member and their patient and strictly limiting sexual contact and sexualized interactions with former patients and persons who are interdependent with a member's patient. Important features of this unique relationship, often described as a fiduciary relationship, include the following:

(a) The relationship between a member and their patient must be understood in the context of the following ethical pillars of members' obligations as reflected in the CMA *Code of Ethics and Professionalism*:

i. Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient.

ii. Never exploit the patient for personal advantage.

(b) The relationship between a member and their patient is a professional relationship founded in trust and characterized by a power imbalance which extends beyond the termination of the relationship.

(c) Patients are by definition vulnerable when seeking medical care because:

i. they rely on the specialized training and knowledge of members to diagnose and treat them; and

ii. diagnosis and treatment calls for patients to allow members to touch parts of their body and access their personal information because of members' unique ability to provide them with the medical care they seek.

In this context, members must not use their position of power and trust to exploit patients physically, sexually, emotionally or psychologically.

(d) The boundaries of a relationship between a member and their patient are defined by the limits of appropriate clinical or professional conduct which is focused on the best interests of the patient. They require keeping an appropriate emotional and physical distance, the confines of which are defined by the nature and scope of the medical services sought and provided.

(e) The relationship between a member and persons who are interdependent with a member's patient is often subject to the same power imbalances as the member-patient relationship such that appropriate sexual boundaries with interdependent persons must be maintained.

(f) Patients who receive care from a member for mental health issues are particularly vulnerable and the power imbalance is enhanced.

(g) Good communication is essential to the relationship. Clear communication by a member with their patient as to what to expect during a clinical encounter, including the physical examination and taking a history, is the most effective way to avoid misunderstandings as to the purpose and scope of the clinical encounter.

(h) Failure to keep appropriate boundaries, especially sexual boundaries, prevents a member from providing objective care to a patient and results in harm to the patient.

3. Scope of this Standard of Practice

(a) To Whom and in what circumstances does it apply?

i. This Standard applies to all members and associate members of the College, including physicians, surgeons, clinical assistants, physician assistants, and all educational registrants.

ii. The requirements of this Standard apply to all encounters with patients, former patients and persons who are interdependent with a member's patient in any setting, whether in person or through electronic communication and is not limited to encounters for the purpose of providing medical care.

(b) Who is a patient for the purposes of this Standard?

i. A patient includes any person to whom a member provides medical care regardless of the setting in which that care is provided and may include a former patient as described below.

ii. A member provides medical care to a person when the member engages in one or more of the following activities in relation to that person:

1. gathering clinical information to assess the person;
2. providing a diagnosis;
3. providing medical advice or treatment;
4. providing counselling;
5. creating or contributing to a medical record;
6. charging or receiving payment for providing medical services; and
7. prescribing a drug for which a prescription is needed.

iii. A person is a patient of a member for the duration of any single encounter during which medical care is provided to that person by the member. That person remains a patient for a reasonable period of time after that encounter ends, including in between and following multiple encounters. What is a reasonable period of time depends on the circumstances of and surrounding the encounter (s), the patient and the member. For example, both a person who attends a member for single encounter at walk-in clinic and a person who has been seeing the member for regular care for many years since childhood are patients. In determining what is a reasonable period, the following factors are relevant:

1. whether there was a reasonable expectation that care would extend beyond a single encounter;
2. the number of encounters;
3. the length of time over which the encounter(s) occurred;
4. the length of time in between the encounters;
5. the duration of the encounter(s);

6. the degree to which the encounter(s) involved intimate examinations and/or the exchange of sensitive information;
7. whether care has been transferred to another member;
8. the nature and extent of the patient's vulnerability in relation to the member;
9. the nature of the care sought from or provided by the member;
10. the understanding of the patient in terms of the member's role in their medical care;
11. the circumstances that led to the termination of the member-patient clinical relationship following one or more encounters, including whether sexual contact between the member and the patient was contemplated by either of them before the clinical relationship ended;

iv. The criteria set out above is for the purposes of establishing who is a patient of a member for this Standard and may not apply to other circumstances.

4. Sexual Boundary Violations – the Spectrum of Prohibited Conduct

Sexual boundary violations are best viewed as prohibited conduct or acts along a continuum as opposed to an exhaustive list of specific prohibited acts or conduct which result in mandatory pre-determined consequences. Violations vary in severity and encompass a spectrum of conduct and behaviour. They range from failing to take appropriate steps to respect a patient's privacy and dignity when conducting or offering to conduct a physical examination or making sexually suggestive comments to committing sexual assault. It is important that members and patients understand the nature and scope of behaviours that fall within the spectrum of prohibited conduct while recognizing that the examples provide guidance but do not constitute an exhaustive list. The following provides guidance as to what constitutes member-patient sexual contact and sexualized interactions.

(a) Member-patient Sexual Contact

i. Any form of sexual contact between a member and their patient is strictly prohibited, regardless of the circumstances or setting, and the onus is on the member to ensure that appropriate boundaries are maintained.

ii. Member-patient sexual contact includes but is not limited to the following contact between the member and their patient, regardless of whether the member believes that the patient has consented to the sexual contact or the setting in which the sexual contact occurs:

1. sexual intercourse;
2. genital to genital, genital to anal, oral to genital, or oral to anal contact;

3. masturbation of a member by, or in the presence of, a patient;
4. masturbation of a member's patient by that member;
5. encouraging a member's patient to masturbate in the presence of that member;
6. the member fondling or sexually touching of any part of a patient's body, including the genitals, anus, breasts or buttocks of the patient. This does not include performing an appropriate physical examination of these body parts that is clinically indicated as part of an encounter for the purpose of providing medical care to the patient;
7. kissing of a romantic or sexual nature with a patient; and
8. sexual acts by the member in the presence of the patient.

(b) **Sexualized Interactions**

i. Sexualized interactions between a member and their patient is a boundary violation and is prohibited.

ii. What constitutes a sexualized interaction with a patient must be viewed from the perspective of the patient. The prohibited conduct can occur in the context of any encounter with a patient, whether the encounter is a clinical one for the purpose of providing medical care or an intentional or chance encounter outside of the clinical setting. It includes an encounter over social media or other forms of digital communication.

iii. Appropriate medical care will sometimes require a member to ask relevant questions of a personal nature, including questions about sexual health or involve the member conducting an examination of their patient's breasts, genitalia or anal area. These require appropriate explanations and provisions for privacy and if conducted appropriately are not sexualized interactions and are not prohibited.

iv. Sexualized interactions include any incident or repeated incidents of objectionable or unwelcome conduct, behaviour or remarks of a sexual nature by a member towards a patient that the member knows or ought reasonably to know will or would cause offence or humiliation to the patient or adversely affect the patient's health and well-being. It includes sharing of images or remarks through social media or other digital communication. It does not include conduct that is professional and clinically indicated as part of an encounter for the purpose of providing medical care to the patient.

v. In the context of an encounter for the purposes of obtaining medical care, the patient is in a particularly vulnerable situation having put their trust in the member to limit the interaction during that encounter to what is reasonably expected to

provide the care they are seeking. 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:

1. not providing privacy while the patient is undressing or dressing;
2. assisting with undressing or dressing, unless the patient is having difficulty and expressly consents to such assistance;
3. providing inadequate draping;
4. 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;
5. making remarks about a patient's sexual orientation, gender identity or activities that could be perceived as being judgmental or discriminatory;
6. making comments or gestures that could be construed as flirtatious, seductive or sexual by a patient, including reference to the patient's appearance or clothing;
7. requesting details of the sexual history or sexual behaviour of a patient when not medically indicated or without explaining why it is relevant to their medical care;
8. discussing a member's own or others sexual preferences or activities with a patient;
9. not explaining the scope of or need for intimate or sensitive examinations or not obtaining informed consent before conducting intimate or sensitive examinations;
10. not providing the patient with an opportunity to question or refuse an intimate or sensitive examination or to withdraw consent;
11. using unorthodox examination techniques, including inappropriate touching of the breasts, genitalia, or anus;
12. intentional touching of the breasts, genitalia, or anus during an otherwise clinically indicated examination where the touching is not clinically indicated;
13. failing to use gloves when examining genitalia or anus;
14. sexualizing body contact, which can include hugging in some circumstances. This does not prohibit hugging in appropriate circumstances where there is no sexual aspect to the physical contact; and
15. unnecessarily scheduling appointments for examinations outside normal office hours for any reason not related to providing medical care.

vi. In the context of encounters between a member and their patients outside of the clinical setting, sexualized interactions also include:
    1. socializing with a patient or former patient in the context of developing an intimate romantic or sexual relationship;
    2. responding sexually to advances made by a patient or former patient; and
    3. initiating any form of sexual advance toward a patient or former patient;
    4. sending sexually explicit emails or text messages; and
    5. making inappropriate advances on social media.

These lists are provided as guidance and are not exhaustive.

5. Persons Interdependent with the Patient

A member often communicates with a person who is interdependent with their patient in the context of providing care to their patient and may develop a relationship with that person. An interdependent person may be as vulnerable as the patient. This is particularly so for the adult parents or guardians of patients who are minors.

(a) For the purposes of this Standard, an interdependent person can be any person who has a close relationship with a member's patient and is involved in their patient's medical care, including, but not limited to their patients' parents, spouse, children, legal guardian or caregiver.

(b) A member must never use their professional relationship with a person who is interdependent with a member's patient to establish or pursue sexual contact with or sexualized interactions with that person. The factors to be considered in determining whether sexual contact or sexualized interactions with a person who is interdependent with a member's patient is a boundary violation include but are not limited to:
    i. the duration, frequency and type of care provided to the patient;
    ii. the degree of emotional dependence of the patient and or the interdependent person to the member;
    iii. the extent to which the member used any knowledge or influence obtained from providing medical care to the patient to establish or pursue sexual contact with or sexualized interactions with the interdependent person; and
    iv. the extent to which the patient is reliant on the person who is interdependent with them.

6. Former Patients

There is always a risk that a member may use or exploit the trust, information, emotions or power created by any former relationship with a patient.

(a) The inherent power imbalance from any member-patient relationship can continue long after that relationship ends. Any relationship or encounter between a member and their former patient which includes sexualized interactions or member-patient sexual contact is strongly discouraged for that reason.

(b) The onus is on a member to satisfy the College that a "reasonable period" has elapsed in accordance with section 3(b) above before engaging in what is otherwise prohibited conduct as defined in this Standard of Practice with a patient.

(c) A member who is considering engaging in a sexual relationship with a former patient must first consider the risks and whether the contemplated contact or interactions would be considered prohibited contact. They should seek advice from an experienced and trusted colleague, their professional indemnity insurer (CMPA for many members), legal counsel or contact the Registrar of the College to ensure that the member fully understands the risks and potential consequences before having sexual contact or engaging in sexualized interactions with a former patient.

7. Psychotherapeutic Relationships

The risk that a member may use or exploit the trust, information, emotions or power imbalance associated with a relationship with a patient where a member has provided psychotherapeutic care to their patient is particularly concerning given the unique nature of that relationship. Patients with mental health issues are particularly vulnerable and the power imbalance is enhanced. The nature, scope and duration of the psychotherapy provided has a significant impact on the risk.

(a) A member who has had a significant psychotherapeutic relationship with a patient must not have sexual contact with or engage in sexualized interactions with that patient at any time during or after the psychotherapeutic relationship. Significant psychotherapeutic relationships include, but are not limited to relationships between:

   i. a psychiatrist and their patient;

   ii. any member and their patient where the member has provided therapeutic counselling or treatment to the patient for mental health issues beyond what would reasonably be expected of a member as supportive advice or comments related to the provision of medical care to the patient.

(b) There is no "reasonable period" after which member-patient sexual contact or sexualized interactions are no longer prohibited between a member who has had a significant psychotherapeutic relationship with a patient and that patient. All sexual contact or sexualized interactions with that patient are sexual boundary violations.

8. Consequences of Breaching this Standard of Practice

Violating sexual boundaries with a patient, former patient or a person who is interdependent with a patient is a very serious matter. Like the violations themselves, the nature and extent of the measures required to address them and the consequences to a member who has violated boundaries with a patient are best viewed as being on a continuum and determined by the unique circumstances of each case. Serious violations will require formal disciplinary action and usually result in a lengthy suspension of or loss of the member's ability to practice medicine. Less serious violations may require remedial and protective measures, including conditions on a member's practice, but not necessarily result in formal disciplinary action.

COUNCIL MEETING – SEPTEMBER 25, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Standard of Practice for Prescribing Benzodiazepines and Z-Drugs

BACKGROUND:

As one of the Strategic Organizational Priorities, Council approved the draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs to distribute for consultation with the members, public, and stakeholders. Council reviewed the feedback from 124 responses at its June meeting. If you wish to review the feedback you can access it on the CPSM website under the Council meetings or by clicking this link Feedback in June Council Documents

Working Group Changes to the Standard

Over the summer, the Working Group met remotely several times to review the responses in detail and engaged in discussion by email. The Standard was revised to address many aspects of the feedback. The Standard was also revised to prepare a supporting document to the Standard entitled "Contextual Information and Resources". The Standard has become a slimmed down set of rules for prescribing, and the rationale for the rules and supports for prescribers are contained in this contextual document. The Standard will provide a link to the Contextual Information and Resources document. The Working Group considers this will be very useful to prescribers.

The other main changes as a result of the feedback were:

- The tapering guideline was changed to more updated approaches and several were included in the resource section of the Contextual Information.
- The Standard does not apply to seizure disorders. Previously it did not apply to just acute seizure disorders.
- Prescribing can be of a longer duration than three months if for intermittent use (ie, for flying, for certain medical/dental procedures).
- The lengthy rules for prescribing Alprazolam have been streamlined to "should be avoided/replaced".
- The wording for statutory duty to report impairment of patients to relevant authorities (such as MPI for driving) was added as an addition to just advising the patient that they might be impaired when using these drugs.

- Working with pharmacists was added in the Standard. There is also a section in the Contextual Information and Resources on working with pharmacists.
- The Standard was reorganized into an order that best reflects the order prescribers will likely deal with patients.

The Working Group also eliminated its prior recommendation to Council to have benzodiazepines and Z-Drugs included as M3P drugs requiring triplicate prescriptions. It was thought that the needed improvements in prescribing will come about by the introduction of the Standard by itself. There was feedback both for and against the inclusion of benzodiazepines and Z-Drugs as M3P drugs.

Council will be asked to approve the Standard. Council will not be asked to approve the Contextual Information and Resources document as this will be updated periodically as new resources and information becomes available.

Attached are the proposed Standard and the Contextual Information and Resources document. Also attached is the previous draft Standard for comparative purposes. There is no redlining due to the differences in the document, including organizational changes.

RECOMMENDATIONS OF THE WORKING GROUP

The recommendations of the Working Group are for Council to:

1. Approve the Standard of Practice for Prescribing Benzodiazepines and Z-Drugs
2. Not include Benzodiazepines and Z-Drugs in the list of M3P Drugs (Previously, the Working Group had recommended that these be included on the M3P. This was amended based upon feedback and experience with M3P under COVID-19.)
3. Recommend to the Monitored Drug Review Committee that Alprazolam be removed from the Manitoba Drug Benefits and Interchangeability Formulary

Strategy for Implementation

Where do we go from here? The implementation focus will be educational for the purposes of achieving safe prescribing practices, and not punitive in approach. This is a similar approach taken by CPSM after the implementation of the Standard of Practice for Prescribing Opioids. The intent is to take a "remedial" approach overall, mindful that the threat of serious discipline could lead some physicians to abandon patients, leaving them to secure benzodiazepines and Z-Drugs from a potentially contaminated street supply.

One of the key tools CPSM intends to use, to work with physicians to improve prescribing practices, is the Physician's Prescribing Profile. Working with Manitoba Health, we will prepare a history of the benzodiazepine and Z-Drug prescriptions of physicians. Those physicians

prescribing very high amounts will be contacted by CPSM to participate in a review. Under that review, CPSM and physician will discuss the nature of their practice, the patient(s), prescribing practices, options, etc.

Date of Implementation

When should this Standard come into effect? The key goal is to develop safe and effective prescribing practices. At the same time, the need to protect patients from abandonment or tapering that is too aggressive is fundamental. Similar to the Opioid Standard, CPSM has heard on many occasions that the medical profession is already moving to the Standard of Practice for Prescribing Benzodiazepines and Z-Drugs that was circulated in draft for consultation with the membership. This can be regarded positively.

The recommended effective date for implementation is October 1, 2020. If Council approves this Standard of Practice, a notification will be sent to members and stakeholders.

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

As a self-regulating medical profession, physicians must ensure they have the knowledge, skills, and clinical competence to prescribe benzodiazepines for those patients requiring such medication. Benzodiazepines are potential drugs of abuse and increase the risk of respiratory depression associated with opioids when prescribed concurrently. These drugs also cause impairment and can be highly addictive. Accordingly, patient safety is paramount, and the societal harms of prescribed benzodiazepines and Z-drugs which may be abused are to be considered in determining whether this Standard of Practice is warranted.

The Contextual Information and Resources document commences by outlining the background and public interest in regulating the prescribing of benzodiazepines and Z-Drugs.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

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

Recommend, to the Monitored Drug Review Committee, that Alprazolam be removed from the Manitoba Drug Benefits and Interchangeability Formulary.

DRAFT FOR SEPTEMBER COUNCIL – FINAL FOR APPROVAL

Prescribing Benzodiazepines and Z-Drugs

(including Zopiclone and other drugs)[1]

PREAMBLE

This Standard establishes the standard of practice and ethical requirements of all members in relation to prescribing benzodiazepines and/or Z-Drugs for maximum safety for all patients whether in the community or in a health care facility. **This Standard does not apply to the use of these drugs in the treatment of cancer, palliative and end-of-life patients, seizure disorders, bipolar/psychotic disorder, and acute alcohol withdrawal.** Medical evidence of the risk to benefit ratio of prescribing benzodiazepines and/or Z-Drugs is altered over time, so prescribing these drugs must be in accordance with current medical knowledge. This Standard recognizes that in prescribing benzodiazepines and/or Z-Drugs each member exercises their clinical judgment, which is to be that of a member acting reasonably in the circumstances with current medical knowledge.

STANDARD OF PRACTICE

1. Reasonable efforts are to be used to optimize non-pharmacological treatment modalities first (i.e., Cognitive Behaviour Therapy, improved sleep habits, elimination of caffeine, etc.) if available, and then optimize non-benzodiazepines or non-Z-Drug treatment modalities.

2. To mitigate risk of harm the member must use reasonable efforts to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN. This will mitigate the risk of harmful drug interactions and combinations and will prevent patients from obtaining prescriptions from multiple providers.

3. Members must prescribe the lowest effective dosage of benzodiazepines or Z- Drugs for the shortest possible duration and only exceed the maximum recommended dosage in exceptional circumstances and document this.

4. Long term use must be supported by current clinical evidence. Benzodiazepines and Z-Drugs may be appropriate for certain uncommon indications.

5. Discuss the following with the patient and document it in the medical record:
    a. Treatment goals including specific and realistic goals and an eventual possible discontinuation strategy;
    b. Non-pharmacological therapies;

[1] See Table near end for drugs included in this Standard.

c. The modest benefit of long-term benzodiazepines and Z-Drugs;
d. Risks associated with treatment; and
e. The impairment caused by these drugs, particularly the dangers of driving, operating heavy machinery, or performing safety sensitive tasks, providing child or elder care if impaired.

6. Alprazolam (Xanax) has been identified as a drug with significant risks of abuse and diversion in Manitoba and should be avoided and/or replaced.

7. Members must carefully consider all concurrent medical conditions in the context of decisions to prescribe or continue to prescribe these medications:
    a. Heart failure, obesity, sleep apnea, chronic lung disease, alcohol and substance use disorders and renal or hepatic insufficiency and other chronic conditions or pregnancy compound the risk of these medications in unique ways.
    b. Patients must be regularly screened for the presence or emergence of mental health disorders (particularly mood and substance use disorders) which may complicate management.

8. In the course of managing patient care on these drugs (particularly while tapering), a substance use disorder may develop or reveal itself, and physicians must be able to appropriately diagnose and manage the patient's care needs. Appropriate care management can include referral to a physician with expertise and can include slow tapering of benzodiazepines and Z-Drugs to minimize the effects of withdrawal. Periodically attempt a trial of slow tapering (and if possible, collaborate with a trusted pharmacist identified by the patient). Use tapering guidelines and equivalency tables referred to in the Contextual Information attached to this Standard of Practice. Appropriate care management does not include abruptly discontinuing or an ultra rapid decrease of these drugs after long term use. Where tapering is not feasible, if there is documented benefit to the patient outweighing the potential harms, then continue with the treatment. Tapering of long term benzodiazepines and/or Z-Drugs is difficult, though possible.

9. Combining benzodiazepines and/or Z-Drugs with themselves or with other medications compounds risk of harm:
    a. If prescribing benzodiazepines and/or Z-Drugs, physicians must consider potential drug interactions with prescribed, over the counter, and recreational psychoactive substances including alcohol, opioids, gabapentin, and other benzodiazepines, dimenhydrinate and diphenhydramine, and document their advice to patients to avoid these;
    b. If patients with complex care needs are receiving multiple sedating medications, the physician must consider seeking the opinion of relevant consultants such as psychiatrists, pain specialists, addiction medicine specialists, pharmacists, and others to work toward a collaborative medication regimen that minimizes risk as much as possible.

c. Only in exceptional circumstances prescribe opioids together with benzodiazepines and/or Z-Drugs. Patients must be informed of the increased risk of death with this combination, and the discussion documented.
d. Only in exceptional circumstances prescribe two or more benzodiazepines and/or Z-Drugs concurrently unless in the context of a taper.

10. Members must be aware of and comply with statutory reporting duties in the context of disease or disability, including a treatment regimen, that is expected to cause impairment to any relevant authorities (e.g. the MPI Registrar of Motor Vehicles).

PRESCRIPTION WRITING

11. Explicit instructions must be provided to the patient regarding appropriate use, quantity, and number of days the supply is intended to last. A dispensing interval, indicating the number of days the supply is anticipated to last, must be noted on the prescription (e.g. dispense X tablets every Y days).

12. Only write a prescription for a maximum of three months, with dispensing to be authorized for no more than a one-month supply unless it is for intermittent use. On an exceptional basis, members may authorize a dispensing interval of up to three months for patients:
    a. in remote communities; and
    b. travelling, if the patient has been on a stable long-term prescription.

OLDER ADULT PATIENTS – ADDITIONAL

13. For older adult patients recognize that new starts of benzodiazepines and Z-Drugs must be carried out with extreme caution and not be used as first choice for insomnia, agitation, or delirium, nor for managing behaviours arising from dementia and delirium.

14. Ensure that dosing takes into consideration declining renal, hepatic and cognitive function and polypharmacy in older adult patients.

15. In prescribing for older adult patients, the member must recognize and discuss with the patient additional risks, including but not limited to:
    a. Falls and subsequent fractures related to sedation, confusion, drowsiness and postural instability;
    b. Impairment of psychomotor skills, judgment, and coordination increases the risk of motor vehicle and other accidents;
    c. Negative effects on cognition, memory, delirium and a possible link to cognitive decline and dementia.

APPLICABLE DRUGS FOR THIS STANDARD

Benzodiazepines		Z-Drugs
Alprazolam (Xanax®)	Lorazepam (Ativan®)	Eszopiclone
Bromazepam (Lectopam®)	Midazolam (Versed®)	Zolpidem
Chlordiazepoxide (Librium®)	Nitrazepam (Mogadon®)	Zopiclone
Clobazam *to be started by Neurologists only	Oxazepam (Serax®)	
	Potassium-Clorazepate	
Clonazepam (Rivotril®)	Temazepam (Restoril®)	
Diazepam (Valium®)	Triazolam (Halcion®)	
Flurazepam (Dalmane®)		

Contextual Information and Resources for Standard of Practice for Prescribing Benzodiazepines and Z-Drugs

CONTEXTUAL INFORMATION for STANDARD OF PRACTICE

Background

Medical evidence of the risk to benefit ratio of prescribing benzodiazepines and/or Z-Drugs has altered over time, so prescribing these drugs must be in accordance with current medical knowledge. Drugs of dependence have important therapeutic uses, but there is a need to ensure the supply of these medicines is clinically appropriate. In the past two decades clinical guidelines have recommended against long-term use of benzodiazepines and Z-Drugs. The conditions where benzodiazepines are most commonly prescribed (anxiety and insomnia) remain sources of debate in medical circles. Physicians must consider multiple factors when prescribing benzodiazepines. Good clinical judgment and an evidence-based approach remain key to safe and appropriate prescribing. The Standard tries to strike the best balance between the benefits benzodiazepines and Z-drugs provide for many patients with the risk posed to some patients.

Risks of Benzodiazepines in Manitoba

CPSM participates in the Adult Inquest Review Committee of the Chief Medical Examiner to review all deaths involving prescription medications. These reviews indicate deaths from other drugs are climbing rapidly while opioid deaths have levelled off. Alprazolam and Gabapentin, as well as diphenhydramine, have become significant drugs of abuse in Manitoba.

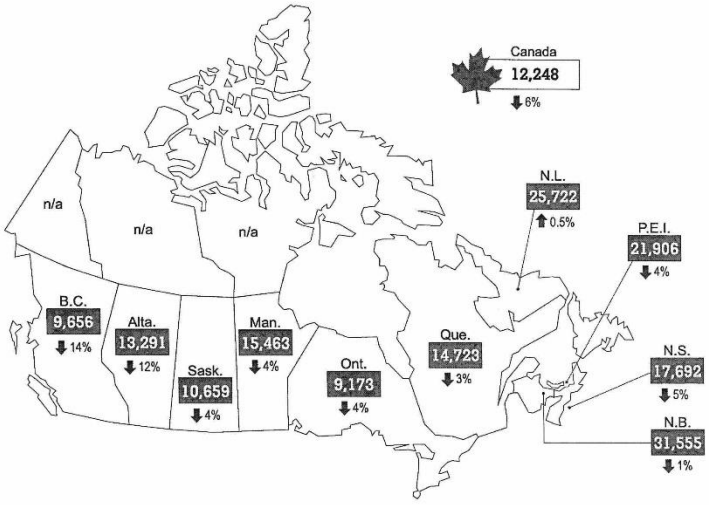
- Alprazolam is the benzodiazepine that contributed to the largest number of overdose deaths last year.
- Most opioid deaths can be attributed to one or more opioids combined with other drugs, often benzodiazepines and/or Z-Drugs.
- The two drug classes that were the top contributors to opioid overdoses were benzodiazepines and antidepressants from 2014-2017.
- Alprazolam, Zopiclone, and/or SSRIs contributed in total to 11, 9, and 8 drug overdose deaths respectively from 2016-2018.

The lessons learned from this provincial death data should transform physician prescribing practices. The Standard is to urge physicians to **be mindful of polypharmacy - the overall risk may outweigh the benefit from individual medications. Opioids, benzodiazepines, antidepressants, Z-Drugs, antipsychotics, and gabapentin all interact with each other often contributing to these deaths.**

Outside of Atlantic Canada, Manitoba has the highest rate of prescribing benzodiazepines and related drugs, at 50% higher than neighbouring Ontario and Saskatchewan. In 2017 there were 15,463 defined daily doses per 1000 population for these drugs.

Pan-Canadian Trends in the Prescribing of Opioids and Benzodiazepines, 2012 to 2017

Figure 5 Defined daily doses per 1,000 population, Canada,* for benzodiazepines and benzodiazepine-related drugs, 2017



British Columbia and Alberta had the largest decreases in the rate of prescribed benzodiazepines and benzodiazepine-related drugs.

Notes
* Data was not available for the territories.
↓ ↑ Percentage change in prescribing from 2016 to 2017.
n/a: Not available.
Source
Prepared using data from CompuScript, IQVIA.

A study in Manitoba in 2016 concluded that a limited segment of the population that received benzodiazepine prescriptions was classified as sustained users, and a smaller proportion of that group escalated to doses higher than those recommended by product monographs and clinical guidelines. https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500380

Risks of Benzodiazepines in General

Benzodiazepines and Z-Drugs carry significant risk such as:

- Sedation, confusion, drowsiness and postural instability contributing to the risk of falls and subsequent fractures;
- Impairment of psychomotor skills, judgment, and coordination increasing the risk of motor vehicle accidents;
- Negative effects on cognition and memory, delirium, drug-related pseudo dementia and a possible link to cognitive decline and Alzheimer's disease;
- Dependency and abuse potential;
- Risky interaction with medications or herbals;
- Sleep automatism (in the case of Z-Drugs), including food binging, and even driving while asleep or in a sleep-like state.

The Standard recognizes that:

- Initiating benzodiazepines and/or Z-Drugs in hospital substantially increases the risk of long-term use and dependency.
- Cognitive behavioural therapy, brief behavioural interventions and tapering protocols have a proven benefit in sedative-hypnotic discontinuation and are also beneficial in improving sleep.
- The number needed to treat with a benzodiazepine and/or Z-Drugs to get improved sleep is 13, whereas the number needed to harm is only 6. [BMJ: doi: 10.1136/bmj.38623.768588.47(published 11 November 2005)

Risks of Benzodiazepines in the Elderly

Benzodiazepines and/or Z-Drugs have been identified as problematic medications for use in older adults and carry significant risks. Large scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or Z-Drugs. Older patients, their caregivers and their health care providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium.

Benzodiazepines and Z-Drugs carry significant risks beyond those for the general patient population:

- Sedation, confusion, drowsiness and postural instability contributing to the risk of falls and subsequent fractures;
- Further impairment of psychomotor skills, judgment, and coordination increasing the risk of motor vehicle accidents;

- Negative effects on cognition and memory, delirium, drug-related pseudo dementia and a possible link to cognitive decline and Alzheimer's disease.

Driving or Operating Heavy Machinery and Benzodiazepines and Z-Drugs

MPI, in its Drug Impaired Driving educational sessions for physicians and other health professionals, highlights the potential perils associated with driving among individuals who are prescribed benzodiazepines and Z-drugs. This is reflected in the CMA Guide for determining medical fitness to operate motor vehicles, which also highlights the peril associated in combination with alcohol.

MPI's advice to prescribers is for any patient provided with a new prescription or an increase in dosage that they should temporarily stop driving until they can be reassessed by the prescriber (please note that this would generally not call for a notification of MPI in accordance with the mandatory reporting requirement). The prescriber can determine whether it is reasonable to resume driving when the clinical reassessment is conducted. Should some degree of functional impairment be suspected at the time of reassessment, the prescriber should, at that point, report to MPI with an appropriate recommendation, which could be that the patient's driver license be suspended or that a functional driving assessment be conducted.

The same applies with necessary modifications to patients who operate heavy machinery. Such patients should also be provided with a note indicating they should not operate such equipment for either a limited time period or until reassessment.

Application of Standard

This Standard applies to Benzodiazepines and what are known as the Z-Drugs (Zopiclone, Zolpidem, Zaleplon, and Eszopiclone) because of the similarity of these drugs in prescribing for similar medical conditions, risks, addictions (abuse and diversion), and use.

BENZODIAZEPINE RECEPTOR AGONIST EQUIVALENCY ESTIMATES

(Diazepam 10 mg as reference)

	Ashton	Kalvik et al.	Shader & Greenblatt	Alessi-Severini et al.
Diazepam	**10 mg**	**10 mg**	**10 mg**	**10 mg**
Alprazolam (Xanax®)	0.5 mg	1 mg	1 mg	1 mg
Bromazepam (Lectopam®)	5 mg	6-12 mg	NA	10 mg
Chlordiazepoxide (Librium®)	25 mg	20-50 mg	50 mg	20 mg
Clobazam	20 mg	NA	NA	20 mg
Clonazepam (Rivotril®)	0.5 mg	1-2 mg	0.5 mg	0.5 mg
Potassium Clorazepate	15 mg	15 mg	15 mg	NA
Flurazepam (Dalmane®)	30 mg	30 mg	30 mg	30 mg
Lorazepam (Ativan®)	1 mg	1-2 mg	2 mg	2 mg
Oxazepam (Serax®)	20 mg	30 mg	30 mg	20 mg
Nitrazepam (Mogadon®)	10 mg	10-20 mg	10 mg	10 mg
Temazepam (Restoril®)	20 mg	20-30 mg	30 mg	30 mg
Triazolam (Halcion®)	0.5 mg	0.5 mg	0.25 mg	0.25 mg
Zaleplon	20 mg	NA	NA	20 mg
Zolpidem	20 mg	NA	10 mg	NA
Zopiclone	15 mg	NA	NA	7.5 mg

Ashton H. benzo.org.uk : Benzodiazepine Equivalence Table. http://www.benzo.org.uk/bzequiv.htm. Published 2007. Kalvik A., Isaac P., Janecek E. Benzodiazepines: Treatment of anxiety, insomnia and alcohol withdrawal. Pharmacy connection Sept/ Oct 1995 20-32. Shader RI, Greenblatt DJ. *J Clin Psychopharmacol*. 1997;17(4):331. Alessi-Severini S, Bolton JM, Enns MW. Sustained Use of Benzodiazepines and Escalation to High Doses in a Canadian Population. *Psychiatric Serv*. 2016;67(9):1012-1018.

Suggested Resources

Managing Benzodiazepine Use in Older Adults by the Centre for Effective Practice in Ontario is an **excellent clinical tool** which can be adapted for other ages.

Deprescribing Benzodiazepine Receptor Agonists: Evidence Based Clinical Practice Guideline issued by the College of Family Physicians of Canada is a helpful resource.

Prescribing Drugs of Dependence in General Practice Part B, by the Royal Australian College of General Practitioners includes a framework for accountable prescribing of benzodiazepines in a practical guide that physicians can use to minimise harm and maximise benefits to patients. There are terrific **resources** included such as examples of responses to patient requests for benzodiazepines, communications with patients, practice policies and forms, patient agreements, drug and alcohol assessment tool, and a GP Guide to Insomnia.

Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder Among Older Adults has useful guidance on either preventing the development of Benzodiazepine use disorder or optimally assessing and treating older patients who have developed such a disorder. The tapering guidance is helpful and can be applicable for other ages.

Patient Pamphlet: Insomnia and Anxiety in Older People: – Sleeping pills are usually not the best solution.

Toolkit: Less Sedatives for Your Older Relatives – A toolkit for reducing inappropriate use of benzodiazepines and sedative-hypnotics among older adults in hospitals.

Toolkit: Drowsy Without Feeling Lousy – A toolkit for reducing inappropriate use of benzodiazepines and sedative-hypnotics among older adults in primary care.

www.mysleepwell.ca has an online hub of cognitive behaviour therapy for insomnia.

Ementalhealth.ca has information for both patients and physicians.

Tapering

Gradual dose reduction is the central tenet in discontinuing benzodiazepine and Z-Drugs and supervision is the preferred tapering strategy. Patient preference is not a valid reason to defer tapering.

Various taper plans, suggestions, and schedules are included in the resources above.

Working with the Pharmacist

With a high level of knowledge of dosage forms, equivalencies, tapering tools, and the potential for compounding intermediate dosage forms when necessary, as well as the most frequent contact with shared patients, pharmacists can and should often play an active role in planning and providing feedback during and after benzodiazepine and Z-drug tapers. Some pharmacists can assist in preparing tapering schedules.

Furthermore, collaborating and communicating with the pharmacist especially when tapering is in progress is beneficial because the pharmacy maintains ongoing documentation on patient interactions and any issues/concerns they may have noted over time. Providing the pharmacy with a patient care plan for tapering will keep all healthcare providers informed, especially if the patient contacts the pharmacist if they are experiencing any withdrawal symptoms or are requesting early refills. Randomized controlled trials have shown sedative-hypnotics deprescribing rates of 43% when pharmacists and physicians worked in collaboration.[1]

Consider a tripartite agreement with the patient-pharmacist-physician. Having a patient use only one pharmacy for their prescriptions helps the pharmacist know and assess the patient and enables the physician to inform the pharmacist in advance of special requests.

[1] Martin P, Tamblyn R, Benedetti A, Ahmed S, Tannenbaum C. Effect of a Pharmacist-Led Educational Intervention on Inappropriate Medication Prescriptions in Older Adults: The D-PRESCRIBE Randomized Clinical Trial. JAMA 2018:320:1889-98

DRAFT FOR JUNE COUNCIL

Schedule N - Prescribing Benzodiazepines and Z-Drugs

(including Zopiclone and other drugs)[1]

PREAMBLE

This Standard establishes the standard of practice and ethical requirements of all members in relation to prescribing benzodiazepines and/or Z-Drugs for maximum safety for all patients whether in the community or in a health care facility. **This Standard does not apply to the use of these drugs in the treatment of palliative and end-of-life patients, acute seizure disorders, akathisia, and alcohol withdrawal.** Knowledge of the risk to benefit ratio of prescribing benzodiazepines and/or Z-Drugs has altered over time, so prescribing these drugs must be in accordance with current medical knowledge. These drugs are a known major contributor to excess deaths, especially due to polypharmacy, in Manitoba. This Standard recognizes that:

- Every member is professionally responsible for each prescription the member provides to the patient.
- In prescribing benzodiazepines and/or Z-Drugs each member provides their clinical judgment, which is to be that of a member acting reasonably in the circumstances with current medical knowledge.
- Initiating benzodiazepines and/or Z-Drugs in hospital substantially increases the risk of long-term use and dependency.
- Cognitive behavioural therapy, brief behavioural interventions and tapering protocols have a proven benefit in sedative-hypnotic discontinuation and are also beneficial in improving sleep.
- The number needed to treat with a benzodiazepine and/or Z-Drugs for improved sleep is 13, whereas the number needed to harm is only 6.

STANDARD OF PRACTICE

1. The member should use reasonable efforts to optimize non-pharmacological treatment modalities first and then optimize non-benzodiazepines or non-Z-Drug treatment modalities.

2. To mitigate risk of harm the member must use reasonable efforts to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN. This will mitigate the risk of harmful drug interactions and combinations, and will prevent patients from obtaining prescriptions from multiple providers.

[1] See Table near end for drugs included in this Standard.

3. Prescribe the lowest effective dosage of benzodiazepines or Z- Drugs for the shortest possible duration and only exceed the maximum recommended dosage in exceptional circumstances.

4. Long term use must be supported by current clinical evidence recognizing that benzodiazepines and Z-Drugs may be appropriate for certain patients.

5. Discuss the following with the patient and document it in the medical record:
    a. Treatment goals including specific and realistic goals and an eventual possible discontinuation strategy;
    b. Non-pharmacological therapies;
    c. The benefit of long-term benzodiazepines and Z-Drugs treatment is modest;
    d. Risks; and
    e. These drugs cause impairment and advise them of the dangers of driving, operating heavy machinery, or performing safety sensitive tasks, providing child or elder care if impaired.

6. Discuss appropriate use with the patient with explicit instructions on the quantity and anticipated days supply, which must be noted on the prescription in the form of a dispensing interval.

7. Only write a prescription for a maximum of three months, but never authorize the dispensing of more than a one-month supply of any benzodiazepine and/or Z-Drug. An exception to dispensing for more than one month, up to three months would be:
    a. For patients in remote communities; and
    b. For patients travelling, if the patient has been on a stable long-term prescription.

8. Consider never starting patients on Alprazolam (Xanax) because it has been identified as a drug with significant risks of abuse and diversion in Manitoba. Recognizing these risks, if considering a start, the member must have extremely strong current clinical evidence. New start for Alprazolam must include urine drug screen testing of patients. Use reasonable efforts to replace existing Alprazolam prescriptions with a longer acting benzodiazepine in accordance with the attached equivalency table. If not replaced, then document why not possible.

9. Physicians must carefully consider all concurrent medical conditions in the context of decisions to prescribe or continue to prescribe these medications:
    a. Heart failure, obesity, sleep apnea, chronic lung disease, and renal or hepatic insufficiency and other chronic conditions compound the risk of these medications in unique ways.
    b. Patients must be regularly screened for the presence or emergence of mental health disorders (particularly mood disorders) which may complicate management.

c. In the course of managing patient care on these drugs (particularly while tapering), a substance use disorder may develop or reveal itself, and physicians must be able to appropriately diagnose and manage the patient's care needs. Appropriate care management can include referral to a clinician with experience in addiction medicine and can include slow tapering of benzodiazepines and Z-Drugs to minimize the effects of withdrawal and does not include abruptly discontinuing these drugs.

10. Combining benzodiazepines and/or Z-Drugs with themselves or with other medications compounds risk of harm:
    a. Determine the lowest effective dose of benzodiazepines and/or Z-Drugs needed to achieve or maintain the treatment goals and periodically consider a trial of slow tapering. Use tapering guidelines and equivalency tables attached to this Standard of Practice. Where tapering is not feasible, if there is documented benefit to the patient, then continue with the treatment. Tapering of long term benzodiazepines and/or Z-Drugs is very difficult, though not impossible.
    b. If prescribing benzodiazepines and/or Z-Drugs, physicians must document their advice to patients that they must avoid other central nervous system and respiratory depressants including alcohol, cannabis, and some over-the-counter medications.
    c. Physicians must exercise caution in prescribing these drugs with muscle relaxants, sedating antidepressants, anticonvulsants, antipsychotics and other sedating medications.
    d. If patients with complex care needs are receiving multiple sedating medications, the physician must consider seeking the opinion of relevant consultants such as psychiatrists, pain specialists, addiction medicine specialists, pharmacists, and others to work toward a collaborative medication regimen that minimizes risk as much as possible.
    e. Only in exceptional circumstances prescribe opioids together with benzodiazepines and/or Z-Drugs. Patients must be informed of the increased risk of death with this combination, and the discussion documented.
    f. Only in exceptional circumstances prescribe two or more benzodiazepines and/or Z-Drugs concurrently unless in the context of a taper.

OLDER ADULT PATIENTS

11. Benzodiazepines and/or Z-Drugs have been identified as problematic medications for use in older adults and carry significant risks. Large scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or Z-Drugs. Older patients, their caregivers and their health care providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium.

12. For older adult patients recognize that new starts of benzodiazepines and Z-Drugs must be carried out with extreme caution and not be used as first choice for insomnia, agitation, or delirium, nor for managing behaviours arising from dementia and delirium.

13. Ensure that dosaging takes into consideration declining renal, hepatic and cognitive function in older adult patients.

14. In prescribing for older adult patients recognize and discuss with the patient additional risks, including but not limited to:
    a. Sedation, confusion, drowsiness and postural instability contributes to the risk of falls and subsequent fractures;
    b. Impairment of psychomotor skills, judgment, and coordination increases the risk of motor vehicle and other accidents;
    c. Negative effects on cognition, memory, delirium and a possible link to cognitive decline and dementia.

APPLICABLE DRUGS FOR THIS STANDARD

Benzodiazepines		Z-Drugs
Alprazolam (Xanax®)	Lorazepam (Ativan®)	Eszopiclone
Bromazepam (Lectopam®)	Midazolam (Versed®)	Zaleplon
Chlordiazepoxide (Librium®)	Nitrazepam (Mogadon®)	Zolpidem
Clobazam *to be started by Neurologists only	Oxazepam (Serax®)	Zopiclone
	Potassium-Clorazepate	
Clonazepam (Rivotril®)	Temazepam (Restoril®)	
Diazepam (Valium®)	Triazolam (Halcion®)	
Flurazepam (Dalmane®)		

BENZODIAZEPINE RECEPTOR AGONIST EQUIVALENCY ESTIMATES

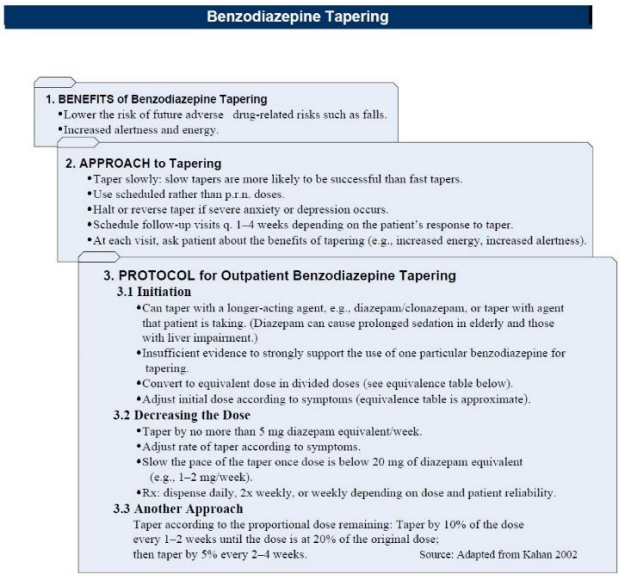
(Diazepam 10 mg as reference)

	Ashton	Kalvik et al.	Shader & Greenblatt	Alessi-Severini et al.
Diazepam	**10 mg**	**10 mg**	**10 mg**	**10 mg**
Alprazolam (Xanax®)	0.5 mg	1 mg	1 mg	1 mg
Bromazepam (Lectopam®)	5 mg	6-12 mg	NA	10 mg
Chlordiazepoxide (Librium®)	25 mg	20-50 mg	50 mg	20 mg
Clobazam	20 mg	NA	NA	20 mg
Clonazepam (Rivotril®)	0.5 mg	1-2 mg	0.5 mg	0.5 mg
Potassium Clorazepate	15 mg	15 mg	15 mg	NA
Flurazepam (Dalmane®)	30 mg	30 mg	30 mg	30 mg

Lorazepam (Ativan®)	1 mg	1-2 mg	2 mg	2 mg
Oxazepam (Serax®)	20 mg	30 mg	30 mg	20 mg
Nitrazepam (Mogadon®)	10 mg	10-20 mg	10 mg	10 mg
Temazepam (Restoril®)	20 mg	20-30 mg	30 mg	30 mg
Triazolam (Halcion®)	0.5 mg	0.5 mg	0.25 mg	0.25 mg
Zaleplon	20 mg	NA	NA	20 mg
Zolpidem	20 mg	NA	10 mg	NA
Zopiclone	15 mg	NA	NA	7.5 mg

Ashton H. benzo.org.uk : Benzodiazepine Equivalence Table. http://www.benzo.org.uk/bzequiv.htm. Published 2007. Kalvik A., Isaac P., Janecek E. Benzodiazepines: Treatment of anxiety, insomnia and alcohol withdrawal. Pharmacy connection Sept/ Oct 1995 20-32. Shader RI, Greenblatt DJ. Can you provide a table of equivalences for benzodiazepines and other marketed benzodiazepine receptor agonists? *J Clin Psychopharmacol*. 1997;17(4):331. Alessi-severini S, Bolton JM, Enns MW. Sustained Use of Benzodiazepines and Escalation to High Doses in a Canadian Population. *Psychiatr Serv*. 2016;67(9):1012-1018.

TAPERING GUIDELINES



Canadian Guideline http://nationalpaincentre.mcmaster.ca/opioid/

COUNCIL MEETING – SEPTEMBER 25, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Standard of Practice for Virtual Medicine Working Group Terms of Reference

BACKGROUND:

At its June 2020 meeting, Council directed the Registrar to proceed with the strategic organizational priority of updating the Standard of Practice for Virtual Medicine. This is particularly timely given the overnight shift to virtual care by much of the medical profession during the COVID-19 pandemic. The Virtual Medicine Standard of Practice (and other rules) are to be updated to reflect the changes and experiences gained by the several months of extensive use by the profession. 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 to mention just a few items. It is considered these changes will not be temporary, but permanent in some way – just how needs to be determined. FMRAC (the national body of Colleges) is also working on standards of virtual care so similar principles can be applied across Canada insofar as possible.

As per CPSM practice, a Working Group is to be formed to develop a draft updated Standard of Practice for review by Council. A subsequent consultation with members, the public, and stakeholders will take place prior to implementation.

Attached are the Terms of Reference for the Working Group on the Standard of Practice for Virtual Medicine. There will be a public representative from Council appointed to the Working Group as CPSM strives to ensure it is acting in the public's interest in the performance of all its functions.

Dr. Elliott will Chair the Working Group. The CPSM will reach out to diverse individuals and organizations to participate in the Working Group. Doctors Manitoba will also be asked to participate in this Working Group which is a unique approach. Doctors Manitoba has acted at the forefront of providing it's members with practical day to day advice on virtual medicine and CPSM hopes to capture this experience in revising this Standard of Practice.

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

Virtual medicine must adhere to the standard of good medical care prescribed by *CPSM Standards of Practice Regulation*:

> 3(1) A member must provide good medical care to a patient and include in the medical care that he or she provides
>
> (a) an assessment of the patient that includes the recording of a pertinent history of symptoms and psychological and social factors for the purpose of making an appropriate diagnosis, when required;
>
> (b) the physical examination of the patient that is required to make or confirm a diagnosis
>
> (c) the consideration of the patient's values, preferences and culture;
>
> (d) sufficient communication with the patient or his or her representative about the patient's condition and the nature of the treatment and an explanation of the evidence-based conventional treatment options, including the material risks, benefits and efficacy of the options in order to enable informed decision-making by the patient;
>
> (e) timely communication with the patient about the care;
>
> (f) a timely review of the course and efficacy of treatment;
>
> (g) the referral of the patient to another member or health care professional, when appropriate; and
>
> (h) the documentation of the patient record at the same time as the medical care is provided or as soon as possible after the care is provided.

Any examination of virtual medicine must include those situations in which virtual care is not in the best interests of the patient or the patient is unable to connect virtually, whether through lack of technology, hearing impairment, challenges with fluency, or inability to utilize technology.

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

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

The Terms of Reference for the Standard of Practice for Virtual Medicine Working Group be approved as presented.

STANDARD OF PRACTICE FOR VIRTUAL MEDICINE

TERMS OF REFERENCE

CPSM WORKING GROUP

Section 1: Background

There is a need for the College of Physicians and Surgeons of Manitoba to have an updated Standard of Practice for members who provide virtual medicine. With the onset of the COVID-19 pandemic, members introduced virtual medicine literally overnight when a new tariff for virtual care was implemented. CPSM immediately introduced some interim guidance on virtual care in March for the pandemic. Members continue to practice medicine with a mix of virtual and physical care utilizing this temporary guidance. Much experience has been gained on the benefits and disadvantages of virtual medicine through the experience since March. Guidance is required on numerous aspects of virtual medicine, including what medical care can or can not be provided by virtual care.

CPSM Council in June 2020 directed the Registrar to establish a Working Group to draft an updated Standard of Practice for Virtual Care. FMRAC will also be reviewing the regulation of virtual medicine across Canada.

For clarity, virtual care refers to the provision of medical care by a Manitoba member to a Manitoba patient; it is not the interprovincial practice of medicine. Virtual Medicine in the *CPSM Standard of Practice Regulation* "means the provision of medical care by means of electronic communication where the patient and the member are at different locations, including but not limited to treating, advising, interviewing or examining the patient."

Section 2: Purpose

The purpose of the Working Group is to develop a draft CPSM Standard of Practice for Virtual Medicine that will be circulated to the 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 in virtual care and for assessing physician performance in Quality Improvement processes or in Complaints and Investigations.

The Standard of Practice must conform to the provisions of good medical care prescribed in the *CPSM Standard of Practice Regulation*:

> 3(1) A member must provide good medical care to a patient and include in the medical care that he or she provides

(a) an assessment of the patient that includes the recording of a pertinent history of symptoms and psychological and social factors for the purpose of making an appropriate diagnosis, when required;

(b) the physical examination of the patient that is required to make or confirm a diagnosis;

(c) the consideration of the patient's values, preferences and culture;

(d) sufficient communication with the patient or his or her representative about the patient's condition and the nature of the treatment and an explanation of the evidence-based conventional treatment options, including the material risks, benefits and efficacy of the options in order to enable informed decision-making by the patient;

(e) timely communication with the patient about the care;

(f) a timely review of the course and efficacy of treatment;

(g) the referral of the patient to another member or health care professional, when appropriate; and

(h) the documentation of the patient record at the same time as the medical care is provided or as soon as possible after the care is provided.

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 virtual medicine.
- To develop a Standard of Practice on Virtual Medicine which will be circulated to the membership, stakeholders, and public for consultation and review the results of that consultation process.
- To finalize a Standard of Practice for Virtual Medicine.

Section 4: Chair and Membership

4.1 Chair

The Committee will be chaired by the President-Elect of CPSM, Dr. Jacobi Elliott.

4.2 Membership

Working Group Membership is to include representatives from:

- CPSM Council
- Family Medicine

- Specialists
- Manitoba College of Family Physicians
- Members of CPSM
- Doctors Manitoba
- And any other representative that the Chair considers appropriate

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 Virtual Medicine.

COUNCIL MEETING – SEPTEMBER 25, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Patient Records Standard of Practice

BACKGROUND:

CPSM has a current Standard of Practice on Patient Records that contains provisions for:

- Record of appointments
- Record content
- Alteration of records
- Record security
- Ownership of records
- Access to or copy of records
- Discharge summary
- Electronic records
- Virtual medicine
- Additional obligations
- Transfer of patient records

The current Standard is to be reviewed as per the cycle of reviewing Standards of Practice. CPSM receives many inquiries about these provisions and it is apparent that an update is required. Furthermore, improved record keeping of members is a frequent direction provided by Complaints/Investigation, Central Standards Committee, and Quality Improvement Committee.

Medical records are integral to:

- facilitate good care
- allow a subsequent caregiver to understand the patient's condition and the basis for the current investigations or treatments
- provide a method of communicating with other team members
- satisfy legal and ethical obligations: College, hospital, and legislative requirements for clear and legible records
- act as evidence: if care is later questioned, it must show events as they happened

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

Patient safety requires that patient records, whether in a community clinic or hospital, are adequate and appropriate records of the care provided for the patient. Good medical care as defined in the *CPSM Standards of Practice Regulation* must include "the documentation of the patient record at the same time as the medical care is provided or as soon as possible after the care is provided." S. 3(1)(h). Good medical care requires good medical records to ensure patient safety. This becomes even more an issue of patient safety when the care is provided by a team and to provide continuity of care by subsequent members.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WLL MOVE THAT:

The Terms of Reference for the Standard of Practice for Patient Records Working Group be approved as presented.

STANDARD OF PRACTICE FOR PATIENT RECORDS

TERMS OF REFERENCE

CPSM WORKING GROUP

Section 1: Background

There is a need for the College of Physicians and Surgeons of Manitoba to have an updated Standard of Practice for Patient Records. The current Standard of Practice for Patient Records is to be reviewed as per the cycle of reviewing Standards of Practice. CPSM receives many inquiries on patient records from both members and patients and the current Standard of Practice does not always provide guidance in some situations where it should. Inadequate Patient Records are not an infrequent source of substandard care in Complaints and Investigations, in Quality Improvement, and in Standards.

Section 2: Purpose

The purpose of 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. This Standard of Practice will be used to promote the current best practices in virtual care and for assessing physician performance in Quality Improvement processes, Standards, or in Complaints and Investigations.

The Standard of Practice on Patient Records must comply with the provisions in the *CPSM Standards of Practice Regulation:*

Record of appointments

10(1) A member must keep a record of his or her appointments with patients and those persons seeking medical care indicating, for each day, the names of persons seen and patients for whom medical care was provided.

10(2) The record of appointments must be retained by the member, or another member who has possession of them, for at least 10 years after the date the record was made.

Patient records

11(1) A member must appropriately document the provision of patient care in a record specific to each patient. Dossiers des patients

11(2) A member must document on the patient record the medical care given to the patient containing enough information for another member to be sufficiently informed of the care provided.

11(3) A patient record must be retained by the member having last custody of the record for at least 10 years after the date of the last entry on the record, and patient records of minors must be retained for at least 10 years after the date the minor becomes 18 years old.

11(4) For greater certainty, a member who provides medical care by virtual medicine must comply with this section.

11(5) A member must retain control of all of his or her patient records unless they are maintained

(a) by another member; or

(b) by a person or organization that employed, engaged or granted privileges to the member and is a trustee under The Personal Health Information Act.

11(6) The obligations under this section are in addition to any other requirements relating to patient records under the Act, The Personal Health Information Act, and any other enactment, by-law, standard of practice, code of ethics and practice direction with which a member must comply.

Notice of intention to close, leave or move medical practice

13(1) A member must give notice of the member's intention to close their medical practice, to take a leave of absence or to relocate their practice or otherwise cease to practice medicine in Manitoba to

(a) the member's patients or their representatives; (b) the college; (c) other members with whom the member refers or consults; (d) the Department of Health, Seniors and Active Living; (e) any regional health authority in which the member has privileges; (f) a personal care home at which the member has privileges that is not operated by a regional health authority; (g) if applicable, the Canadian Medical Protective Association; (h) Doctors Manitoba.

13(2) The notice must include (b) information about where the patient's records are to be located and how the records can be transferred to another member or how copies of the records can be obtained;

Storage and disposition of patient records and supplies

14(1) A member who closes their medical practice or takes a leave of absence must

(a) ensure the secure storage of any patient records for the remainder of the retention period required by subsection 11(3) and the retention of appointment records for the remainder of the period required by subsection 10(2) and the subsequent destruction of the information in accordance with The Personal Health Information Act; and

(b) give the college a copy of the notice sent to patients and information about to whom the notice was sent and the arrangements that have been made for the secure storage of the patient records and appointment records. ….

14(3) The obligations under this section are in addition to any other requirements relating to patient records under the Act, The Personal Health Information Act, and any other enactment, by-law, standard of practice, code of ethics and practice direction with which a member must comply.

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 patient records.
- To develop a Standard of Practice on Patient Records which will be circulated to the membership, stakeholders, and public for consultation and review the results of that consultation process.
- To finalize a Standard of Practice for Patient Records.

Section 4: Chair and Membership

4.1 Chair

The Committee will be chaired by a Councillor yet to be determined.

4.2 Membership

Working Group Membership is to include representatives from:

- CPSM Council
- Family Medicine
- Specialists
- Manitoba College of Family Physicians
- Members of CPSM
- Shared Health (eHealth, Dr. Trevor Lee)
- Health Seniors and Active Living
- Doctors Manitoba
- And any other representative that the Chair considers appropriate

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 Patient Records.

COUNCIL MEETING – SEPTEMBER 25, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Duty to Report Standard of Practice Working Group – Terms of Reference

BACKGROUND:

The current duty to report provisions are scattered throughout the Standards of Practice and legislation and includes duties to report another member to CPSM and self-reporting to CPSM. There are also statutory requirements for a wide variety of reporting including, but not limited to reporting:

- impairment to Manitoba Public Insurance and Transport Canada for driving and flying
- certain communicable diseases to Public Health
- a child in need to Child and Family Services
- sexual abuse of a patient
- births, still births, and deaths of patients
- gun shot wounds to the police
- correctional facilities
- privacy breaches

There is no central document that provides all reporting requirements. The intention is to create one or more of such documents. Furthermore, as societal expectations change regarding public safety, so too must the Standard.

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

Physicians have a legal and professional obligation to maintain the confidentiality of patient information. There are circumstances, however, where physicians are either required or permitted to report particular events or clinical conditions to the appropriate government or regulatory agency. This Standard will set out circumstances that may require or permit physicians to make a report. It is not a substitute for legal advice regarding reporting obligations.

This Standard is necessary to establish governing principles on notification of ongoing competence in practice, whether the reporting is of a colleague or of self. With respect to self-

reporting or reporting of a colleague for matters of health, CPSM recognizes that a member has the right to make decisions regarding his or her health, balanced with CPSM's mandate to serve the public and ensure the safe practice of medicine by its members.

Reporting a patient's medical condition to an external body is required by a wide variety of statutes which recognize the element of public safety is paramount to the confidentiality that exists between patient and physician. For instance, Transport Canada requires stringent reporting of medical conditions for those who are pilots, and to a lesser extent, long-haul truck drivers. The health of pilots must be of such a level to not interfere, or possibly interfere, with the safe flying of an airplane to protect passengers. This is a completely different type of reporting than a privacy breach of patient records to the patient and the Ombudsman.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

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

STANDARD OF PRACTICE FOR DUTY TO REPORT

TERMS OF REFERENCE

CPSM WORKING GROUP

Section 1: Background

There is a need for the College of Physicians and Surgeons of Manitoba to have an updated Standard of Practice for Duty to Report. The current Standard of Practice for Duty to Report is to be reviewed as per the cycle of reviewing Standards of Practice.

Physicians have a legal and professional obligation to maintain the confidentiality of patient information. There are circumstances, however, where physicians are either required or permitted to report particular events or clinical conditions to the appropriate government or regulatory agency.

Section 2: Purpose

The purpose of the Working Group is to develop an updated draft CPSM Standard of Practice for the Duty to Report that will be circulated to the 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 for assessing physician performance in Quality Improvement processes, Standards, or in Complaints and Investigations.

The Standard of Practice on the Duty to Report must comply with the provisions in the *Regulated Health Professions Act, Personal Health Information Act,* and all other legislation.

The current duty to report provisions are scattered throughout the Standards of Practice and legislation and includes duties to report a colleague or self to CPSM. It also includes a wide variety of other mandatory and permissive reporting including, but not limited to:

- impairment to Manitoba Public Insurance and Transport Canada for driving and flying
- certain communicable diseases to Public Health
- a child in need to Child and Family Services
- sexual abuse of a patient
- births, still births, and deaths of patients
- gun shot wounds to the police
- correctional facilities
- privacy breaches

The intent is to create one Standard of Practice that will contain all duty to report provisions in one document. This Standard will establish circumstances that may require or permit physicians to make a report. It is not a substitute for legal advice regarding reporting obligations.

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 the duty to report.
- To develop a Standard of Practice on the Duty to Report which will be circulated to the membership, stakeholders, and public for consultation and review the results of that consultation process.
- To finalize a Standard of Practice for the Duty to Report.

Section 4: Chair and Membership

4.1 Chair

The Committee will be chaired by a Councillor yet to be determined.

4.2 Membership

Working Group Membership is to include representatives from:

- CPSM Council
- Family Medicine
- Specialists
- Manitoba College of Family Physicians
- Members of CPSM
- And any other representative that the Chair considers appropriate

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 the Duty to Report.

COUNCIL MEETING – SEPTEMBER 25, 2020

BRIEFING NOTE

SUBJECT:

Accredited Facilities Criteria

BACKGROUND

Council approved as one of its Strategic Organizational Priorities the review of the Accredited Facilities criteria for accreditation. A Working Group was established and prepared a Report and Recommendations. In its June 2020 meeting, Council reviewed the Report and Recommendations and approved its distribution for consultation with the members, stakeholders, and public. An advertisement was taken out in a Saturday's Free Press. The consultation period ran from June 26, 2020 to July 31, 2020. CPSM also reached out to each accredited facility to advise them of this consultation and to seek their input.

There were nine responses.

Attached are:

- Consultation document to Members and Stakeholders
- Summary of Consultation Feedback and Themes document
- Feedback letters

The Working Group continues to meet to finalize its recommendations from the feedback. No decision is required by Council in this meeting.

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ACCREDITED FACILITIES
Consultation to Members and Stakeholders

Need for an Updated Bylaw

The College of Physicians and Surgeons of Manitoba has, as its **statutory mandate, a duty to serve and protect the public interest**. Patients have a right to safe and good medical care and to be protected from harm, whether care is administered in a hospital or private practice facility. It is CPSM's expectation that each member operating a private clinic must adhere to appropriate measures to ensure no harm comes to patients. Clinics are subject to review by CPSM at any time to ensure recommended practices and procedures are being carried out safely and consistently.

Medical treatment services and procedures can be performed in a wide range of facilities from a tertiary hospital to a physician's office in the community. Hospitals are fully accredited through Accreditation Canada. Doctors' offices are not accredited. There is an in-between area that CPSM is called upon by the legislation to accredit. These are the non-hospital surgical facilities, also known as accredited facilities. A Working Group was formed to determine what types of facilities, performing what treatments, services and procedures should be accredited by CPSM. Members of the public must be satisfied that when they undergo medical treatment services or procedures it is done in a facility accredited by an external body if there is a threshold level of risk identified with that medical procedure.

The current Accredited Facilities Bylaw requires CPSM accreditation only if IV procedural sedation is undertaken on patients. A jurisdictional scan indicated that the Ontario and Western Canadian Colleges generally accredit facilities listed in the recommendations.

SUMMARY OF MAJOR RECOMMENDATIONS BY THE WORKING GROUP

*1 – Accreditation should be based upon diagnostic and treatment services and procedures that have a **sufficient risk of potential harm to the patient**.*

*2 - The **criteria for assessing sufficient risk of potential harm to a patient** include:*

- Level of Anesthesia and/or Sedation
- Need for Medical Device Reprocessing (infection risk)
- Complexity of Procedure and Risk of Complications

*3 – These **treatment services and procedures pose sufficient risk of potential harm** to a patient and should be accredited by CPSM if not performed in a hospital:*

- Procedural sedation[1]
- Oral sedation[2]
- local regional or general anesthesia, provided the standard of care requires monitoring of vital signs as a result of the administration of the drug to induce sedation or anesthesia
- the use of drugs by injection which are intended or may induce a major nerve block or spinal, epidural or intravenous regional block;
- flexible endoscopic evaluation of the gastrointestinal or genitourinary tract;
- cataracts and retinal procedures;
- Lasik therapeutic procedures;
- 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:
    - resection of a deep, major or complicated lesion;
    - 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;
- any tumescent liposuction procedure involving the administration of dilute local anesthesia;
- assisted reproduction technology, uterine evacuation procedures, and hysteroscopy;
- hyperbaric oxygen therapy;
- hemodialysis;
- only ASA 1 and ASA 2 procedures (not ASA 3) [3]
- 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.

[1] (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 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.)

[2] (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.)

[3] American Society of Anesthesiologists Physical Status Classification

*4 – **Privileging** at Accredited Facilities*

- Medical Director would approve privileges for individuals with existing Shared Health/Regional privileges
- Where no Shared Health or Regional privileges exist, or to vet the solo owner/medical director/practitioner:
    - Grandfather current privileged physicians
    - Use established Shared Health credentialing process to vet applicants using a program/specialty lens
    - Implement a non-refundable assessment fee paid to Shared Health/CPSM for the credentialing process
    - Privileges would be granted by CPSM through Program Review Committee

*5 – Strengthen the role of the **Medical Director***

*6 – Create **Practice Directions** to focus on regulation of surgical procedures and interventions that do not meet criteria for accreditation (whether performed in an accredited facility or not) yet require an added element of public safety/protection.*

- cosmetic injections, fillers, venous sclerotherapy and laser use
- hair transplant and
- autologous platelet rich plasma therapy

NOTE: The following procedures can be performed in any typical physician's community clinic and are exempt from being performed in accredited facilities:

PAP smears
Lumps and Bumps
Suturing

To review the full report, click HERE

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

Accredited Facilities consultation comments

Comments from CPSM Members
I am the Medical Director for XXXX. The only anesthesia, is topical or local anesthetic, and perhaps verbal anesthesia. The facility does skin procedures with BBL and laser, has done so for 12+ years. I administer Botox and Fillers for XXXX clients. I perform "Lumps and Bumps" as part of XX Medical Clinic on patients of mine and those referred to me, which I understand are not addressed with this accreditation effort. I do intra-articular, bursar and intra-tendon sheath injections in the office, as well as inserting and removing IUDs, lancing thromboses hemorrhoids, I&D of abscesses, etc. As a "grandfather" in real life (4 boys and counting), is my understanding correct that XXXX would be grandfathered? I find the guideline for accreditation satisfactory. I want to make certain that I am in compliance with your intent as well.
The decision by the committee to not allow ASA 3 patients from an anesthetic point of view to be done in non-hospital-based settings. This would severely interfere with the procedures that we perform at XXX Clinic for Assisted Reproductive Technologies (ART) As you know we have been doing Assisted Reproductive Technologies (ART) at XXX Clinic since 1997 and have gone through The College of Physicians and Surgeons of Manitoba accreditation every 5 years during that time and our most recent accreditation was in 2017 We have been providing conscious sedation with Midazolam and Fentanyl during that time to patients that exceed the BMI criteria that makes them an ASA 3 patient. As discussed, we need to have an exemption to be able to maintain Midazolam and Fentanyl in obese patients that exceed the BMI criteria. Over the past 24 years we have NOT had a complication with conscious sedation and egg retrievals. We always get the consultation for medically indicated problems patients may have a head of time. We have had one occasion when we had an anesthetist come to give Propofol as she had cervical cancer and it was done for better pain management. I hope this is satisfactory to show that we should be exempt from the committee decisions about ASA 3 Patients. If there is any further questions, please no not hesitate to contact me.

Accredited Facilities consultation comments

I have reviewed the prospective bylaw changes for accreditation of Non-hospital Surgical and Medical Facilities (NHSMF). They are a necessary addition to the process in Manitoba going forward as many medical practitioners and non-medical participants in aesthetic medicine are entering into the market. At the very least a facility must be run under the supervision of a qualified MD. Nurse practitioners are allowed to run clinics in Ontario but I think this is courting disaster. The standards can be broadly divided though into 3 levels of care: Level 1 , would be a clinic performing injections and minor procedures such as skin biopsies and non-laser light based treatments. A steam sterilizer and/or disposable instruments are a minimal requirement, with no sedation allowed. Level 2 would be allowed more invasive procedure with local and oral sedation available if required. No IV meds and no inhalation anaesthetics would be allowed though. Monitoring of sterile technique would be an additional accreditation factor to be addressed by the college in a semi-annual manner. At the risk of over-taxing the college if the clinic was trained or certified in laser use then this would be allowed too. A certified laser Specialist, such a s myself, should be available to accredit the facility as well. Level 3 would include the rest of the clinics such as they are now. Here, all standards need to be met for invasive deep surgical procedures under general anaesthesia. The current file on standards should be updated and sent to all clinics in the province wishing to perform any of the various procedures to insure that they are in compliance with the bylaws. If they are not then a sanction would occur and the possible closure of the clinic imposed. There should be no non-medical practitioners allowed to run NHSMF's either.
Hoping this is satisfactory for your purposes , I remain

I write this email to you in my position as the owner and medical director of XXX.

I applaud the CPSM for developing these standards but recommend the following comments, changes or additions:

1. I believe that a Plastic Surgeon should be included in your working group considering a majority of the procedures put forth involve those performed by Plastic Surgeons. I am happy to sit on this group if you are seeking a member of our specialty.

2. If the purpose of the bylaw is to ensure public safety and make recommendations as to procedures that require accreditation, I strongly recommend this report be a consensus agreement between the CPSM, Nursing College, Dental College, Pharmacy College and Public Health Minister. There are many nurse practitioners and aestheticians that fall outside the regulation of the CPSM and therefore would be able to practice unregulated and at the potential risk to the public. Furthermore many of these individuals are working in home basements, salons, and beauty bars with no regulatory body overseeing their infection control. As such these individuals would only fall under the guidance of the public health minister and nursing college. Furthermore pharmacy's in Ontario are allowing botulinum toxin to be administered (ie. Shopper's Drug Mart). I believe it is imperative that these other regulatory boards be involved for the safety of the public. Physicians only make up about 60% of those providing these treatments and as such regulations only serve to regulate us.

2. Many hospital based clinics have minor treatment rooms located outside the main operating area of a hospital. Despite being in a hospital they likely do not meet basic standards of infection control and sterility. Who is regulating and accrediting these sites within a hospital? Many non-hospital facilities perform treatments in spaces that are at a higher level of infection control and yet as a non-hospital site they require accreditation.

3. With regards to credentialing and physicians obtaining privileges beyond their scope of practice, the committee of their peers must also include those members who currently perform these procedures (i.e. a ob/gyn wishing to do breast augmentation should be reviewed by both Ob/Gyn and Plastic Surgery). Performing these operations during a weekend course or a few times during fellowship outside Canada does not qualify one to perform these operations safely. A thorough understanding of complications and taking care of the complications without burdening another specialist must be undertaken. The standard should be set as to what is performed in Canada and not use the US or another country with less regulatory control.

4. Appropriate credentialing to avoid confusion among the public must be mandatory on marketing/advertising and social media content. Only certificates/diplomas provided by organizations or groups who are recognized by the RCPSC or the American Board should be able to be advertised. There are numerous cosmetic diplomas that can be obtained following a multi-weekend course with no formalized or recognized testing by peers in the profession. They are advertised as if they are representative of substantial educational training and thereby potentially pose a risk to the public.

5. Bylaws and recommendations with regards to injectables/filler and laser treatments must define a basic education/training level for these procedures. Other provincial jurisdictions have also put this into place. Performing a week-end course or a webinar does not qualify a physician/nurse to be able to perform these procedures safely. Furthermore, do these professionals have the proper storage of products, knowledge to provide, or the ability to access reversal agents. We cannot rely on industry to monitor this or physician self-regulation. Once again this is must also include input from Public Health.

6. Professionalism on social media and advertising must be kept to the highest standards. An individual cannot make claims that they are "best", "top", or "#1". Furthermore one individual cannot claim that they are better than another individual. These are standards clearly provided by The American Society of Aesthetic Plastic Surgery.

7. Stating “lumps and bumps” unfortunately is a very general term. We often perform, and have for many years, carpal tunnel surgery, trigger finger, dupuytrens surgery (no major nerve blocks and no sedation of any kind) and often done in a office type setting. The procedures that should be allowed without accreditation should be an exhaustive list in order to leave no room for error or misinterpretation.

I have previously emailed some initial thoughts about standards of care as it would pertain to Lasik centers This email is a follow up to my first email.

To begin with, I feel that ASA 3 patients should be allowed to have eye surgery, especially cataract surgery, in non-hospital accredited facilities. A high proportion of my cataract patients would fall in this ASA 3 category and I do not think I have a unique practice. Limiting cataract surgery at accredited facilities to only ASA 1 or 2 is too restrictive. Offering cataract patients with ASA 3 status the option of eye surgery at accredited facilities, such as XXXX Centre, would not be an increased risk of an adverse event when compared to non-hospital Shared Health facilities such as Misericordia Health Centre. The following are the reasons for my opinion.

The evolution of cataract surgery has allowed for minimally invasive treatment, with less sedation required to keep the patient comfortable. Thus over time, I have been increasingly comfortable treating ASA 3 cataract patients at XXXX Centre. I prefer to treat some of these patients at XXXX rather than at Misericordia. At XXXX there is always an anesthetist present in the operating room as per present College guidelines. At Misericordia there is an anesthetic assistant in the operating room with an anesthetist in charge of 3 to 4 rooms. If I have the occasional patient that I feel may need constant intraoperative monitoring by an anesthetist, I book the patient's cataract surgery at XXXX Centre. This is because I do not have to make special arrangements to have an anesthetist present for their surgery. If there was an adverse event at XXXX requiring transfer to a hospital, of which I have had 1 in 25 years, the patient would receive the same high level of medical care that they would receive at Misericordia Health Centre. At both locations transfer to a hospital would be required.

Operating on ASA 3 cataract patients is no different in either a College accredited facility such as XXXX Centre or a non-hospital Shared Health facility such as Misericordia Health Centre. In both locations ASA 3 patients have cataract surgery with topical anesthesia and they are typically given at most minimal iv sedation. In both locations they are usually given no sedation or 0.5 mg po Ativan. In both locations patients would be transferred to a hospital if there was an adverse event. Treatment of ASA 3 cataract patients should be allowed in accredited facilities, especially when the preoperative assessment and expectation concludes that no iv sedation will likely be necessary.

At the present time any ophthalmologist doing cataract surgery at XXXX Centre is given less surgical time at Misericordia. Although this is not a College issue, restricting ASA 3 cataract surgery to only Misericordia Health Centre would presently increase the wait time for these patients, since their only point of access to cataract surgical care would then be Misericordia Health Centre.

I also feel that treating ASA 3 patients should be allowed at Lasik centres. The vast majority of PRK/Lasik patients would be ASA 1 and 2 but there are situations where ASA 3 patients request "cosmetic" PRK/Lasik surgery. There are situations, however, where PRK/Lasik is used for therapeutic reasons as the preferred treatment option for a medical condition. PRK/Lasik is not available in a hospital setting for these medically necessary treatments. Manitoba Health still covers the cost of their medically necessary treatment. To say that ASA 3 patients cannot be treated would prevent them from receiving the treatment of choice for their medical eye condition. These patients again receive at most only 0.5 mg of sublingual Ativan to alleviate some of their nervousness and the surgery is done with topical anesthetic.

My final comments are more related to my stage of practice and points of clarification. As an owner/operator of a XX centre. That could mean giving up my Shared Health privileges and stopping cataract surgery but wanting to continue my PRK/Lasik practice for a time. My understanding of this draft document is that ophthalmologists having privileges at a Lasik/PRK centre do not need any Shared Health privileges, since Shared Health privileges don't exist for Lasik/PRK. I, or someone in the same situation, could give up their Shared Health appointment and stop cataract surgery, but continue providing Lasik/PRK. This could happen as long as the Lasik/PRK centre being used maintained its accreditation with the College. Is this interpretation correct? This would be similar to what presently occurs locally at Lasik MD. Surgeons fly into Winnipeg to treat patients with Lasik/PRK and then the surgeon returns home. These surgeons have a Manitoba license but no Shared Health privileges. One difference between these two situations would be that I reside in Winnipeg to provide initial postoperative care whereas they leave within several days.

Thank you for inviting comments with respect to the ACCREDITED FACILITIES BYLAW CONSULTATION

Accredited Facilities consultation comments

I write to you,in my role, as Medical Director of XXX

It is certainly important for the safety of the public that outpatient facilities (hospital or non hospital based) are held to the same standards and expectations. For example in most ambulatory facilities patients would expect procedures to be done by their surgeon not an unidentified hospital designate.

Thank you for undertaking this review.

I would like to make some general observations based on experiences /observations;
Most untoward patient events over the last several years have taken place in dental/oral surgical offices. While this is somewhat outside the realm of CPSM, it is CPSM anesthesiologists who may be involved in these cases. Recent Covid events have certainly elucidated differences in standards/approaches between the two colleges. I still hear of dentists/oral surgeons complaining of the need for Preop Hx&Px. In the attempt to protect the public, standardizing accreditation and Guidelines between these two colleges would seem a worthy goal.
There is a suggestion that 'lump and bump surgery ' is so common and has a low morbidity that it need not be accredited, this is realistic,but Guidelines for sterilization requirements,pathology specimens etc are worthwhile to assure standardization and safety .
While multiple specialties are becoming involved in cosmetic medicine, neurotoxins and fillers, there may be a difference in how complications are handled between low and high-volume practitioners. Publications and presentations on the horrendous complications intravascular injections of fillers are easily found and becoming more and more frequent. A recent survey has indicated many injectors of hyaluronic injectables, don't carry hyaluronidase as treatment for these patients or know how to use it properly.
Certainly there is a role for CPSM in this area.
For small surgical clinics, with a single owner/operator /medical director there is a risk of lines /standards being blurred for convenience. Operating/ recovery rooms may be constrained especially with new Covid self-distancing realities. Low volume facilities could potentially have issues with drug supply/shelf life.
As well, these types of facilities may lend themselves to blurring the public's perception as to scope of their training such as OB/GYN practitioners expanding into cosmetic medicine and cosmetic surgeries (breast etc) or Otolaryngologists claiming to be a non-Canadian designated specialty of Facial Plastic Surgery , or fancy misleading websites stating" Winnipeg's first and only fellowship-trained Facial Plastic Surgeon. Unlike a 'general plastic surgeon,' has 6 six years of specialized training. "that tend to confuse and mislead the public. Making claims that cannot corroborated but are misleading" Dr. ..... is one of the top cosmetic and reconstructive facial surgeons in the country."
For single user clinics, reporting pathways for Complications, Medical Standards reviews should be clearly established. For example, XXXX reports to CPSM (for all complications) and to Misericordia Standards committee for cataract issues.
Out of interest, would Pan Am Clinic and hospital day surgical clinic be considered hospital or non-hospital based?

With respect to **specific Accreditation Recommendations**;

It would have been preferable to have included a Plastic Surgeon on the working group.

1, 13. 3.4.8. "Any procedure that the Committee directs, which must be performed in an approved, non-hospital medical or surgical facility" should prob read may or could. Must would indicate that it could not be performed in a hospital based clinic or facility.

"19.1.2 delete ASA Level III from the procedures that can be performed", this cannot apply to local cases as there may be many instances for excisions of skin cancer cases that these patients will be treated more expediently in a clinic setting.

2 Practise Direction seems reasonable, but working group would be remiss not to include a Plastic Surgery representative as they will represent original stakeholders in this area.

3.Grounds for inspection "may be performed at the discretion of the CPSM."
CPSM should certainly be informed of New services or procedures and a dialogue could ensue. College Inspection denotes a detailed facility review and takes a significant effort to prepare. I would not think that this would warrant the time or cost to either group. A dialogue and site visit is most likely a better description of what I imagine is meant.
Similarly, a critical incident and all complications are currently to be reported. A critical event should necessitate a discussion and possible site visit in a more expedited fashion, than an "inspection" implies.

1. "Strengthen the Role of Medical Director including responsibility for the following in addition to the responsibilities in the current Bylaw: 1) the procedures are performed in accordance with current accepted medical practice". This may imply a specific knowledge and judgement in fields of practice other than that of the Medical Director and a potential liability. This may be too onerous for the Medical Director to be considered an expert in other areas of medicine /surgery.

1. Privileging, 18.3 &18.4. Renewing privileges on an annual basis seems an excessive amount of work on both parties, it would seem more logical to inform CPSM of any changes on annual basis for both users and procedures. As all practitioners working at a surgical facility require admitting privileges in a SH or Regional Facility, then CPSM should inform Facilities of any change in member status. For Medical facilities, again, in order to treat patient complications physicians should have admitting privileges. For offices only performing injectables, then consideration of low /high volume users are important as are guidelines credentialing etc. In some facilities, such as XXXX, users belong to not only. CPSM but others to the Dental College, clarification of jurisdiction rules etc may need to be clarified. At this time as XXXX is a CPSM facility all users follow CPSM guidelines

Thank you for allowing comments

I have been a practising community Cardiologist in Winnipeg for over 10 years, and am writing this in response to the request for feedback regarding the proposed Accredited Facilities Bylaw for non-hospital medical/surgical facilities.

I must say that it is disheartening to see that the proposed bylaw does not specifically include Cardiac Exercise Stress Test laboratories in the list of facilities that should require accreditation by the CPSM.

While Stress Tests are generally associated with just a small degree of risk, this risk does include serious complications such as myocardial infarction and death. Furthermore, the risk associated with these tests is low only if:

(a) patients are selected appropriately for referral,

(b) requisitions are screened properly by the diagnostic facility,

(c) tests are conducted and supervised by qualified personnel in a fashion that meets published standards, and

(d) results are reviewed thoroughly and interpreted accurately by a qualified physician.

If any of the above criteria are not met then the risk to patients increases, and of particular concern is that an adverse event that occurs as a result could be catastrophic.

Upon further investigation I learned that Cardiac Exercise Stress Test facilities have not been on the list of those that require accreditation by the CPSM, and that documented standards regarding the operation of these facilities do not exist in Manitoba. I proceeded to carry out a jurisdictional scan myself and discovered that documented standards specific to Cardiac Exercise Stress Test facilities do in fact exist in other provinces in Canada:

1. In Alberta these facilities require accreditation by the CPSA[6].

2. In Saskatchewan the CPSS has adopted Alberta's standards[7].

2. In Ontario there is an organization known as the Cardiac Care Network that has produced a comprehensive document that details standards for the provision of all ECG-based diagnostic testing in that province[8].

…… It is therefore extremely discouraging to read the proposed bylaw as it is currently written, as Cardiac Exercise Stress Test laboratories are noticeably absent from the list of facilities that would require CPSM accreditation going forward.

To reiterate, our neighbouring provinces have previously recognized that Cardiac Exercise Stress Tests are associated with sufficient risk such that documented standards regarding the operation of the facilities that perform these tests are warranted, and, particularly in the cases of Alberta and Saskatchewan, that accreditation of these facilities by their respective Colleges should be required. Considering this along with what I have unfortunately witnessed in real-world practice in this province, the time for the CPSM to follow suit and accredit Cardiac Exercise Stress Test facilities in Manitoba is long overdue. I sincerely hope that the CPSM will not wait for more serious harm to come to a patient in one of these facilities before it decides to do so.

REFERENCES

1. American College of Cardiology / American Heart Association Clinical Competence Statement on Stress Testing. A Report of the American College of Cardiology / American Heart Association / American College of Physicians — American Society of Internal Medicine Task Force on Clinical Competence. Circulation 2000; 102: 1726-1738.
2. Recommendations for Clinical Exercise Laboratories. A Scientific Statement From the American Heart Association. Circulation 2009; 119: 3144-3161.
3. Exercise Standards for Testing and Training. A Scientific Statement From the American Heart Association. Circulation 2013; 128: 873-934.
4. Protocol for Cardiac Physiologist Managed Exercise Stress Testing 2003 (British Cardiac Society). http://www.bcs.com/documents/tech_protocol_2003.pdf.
5. Safety and Performance Guidelines for Clinical Exercise Stress Testing (The Cardiac Society of Australia and New Zealand). https://www.csanz.edu.au/documents/guidelines/investigations_procedures/Clinical_Exercise_Stress_Testing.pdf.
6. http://cpsa.ca/wp-content/uploads/2015/04/Standards_Cardiac_Exercise_Stress_Testing.pdf
7. https://www.cps.sk.ca/imis/CPSS/Programs_and_Services/Non-Hospital_Treatment_Facility_Program.aspx
8. https://www.corhealthontario.ca/resources-for-healthcare-planners-&-providers/ecg/ECG-Standards-Document-FINAL.pdf

Members of the Public

Response to Consultation on Accredited Facilities.

Accredited Facilities consultation comments

As stated, The College of Physicians and Surgeons of Manitoba has as its statutory mandate a duty to serve and protect the public interest. Patients have a right to safe and good medical care and to be protected from harm, whether care is administered in a hospital or private practice facility.
This initiative is an excellent example of the college fulfilling its responsibilities both to patients and practitioners.
I support the summary of recommendations being proposed.
I particularly like the expanded criteria as the processing of medical devices - can lead to infections. In terms of complexity of procedures and risk to complications - there has been quite a change from what used to be done in hospital and is now done in clinics - so I can't comment on the specific procedures. I'm glad to see it addressed.
In terms of the role of the medical director and privileging as a member of the public we can't comment on how it should be done. It is important and we would expect it to be done by the appropriate people. In this case by CPSM, Shared Health or whomever. The same applies to hospital procedures, our concern there that it is done and we can feel safe.
Overall, the report is well done and the college is to be commended for continuing to fulfill its statutory mandate a duty to serv and protect the public interest.
Keep up the good work and thanks

Stakeholders

Manitoba Health, Seniors & Active Living

Accreditation of Facilities:

- You will likely be aware that the proposed recommendations would need to uphold the principles of The Canada Health Act, and the requirements of provincial legislation and regulations, and specifically, The Regulated Health Professions Act and The Health Services Insurance Act (HSIA). Particular consideration should be given to sections 64.1 and sections 119 through to 130 of the HSIA.
- Our preliminary review suggests that the proposed accreditation recommendations seems to align with the aforementioned legislation. The recommendations could be more explicit in stating that all facilities seeking accreditation are to have obtained the necessary approvals as required under provincial legislation.
- With the aim that all recommendations should serve to strengthen provincial and clinical governance and oversight functions and patient safety standards, serve to create complementary healthcare service delivery between the public and private sectors, it appears that recommendation 4 – privileging at accredited facilities – supports achievement of these objectives through adoption of Shared Health's credential review process.

MHSAL
Manitoba Health, Seniors and Active Living appreciates the opportunity to provide feedback regarding Accredited Facilities "Summary of Major Recommendations." Several branches within the department have reviewed this information.

Response: The department offers the following for consideration by the College of Physicians and Surgeons.

- Generally, the department does not have any fundamental concerns with the changes as noted in the recommendations as it is the department's understanding that these changes have been in the process of being considered for some time.

- The department requests that a comprehensive list of areas that would not be captured within accreditation processes once the changes are in place be provided to the department to ensure there is ample communication and lead time to allow the opportunity to transition to alternate forms of accreditation for areas that are no longer included in the current process.

- It is noted that under *The Health Services Insurance Act,* (HSIA) labs must be approved to operate by an approving officer designated by the Minister. The procedures performed in labs must also be approved by the approving officer. In the past, this officer was the ADM of Health Workforce. The definition of Lab in the Act is:

  "laboratory" *means a place where*

  (a) the diagnostic examination or treatment of patients is performed by means of radiation emitting or non-radiation emitting medical imaging devices, or

  (b) operations and procedures, including the collection of specimens from the human body, are performed for the purpose of obtaining information for diagnosis, prophylaxis or treatment,

  but does not include

  (c) the office of a medical practitioner where diagnostic laboratory procedures prescribed by regulation are performed by the medical practitioner or an employee under his or her supervision solely for the diagnosis of patients of the medical practitioner,

  (d) the office of a dentist, as defined in The Dental Association Act, where diagnostic laboratory procedures are performed solely for the diagnosis of patients, or

  (e) the office of a person engaged in the practice of chiropractic, as defined in The Chiropractic Act, where diagnostic laboratory procedures are performed solely for the diagnosis of patients;

  The Diagnostic Laboratories Regulation under the Act provides:

  College of Physicians and Surgeons requirements
  5 *The owner or operator of a diagnostic laboratory shall operate the laboratory in compliance with the standards for diagnostic laboratories prescribed by The College of Physicians and Surgeons of Manitoba, as amended from time to*
  time.

- The department identifies that this is the point where the HSIA and the CPSM accreditation intersect. As the changes being proposed by the CPSM appear to apply to non-hospital surgical facilities, which may or may not have labs in them, the department requests information as to whether these changes will result in any implications/changes for labs.

In addition the CPSM currently falls under "*The Regulated Health Professions Act*" and the Act provides the following:

Application of this section

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.

Facilities must apply for accreditation

183(2) A facility to which this section applies must apply, in accordance with the by-laws, for accreditation under this section.

Prohibition

183(13) No member or medical corporation shall utilize a diagnostic or treatment facility the accreditation of which has been cancelled and that the council has ordered to cease operation.

Member must not work in non-accredited facilities

183(14) A member must not perform or cause to be performed diagnostic or treatment procedures in a facility that, in the council's opinion, requires accreditation under this section, but is not accredited

- The department seeks confirmation as to whether the proposed changes would require any facility or class of facility to be exempted by regulation from the application of section 183. In addition to what types of facilities that the CPSM is accrediting now, the department seeks to identify what facilities will no longer be accredited if the CPSM proceeds with the proposed changes?
- The department requests that the changes to accreditation process ensure that 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 in the accreditation process. To ensure that facilities continue to strive for quality as the degree of excellence, the extent to which an organization, private or public meets clients needs and exceeds their expectations in order to reduce and mitigate unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes must remain a priority.
- If you would like to discuss an of these comments please contact XXX.

College of Physicians & Surgeons of Alberta

On behalf of CPSA, thank you for the opportunity to read your draft standard and provide feedback.

The update is thorough; the listing of additional areas requiring accreditation adds clarity to the expectations of accredited facilities.

If you have any other questions or require additional information, please let me know how I may be of assistance.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING –SEPTEMBER 25, 2020

ITEM FOR INFORMATION

SUBJECT:

Strategic Organizational Priorities Update

BACKGROUND:

A Progress Tracking Document for the Strategic Organizational Priorities is attached.

Some of the Priorities are "on hold" until FMRAC provides a framework or national level agreement and direction. Included are the new three Strategic Organizational Priorities: Virtual Medicine, Duty to Report, and Patient Records. These were all part of the multi-year review of the Standards of Practice and Practice Directions that CPSM is undertaking. These are listed separately as each is a significant priority requiring a Working Group to proceed with the review.

The Strategic Organizational Priorities for Authorizing Medical Cannabis and Prescribing Benzodiazepines and Z-Drugs are marked as "Achieved" pending approval by Council at this meeting. If not approved the progress tracking chart will be amended.

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	Sep-20	Achieved	For Council Approval - Sep 20
Cannabis Authorization Standard of Practice		Sep-19	Sep-20	Started Nov 2019	Sep-20	July/August 2020	Sep-20	Sep-20	Achieved	For Council Approval - Sep 20
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	On Track	Council to review and approve for consultation
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	Not Started	
Patient Records - Standard of Practice		Sep-20	Mar 21		Dec 20	Jan 21	Mar 21	Apr 21	Not Started	
Duty to Report - Standard of Practice		Sep-20	Jun-21		Mar 21	May 21	Sep 21	Sep 21	Not Started	
Standards of Practice Ongoing Review - 4 Year Cycle		Jan-20	Dec-24						Delayed	Delayed due to COVID-19

Last revised: Sep 10, 2020

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – SEPTEMBER 25, 2020
NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Amendment to Central Standards Bylaw

BACKGROUND:

The Central Standards Bylaw sets out the grounds for the Committee to refer a matter to the Registrar for further action, at her discretion.

Referral to the Registrar

14. Central Standards may refer a member to the Registrar in the following circumstances:

a. the member failed or refused to allow Central Standards to carry out an action permissible under s. 99 of the RHPA; *(NB - section 99 grants CPSM powers to investigate a member)*
b. in the opinion of Central Standards, a remedial program is unlikely to be successful;
c. the member has failed or refused to follow the remedial program recommended or required by Central Standards or by a Subcommittee or comply with a direction made pursuant to ss. 182(4) of the RHPA;
d. Central Standards determines that there is evidence of misconduct or incompetence on the part of the member such that a remedial program would be inappropriate;
e. the member has failed to comply with an undertaking given to Central Standards;
f. in the opinion of Central Standards, the state of the member's health or competency is such that a clear danger to the public is perceived to exist.

The Committee is often faced with issues that a member's care may not meet the appropriate standard of care required for that patient. Both sections (d) and (f) address the standard of care through misconduct, incompetence, or danger to the public. Both sections require either a final determination to be made by the Committee, namely that there is evidence of incompetence or misconduct, or a clear danger to the public.

However, the Committee may not have access to sufficient information to make a final conclusion of a clear danger to the public, yet at the same time, the Committee considers it has enough information to warrant a thorough review and possibly investigation of the member's care in the public interest and to ensure patient safety. In those situations, the Committee has faced difficult

decisions – obtain further information for its review which causes delay and possible compromise to patient safety is one option. Another option is to make a determination on what might be considered to be insufficient information and review.

An additional criteria for a referral to the Registrar could provide grounds for referral yet not require a final determination by the Committee. The additional criteria could be that in the opinion of the Committee, the member's standard of care and/or competence may pose a serious risk to patient safety. This would provide a slightly lower threshold for a referral from the Committee to the Registrar.

Another note is that section (f) requires a "Clear danger to the public". It is suggested that the word public be replaced with patient safety.

At its meeting on September 4th, 2020, the Central Standards Committee passed a motion recommending that Council amend the Central Standards Bylaw 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".

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

As a self-regulated medical profession, physicians must ensure they have the knowledge, skills and clinical competence to practice medicine safely and the responsibility lies with the members of CPSM to ensure this high standard of practice. The practice of medicine is complicated, and its consequences can be life altering for patients. Patient safety must be paramount in all actions of the Central Standards Committee. These amendments will assist the Central Standards Committee to ensure the high practice standards required to all members are adhered to.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

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".

COUNCIL MEETING – SEPTEMBER 25, 2020

ITEM FOR INFORMATION

SUBJECT: Registrar's Report

1. Prescribing Practices Program Update

- Opioid Prescriber Profile – CPSM is working with the Provincial Drug Program to generate a Standardized Opioid Utilization Report (Prescriber Profile) for each physician prescribing opioids in Manitoba. The profile will analyze various opioid prescribing parameters using data from the Drug Program Information Network. This is an educational initiative and is now in the final phases of categorical comparison of physicians and their opioid prescribing practices.

- Audits - The Prescribing Practices Program has now conducted its first truly interdisciplinary practice audit in collaboration with CRNM and CPhM. After this particular practice group's audit, we hosted a 2-day workshop for them and are working closely with them to improve their methadone and buprenorphine prescribing patterns. For audits, this model holds great promise for interdisciplinary quality improvement work within the interdisciplinary team environment.

- Chief Medical Examiners` Death Review – Reviews all deaths involving prescription medications as well as deaths involving methadone and buprenorphine/naloxone (Suboxone). All prescribers involved receive standard cover letter plus a summary of the ME report, along with feedback on prescribing practices noted. 170 letters were sent in 2018 to 2019.

- Support around the implementation of the Opioid Prescribing Standard through online resources and individual case support/mentoring.
  - The Prescribing Practices Program developed an online list of resources, clinical tools, relevant Continuing Professional Development opportunities and Frequently Asked Questions to support physicians in implementing the Standard of Practice. Resources and Frequently Asked Questions were also developed for patients. These documents are housed on CPSM's website and are continually monitored and updated.
  - Physicians often contact CPSM with questions regarding resources for their patients who are experiencing difficulties with a variety of substance use and addiction issues. Other calls involve difficulties with prescribed opioids where there is no current clear diagnosis of ongoing chronic pain, addiction or a range of related issues. Providers often seek support in establishing a clear diagnosis and determining appropriate treatment options moving forward.
  - To support physicians, individual mentoring is offered that includes:
    i. Informal case discussion via phone or email.
    ii. Inquiries regarding the Standard of Practice for Prescribing Opioids are addressed in writing as needed.
    iii. Concerns and discussions are documented, and further support is offered.

2. Registration

The annual Certificate of Practice renewal process will commence on September 21, 2020. The deadline for renewal is October 31, 2020.

The questions on the renewal form for Physician Health were modified to clarify language and expectations of members to report. Examples of reportable medical conditions were provided to ensure members understand their requirements to report. The new questions include a preamble for context to assist members when completing the form.

Preamble to question 4:

Members have a legal and ethical responsibility to disclose to the College any physical or mental illness or disorder that impairs or may impair their ability to safely and competently engage in their professional practice, including any condition that may compromise the delivery of competent care. This duty is a fundamental component of self-regulation and is essential to patient safety and the integrity of the medical profession.

The College takes a confidential, supportive and rehabilitative approach to members who are experiencing both acute and chronic illness. Examples of reportable conditions include but are not limited to: cancer, neurological disorders, chronic pain, and mental health diagnoses, including depression and addiction.

Questions page:

Note: Questions 4 a) and b) exclude blood-borne pathogens; Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) or Human Immunodeficiency Virus (HIV). These are addressed separately at question XX.

4. a) Do you have, or has anyone ever advised you that you have, a physical or mental condition or disorder, including any addiction to alcohol or drugs, that may have the potential to impair your ability to engage in the practice of medicine in a safe and effective manner?

4. b) Have you ever had, or been advised that you had, a condition or disorder as described in question 4. a) that has the potential to reoccur?

3. Electronic Document Records Management System (EDRMS)

The Electronic Document & Records Management System (EDRMS) Project was "stalled" as a result of COVID-19 in March. At that time, we had received 4 proposals from consultants specializing in this area. We resumed the process in June and completed a Vendor Request for Proposal "scoring & selection process". As a result, Gravity Union Solutions was chosen as the successful proponent. This remains one of CPSM's priority initiatives for 2020-2021.

Gravity Union Solutions is the same organization that was selected by CPSBC and CPSO. Accordingly, we are in good company with the choice of this solution that will combine the Collabware platform to create intelligent electronic content management for use with SharePoint & Office 365 to improve CPSM’s information and records management.

The one thing that stood out from all the proposals received was the importance all the vendors placed on strong and regular communication to staff throughout the process. This will be critical to the success

of the staff's adoption and support as we move through the implementation. Gravity Union was particularly strong in this area and offered assurances that they will bring this level of support to us.

Benefits to CPSM will include increased productivity through:

- Electronic capture of all information content across CPSM
- Improved information sharing across departmental work groups and system boundaries
- Reduced manual effort through streamlined business processes
- Faster and more accurate retrieval of documents
- Ease and flexibility for staff by enabling access to information quickly leading to less tedious and frustrating work
- Reduced business risk by reduced risk of loss / inappropriate destruction of important corporate information
- Greater security and access control over sensitive information; comprehensive audit trails

A timeline for transition has been developed toward a completion date of April 2021.

4. Media Inquiries

Over the summer there were two flurries of inquiries from the media. One related to a physician's social media posts opposing the effectiveness of wearing masks to counter the spread of COVID-19. Another flurry of inquiries was in relation to medical notes required from physicians for exemptions to wear masks and exemptions from school attendance due to medical grounds in the COVID-19 pandemic. In these communications with the media CPSM stressed the importance of physicians following the direction and messaging of Manitoba Public Health.

5. COVID-19 Pandemic

CPSM issued a set of FAQs to guide the profession on two contentious issues for some patients and the public. These were regarding medical notes for:

- Exemptions from wearing masks where required to wear a mask
- Excusing attendance at school due to a medical condition of the student or of an immediate family member with whom they reside.

CPSM worked with Doctors Manitoba and Public Health to reinforce the one message for public safety during this pandemic.

I am working with others on Lessons Learned from COVID-19. This can help inform decision-making in the subsequent waves and for other pandemics or emergency events.

6. Meeting with Members of Parliament

At their request, Dr. Ripstein and I along with Kathy Kalinowsky met with Ms. Dancho and Mr. Lamoureux on the issue of cannabis grow-ops that are of significant concerns to many of their constituents. The Health Canada system authorizing medical cannabis to be grown by patients or others on behalf of patients was explained.

7. FMRAC Snapshot

Please see the attached for the update on the Federation of Medical Regulatory Authorities of Canada.

000143

Snapshot 2019 – 2020

Year in Review

Dr. Scott McLeod
President

Dr. Linda Inkpen
Immediate Past-President

Ms. Fleur-Ange Lefebvre
Executive Director & CEO

COVID-19 pandemic

- FMRAC Offices closed from 13 March 2020 to present day
  - FMRAC leases office space from the Medical Council of Canada (MCC); as an essential service, MCC was able to keep the building opened for basic services (IT, mail, etc.) and reopened for Phase One for essential services only (employees who must be on the premises in order to do their jobs) on 4 August 2020; there is no set date for Phase Two
  - All FMRAC staff continue to work from home

- Registration and licensure – FMRAC worked closely with its Members, the Royal College of Physicians and Surgeons of Canada (Royal College), the College of Family Physicians of Canada (CFPC), the MCC, the Association of Faculties of Medicine of Canada (particularly the Standing Committee on Postgraduate Medical Education), Resident Doctors of Canada, the Canadian Federation of Medical Students and the Canadian Resident Matching Service to arrive at satisfactory processes to register and license the graduating cohort of residents and students, and to ensure a fair match in 2021
  - *FMRAC Statement on Licensing the 2020 Graduating Cohorts (24 March 2020)* https://fmrac.ca/licensing-the-2020-graduating-cohorts/
  - *FMRAC Statement on Requirements for Full Licensure for the 2020 Graduating Cohort (26 March 2020)* https://fmrac.ca/statement-26-march-2020-2020-graduating-cohorts-requirements-for-full-licensure/

- 2020 FMRAC Annual Meeting and Conference – this event that was to have taken place in Halifax from 5-9 June 2020 was cancelled
  - The venue agreed to waive any penalty and allow FMRAC to use the deposits and contractual financial commitments to hold its meeting there in 2023

- Variance report compared with the previous year – the cancellation of several events and meetings (FMRAC Annual Meeting and Conference, President and staff participation at various conferences, and in-face meetings of the Board and working groups) resulted in savings of $50,000 to $55,000 in the first quarter (1 April to 30 June 2020) only

Organizational priorities

- Physician competence – the FMRAC *Statement on Physician Continuous Quality Improvement* was approved in October 2019 (https://fmrac.ca/physician-continuous-quality-improvement/)
- Prescription opioids – the *Framework for FMRAC Members on a Regulatory Approach to Physicians Who Prescribe Opioids* was approved in February 2020 (https://fmrac.ca/prescription-opioids/)
- Streamlined registration – ongoing
- Artificial Intelligence and the Practice of Medicine – ongoing
- Standardizing certificates of professional conduct – ongoing
- The impaired physician – the mandates of the working group was approved in February 2020
- Virtual care – new
- Bias and discrimination in medical training and practice – new

Board of Directors – issues and highlights

- July 2019 – MGen Andrew Downes, Surgeon General, accepts the invitation to participate as an observer at FMRAC Board meetings, on behalf of the Canadian Forces Health Services
- 20 August 2019 – by-laws; representatives to outside bodies; stem cell therapies; prescription opioids
- 18 September 2019 – verification of postgraduate medical education training
- 8 October 2019 – annual priority-setting; telemedicine framework; telemedicine standard of practice; Health Canada's Agile Regulations consultation paper; title protection
- 4 December 2019 – approval or affirmation of the financial policies; approval to work with the Federation of State Medical Boards (U.S.) on a plan to co-sponsor and co-host the 2022 International Association of Medical Regulatory Authorities International Conference on Medical Regulation in Canada (most likely Vancouver) – *N.B. All further work on this event has been halted due to the pandemic, with no further commitment on the part of FMRAC.*

Activities that are ongoing throughout the year

- Annual Meeting and Conference preparation and program development – *N.B. The 2020 event that was to take place in Halifax, NS from 6-8 June 2020 was cancelled due to the pandemic*

- Committee and Working Group meetings
  - *Core activities*
    - FMRAC Integrated Risk Management System (FIRMS) – meetings of the subject-matter expert subcommittees and the Risk Management Committee to streamline and convert to plain language the standards; in October 2019, the Board approved the revised standards
    - Registration Working Group – the practice eligibility routes to certification of the Royal College and CFPC; mandatory CPD reporting; streamlining the standards
  - *Working Groups*
    - Artificial Intelligence and the Practice of Medicine
    - Streamlined Registration
    - Prescription Opioids
    - Physician Competence
  - *Audit and Finance Committee*

- Surveys of Members and other stakeholders on a wide variety of issues, e.g.:
  - License application and renewal fees (done annually)
  - Number of MRA employees (including per department)
  - Boards of inquiry
  - Billing numbers

- Stem-cell therapies
- Medical student and resident sanctions
- University-based practice-ready assessments
- Title protection
- Compliance with mandatory CPD requirements
- Clinical assistants (done at the request of the General Medical Council in the U.K.)
- Emergency licensure
- Point-of-care ultrasound (POCUS)
- Continuing education specific to indigenous health and health care issues
- Moonlighting licenses
- Board / Council evaluations
- Pandemic issues
  - Flexibility in licensure during the pandemic
  - Licensing recently retired physicians
  - Provisional requirements for the 2020 graduating cohort (medical students and residents)

Federal Government – Health Canada

- Consultation on cannabis health products that do not require health care practitioner oversight
- Safe supply of opioids for people with addictions
- Cannabis for Medical Purposes – physicians authorizing unusually high amounts for people who grow or have someone grow their product
- Agile Regulations consultation paper
- Medical Assistance in Dying and the September 2019 judgement from the Québec Superior Court

External activities throughout the year

- Royal College Task Force on Periodic Reaffirmation of Certification (Dr. Heidi Oetter and Ms. Fleur-Ange Lefebvre)
- CFPC – Royal College – CMA Virtual Care Task Force (Dr. Oetter and Ms. Lefebvre)
- Council on Licensure, Enforcement and Regulation International Meeting in Vancouver, BC (Ms. Lefebvre)
- Canadian Patient Safety Institute consultations and annual general meeting (Ms. Lefebvre)
- Canadian Medical Association – National Health Summit (Dr. Linda Inkpen and Ms. Lefebvre)
  - Dr. Inkpen participated on a panel on licensure issues, including pan-Canadian licensure
- Canadian Medical Protective Association Annual General Meeting (Ms. Lefebvre)
- Canadian Forces Health Services – Memorandum of Understanding on the exchange of information about complaints involving military physicians
- Ms. Lefebvre attended and presented at meeting of the CPSNL Council

COUNCIL MEETING – SEPTEMBER 25, 2020

ITEM FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The full Executive Committee met on August 7 and September 2, 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.

Application for Reinstatement

The Executive Committee met to consider an application for reinstatement from a physician who has applied previously on several occasions unsuccessfully. This time the Executive Committee did not hear or consider on its merits the matter of that physician's application for reinstatement on the basis of *res judicata* (decision was previously decided) and abuse of process (re-arguing the case is abusive) and dismissed the application without a hearing.

Appeals of Investigation Committee Decision Hearing

There were three appeals of the decisions of the Investigation Committee heard by a panel of the Executive Committee. The decisions of the Investigation Committee was confirmed.

AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

Since the Council meeting in June, the Finance Audit & Risk Management Committee has not meet. At this time, there is nothing new to report. The Finance Audit & Risk Management Committee will meet on November 12, 2020 and at that meeting, we will review the CPSM's financial matters.

Respectfully submitted,
Dr. Jacobi Elliott
Chair, Audit & Risk Management Committee

PROGRAM REVIEW COMMITTEE REPORT:

Program review has not met over the summer but discussed several issues virtually including review of new lab and x-ray community facility inspections. While not strictly within the terms of reference of the committee, concerns over Dynacare lab wait times was relayed to the Deputy Minister by the Registrar.

Respectfully submitted,
Dr. Wayne Manishen
Chair, Program Review Committee

COMPLAINTS COMMITTEE REPORT:

Business has adapted well to the COVID environment. We reviewed complaints or other matters that have been referred to the Committee. From the start of this fiscal year, May 1, 2020, we have opened 34 new cases. A meeting will be held on September 15th, 2020. We are in the process of converting to paperless.

Complaint Received	Total Cases
May/2020	9
June/2020	5
July/2020	10
August/2020	10
Grand Total	34

Respectfully submitted,
Dr. Heather Smith
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

IC meetings will start on September 9th, 2020
IC will meet on monthly basis to expedite processing the outstanding files.

Staff from our department were quite involved in the boundary violation working group, and we continue to be busy with investigations.

We have added a social worker who will be assisting complainants through the process.

Respectfully submitted,
Dr. Nader Shenouda
Chair, Investigations Committee

QUALITY IMPROVEMENT COMMITTEE REPORT:

The Quality Improvement Program activities have resumed after a pause 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 September.

A cohort had been launched January 2020, comprising 159 participants. The work of the March 2019 cohort overlapped into this fiscal year as well. The participants to date have all been family physicians. The response has been good, with almost all participants submitting the required information and completing program requirements within a reasonable timeframe.

We plan to begin involving specialists in the program in 2020, beginning with psychiatry, general surgery, and pediatrics. A launch for psychiatry had been planned for March. In June, we contacted the first cohorts randomly selected for psychiatry and general surgery. Uptake was low, so the full cohort will launch in September. Dr Singer will present to the Department of Pediatrics Grand Rounds on September 24, 2020. A pediatrics cohort will launch later this fall.

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. We added the criterion of [CCFP after 2014] to our filter requirements for the 2020 intake as this specific examination is captured in the iMIS database. This will result in more physicians participating in the Quality Improvement program each year as there will be fewer deferrals. 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
- 1 – Awaiting first review by QI Committee
- 4 – Pending remediation/follow-up review

We have also had one case of non-compliance with program requirements; this case was referred to the Central Standards Committee.

Below is a summary of initiations/participants/completions for the 2019 and 2020 cohorts:

QI PARTICIPANTS

YEAR	INITIATED	PARTICIPATED	COMPLETED
2019	294	194	189
2020	157	88	49

In 2020, 41 participants were deferred. 28 participants from the January 2020 cohort have chosen to be deferred to the September 2020 cohort.

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 a status of 3 credits/hour, the highest level available.

Respectfully submitted,
Dr. Christine Polimeni
Chair, Quality Improvement Committee

STANDARDS COMMITTEE REPORT:

To be provided at Council

Respectfully submitted,
Dr. Roger Suss
Chair, Central Standards Committee

000150

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:				

ADDENDUM – Item 15 September 25, 2020 CPSM Council Meeting

Report of Central Standards Committee to Council September 2020

The Central Standards Committee (CSC) met once since June on September 4.

The new CSC reviewed the mandate of the College and the Committee as it relates to supervising the practice of medicine in Manitoba, recognizing that much of this work is performed through subcommittees. Those subcommittees have widely varying processes and often report both to their regions and to the College. The CSC has chosen to form a working group to clarify College expectations of Standards subcommittees. The Chair Dr Suss and the Assistant Registrar Dr Mihalchuk have begun meeting with the regions and with subcommittee chairs as a first step in increasing communication between the CSC and its subcommittees.

The CSC continues to perform some direct audits including Elderly Physician Audits and Referrals from the Chief Medical Examiner.

The Quality Improvement Committee continues to aid the College in meeting some of its mandate to supervise the profession.

By the end of the year the CSC hopes to be able to standardize its communication with its subcommittees sufficiently to be able to report the following outcome measures to Council.
Number of charts/physicians audited.
Number of letters of advice given.
Number of educational undertakings signed with individual physicians.
Number of referrals made to the Registrar.
Number of referrals made to other regulatory bodies.
Number of educational communications directed to the membership at large.

Roger Suss
Chair Central Standards Committee