September 2021 Council Meeting

Wednesday, September 29, 2021 | 8:00 a.m. |

AGENDA

Virtual Meeting via Zoom

	Time	Item		Action	Presenter	Page #
8:00 am	5 min	1.	Opening Remarks			
8:05 am	0 min	2.	Agenda	Approval	Dr. Elliott	
8:05 am	0 min	3.	Call for Conflict of Interest		Dr. Elliott	
8:05 am	5 min	4.	Council Meeting Minutes June 9, 2021	Approval	Dr. Elliott	3
8:10 am	30 min	5.	Standard of Practice Virtual Medicine	For Approval	Dr. Elliott/ Ms Kalinowsky	10
8:40 am	15 min	6.	Standard of Practice Exercise Cardiac Stress Testing	For Approval	Dr. Suss/Dr. Mihalchuk	84
8:55 am	25 min	7.	Truth and Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners – Terms of Reference	For Information	Dr. Ziomek/Ms Kalinowsky	88
9:20 am	10 min	8.	--- Break ---			
9:30 am	25 min	9.	Prescribing Practices Review - Terms of Reference	For Approval	Dr. Ziomek	94
9:55 am	20 min	10.	Standard of Practice Episodic, House Calls, and Walk-in Clinics - Terms of Reference	For Approval	Dr. Mihalchuk	101
10:15 am	5 min	11.	Strategic Organizational Priorities Progress Tracking	For Information	Dr. Ziomek	105
10:20 am	25 min	12.	Standards Subcommittee Report & Guidance Document	For Information	Dr. Mihalchuk/ Dr. Suss	106
10:45 am	10 min	13.	-- Break --			
10:55 am	10 min	14.	Accredited Facilities and Standards Committees	For Approval	Dr. Mihalchuk	139
11:05 am	15 min	15.	Registrar/CEO Report	For Information	Dr. Ziomek	142

11:20 am	**15 min**	**16.**	**Committee Reports (written, questions taken)** **i. Executive Committee** **ii. Finance, Audit & Risk Management Committee** **iii. Complaints Committee** **iv. Investigation Committee** **v. Program Review Committee** **vi. Central Standards Committee**	**For Information**		**151**
11:35 am	**15 min**	**17.**	**Review of Self-Evaluation of Governance Process – In Camera**			**157**
3 hrs 50 min			**Estimated time of sessions**			

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MINUTES OF COUNCIL

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on Wednesday, June 9, 2021 via ZOOM videoconference.

1. CALL TO ORDER

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

COUNCILLORS:
- Ms Leslie Agger, Public Councillor (left at noon)
- Ms Dorothy Albrecht, Public Councillor
- Mr. Christopher Barnes, Associate Member
- Dr. Brian Blakley, Winnipeg
- Dr. Kevin Convery, Morden
- Dr. Jacobi Elliott, Grandview
- Mr. Allan Fineblit, Public Councillor
- Dr. Ravi Kumbharathi, Winnipeg
- Dr. Daniel Lindsay, Selkirk
- Ms Lynette Magnus, Public Councillor
- Dr. Wayne Manishen, Winnipeg
- Dr. Norman McLean, Winnipeg
- Ms Marvelle McPherson, Public Councillor
- Dr. Charles Penner, Brandon
- Ms Leanne Penny, Public Councillor
- Dr. Ira Ripstein, Winnipeg
- Dr. Mary Jane Seager, Winnipeg
- Dr. Nader Shenouda, Oakbank
- Dr. Eric Sigurdson, Winnipeg
- Dr. Brett Stacey, Flin Flon
- Dr. Roger Süss, Winnipeg
- Dr. Anna Ziomek, Registrar

REGRETS:
- Dr. Brian Postl, Winnipeg
- Dr. Heather Smith, Winnipeg

MEMBERS:
- Dr. Jessica Burleson (left at noon)

STAFF:
- Dr. Ainslie Mihalchuk, Assistant Registrar
- Dr. Karen Bullock Pries, Assistant Registrar
- Ms Kathy Kalinowsky, General Counsel
- Mr. Dave Rubel, Chief Operating Officer
- Dr. Marilyn Singer, Quality Improvement Director
- Dr. Garth Campbell, Consultant, CC/IC
- Ms Jo-Ell Stevenson, Manager Qualifications
- Ms Wendy Elias-Gagnon, Communication Officer
- Ms Karen Sorenson, Executive Assistant
- Ms Lynne Leah, Executive Assistant
- Mr. Jeremy de Jong, Legal Counsel (Item 6)
- Ms Lynne Arnason, Legal Counsel (Item 10)

2. ADOPTION OF AGENDA

IT WAS MOVED BY DR. BRIAN BLAKLEY, SECONDED BY DR. ERIC SIGURDSON:
CARRIED:

That the agenda be approved as presented.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

Dr. Elliott 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. NADER SHENOUDA, SECONDED BY DR. ROGER SÜSS:
CARRIED

- That the minutes of the March 19, 2021 meeting be accepted as presented.

5. STANDARD OF PRACTICE – VIRTUAL MEDICINE

Adopted in the beginning of the COVID-19 pandemic, virtual medicine has been very beneficial for many patients. However, virtual care is not appropriate for every patient encounter and in-person care is often required, either for that encounter and at least intermittently. It is critical that virtual medicine be balanced with in-person appointments to provide good medical care to patients.

The draft Standard of Practice for Virtual Medicine recommended by the Working Group (chaired by Dr. Elliott) includes the ethical, professional, and legal obligations for members practicing virtual medicine. A survey of the public will be part of the communications plan.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. ROGER SUSS:
CARRIED

Council hereby approves the draft Standard of Practice Virtual Medicine for distribution and consultation with the membership, the public and stakeholders.

6. (A) STANDARD OF PRACTICE - DOCUMENTATION IN PATIENT RECORDS

The current Standard of Practice for Patient Records was chosen as a Strategic Organizational Priority and scheduled for review in 2020/21. The Working Group chaired by Dr. Stacey determined that the best approach would be to separate the current Standard for Patient Records into two documents, a Standard for Documentation in Patient Records, and a Standard of Practice for Maintenance of Patient Records.

Good medical care and patient safety require good patient records. The Standard now addresses the use of templates and macros, copying and pasting, billing documentation, and a cumulative summary of care. The Working Group recommends that that Standard be distributed for consultation.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. ROGER SÜSS that:
CARRIED

Council hereby approves the Draft Standard of Practice for Documentation in Patient Records for distribution and consultation with the membership, the public and stakeholders.

6. (B) STANDARD OF PRACTICE -MAINTENANCE OF PATIENT RECORDS

The Working Group recommended to Council a draft Standard of Practice for the Maintenance of Patient Records. The new draft Standard contains provisions for custody and control, maintenance agreements, and patient record abandonment. The Working Group recommended that the Standard be distributed for consultation.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. ROGER SUSS:
CARRIED

Council hereby approves the Draft Standard of Practice for Maintenance of Patient Records for distribution and consultation with the membership, the public and stakeholders.

7. STANDARD OF PRACTICE - DUTY TO REPORT

Creating a Duty to Report Standard of Practice was a CPSM Strategic Organizational Priority. A Working Group, chaired by Dr. Convery. This Standard of Practice is a centralized document that provides all reporting requirements. This Standard also establishes governing principles on notification of ongoing competence in practice, whether the reporting is of a colleague or of self. The Standard was modified following the feedback received in consultation.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. IRA RIPSTEIN that:
CARRIED

Council hereby approves the Standard of Practice Duty to Report Self, Colleagues, or Patients to be effective July 1, 2021.

8. STANDARD OF PRACTICE - PERFORMING OFFICE BASED PROCEDURES

Council recognized the need for CPSM to have a Standard of Practice to establish minimum practice requirements for those members conducting more complicated medical procedures in their offices so included the development of this Standard of Practice as a Strategic Organizational Priority.

The Working Group formed, led by Dr. Kevin Convery, recommended to Council that CPSM create a Standard of Practice for Office Based Procedures. These procedures pose a higher risk to patient safety yet do not meet the threshold for accreditation. These procedures are usually not performed for medical purposes and may be financially incentivized.

The Working Group recommends that the Standard of Practice for Performing Office Based Procedures be distributed for consultation. The Working Group also recommends that CPSM present the Standard of Practice to the Minister of Health and Colleges for other Regulated Health Professions to ensure that other regulated health professionals and unregulated aestheticians adopt at least similar, if not higher standards of practice to ensure patient safety regardless as to who provides these procedures.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. BRIAN BLAKELY that:
CARRIED

1. Council hereby approves the draft Standard of Practice Performing Office Based Procedures for distribution and consultation with the membership, the public and stakeholders.

2. CPSM present the Standard of Practice to the Minister of Health and Colleges for other Regulated Health Professions to recommend that other regulated health professionals and unregulated aestheticians adopt at least similar, if not higher standards of practice to ensure patient safety regardless as to who provides these procedures to ensure patient safety.

9. STANDARD OF PRACTICE - HOME BIRTHS

CPSM is the only regulator in the country that has such a Standard, and the Society of Obstetricians and Gynecologists of Canada provides clinical guidelines on how a physician is to support patients in out of hospital births. A Working Group, chaired by Dr. Ripstein, was formed consisting of the leading experts in the province. The Working Group recommends to Council that the Standard of Practice on Home Births be rescinded.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. ERIC SIGURDSON that:
CARRIED

Council rescind the Standard of Practice for Home Births.

10. STANDARD OF PRACTICE - MEDICAL ASSISTANCE IN DYING

An informal Working Group was convened to review the legislative amendments to the Criminal Code and to revise the Standard of Practice Medical Assistance in Dying to ensure that it is

consistent with and reflects the changes to the legislative framework in which MAiD is permissible. It has also been updated to include reference to the Provincial MAiD Clinical Team.

There is no duty to consult with members, stakeholders, and the public when revisions are made. The revisions to the existing Standard of Practice arise from a need to ensure compliance with the amended legislation.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MS MARVELLE MCPHERSON that:
CARRIED

The revised Standard of Practice for Medical Assistance in is approved, to be effective immediately.

11. STRATEGIC ORGANIZATIONAL PRIORITIES

For 2021-2022 the Strategic Organizational Priorities are:

- Prescribing Practices & M3P
- Truth and Reconciliation - Indigenous Anti-Racism Initiatives
- Standard of Practice Episodic Care / House calls / Walk-in clinics

12. STANDARD OF PRACTICE EPISODIC/HOUSE CALLS/WALK-IN CLINIC CARE

As the Standard of Practice Episodic/House Calls/Walk-in-Clinics was chosen as a 2021-2022 Strategic Organizational Priority, this separate agenda item was not discussed.

13. OPERATING BUDGET 2021-2022

The CPSM 2021-2022 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. NADER SHENOUDA, SECONDED BY DR. IRA RIPSTEIN
CARRIED WITH ONE OPPOSED

That the 2021-2022 Annual Operating Budget be approved as presented.

14. APPOINTMENT TO COMMITTEES

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

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. CHARLES PENNER that:
CARRIED

Council appoint membership in Committees for 2021-2022 as recommended by the Executive Committee.

15. ACCREDITED FACILITIES BYLAW

As part of a recent Strategic Organizational Priority, the Accredited Facilities Bylaw was amended to include various new procedures that if performed in a non-hospital medical or surgical facility, then CPSM accreditation of that facility would be required. A further refinement is required.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. MARY JANE SEAGER that:
CARRIED

1 - Council approve the following amendments to the Accredited Facilities Bylaw:

- s.13.3.3.iv "cataracts and retinal procedures" and 13.3.3.v "Lasik therapeutic procedures" be replaced with:
  "13.3.3.iv. the following Ophthalmological Procedures:
    - Cataract surgical procedures
    - Corneal laser procedures
    - Retinal procedures limited to scleral buckling and vitrectomies
    - Lasik therapeutic procedures"

2 – Council approve the following amendments to the Accredited Facilities Bylaw:

- s. 1.1.11 ""Standards" means the Standards approved by Council for facilities" be replaced with:

  ""Standards" means the Standards approved by the Committee for facilities."

16. 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.

17. COVID-19 PANDEMIC

Recent developments in COVID-19 and the protocol for transferring patients out of province was discussed.

18. MEETING DATES AND ATTENDANCE RECORD

Meeting dates for 2021-2022 and past 2020-2021 attendance record were presented to Council for information.

19. 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 1:10 p.m.

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Dr. J. Elliott, President

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Dr. A. Ziomek, Registrar

COUNCIL MEETING - SEPTEMBER 29, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Standard of Practice Virtual Medicine

OUTCOME SOUGHT: Approval by Council of this Standard of Practice.

BACKGROUND:

As a Strategic Organizational Priority, the Working Group had prepared a draft Standard of Practice recognising the immediate adoption of virtual medicine by the profession at the outset of the pandemic in March 2020. This draft Standard was distributed to the public, stakeholders, and members as per the direction of Council in June.

There is a current Standard of Practice for Virtual Medicine that is several years old. It is inadequate for the advent of full-scale virtual medicine brought on by the COVID-19 pandemic.

Consultation Process

CPSM launched a public consultation of the draft Standard. It is as critical to get the public's feedback as it is to get physician feedback. To ensure the consultation was readily accessible to the public, it was available as an online survey with predetermined questions and an option to provide additional comments. The actual Standard was available too for comment. Registrants had the opportunity to submit their feedback in written form as usual.

CPSM communicated the consultation in several ways:

To registrants:

- Placed announcement on CPSM website
- Email from the Registrar to every Registrant
- Announcement in the June Newsletter
- Email reminder from the Registrar partway through the consultation window

To the public:

- Placed announcement on CPSM website
- Placed ad in the Winnipeg Free Press (with QR code linking directly to survey)

- Targeted media outlets to have Dr. Mihalchuk on air to encourage public participation in the consultation - CTV Morning Show and CBC Radio.
- Invited stakeholders to provide feedback and share the consultation with their network and/or on their social media platforms (i.e. Manitoba Institute for Patient Safety, Assembly of Manitoba Chiefs, Manitoba Metis Federation, Immigrant and Refugee Community Organization of Manitoba, Manitoba Possible, Manitoba League of Persons with Disabilities)

Patient Survey Feedback

The survey was a tremendous success with 176 responses. CPSM has undertaken a survey and hopefully we can replicate it for some other consultations in the future. The survey was prepared by the new Communications Officer at CPSM, utilizing her experience (in addition to utilizing her experience to approach the media for interviews).

Attached are the survey questions, results, and feedback comments from the survey.

This was very helpful to inform the Working Group of how virtual medicine is working now, what patient expectations are, and how it can be improved (or even limited) in the future. The diversity of experiences and comments show the wide range of virtual medicine undertaken in the province.

Member and Stakeholder Feedback

There were 25 responses from the members and 10 responses from the stakeholders. Attached is a Summary of the Feedback, as well as the complete feedback from members and Stakeholders. The main themes to the feedback are summarized for your review. As always, the feedback is very helpful and improves the Standard.

CHANGES TO THE VIRTUAL MEDICINE STANDARD OF PRACTICE:

The Working Group met twice to consider the feedback.

As a result of the feedback the following are the main changes to the Standard of Practice for Virtual Medicine. The amended Standard as recommended by the Working Group is attached, for consideration for approval by Council. A track changes copy and a clean copy are provided so that the amendments can be easily viewed.

1 – For greater clarity defined electronic communication as telephone, video, email, text, or other internet hosted service or app, s. 1.1

2 – Application – Added the section on Application in 1.2 - This Standard does not apply to medical consultations or communications between CPSM members, nor to communications between CPSM members and other regulated health professionals. This Standard does not apply to emergency nor urgent care within the health care system.

3 – The General Provision was revised to provide additional clarity and focus on the blended model of in-person and virtual medicine:

> Each member's practice of medicine must include timely in-person care when clinically indicated or requested by the patient. It is not an acceptable standard of care to solely practice virtual medicine. [1] A blended care model balancing in-person and virtual medicine is required if providing virtual medicine. S. 3.1

4 – The patient has the right to ask for and receive in-person care. S. 4.2.1.iv, and 5.1.1.i

5 – Distant Rural and Remote Patients given more access to virtual medicine.

Members providing virtual medicine exclusively in remote communities may do so if part of the institutional health care system. S. 3.1 footnote

For the provisions requiring the member to have the ability themselves to provide a timely physical assessment of the patient or perform in-person assessments prior to a referral to specialists there is, "A limited exemption applies for patients in distant rural, remote, or institutional locations if this will hinder access to care." S. 5.2.1.ii and s. 5.5.1.iv

6 – Expansion of Institutional Supports

Members providing care for Ongomiizwin Health Services and Northern Manitoba, CancerCare Manitoba, or other public organizations supporting medical care including hospitals or long-term care facilities, may rely upon institutional supports and systems for the delivery of virtual medicine. For instance, if safe to the patient, a physician providing care to a remote community may rely upon a nurse practitioner in the community to perform a physical assessment, or a specialist may rely upon a family doctor in a rural area to perform a physical assessment. These institutions might also have special alternate arrangements for delivery of care to distant rural and remote patients. S. 5.2.2 and footnote

7 – Specialists – The need for a physical assessment prior to referral was strengthened, but it can be waived by the specialist or if the patient is in a distant rural or remote community and the in-person assessment may hinder access to care.

8 – Video as the Preferred Medium for Virtual Medicine was added, both to address the patient survey and as a best practice for patient-physician interaction.

9 - Additional protections for privacy, confidentiality, and consent were included. These were largely instigated by the patient survey results.

CONTEXTUAL INFORMATION AND RESOURCES

A document outlining further information to assist members in their understanding is prepared and attached.

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 has now emerged as one of the preferred mediums of accessing medical care for many patients, and for some physicians. However, it is not always the optimal way to access or provide good medical care, and in many instances precludes the provision of good medical care. The Standard tries to ensure virtual medicine is good medical care, and if it can not be used to provide good medical care, then must not be utilized. Achieving the balance between in-person and virtual medicine is critical for good care. That balance is specific to each individual patient encounter.

In drafting the Standard of Practice for Virtual Medicine the Working Group tried to ensure the minimum requirements for virtual care are established in the interest of the public for patient safety to ensure the provision of good medical care.

The patient survey provided great information to inform the Working Group on the perspective of the patients and their mixed experiences with virtual medicine. Many of their comments and results led to changes in the Standard.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> The Standard of Practice for Virtual Medicine, as attached, is approved, to be effective November 1, 2021.

VIRTUAL MEDICINE STANDARD OF PRACTICE
SUMMARY OF PATIENT SURVEY FEEDBACK

1 – FAVOURABLE OVERALL

Overwhelmingly favourable experiences with virtual medicine.

2 – CONTINUATION OF VIRTUAL MEDICINE POST-PANDEMIC

Patients want virtual medicine to continue in the future post-pandemic.

3 – BLENDED CARE OF IN-PERSON AND VIRTUAL MEDICINE REQUIRED FOR FUTURE

Patients consider virtual medicine good for visits such as prescription refills for some chronic but stable conditions, very minor new conditions, and if with a long-standing patient-doctor relationships, or at times with certain specialists depending upon the condition. However, many patients indicated that there are many conditions and circumstances that require in-person care and this must be provided in a timely manner. In-person care should be the usual care, with virtual care augmenting in-person visits.

4 – ACCESS TO MEDICAL CARE

The ability to skip travelling to the physician's office was mentioned many times by those outside Winnipeg as providing easy access to medical care. Even within Winnipeg, many indicated it was easy to have elderly parents attend without adult children having to take time off their work, parents appreciated not having to transport all children to physician's office just to see one family member, and many patients said they actually addressed medical issues virtually that they would have neglected if they had to attend in person and take time off work.

5 – CONVENIENCE

Patients liked not travelling to physician's offices, not parking, and not waiting in waiting rooms. They liked the ability to answer the phone when the doctor called.

6 – VIRTUAL MEDICINE FAILING TO MEET THE STANDARD OF CARE

There are numerous examples provided of patients alleging their doctor was not able to correctly diagnose a condition over the phone which should have been seen in-person. Many say their health suffered as a result. These items are highlighted in red.

7 – SOME PHYSICIANS REFUSING TO SEE PATIENTS IN PERSON

Patients struggled with physicians providing only virtual care or limited access to in-person appointments that were delayed.

Some patients were dissatisfied that their doctor failed to conduct any in-person examinations during long periods of COVID. This may not meet the standard of care, depending upon the circumstances, though it is difficult to understand how a family doctor or a specialist (minus psychiatry) could meet the standard of care with a total virtual practice.

8 – BLENDED CARE OF IN-PERSON AND VIRTUAL MEDICINE REQUIRED FOR FUTURE

Patients consider virtual medicine good for visits such as prescription refills for some chronic but stable conditions, very minor new conditions, and if with a long-standing patient-doctor relationships, or at times with certain specialists depending upon the condition. However, many patients indicated that there are many conditions and circumstances that require in-person care and this must be provided in a timely manner.

9 – PHYSICIANS MUST PROVIDE TIMELY IN-PERSON APPOINTMENTS IF REQUESTED BY PATIENT

Patients are insistent that they should obtain in-person appointments if that is their preference and/or they believe their condition may require in-person care. Several alleged that their doctors refused their demands of in-person care.

10 – VIRTUAL CARE CAN NOT BE DONE FOR ANNUAL PHYSICALS

Several patients indicated their doctors were not conducting annual physicals due to COVID or physicals required for certain assessments. They thought this was wrong.

11 – DIFFICULTY IN COMMUNICATION

Some expressed difficulty in communication through virtual medicine. Many said they found it difficult to describe their condition and preferred in-person care. Some patients mentioned difficulty in hearing making virtual medicine more challenging and not as effective.

12 – VIDEO SEEN AS THE BEST MODALITY FOR VIRTUAL MEDICINE

While most virtual medicine is conducted by telephone, many patients stated that video was preferred as the doctor could then see the condition if visible or could catch subtle communication and body language queues (such as not understanding the questions).

13 – DIFFICULT TO ESTABLISH DOCTOR-PATIENT RELATIONSHIP IN VIRTUAL MEDICINE

Many patients indicated that virtual medicine worked well for them since they had lengthy relationships with their doctors, but some indicated it would be difficult for new patients and doctors.

14 – PRE-SCREENING BY OFFICE STAFF UNHELPFUL

Several indicated that the pre-screening by office staff at the medical clinic was unhelpful or at times seemed design to deter patients from attending in person.

15 – IMPORTANCE OF ESTABLISHING IDENTITY AND CONFIDENTIALITY

Many stated that there are important requirements for virtual medicine. The confidentiality should be for both the physician and the patient.

16 – ACCESS TO CARE FOR FIRST NATION PATIENTS

"Please keep it in place. We need it. Especially for my First Nations brothers and sisters who live in these communities and now have increased access to doctors services. We didn't have good access to doctors before in our communities and now we do, so please do not take it away from us. Some of our health centers only have a doctor once a week for a half-day, once a month, or even less. How can that access provide adequate health care to our community members? It can't. Now we can see doctors more often as we have this virtual option available to us. It is complementing our current health care services in our communities, not competing with them. so please do not take it away or make it difficult to access for us with new rules. We can't lose it or have it taken away from us or make it difficult to access with all these new rules you are suggesting about the doctor needing the ability to see us personally in person themselves. having them able to refer to another doctor is much better than putting up a roadblock of that same doctor has to see us personally. How can we do that when we live in places like Garden Hill, Red Sucker Lake, Berens River, Nelson House etc, and the doctor we saw lives in Winnipeg. We got seen by the doctor and we otherwise would not have been seen, so that is what matters to us. Some of our Elders now can see a doctor when they otherwise would not. If the doctor decides on the virtual appointment that we need to fly down to Winnipeg to get extra in-person treatment then that is good enough. They can decide that then, don't stop them from seeing us all together because the doctor isn't physically there to see us too. It is increasing our access to healthcare services in our communities and can not be taken away or restricted in order to make it difficult for us to see a doctor. Virtual appointments are doing a good thing for our communities and we don't want to lose them. Don't take them away from us or make them hard or impossible for us to access them. Our people need these services."

SUMMARY OF MEMBER AND STAKEHOLDER FEEDBACK

1 – VIRTUAL MEDICINE TO CONTINUE

Introduced during the pandemic, virtual medicine has been overwhelmingly successful in providing care to many patients.

2 - DEFINITION OF VIRTUAL MEDICINE

Many requested a more comprehensive definition of virtual medicine – to include the examples of telephone, text, email, video, or internet based platform.

3 – RURAL AND REMOTE EXEMPTION FOR IN-PERSON CARE

This was probably the most commented on aspect of the feedback from the profession.

There are provisions in the draft Standard that:

- require virtual medicine to complement in-person care.
- indicated that an acceptable standard of care requires in-person care and that it is an unacceptable standard of care to solely practice virtual medicine.
- require the doctor providing virtual care to have the ability to provide in-person care themselves.

The intent of the provisions were to require a blend of in-person and virtual care and to prevent the type of solo virtual medicine that can not meet the requirement of good medical care.

Many physicians questioned whether this was to be interpreted as an overall requirement for a practice (ie can not conduct an entire practice over the phone) or on an individual patient basis (must see each patient in-person at least once). Many provided excellent examples of excellent virtual care they provided virtually to patients and how the need to provide in-person care would either be difficult, costly, or not timely:

- Psychiatric consults in a personal care home
- Specialist care (often one or two visits) provided for rural/remote patients without them having to travel the distance to Winnipeg
- Increased medical care access for First Nations patients on reserves
- Some work shifts for RHAs/HSC/Children's clinics that provide exclusively virtual medicine
- Their clinic uses a team based approach to provide in-person care
- Emergency medicine delivered by paramedics on instruction by physicians

Several physicians stated that they were able to have patients obtain certain tests (or listen to their chest or blood pressure) in their community which then did not require an in-person assessment in Winnipeg.

The requirement to provide timely in-person care to patients located at great distances would hinder access to medical care. (ie patient in Churchill being treated by Winnipeg doctor).

4 – ONGOMIIZWIN HEALTH SERVICES AND NORTHERN HEALTH SINGLED OUT

There are many other institutional supports that exist that can provide excellent virtual medicine, such as Cancer Care, pediatric emergency at Children's Hospital, RHAs, institutional clinics, and other institutions that support medical care in the north or rural and remote areas.

5 – PSYCHIATRY MOST SUITABLE FOR VIRTUAL MEDICINE

A recurring theme was an exemption to in-person care requirements for psychiatry (and mental health) since it lends itself quite well to virtual medicine.

6 – REFERRAL TO A SPECIALIST REQUIRING IN-PERSON EXAMINATION

Some specialists documented they receive referrals without the patient having been seen by the referring doctor in person which they considered problematic. Others noted that the in-person visit was problematic due to the remote location of the patient, or that it was obvious that a referral was required (addictions medicine referring to hepatology as one example).

7 – OPIOID AGONIST THERAPY AND ADDICTIONS MEDICINE

The shortage of physicians who provide opioid agonist therapy (methadone/suboxone) in rural and remote communities and the high demand for frequent patient encounters by many of these patients means that this care is frequently provided by virtual medicine, and often by team members. Often there are no Opioid Agonist Therapy providers in communities where there is a need, so care is provided by a mix of virtual and other care givers.

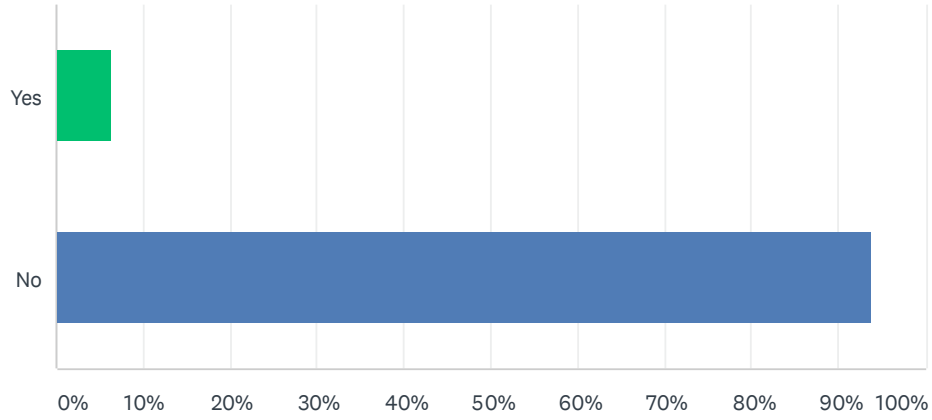
Patients relying on opioid agonist therapy from other jurisdictions may travel to Manitoba and require temporary bridging of their methadone. This is usually done by virtual medicine given the immediacy of the need and/or the location of the patient and/or the difficulty of the patient accessing medical care as some are vulnerable patients.

8 - PRIVACY AND CONFIDENTIALITY

Several noted the importance of privacy and confidentiality for both the patient and the practitioner. Similarly, consent from the patient for virtual medicine should also be a requirement.

Q1 Are you a physician currently practising in Manitoba?

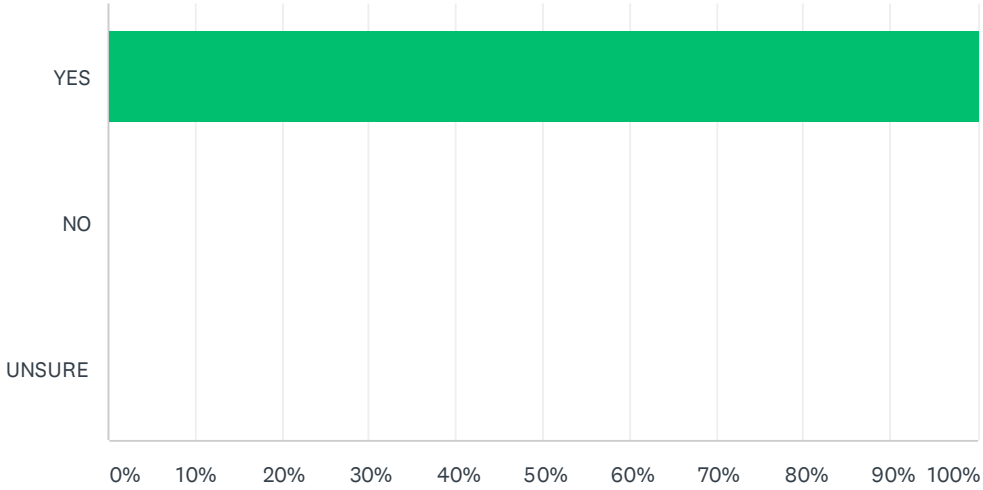
Answered: 176 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	6.25%	11
No	93.75%	165
TOTAL		176

Q2 Have you, or a dependent family member, participated in a virtual medicine visit (phone, video, text, email) with a doctor in the past 15 months?

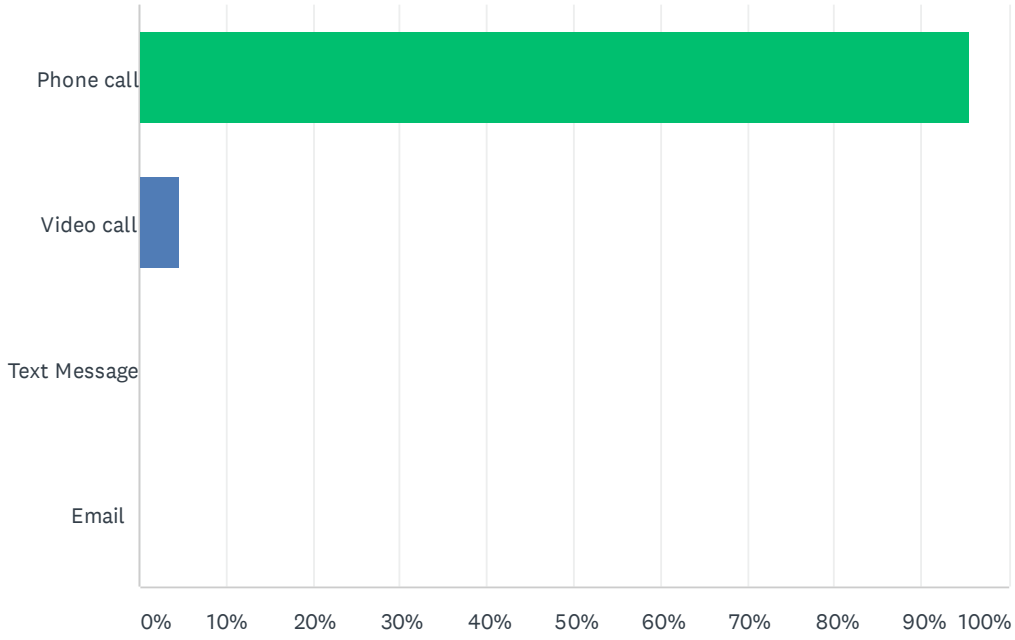
Answered: 176 Skipped: 0



ANSWER CHOICES	RESPONSES	
YES	100.00%	176
NO	0.00%	0
UNSURE	0.00%	0
TOTAL		176

Q3 How did you interact with the doctor during your virtual appointment?

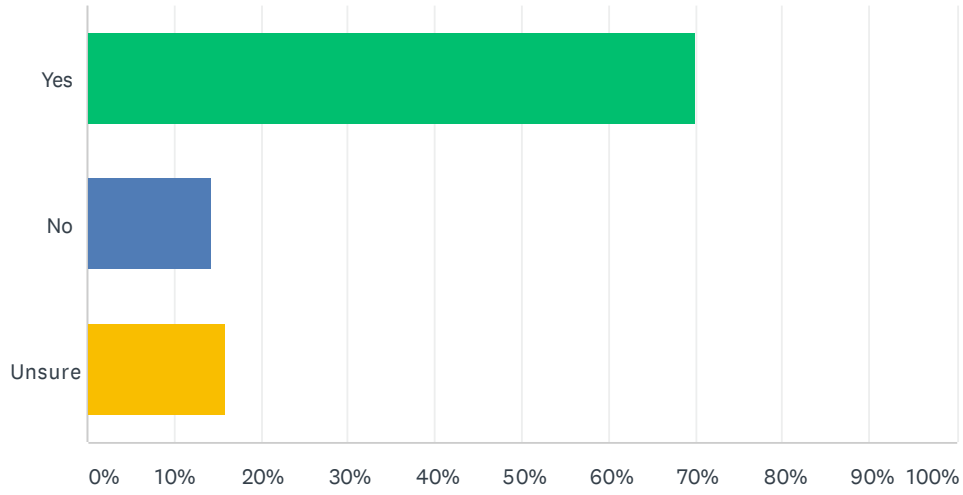
Answered: 176 Skipped: 0



ANSWER CHOICES	RESPONSES	
Phone call	95.45%	168
Video call	4.55%	8
Text Message	0.00%	0
Email	0.00%	0
TOTAL		176

Q4 Before beginning your appointment, did the doctor confirm your identity?

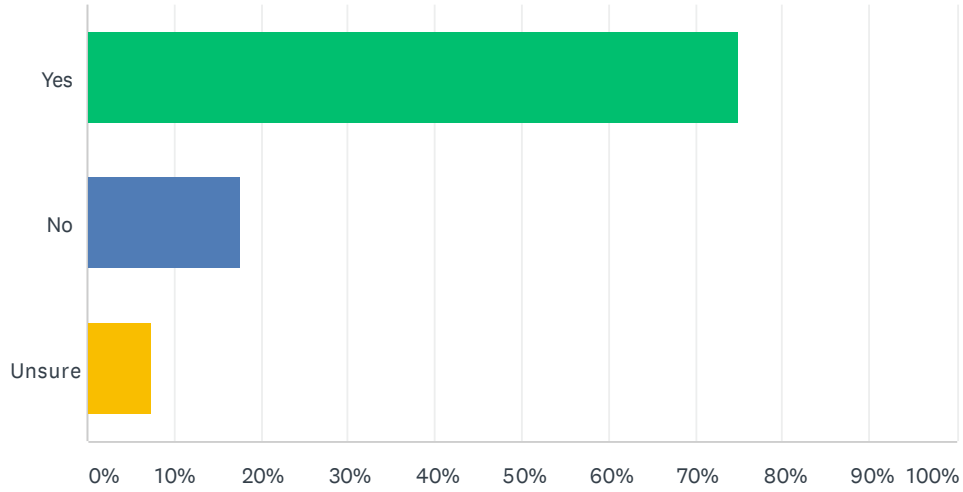
Answered: 176 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	69.89%	123
No	14.20%	25
Unsure	15.91%	28
TOTAL		176

Q5 Do you feel your needs were met by virtual medical care?

Answered: 176 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	75.00%	132
No	17.61%	31
Unsure	7.39%	13
TOTAL		176

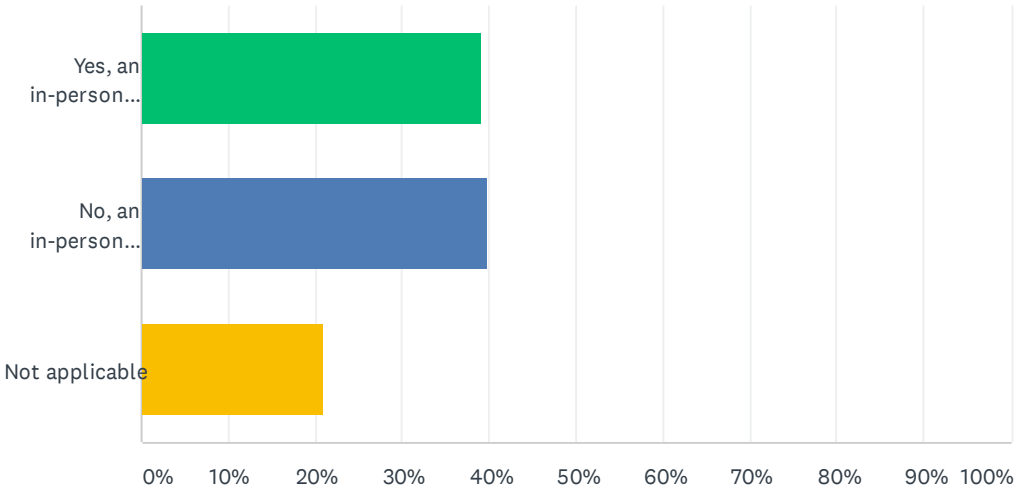
Q. 5 - Do you feel your needs were met by virtual medical care? (Yes/No with the option to add a comment) If you have any additional comments about your experience with virtual medical care, please enter them here.
Felt appointment was rushed, no personal interactivity, lack of empathy; had never met primary doctor prior to virtual visit
My doctor and I have known each other for over 18 years
much prefer it for certain topics. A med renewal (long standing medication)- much easier, less wait time to do it over the phone.
It is great for: 1) quick follow-ups, 2) receiving the results of tests, 3) questions about minor medical problems
The phone call was for a simple lab result and a phone call was sufficient
It does feel like something is missing without that face to face contact but in terms of task completion my needs were met i.e. reviewed medication and lab values. Did not have weight or blood pressure results other than what I provided from home
The patient (a family member) doesn't trust the physician or understand the process, so they were not wanting to discuss the issue - ended up as an unhelpful appt and the patient was left with the same issue
I would prefer a video call (the doctor doesn't need to show his/her face but I wish I could show the doctor what I am talking about).
For most part needs were met but was a prenatal appointment so didn't get the weight, blood pressure, urine tests done
My needs were met on a temporary basis only. Also, the discussions were based on in-person visits that we had had prior to the pandemic. My doctor and I have already agreed that once they settled down, I will need to be seen for an in-person visit when things settle down.
Fantastic. Many needs do not need in person visits to be addressed. I feel strongly about wanting this access in the future to not have to miss half a day of work for simple needs.
It was a great experience. It was much easier than waiting to see a doctor in a packed waiting room. It was much more private than going to a clinic with other patients arounds me.
I love the convenience of virtual care - I can stay at work or with my children and not have to travel, wait in a waiting room, pay for parking, etc.
A telephone call Dosent compare to face to face conversation
I think she said "Hi X", but she didn't ask DOB, address etc to confirm
i felt a little rushed
The purpose of the call was regarding prescriptions (refills) and was not dealing with new health conditions
I also had in person visits
For straightforward issues, especially if following up with a pre-existing condition, this makes a lot of sense. Obviously for something new that requires an examination, in person still required.
The physician determined that I needed an in person appointment as there were too many questions that had concerning answers.
It is better than nothing, but in-person care is preferred.
Found it difficult to explain issues over the phone
In the 7 appointments some needs were met, some partially, some not at all.
Only took care of half my needs. Some things require in person visit such as physical injury to make proper assessment. Felt rushed in apt. Even after being specific Dr. got prescriptions wrong.
I really appreciated the virtual care because I got excellent care without having to drive 8hrs round trip to see the doctor.

I only needed a form completed for work so the call appt was sufficient. We did start out on a video call but poor internet connection at my end ended the video call.
For routine care safer and less greenhouse gas generation.
Very convenient!
I would be ok to continue with a certain amount of virtual appointments post pandemic, but I think video needs to be available.
On 2 occasions, I requested phone appointments because I am immunocompromised and cannot currently can not get COVID shots because thy would not be effective due to ongoing IV treatments I am undergoing. This means that I risk COVID exposure going to hospitals and clinics.
I hadvto takw my blood pressure and weight and call the office to add to my file.
At the time of the virtual visit there were very few in-person appointments happening. Going forward I hope the patient will have a choice if they want virtual or not.
Convenient and preferred (when suitable)
Prescription renewal and reviewing test results from in person appointments
I would like to be able to do a virtual follow-up so the professionals can have assurance as to whether their advise works.
We have had calls with our family Dr, texts to notify us of completed test results, observed the test results by email and then discussed them with our family Dr by phone. As a retired RN I am impressed with this system. Also as my husband has seen our family Dr in person, I am on his cell phone, on speaker phone, with our family Drs permission, and able to participate in the check up conversations as my husband prefers. Again this is a great way to practice medicine
I have seen both doctors over a number of years so checking my identity was not needed
Video appointment is a preferred option versus just a phone call
By virtual care, by physician did not get to hear my lungs, or assess me in person. His office refused to see me despite having negative covid test.
it was a minor ailment but required a prescription, anything more serious and I don't think a virtual appointment would be suitable
I would have preferred a videoconference call so that I could see as well as hear / speak with my physician
I do not think it is an answer for all appointments but for simple needs it worked perfectly and save a 200km return drive
Referrals not done
with my GP for RX refills, yes, with my cardiologist- not at all; he was in a rush, didn't want to answer questions, then hung up five minutes into a 15 minute appointment before I'd finished asking all my questions.
I have had phone appointments with both my medical practitioner and my Rheumatologist and found both satisfactory. I hope this can continue and in fact be expanded to include face to face via technology. I live 4 hours from Winnipeg so that is very difficult!!
Video chat would have been useful.
video would have enhanced the experiences
My Doctor admitted he could not properly diagnose my condition over the phone and refuses to see me due to Covid restrictions.
Before being accepted for a telephone call the receptionist grilles you and then decided if one was warranted. Getting a phone appointment was a month later., only to be told you should come in two weeks later. Advised could send photo of issue which doesn’t show anything when it is internal.
I had a lump on my arm and it was difficult to explain without the doctor seeing it.
Refill of prescriptions less stress eg for hyperlipdemia. As patient signs symptoms described for recurrent lab work. Faster results

I liked it, as I have a chronic illness and I didn't have to drive across the city and waste valuable energy to go to the doctor.
Please read above notes/ comments I wrote.
I have had virtual appointments for post surgery follow up and pre surgery anesthetic, as well as GP and phone walk in appointments. I love them. They are easier for me to schedule around work with the least interruptions. For routine, prescription refills and minor ailments I find these appointments efficient and thorough and I hope this practice continues. At no time have I felt like that the doctors were not able to care for m needs effectively through virtual or phone calls. I was scheduled for face to face appointments when needed. I sure hope this standard of care will continue beyond the pandemic.
I had a physical over the phone. My doctor basically did a history but it felt superficial.
In the before times I would have to sit in the waiting room for 2+ hours to see doctor for a prescription refill. Now I can be at home … and still wait one hour past the predetermined time for her to call me. Beats wasting 3 hrs (incl travel time) for a 7 minute in person visit.
For some of my appts my needs were met but not for some
I have two virtual apps. One with my GP and another with my Endocrinologist
patient/doctor interaction is critical, how do you check BP over the phone? How does the doctor assess visual queues, skin pallor, overall condition over the phone? Is the expectation that a patient tell the doctor what they think the problem is? Whose the doctor?
Not giving prescriptions that are taken routinely should not need a virtual appointment. Seem just a money grab.
It was an excellent use of both of our time!
This is an excellent way to see your doctor for minor issues.
I feel that some things need to be seen or felt by an experienced physician especially when you do not have access to video feed
I don’t feel my doctor listened to me.
Felt safer this way than going into the office. Accomplished everything that an in person appt would have done. Appt were pretty much on time
It's hard to explain symptoms. A physical examination is important. A Doctor could notice what you can't,or can't explain
I felt the appointment was very, very short. I felt like the doctor wanted to get off the phone asap. (he was about 40 minutes late calling me, so perhaps trying to make up time)
My phone appointment was supposed to be at 11:00 a.m. I had indicated that I would like them to use my cell
I monitor my BP and P to observe my results and able to give info.
much prefer it for certain topics. A med renewal (long standing medication)- much easier, less wait time to do it over the phone.
The phone call was for a simple lab result and a phone call was sufficient
I really appreciated the virtual care because I got excellent care without having to drive 8hrs round trip to see the doctor.

Q6 If necessary, was the option for an in-person appointment offered to you by the doctor who saw you virtually? (If applicable)

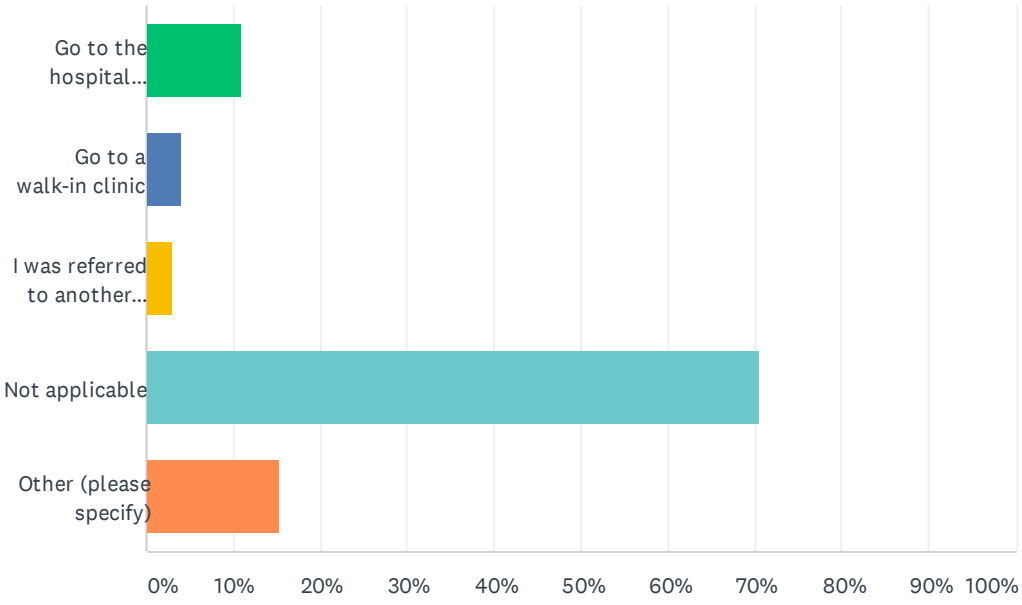
Answered: 176 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes, an in-person appointment was offered to me	39.20%	69
No, an in-person appointment was not offered to me	39.77%	70
Not applicable	21.02%	37
TOTAL		176

Q7 If you answered NO to the previous question, were you directed to do any of the following if your symptoms worsened or if new ones appeared?

Answered: 176 Skipped: 0

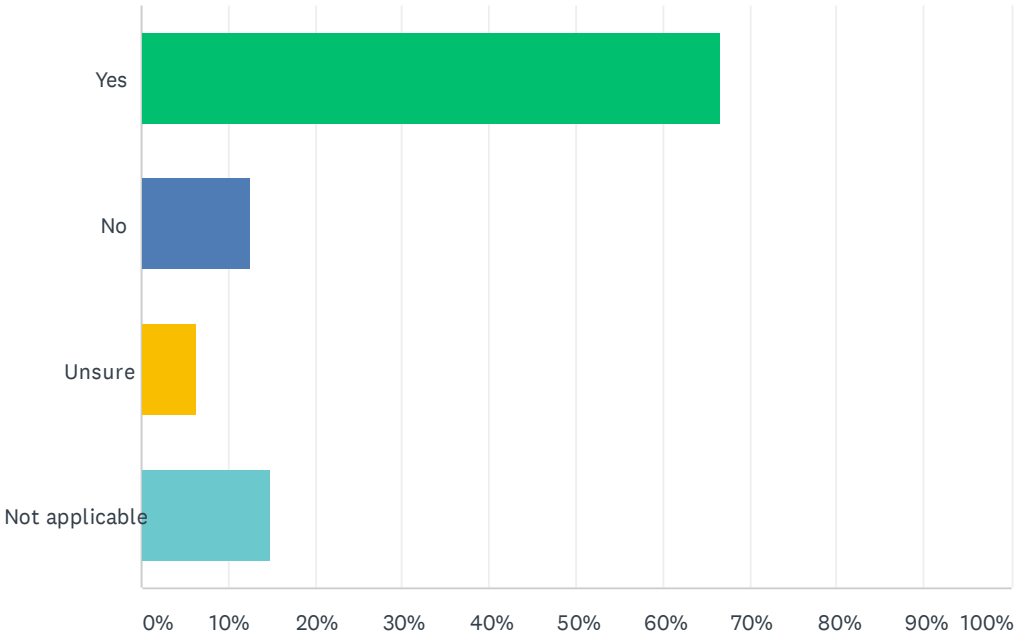


ANSWER CHOICES	RESPONSES	
Go to the hospital Emergency Room or Urgent Care	10.80%	19
Go to a walk-in clinic	3.98%	7
I was referred to another physician	2.84%	5
Not applicable	70.45%	124
Other (please specify)	15.34%	27
Total Respondents: 176		

Q. 7 - If you answered NO to the previous question, were you directed to do any of the following if your symptoms worsened or if new ones appeared? Other (please specify)
offered to you by the doctor who saw you virtually?
My doctor has been very accomodating during COVID-19, it has been great to have telephone, email and text
I cannot recall if I had the option but preferred phone/virtual
I was referred to a specific physician who has agreed to take on all in person referrals that could not be done by my doctor personally. The doctor who saw me in person, knew the doctor who referred me and said he agreed
I have multiple physicians, and most of them are doing virtual care. I have been referred to other doctors or
I was offered if a follow up appointment today as necessary
I was offered a Drs appt by the secetary-who didnt have a clue if a phone call would be sufficent.
Contact the doctor again.
Go for blood work at a lab
In one instance I was referred to specialists but in another I was passed on to an unknown Dr. And in another
He said perhaps the next appointment could be in person…it was not
Blood work
No
Advised to call back.
I was able to send a photo by email and obtain a prescription. Initially she suggested waiting two weeks but I pushed to have something done immediately. Once she viewed the photos, I was immediately provided with a
I was not told this. Once I was told to get a Covid test and if it were negative I could go in to see my doctor
The interaction was strictly to report the results of lab tests.
No (cardiologist).
never told what to do if condition worsened
No options were provided to me at all
Not offered.
At first I wasn't until a further phone call.
I was screened by having to send pictures,in regards if my doctor would actually warrant an in clinic
Call back if issue persists
Call back
Wasn't directed to do anything, I guess it's "assumed" that you would "know" to go the the ER if necessary.
The phone call was the first contact. The doctor decided I needed to come into the office after the call.
I was asked to email some info to her through Medeo.
I believe I was told to call back if I had any issues; it seemed appropriate to me at the time.

Q8 Compared to an in-person appointment, was it clear to you how to proceed if your symptoms worsened or if new symptoms appeared?

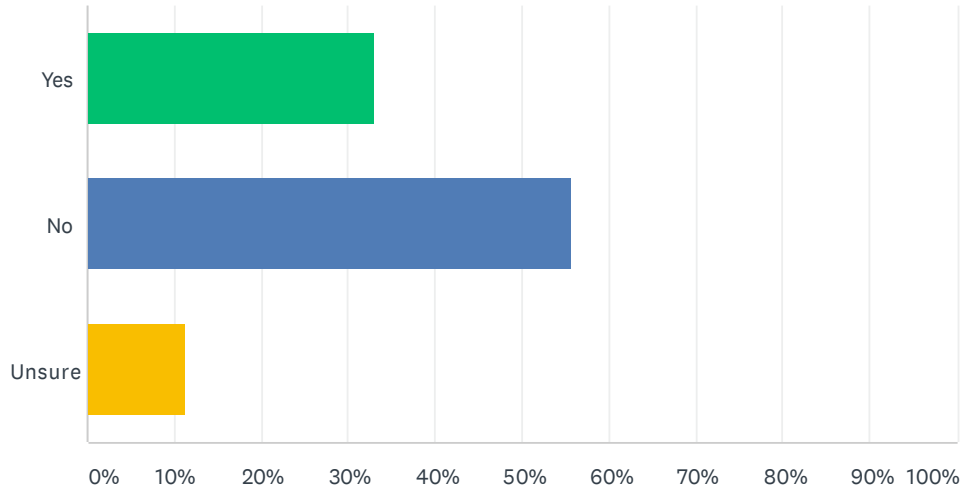
Answered: 176 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	66.48%	117
No	12.50%	22
Unsure	6.25%	11
Not applicable	14.77%	26
TOTAL		176

Q9 Do you have different expectations of a doctor during a virtual appointment compared to an in-person appointment?

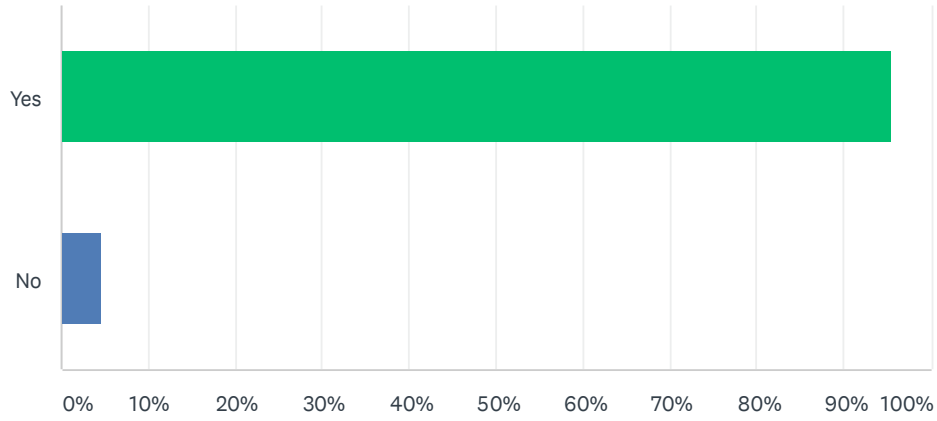
Answered: 176 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	32.95%	58
No	55.68%	98
Unsure	11.36%	20
TOTAL		176

Q10 Do you think patients should have the option to choose between virtual medicine (phone, video, text, email) or in-person appointments after the pandemic?

Answered: 176 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	95.45%	168
No	4.55%	8
TOTAL		176

Q. 10 - Do you think patients should have the option to choose between virtual medicine (phone, video, text, email) or in-person appointments after the pandemic? (Yes/No response with option for comments)
Although I prefer in-person visits, others appreciate the convenience of not having to travel and sit in the waiting room, or bad weather. I would not advocate taking away the choice.
very time efficient for patients and their caregivers. Waiting is done in your own home rather that in an office waiting room where other exposures occur. Time saved in transportation.
Yes, but it should be a shared decision between patient and physician, as the physician is best-suited in determining if a health concern needs to be examined in person.
I do because everyone has different technology and if I only had a cell phone I would want to text my doctor
For routine follow up appointments, virtual can be very appealing. For a new issue or where there is something to show a physician, like a rash, in person is best.
As above. For simple medication renewals, or for psychotherapy (once an ongoing relationship is established), for medication follow up and other times where a physical exam is not crucial.
Definitely yes, a virtual appointment is much more convenient, saves travel time, and saves waiting time especially for a follow-up of lab results, an ongoing medical condition or for a minor medical issue.
Regular check ups don't need to be in person.
Virtual should be limited to simple lab reviews or test results but ONLY when the results are negative. Any positive test result of significance needs to be done in person. All physical exam scenarios need to be done in
I think that virtual appointments are appropriate in some situations i.e. follow up but not necessarily for initial assessment.
Virtual appt work great for some people, but others really need to be seen in-person
don't need to see the doctor's face but I just want to be able to show the doctor what I am talking about. If I ever have to explain an injury, I can also show the doctor say where I fell so it would actually enhance the doctor's ability to determine my condition. We just need to figure out a secured way so that patient's privacy is protected. Honestly I don't think you need to equip every doctor's office - but perhaps each clinic would have one dedicated machine (and it will also enhance security) in one single room - that way you could communicate your ID with the patient easily, so that the patient knows s/he is NOT talking to a random stranger but a genuine medical professional.
The Dr. should see you at least once a year for and exam. i liked the virtual as we live 45 mins from our Drs. clinic and there were times when it ws just questions I needed answered and it was nice to talk on the phone versus driving all the way to the clinic and waiting.
Clearly once the doctor has a baseline of your overall health or health concern, of course some things can be dealt with on the phone or via video chat. However, in no way will a virtual appointment always replace an in person appointment.
ABSOLUTELY 1000x. I actually feel that more patients could be seen, less work would be missed, appointments or issues would not be delayed until a convenient or possible time that matched schedules could be made. Parking costs are an issue for many patients seen at Winnipegs largest clinics, this is reduced with virtual access also. I'll add that it may improve the mental health and work life balance of physicians which is great for everyone and may provide more opportunities for care if shorter windows of appointments times can be made for physicians with other personal family responsibilities or cross appointments. Resounding YES - I cannot identify a single reason to not have this option.

This option DEFINITELY should be allowed. Virtual medicine is safe and very convenient for people who can not make it into a medical clinic for something that can be resolved over the phone or virtually. It also helps my people who live in rural, remote, and underserviced communities (especially First Nations communities) to provide access to a doctor that they didn't have access to previously. If it is the difference between not being able to see a doctor at all vs seeing one virtually, it is a no-brainer that this must be allowed to continue after the pandemic. This is the way of the future and seeing as it is safe, then I am all for this being allowed to continue. Please continue this as an allowable option post pandemic.
I think this should be triaged by a medical professional prior to the appointment, but I love the convenience of virtual appointments and have not found any decrease in care during the pandemic. Actually, because it is much easier to have a virtual appointment I find that I am more likely to follow-up with my physicians and that the level of care I receive has actually increased, as well as my personal satisfaction with my care. I love virtual appointments and hope to see them stay even after the world returns to normal.
Person to person conversations are the best If the client finds it difficult to visit the Dr some info virtual may be very helpful
For some patients due to age / mobility issues it may be difficult to attend in person .
In certain situations, you can not replace seeing a person's demeanour and body language.
Depends on the case
I think there should be clear guidelines that govern what is appropriate to have in a virtual visit and what requires an in-person. I don't think this should be a patient-driven choice. Also, if someone hasn't had an in-person appointment for a certain period of time, they probably should have to before any other virtual visits
i prefer the less costly option which is virtual, I think.
See answer #5. Follow up things can be much faster if we can do virtual.
If it is just for prescription renewals, not having to miss time away from work certainly is better for me. If I feel that I need to see the physician in person, I should be able to ask for that as well. The choice should be mine to
In-person care should be the preferred approach unless physical limitations like rural/remote living or disabilities create barriers to in-person care.
It depends on the reason for seeing the doctor. Technology always adds a layer to the interaction that is impersonal. Sometimes, the emotional reassurance of seeing a person face-to-face is very helpful, especially for patients who live alone or have more social isolation.
Minor items such as prescription renewals do not require an in person if conditions remain the same.
There is something limiting about a virtual appointment that makes it less desirable for certain medical problems such as abdominal/digestive issues.
Not all issues can be dealt with virtually ie physical injuries, serious illnesses, abnormal tests results that will require serious medical/surgical treatment . Renewing prescription, normal test results etc ok
It saves a lot of travel and expense.
unpleasantness of dealing with people. Also , I am sure it would allow them to cram more people in a day, so there is an increase in their bank account . Kaa-Ching!! Is this survey setting up the public to justify a move in this direction? If so that would be disgraceful! Patients should have the right to choose, but never doctors , once this pandemic is over.
For some appts that do not need a physical exam, virtual appts is time efficient for the patient. On a separate occasion, I called because of an earache and was offered a video appt which was surprising and thru the conversation with the doctor, it was determined to be a viral infection without a physical exam.
Especially if just to get test results etc
Virtual visits eliminate waiting room contact and interaction, which are undesireable
More efficient for people working during clinic hours. Less time travelling. But potential for diminished relationship is of concern.

Sometimes an examination is not required . My expectations are that the doctor will ask probing & necessary questions & from that determine whether an in person appointment is required.
It's more efficient for matters not requiring an exam, in person
If I am not dealing with a contagious disease I want to speak face to face with the practitioner, and not be at the other end of a phon line
I liked a short visit for something that I could explain over the phone
I have been to my doctor for a physical, which was delayed by 7 months. I expect a longer conversation if the appointment is by phone, - which I felt did happen when I had that appointment. I think text or email is fine for follow up after an appointment, or pre-appointment- which we have done with my husband's specialist - but not instead of an appointment. I see the value of phone/video appointments for problems that have been identified in past - eg a bad cold or sinus infection which might need an antibiotic would be an example. I think my doctor would be able to figure out if antibiotics were needed, in a virtual appointment, or if it is more likely viral. The benefit would be limiting potential spread on the way to the doctor's office and in the waiting room
I have never been offered email, except when one specialist asked me to email his assistant with background on my condition. It would be useful to be able to use email to update a doctor about my condition between appointments, or to request copies of reports.
I felt my phone appointments were rushed and disconnected. It is very different from being in my doctor's office.
Phone or virtual medicine is easier on the patient—no trip to the clinic, "dead" waiting time etc, and the care is the same in so many circumstances. The physician will likely also be able to assess which patients need to be seen in person. Virtual visits are good!
It's time saving for both patient and physician. More convenient, less travel, cost effective.
Time is precious and this option eliminates travel time, parking costs and wait room time. If it is something I can describe without the doctor needing to see it physically, this is a great option. I would go for in person if I felt the situation warranted it.
Keep virtual medicine!
In person appointments should continue for most areas of making a medical diagnosis, when ongoing assessment is necessary, physicals, and some other areas. Virtual medicine, for repeat prescriptions that don't require in person visits, and for reviewing most test results should continue.
A "no touching" appointment, done virtually, may be as effective, more efficient, and less time-consuming. The pandemic will make me more leery of the "waiting room".
The experiences we have had with my husband seeing our family Dr virtually we're very satisfactory.
In my case I had no new symptoms to present to the doctor.
Virtual appointments could be used for non-urgent situation
Should keep the ability for video appointments and if an office does not offer video appointments, should post-pandemic
I did not like not having the option to come in. The physician just treated me prophylactically with antibiotics, despite not giving me in-person exam that I needed, i.e. to listen to my lungs, and potentially refer me for an x-ray of my chest. In this case, the request for a virtual visit seemed not to be clinically appropriate, and I did not appreciate the lack of option to come in person for a visit despite.
There are many occasions, like reports from tests or prescription renewals where phone is much better as don't have to sit waiting
theirs to limit. That is to say, if there were no government imposed restrictions which must be followed, the physician can't say refuse to see the patient in person if the patient is most comfortable with an in-person appointment.
If the visit does not really require the doctor to look at the physical problem I don't see why it can't be done over the phone. It is much more convenient and saves time for both parties I think.

I do see value in the option of virtual medicine. There are times when a matter could be resolved via a telephone discussion as opposed to a full in-person visit. My virtual appointment included a full questionnaire in advance of the telephone appointment, which assisted the physician in understanding my health concern better
Virtual appointments may be much more efficient for both physician and patient and still as effective for some appointments. There needs to be a an effective, equitable manner to determine if a virtual appointment is sufficient. this should not necessarily be left solely to the physician to decide.
I was very frustrated when my sister got out of the St Boniface (over 2 weeks). She had to find a Dr and her new doctor just wanted to meet over the phone. I am fortunate to have a much more thorough Dr
I would prefer to wait at home for an appointment/call rather than sitting in a waiting room. The amount of time I have saved from virtual appointments have been lifechanging. Also, not having to pay for parking is a bonus. There are great benefits to being able to virtual medicine.
I found virtual appointments worked very well for me with a thoracic surgeon and radiation oncologist as they could see the necessary scans - in person they would still just have liked at the scans. But for some things I think in person visits are necessary.
Sometimes transportation is a barrier for patients to access care, virtual medicine can be much easier for simple appointments
Depending on the condition I would feel more comfortable if the doctor/specialist could see a symptom I am trying to explain, i.e., weight loss, ascites, etc.
Not all doctors visits require an in person chat. Sometimes a question or concern could be dealt with thro phone or text before hand. If a serious concern then a visit
For specialist appointments they should be in person. How can you examine someone properly over the phone or by video? For GP it depends on the issue.
If the doctor makes it clear what can be done in a virtual appointment and what needs to be seen.
Absolutely. It is far more convenient and time saving for me!
a hydrid model is great , some in person, some virtual is a great mix and allows for a better standard of care/follow-up by the dr's - a check in so to speak....works great
I have to see my doctor every few months for medication. Doing this virtually is much more convenient for me. If blood work is needed, I can go to a Dynacare office close to my home. If I need to see my doctor in person, I have that option. I much prefer virtual appointments for "standard" visits.
hard to diagnose someone when you can not physically touch them. in my case thats what has been happening for the last 17 months. it is absolutely ridiculous.
I feel virtual appointments can be accommodated for some simple needs such as a prescription refill however very difficult to describe some symptoms over the phone when visually the doctor needs to see the patients problems. Very dissatisfied with my present interactions with my Doctor.
left many undiagnosed items. I don’t see why doctors could not see people over the past year when physiotherapists, chiropractors, dentists , massage therapists etc saw people and helped deal with their medical issues.
Absolutely in some instances. For maintenance drug (thyroid meds) refills. Blood work requests can be sent out and if results come back with concerns, an in-person appt can be made if necessary.
If iamcapable to make that decision, then yes.
Virtual appointments are so convenient and a better use of everyone's time in many cases. No parking fees. Many people have trouble getting out and that eliminates transportation issues
As a senior it is hard to explain symptoms and I felt I was being given the brush off on several occasions over the phone.
Most Patients are more aware of their medical conditions. Signs and symptoms can be explained for doctors to make definitive diagnosis. If not sure THEN in person meeting or investigation by lab or X-ray etc. Lots of my times before COVID were for persciption refills and recurrent sinusitis due to my medical condition

If I don't need any hands-on or examination, then I would love to continue to have the opportunity to do a phone consult with my GP and specialists. It is more efficient for me, and not all doctor's visits require it to be in-
in regards to any swelling concerns, as I have explained and / or rashes. By sending pictures to your GP, for approval of an in clinic appointment does not help with the concern. You can not feel edema or a rash through a picture.
If meeting with physician to review lab results or other follow-up, virtual would be sufficient
It is quick and efficient to 1. Learn of test results via phone, 2. get prescriptions over phone for non-serious ailments i.e. ointment for rash, 3. If patient has questions then a phone call is a good initial step to talk of symptoms and learn of its seriousness, how to recognize symptoms if condition worsens and at what point do you visit doctor or Emergency.
I feel the doctor was very thorough and I was medicated as needed and doctor called back to see how I was doing and again offered I. Person if I needed we were able to text with pictures in comparison as well which determined what further treatment was newdes
Virtual is good if the problem does not require a visit. Just need advise. I worry that not having a man in person appt, something can be missed such as Hugh blood pressure which normally gets monitored each visits.
Virtual appointments may suit some people for a variety of reasons but if a person wishes to be seen in person, that request should be considered.
As I stated above, wasting 2-3 hrs in the waiting room and then only seeing doctor for 5-7 minutes where the same can be done over the phone is just logical. I don't get paper prescriptions as she sends electronically to pharmacy. Results of negative tests is another example.. no need to see her. If I needed to see doctor in person I would request an in person appointment. If condition requires immediate attention I normally end up going to walk in or minor injury clinic as it is impossible to get an in person appointment when needed.. normally 3 week wait. Receptionist always says go to walk-in.
Some appts are just to receive refills for prescriptions and I think for patient and for the physicians it makes more sense. I have experienced going to office and waiting 1-2 hrs just to be in room 5 mins to get refills. I think people with chronic conditions have had enough experience to know when a phone call is good enough to deal with situations and know when it's actually time to see a doctor
There are things that you may need to discuss and have examined that can't be done over the phone
I think virtual appointments have value in certain settings. If it's just the "check in", then I'm all for it. If you have a serious chronic condition that waxes and wanes, I think it important that you actually see the doctor, because they are trained to recognize subtle changes that the patient may not. Monitoring BP, bloodwork, and visual diagnosing is so very critical. If you have a good relationship with your doctor, and both stay on top of your condition, then there is some leeway, but it should be limited.
My ultimate diagnosis of Pneumonia was delayed a couple of months, by diagnosing Asthma over the phone. If I had first personally seen the Dr at the initial onset of coughing I think the Pneumonia problem would have been obvious. Complex patients cannot be dealt with virtually.
Again should be able to Rx for blood pressure and thyroid on a yearly basis as no problems so no visit needed. Should not need a appointment virtual or in office every 3 months.
For working families, this is such a useful option. It saves time for both patient and physician and relieves waiting room times for others who do need to be physically seen. Keep it!!
In some cases, it should be the doctor's decision if I need to attend in person based on the virtual appointment.
For quick routine matters, a phone call served me well. As I am shy? this method put me very much at ease and I was able to ask more pertinent questions.
I feel more comfortable in person explaining and showing the things directly to the physician versus trying to explain yourself over a telephone. The explanation sometimes does not always show the big picture.

You should be able to book in person if that is what you prefer.
Couldn’t be for a reason that the person would have to examined
But only for minor things like prescription refills. I feel a patient should be physically examined for health issues.
Diagnosis over the phone for many reasons can be dangerous. The personal interaction between my physician and I is very important for them to see how my condition is progressing etc. After the pandemic, I feel it should only be in person visits.
Doctors need to check you out physically in order to properly diagnose.
For something minor or to have a prescription renewed, online or phone is appropriate.
Routine refills okay over phone. My husband has health problems, they made a phone appointment for dizziness and migraine, he’s deaf, he has hearing aids but cannot handle the phone, I was asked to explain his migraine, where it was etc., I can explain my problems but I cannot tell a doctor in the phone how some one else is feeling.
If able to monitor their situation properly.
If I was unsatisfied; thought a doctor needed to see something because they did not acknowledge my concern, I would want the option. Until now, I have not had an issue but I do have MS and I may not be aware of what I might need.
Being a young family, I like having the option to a phone call with the doctor for ongoing and follow up after an initial visit in person with the Doctor. It's easier to keep on top of our own health and our family when we don't have to bring our kids into the clinic every time.
Video for sure, phone maybe. I think text and email is not appropriate
Depending on the patient's age , some prefer the system they have been used to through the years . The younger ones prefer virtual ,short and quick and done .
I would be very happy with virtual appointments as they save time and I don't have to wait in a waiting room. Would also be great for people that can't access a physician easily.
physical mobility issues (or other logistical barriers). These patients otherwise would have compromised care if they were unable to make in-person appointments due to such barriers. Virtual care would easily overcome this issue.

Q. 11 - What rules do you think should apply to doctors when they are providing virtual medicine to patients? What would make you feel safe? (Open-Ended Response)
To be judicious in determining if a phone visit requires personal contact. Privacy maintained as well as accurate record keeping. Some degree of defensive medicine is required to keep malpractice lawyer away!
positive id of patient
Physicians should be required to follow the same rules for virtual care as in person.
They should have video call instead of a phone call
Have a good relationship with my doctor
Ensuring my medical file is current and kept up to date in the e-system for other practitioners to access.
Proper identification of both Dr and patient to ensure you're communicating with the right person.
confidentiality is important- location of both physician and patient is part of this. Where my records are stored is important- not in the USA where privacy rules are different.
I am comfortable with phone
I do not feel unsafe dealing with my physician. I feel that my private health information is as protected as if I was in person.
The doctor should be in a private room. No other family members should be allowed in.
Treat patients as you wanted to be treated.
Basing the virtual appointment off the type of care needed.
To be used for very low risk/low acuity situations
Timeliness, Confirmation of Identify, Purpose for visit, Next steps clearly identified with appropriate timelines. For example, if consult when should you expect to hear something.
Follow up should be very clear - especially for patients who are not savy in navigating the health care system. More options to get clarity after the virtual appt would be helpful
Ask if it's a good time to talk, if you have privacy
to my family doctor then of course I know his voice but if it is someone else then we must have a way to ensure security as well as patient's privacy is taken care of. Doctor(s) or medical professional can show their IDs in their first session.
That patients be asked if they have any concerns that need to be addressed in person appt or if they are fully comfortable with the virtual assessment
Have a set appointment time and call on time
I am not in favor of Virtual visits ..!!
Verify patient information.
Same as in person appointments.
I felt safe with my Dr. during our virtual visits, as I work in the health field . I also felt he had more time with me versus in person.
I had no concerns with safety with my doctor on a virtual appointment during the pandemic. So I am unsure how to answer.
Confirm the patient identity Give patients opportunity to ask question or voice their concerns. Especially because most doctors appointments are overly rushed.
Clear guidance on software, communication methods that can maintain patient privacy are important. So not entirely sure about texting, how do you add the security features that you can have with verified emails or approved virtual platforms ? If there is a privacy solution for texts, I'm on board.

I think it is safe in its current state, but if there is the ability to refer to an in-person doctor (not necessarily the same doctor I saw virtually), then I am fine with that. Again, it is a convenient option to have available for things that otherwise might be left untreated or allowed to progress to very serious states if seeing a doctor in person is not convenient or not available to someone...ESPECIALLY for those people in underserviced areas. Those people in underserviced rural and remote areas REALLY NEED THIS SERVICE TO REMAIN IN PLACE. Please keep it. As an Indigenous person who has relatives living in these areas, my family members have now been able to access a doctor more readily via virtual appointments. I really have seen its value firsthand for my family members and for my people, in general, living in our First Nations communities. This service is helping us and can not be taken away otherwise we will be taking a step backward.
Always follow up if there are even minor concerns.
Dunno
I know my Drs and feel safe.If the internet is safe good.In my case if it is hacked the listener would be bored.No secure numbers-maybe some adds re medicine-just delete.
Confidentiality is important. If at work, not all people have access to a private space.
be in a private setting - their office or at home, not in public
Should be extra cautious when prescribing any narcotic.
make sure they have thoroughly discussed my symptoms and provide clear options
Confirm identity. Offer in person appointment if necessary. Follow up.
I think they are doing a good job
Know why they are calling you
permitted.
than MB.
Make sure there is enough time to discuss symptoms and options. That they ask questions and not act rushed or impatient. If they are unclear with a diagnosis to encourage in person visits, additional testing, etc. I would also like the opportunity to meet consistently with 1 virtual dr or a group of doctors and be able to follow up with the virtual doctor if I have questions or need additional treatment.
Whatever he did was fine.
dr to consider whether visit by virtual is able to succeed.
Requirement that video/phone call not being recorded. Patient gets to choose if need to have physical appt, not be told it's OK to be virtual only.
HIPPA compliant communication ie phone or secure video
They keep asking questions. Make sure they get to the bottom of the problem. Don't just take "Im not sure" for an answer
Data security needs must be met as per normal and the option for in person must remain.
All the same rules, with some more strict considerations around privacy and a low-threshold for arranging an in-person visit if needed. Should not be a replacement for in-person care but a complement to care.
Not sure.
More investigative questions based on your medical history.
My doctor completely stopped in office visits for almost an w tire year. My breathing worsened from my COPD and I still couldn't get an in person visit. I was worried about my health and didn't know where to go or how my doctor could tell if my copd wa s getting worse. I wished they had in person visits
The same rules as at the in-person visits. The patient should always have the option of in-person visits.
If patient asks for in person apt. it should be granted. Proper ID made at start of apt. Brief followup at next in person visit. Copy of prescription sent immediately to patient via text to ensure accuracy otherwise will only find out when go to pharmacy (one week later, rural areas require travel)
If the patient requests to be seen, the doctor should arrange that, either with themself or refer to another

If the doctor explained that based on our conversation, he may request an in office appointment to better understand my medical concern; that an in office appointment is always an option
I felt safe even the one time he asked me to come in for an in person visit. The clinic went above and beyond COVID-19 safety measures.
This is too broad and vague a question to intelligently answer
Follow up call within 7 to 10 days
Appointment times shouldn't range more than half an hour. As waiting for an appointment anytime between 1-2 hours is long
Thorough assessment to determine if in person appt is needed. However, if patient calls for an appointment that might need a physical exam, then I think an in person appt should be the first appt and not after a virtual appt
I think if it is agreed to by the doctor and the patient that a virtual appointment is the best option it should be provided if possible especially if the patient is known to the doctor.
Confirming patient identity, etc
New doctor: provide qualifications: existing doctor: maintain time or advise of delays via text
They should still find ways to do things that they would normally and regularly do in person, such as physical exams, taking blood pressure measurements, and taking body temperature readings.
Zoom might be preferable to a phone call to enhance sponsoring a good relationship. Some conditions must be done in person.
I think for initial Prescriptions a doctors visit maybe an order in some cases. I think for prescription renewals, virtual visits work just fine. The most important thing is clear communication and ability for the doctor to answer all my questions.
To confirm patient identity. Option for prompt in person visit if required, not just be sent to urgent care or
Nothing would make me feel safe on a virtual visit
Not sure.
You should have the option of an in person visit if needed.
I think an established relationship is important. I certainly think new prescriptions, especially of painkillers, needs in person contact. My husband ended up sick enough early on in the pandemic that he required a hospital stay of a week with different courses of antibiotics. Between waiting for a Covid test result and an initial phone appointment, he was severely dehydrated by the time we went to emergency. I'm don't think a phone appointment was sufficient - especially after the negative Covid test.
It's fine as is
Time spent is essential. It should not be rushed and all questions should be answered. It is nice to not have to wait, as a rule.
The proposed standards for creating and maintaining records do not address the patient's right to directly access to the electronic record, in order toto view it, add notes or correct inaccuracies. If the record belongs to the patient, then the patient should have secured access to it, as is allowed in other provinces.
Be on time when there is a phone appointment. The call display should indicate the doctor's office number vs. private caller. Muy mother refused to have phone appointments. I found a physician who would have in person appointments.
I feel safe, in person or virtually, as I have confidence in my physician's education, care and professionalism.
Secure electronic media, good secure records, method to ensure against impersonation of patients.
Previous in person appointment so doctor knows patient.
Identify and follow up.
Privacy is very important. Clear sound on phone is important. Option to be seen in person
Confidentially and knowing you are being heard
I already feel safe. No changes needed.

I have never had an issue with any of my doctors and feel safe. If I ever need or want more clarification, or an in person appointment, that has always been provided.
I feel very safe in most cases.
Video identification or personal ID code most of the time.
No comment
Confirmation of Patient ID eg Health card # Confirmation if any one else is participating in the call eg spouse
Time to ask any questions and not feel rushed
I felt safe with the phone appointments. However a patient should have the option of in person care at any time.
Depending on the circumstances I believe an in person appointment should be offered within 48 hours if
Secure medium
I think physicians should be informed that if a patient requests an in-person visit, unless there is good clinical reason to instead require a virtual visit, an in person visit should be provided. Bullet #6 of the Standard of Practice regarding Virtual Care should be amended to provide advice to physicians on this too. Virtual care should not be denied by the physician unless there is good clinical reason for instead providing virtual care.
Should always have option to follow up with in person. Video or pictures are good if needing to show dr
If they feel they cannot address issue virtually, they request an in person appointment. They should air on the side of caution.
Verify if it is an appropriate place/manner to proceed with virtual care, verify patient identity and document virtual interaction for future reference.
They must be in the room allow or if accompanied by a support, the patient must be able to see them on the screen or speak to them as a group so that all conversation is for the group. The patient must be informed in advance of discussing personal health information. The support persons full name and roll/title/profession must be disclosed. They should be in a professional setting that ensures confidentiality. Working remotely opens concerns that others may hear the content of a discussion and that is a very concerning risk.
Making sure you have the correct person on the phone; ie. confirming identity; letting the patient know that the phone call is confidential; and ensuring that they offer an in person follow up if they think it is needed to give the proper diagnosis or treatment.
Knowing that the telephone call was secure. If email was used, knowing that electronic transmission was secure
Recording should not be allowed. There should be a separate fee schedule that is appropriate to the services that may be offered. Virtual appointments should be offered in the most interactive manner possible -- this means video conference, not just phone call. Rules around the secure area from which a physician is attending the virtual appointment to ensure privacy.
Patient chooses their option of visit. Plus they have to provide some means to ensure it is actually their patient.
I think there should be systems in place for in person care if required.
Confirmation letter of the visit details
same as an actual visit
Identification mostly. I had no issues of feeling unsafe.
Choice
Make sure they call at the time they say they will, sit in a closed room with the door shut so that your privacy is maintained, tell us patients if you have a learner or someone else listening in
Mask, gown, gloves should protect them and mask for patient.
Follow up by the doctor is essential.. Test results if required should be reported to patient sooner than later.
Ensure your patient is comfortable with the process. If it is a phone appointment you cannot read an visual clues your client may present -they may say yes but if you could see them you would be able to tell they were puzzled or uncertain. A video appointment would be better in all circumstances than a telephone or email.
Depends on the situation. I am a retired nurse so have some medical knowledge!

Clear expectations for what they would need to see you for in person. Although I feel I can decent that, perhaps others would need that to be made clear.
Not sure.
Rules-be professional but also be compassionate, act like you actually care!
Same as in office, privacy, duty of care
I would think the same rules as an in-person visit should apply to a virtual visit.
none.
The option to see the doctor in person. In my phone interactions I was rushed through and felt my concerns were not addressed. As mentioned he indicated he could not diagnose my issue without seeing me but would not offer an in person appointment. Told Me until Covid ended this would be the case. This is unacceptable.
Limited items. Someone may think it is a minor issue but it may not be but they are uncomfortable going to a doctors office.
I found it was handled fine. I was asked specific questions to verify my identity and also if I was able to speak privately.
Nil
Going to an in-person visit would make me feel safe and not having to explain all my symptoms to his office staff
Identity check
If definitive diagnosis is in doubt then in person meeting. Patients must take responsibility for their care if not satisfied. They can ask for in person follow up.
Confirmation of identity including PHIN and MHSC.
I have had a few serious reactions from medications. I would prefer to speak across , in person with my GP.
Asking for verification. Ask the patient the reason for the call so they can verify. I would prefer video calls as I gave access to zoom or ms teams. It would be nice to have that option and save a 6 hr drive (one way)
Confirming identity with PHIN or other health card id
1. Privacy 2. Never, ever shut down a patient for asking questions....never rush through the conversation
Limited ailments to be handled virtually or face to face appointment to follow virtual for a more thorough check. The doctors I have seen virtually during the pandemic have upheld their professional standards! I have had no lapse in care.
calling me back was very vital. Being able to wait for your doctor in the comfort in your own home and not worrying that someone who is sick may be attending the office at the same time as you do gives great comfort. I truly value virtual appts since Covid as my family has been able to use them many times and has been seen when needed
I feel safe when speaking to my dr. Getting test results emailed to me in a secure manor makes me feel safe
The option to be seen in person.
I can't imagine what rules could be crafted to meet all of the possible scenarios. I would never feel completely safe because in 2017, my doctor found a large mass in my abdomen. I was asymptomatic and it would have never been found virtually.
Only prescribe regular repeat meds.
?
I think when a patient is a long time patient having medication prescribed virtually is safe , however I think a patient should be seen by physician once a year. If a new patient then once every six months I think it would depend on the type of medication being prescribed as well
Seeing the doctor in person
More frequent "touching base" appointments would help I guess. I'm not a fan of virtual appointments. How can a doctor diagnose problems if they can't see/feel it? How do they notice when a patient is hesitant to indicate where there is some concern or problem? My internet isn't great, buffering is common so only option is phone.....kinda sucks.

Patients with multiple chronic medical issues should not use virtual/phone appointments.
In person visit, how does the Dr really know if there really speaking to the actual patients with the ID, can't prove its really there patients.
.??
Confirm identity, introduce themselves, use secure virtual formats, ensure patients understand how to proceed if symptoms worsen, offer in-person follow up if doc concerned
I trust the Doctor's judgment on how to proceed after the virtual appointment.
Make sure the dr listens and answers your queries.
The option should be offered each time for an in person visit not just virtual.
They should have to give you the same amount of time as an in person visit. Virtually, it is too easy to dismiss you and hurry the appointment.
If the person needs to be examined or if the Dr is confused as to what patient is telling them, they should be seen in person
I don't know. But if I have pain It's up to me to accurately describe where it is. With a physical examination, you can show the doctor exactly where it is.
Doctors should also offer in person. Doctors should not try to shorten appointments. Doctors should be aware before they talk to the patients - when possible - why the patient might be there. (ie - a doctor sends you for a test. you are there for results. but he asks you why you are there. Are these things not written down?)
If not sure about diagnosis, make in person appointment only.
make the phone calls at the time specified on the appointment notice, not an hour earlier.
Getting them to return a call. Difficult to get beyond receptionist.
Giving routine refills, test results, keep the doctor for in person visits and a nurse/nurse practitioner, some one who has more time, not so intimidating, who you don't mind saying I'm sorry but I can't hear you, speak up, as u know most doctors speak in a very low voice, maybe it's the elderly ones like us that have that problem. If a nurse contacts first, they can make a decision if a person needs to see a doctor.
Taken seriously.
I felt perfectly safe with my phone consultation, but that was with my primary caregiver. With a new caregiver, I feel the first visit should always be in person.
They should be in a room alone while on the phone
Virtual apts should be visual and not by voice call only.
I read the draft and I am not aware of any new ideas. I like a virtual appt when it saves me driving 1 1/2 hours to get to a doctor or lab. Rural people spend money, time, and stress to go into Wpg and sometimes it seems like it could be done in a closer, rural place. Thank you!
In person assessment at least twice a year If the patient wants virtual appointments.
Ensured confidentiality ad ability to have in-person assessment when appropriate
Nothing really - I like that I will be able to choose video for things I want and see my doctor in person for things I want to be seen in-person. I have been using phone through my insurance for a while.
A virtual visit is not much different than an in-visit. Questions , answers , prescriptions renewal . If there is any confusion , then it should be reverted to an in-visit .
Taking only to patients. Memebers of family attempt to ask questions about pt.
At the end of each encounter, I would like to be asked if I would like the doctor to arrange an in-person visit for me and know where and when that visit will be. It would not have to be with the same doctor, I just would want to know that I don't have to find out where to go myself.
n/a
as outlined in CPSM document
Same rules as if it were in person. All rules should apply

Q. 12 - Is there anything else you would like to add, or share related to the delivery of virtual medicine by physicians? (Open-ended response)
Humans should avoid being isolated unnecessarily. Virtual visits serve a purpose especially when monitoring a chronic condition. Physicians can augment virtual visits with a good old fashioned house call. Manitoba health still covers house calls.
no
The draft standard is very clear and well-written: we will consider CPSM's work as we update our own standard. Very well done!
some doctors are calling excessively in the name of follow-ups, and this adds to their billing. The college should look into how these doctors are having follow-ups twice or thrice a wek
Yes, the 4.2.1 iiii the patient should not be burdened by the virtual visit (i.e. if the patient does not have internet or a cell phone - then they should not have a virtual visit). In person, visit must occur - the virtual visit should benefit the patient. 6.1. 3 adding something about If Opioid are prescribed during a virtual visit then fax triplicate directly to pharmacy of client/patient choice. This must be for a longitudinal patient-physician treating relationship, minimal amount of drug needed until an in-person appointment can be made and weaning off/tapering/deprescribing discussion to be done at every opportunity and documented.
No
I hope it stays (both as a patient and as a physician). It has increased attendance at appointments as people do not have to travel from work, miss more work, for subjects that can be managed remotely just as well as from
I think it is a great service for most non-urgent general medical matters.
No
Secretary staff should not be the ones to provide clinical advice or take medical histories
No
In person assessments are the rule, not the exception
There is a risk that something is missed during a virtual visit i.e. incidental finding.
It is a great option for people who want to engage virtually but not great for other people who cannot engage by phone or other virtual means as easily - so their care will 'fall through' too easily.
Very convenient esp for a working person. I;m more likely to make an appt rather than putting it off because I can't miss work.
That the virtual contact be the same scheduled amount of time as an in person appt, so there isn't a feeling of being rushed etc
Would be difficult if you didn't know your dr. But if you do its a convenient option. I think it removes barriers to seeing physician
Virtual care reduces time and expense required to drive, park, wait etc to see a doc in person. Zoom calls or telegraphy might be better than just a telephone call for when the doc needs to see something on a patient
Making access to doctors easier is good in my books!
In no way should virtual appointments be a substitute for an in-person visit on a regular basis. The relationship with your healthcare provider is important. That relationship can only be nurtured over time, and by actually seeing each other.
If many physicians make this switch, how will you monitor the impact on health equity.... ex. if more appointment times shift to virtual how will you ensure equal availability of physicians for the populations that do not have the same access. At the same time, this may solve some issues with being able to access communities, have interpreters, reduce inequities in other ways....

Please keep it in place. We need it. Especially for my First Nations brothers and sisters who live in these communities and now have increased access to doctors services. We didn't have good access to doctors before in our communities and now we do, so please do not take it away from us. Some of our health centers only have a doctor once a week for a half-day, once a month, or even less. How can that access provide adequate health care to our community members? It can't. Now we can see doctors more often as we have this virtual option available to us. It is complementing our current health care services in our communities, not competing with them. so please do not take it away or make it difficult to access for us with new rules. We can't lose it or have it taken away from us or make it difficult to access with all these new rules you are suggesting about the doctor needing the ability to see us personally in person themselves. having them able to refer to another doctor is much better than putting up a roadblock of that same doctor has to see us personally. How can we do that when we live in places like Garden Hill, Red Sucker Lake, Berens River, Nelson House etc, and the doctor we saw lives in Winnipeg. We got seen by the doctor and we otherwise would not have been seen, so that is what matters to us. Some of our Elders now can see a doctor when they otherwise would not. If the doctor decides on the virtual appointment that we need to fly down to Winnipeg to get extra in-person treatment then that is good enough. They can decide that then, don't stop them from seeing us all together because the doctor isn't physically there to see us too. It is increasing our access to healthcare services in our communities and can not be taken away or restricted in order to make it difficult for us to see a doctor. Virtual appointments are doing a good thing for our communities and we don't want to lose them. Don't take them away from us or make them hard or impossible
Our province is so diverse and wide spread, and not everyone lives in a major centre with access to multiple primary and specialist physicians. I think that maintaining and even expanding virtual care is a way to increase health equity and even addresses some of the TRC Calls to Action related to health.
Important for patients to feel they are given adequate time to discuss their needs.
the call 1x and if you don't answer, you've missed your appt is a little ridiculous. Meanwhile you can sit in their office and wait on them for 1 hour sometimes more.
No
I like the option to meet virtually but also want to know I can go in person for more serious issues
No
Great work!
My dr offered phone consultations. I would have preferred video consultation so I could show her the issue on my foot
KEEP VIRTUAL MEDICINE!! Very helpful and increases access to care that normally discriminated against those that don’t have the luxury of time and transportation to see a doctor in person.
Whenever my dr called he asked me what I needed even when he was calling to give me results etc
Not at this time
None
Thought it was useful.
I think this is a great alternative to always having to go to a waiting room and sit and wait for a doctor. I have never felt rushed during a phone call. I also am not surrounded by very sick people who are coughing and sneezing. They are there to see the physician because they are sick, but I don't want to catch it.
No.
Something is often "lost in translation" over virtual formats, and in-person assessment is often important for adequate communication and care; that's why I think virtual medicine should just be one tool to use when indicated to complement care - not to replace it.
I like to feel I am always welcome to see a doctor in-person, and not that I am pushed towards the virtual option.
No
I felt that the reason the doctors closed their doors was for their own safety and preference and didn’t have much to do with how patients were doing to manage through all this.

Patients need support in helping them prepare for and maximize virtual appointments and doctors need to make adjustments in their care to compensate for the limitations of virtual visits.
It should only be used sparingly for routine followups, prescription renewal etc. It should not replace real apts. but complement them when appropriate.
I think it is a really good thing that has a place. I know that when I am at home, if there is a question about my medicines I can just go look at them, but if I was at the doctor's office, I might not have them with me.
If lab work is required, how would I receive the requisition without attending the doctor's office? Can it be sent to the lab? would it be sent to me by email or fax?
My doctors were awesome. Even my cardiologist called me to see how I was doing because he hadn't seen me for so long. I usually have visits in person every six months until the virus hit.
There are many different doctors that I have. I am giving the positive comments regarding only one of my doctors. It would be a different story if I was commenting on some other doctors. Why doesn't your survey
mobility issues, simple appts that do not need a physical exam, etc. I would not like to see physicians abuse this privilege by limiting the types of appointments available to the patient. Currently my physician sees patient in person only one day a week. I also wonder if physicians are compensated at the same rate for virtual vs in person appointments. If they were, my concern is that physicians would not provide the same quality of care for all medical needs.
once pandemic has ended as the convenience for the patient is beneficial. My doctor is very busy and I can spend up to 2 hours waiting for my in person appointment but the virtual appointments I had were on time. This is especially important when you are not feeling well and it is difficult to get to an in person appointment and wait such long times.
No
Waiting is still waiting. My last appointment two weeks ago the specialist was over one hour late with his call. N9t a good first impression and reinforces preconceived notions of specialists. There was no mention of this delay by either party.
There probably is, but nothing comes to mind at the moment.
Positives and negatives. Must have in person appointment annually at the minimum. GP should be paid ascmuch for virtual as inperson. No cheaping out by the government!
Convenient, efficient especially for prescription refill and issues that do not require personal exam. It also appears to be quicker to get an appointment.
Cancer care cannot be conducted virtually to my satis faction. Visual conversation is far more satisfying.
No
I was seen by a Dr. though Zoom for 6 months. It really helped me
I think a combination for options would be best. Some mechanism would be necessary to make sure doctors don't choose virtual delivery entirely for their own convenience. I find younger doctors are more likely to be less engaged with patients in the first place, too much focus on technology, rather than looking the patient in the face while having a conversation, or even being willing to examine a patient. I would be happy to have a combination of in person and virtual appointments. But not exclusively virtual appointments.
Virtual medicine is a good option. Email should be offered more to patients. as appropriate. A patient's eChart record should be accessible directly by the patient in a secured electronic system.
During COVID, it was necessary to have virtual appointments, but when we it is safe, I would prefer the human contact to feel taken care of.

Like so many other parts of our culture, it is good that medicine is considering new ways of interacting with patients following the past year or so of COVID. Thank you for using this time as an opportunity re-think established norms and practices!
My doctor is extremely personable and an excellent listener and I think this is why I feel completely comfortable talking to him by phone about a medical issue or follow up. Listening is very important for a virtual appointment.
No
Calls need to be on time and if not, an office assistant could call the patient to notify them of the revised time or to set up a new time. Everyone's time is valuable, not just the physician's time.
I think most medical refills on prescriptions and minor health issues could be done virtually
This option makes sense for so may patients ex. Mobility impaired.
Virtual medicine should only be used as an "add on" to in person care. I had previously met all of my doctors before the delivery of virtual medicine. There are times that I would not be comfortable receiving virtual care if I had not previously met the physician.
I am very comfortable with virtual visits, other than at CancerCare Manitoba, where I feel they should all be in
I trust my Dr. more than the internet. Sometimes I need an answer that could be supplied by text.
Faster service I can actually view test results hence ask for clarification or repeat tests in future. Safer in regards to Pandemic I felt our family MD wasn't as rushed with us. I felt I had more say in my husbands treatment plan especially regarding repeat tests
Video appointments would add to the personal nature of the appointments and allow the ability to show
no
It is a valuable option for both patient and doctor
Yes, there should be some remedy offered to patients, if their physicians do not offer in-person care. My concern is that some physicians are choosing to provide virtual care for their convenience, despite some patients like myself feeling that in-person care is needed. This is an access to treatment issue that the CPSM needs to monitor. It is unfair for physicians to say "no in-person visit" if you have some symptoms, despite having negative covid 19 tests. It is not right to say you can't come in until you are not symptomatic. I need to come in so you can hear my lungs, possibly send me for an x-ray to ensure that I do not have pneumonia, and only then prescribe what you think is needed based on your in-person assessment.
No
It is a step on the right direction to efficiency in our health care system.
I think this type of care is appropriate for certain situations and should be available to patients when needed; especially during winter months when travel can be troublesome.
I think in person evaluation will always be the best option. A lot can be missed by limiting an interaction to virtual options and while they can improve access to care, they do not offer the same ability to asses a persons overall health and well-being. Also, I think that while I said it should be the patient's choice in they want an in-person appointment over a virtual, the physician would have to assess where to require an in-person evaluation of the patient. There could as easily be cases where the doc should be insisting on an in-person as well.
I appreciate being able to have both options!
none at this time
This is long overdue. Glad to know CPSM is working to establish provisions in legislation and standards of practice to allow and regulate such activity. Should also allow for patient advocates, decision-makers to attend from various locations so that family may be involved in patient discussions with physician to ensure all that are involved in the patient's care are in discussions and have access to the same information.
No
I would be nice to have a centralized provincial virtual care service offered like some provinces have available. I would like to be able to make an appointment online and have a timely virtual appointment.
I think it is a treat option for routine things

I found it very handy not to have to drive to an appointment when the information could be shared on the phone. Big time saver.
This opens up amazing opportunities for patients in northern, remote and rural locations to receive care!
I am currently seeing a liver specialist that I have never met in person. I would feel more comfortable to have met him in person at least once considering the severity of my disease.
Not all doctors are cut out for this. I have had a doctor who is a man of few words and had to ply him with questions to get adequate answers. He also seemed impatient and dismissive.
I appreciated the option. It made health care more accessible to me since I have a full time job and I could take a call from anywhere. Plus if there was wait time it didn't take me away from work. Saved travel time and
No
Yes-I absolutely feel that the doctors have taken advantage of this Pandemic….hiding behind the "Covid Curtain"…not doing "in person" visits when the issue absolutely warrants it….why do you think so many people are dying from other health issues not related to Covid during this pandemic????
i think it worked great - was very happy, saved time if regular visits are required, good check in capability to track symptoms/changes in symptoms - worked for both my wife and I very effective
I strongly urge the use of virtual appointments to continue post-pandemic. I feel much safer having a virtual appointment for prescription renewals that having to sit in a waiting room full of sick people.
it may work for simple issues thats about it.
I feel my Doctor using Covid as an excuse not to see me. I am suffering and unable to get proper medical attention. Even with being fully vaccinated I can not get in to see him. I am very frustrated with this virtual practice. I don't know if all GP's are doing this but it has to change.
I think it might make doctors too complacent. It's easier to make a phone call and get paid.
I think the virtual method is 100% necessary for some visits. I have also used it for my elderly parents where it is really difficult for them to be there in-person when it is not necessary. (Discussing results of blood test, sharing photos of skin issue on a secure site to monitor change, consulting while experiencing fever and weakness)
No
I hope this continues and that video calls are used more rather than just phone ....where appropriate.
Some things can not be diagnosed via the telephone and it is ridiculous how this has become the only way to get medical help these days.
This is innovative care that breaks with old paradigm of care. It will scare those entrenched. Both patient and physicians need to explore the full value of this streamlined service. Hurry up and wait is still prevalent for specialist appointments. So the question now is how to fix this boondoggle of backlogged appoints and care.
I really like this new option of consulting with my physicians.
No
Answered in 11
Let patient know if there are time limits to the length of the call.
I, overall, for test results and getting advice and subsequent info on minor ailments LOVED the telephone appt esp. since we are at the cottage for very ling periods of time
It is so much nicer to wait at home or schedule a time at work so I can skip out for a simple appointment without having to drive/ride public transit. The time frame is so much shorter with virtual appointments. I attended a doctor appointment through EQ care for poison ivy and I had the opportunity to send pictures of the rash and a live video feed of the rash. It is so convenient and I received great care.

I hope we have more of this it truly is helpful when you are unable to get into the doctor especially for minor
issues or if you are unable to leave work and get to doctor in time before they close being able to FaceTime and text is amazing as well again in the safety of your own home if need be. I hope they continue offering virtual services for non urgent appointments. I threw my back out once and could not stand let alone drive. The doctor was able to get me muscle relaxers and anti inflammatory medications and filled up a few days later to see how I was doing and see if I should be seen or crates. It was truly truly appreciated as I was in so much pain from the pinch in my back. I could not imagine walking to a doctors office and having to sit for a few Hours waiting to be seen Truly a valuable service
I just wish making an in person appt wouldn't be such a long wait. This is due to the majority of her days are virtual therefore her in person spots are few and far between.
I really really want to continue this phone process. It's so much easier than going down there, parking, waiting and the reverse to go home. An in person visit is still available but a lot of appointments can be done over the
Would like virtual visits to be via Zoom or FaceTime. Like that I was able to get prescription via doctor's portal for physio (for insurance purposes) and not have to go to her office. Would prefer if appointment reminders were factored in to system like emails I receive from my dentist. Virtual visits is one of the best things to have happened in this pandemic.
My dr offered phone consultations. I would have preferred video consultation so I could show her the issue on my foot
physicians and patients time and reducing stress. Having an appt and going to office and sitting for hours is ridiculous. I also think with the use of nurse practitioners perhaps physicians time could be eased up with delegating the phone appts to them I know if I just need my refills filled I don't have to speak with MY physician to do that. I think the phone call is a great idea but think to maintain dr/patient relationship maybe using FaceTime would be more effective
Things are being missed medically.
I think there is an expectation that a patient know what is a relevant symptom and what isn't.....what should they mention to doctor when talking to them. How do doctors "tease out" what is important? Are they all trained to do that? I'm thinking "not". What about the elderly? They have trouble hearing and processing questions, especially when it's "rapid fire" which happens when doctors are in a rush cause they are behind.
COVID19 de-railed the Public Health care system. Virtual Medicine has it's place as a last resort, otherwise it is dangerous.
I feel very strongly about in person visit with our own physician, not another physician who changes your medications.
It's one of the very few good things that came out of Covid. And we should keep it!! We're busy and this is such a wonderful option. Still need for in-person visits of course. But this serves a huge population. Not to mention those who need to travel to city centers to see specialists, etc! Do everything you can to keep this vital option. I believe my doctor likes it too.
Hopefully this will help to improve efficiency in our medical system.
A face to face visit proved uncomfortable.
I would prefer to be given the option when you call to select either an in person or by phone versus being told by the staff that it is strictly by phone.
I sure hope virtual medicine does not become the norm. It is not going to be a good way to keep track of a patient and too easy to dismiss the care a patient might require.
It seems a lot of Doctors only work a few days at the clinic I go to. It's hard to get timely appointments (even before the pandemic). Now they want to move to more virtual visits. I disagree with this. I believe in person visits give the best approach to attending health issues.

It would be helpful if doctors could email patients the results of tests. That would be very good to have those papers in hand.
I personally feel it can be very dangerous in some situations. Results over the phone is okay, as long as it isn't bad news for the patient. Ethically this would not be okay for me.
virtual appointments should only be used for minor ailments or if absolutely necessary because of pandemic requirements.
Walk-ins don’t replace your doctor. Easier access is required. Even an email to convey test results has been a challenge.
Personally I feel more comfortable with an in person visit, my doctor would know if I looked yellow and had a kidney problem, not possible on a phone. Refills okay, test results okay, clearer voices on phone okay.
In rural there are towns with no dispensing pharmacy. There are deliveries but what happens if not delivery
As noted in #11, the first visit s/b in person
No
Virtual apts should be visual, not phone.
No. I think I said what I wanted to say.
Think this is great! Much easier! At least one good thing came out of this pandemic!
I think virtual medicine is here to stay . In visits will happen if the virtual was not satisfactory to either .Periodic Health Examinations will continue as in-visits .
Upgrade patient's phones, it is hard to find patients sometime
Love virtual visits
Continue post-pandemic

Comment
CPSM Members
I feel that section 2.2 does not fully cover the many settings in which virtual medicine could and should be applied. I hope that this becomes one more tool in a physician's armamentarium of patient care and that most physicians continue to provide a blend of in-person and virtual care throughout their practice. As written: *CPSM recognizes the importance of virtual medicine in providing care and access to care especially for patients in remote and underserviced areas, patients with mobility constraints, and in a pandemic.* I would suggest that the final phrase "*and in a pandemic*" be expanded to include "times of natural disaster, public health restrictions or similar constraints." I also feel that section 3.1 is too restrictive. As written: *An acceptable standard of care requires regular in-person care. It is an unacceptable standard of care to solely practice virtual medicine.* The practice of psychiatry and mental health services is evolving rapidly. I would consider it poor practice to make a patient fly into Winnipeg from northern Manitoba purely to satisfy this criterion. I would suggest that this clause reflect this.
Section 4.2.1.ii may contradict the previous document on virtual care: https://cpsm.mb.ca/assets/Practice%20Directions/Information%20Sheet%20on%20Virtual%20Medicine%20Across%20Provincial%20and%20International%20Borders.pdf CPSM registered physicians can practice medicine and treat patients in Nunavut (either virtually or physically) without obtaining a license to practice medicine in Nunavut. This is under an agreement made with the Government of Nunavut. There is an agreement between Ontario and Manitoba for Manitoba to provide acute medical care to NW Ontario residents including follow-up. The position of the College of Physicians and Surgeons of Ontario as set out in its website, based upon Ontario legislation, is the following: Expectations for Non-CPSO Members when Providing Telemedicine in Ontario The following expectation applies to physicians who are not CPSO members, but who are licensed to practice medicine in another jurisdiction and who provide care via telemedicine to patients located in Ontario. 7. Physicians who are not CPSO members must comply with licensing requirements in the jurisdiction in which they hold licensure and provide care in accordance with the standard of care. I believe just confirming identity should be enough.
I am very pleased with this guideline overall. I particularly like: 4.1.1., 5.2.1.ii, 5.2.1.iv., and 6.1.3. I have only one comment:

My biggest concern about virtual care is an extension of walk-in clinic care, ACCESS Centre care, Urgent Care and ER care. Sometime after a patient has been seen we will sometimes receive a copy of a test result. Usually, there is no indication whether the result has been dealt with. For the safety of the patient, I believe any result sent, should be accompanied with a note indicating how the result was dealt with. If the ordering doctor or NP has advised the patient to see me, I am okay with that. I feel it is unethical to leave that result floating around or even to force me to track down the patient and ensure it was dealt with when the fee the ordering physician was paid for the visit covers dealing with the result. I request that the guideline makes it clear that the doctor carrying out a virtual visit is responsible to deal with an investigation result OR direct the patient to see their usual physician.

Thank you for the opportunity to comment on the guideline.

Thank you for the opportunity to comment. This standard is welcome as it addresses may concerns about the potential negative aspects of Virtual care.
I have two concerns:
5.1.2. This was presumably included to address specific issues pertaining to Omgomiizwin HS. What about other organizations that legitimately support patient care, particularly to rural and First Nations patients. I am finding it difficult in reading this clause to understand how this differs from other institutional supports such as my clinic which a WRHA clinic which provides care to Northern Manitoba patients, or CCMB which does the same.
5.2.1 (iv) While I understand and agree with the intent of this clause it will without doubt lead to delays in patient care. When I provide care to patient in Northern Manitoba virtually, I can arrange a physical exam when necessary, recognizing the time for, and inconvenience of travel. If I need to wait for that physical exam before referring a patient to a specialist when I know that physical exam will not change the need for that consultation, the patient will need to make an extra trip to Winnipeg and this will lead to delays in a system that is already stretched in its ability to provide timely specialist services.

My one concern is with respect to the title. In most settings- clinical, academic, literature and conferences- virtual medicine refers to any combination of telephone and video-based interaction with the patient

The standard specifies that this relates to patient interactions by electronic means- I am interpreting this to me in email, messaging services, webbased and video- and this does not include telephone

If it does include telephone I would specify that because I am not sure “electronic means” will be commonly interpreted as including telephone

If the standard excludes telephone then you may want to rename it as there is potential to cause confusion with how the term is commonly used

Virtual medicine is new ,I am following standard of practice

I work full time as an inpatient psychiatrist at Selkirk Mental Health Centre and also see emergency room consults at Selkirk Regional Health Centre. This aspect of my job is in person. I also see a handful of outpatients virtually in rural areas. I do not agree with section 3. General Provision in the standard that states that it is unacceptable to solely practice virtual medicine. Given my experience as a psychiatrist in a number of different settings, I have not had one concern from myself or patients that my outpatient

practice is solely virtual. Psychiatry is one of the few specialities that lends itself to have a virtual practice. I have patients as young as 18 and as old as 80 that are all happy with the multiple virtual options I offer. There have been no patients that have turned down my offer of consultation when I have offered virtual consultation. I am an author on a paper published in the Canadian Journal of Psychiatry on psychiatric emergency room assessments done virtually within Winnipeg. This paper explains how successful virtual care has been prior to the pandemic. General outpatient are even more suited to virtual care than emergency room psychiatry. There is a lot of literature on telepsychiatry and it would not support this standard of care. It should be reviewed. There should be added exceptions to the standard of care excluding psychiatrists from the rule that our practice can not be solely virtual medicine.

There should also be a change to section 6.1.3, as benzodiazepines and Z-drugs can be prescribed safely to appropriate psychiatric patients through virtual means. This should be removed from the standard of care or there should be an exception for psychiatrists as we are very comfortable prescribing these medications safely to our emergency, inpatients, and outpatients.

This is well written.

Overall, I think this guideline is very well written. Thank you.

I do have a couple of comments/concerns with the wording of one of the points:

"5.2.1.ii. Have the ability themselves to provide a timely physical assessment of the patient. Referring patients to a walk-in clinic or the Emergency Department in non-emergency circumstances is not appropriate care;"

To me, the way this is worded, it seems that this would require patients that are accessing virtual services from areas that are less accessible to medical care to come in for a physical exam to access the same provider. I am sure this is not the intent of the statement.

I will regularly provide consultation to patients from remote areas or for patients that are from far away. Instead of having them come in to see me for a blood pressure or to listen to their chest, I will make arrangements for them to have those things done in the community and not require them to fly down or drive down.

I am hoping that the guideline could read something like: "Have the ability to provide a physical exam themselves or personally arrange for them to have a physical exam in an appropriate medical setting if needed. Directing patients to a walk-in clinic or an Emergency department without the clinic or Emergency Department first accepting the patient is not appropriate"

This would prevent virtual care from being used as a triage system and a blanket (go to the emergency department or nearest walk-in) but would also prevent practitioners feeling that they are not following the guidelines if they arrange appropriate follow-up but do not do the physical examination themselves. It would require a practitioner to either see the patient themselves or find the patient an appropriate place to get a physical exam done and not just leave it up to the patient to find their own. It would also give the receiving ER, nursing station, or clinic some clinical context regarding the concern that the original physician has regarding the patients medical issue.

I have tried to explain my concerns but please feel free to call me an any time to discuss if there are any questions.

3.1. An acceptable standard of care requires regular in-person care. It is an unacceptable standard of care to solely practice virtual medicine.
- I do not think the initial statement or the secondary prohibition are required. In a team based model it could be acceptable for the practitioner to soley practice virtual medicine. Not all care "requires in-person" attention to be sufficient, acceptable or exemplary. For example, why could mental health services not be provided exclusively by videoconference? The prohibition would apply to for example a psychiatrist providing consultative services to patients in remote locations. Why would this be unacceptable? As robotic assisted surgery becomes more common, would we want to prohibit a properly trained surgeon from providing services by "electronic means" operating one day per week in 5 different rural/remote hospitals that would otherwise have no surgical coverage? What if a physician acquired a short- or long-term disability that only allowed them to provide electronic consultative services to patients and or colleagues? Would this person need to leave the practice of medicine even if they could continue to use their intellect and voice to care for patients, but not see patients in person?
As this is written, this will severely limit some providers who may otherwise be able to provide very valuable services to traditionally underserved communities.
If the intent is to prohibit "walk-in" virtual care or virtual care untethered to a traditional practice that provides a lower quality of care, regardless of speciality, thought should be placed to be specific to the types of care that could be of equal quality (or better quality) if provided virtual versus the opposite.

5.1.2. Members providing care for Ongomiizwin Health Services and Northern Manitoba may rely upon institutional supports and systems for the delivery of virtual medicine.
- Why are these specific caveats necessary? This implies others may not rely on institutional supports to delivery virtual medicine. Are there not remote or hard to access locations in other health regions that might benefit from institutional supports? What about an urban environment where physical distancing protocols might require virtual care (e.g. outbreak in a homeless shelter)? Does the environmental impact of driving an hour to see a physician not merit institutional supports to enable if the care could be provided virtually? This caveat seems unnecessary or should be applied more broadly to any situation where it would be appropriate or necessary to "rely upon institutional supports and systems"

5.2.1.ii Have the ability themselves to provide a timely physical assessment of the patient. Referring patients to a walk-in clinic or the Emergency Department in non-emergency circumstances is not appropriate care;
- This is incongruent with the use of virtual care in remote settings. How could one be able to provide timely care themselves to a patient in Churchill if they are in Winnipeg? It should be noted that care in Churchill is managed by the WRHA, do the administrators need to fly up to Churchill regularly to make sure the hospital is running properly?
This provision would prohibit arrangements between care providers that could coordinate timely physical assessment without it being done by the individual providing the virtual care. While referrals to walk-ins or Emergency Departments for non-emergency circumstance is undesirable, the first line appears to prohibit care arrangements that might improve access to physician care in the case that members feel they cannot provide service if they themselves cannot assess the patient in a timely manner, when it might be perfectly reasonable for the member to have an established system that could ensure timely care (i.e. team-based care).

It is great to have this guide as we begin to make virtual medicine a more standard form of care going forward.

"5.2.1.ii. Have the ability themselves to provide a timely physical assessment of the patient. Referring patients to a walk-in clinic or the Emergency Department in non-emergency circumstances is not appropriate care;"

Perhaps the statement could note that virtual care physician should do as best as possible within their means to arrange for a physical assessment not necessarily providing it themselves as this may not be possible for some practitioners providing virtual care from home or remote settings but hopefully the statement could encourage virtual care physicians to liaise with clinics that have the capacity to see patients in person so that a relationship and expectations for this are already established.

I appreciate the opportunity to provide feedback on the Virtual Medicine Standard of Practice that is under development by the College.

I definitely feel that virtual care has been a welcome enhancement to the range of ways that medical care can be provided to Manitobans, and has really enhanced the partnership in ongoing care that I have with my patients. I have used virtual care in a various settings in my practice with quite positive benefits to my patients.

In particular, virtual care has been a very helpful tool to deliver ongoing care to my patients that live in remote or under-resourced communities (as I practice specialized care), have challenges with accessibility, and where it has allowed me to maintain continuity of care for my patients.

The draft guideline is overall well done, but one section in particular raises some concerns for me in how it might be interpreted or need to be applied.

Specifically I refer to "5.2.1.ii. Have the ability themselves to provide a timely physical assessment of the patient. Referring patients to a walk-in clinic or the Emergency Department in non-emergency circumstances is not appropriate care;”

I definitely view that the main thrust of virtual care should be to serve as an adjunct to in-person care, and not a replacement for it, and that it is part of a comprehensive approach to providing care to patients. My concern is that as this statement is worded, a practitioner would not be able to offer valuable virtual care to a patient if that patient would not have a means to be seen by me specifically in a timely manner, such as would be the case if the patient lives in a remote location within Manitoba.

I can envision a few scenarios where a practitioner with is entering into a virtual encounter responsibly might nonetheless fear that they have run afoul of this policy. These could include encounters where: It is clear that urgent care is required (I don’t like the term emergent); It is clear that care is required that is beyond the scope of the practice environment that the virtual physician is working in (needs consultation or specialized assessment); It is not possible for the patient to be seen physically by virtual physician in an appropriate timely manner (e.g. remote location); It is an unreasonable use of health resources for the patient to be seen physically by the virtual physician (remote location and non-urgent issue); The patient prefers to be seen in an alternate location.

The populations that I anticipate would be the most vulnerable to a strict interpretation of this policy as written include: patients in remote/under-resourced settings; patients using virtual care to access a level of specialized or follow-up care not available locally; patients with prior care relationships with a practitioner who prefer to initiate their care with that provider; and patients with difficulty accessing or navigating the health care system, especially if they will end up needing to be seen twice to adhere to this guideline. I do not believe that that is the intent of the guideline as drafted.

As remedy, I think that the important point to highlight in the guideline is that when a physician begins an encounter for virtual care, they should have in place reasonable options to provide timely in-person care for

that patient if it becomes necessary, but that if that is not reasonably possible, then they have a duty to ensure that appropriate and timely assessment is arranged with proper communication, documentation and follow-up of any necessary transfer of care such as to a local health care setting to ensure appropriate timely assessment.

Perhaps wording such as "Have the ability to provide a timely in-person assessment themselves or personally arrange for them to have an in-person assessment in an appropriate medical setting, if deemed necessary, consistent with the College's policies regarding transfer of care. Directing patients to another health care facility, such as a walk-in clinic or an Emergency department, without appropriate communication and transfer of care is not appropriate."

Thank you for your consideration of my feedback, and I would be happy to follow-up to clarify any points if that is helpful.

Thanks for the opportunity to provide feedback on the Virtual Medicine Standard of Practice. I am grateful that this standard is being developed and I want to contribute some feedback.

Regarding: "5.2.1.ii. Have the ability themselves to provide a timely physical assessment of the patient. Referring patients to a walk-in clinic or the Emergency Department in non-emergency circumstances is not appropriate care;"

I understand that there are a number of considerations regarding this item. However, I am concerned that the way this is written, it will create barriers to patient care. This would require those using virtual services even if in a remote or under-resourced region to come see physically the same provider who provided virtual care. If providers feel they are only able to provide virtual care if they can arrange to physically see the patient themselves, this will inevitably create inequities to accessing care, especially during the current pandemic, and likely beyond.

The way this item is written, I worry that those who will be most affected are those who already face the brunt of inequity in our health system. I am concerned about populations in under-resourced or remote communities and especially those populations using virtual means to access care that has not been made available to them in their local context.

To put it simply, those who are in well resourced areas will likely have full access to virtual care while those in under-resourced areas will not.

Please consider modifying this item to the effect of "...physical assessment of the patient or directly arrange for a physical assessment in the appropriate medical setting if indicated."

I have reviewed the standard on virtual medicine. I do not practice virtual medicine as I work in the ICU/hospital setting. However, I believe this standard is quite good. I did notice however, that there is no mention of using a secure platform (MS Teams vs Zoom for instance). I would think this is important as all medical interactions should be private and confidential.

It is unclear to me how the expectations expressed in 5.2.1 of being available for physical assessment are achievable- a. In remote settings; b. For example in covid 19 virtual care. If patient is clinically deteriorating they are sent to acute care, ER with support of paramedics- the physic assessment is not going to be done by the provider of virtual care.

This item seems problematic in the setting that led to the need for virtual care in the first place.

Happy to discuss further.

Initial draft looks good.

I have a colleague who has been doing Preop "physicals", preschool "physical" and drivers "physicals" virtually and until recently has not disclosed on the forms that these were not in person assessments. Completion of the exam portion were based on asking the patient on the phone if they had a heart murmur or abdominal issues and then documenting nil, acute. Some of these patients were not known to the physician or only superficially known.
Appropriateness of type of encounters should be addressed in your draft as well as disclosure that the information was obtained virtually so that the anesthetist, surgeon or authority can gauge the validity for the report.

I am an otolaryngologist in Winnipeg. Since the introduction of virtual care tariffs my colleagues and I have noticed a disturbing trend. Very commonly (almost daily) we receive referrals from physicians based solely on virtual visits. The patient has often had multiple virtual visits for the same problem but has never been examined by the referring physician. In many cases the patient has been treated with one or more medications (often unnecessary and/or inappropriate) . Several patients have told me that the referring physician is only providing virtual care and has refused the patient's request for an in-person visit.

I think that it should not be a requirement that a patient of mine (established dr pt relationship) should be required to be in Manitoba for a phone call virtual visit to discuss test results. Of course, if the results were bad in a life changing way, I would not do that over the phone. But many results are simple such as a person's lipid results or A1C or TSH requiring just diet advice or medication adjustment. If the patient happens to be visiting family out of province, or on vacation and wants to have this visit occur then, that should be ok. I don't think new patients, or patients who have moved out of province should be done virtually. Please consider making the in province rule have room for the established patient who just happens to be traveling. Or even truckers who need their results that are established patients. Thank you.

The following excerpt from the virtual medicine draft perhaps needs editing:

5.2.1.iv. Ensure patients referred to specialists are appropriately investigated and treated before referral. <u>If an assessment of the patient’s presentation would normally include a physical before referral, the referring member must ensure that one is done. It is unacceptable to not perform or defer such a physical examination;</u>

Virtual medicine can include a "virtual physical" in that review of photographs and disclosure of the initial assessment in the setting of a pandemic and PH restrictions on attendance at community practice clinics creates additional considerations to be take in to account.

A suggestion might be:
5.2.1.iv. Ensure patients referred to specialists are appropriately investigated and treated before referral, to the best of the of the referring physician's ability given the circumstances at the time.

1) The virtual physical exam or CPE does not make sense and there should not be Tarif for that to bill same amount of money as Physical Exam in person.
This was not making sense even in the beginning of pandemic when 99% of patients were getting virtual care and now since 50% or more of the population vaccinated and we are going back to near normal in many ways, virtual physical exam should not be allowed.

2) Before pandemic if the patient does not require follow up on his/her symptoms and the labs ordered were normal; the FP were not calling the patients for a visit (which was in person) to tell them the results are normal.
With virtual medicine, some of the FP taking advantage of this and calling the patients or let their clinical/physician assistants to call the patient your blood results came back and are normal and bill for a virtual visit. Things like that should be monitored.

3) CPSM and Manitoba CFP need to act on the way the clinics are functioning in Winnipeg.
There are way too many walk in clinics in Winnipeg. Many patients are getting access to the GP but does not have regular FP! It should not be like that.
For example there is a model of Health Network, available in some provinces (group of family physicians are connected to a clinic) so if patient is not able to see his FP that day can see one of the FP in the same network, then there is accountability and good practice and good record keeping of this patient.
In virtual medicine the situation is even worse, patient and the physician can take advantage of the situation.

The physician prescribes to walk in patient who he/she never met before, and is not a patient of any of the doctors working in the same clinic, is not good standard of practice.

Thank you for the opportunity to provide feedback on virtual care.

My only comment would be with reference to 5.2.1.ii Frequently one of the benefits of virtual care is providing information and ongoing care without a patient coming into winnipeg. I work in the interlake and have a very good relationship with the primary care providers in the area. So if a virtual appointment is provided and I feel they need to be seen more urgently I will facilitate the appt but it may not be done by myself.

This has worked quite well over the years and I would be concerned the wording may limits this in the future.
The continuity of care is essential as a specialist and fully agree using an ER or walk in, as an adjuvant, is not appropriate. However using a team approach with consultants and primary providers is good medicine.

I appreciate the time and apologize if my interpretation of this issue was incorrect. thank you in advance.

I have OAT patients who travel out of province occasionally for vacations or for family emergencies. They have sometimes earned enough carries to take their doses with them, but sometimes this is not safe for many reasons and they have to consume their dose daily at a pharmacy convenient to their location. OAT prescribing is not a service that is usually available out of province, as would be the case if a patient who was travelling had a UTI or strep throat and could access a walkin clinic at their out of province location. Will there be a provision for being able to prescribe methadone, Suboxone or Kadian in another province since this is not a service that can be accessed in another province and there are sometimes issues that arise during the trip that necessitate contact with the patient? If a patient is driving back from another province

and is delayed for example by weather or any other obstacle, the prescription may need to be sent to a different pharmacy than the one previously arranged.

I am seriously concerned that the wording and restrictiveness of the standard will unduly remove the ability for providers to support their patients during times of travel or periods of transition (ie. moving to/from another province), and provide undue restrictions to expanding care to rural and remote areas, potentially resulting in serious harms including death from opioid overdose. This is particularly true for patients who are prescribed opioid agonist therapy, or other restricted medications (ex. opioids for chronic pain) and who thus have limited options for accessing in-person care, including long wait times, during times of travel or transition to other areas. Additionally it may substantially impact those who require OAT support and who do not have an authorized prescriber who attends their community for in-person assessments, but could otherwise access services through telehealth assessments in partnership with their local providers.

The wording restricts the ability to provide virtual support by specialists (including addiction medicine specialists) in conjunction with local healthcare providers, including nurses, nurse practitioners and physicians. I would suggest an addition to the General Provision 3.1 to include the possibility of providing longitudinal virtual care, in conjunction with in-person care provided by a local health care provider. Without this provision we will continue to have Manitobans in rural and remote areas having unacceptable restrictions to care.

Regarding 4.1.2 and 4.1.3 - **There must be a caveat to this to be able to support patients who are traveling or in periods of transition (ex. moving from one province to another, or visiting their home community in North Western Ontario), particularly when they're prescribed controlled medications including OAT**. It is longstanding national practice that OAT prescribers send prescriptions out-of-province to support their patients during times of travel. At times, this also requires phone assessments to deal with unforeseen issues (ex. delay in return, thus a need for a new prescription, or a change in prescription). If we are not allowed to provide this type of care, these patients will have NO access to care in most areas, and will be at risk of relapse and thus other opioid related harms including fatal and non-fatal overdose.

Regarding 5.1.2 - Ongomiizwin Health Services is only one agency that provides care to the north. I would suggest omitting the agency name, or adding a caveat including 'other institutions that support care in the north' - this will also likely continue to shift with time, so a more generic statement may be preferable as to not need to update continually.

Regarding 5.2.1.iv. - at times the requirement for a physical assessment may delay the referral substantially, particularly when providing care to vulnerable populations who may have difficulty attending appointments, and providing consultative services to remote populations. **I believe the wording in this point is too stringent.** It may be more appropriate to suggest that if an assessment would normally include a physical, but the referral is deemed urgent or the time necessary to complete a physical would substantially delay the process and is deemed unlikely to change the need for referral, the referral can be sent immediately but every effort should be made to complete the physical assessment and amend the referral with the physical exam details as soon as possible. It may also be worthwhile in supporting remote care to state that the physical exam can also be arranged to occur with a local healthcare provider, and added to the referral at a later date. For example, if I see a patient with alcohol use disorder virtually from a remote community for assessment and treatment planning, and they require a referral to hepatology for significant alcohol related liver disease (based on ROS and labwork), a physical exam would generally be indicated. However, if I am providing a telehealth assessment, and there is no physician physically in the community, the requirement to wait until a physician flies into community (which can be lengthy in some areas depending on staffing and especially during the pandemic with travel restrictions), or the patient flies down to Winnipeg to see me to

send the referral causes an unnecessary delay and substantially increases the demands on the patient (and thus the potentially for them to be lost to care) and travel costs for the system.

Regarding 6.1.3 - At times, patients arrive in Manitoba from other jurisdictions on prescribed OAT without realizing that availability of OAT prescribers and restrictions around OAT are much more limited in this province. They may assume that they can access Suboxone, or even methadone or Kadian, in their small rural community, which is often not the case. If we completely restrict the ability to provide bridging OAT prescriptions through virtual care, these patients will have NO access to continued care and will be at risk of significant relapse and related harms including overdose deaths. Also, if other provinces institute similar restrictive virtual medicine standards, these patients would NOT be able to access ongoing care from their previous prescriber, because it too would be virtual across borders. This leaves patients extremely vulnerable during periods of travel and transition, and has the potential to cause serious harm.

Thank you once again for the opportunity to provide feedback on this important standard. I would be happy to discuss further if there are any questions.

Thank you for the opportunity to provide comments on the draft virtual care standards. The virtual draft standard looks very good and I totally agree with most of it especially the piece about the member must not use virtual care as the sole method of patient care.

- **I recommend it be adopted as is but I have just one addition to make:**

If a patient wants to be seen in-person, the member must make arrangements to assess the patient in-person by him/her or with a team member. (this can be added under 2.6 or 4.2)

- **Can you also clarify the following?**

If the patient is situated in Manitoba, but the member is doing virtual care from another province or out of country, are they still covered under CPSM's license to engage in such practice? Or the member should also be in MB to provide virtual care? Docs MB and MHSAL negotiation will prohibit the member from billing for the services provided when member is out of the province. However, I am interested to know the CPSM's stance on provision of such care.

4.1.1- seems like an attempt to reflect MHSC and Doctors Manitoba parameters for billing purposes. Not optimally worded, as it could be interpreted that the physician must be in Manitoba, or the patient must be in Manitoba. Is licensure listed in every standard? The standard is for licensed Manitoba physicians, so by definition it only applies to physicians who are members of CPSM. I thought the verbage had moved from license to some other term.
4.1.2 is redundant after 4.1.1 as the conditions in 4.1.1 preclude virtual medicine from any other jurisdiction other than Manitoba (again a reflection of the billing parameters)
4.1.3 references other resources- but not included in the material. (The boundaries are stretched for practical considerations, rather than addressing the principle of virtual care)

The option to bill patients for services not covered under MHSC is an option. The College can provide guidelines in terms of licensure, patient domicile versus location at the time of the virtual visit. I understand that a physical visit of a doctor and a patient is regulated by the location in which the visit takes place. If I am travelling abroad, meet a patient of mine, with whom I am familiar, and even if I have access to their medical record (which I could), any medical advice given by me would be regulated by the country in which the visit took place.

The electronic world has removed barriers. The College has not addressed the new reality of virtual medicine in terms of an ongoing physician patient relationship regarding a virtual visit of the two parties to discuss a medical concern. Liability insurance providers have not addressed the new reality to my knowledge either. Relying on the MHSC parameters to dictate College policy evades the underlying reality of virtual medicine, and if negotiated to be different at some point, would require the College to change their standard. Forcing MHSC to be inflexible with regard to patient and physician location because of a College standard that is based on the initial negotiated parameters of MHSC and DM puts everyone, doctors and patients in a loop that could be avoided if the concept and principles of virtual medicine were addressed head on at the outset.

The doctor's physical location, whether in the office, or at the lake, should not impact the quality of virtual care. The location of the participants, doctor and patient should be immaterial to the CPSM, as it is the content, and actions of the virtual visit that are to be regulated. If a physician sees a patient at a campground in Manitoba, or if a doctor at one campground does a virtual visit with a patient at a different campground, the exchange of information is the critical factor. Having a geographic barrier for virtual medicine makes the virtual part of it incomplete. Access to the patient's medical records can be important, especially if the patient is not well known to the physician.

Virtual visits with individuals the physician has no prior relationship with are the most challenging, and are not specifically addressed. The College could specify that access to medical records either at the time of the virtual visit, or shortly afterwards are necessary for appropriate virtual care. The unknown patient could potentially take advantage of the physician's lack of their medical knowledge in a virtual visit, with the result being an unwelcome outcome.

Observations respectfully submitted
Gordon Dyck MD

2.2. CPSM recognizes the importance of virtual medicine in providing care and access to care especially for patients in remote and underserviced areas, patients with mobility constraints, and in a pandemic.

I reword this to:

CPSM recognizes the importance of virtual medicine in providing care and access to care especially for patients in remote and underserviced areas, patients with mobility constraints, those with cognitive impairment, those with limited psychosocial supports, those who are economically disadvantaged and in a pandemic. Whenever in person care would be a barrier to care virtual medicine must be offered as an alternative.

3.1. An acceptable standard of care requires regular in-person care. It is an unacceptable standard of care to solely practice virtual medicine.

I am uncertain if you are referring to someone doing virtual medicine as a sole service option (ie they never do in person care for anyone) OR if you are referring to an individual patient. I think you mean the former. If you mean the latter then that is not correct. Sometimes MB telehealth is the only service provided for an individual patient and they would never be seen in person. Economics would prevent this in some cases (eg “I cannot see you for Psychiatric Care via MB telehealth unless you can assure me that you will fly to Winnipeg to see me at least once”)

4.2.1. Members using virtual medicine to provide medical care to patients must:

I think you need to add two bullets

- You must offer the patient the opportunity to, as an alternative to meeting via phone, come into your office for an in person visit (ie consent to meet virtually with no coercion) if that is an option within public health rules
- You must have a plan of action for if the call is disrupted (eg if there is a technology failing, when you will call back, another number to call, revert from ZOOM to telephone)

5.1.1.iv. Use video technology if available, if in the best interest of the patient, and if preferred by the patient.

I would rephrase this. The patient should be offered the opportunity for a video appointment but a telephone assessment is acceptable at their request.
Many elderly patients, those in nursing homes and economically disadvantaged are not comfortable with nor able to obtain video assessment technology

5.1.2. Members providing care for Ongomiizwin Health Services and Northern Manitoba may rely upon institutional supports and systems for the delivery of virtual medicine.

I am uncertain why these two groups are singled out. What about patients in nursing homes, patients in rural hospitals, patients with dementia in rural settings, homeless people? Should not institutional supports and systems be made available to all who require it?

In my practice (Geriatric Psychiatry) I have found the availability of virtual medicine to be a tremendous enhancement. I have been able to "see" patients more quickly (for example nursing home consults completed with minutes of the request), provide more frequent follow-up (particularly advantageous when starting Rx for patients living many hours outside of Winnipeg) and have found the service to be welcomed by patients. Time and research will tell us about outcomes.

Stakeholders
Thank you for providing us with the opportunity to review your standards. I have no substantial feedback on this standard.
Thank you for the opportunity to review the draft Virtual Medicine draft standard. Here are a few comments for consideration: One of the documented intents of the standards is to support services for those in northern and remote environments however there is a clear expectation that in-person assessments are required in a reasonable time. How do you balance the need for service and the potential improved access for those in these communities with the message that an in-person assessment is essential. Does this continue to limit access? Is this requirement necessary for those seeking services for psychiatry services for example. How could you offer guidance that would support ongoing / improved access given the limiting prescriptive standard in 5.2.1.ii? Provision 4.1.3. speaks to out of province registration requirements. It is our understanding that there is no need for registration for Manitoba physicians to provide services to citizens in some other provinces. I would suggest that you note the expectation that even without registration in a jurisdiction, there is still a requirement that the practitioner consider the legal and regulatory and clinical practice requirements of that client's non Manitoba context. For e.g. even if a physician is not registered in Ontario when providing virtual services to a family who are Ontario residents, the physician needs to comply with child protection reporting requirements set by Ontario Child Protection legislation. Further the MB practitioner must comply with Ontario privacy legislation access rights despite not being registered in that province. In summary, even if professional registration is not required, the physician must meet critical practice expectations that are relevant to the client and jurisdictionally required. Manitoba physicians cannot rely on the CPSM to dictate what they need to know about the legislative and regulatory requirements of the patients jurisdiction. Happy to provide greater explanation or clarification to these comments if needed.
The Canadian Medical Protective Association – see attached
Manitoba Health and Senior Care has no concerns in relation to this proposed Standard.
I appreciate the opportunity to participate in this review and had a few comments identified below in green. 1. 4.2.1.ii. Take appropriate steps to confirm the patient's identity and that the patient is located in Manitoba – what about border communities (i.e. Flin Flon MB doctor and patient is located in Creighton SK) 2. 5.1. Assess the Appropriateness of the Use of Virtual Medicine for Each Patient Encounter - any consideration of Manitoba accessibility standards for communication needs? (i.e. deaf/hard of hearing appropriateness for virtual). I note it touches on this in 5.2.1.v but it may make sense to determine appropriateness before the visit is scheduled.

Doctors Manitoba – See attached

The effects of the COVID-19 pandemic and changes in the health care environment have required health professionals in all fields to adapt to new processes and technologies. Virtual care is one such adaptation. The College of Pharmacists of Manitoba (CPhM) recognizes both the potential benefit to patient care and the need for regulation to ensure patient safety maintained. CPhM appreciates the opportunity to provide feedback on this policy.

1. **Definition**

The definition of virtual care would be enhanced by expanding it to state electronic communication must occur securely. Virtual care provided through unsecure means (such as undecrypted text message, email) could place patient privacy at risk.

Additionally, CPhM is concerned the practice of co-signing an international prescription, after the review of a questionnaire without a patient-physician relationship, could be misinterpreted as virtual care. The College of Physician and Surgeons of Manitoba's (CPSM) position on this practice is made clear in other policies and standards of practice, however it would be beneficial to restate that position in this standard of practice to ensure uniformity.

2. **General Provision**

This section would benefit from elaboration. The requirement for in person care will vary on the individual patient and care being provided. Currently this section is very open and could be difficult for practitioners to follow. A walk-in physician may only see a patient virtually once, would this prohibit them from practicing virtual care? Regular in-person care may benefit from a connection to time-frame or chronic nature of patient/physician relationship.

3. **Prior to Engaging in Virtual Medicine**

What safeguards are in place to confirm that a physician is authorized to practice in Manitoba. Is there a method to ensure that this is a service provided by a specific licensed physician or are all physicians automatically eligible?

This section requires physicians to confirm a patient is physically located in Manitoba, this section could benefit from further elaboration as the reason for this is unclear. Are physicians prohibited from providing care to patients outside of Manitoba because they would not be able to provide a timely physical assessment if needed? What if patient is a Manitoba resident but is just temporarily out of the province? Can a physician practice while they are out of the province? This section addresses the patient's physical setting however the physician's physical setting, especially when working remotely, is crucial to safeguarding patient privacy and can affect the physician's ability to provide optimal care. Adding a statement requiring physicians to assess the appropriateness of their own physical setting would enhance this section.

4. **During and After Engaging in Virtual Medicine**

A physician must have access to a patient's medical record to engage in virtual care. A remote/virtual working model presents unique challenges to protecting the privacy and security when compared to a typical office/clinic model. Access to records should comply with PHIA and a statement indicating this would strengthen this section of the practice direction. Physicians must have the ability themselves to provide a timely physical assessment of the patient. How will this be enforced or even tracked?

5. Prescribing and Authorizing
   It is important that accessibility and patient autonomy are not hindered by the virtual process. Physicians practicing virtually or remotely should still be available to other health care providers in a timely manner for clarifications and important healthcare related correspondence. Additionally, patients who are cared for virtually are less likely to receive a physical prescription. It is important for a patient to retain the ability to choose which pharmacy their prescription is sent to. Addressing these two points would enhance the policy.

   The current M3P program requires evaluation to support virtual medicine and other environmental changes in Manitoba and to establish a solid foundation past the expiry of the current exemptions to the M3P program. CPhM is happy to work with the College of Physicians and Surgeons on this matter.

   Kind regards on behalf of the College of Pharmacists of Manitoba.

The following is a list of responses we hope you find helpful to assist in your revisions of these crucial Standard of Practice documents.

Regarding SoP Virtual Medicine: 4.2.1.ii

1) The document indicates Physicians - PAs provide virtual care. With Ontario and Alberta Regulating PAs, I could see a corporation using PAs under a Physicians "supervision" providing contracted services according to provincial guidelines in the future. Should the wording be more specific and indicate authorized members i.e MD/PA/Cl.A.?

2) If a MB resident living outside of MB contributes to MB economy/tax then it should be fair that we care for them wherever they live.

3) This article does require some clarity. For patients who have cabins a few hours away in Ontario, must they travel over the border in order to have a virtual appointment with their provider in Manitoba? Does the document need to state that location was confirmed for each virtual visit?

4) Manitoba PAs are currently providing virtual care to patients who live outside of Manitoba close to the border. They have provided virtual care to patient's temporarily visiting other provinces so the Standard of Practice would change current practices.

5) This article does create some confusion as it does not specifically mention Manitoba residents needing medical assessment while abroad. Either provincially or internationally. Additionally, this article does not address residents from other provinces that routinely access health are in Manitoba. Can these 2 points be clarified to avoid the unintentional repercussion of limiting access to medical care and the negative impact that could have on the public?

6) What would the definition of “appropriate steps” be specifically? Should it read “reasonable steps” instead?

Regarding SoP Virtual Medicine: 5.1.1.i

1) In-person assessment should be determined in an appropriate and timely manner

2) The care provider should explain the reasoning of in-house exam to the best of their abilities. If the patient refuses to come in then the provider should advise the patient of the possible risks of not being assessed in person. The provider should document that reasonable effort was attempted to further investigate the possible clinical problem

3) Patients been using virtual care for convenience or perceived risk surrounding the pandemic, both of which might be considered inappropriate for virtual care, but often the request to be seen in person is refused

4) This article would be necessary to ensure that providers in the community do not refuse in-person visits or conduct in-person visits when it is not in the best interests of the patient and the public. This article does not provide direction or establish the standard for a situation where the patient is not able or agreeable to be seen in person. Perhaps this should be addressed because many patients are elderly with limited mobility or have financial or social issues that keep them from coming to in-person visits. The concern would be potential for patients being sent to the urgent care or ER for in-person assessment which can lead to unnecessary harm and burden on the already stressed system.

5) Should it be written in a language that implies the onus is on the clinician to schedule an in-person assessment vs advising the patient and providing guidance for them but not necessarily arrangement on their behalf? If the patient fails to attend, is the clinician responsible for outcomes?

Regarding SoP Virtual Medicine: 5.3.3
1) Does confidential storage mean recording the appointment?

2) Can the CPSM review and approve a virtual health care platform to secure the medical content? To provide CPSM with additional insight into the Manitoba PAs role in Virtual Medicine, we asked our members to comment on the following question: “Does CPSM SoP Virtual Medicine and Contract of Supervision accurately address the physician/PA relationship within a virtual medicine content? (ie: Do both physician/PA need to be onsite for virtual care?) Please expand on your thoughts and how this applies to your practice.”

1. No it does not. However, PA delivered Virtual Care is possible with telecommunication similar to remote practice. However, I believe the Contract of Supervision and Practice Description require authorization for Virtual Medicine to be inserted for this authorized practice

2. 2. PAs should act as an extension of the Physician and its physical location should not be a factor. I feel that we can provide virtual medicine care with physical distance between PA and his/her supervising physician.

3. In general, we treat virtual care the same as in person care; that the supervising physician needs to be accessible as required

4. I have access to EMR from home. There are days when all clinic appointments are virtual. On these days, I call the patient and conference call the supervising physician for review. However, my Contract of Supervision stipulates that both physician/PA must be onsite. In my clinic, our dietitian and social worker are working from home by making their phone number private to call patients for their appointments.

5. The templates for the institutional and non-institutional Physician Assistant Practice Descriptions that were recently used across Manitoba do not contain sufficient inclusion of Virtual Medicine. The Virtual Medicine SoP does not directly address the common and complex relationship that exists

between a Physician Assistant, their Physician supervisors, and Society. Because of this, access to medical care could be negatively affected because the SoP could limit the Physician/PA team to in-person visits through failure to include/mention. I am not involved in Virtual Medicine, but I am concerned that there could be an unintended negative social impact through unnecessary restriction of access to PAs through Virtual Medicine.

6. I would like clarification on this; virtual billing fees are already reduced; what's the incentive for an MD to use a PA if they must be present for the virtual visit? My MDs aren't present in the exam room when I'm seeing patients, what's the difference if we review after?

7. I don't think the SoP needs to be onsite specifically because someone is being seen virtual.

To provide CPSM with additional insight into the Manitoba PAs role in Virtual Medicine, we asked our members to comment on the following question: "Is there any other feedback you have for the CPSM regarding these three SoP updates?"

1) Thank you for this opportunity

2) I am happy that CPSM is updating the SoP and I would love this format of review more often. Thank you.

3) Physician Assistants play a vital role in the Manitoba healthcare system. They have a significant impact on the health and wellness of our society and improve access to medical care in institutional and non-institutional settings throughout Manitoba. CPSM should consider specifically mentioning these associate members, whenever possible, in the standards of practice to help define how the PA/MD relationship should be evolving to protect the public as further implementation of these interdisciplinary teams continues.

During this review, I identified a few questions and concerns about how these Standards would apply to the role of physicians who provide the Online Medical Support (OLMS) for field paramedics. Specifically:

1) The virtual Care Standard maintains that a physician providing virtual care must have the ability to "provide a timely physical assessment of the patient". This is logistically impossible for the OLMS Physician who is often discussing cases across the entire province. Does the CPSM consider our OLMS to be virtual care?

2) In the Virtual Care Standard, clause 5.1.2, states "Members providing care for Ongomiizwin Health Services and Northern Manitoba may rely upon institutional supports and systems for the delivery of virtual medicine". Could we ask for a similarly worded clause that states " OLMS physicians providing advice to paramedics for the care of prehospital patients may rely upon service supports and systems for the delivery of virtual care"?

The above identified concerns are shared by the College of Paramedics of Manitoba. As such, I have included Trish Bergal, the Registrar of the College of Paramedics in this e-mail. I was hoping that Trish and I might be able to meet with yourself or other representatives from the CPSM to further clarify the role of the OLMS physician in the context of these new Practice Standards.

We have had an opportunity to review and would like to provide the following comments:

CPSM position is opposite of CRNM's with regard to the jurisdiction of registration of the care provider, which is still up for debate. The Standard could benefit from a bit of additional clarity with respect to practicing virtual medicine with patients located outside of Manitoba. For example, 4.1.3. implies that physicians may provide care across Manitoba borders if they comply with local laws, however section 4.2.1.ii. seems to suggest that the physician must confirm the patient's location in Manitoba. What if the patient is not in Manitoba?

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

July 14, 2021

Via email: virtualmedicine@cpsm.mb.ca

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

Dear Dr. Ziomek:

Re: CPSM, Consultation on *Virtual Medicine* Standard of Practice

The Canadian Medical Protective Association (CMPA) appreciates the opportunity to provide feedback to the College regarding the draft *Virtual Medicine* Standard of Practice.

As you know, the CMPA delivers efficient, high-quality physician-to-physician advice and assistance in medico-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 medico-legal issues.

The CMPA welcomes the College's initiative to update its Standard concerning Virtual Medicine. We are pleased to offer the following comments regarding the draft Standard.

Virtual Medicine

The CMPA recommends that the draft Standard be updated to provide greater specificity regarding the regulatory expectations for virtual medicine as well as additional practical guidance.

While the general principles included in the draft are important, the CMPA submits that amendments would be beneficial with more specific guidance given the evolution of virtual medicine over the past several years, and particularly the rapid and broad adoption of virtual medicine in the context of COVID-19.

Definition of "Virtual Medicine"

The CMPA recommends that the College amend the definition of "virtual medicine" in the draft Standard to align with the definition in the accompanying *Information Sheet on Virtual Medicine Across Provincial and International Borders*.

The CMPA supports the inclusion of a clear definition in the Standard regarding the breadth and definition of virtual medicine as the term is not used uniformly amongst physicians.

In our experience, it is not always clear to physicians in this changing environment what aspects of the delivery model constitute "virtual medicine" and the applicable regulatory expectations. For example, many physicians are not certain whether all care provided in the absence of an in-person visit qualifies as virtual medicine, including telephone calls or email.

While we recognize that a broad definition has been included in the draft Standard, it would be helpful if the examples of the different types of electronic communication used in the definition of "virtual medicine" in the *Information Sheet* (i.e., "telephone, video, email or text") were also incorporated in the definition "virtual medicine" in the Standard. This would assist in addressing any misapprehensions regarding the College's expectations and clarifying the application of the Standard.

Appropriate Use of Virtual Medicine

The CMPA recommends updating some of the general expectations in the current version of the draft Standard to provide more specific advice regarding the management of patients through virtual medicine. As the use of virtual care is quickly evolving, more frequent updates to the Standard would also be helpful.

Since the onset of the pandemic, the CMPA has received numerous calls from members with inquiries about various aspects relating to the implementation and appropriate use of virtual medicine.

It would be helpful to reconsider some of the general expectations in the draft Standard, as currently worded, including the broad requirements that "an acceptable standard of care requires regular in-person care" regardless of context or circumstances and for physicians to "assess the appropriateness of the use of virtual medicine for each patient encounter".

The CMPA recommends that the College provide more specific guidance regarding the following issues:

- The types of clinical issues and encounters that are best-suited to virtual medicine and the media that should be used depending on the situation (*e.g.*, telephone, videoconferencing, *etc.*).
- Practical guidance for selecting appropriate virtual medicine platforms, communicating with patients regarding scheduling of virtual medicine encounters, appropriate settings for such encounters, and devices that should or should not be used (*e.g.*, not a public computer); and

- Strategies for integrating virtual and in-person care modalities.

We know from our discussions with physicians that they sometimes struggle to understand the College's expectations for the exercise of "professional judgment" when determining whether virtual medicine is appropriate in a particular circumstance, particularly in the context of the current pandemic.

It would be beneficial if the College provided relevant factors as well as specific examples to consider when determining whether a patient encounter is or is not suitable for virtual medicine. It would also be helpful to clarify how these factors change when providing virtual medicine during the pandemic as well as after public health measures related to the pandemic are withdrawn. For example, the new CPSNS Standard on Virtual Care helpfully provides examples of the types of conditions/care that are appropriate for virtual care and those that are not. At the very least, the draft Standard might be amended to refer physicians to resources that contain such practical guidance, including the CMA's *Playbook on Virtual Care*, for example.

Privacy Considerations

The CMPA recommends that the draft Standard specifically address the necessary steps that should be taken by physicians to meet privacy and security requirements.

It can be challenging for physicians to know the form of consent that must be obtained, when such consent should be obtained, and what technology has appropriate security standards. In this latter regard, the current version of the draft Standard provides limited information to physicians regarding privacy issues related to virtual medicine.

For example, the CPSBC Standard on Virtual Care provides that consent to use virtual care should be obtained from the patient during the initial virtual care visit. It would be helpful if this type of additional guidance were provided to physicians in the draft Standard.

Remote Practices

The CMPA recommends the development of a consistent approach amongst the Colleges with respect to licensure requirements for the provision of virtual medicine.

With the expansion of virtual medicine, physicians have greater flexibility with respect to where they locate their practice. We are therefore pleased to see that the College has published the *Information Sheet on Virtual Medicine Across Provincial and International Borders* that clarifies requirements for this practice of virtual medicine.

We note, however, that there remains inconsistency in the regulatory approaches across the country in terms of the licensure requirements for physicians providing care from out of province. For example, the CPSBC states in its Standard on Virtual Care that physicians who are licensed with another regulatory body do not need to obtain an additional licence to provide care to patients in BC. The CPSO and the CPSNS take a similar approach. However, the CPSNS also states that physicians licensed in Nova Scotia who deliver care into other

jurisdictions in Canada will be held to the standards of that jurisdiction, while subject to the regulation of the CPSNS. The CPSM appears to require out of province physicians to register with the College. In Alberta, the College allows out of province physicians to provide care without licensure in Alberta if the total number of "telemedicine events" are limited to five times per year.

The CMPA is hopeful that an agreement can be reached with the members of FMRAC that will create a more consistent regulatory framework for virtual medicine.

CMPA Assistance

Because the CMPA provides liability protection to the majority of physicians in Manitoba, we request that the reference to "liability insurance" in the draft Standard be amended to read "liability protection". We request a similar amendment to the reference to "insurance" in the second last paragraph on the first page of the CPSM *Information Sheet on Virtual Medicine Across Provincial and International Borders*.

You are likely aware that the CMPA is a mutual defence organization and not an insurance company. As such, the CMPA prefers to avoid, where possible, the use of any language that could be construed as suggesting it is an insurer."

Conclusion

We trust these comments will be helpful to the College in finalizing the *Virtual Medicine* Standard. The CMPA would also be pleased to provide additional comments on any revisions to the Standard.

Yours sincerely,

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

LAC/ml

cc. Dr. M. Cohen

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VIA EMAIL

Dr. Anna Ziomek
Registrar
College of Physicians and Surgeons of Manitoba
1000-1661 Portage Ave.
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virtualmedicine@cpsm.mb.ca

Dear Dr. Ziomek:

Thank you for the opportunity to provide the input of Doctors Manitoba respecting the proposed CPSM Standard of Practice for Virtual Medicine.

We have appreciated the opportunity to work with you as the Guidelines were being prepared by the CPSM. We have shared the Guidelines with our members, and we have provided ongoing advice to members in meeting their obligations. For the most part, we believe the proposed Standard codifies the concepts in the Guidelines, and provides a good platform for the continued use and expansion of virtual medicine.

As you are aware, we are actively engaged in negotiations with Manitoba Health to ensure that physicians will continue to be able to provide virtual medicine to Manitoba patients, where appropriate, following the end of the pandemic. Many patients have expressed satisfaction with receiving care without having to travel to their physician's office; there is great interest among physicians to continue providing virtual medicine where appropriate.

Given our engagement with the CPSM, we have very few comments on the provisions of the Standard.

Ability to provide timely physical assessment

We note Section 5.2.1.ii requires all members providing virtual medicine to "have the ability themselves to provide a timely physical assessment of the patient. Referring patients to a walk-in clinic or the emergency department in non-emergency circumstances is not appropriate care."

We agree this is reasonable in most situations. Physicians providing virtual medicine must provide patients with adequate direction and follow up, and we agree that simply directing patients to a walk-in or ER for non-urgent concerns would not be sufficient in most circumstances.

However, an area of tremendous potential for virtual care is greater access to health care for Manitobans outside of urban centres. Our members provide virtual care to patients in remote locations, including First Nations communities and other centres where there are few options. We note that the Standard acknowledges these challenges in Section 2.2.

We expect a referral of a patient in a remote First Nation community to the local nursing station in the course of a virtual medicine visit would be seen as an entirely reasonable direction for non-emergency circumstances. Similarly, where regions are left without access to community physicians

(where virtual medicine is most vital), directing patients to a facility for a physical assessment is not unreasonable.

We recommend some wording to qualify the duty in Section 5.2.1.ii - if only to reference the general principles in Section 2.2 - to reflect the reality of access to health care in all areas of Manitoba.

“Quotas” for virtual care

We agree that virtual medicine is intended to optimize and complement patient care (as set out in Section 2.3). Each physician has the obligation to ensure that virtual medicine is appropriate in each circumstance.

Certain health leaders in Shared Health and regional health authorities have purported to impose a “quota” on physicians practising in facilities, mandating a certain percentage of their patient visits must be delivered through virtual medicine. We believe this is intended to relieve the current stress on facilities, but should these directions persist, this could affect patient care and create a conflict with the Standard.

Some areas of practise are less conducive to virtual medicine (for example, there is no “virtual” equivalent to the extensive testing required by an allergist); there are no virtual alternatives to a wide range of procedures from annual physicals to immunizations to pap smears. Where a member determines that in person visits are medically required, we believe both Doctors Manitoba and the CPSM agree this must take precedence over “quota” direction given by health leadership.

We are not suggesting any change to the Standard, because we agree with the Standard. However, we would appreciate the College raising the issue with health leadership in Manitoba. In the event that our members should raise concerns that any such direction creates a conflict with the Standard, we propose working together to advocate for our members.

Again, we wish to thank the CPSM for the opportunity to participate in this consultation. We expect we will remain in contact on this issue, as we work with Manitoba Health to allow virtual medicine to play an expanded role in providing the best possible care to Manitoba patients.

Sincerely,

Andrew Swan

ANDREW SWAN
General Counsel

AS/jb

Standard of Practice

Virtual Medicine

Initial Approval: **Effective Date:**

DRAFT

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the *Regulated Health Professions Act*, Regulations, and Bylaws. All members must comply with Standards of Practice of Medicine, per section 86 of the *Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of the *Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

1. DEFINITION AND APPLICATION

1.1. Virtual Medicine means the provision of medical care by means of electronic communication (telephone, video, email, text, or other internet hosted service or app) where the patient and the member are at different locations, including but not limited to treating, advising, interviewing or examining the patient. *CPSM Standards of Practice Regulation*, s. 1.

1.2. This Standard does not apply to medical consultations or communications between CPSM members, nor to communications between CPSM members and other regulated health professionals.

2. ETHICAL, PROFESSIONAL, AND LEGAL OBLIGATIONS

2.1. Providing care by virtual medicine does not alter the ethical, professional, and legal obligations of members to provide good medical care.

2.2. CPSM recognizes the importance of virtual medicine in providing care and access to care, especially for patients in remote and underserviced areas, patients with disabilities, patients in institutional settings, limited psychosocial supports or economic means, and in a pandemic, or state of emergency.

2.3. Virtual medicine is to be used to optimize and complement in-person patient care.

2.4. The role of CPSM is to regulate members and their use of technology, not technology itself.

2.5. Members must provide virtual medicine in accordance with this Standard of Practice.

3. GENERAL PROVISION

3.1. Each member's practice of medicine **must include timely in-person care** when clinically indicated or requested by the patient. It is not an acceptable standard of care to solely practice virtual medicine. [1] **A blended care model balancing in-person and virtual medicine is required if providing virtual medicine**.

4. PRIOR TO ENGAGING IN VIRTUAL MEDICINE

4.1. Licensure

4.1.1. Physicians providing virtual medicine to Manitoba patients located in Manitoba must be registered as members of CPSM.

4.1.2. Members must be aware of and comply with the licensing requirements in the Canadian jurisdiction in which the patient is located. Many jurisdictions require physicians to hold a license and have liability protection to treat a patient located in that jurisdiction.

4.1.3. If providing care across the Manitoba border, physicians must be familiar and comply with the legalities of licensure as outlined in the Contextual Information and Resources document following this Standard.

4.2. Establishing the Patient-Physician Relationship

4.2.1. Members using virtual medicine to provide medical care to patients must:

4.2.1.i. Disclose their identity to the patient and confirm confidentiality of the encounter;

4.2.1.ii. Take reasonable steps to confirm the patient's identity and that the patient is located in Manitoba;

4.2.1.iii. Ask the patient if the physical setting is appropriate given the context of the encounter and ensure consent to proceed;

4.2.1.iv. Offer the patient the opportunity for in-person care.

5. DURING AND AFTER ENGAGING IN VIRTUAL MEDICINE

5.1. Assess the Appropriateness of the Use of Virtual Medicine for Each Patient Encounter

5.1.1. Members providing virtual medicine must:

5.1.1.i. Assess the patient's presenting condition and the appropriateness of virtual medicine to provide care; if not appropriate, then must recommend and offer an in-person assessment;

5.1.1.ii. Ensure they have sufficient knowledge, skill, judgment, and competency (including technological) to manage patient care through virtual medicine;

[1] Members providing virtual medicine exclusively in remote communities may do so if part of the institutional health care system.

5.1.1.iii. Ensure they have satisfactory technology to provide virtual medicine;
5.1.1.iv. Use video technology if available, if in the best interest of the patient, and if preferred by the patient.

5.2. Provide Good Medical Care

5.2.1. Members providing virtual medical care must:

5.2.1.i. Provide all elements of good medical care as required. *CPSM Standard of Practice Regulation*, s. 3 *LINK*

5.2.1.ii. Have the ability themselves to provide a timely physical assessment of the patient. A limited exemption applies for patients in distant rural, remote, or institutional locations if this will hinder access to care.[2] Directing patients to another healthcare facility, a walk-in clinic, or the Urgent Care or Emergency Department in non-urgent or non-emergent circumstances in lieu of an in-person assessment is not appropriate care;

5.2.1.iii. Ensure continuity of care and have the same obligations for patient follow-up as in in-person care;

5.2.1.iv. Ensure patients referred to specialists are appropriately investigated and treated before referral. If an assessment of the patient's presentation requires a physical before referral, the referring member must ensure that one is done. It is unacceptable to defer such a physical assessment to the specialist unless agreed to in advance. An exemption applies for patients in distant rural, remote, or institutional locations if this will hinder access to care;

5.2.1.v. Pay additional attention to ensuring the patient understands the information exchanged and is not hindered by the technology;

5.2.1.vi. Adapt the technology for virtual medicine for patients who are deaf, hard of hearing, or visually impaired.

5.2.2 Members providing care for Ongomiizwin Health Services and Northern Manitoba, CancerCare Manitoba, or other public organizations supporting medical care including hospitals or long-term care facilities, may rely upon institutional supports and systems for the delivery of virtual medicine.[3]

5.3. Medical Records and the Privacy, Confidentiality, Security of, and Access to Patient Records

5.3.1. Members providing virtual medicine are required to create and maintain patient records the same as in in-person care and adhere to that Standard of Practice.

[2] Specialists have a greater latitude in providing timely care, usually due to health care system waits or the difficulties for many patients to travel distances.

[3] For instance, if safe to the patient, a physician providing care to a remote community may rely upon a nurse practitioner in the community to perform a physical assessment, or a specialist may rely upon a family doctor in a rural area to perform a physical assessment. These institutions might also have special alternate arrangements for delivery of care to distant rural and remote patients.

5.3.2. Members should usually have active access to the patient's medical record while providing virtual medicine.

5.3.3. Members must carefully consider the appropriateness of obtaining photo or video from patients by electronic means and ensure the consent, lawful viewing, and confidential storage of such patient records.

6. PRESCRIBING AND AUTHORIZING

6.1. Members using virtual medicine must:

6.1.1. Conduct an assessment in accordance with the standard of care before prescribing or authorizing a drug, substance, or device, and only proceed to do so if appropriate;

6.1.2. Exercise caution when providing prescriptions or other treatment recommendations to patients they have not personally examined;

6.1.3. Not prescribe opioids or benzodiazepines or Z-Drugs or authorize cannabis for medical purposes to patients whom they have not examined in person, or with whom they do not have a longitudinal treating relationship, unless they are in direct communication with another regulated healthcare professional who has examined the patient.

Contextual Information and Resources

DRAFT Virtual Medicine

The Contextual Information and Resources are provided to support members in implementing this Standard of Practice. The Contextual Information and Resources do not define this Standard of Practice, nor should it be interpreted as legal advice. It is not compulsory, unlike a Standard of Practice. The Contextual Information and Resources are dynamic and may be edited or updated for clarity, new developments, or new resources at any time.

Importance of Physical Assessments to meet the Standard of Care

The art and science of medicine usually requires in-person care to create trust with the patient, demonstrate empathy, support patients, correctly assess the medical condition, and enhance the connection between patient and physician. In-person encouters are often critical for the non-verbal element of communication between patient and physician.

Many physicians adapted to virtual medicine immediately in March 2020 due to the COVID-19 pandemic, and Manitoba was in a state of lock-down restrictions. This permitted virtual medicine to treat medical conditions that otherwise would have required in-person care.

CPSM encourages its members to provide in-person medical care for most of their practice because the physical assessment of patients is critical to good medical care and the patient-doctor relationship. Prescription refills for long-standing patients may not require a physical assessment, nor would delivery of the most favourable test results.

Virtual Medicine Not Meeting the Standard of Care

The requirement is to provide timely in-person medical care. Examples of virtual medicine that do not meet the Standard are:

- Physicians not offering in-person appointments, including during a pandemic, unless advised by a health authority to not see patients in person
- Virtual medicine-based businesses that do not offer timely in-person appointments by the same physician
- Physicians unnecessarily restricting in-person visits with patients or having very limited in-person appointments.

Good medical care usually requires in-person assessments unless for refills or chronic care for long-standing patients. The following are examples of likely failing to provide good medical care through virtual medicine:

- Complete physicals
- Assessments for return to work unless mental health

- Acute change in patient's condition
- Any concern that requires direct hands-on examinations, i.e., abdominal examination
- Any concern that requires a direct visual observation

Referrals to a Specialist Without a Physical Examination

Numerous specialists have advised that they have been referred patients who have not been seen in-person for medical care that could have been provided by a family physician in-person.n. For instance, an ENT has received many referrals for earaches, but the family doctors have not performed an in-person examination which would have detected a condition that the family doctor could address.

The general rule for good medical care is to perform a physical examination prior to referral to a specialist. There are, however, examples of referrals that can be made to specialists without having first seen the patient. These include:

- Obvious significant or urgent medical conditions
- Referral of long-term substance use disorder to hepatology or addictions medicine
- Referrals of distant rural and remote patients if the in-person assessment will hinder or unduly delay care

Mental Health and Psychiatry

While the counseling for mental health matters might seem best suited for virtual medicine, CPSM will caution that many aspects of mental health care require in-person care to be competent care. A physical assessment might be required to assess the patient's appearance, actions, mannerisms, countenance, etc. This may or may not be achieved by video, and video is highly encouraged by CPSM for all virtual encounters in mental health. Similarly, the creation of a successful patient-physician relationship is more likely in person than through virtual medicine.

An exemption may exist for treating those patients in rural and remote areas or living in institutions (personal care homes, group homes, hospitals, correctional centres, etc.) where in-person access may be difficult.

Video Preferred Option

A CPSM survey of patients indicated that 98% of virtual medicine patient encounters were undertaken by telephone. Patients in the same survey indicated their strong preference for video clinical encounters, not telephone. The Standard mandates the use of video technology if available, if in the best interest of the patient, and if preferred by the patient. Video is the preferred option. However, if a video option is unavailable or refused by the patient, default to a telephone may suffice if deemed safe for the patient.

Considering Patient Preferences Regarding Virtual Medicine

Considering and negotiating patient preferences is not merely an information exchange but an opportunity to initiate a dialogue between physician and patient in which both attempt to arrive at a mutually satisfactory course of action. When deciding between virtual vs. in-person visits or video vs. telephone options, the physician may use the following framework:

Elicit Preferences

What are the patient's circumstances (convenience, mobility, financial, location, social, and communication limitations)?

Determine Goals

What are the goals of this visit? For the patient? For the physician?

What are the benefits and detriments of virtual vs. in-person visit or video vs. telephone visit for that particular patient encounter?

Virtual Care for Distant Rural and Remote

CPSM recognizes the importance of virtual medicine for many patients living in some distant rural and remote areas, especially those residing in First Nations. Virtual medicine has enabled these patients to access health care with greater ease which is supported by CPSM. Physicians treating patients residing in these areas are encouraged to continue using virtual medicine, so long as it is safe for the patient and provides good medical care. The Standard will be interpreted in the context of that care for patients.

For instance, CancerCare may continue to do virtual medicine without seeing these patients if safe to do so. The same for obstetricians and pediatricians conducting medical care in the North through institutional supports – which may include having a nurse practitioner in the community perform the physical assessment, or a urologist in Winnipeg may utilize photos or videos to assess and treat remote patients that would otherwise require lengthy travel to an urban centre for a quick assessment. These are just a few examples of virtual medicine that could be utilized for distant rural or remote patients.

Virtual Care for Opioid Agonist Treatment

For Opioid Agonist Treatment, CPSM recognizes the importance of virtual medicine providing immediate medical care in situations where in-person care might not otherwise be possible. Access to continuous good medical care (whether virtual or in-person) is in the best interest of this unique patient group receiving opioid agonist treatment.

Across Provincial and International Borders

See INFORMATION SHEET ON VIRTUAL MEDICINE ACROSS PROVINCIAL AND INTERNATIONAL BORDERS

Suggested Resources

- Virtual Care Playbook by CMA/CFPC/RCPSC. This playbook was written to help Canadian physicians introduce virtual patient encounters into their daily practices. https://www.cma.ca/virtual-care-playbook-canadian-physicians

- Virtual Care in the Patient's Medical Home by CFPC. The Patient's Medical Home is the model of family medicine for Canada supported by the CFPC. https://www.cma.ca/virtual-care-playbook-canadian-physicians

- Virtual Care Guide for Patients by CMA/CFPC/RCPSC. This has been prepared to help patients prepare for virtual visits with their physician. https://www.cma.ca/sites/default/files/pdf/Patient-Virtual-Care-Guide-E.pdf

- See Doctors Manitoba for Resources and Tariffs https://doctorsmanitoba.ca/managing-your-practice/covid-19/virtual-care

  https://doctorsmanitoba.ca/managing-your-practice/covid-19/virtual-care/virtual-care-across-borders

COUNCIL MEETING - SEPTEMBER 29, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Standard of Practice Exercise Cardiac Stress Testing

BACKGROUND

Exercise Cardiac Stress Testing poses sufficient risk of potential harm to a patient to require specific standards of practice to be adhered to by those members supervising this test. While reviewing the Accredited Facilities Bylaw it came to the attention of the Working Group and Council that in Manitoba there were no specific requirements for exercise cardiac stress testing. Most other provinces have such requirements.

The draft Standard applies to members supervising and interpreting Exercise Cardiac Stress Testing and medical directors of facilities in which exercise cardiac stress testing occurs.

A diverse Working Group of cardiologists, both in the hospitals and in the community, have met under the leadership of Dr. Suss to prepare the attached draft Standard of Practice for Cardiac Stress Testing. The Working Group benefitted by utilizing some of the regulatory approaches adopted by others in Canada.

The Working Group recommends that this draft Standard be distributed to the public, stakeholders, and members for consultation. Given the specificity of the technical requirements, an advertisement in the Saturday newspaper is not being considered. It will be on the website should the public wish to comment.

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.

The CPSM Standard promotes patient safety and quality care in facilities performing cardiac stress testing in facilities where diagnostic services are provided by physicians. CPSM has developed a best-practice standard for patient safety. It is recognized that the cardiac stress test on individuals with compromised cardiac systems can pose a relatively rare though very serious risk of heart attack, thereby necessitating specific regulation.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> The Standard of Practice Exercise Cardiac Stress Testing, as presented, be approved for consultation with the public, stakeholders, and registrants.

DRAFT Standard of Practice

Exercise Cardiac Stress Testing

Initial Approval: **Effective Date:**

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the *Regulated Health Professions Act*, Regulations, and Bylaws. All members must comply with Standards of Practice of Medicine, per section 86 of the *Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of the *Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

1. Preamble and Application

1.1 Exercise Cardiac Stress Testing poses sufficient risk of potential harm to a patient to require specific standards of practice.

1.2 This Standard applies to all members supervising and interpreting exercise cardiac stress testing and the medical directors of facilities in which exercise cardiac stress testing occurs, including in hospitals or other health authority facilities or non-hospital medical or surgical facilities or any other facility where performed.

2. Qualifications

2.1. Members supervising, interpreting, or serving as medical director for exercise cardiac stress testing must be:

2.1.1. Certificants of the Royal College of Physicians and Surgeons of Canada in Adult Cardiology or have specialist training in Adult Cardiology acceptable to the Registrar or

2.1.2. Approved by CPSM to interpret electrocardiograms and maintain up-to-date certification in advanced cardiac life support and provide satisfactory evidence of training and competence assessment in exercise cardiac stress testing[1]

[1] For guidance on training and competence, see Clinical Competence Statement on Stress Testing – A Clinical Competence Statement by the American College of Cardiology and the American Heart Association - LINK

3. Prior to Supervising Exercise Cardiac Stress Testing

3.1. Prior to supervising an exercise cardiac stress test the member must ensure the following are reviewed:

- 3.1.1. A clinical history and physical examination, including medications (if not done by the member supervising the test, then the information and findings must be verified).
- 3.1.2. Baseline electrocardiogram.
- 3.1.3. Baseline electrocardiogram.
- 3.1.4. A real-time assessment of the risk of stress testing.

4. Quality and Patient Safety

4.1. The member responsible for supervising the test must remain onsite and available immediately while patients are undergoing exercise cardiac stress testing.

4.2. An exercise cardiac stress test may only be undertaken at a location that permits uninterrupted resuscitation to be performed on unstable patients during extrication on a stretcher and loading into an ambulance.

4.3. In the event of a death within the facility, the Medical Examiner must be notified prior to moving the body or removal of any lines or tubes from the body and CPSM notified within one week.

5. Responsibilities of the Medical Director

5.1. Medical Directors[2] of facilities where exercise cardiac stress testing occurs must be responsible to ensure:

- 5.1.1. staff are adequately qualified and have obtained sufficient training to participate in exercise cardiac stress testing including certification in Basic Life Support
- 5.1.2. continuous, adequate and effective direction and supervision of clinical staff.
- 5.1.3. an adequate quality assurance program is in place.[3]
- 5.1.4. The selection of testing procedures and equipment used.
- 5.1.5. equipment meets or exceeds the standards of the Canadian Standards Association or its equivalent and is maintained regularly
- 5.1.6. a manual outlining necessary office protocols and procedures including those required to meet the standards for exercise cardiac stress testing is maintained and current.

[2] In large institutional settings it is recognized the medical director may not have authority over all matters and may authorize others to act or the decisions may be made by the institution or the health authority.

[3] For ideas on quality assurance, see Clinical Competence Statement on Stress Testing – A Clinical Competence Statement by the American College of Cardiology and the American Heart Association, page 2 - LINK and other resources provided.

5.2. Medical Directors of facilities where exercise cardiac stress testing occurs must have at a minimum, the following medical emergency equipment and supplies readily available prior to exercise cardiac stress testing:

5.2.1. Stethoscope and blood pressure measurement device with various cuff sizes

5.2.2. Stretcher and backboard for cardio-pulmonary resuscitation if the stretcher is not suitable

5.2.3. ASA non-coated chewable tablets (81mg or 325 mg), and Nitroglycerin spray

5.2.4. automated external defibrillator

6. Documentation

6.1. The member supervising exercise cardiac stress testing must ensure a clinical record is created for each patient which contains, at a minimum, the following:

6.1.1. A relevant clinical history and physical examination
6.1.2. Current medication list
6.1.3. 12-lead electrocardiogram before, during and after the test
6.1.4. Name of the test performed
6.1.5. Total exercise time
6.1.6. Clinical response during and after testing
6.1.7. Presence or absence of arrhythmias
6.1.8. Measurement and character of ST-segments
6.1.9. Heart rates: estimated age-predicted target heart rate, and heart rate achieved
6.1.10. Blood pressure measurements before, during and after the test
6.1.11. Reason for stopping the test

Additional Resources

- College of Physicians and Surgeons of Alberta, Cardiac Exercise Stress Testing Standards - LINK
- Cardiac Care Network – Standards for the Provision of Electrocardiography (ECG) – Based Diagnostic Testing in Ontario 2017 - LINK
- Recommendations for Clinical Exercise Laboratories – A Scientific Statement from the American Heart Association (Circulation 2009:119:3144-3161) - LINK
- Exercise Standards for Testing and Training – A Scientific Statement from the American Heart Association (Circulation 2013;128:873-934) - LINK
- Clinical Competence Statement on Stress Testing – A Clinical Competence Statement by the American College of Cardiology and the American Heart Association - LINK

COUNCIL MEETING - SEPTEMBER 29, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Truth and Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners

BACKGROUND

At its meeting in June, Council established Truth and Reconciliation – Addressing Anti-Indigenous Racism by Medical Practitioners as a Strategic Organizational Priority.

Code of Ethics and Professionalism

The Code of Ethics and Professionalism contains the following:

> 43. Commit to collaborative and respectful relationships with Indigenous patients and communities through efforts to understand and implement the recommendations relevant to health care made in the report of the Truth and Reconciliation Commission of Canada.

Truth and Reconciliation Commission

The Truth and Reconciliation Commission issued 94 Calls to Action. There are two that can be applicable to CPSM:

> 23. We call upon all levels of government to:
>
> i. Increase the number of Aboriginal professionals working in the health-care field.
> ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
> iii. Provide cultural competency training for all healthcare professionals.
>
> 24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

There is a call to action for the law societies (governing body of the legal profession) to implement cultural competency training.

> 27. We call upon the Federation of Law Societies of Canada to ensure that lawyers receive appropriate cultural competency training, which includes the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and

> Aboriginal rights, Indigenous law, and Aboriginal– Crown relations. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

However, there is no equivalent call to action for the Federation of Medical Regulatory Authorities of Canada to do so for the Colleges of Physicians and Surgeons.

There are seven Calls to Action under Health, numbered 18-24 that you may be interested in reviewing.
https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf

Persons Involved

Any Truth and Reconciliation Anti-Indigenous Racism priority must be led by and informed by indigenous physicians, indigenous members of CPSM, and indigenous community members. Over the summer CPSM has met with Dr. Lisa Monkman, an Indigenous physician who has agreed to lead the group of Indigenous CPSM members (and others) that will inform CPSM of how to fulfill the calls to action from the Truth and Reconciliation Commission.

CPSM is currently working with Dr. Monkman to determine the membership of the CPSM Indigenous Advisory Circle and seek volunteers.

Indigenous Advisory Circle

Rather than a traditional Working Group, it is proposed that this group of indigenous physicians, members, public representatives, and others be referred to as an Advisory Circle. This is an important distinction as usually the Working Group is given a defined specific task, usually with a specific deliverable to be produced (ie a Standard of Practice). However, in this instance, the Indigenous Advisory Circle will be asked to advise CPSM on how to address Truth and Reconciliation and it is CPSM's responsibility to listen to the Advisory Circle and then determine if and how to implement their recommendations. This will be a different role for Council in its governance.

The Recommendations and advice from the Advisory Circle are to be in respect to physician practice to seek to end anti-Indigenous racism in the practice of medicine.

The full name of the Strategic Priority will be Truth and Reconciliation – Addressing Indigenous Racism by Medical Practitioners. The full name of the Advisory Circle will be the Truth and Reconciliation – Addressing Indigenous Racism by Medical Practitioners Advisory Circle.

Cultural Competency Training

As per the Truth and Reconciliation Commission, one of the items the Advisory Circle will consider is mandatory cultural competency training. Several members of Council and the Registrars are enrolled in the cultural competency program established by the WRHA. It is called the Manitoba Indigenous Cultural Safety Training. Some Councillors may have taken it already and it has apparently received very favourable reviews. It is an 8 hour asynchronous training module that includes a group component. We look forward to taking this course in the fall.

The College of Physicians and Surgeons of Newfoundland and Labrador has worked with Memorial University to prepare a two hour compulsory indigenous cultural competency program for Indigenous health. CPSM is in the process of arranging to view this program that is specific to Newfoundland and Labrador.

Canadian Medical Association Initiative

The CMA has funded and launched a short film to invite reflections on Indigenous peoples' experiences with the health care system. The 35 minute film, *The Unforgotten*, is "shining a light on the impacts of colonialism and systemic racism on the health and well-being of Indigenous peoples." There is also a toolkit for educational purposes to further understand and reflect on this topic. https://theunforgotten.cma.ca/

It would be helpful for all councillors to watch this film prior to the September 29 meeting of Council.

Terms of Reference

The Terms of Reference are rather wide open given the nature of this work. Indeed, rather than having Council establish what to do in a Terms of Reference, it is up to the Indigenous Advisory Circle to advise Council and CPSM what to do. Council will make the determinations on what to do.

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

This section has been explained in detail in past submissions to Council. See page 46 of the March 2021 Council meeting agenda

This is only more important as mainstream society is gaining a greater understanding of residential schools and the many children whose deaths are unrecorded and are buried in unmarked graces.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves the Terms of Reference for the Truth & Reconciliation – Addressing Anti-Indigenous Racism by Medical Practitioners Advisory Circle as attached.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

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TRUTH AND RECONCILIATION – ADDRESSING ANTI-INDIGENOUS RACISM BY MEDICAL PRACTITIONERS
Terms of Reference
CPSM Indigenous Advisory Circle

Note:

The term Indigenous is used to include First Nations, Metis, and Inuit in Manitoba.

Section 1: Background

Two recent high profile incidents in health care have launched the issue of racism in healthcare to the forefront – healthcare workers in BC ERs playing a game to guess the Blood Alcohol level of Indigenous patients and Quebec nurses taunting and mocking Joyce Echaquan while she was dying (which she recorded). This has led to a call by Indigenous organizations and others for the adoption of Joyce's principle.

> "Joyce's Principle aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional, and spiritual health. Joyce's Principle requires the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health."

There are calls to action from the Truth and Reconciliation Commission and the Missing and Murdered Indigenous Women and Girls Inquiry which may place responsibilities on healthcare professional regulators. The BC Government launched an external investigation which released its report in November 2020, "In Plain Sight: Addressing Indigenous -Specific Racism and Discrimination in BC Health Care". Although the report is from British Columbia, much of that report may be applicable to Manitoba. The Manitoba inquest into the 2008 death of Brian Sinclair exposed racism in the health care system and by healthcare providers and Manitoba, the RHAs, and the University have responded with various changes, yet anti-Indigenous racism still exists in healthcare.

FMRAC recently has adopted, as one of its ongoing priorities, Addressing Racism in Physician Practice. At this point the Working Group is concentrating on Indigenous, Inuit, and Metis which is not to ignore the racism that negatively affects others and is highlighted by the Black Lives Matters movement.

CPSM was an attendee at the two-day January summit hosted by the federal government on "Addressing Anti-Indigenous Racism in Canada's Health Care Systems". At that summit, the federal government announced the National Consortium for Indigenous Medical Education and the commitment to the development of Indigenous health care legislation and a federal Indigenous health care authority. Both were very well received.

The *Code of Ethics and Professionalism* contains the following:

> 43 Commit to collaborative and respectful relationships with Indigenous patients and communities through efforts to understand and implement the recommendations relevant to health care made in the report of the Truth and Reconciliation Commission of Canada.

Section 2: Purpose

The purpose of the Truth and Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners Advisory Circle is to provide advice and recommendations to help CPSM reflect on its own processes and identify how it can and better guide the physicians and other CPSM members who provide medical care to Indigenous patients and to create better understanding and support of Indigenous patients.

Section 3: Leadership and Membership

The Committee will be led by Dr. Lisa Monkman.

The Advisory Circle Membership is to be led by and include representatives from the Indigenous physicians, Indigenous CPSM members, and indigenous community members (i.e. scholars, leaders, elders, traditional knowledge keepers, and traditional healers). Other affiliated members will include non-Indigenous members such as the Associate Dean – Continuing Competency and Assessment at the College of Medicine and others. Support will be provided from the CPSM Staff.

COUNCIL MEETING - SEPTEMBER 29, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Prescribing Practices Review

BACKGROUND

Chosen by Council as one of the Strategic Organizational Priorities in June 2021, Prescribing Practices will be a joint review of many aspects of prescribing which is one of the core treatments performed by physicians and CPSM members.

Prescribing has changed dramatically with COVID-19 pandemic rules, the introduction of virtual medicine, technology, and in general changing societal expectations around expected convenience of access to drugs. Of course, patient safety for prescribed drugs is absolutely critical.

The Working Group will be jointly operated and coordinated with the Colleges of Pharmacy and Registered Nurses as prescribing is important to these colleges' members. The College of Pharmacy has already prepared an environmental scan and summarized the legislation in the various acts and regulations. This is a significant work and provides a significant acceleration of the tasks to be undertaken by the Working Group. CPSM is grateful that the College of Pharmacy has undertaken this work.

Manitoba Prescribing Practices Program (M3P)

Much of the prescribing review will focus on the M3P which will then determine some of the other aspects of prescribing review. For those who are not physicians, the M3P drugs are a list of controlled substances that must be prescribed using a certain triplicate pad. The drugs include opioids, some benzodiazepines, and others that have a societal impact beyond treatment and may be subject to abuse. The Councils of the Colleges of Pharmacy and Physicians & Surgeons jointly designate which prescribed drugs are M3P drugs.

In light of the COVID-19 pandemic, the College of Pharmacists of Manitoba (CPhM), College of Physicians and Surgeons of Manitoba (CPSM), and the College of Registered Nurses of Manitoba (CRNM) have temporarily allowed M3P prescriptions to be faxed directly to the pharmacy of the patient's choice. Provided the prescription meets all facsimile prescription requirements, it can be faxed using one of the following formats:

- A M3P form;
- A prescription generated utilizing the prescriber's electronic medical record's (EMR) prescription function; or
- A handwritten prescription.

It should be noted that transfers and verbal orders of M3P prescriptions between pharmacies and electronic or e-mail transmission of M3P drugs is still not permitted.

Although these directions were introduced due to the pandemic, they are not only maintaining safe access to M3P drugs but also allowing flexibility and convenience for prescribers and patients who require M3P medications. Faxing M3P prescriptions also keeps the prescription only between prescriber and the patient's choice pharmacy, potentially reducing loss, forgeries, or delays.

In many ways, COVID-19 has required us to integrate technological advancements that would have otherwise come years later. Consequently, the pandemic has presented an unplanned "pilot project" wherein faxing M3P prescriptions has become permissible.

Controlled Drugs and Substances Act - Section 56 Exemption

Under the Canadian *Controlled Drugs and Substances Act* establishes rules for prescribing certain drugs and substances that are often abused and would otherwise be illegal to possess.

At the onset of the COVID-19 pandemic in March 2020, Health Canada first announced federal exemptions under subsection 56(1) of the *Controlled Drugs and Substances Act* and its Regulations, in order to maintain Canadians' access to narcotic and controlled substances for necessary medical treatments (e.g., treatment of substance use disorders and chronic pain). Health Canada recently announced that the exemption will remain in effect until **September 30, 2026**, demonstrating the ongoing need to prevent delays and interruptions in patient care. This exemption has been implemented in all or in part by all other provinces across the country, with the exception of Manitoba.

If implemented in its entirety, the *Controlled Drug and Substances Act* exemption would:

1) Permit pharmacists to extend and renew existing prescriptions;
2) Permit pharmacists to transfer prescriptions to other pharmacists;
3) Permit practitioners to verbally prescribe (e.g., via telephone) prescriptions with controlled substances; and,
4) Allow pharmacy employees to deliver controlled substances to patients (at their homes or an alternate location).

The Colleges of Pharmacists, Physicians and Surgeons, and Registered Nurses of Manitoba have communicated the urgent need for implementing this exemption on several occasions. Although this federal exemption has been implemented in every other province, it has not been implemented in Manitoba to date due primarily to provincial legislative barriers relating to the Manitoba Prescribing Practices Program (M3P).

As a result, the three Colleges have jointly introduced interim measures that expand the method of transmission for M3P prescriptions and enhance access to safe narcotic and controlled drug use in personal care homes/long term care settings and for palliative care patients in the community.

Despite the interim measures implemented by the three Colleges, challenges with safe and timely patient access to these drugs persist. Even with the temporary easing of public health measures and increased vaccination rates, Canadians will continue to face waves and mandatory public health measures (e.g., closures, social distancing, quarantine, etc.) in the coming months and years, as we grapple to live with emerging strains of the virus.

Although these restrictions were, and will continue to be, undisputedly necessary and lifesaving to many, they have a disproportionately negative impact on the health and well-being of the most vulnerable of our society. According to preliminary data from Manitoba's Office of the Chief Medical Examiner, between January and December 2020, 372 people lost their lives to overdoses in the province, the majority of which were linked to opioid abuse. This figure exceeds all of 2019 by 87 per cent; a tragic indicator that Manitobans require increased access to opioid agonist therapy (drugs covered under the CDSA), during and post-pandemic.

Implementing subsection 56(1) exemption to its full extent will afford pharmacists and practitioners alike the ability to ensure patients have continued safe access to all their prescribed medication treatments in a timely manner, while observing recommended public health measures as they occur in the coming months. Allowing pharmacists and prescribers this ability further provides for increased efficiencies in the health care system, offering these valuable resources to be allocated to more emergent situations.

Regulations and Rules of Prescribing

Given the difficulties and dangers of prescribing, it is a highly regulated reserved act. There are government provisions in the regulations of CPSM, Pharmacy, and Registered Nurses. There are also various Standards of Practice and Practice Directions on elements of prescribing. Some are joint with the other colleges and some are those of just CPSM. All are to be reviewed. A likely outcome will be a request for amendment of regulations to permit better prescribing.

Purpose of Working Group

The purpose of the Working Group is to review the following prescribing practices:

1. Possible elimination or reform of the M3P
2. Tramadol inclusion in M3P
3. Transmission of prescriptions: e-prescribing
4. Enhanced Prescribing Powers for Clinical and Physician Assistants and Residents
5. Review the Standard of Practice on Prescribing Requirements
6. Review of Practice Directions (or Joint Statements) regarding prescribing
    a. Dispensing Physicians
    b. Electronic Transmission of Prescriptions
    c. Facsimile Transmission of Prescriptions
    d. Manitoba Prescribing Practices Program (M3P)
    e. Prescribing Practices: Doctor/Pharmacist Relationship
    f. Rural Remote and Underserved populations: Access to Prescribed Medications

7. Review Regulations on Prescribing

8. Consider whether the prescribing rules are for just prescribing in the community and for out-patients or whether it also includes in-patients in the hospitals and personal care homes and other such residential health care facilities.

9. Exemption for Prescribers Prescribing and Pharmacists Providing Controlled Drugs and Substances Under s. 56. (This exemption provides practitioners with the authority to issue a verbal prescription for controlled substances. This exemption provides pharmacists with the authority to transfer a prescription and to prescribe, sell, or provide it to patients).

10. Review other prescribing matters the Working Group considers appropriate for 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

Prescribing can be difficult and dangerous yet can yield tremendous outcomes in health benefits. Any changes to prescribing must be done solely in the interest of the public and must adhere to the highest standards of both patient safety and societal safety. A risk assessment will be undertaken of each and every recommended change to ensure the patients remain safe, yet there is still access to drugs. The access may be eased or limited, depending upon both patient safety and societal safety. Many of the drugs may be abused, and so access to these drugs may differ due to the deleterious impact on society.

Prescribing must be done by those with the appropriate knowledge, skill, and judgment. This will better allow for patient safety. A review of qualified prescribers will form part of the review.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> The Terms of Reference for the CPSM Prescribing Practices Review, be approved as attached.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

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PRESCRIBING PRACTICES REVIEW
Terms of Reference
Working Group

Section 1: Background

There is a need for the College of Physicians and Surgeons of Manitoba to review many aspects of prescribing. This has been brought to the forefront by the COVID-19 pandemic and the advent of virtual medicine, new processes and modalities for prescribing, and new technologies. With the passage of time the reliance on out-of-date technology for faxing of prescriptions is questionable.

During COVID-19 with virtual medicine introduced and patients told to not congregate in waiting rooms, CPSM introduced the ability to renew chronic non-M3P prescriptions by phone or fax. This was dependent upon on the prescription and patient and required using clinical and professional judgment and knowledge of the patient.

Providing new prescriptions for drugs on the M3P schedule usually requires an in-person visit to conduct an assessment and physical examination. During these unprecedented times in the pandemic, physicians are required to use their professional judgement in determining if a new M3P prescription can be provided relying on virtual medicine instead of an in-person visit. Temporarily during the pandemic, prescriptions for drugs on the M3P schedule can be faxed directly to the pharmacy of the patient's choice. The anecdotal success during the pandemic leads one to question whether this should be made a permanent measure.

There are prescribing limitations for certain registrants, including clinical assistants, physician assistants, and residents. These are particularly restrictive for clinical assistants and physician assistants who work in hospitals. The regulations were drafted in a restrictive manner because both physician assistants and clinical assistants were newly registered classes and there was uncertainty in the role they would play in team based care. The success of clinical assistants and physician assistants in the health care system is fully evident now and their prescribing powers could reflect this.

With the passage of time there is a need to review the Standard of Practice on Prescribing Requirements and various Practice Directions, some of which are joint with the Colleges of Pharmacy and Registered Nurses.

Finally, clarification is to be provided as to whether the prescribing rules are applicable to prescribing in the community and for out-patients or whether it also includes orders in the hospitals/personal care homes or other residential health care facilities.

Section 2: Purpose

The purpose of the Working Group is to review the following prescribing practices:

1. Possible elimination or reform of the M3P;
2. Tramadol inclusion in M3P
3. Transmission of prescriptions: e-prescribing
4. Enhanced Prescribing Powers for Clinical and Physician Assistants and Residents
5. Review the Standard of Practice on Prescribing Requirements
6. Review of Practice Directions (or Joint Statements) regarding prescribing
    a. Dispensing Physicians
    b. Electronic Transmission of Prescriptions
    c. Facsimile Transmission of Prescriptions
    d. Manitoba Prescribing Practices Program (M3P)
    e. Prescribing Practices: Doctor/Pharmacist Relationship
    f. Rural Remote and Underserved populations: Access to Prescribed Medications
7. Review Regulations on Prescribing
8. Consider whether the prescribing rules are for just prescribing in the community and for out-patients or whether it also includes in-patients in the hospitals and personal care homes and other such residential health care facilities.
9. Exemption for Prescribers Prescribing and Pharmacists Providing Controlled Drugs and Substances Under s. 56. (This exemption provides practitioners with the authority to issue a verbal prescription for controlled substances. This exemption provides pharmacists with the authority to transfer a prescription and to prescribe, sell, or provide it to patients)
10. Review other prescribing matters the Working Group considers appropriate for patient safety.

The Working Group is not to review Opioid Agonist Treatment (methadone and suboxone), nor the Standards for Prescribing opioids, benzodiazepines, or authorizing cannabis for medical purposes. The Working Group should not review these matters within Prescribing Practices Program:

- Chief Medical Examiners` Death Review
- High Dose Opioid Prescribing Review
- CPSM Opioid Prescriber Profile
- Fentanyl Prescribing Review
- Generic Oxycontin Prescriber Education

The Working Group is to develop and draft recommendations for improvements in prescribing that can be utilized to promote current best practices and enhance patient safety.

Section 3: Roles, Functions, and Accountabilities

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

- To make recommendations to CPSM Council on prescribing in general.
- To develop a Standard of Practice on Prescribing Requirements which will be circulated to members, stakeholders, and the public for consultation and review the results of that consultation process. And to finalize the Standard of Practice.

- To make recommendations on the future of M3P
- To make recommendations on the prescribing of tramadol (M3P inclusion)
- To make recommendations on the exemption for Prescribers Prescribing and Pharmacists Providing Controlled Drugs and Substances Under s. 56
- To make recommendations on transmission of prescriptions
- To make recommendations on enhanced prescribing for clinical and physician assistants
- To review the Practice Directions and Joint Statements relating to prescribing and recommend improvements
- To review the Regulations on prescribing and recommend improvements
- Clarify the application of prescribing rules for out-patients and in-patients.

The Colleges of Pharmacy and Registered Nurses are to be involved significantly as many of the prescribing matters are completely interconnected for the membership of the three colleges (Nurse Practitioners for CRNM). The knowledge and experience of pharmacists is particularly important to capture and act upon for the future success of new prescribing initiatives and practices.

The wide-range of items may necessitate a one and a half to two year time frame for completion of all items. Individual items can be started and finished at different times.

Section 4: Chair and Membership

4.1 Chair

The Committee will be chaired by TBD.

4.2 Membership

Working Group Membership is to include representatives from:

- CPSM Council
- Family Medicine
- Specialists
- Clinical Assistant and/or Physician Assistant
- College of Pharmacists of Manitoba
- College of Registered Nurses of Manitoba
- Public Representatives
- And any other representative the Chair considers appropriate

Section 5: Meetings

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

COUNCIL MEETING - SEPTEMBER 29, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Standard of Practice for Episodic, House Calls, and Walk-in Clinics Primary Care

BACKGROUND

At its June 2021 meeting, Council established its upcoming Strategic Organizational Priorities. One of these is to develop a Standard of Practice for Episodic, House Calls, and Walk-In Clinics Primary Care.

Continuity of primary care is fundamentally important for the delivery of good medical care. Much of the medical system requires each person having a family doctor to provide continuous medical care. Continuous medical care includes not only a longitudinal relationship between patient and physician, but also referrals to specialists, ordering of tests and follow-up, prescribing of long-term drugs, and at times, multiple attempts to treat medical conditions.

However, not all persons have family doctors – whether due to a shortage of family doctors in the community, the patient not trying to obtain a family doctor, or various other reasons. Some patients without family doctors seek medical care from alternative sources – walk-in clinics or other sources, including urgent care/emergency departments. Other patients may not be able to access their family doctor in a timely manner or at a time that is suitable for their schedule, so they resort to other alternative medical care delivery. This fragmented care can create challenges in providing good medical care.

Walk-In clinics have filled the void for many patients, whether due to the availability of same day clinical encounters, convenient hours (open weekends and evenings), convenient locations (maybe close to work or home), etc. Walk-in clinics play an important role in providing same day medical care to those who require it. These also can play an important part in providing medical care for those who are travelling (for instance, the patient from The Pas who is in Winnipeg and requires medical care for strep throat).

Some practice groups offer medical care on a same day walk-in or appointment with one physician in the practice group. That physician providing the episodic care will have access to the patient's medical charts and will also be familiar with the style of the usual family doctor. In those cases, the usual family doctor may or may not be responsible for follow-up and referrals.

The traditional model of a doctor attending bedside in the patient's home to deliver medical care has almost disappeared. Some family physicians may still offer house calls for long-standing patients in their time of need. And physicians working in the WRHA Access Centres run a house call service for their patients unable to attend one of their physicians in the clinic. There are also limited house call services available in Winnipeg. While many patients use house calls because they are too ill to attend at a medical clinic, many resort to house calls because of mobility constraints – whether due to

disability, socio-economic, or other. For instance, anecdotally, one of the higher users of house calls is the single mother of multiple children who can avoid taking the entire family on a bus for an appointment of one sick child.

Some have accused walk-in clinics of churning patients quickly for financial gain. Like any care provided, it depends upon the individual physician.

To ensure good medical care in episodic, house calls, and walk-in clinics CPSM will develop a Standard of Care for this type of care. Many other medical regulatory colleges in Canada have established rules to guide members in treating patients in episodic and walk-in clinics. There are no special rules for house calls, though some of that will fall under episodic care.

The specific areas requiring guidance will be left to the Working Group, though will likely include the following:

- Standard of care for this medical care
- Linking care to the family doctor
- Patient records requirements
- Test ordering and referrals to specialists or clinics
- Continuity of care and follow-up
- Prescribing requirements

Terms of Reference for the Working Group have been formed and are attached. The Terms of Reference require approval by Council.

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

This Standard is required to ensure the continuity of care in a fragmented primary care delivery environment. Critical to required good medical care is patient safety. The Standard will ensure that the medical care is provided in the patient's interest. This Standard will recognize that episodic, house calls, and walk-in clinic primary care plays an important role in the delivery of medical care, but that additional guidance to the profession is required to ensure it is safe and good medical care providing for continuity.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> The Terms of Reference for the Standard of Practice for Episodic Care/House Calls/Walk-In Clinics working group be approved as attached.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

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STANDARD OF PRACTICE
FOR EPISODIC, HOUSE CALLS, AND WALK-IN PRIMARY CARE
Terms of Reference
CPSM Working Group

Section 1: Background

There is a need for CPSM to have a Standard of Practice to establish minimum practice requirements for those members providing care that is episodic, house calls, or in a walk-in primary care basis. This is a Strategic Organizational Priority for CPSM.

There is no specific Standard of Care that establishes the minimal standard of care required for episodic, house calls, or walk-in care. However, the provisions of good medical care and all other Standards of Practice are required notwithstanding the type of care. The provisions for good medical care are included in the CPSM Standards of Practice Regulation:

> Medical care
> 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.

This an identified gap in the standard of care provided in a non-institutional environment. Fragmented care delivery often lacks the continuity of care required for the delivery of best

medical care, yet there is a role for episodic, house calls, and walk-in care. This is especially in light of not all Manitobans having a family physician, the lack of availability of their family physician, inability to travel to the physician's office, travelling within the province or from another province, and convenience of hours amongst other factors.

Section 2: Purpose

The purpose of the Working Group is to develop a draft CPSM Standard of Practice for Episodic, House Calls, and Walk-In Primary Care that will be circulated to members, stakeholders, and the public in spring or summer 2022 and finalized for implementation in 2022. This Standard of Practice will be used to promote the current best practices and ensuring patient safety. For clarity, this Standard will not apply to hospital care.

The draft Standard might consider a requirement that every member review e-Chart if providing episodic care/ house calls / walk in clinic primary care.

Section 3: Roles, Functions, and Accountabilities

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

- To develop and recommend to Council a Standard of Practice on Episodic, House Calls, and Walk-in Primary Care which will be circulated to members, stakeholders, and the public for consultation and review the results of that consultation process.
- To finalize a Standard of Practice for Episodic, House Calls, and Walk-in Primary Care.

Any Standard must ensure patient safety and be in the public interest.

Section 4: Chair and Membership

4.1 Chair

The Committee will be chaired by TBD.

4.2 Membership

Working Group Membership is to include representatives from:

- CPSM Council
- Family Medicine
- Physicians practicing house calls and in walk-in clinics
- Public representatives
- Representatives from Government and/or Shared Health
- And any other representative the Chair considers appropriate

Section 5: Meetings

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

CPSM
STRATEGIC 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
Virtual Medicine - Standard of Practice		Sep-20	Jun-21		Jun 21	Jul 21	Sep 21	Oct 21	On Track	September Council for approval
Patient Records - Standard of Practice		Sep-20	Mar 21		Jun 21	21-Jul	Sep 21	Oct 21	Delayed	The Standards require further review on one matter and was not ready for the September Council meeting
Duty to Report - Standard of Practice		Sep-20	Jun-21		Mar 21	Apr 21	Jun 21	Jul 21	Achieved	June Council approval
Office Based Procedures - Standard of Practice		Jan-21			Jun 21	Jul 21	Sep 21	Oct 21	Delayed	Significant feedback in the consultation and a tight turn around time over the summer prevented finalization in Sept. It will be finalized for December.
Prescribing Practices Review		21-Sep							Not Started	To commence in Fall of 2021 if Council approves Terms of Reference. This may be multi-year initiative
Truth & Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners		Sep-21							Not Started	To commence in Fall of 2021 if Council approves Terms of Reference. This may be multi-year initiatives
Episodic Care, House Calls, Walk-Iin Clinics - Standard of Practice		Sep-21	Jun-21		22-Mar	22-Apr	22-Jun	22-Jul	Not Started	To commence in Fall of 2021 if Council approves Terms of Reference
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	

Last revised: September 14, 2021

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING - SEPTEMBER 29, 2021

FOR INFORMATION

TITLE: Standards Subcommittees Guide for Operations Handbook

BACKGROUND

CPSM Standards sub-committees are a legislated means by which CPSM is expected to supervise the practice of medicine. The main mechanism for Standards sub-committees to achieve this duty of self-regulation is through audit and practice assessments of individual CPSM members.
They must also uphold the mandate of CPSM to supervise the professional competence of members using the full scope of options outlined in the regulation, and with a focus on supporting education and quality improvement for members. This approach ensures the CPSM is fulfilling its duty to protect the public.

Standards activities that are focused at a system level; on the complexity of team-based care, interaction between professions and that are reviewed and evaluated by a group of interdisciplinary professionals are critically important to quality improvement of the health system, but are outside of the scope of the CPSM and do not fulfill our regulatory mandate.

A Working Group of participants in Standards Subcommittees and public representatives met to discuss improvements to the work undertaken by the diverse standards subcommittees.

As a result of the meetings of the Working Group, a Guide for Operations handbook has been prepared to facilitate consistency and standardization in approach and deliberation around the activities of Standards sub-committees as well as outcomes, data collection, and reporting, with the goal of enhancing CPSM's supervision of the profession of medicine. The handbook contains helpful guidance on the following:

- Formation and meeting frequency
- Process for selection and review of cases
- Decision and disposition of cases
- Data collection, reporting and communication between subcommittees and Central Standards Committee
- Tools and Resources

This handbook will provide guidance and establish the expectation for each standards subcommittee to ensure each is meeting its mandate to supervise the competency of the practice of medicine.

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.

This report is being provided to Council for information only. A significant amount of work was undertaken to prepare this Handbook. Both Drs. Mihalchuk and Suss will explain to Council the highlights and how this new handbook will paly an integral role in self-governance to improve the standard of care provided to patients throughout the province of Manitoba. With this handbook those physicians on the Standards Committee will ensure their processes and decision making in reviewing the care provided by their colleagues meets the required standard of care. Patient safety is to be at the forefront of all decision-making in the supervision of the practice of medicine carried on by the area and other standards committees.

STANDARDS SUB-COMMITTEE

Guide for Operations

Information to establish operational standards for CPSM Standards Sub-Committees

Preamble

CPSM Standards sub-committees are a legislated means by which the CPSM is expected to supervise the practice of medicine. The main mechanism for Standards sub-committees to achieve this duty of self-regulation is through audit and practice assessments of individual CPSM members.

The purpose of this handbook is to facilitate consistency and standardization in approach and deliberation around the activities of Standards sub-committees as well as outcomes, data collection, and reporting, with the ultimate goal of enhancing CPSM's supervision of the Profession of Medicine.

Applicable Legislation & Regulation

The following principles are to be guided by and be compliant with the Regulated Health Professions Act (RHPA) and CPSM General Regulation. They must also uphold the mandate of CPSM to supervise the professional competence of members using the full scope of options outlined in the regulation, and with a focus on supporting education and quality improvement for members. This approach ensures the CPSM is fulfilling its duty to protect the public.

Standards committees have protection under the Evidence Act so that any materials, reports, discussions, minutes, reviews, correspondence/emails are not to be shared in litigation, inquiries, or any other tribunal. CPSM is not subject to FIPPA. Standards documents do not form part of the patient's record so are not disclosed under PHIA. However, only matters that relate to its responsibilities of professional competence have the protection under that Evidence Act and are outside the domain of FIPPA. Nothing from Standards can go to other areas of CPSM such as Complaints and Investigations or to the Physician Health Program other than through a referral by the Registrar and even then, a review or investigation must start anew.

If any member of a Standards sub-committee is called upon to either provide records of a standards review or to testify as a witness at an inquiry or legal proceeding, they must contact CPSM's General Counsel for legal advice prior to any action being undertaken.

CPSM Standards Sub-Committees vs. System-Level Standards Committees

Standards activities that are focused at a system level; on the complexity of team-based care, interaction between professions and that are reviewed and evaluated by a group of interdisciplinary professionals are critically important to quality improvement of the health system, but are outside of the scope of the CPSM and do not fulfill our regulatory mandate. Integrity of the CPSM Standards' process requires that the composition and focus of Standards sub-committees remains limited to CPSM members and the supervision of the practice of medicine.

CPSM Standards Sub-Committees

- **Area Standards Sub-Committees**
  - Winnipeg Regional Health Authority
  - Prairie Mountain Health
  - Interlake/Eastern
  - Brandon Regional Health Centre
  - Selkirk
  - Northern
  - Southern
  - Portage
- **Hospital Standards Sub-Committees**
  - Altona Community Memorial Health Centre
  - Bethesda Hospital
  - Boundary Trails Health Centre
  - Carmen Memorial Hospital
  - Gladstone Health Centre
  - Morris/Emerson Standards Committee
  - Ste. Anne Hospital
  - St. Claude/Notre-Dame-de-Lourdes/Treherne
  - Vita & District Health Centre
- **Non-Hospital Standards Sub-Committees**
  - Brandon Regional Health Centre Psychiatry
  - Eden Mental Health Centre
  - Selkirk Mental Health Centre
  - Assiniboine Surgical Centre
  - Ageless Cosmetic Clinic
  - First Glance Aesthetic Clinic
  - Heartland Fertility & Gynecology Clinic
  - Manitoba Clinic Endoscopy Suite
  - Maples Surgical Centre
  - Visage Clinic
  - Women's Health Clinic
  - Western Surgery Centre
  - Winnipeg Clinic (Endoscopy)
- **Provincial Standards Sub-Committees**
  - Cancer Care Manitoba
  - Orthopedics
  - Endoscopy
- **Maternal Perinatal Health Standards Committee[1] (MPHSC)**
- **Child Health Standards Committee[1] (CHSC)**

1 – Operated by CPSM

Contents

Formation of a Sub-Committee and Meeting Frequency

A. Composition:

- All committee members must be members of the CPSM with the exception of the MPHSC Committee that includes a midwife.

- **Area/Hospital/Non-Hospital Standards Committee** – The sub-committee shall consist of a minimum of three members with quorum also being a minimum of three.
- **MPHSC** - The sub-committee shall consist of 10 members including the chair.
- **CHSC** - The sub-committee shall consist of 8 members including the chair.
- **Provincial Standards Committee** - Central Standards Committee will appoint the members of each Provincial Standards sub-committee taking into account the recommendations on appointments received from the Manitoba Clinical Leadership Council. Central Standards Committee will determine the number of members appropriate for each Provincial Standards Committee.
- **Cancer Care Manitoba Standards Committee** - The sub-committee will consist of at least eight members including the Chair. All members will be from Cancer Care Manitoba Medical Staff.

B. Meeting Frequency: It is recommended that Standards sub-committees shall meet a minimum of four times a year. Each meeting shall not exceed 4 hours of meeting time.

C. Appointment of Members: The Central Standards Committee is required to ratify all Chairs of a Standards sub-committees annually and when a new Chair has been appointed. Chairs of Standards sub-committees will approve their sub-committee's membership including any changes in members throughout the course of the year. There are no limits to terms in office.

D. Declaration of Confidentiality: Subsections 140(2) and 140(3) of The Regulated Health Professions Act clearly states that absolute confidentiality is required of all individuals who act in an official or other capacity with the College of Physicians and Surgeons of Manitoba. All councillors, committee members, consultants, contractors and employees of the College are expected to maintain confidentiality and share information only to the extent necessary to perform their duties. ***Appendix A***

E. Conflict of Interest: Those engaged in the administration of a region/hospital/department may be in a conflict of interest and should not be on a Standards committee. Physicians who hold administrative or disciplinary positions with an HR component (hiring/firing, resource decisions, and performance conversations) can not be a member of the Area Standards Committees or on the Provincial Standards Committees (e.g. Cancer Care, Orthopedics, Child Health). Individuals who refuse to complete a Conflict of Interest Declaration cannot be approved by CPSM as committee members. ***Appendix B***

Process for Selection and Review of Cases or Audits

All Standards sub-committees must follow a consistent process for reviewing matters:

A. *Criteria to determine how and what is selected for review by the Standards sub-committee*

Every Standards sub-committee must determine how they will identify cases for review and how the review is to be undertaken relative to their focus and scope. For instance, are there random audits, referrals from others, focused audits on a particular practice, disease, clinical presentation, clinical outcome, or procedure, etc.? Standards sub-committees should endeavour to review cases of near-misses, harm or death where outcomes are potentially preventable and seek opportunities to prevent future harm or death through individual and group feedback.

Criteria for Case Reviews include:

1. **Clinical Audit** – defined as a review performed for the purpose of education and improvement in practice that permits feedback on the care, treatment and overall management of patients and their illnesses. Options include but are not limited to:
    a. Adverse Patient Outcome (e.g. suicide, overdose, stroke)
    b. Risk of Harm (e.g. surgical complication)
    c. Adherence to best practice (e.g. management of specific diseases)
    d. Low volume, high risk procedures
2. **Referred concern –** a review of care identified as a concern by a CPSM member, member of another regulated healthcare profession, health system administration, or any other individual or body.
3. **Random Audit** – routine quality review to supervise the practice of members without a specific 'for cause' event identified.

B. *The Process for Chart Review by the Standards Sub-Committee*

- **Determine the Focus of the Audit**
    - See above (A.)
- **Choose the Audit Tool**
    - A quantitative audit tool should be based on best practice and should include all variables relevant to the delivery of care.
    - Sample audit tools are included in ***Appendix C***
    - Audit tools should include the Framework for Decision and Disposition for Standards Committees ***Appendix D***
- **Audit and Analyze the Data**
    - The scope of the audit should be determined with consideration of available resources, timeliness of completion and potential settings where the care is delivered.
    - Data should be reviewed and collated to facilitate sub-committee review.
    - Data containing patient identifiers must be maintained securely.

- The Evidence Act protects all data collected under the auspices of Standards.

- **Sub-Committee Review**
  - The Chair of the Standards sub-committee should prepare/share a summary of the case including the **Framework for Decision and Disposition for Standards Committees** options outlined below and in ***Appendix D*** for the sub-committee's consideration of each case.
  - The sub-committee will review the summary of the cases, discuss appropriate disposition of each case, and develop a consensus on the final outcome per the Framework for Decision and Disposition for Standards sub-committees.

C. ***Documentation and Evidence Act Protection***

Correspondence with standards committees or any other documents stamped with The Evidence Act stamp should not be copied to, or placed in, a patient record or hospital chart.

STAMP

- Any report, statement, memorandum, recommendation, document, correspondence, produced or made by a standards committee (i.e. minutes, educational letters, commitments, any documents with identifiers of patient, physician and other professionals, facility)

DO NOT STAMP

- The medical record.
- General reports or recommendations developed for the purpose of fulfilling the reporting obligations of a standards committee (e.g. statistical reports, summaries of committee actions, documents with no patient, physician or other professional identifiers)
- Documents prepared for the referral of a case/physician or other professional by a standards committee for further action by an administrative process

Decision and Disposition

To facilitate consistency with audits and case reviews, it is essential for all Standards sub-committees to use a common approach to decision making:

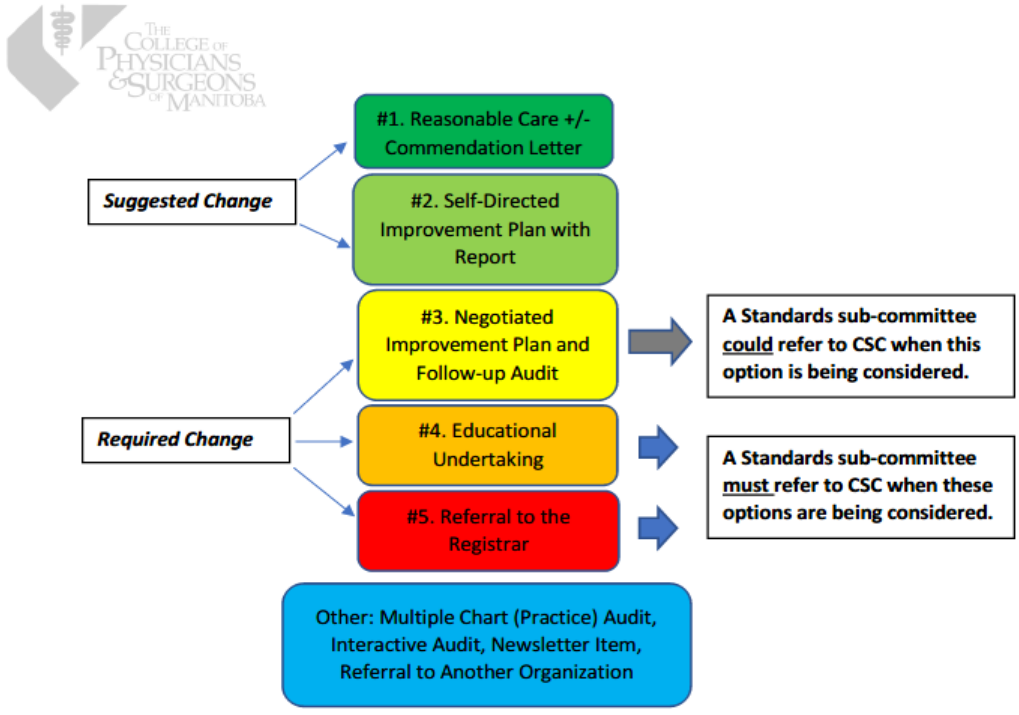
- The review of each case should provide the member with feedback about the care they provided and identify opportunities for improvement along a spectrum from commendation for providing excellent care to a requirement for improvement. In serious cases where significant harm has occurred, there is deemed to be a risk to patient safety due to concerns with a member's practice, there is a repetitive lack of improvement, or a concern for professional misconduct or negligence a referral should be made to the Registrar.

- This focus on a non-punitive (educational with follow up when needed) approach is one way that Standards committees can support engagement of members and continuous quality improvement within the profession.

Per regulation, a Standards sub-committee may take such steps as it determines may improve the knowledge, skill, or safety of one or more members in carrying out the practice of medicine including:

- making recommendations to a member;
- advising Central Standards Committee to:
  - make recommendations to the administration of a hospital, regional health authority, or other facility where the members provide health care services;
  - refer a member to the Registrar for danger to patient safety, incompetence, or the standard of care may pose a risk to patient safety
  - request and accept a member's undertaking
  - develop guidelines or protocols for consideration by Central Standards.

The following is a Framework for Decision and Disposition for Standards Committees to guide deliberation and decisions of case reviews.



***Suggested Change*:**

Decisions that fall under the **suggested change** categories are well within the authority of a standards sub-committee to deliver to member(s). No formal referral to CSC is required.

1. **Reasonable Care +/- Commendation Letter** – applies when the sub-committee believes the standard of care has been met and the audit feedback highlights minimal suggested changes to practice. A letter commending the member for their audit results may be shared with the member.
2. **Self-Directed Improvement Plan with Report** – applies when the sub-committee believes the standard of care has been met but the audit feedback highlights some suggested changes to practice that would support quality improvement. The member is asked to create an improvement plan and provide the Standards sub-committee with an update on their progress with implementation at a prescribed interval.

Required Change:

Decisions that fall under the **required change** categories listed below may necessitate a referral to CSC to manage any concerns identified and/or to execute the functions of the standards process including educational undertakings and/or a referral to the Registrar. A referral to CSC may protect the integrity of the committee, support objective feedback conversations, and reduce the potential for conflict between committee members and their audited peers.

3. **Negotiated Improvement Plan and Follow-up Audit** – applies when the sub-committee believes the standard of care may not have been met and/or the audit feedback identifies required changes to future practice for patient safety and to improve the standard of care. The member is accountable to create an improvement plan addressing the required changes and the sub-committee assigns a time frame for the improvement plan to be implemented and a follow-up audit to take place. Sub-committees may decide to provide this level of intervention themselves or may refer the matter to CSC for discussion and negotiation with the member.
4. **Educational Undertaking** – applies when the sub-committee believes the standard of care has not been met and a required change in practice involving mandatory education or retraining is necessary to support ongoing safe patient care. Sub-committees should refer these matters to the CSC for an objective external review and final recommendation. A formal agreement between the member and CPSM would be put in place to ensure the necessary education happens and follow-up auditing is arranged at an appropriate interval.
5. **Referral to the Registrar via CSC** – applies when the sub-committee believes the standard of care has not been met and that educational interventions would not be or have not been effective in bringing about the required change. This would also apply in cases where there is evidence of misconduct or incompetence where remediation would not be appropriate. Referral to the Registrar may also happen if the member failed or refused to allow CSC to carry out an action permissible under s. 99 of the *RPHA*; if the member refused to follow a remedial program recommended by CSC, if the member fails to comply with an undertaking

given to CSC; if the state of a member's health or competency is such that a clear danger to patient safety is perceived to exist or if in the opinion of CSC, the member's standard of care poses a risk to patient safety. LINK - CSC Bylaw – Section 14

- *Sub-committees shall refer to CSC for an objective external review and final recommendation when they are considering this outcome for a particular member.*

Other – in some circumstances, the sub-committee may decide they need more information about a case or a member's practice pattern to determine an appropriate outcome of an audit or standards review. Sub-committees may choose to do a deeper dive into a member's practice including multiple chart reviews (a practice audit) or provide an in-depth review of a practice with an interactive audit intended to support reflection and coaching as part of the auditing process. In other situations, the review of cases or a member's practice may highlight important learning that would be prudent to share with a larger group of members, up to and including the whole profession. These items would be submitted to CSC for inclusion in the CPSM newsletter. Finally, case reviews and the committee deliberations may lead sub-committees to reflect on important changes that are needed within the system to support safe patient care. Such recommendations should be forwarded to CSC for communication from the Registrar to the identified external stakeholders. Where case reviews identify concerns related to the practice of another regulated health profession, this information should also be shared with CSC for communication via the Registrar to the other regulatory body.

In all of the above options, the decision-making process is intended to afford the sub-committee the latitude to use discretion in determining the final outcome of an audit or case review. The majority of outcomes can be adequately supported at the level of the sub-committee and tools for standardized and streamlined communication of these various outcomes to members are included as ***Appendix E, F, G & H***

Data Collection and Reporting to CSC

Consistency in decision-making around cases permits the standardization of reporting to articulate clear outcomes from the deliberations of Standards sub-committees and the large number of case reviews that are done in the province each year. This can assist in improving members' provision of medical care to patients on an individual basis, an area, and at times, across the province. At a provincial level, the CSC might determine that specific areas of care require further improvement and follow-up or that leading practices in some areas should be modelled and shared for other areas to follow.

A. <u>Standardized Quarterly and Annual Reporting</u>

- Standardized reporting should occur quarterly in June, September, December with a more detailed annual report submitted by April 30th to facilitate sharing at the CPSM's AGM in June. Reports should be submitted in a de-identified fashion, with recording of the number of cases

reviewed by a sub-committee and a summary of the outcomes for each case. No personal health information or member identifiers should be included. Any systems issues or learnings to be shared with the profession should be submitted as well as any information that would need timely sharing with stakeholders through the Registrar.

- A standardized format for reporting should be provided to sub-committees and the use of electronic forms linking into CPSM databases optimized to permit timely report generation within the CPSM Department of Quality.
- The annual report should include both qualitative and quantitative information relative to the focus of the sub-committee's work in the past year, identified improvements in practice and insights into future standards activities.
- Sample reports have been included in ***Appendix I & J.***

B. <u>Other Data Collection and Reporting Requirements</u>

- **Dispositions with Structured Intervention**: all matters with a disposition of educational undertaking or referral to the registrar to CSC as per the Framework for Decision and Disposition for Standards Committees ***Appendix D*** must be referred to the CSC. A referral to CSC may be contemplated for a disposition of a negotiated improvement plan but is not required in all cases. Discretion regarding the need for CSC in the context of a negotiated improvement plan is left to the sub-committee Chair and the sub-committee.
    1. **Major system issue:** Issues raised through the work of Standards sub-committees requiring the attention or action of a body outside of CPSM at the level of a health authority or with provincial influence should be referred to CSC for escalation; or at a minimum have a cc to the CSC Chair on any communication to the non-CPSM body. Minor systems issues identified for action at a local (hospital or facility) level may be included in the quarterly or annual report but do not require direct notification of the CSC chair. Communication to bodies outside of Standards sub-committees should be done without providing the identification of the patient(s) or health care provider(s) relevant to the case(s) reviewed.
    2. **Recommendations to Another Regulated Health Care Profession:** Should be reported to CSC/CPSM for sharing with that Regulated Health Profession's College through the Registrar including the patient and practitioner's identifiers, with appropriate safeguarding of personal health information.
    3. **Record Keeping:** Given the highly sensitive nature of the material addressed through the work of Standards sub-committees (both from a PHIA and member confidentiality perspective), it is prudent to ensure secure storage of any records kept of cases and/or detailed meeting minutes. It is recommended that sub-committees submit their documentation for secure electronic storage with CPSM and/or have processes in place to ensure scheduled shredding of materials that are no longer required.
    4. **Safe Transfer of Standards Sub-Committee Materials and Charts using Electronic Means:** Compliance with PHIA is required and PHIA permits the sharing of personal health information to comply with professional regulatory requirements. This permits the sharing patient records amongst CPSM Standards sub-committees. As above, given the highly

sensitive nature of the material, information must be shared through secure means such as password protected files and emails accessed only by the individual (or their assistant) and not generic "family" email addresses. Many file sharing platforms (e.g. Dropbox, Sharefile) may have servers in the US and therefore may be subject to the US Patriot Act whereby the information can be viewed by US authorities. Accordingly, unless this can be prevented, these should not be utilized.

Communication between CSC and a Standards Sub-Committee

Communication between CSC and sub-committees is critical for the ongoing success of processes and to ensure timely, consistent, and meaningful supervision of the practice of medicine. It is an area of opportunity for improvement based upon feedback from the environmental scan of select existing committees across the province. Communication between Standards sub-committees is also seen as valuable and in need of guidance to support meaningful exchanges.

Key principles:

- Communication needs to go both ways between CSC and a sub-committee.
- Sub-committees should communicate regularly with CSC through identified reporting mechanisms including making referrals of cases/members to CSC for further review and deliberation.
- CSC should provide a response to the sub-committee when a referral has been made including the outcome decided for that referred case/member.
- CSC may request of a sub-committee additional details around any case(s) they identify of interest through the de-identified reporting process.
- Sub-committees may refer a case/member to another sub-committee with either the outcome of a review they have completed, or to a request for a review of a given case/member. Sub-committees in receipt of a referral from another sub-committee have a duty to review the case and provide a summary of the outcome to the referring Standards sub-committee. All communication between sub-committee Chairs should include a cc to the Chair of the CSC for visibility, accountability, data collection, and follow up (if appropriate). Where a case/member may need a referral for an educational undertaking or a Registrar's referral, a direct referral to CSC is required.

Tools and Resources for use by a Standards Sub-Committee

- Declaration of Confidentiality and Conflict of Interest Declaration Forms - ***Appendix A & B***
- Audit Tools - ***Appendix C***
- Summary of Framework for Decision and Outcomes of Standards Committees - ***Appendix D***
- Communication Templates and Letters – Outcomes #1, #2, #3 & #5 – ***Appendix E, F, G & H***
- Quarterly and Annual Report Templates – ***Appendix I & J***
- Honoraria Form and Personal Information Form– ***Appendix K & L***

Appendix A

DECLARATION OF CONFIDENTIALITY

Subsections 140(2) and 140(3) of *The Regulated Health Professions Act* clearly states that absolute confidentiality is required of all individuals who act in an official or other capacity with the College of Physicians and Surgeons of Manitoba. All councillors, committee members, consultants, contractors and employees of the College are expected to maintain confidentiality and share information only to the extent necessary to perform their duties.

I understand, and agree to, the confidentiality clause of *The Regulated Health Professions Act*:

Confidentiality of information

140(2) Every person employed, engaged or appointed for the purpose of administering or enforcing this Act, and every member of a council, a committee of a council or board established under this Act, must maintain as confidential all information that comes to his or her knowledge in the course of his or her duties and must not disclose this information to any other person or entity except in the following circumstances:

a. the information is available to the public under this Act;

b. the information is authorized or required to be disclosed under this Act;

c. disclosure of the information is necessary to administer or enforce this Act or the regulations, bylaws, standards of practice, code of ethics or practice directions, including where disclosure is necessary to register members, issue certificates of registration or practice, permits and licences, grant approvals or authorizations, deal with complaints or allegations that a member is incapable, unfit or incompetent, deal with allegations of professional misconduct, or govern the profession;

d. disclosure of the information is

   i. necessary to administer or enforce *The Health Services Insurance Act* or *The Prescription Drugs Cost Assistance Act*, or

   ii. to the medical review committee established under *The Health Services Insurance Act*;

e. disclosure of the information is

   i. authorized or required to be disclosed by another enactment of Manitoba or Canada, or

   ii. for the purpose of complying with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of information or with a rule of court that relates to the production of information.

Appendix A

f. the information is disclosed to a body that has statutory authority to regulate

i. a profession in Manitoba, or

ii. the practice of the same or a similar health profession in any other jurisdiction,

if disclosure is necessary for that body to carry out its responsibilities;

g. the information is disclosed to a person who employs or engages a member to provide health care, or to a hospital or regional health authority that grants privileges to a member, if the purpose of the disclosure is to protect any individual or group of individuals;

h. the information is disclosed to a department of the government, a regional health authority or another agency of the government, or any department or agency of the government of Canada or a province or territory of Canada, dealing with health issues

i. if

a. the purpose of the disclosure is to protect any individual or group of individuals or to protect public health or safety, or

b. the information concerns the practice of a health profession in any jurisdiction, and

ii. the information does not reveal personal health information;

i. disclosure of the information is necessary to obtain legal advice or legal services;

j. the information is disclosed with the written consent of the person to whom the information relates.

Limits on disclosure of personal information and personal health information

140(3) When disclosing information under subsection (2), the following rules apply:

a. personal information and personal health information must be disclosed only if non-identifying information will not accomplish the purpose for which the information is disclosed;

b. any personal information or personal health information disclosed must be limited to the minimum amount necessary to accomplish the purpose for which it is disclosed.

I understand that failure to comply with this clause may result in disciplinary action from Council or the Registrar of the College of Physicians and Surgeons of Manitoba or dismissal.

_____ _____

Date Signature

_____

(Name in Print)

Appendix B

Conflict of Interest Declaration for Central Standards Committee Membership

The Central Standards By-Law of The College of Physicians & Surgeons of Manitoba states that: "A Committee Member must not participate in a review of the work of any individual over whom the Committee Member has direct administrative or disciplinary responsibility."

Prior to participation in standards committee activities, each member or candidate is asked to provide the following information.

I wish to participate as a member of the **Enter Name of you Standard Committee here**.

I, _____, state that I hold the following position(s):

_____

_____

I declare that (choose one):

_____ There is no conflict of interest or potential for conflict of interest with participation in standards committee activities. OR

_____ There is a conflict of interest or potential for conflict of interest with participation in standards committee activities for the following reasons:

_____

_____

If a situation arises at a standards committee meeting where I should excuse myself from participating because of this, I will do so.

If my circumstances change, I will inform the Chair of the Central Standards Committee.

Signed _____ Date _____

Once form is completed, please forwarded to Kim Hare at khare@cpsm.mb.ca

Appendix C

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

1000 – 1661 PORTAGE AVENUE, WINNIPEG, MANITOBA R3J 3T7
TEL: (204) 774-4344 FAX: (204) 774-0750
TOLL FREE (MB ONLY) 1-877-774-4344

CLINICAL AUDIT FORM

REVIEWER:

DATE:

PHIN #	Patient Initials	Year of Birth	Gender	Date of Visit
Diagnosis:				

Comments:

OVERVIEW OF CHART

MEDICAL RECORD KEEPING: ☐ Satisfactory ☐ Needs Improvement

Comments:

MEDICAL MANAGEMENT: ☐ Satisfactory ☐ Needs Improvement

Comments:

OVERALL ASSESSMENT

STRENGTHS:

Appendix C

CONCERNS:

SUGGESTED PRACTICE CHANGES:

REQUIRED PRACTICE CHANGES:

OTHER OUTCOMES: (SUCH AS PRACTICE AUDIT/ NEWSLETTER ITEM/ REFERRAL TO ANOTHER ORGANIZATION)

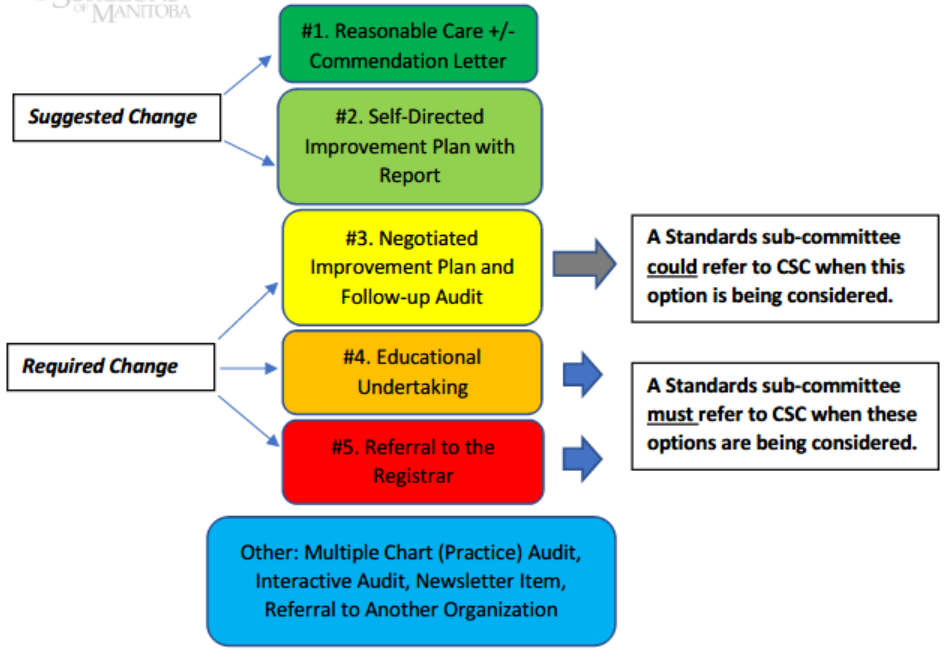
Signature	Reviewer Name	Date

Appendix C

FOR STANDARDS SUB-COMMITTEE USE ONLY: (Outcome from review)

Framework for Decision and Outcomes of Standards Committees

Options 1-5 and other to guide deliberation and decisions.

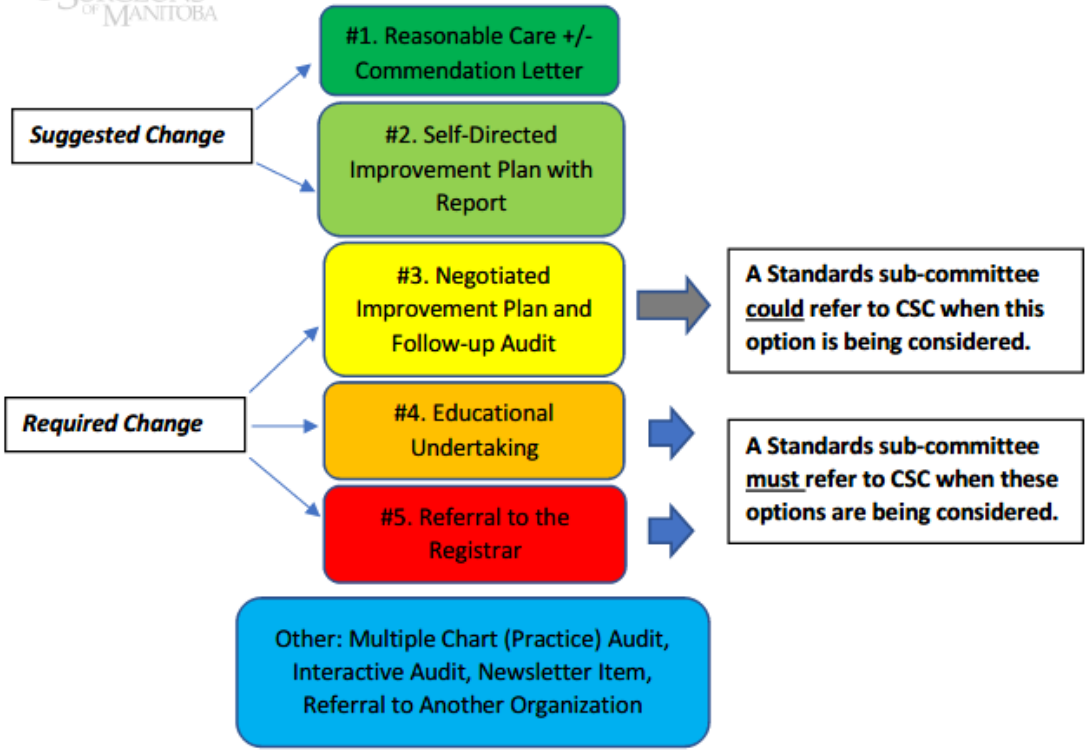


Suggested Change Outcomes		Required Change Outcomes			Other
Option #1 Reasonable Care	**Option #2 Self Directed Improvement Plan**	**Option #3 Negotiated Improvement plan**	**Option #4 Educational Undertaking**	**Option #5 Referral to CPSM Registrar**	**Practice Audit Newsletter Item Referral to another Organization**

Signature | Committee Chair Name | Date

Appendix D

Framework for Decision and Outcomes of Standards Committees



Appendix E

Insert Date

PERSONAL & CONFIDENTIAL

Dear Insert Dr.'s Name,

RE: Patient Name:

DOB:

PHIN#:

Hospital #/File#:

At its most recent meeting, the *insert committee name* reviewed the above mentioned chart and your letter of response (if applicable).

The insert committee name commends you on providing reasonable medical care and hopes that you have reviewed and reflect on the Committee's comments and any suggestions for improvement made.

The insert committee name appreciates your engagement in the continuous quality improvement of your practice to ensure the highest quality of care for your patients.

Please do not hesitate to contact me if you have any questions.

Yours sincerely,

Appendix F

Insert Date

PERSONAL & CONFIDENTIAL

Dear Insert Dr.'s Name,

Thank you for your patience in waiting for the outcome of your chart audit review to be reviewed by the insert committee name. At its most recent meeting, the insert committee name reviewed the de-identified report of your chart audit which was conducted on insert date and your letter of response.

The insert committee name has identified from your chart audit review that there are aspects of your practice or documentation where a change is **recommended** to ensure ongoing safe and quality patient care. The insert committee name requests that you reflect on the comments of the auditor and provide to the insert committee name by this insert **date** an outline of how you plan to improve your practice or documentation. The purpose of putting this plan into writing is to support you in identifying, committing to and successfully making a change in your practice. The insert committee name has requested that you provide a self-report on your progress with the recommended change(s) to your practice in X interval.

The insert committee name appreciates your engagement in the continuous quality improvement of your practice to ensure the highest quality of care for your patients.

Please do not hesitate to contact me if you have any questions.

Yours sincerely,

Appendix G

Insert Date

PERSONAL & CONFIDENTIAL

Dear Insert Dr.'s Name,

Thank you for your patience in waiting for the outcome of your chart audit review to be reviewed by the insert committee name. At its most recent meeting, the insert committee name reviewed the de-identified report of your chart audit which was conducted on Date, 202X, and your letter of response.

The insert committee name has identified from your audit that you have aspects of your practice or documentation that **require change** to ensure ongoing safe and quality patient care. The insert committee name requests that you meet with **insert supervising Dr's name** to discuss and identify specific improvement opportunities. The purpose of this conversation is to support you with quality improvement for your practice and enhance your success with the changes you have identified. The insert committee name have also requested a repeat chart audit in **X year** to assess your progress with your identified improvements.

You are asked to call insert relevant number and book an appointment through insert contact person to speak with insert supervising Dr.'s name to identify a reasonable improvement plan. This meeting can be conducted over the telephone or via ZOOM/Microsoft Teams at your convenience

The insert committee name appreciates your engagement in the continuous quality improvement of your practice to ensure the highest quality of care for your patients.

Yours sincerely,

Appendix H

Insert Date

PERSONAL & CONFIDENTIAL
Chair, Central Standards Committee
College of Physicians and Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg MB R3J 3T7

Dear Dr.:

Re: Dr. X
Patient Name:
Patient DOB:
Patient DOD: (if applicable)
PHIN #:
Hospital or Health Centre (including dates) Patient Seen

At its meeting on Date, 202X, the insert committee name reviewed the results of an audit conducted on Dr. X. The insert committee name has identified that Dr. X requires change to ensure ongoing safe and quality patient care.

(Give context to why the referral)

I am referring this matter on behalf of the insert committee name to you for further review and action by you as appropriate. This referral is being made under s13 a Subcommittee may take such steps as it determines may improve the knowledge, skill or safety of one or more members in carrying on the practice of medicine, including but not limited to do one or more of the following: *(choose appropriate recommendation)*

a. make recommendations to a member;

b. advise Central Standards to:

i. make recommendations to the administration of a hospital, regional health

authority, or other facility where members provide health care services;

ii. refer a member to the Registrar in accordance with section 14 of the Central Standards Bylaw;

iii. request and accept a member's undertaking in accordance with section 15 of

the Central Standards Bylaw and, where such advice is given provide complete supporting information and documentation to Central Standards;

c. develop guidelines or protocols for consideration by Central Standards.

Yours sincerely,

Appendix I

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

1000 – 1661 PORTAGE AVENUE, WINNIPEG, MANITOBA R3J 3T7
TEL: (204) 774-4344 FAX: (204) 774-0750
TOLL FREE (MB ONLY) 1-877-774-4344

(Insert Committee Name) Standards Committee
202X Annual Report

Dates 202X

Committee Attendance:

Location of Meetings:

Table I: Quantitative Report - Total Cases Reviewed for 202X

		***Framework for Decision and Outcomes of Standards Committees (see last page of report)**				
		Suggested Change Outcomes		**Required Change Outcomes**		
Cases Reviewed	**Total**	**Option #1 Reasonable Care**	**Option #2 Self Directed Improvement Plan**	**Option #3 Negotiated Improvement plan**	**Option #4 Educational Undertaking**	**Option #5 Referral to CPSM Registrar**
Clinical Audit : Adverse Patient Occurrences						
Referred Concern						
Random Audit						
Not an APO						

*Other outcomes	Total
Practice Audit or Interactive Audit	
Newsletter Item	
Referral to Another Organization	

Appendix I

Action by Subcommittee s13 Central Standards Bylaw

13. A Subcommittee may take such steps as it determines may improve the knowledge, skill or safety of one or more members in carrying on the practice of medicine, including but not limited to do one or more of the following:
    a. make recommendations to a member;
    b. advise Central Standards to:
        i. make recommendations to the administration of a hospital, regional health authority, or other facility where members provide health care services;
        ii. refer a member to the Registrar in accordance with section 14 of this Bylaw; or
        iii. request and accept a member's undertaking in accordance with section 15 of this Bylaw and, where such advice is given provide complete supporting information and documentation to Central Standards;
    c. develop guidelines or protocols for consideration by Central Standards

Narrative Report:

How has your sub-committee improved the knowledge, skill, or safety of College members in carrying on the practice of medicine in the past year?

Is there evidence of improvement in patient care?

What areas have you identified to focus your Standards Committee work on in the coming year?

Sub-committee Chair comments to Central Standards Committee Chair

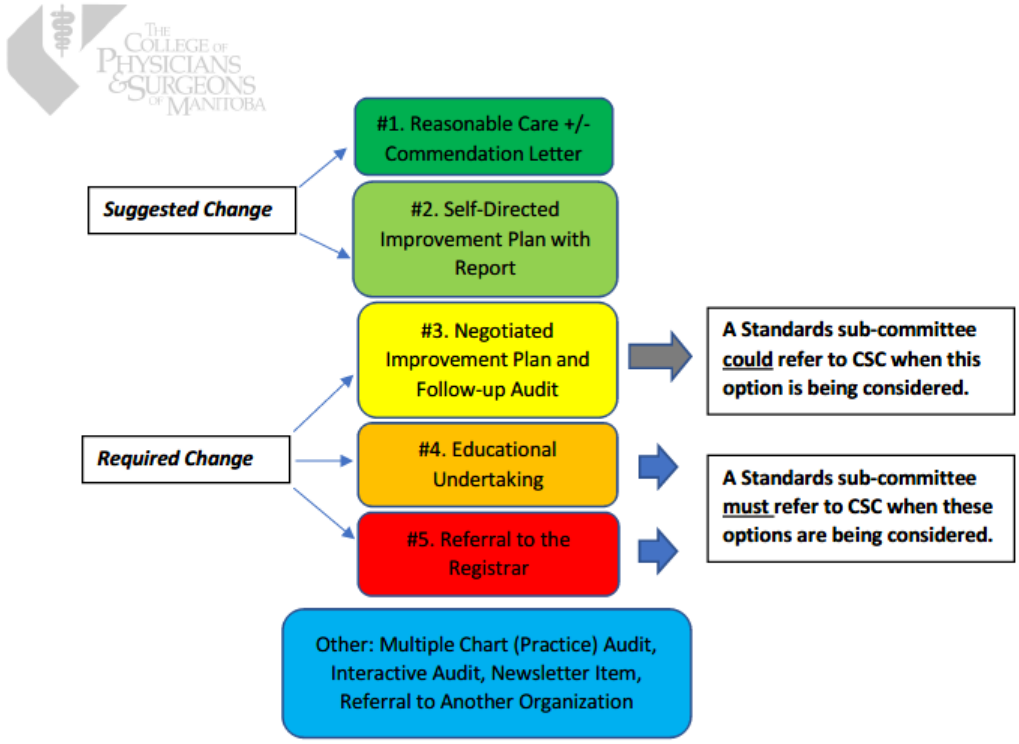
Submitted by: _____

Appendix I

(For Standards sub-committee reference only. Not required in submission of annual report)

*** Framework for Decision and Outcomes of Standards Committees**

Options 1-5 and other to guide deliberation and decisions.



Appendix J

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

1000 – 1661 PORTAGE AVENUE, WINNIPEG, MANITOBA R3J 3T7
TEL: (204) 774-4344 FAX: (204) 774-0750
TOLL FREE (MB ONLY) 1-877-774-4344

(Insert Committee Name) Standards Committee
202X Quarterly Report

Dates 202X

Committee Attendance:

Location of Meeting:

Table I: Quantitative Report - Total Cases Reviewed for Quarter X or from Month to Month 202X

		***Framework for Decision and Outcomes of Standards Committees** **(see last page of report)**				
		Suggested Change Outcomes		**Required Change Outcomes**		
Cases Reviewed	**Total**	**Option #1 Reasonable Care**	**Option #2 Self Directed Improvement Plan**	**Option #3 Negotiated Improvement plan**	**Option #4 Educational Undertaking**	**Option #5 Referral to CPSM Registrar**
Clinical Audit: Adverse Patient Occurrences						
Referred Concern						
Random Audit						
Not an APO						

*Other Outcomes	Total
Practice Audit or Interactive Audit	
Newsletter Item	
Referral to Another Organization	

Appendix J

Any urgent issues addressed?

Sub-committee Chair comments to CSC:

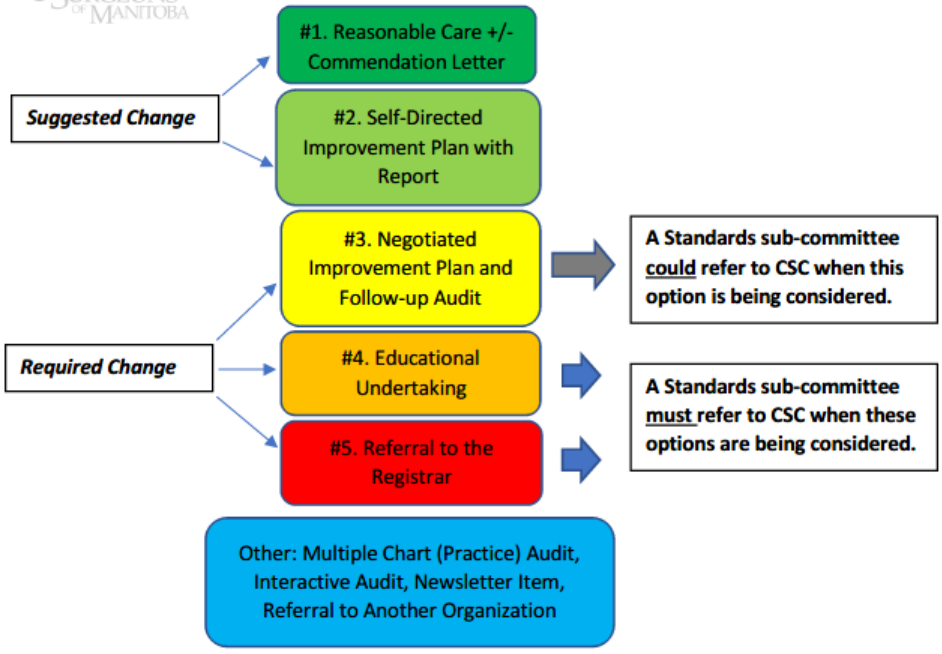
Submitted by: _____

Appendix J

(For Standards sub-committee reference only. Not required in submission of annual report)

*** Framework for Decision and Outcomes of Standards Committees**

Options 1-5 and other to guide deliberation and decisions.



Appendix K

1000 – 1661 Portage Avenue
Winnipeg, Manitoba R3J 3T7
Tel: (204) 774-4344 Fax: (204) 774-0750
Toll Free within Manitoba: 1-877-774-4344
Website: www.cpsm.mb.ca

HONORARIA PAYMENT REQUEST

Committee/Meeting Fees and Expenses

Name: _____

Address: _____

Committee/Meeting: _____ Date: _____

_____ hours @ (Up to a maximum of half day or full day)	$135.00/hour	_____
Chair of Committee	$65.00 extra	_____
Evening	$175.00	_____
Morning or Afternoon	$500.00	_____
Full Day	$1000.00	_____
Mileage _____ km @ $0.52/km		_____
*Living Expenses: _____ day(s) (Up to $200.00/day with vouchers)		_____
*Travel Time: _____ hour(s) @ (for explanation, see reverse)	$135.00/hour	_____
Parking		_____
	TOTAL	_____

Signature: _____

This account should be completed, signed, and submitted for approval at the end of the meeting.

*For members who use transportation other than their own vehicles (i.e. flying to Winnipeg), a copy of the airline ticket at economy or lowest possible fare or other written proof clearly identifying the GST MUST be included with this expense form. **IF NO VOUCHER OR PROOF IS ATTACHED PAYMENT WILL NOT BE MADE.**

Approved by (signature): _____

See https://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/Policies/Financial%20Management.pdf **for policies and definitions.**

Appendix L

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

Personal Information Form

This form is to be completed for each new consultant, council or committee member

NOTE: Any expense other than consulting cannot be paid to a Medical Corporation, it must be paid to the individual

Full Name: _____
Last First Middle Initial

Address: _____
Mailing address/Street address

_____
City Province Postal Code

Home Phone: _____ **Alternate Phone:** _____

Email Address: _____

IF PAYMENT MADE TO INDIVIDUAL:

Social Insurance Number (required): _____

Date of Birth (required): _____

IF PAYMENT MADE TO MEDICAL CORPORATION – CONSULTING ONLY:

Medical Corporation (Full Name): _____

Medical Corporation Business Number: _____
(First 9 digits required)

PAYMENT TYPE:

____ **Direct Deposit** – attach VOID cheque **(required)**

____ **Cheque**

Revised 02/2019

COUNCIL MEETING - SEPTEMBER 29, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Accredited Facilities and Standards Committees

BACKGROUND

There are nine Non-Hospital Medical Surgical Facilities listed under Non-Hospital Standards Committees under Schedule C of the Central Standards Bylaw. Only one currently has an operating Standards Committee which performs some, but not all, of the functions of a Standards Committee.

As you may recall, the accreditation of all Non-Hospital Medical Surgical Facilities was realigned to the Program Review Committee from the Central Standards Committee. As part of its continuing accreditation of these facilities, the Program Review Committee has introduced new and more robust Adverse Patient Outcome processes that are now built into MANQAP oversight of NHMSF. For every adverse patient outcome, the medical director and physician most in charge of the medical care are asked to provide their reflections on what occurred and identify the improvements undertaken to prevent such a reoccurrence insofar as possible:

> Action taken by the facility to prevent future occurrences (e.g., policy changes, re-education, changes in procedure(s). Please specify changes and attach any pertinent documents.

Here is a link to the Adverse Patient Outcome form.

Under the new Adverse Patient Outcome review process, upon consideration of the Assistant Registrar of any concerns, a review is undertaken by one or more medical consultants with clinical expertise matched to the Adverse Patient Outcome (ie an anesthesiologist reviews the work of their peer anesthesiologist, an ENT reviews the work of an ENT).

The Program Review Committee will review all Adverse Patient Outcomes and the medical consultants' reports. As part of the review, the Program Review Committee may identify cases that raises concerns about either the accredited facility itself or about the practice of an individual physician. In the former, the Program Review Committee will address the facility issues. In the latter, the matter is referred by the Program Review Committee to the Registrar who determines whether the subsequent review is to be under the auspices of the Central Standards Committee (educational improvement) or the Investigation Committee (disciplinary).

It should be noted that several of these non-hospital medical and surgical facilities may only have 1-2 practicing doctors, thus making Standards Committees difficult. In other facilities, there are physicians with different practice areas (ie, plastic surgery, anesthesiology, and ophthalmology).

Meaningful peer review exclusively through a Standards Committee may not be possible. Functioning as an effective Standards Committee may not be achievable, practical, nor useful for many of the very small facilities that now require accreditation due to the expansion of accreditation criteria that recently occurred. The purpose of Standards Committees is to supervise the practice of medicine by members. It is rather questionable or dubious whether one can supervise one's own practice of medicine.

Accordingly, it is recommended that these nine facilities (plus 15+ new facilities that are added following the recent amendments to the Accredited Facilities Bylaw to accredit more facilities) should not be required to have Standards Committees. It is further recommended that the names of each of these nine facilities be removed from the list of Non-Hospital Standards Committees included in Schedule C of the Central Standards Bylaw.

The facilities remaining on Schedule C include Brandon Regional Health Centre Psychiatry Standards Committee, Eden Mental Health Centre Standards Committee, and Selkirk Mental Health Centre Standards Committee.

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

The Accredited Facility Bylaw requires every accredited facility to have in place both quality assurance and quality improvement processes. There are further protections and reviews for accredited facilities to ensure patient safety is paramount in the provision of their medical care. These provisions include prospective reviews for patient safety.

CPSM has created a new and robust Adverse Patient Outcome review process to provide true peer review by independent medical consultants and oversight and decision-making by the Program Review Committee. This will expand the regulation and oversight of the accredited facilities and is a more detailed approach to regulating the risks to patients, especially if patient safety may have been compromised.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

The following Standards Committees are deleted from Schedule C of the Central Standards Bylaw:

Assiniboine Surgical Centre Standards Committee

Ageless Cosmetic Clinic Standards Committee

First Glance Aesthetic Clinic Standards Committee

Heartland Fertility & Gynecology Clinic Standards Committee

Manitoba Clinic Endoscopy Suite Standards Committee

Maples Surgical Centre Standards Committee

Visage Clinic Standards Committee

Women's Health Clinic Standards Committee

Western Surgery Centre Standards Committee

Winnipeg Clinic (Endoscopy) Standards Committee

COUNCIL MEETING – SEPTEMBER 29, 2021

ITEM FOR INFORMATION

SUBJECT: **Registrar/CEO's Report**

COVID-19 PANDEMIC

CPSM Staff Returns to the Office

On September 7, 2021 the staff at CPSM returned to the office. I am very pleased to have them all back and see everyone in person. The Senior Leadership Team developed and implemented a COVID-19 Vaccination policy for staff, visitors and contractors who attend the office. We will continue to monitor the COVID-19 situation in Manitoba and follow the Public Health Directives. I am confident that if we did need to return to a work from home model we are well equipped to do so.

CPSM Senior Leadership Team is in the process of drafting a policy on vaccination requirements for implementation. At this time we are awaiting further details from Public Health on how the testing of unvaccinated staff will be done.

Guidance to the Profession

With the announcement that the Manitoba Government is requiring all direct healthcare providers and workers, including but not limited to physicians, nurses, allied health professionals, and support service staff who have ongoing contact with vulnerable populations, to be fully vaccinated for COVID-19 by October 31, 2021, CPSM released an updated Frequently Asked Questions document on Vaccines. An email was sent to all registrants on September 7 notifying them of the updated information.
https://cpsm.mb.ca/assets/COVID19/CPSM%20Vaccines%20FAQs.pdf

Guidance was also given on COVID-19 Vaccine Exemptions. We worked with Manitoba Public Health and in the FAQ on this topic, included a link to the Manitoba COVID-19 Vaccine: Clinical Practice Guidelines for Immunizers and Health Care Providers.

A FAQ on Ivermectin was also added to CPSM website at
https://cpsm.mb.ca/news/ivermectin-for-the-treatment-of-covid-19

MEETING WITH GOVERNMENT OFFICIALS

Meeting with Deputy Minister

The quarterly meetings between CPSM and the Deputy Minister of Health were to resume after a hiatus due to COVID. A meeting was scheduled with the deputy minister for Monday, September 13, 2021. It was cancelled and is rescheduled to October.

Public Health Orders Meetings

CPSM continues to attend biweekly meetings with the Chief Medical Officers of the Health Regions, Public Health leaders, Program Leads and Shared Health. The meetings are to discuss and collaborate on the next steps required during the COVID-19 pandemic.

COMPLAINTS/INVESTIGATIONS PROCESS IMPROVEMENTS

Our current process for addressing complaints largely involves exchanging written information followed by a committee decision. Anecdotally we understood this to be unsatisfactory to many complainants and physicians. A study out of Australia, where the process appeared to parallel our own, identified frustration for complainants who submitted information without the ability to speak with anyone and who eventually received a written decision that may or not have provided satisfactory answers. Doctors were stressed about the time taken to be informed of a resolution and noted that their care to others was sometimes impacted by hypervigilance in the interim. Both parties felt disconnected.

Part of our process for improvement included that in August 2020 we hired a social worker to try to improve communication with complainants and assist them through the process. This has been helpful, and we began to address ways to further increase our ability to engage patients and members in the process of resolving complaints. We believe that resolving conflict is an integral part of medical practice. This is consistent with Council's direction to increase the number of matters resolved through an alternative dispute resolution process. We were aware of the positive experience with this approach in other jurisdictions.

We also recognize the importance of "right touch regulation" where the appropriate resources are used in the particular circumstance. The RHPA allows a variety of possible actions to address concerns, including:

- referral to the Complaints or Investigation Committee;
- encouraging the complainant and the member to resolve the matter through communication; or
- dismissing the complaint if it is trivial, vexatious or where there is insufficient evidence of conduct of concern to CPSM.

We have not previously utilized these options to their fullest potential and are developing policies and procedures to identify which path would be appropriate based on the nature of the issue at hand. We are optimistic that we can facilitate communication where appropriate and have the Complaints and Investigation Committees review matters that require their particular roles and powers under the RHPA. This would include a more active approach to informal resolution between the parties where the matter is referred to the Complaints Committee, and an automatic referral to the Investigation Committee where the nature of the concern is potentially more serious.

MEDIA

CPSM was mentioned in the media in the following instances during this quarter:

- In June, Dr. Mihalchuk was a guest on TV (CTV Morning Live) and radio (CBC) to encourage patient participation in the Virtual Medicine public consultation.

- In July, CPSM received requests from five media outlets regarding circumcision concerns and the draft Standard of Practice for Office-Based Procedures. Also in July, two local media outlets reported on the license surrender by Dr. Nagy William and an Inquiry Panel decision regarding Naseer Ahmed Warraich.

- During August and September, CPSM has received several inquiries from local and national media related to mandatory vaccines and the use of ivermectin to treat COVID-19.

STAFF MATTERS

Mr. Dave Rubel has informed me that he will be retiring at the end of December 2021. We have engaged Harris Leadership Group to find a replacement Chief Operating Officer.

Dr. Garth Campbell has resigned from his position as Medical Consultant to the Complaints Committee. We are starting the process of replacing him and in the interim Dr. Bullock Pries is managing the complaints that are received.

Day for Truth & Reconciliation – September 30, 2021
CPSM is honouring National Day for Truth and Reconciliation by requiring all staff to take time during the workday on September 30, to watch The Unforgotten, a film about the health and well-being of Inuit, Métis and First Nations peoples. As part of this and CPSM's commitment to cultural competency, Dr. Sara Goulet, an Indigenous physician who practices in Northern Manitoba remote communities, will be presenting to staff on October 1.

GOVERNANCE SESSIONS

As part of continuous improvement, all Councillors will participate in Governance Education. Mr. Bradley Chisholm, Chief Officer, Strategy and Governance at the British Columbia College of Nurses & Midwives who was recommended by the College of Physicians & Surgeons of British Columbia was approached and has agreed to provide governance education sessions to CPSM Council. There will be two 3 hour sessions scheduled, at a date yet to be determined.

Now more than ever before professional health regulators are in the spotlight of the media, government, and the public we serve. Many recent external reviews have outlined significant governance weaknesses. Recognizing the context in which these health regulatory boards are governing, this customized education session, created for health profession regulators, looks at the following key topics:

- What is governance?
- What are the indicators of good governance?
- What about health profession regulation, makes governance more difficult?

- What are the contextual factors that are impacting governance in our industry?
- What are governance shifts being made to respond to changing context?
- What is the role on the regulator in the broader healthcare / health policy environment?
- How does a board bring a strategic perspective to their work?

RENOVATIONS

As previously reported CPSM had secured additional office space in the building during renewal negotiations of the 10th floor lease. Office renovations continue with an anticipated occupancy date of late October. The pandemic has caused delays in all of the manufacturing sector which has impacted all construction projects. Therefore, CPSM occupancy will be later than we expected.

FMRAC NATIONAL COMMITTEES

Federation of Medical Regulatory Authorities of Canada (FMRAC) - Board Member

- FMRAC Registration Working Group
- FMRAC Virtual Care Working Group
- FMRAC Streamline Registration Working Group
- FMRAC Racism and Discrimination Working Group

FMRAC has planned an in-person board retreat scheduled for October 27 & 28, 2021 in Vancouver, British Columbia which I will attend.

Attached is a copy of the FMRAC Year at a Glance document for your information.

Federation of Medical Regulatory Authorities of Canada

Fédération des ordres des médecins du Canada

Snapshot 2020 – 2021

Year in Review

The FMRAC Offices are located on the traditional unceded territory of the Algonquin Anishinabe People. / Les bureaux de la FOMC sont situés sur le territoire ancestral et non-cédé des peuples anishinabe de la nation algonquine.

MISSION

TO ADVANCE MEDICAL REGULATION ON BEHALF OF THE PUBLIC THROUGH COLLABORATION, COMMON STANDARDS AND BEST PRACTICES.

Message from the President

It is with tremendous pleasure that I provide a few words to summarize FMRAC's past year. I think it goes without saying that, during this time, the world has become far different than previous years and that means medical regulators were dealing with many new and complex issues.

FMRAC's core strength comes from the working relationships that we develop among all the Canadian medial regulators, the broader medical community in Canada and the broader international regulatory environment. During such challenging times, it is more important than ever to build strong, supportive and productive relationships with our partners and find common solutions that meet the best interests of all Canadians. I think you will see in this update that FMRAC has remained fully engaged with our partners and continued to learn from everyone so we can best support our Members, the 13 provincial and territorial MRAs, do the best work possible during the COVID-19 pandemic.

Dr. Scott McLeod

Watershed events in 2020 – 2021

1. **THE COVID-19 PANDEMIC**
   a. Adapting to working from home and holding virtual meetings (including complaints)
   b. Registration and licensure requirements for the 2020 and 2021 graduating cohorts (undergraduate and postgraduate)
   c. The rapid adoption of virtual care across Canada
   d. Medical surge capacity and emergency licensure
   e. Physicians making statements that went against the advice of Public Health Officers and the law
2. **ANTI-RACISM** – *the influence and impact of the following movements and events on how MRAs fulfill their mandate to protect the public*
   a. The death of Mr. George Floyd and Black Lives Matter
   b. The death of Mrs. Joyce Echaquan while in hospital and *Joyce's Principle*
   c. The report from Ms. Mary Ellen Turpel-Lafond entitled *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*
   d. The recent discoveries of unmarked graves at several residential schools
3. **THE MEDICAL COUNCIL OF CANADA'S** recent decision to award the LMCC to candidates who have passed the MCC Qualifying Examination Part I
   a. the MCC incorporated the preference stated by the FMRAC and its Members as to which cohorts would be eligible
   b. the MCC cancelled its current MCC Qualifying Examination Part 2 and will revisit this assessment upon receiving the recommendations from its Assessment Innovation Task Force

NEW PRESIDENT-ELECT

2021-22

Dr. Nancy Whitmore, Registrar, CPSO, was elected to the position of President-elect of FMRAC. This is a one-year term followed by two years as President.

Message from the Executive Director and Chief Executive Officer

It was a year for learning: how to adjust and rearrange one's abode to be able to be productive and efficient while working from home; virtual meeting etiquette as we adapted to the rapidly evolving technology that fortunately allowed us to engage with each other in a meaningful manner; to be patient as we realized again and again that the pandemic would be controlling so many aspects of our lives for much longer than originally expected; how to spot the signs that our colleagues may be flagging and in need of encouragement; the importance of taking time off work even with stay-at-home orders; and I could go on. It was also a time to realize just how much we appreciate being in each other's company, working and strategizing and socializing together in the same room.

Most importantly, the past year marks the beginning of a journey into my own understanding of the really difficult issues of implicit bias and privilege and injustice and colonialism. As I strive to listen and absorb information that will help me grow and fulfil my professional mandate, as I grasp the fact that I may yet not know how to listen fully, I am amazed at the honesty and openness of those who share their stories with us. I am grateful to them for putting so much effort and time into helping me.

Ms. Fleur-Ange Lefebvre

PILLARS

THE SIX PILLARS THAT ENABLE FMRAC TO ACHIEVE ITS MISSION AS PROACTIVELY AND CREATIVELY AS POSSIBLE ARE:

P1	establish mechanisms for the effective exchange of information, discussion and collaboration with its members and others, on issues that involve medical regulation	**P4**	be an effective voice to interact with and inform key stakeholders (including governments, the public and media) on medical regulatory matters of national or international importance
P2	develop policies, standards, statements and perspectives on aspects of medical regulation – either pan-Canadian or drafts that can be adapted by the members	**P5**	develop and maintain programs, services and benefits for its members
P3	actively participate in the design and coordination of pan-Canadian health system changes	**P6**	identify and mitigate risk to medical regulation in a timely manner

ORGANIZATIONAL PRIORITIES

#	PRIORITY	PROGRESS AND DEVELOPMENTS	Pillars
A	Artificial Intelligence and the Practice of Medicine (expected delivery – Fall 2021 or Winter 2022)	• Session 1 of the virtual 2021 FMRAC Educational Conference focused on this topic via a series of three, facilitated webinars that included various stakeholder perspectives and working groups that considered issues of current or emerging importance relevant to the mandate of medical regulators. • The working group believes it is premature to recommend minimum guidance to physicians on the use AI tools in patient care until it has become more fully integrated. A report to the Board that reflects a synopsis of activities and issues considered to date, as well as the input and observations of other stakeholders, is being developed.	P1
B	The Impaired Physician (expected delivery – Fall 2022 or Winter 2023))	• The remit is a framework on a regulatory approach to the impaired physician from an occupational health perspective. • Using the World Health Organization's Classification of Functioning (ICF), Disability and Health Checklist as a starting point, FMRAC's framework is progressing, with the need to reinforce or add elements that address the specific needs of the Members • The draft underpinning principles include: justifiability, consistency, equity, transparency, procedural fairness and timeliness. • Many external stakeholders are interested in this file and will be included in the consultation phase.	P2, P6, P1
C	Virtual Care (expected delivery – Winter / Spring 2022)	• The second session of FMRAC's June 2021 educational conference focused on regulatory issues relating to virtual care, comprising various stakeholder perspectives and presentations over two webinars. • The working group's mandate is to consider the development of an updated FMRAC Framework on Telemedicine that reflects any issues that are new or require further emphasis or clarity in a post-pandemic environment. The Framework will build on issues that emerged from the 2021 educational conference and multiple stakeholder surveys during Winter and Spring 2021. This will be the group's focus during Fall and Winter 2021.	P1
D	Physician Competency (expected delivery – Fall 2021)	• A new Discussion Forum on Physician Continuous Quality Improvement was struck. • External consultants (Mr. Steven Lewis, Mr. Andrew Neuner and Dr. Marcie Lorenzen) undertook a scoping review as the first phase of a study on the MRAs' roles in ensuring a physician's competency throughout the career lifespan (from entry to medical school to retirement) – the report was submitted to the Registrars in June 2021 and will be reviewed by the Board in August 2021	P1 P2, P3
E	Streamlined Registration (completed)	The Board suspended further activity at this time on licensure for the purposes of telemedicine / virtual care; and license portability agreements. The Board approved the FMRAC Statement on Fast-tracked Licensure in February 2021.	 P2

SIX CORE ACTIVITIES

#	CORE ACTIVITY	PROGRESS AND DEVELOPMENTS	Pillars
C1	advocacy and common voice – where FMRAC stands publicly and speaks on behalf of the medical regulatory authorities of Canada at the federal level Health Canada Immigration, Refugees and Citizenship Canada Employment and Social Development Canada Justice Canada Industry Canada with the members, the public and the media – promote pan-Canadian standards, even if they are aspirational, especially when members can use them in discussion with their own governments with other national organizations – promote the notion of public interest regulation	FMRAC Statement on Physicians and Public Statements (January 2021) Presentations at webinars put on by: • FMRAC • Coalition for Physician Enhancement • International Association of Medical Regulatory Authorities Federal Government • Medical Assistance in Dying • Cannabis for recreational purposes – health products that do not require health care practitioner oversight • Cannabis for medical purposes – physicians authorizing unusually high amounts for people who grow or have someone grow their product • Safer supply of opioids for patients with substance use disorder • "Agile regulations" consultations on advanced therapeutic products (ATPs) and medical devices that incorporate artificial intelligence • Emergency licensure of physicians during the third wave of the pandemic • Licensure of international medical graduates during the pandemic • Virtual care (with the provincial and territorial governments)	P4, P6 P4 P3 P3, P4, P6 P4, P6 P3, P6 P4, P6 P4, P6 P3, P6
C2	surveillance of political developments and trends that may have an impact on the work of the Members in fulfilling their mandate	• Medical Assistance in Dying – continuing to seek assurance from the Federal Government that the language in the legislation will be clear and consistent • **THE FEDERAL GOVERNMENT** asked for assistance in licensing physicians in an emergency, and FMRAC and its Members were happy to step up to the plabe • There were questions from and meetings with **THE FEDERAL GOVERNMENT** on the advisability and feasibility of licensing international medical graduates to provide medical care during the pandemic	P1, P4 P1, P4, P6 P1, P4, P6
C3	FMRAC Integrated Risk Management System (FIRMS)	• **NINE PROVINCIAL MRAS** are using FIRMS Standards 2.0 • 11 modules of standards with high levels of compliance across all the MRAs • The next phase will identify areas for improvement and possibly MRAs that require assistance • Working with the Healthcare Insurance Reciprocal of Canada (HIROC), FMRAC will offer the FIRMS Standards 2.0 to regulators of other health care professions that are HIROC subscribers	P5, P6 P1
C4	Model Standards for Medical Registration in Canada • FMRAC worked closely with its Members on several issues, in collaboration with other key stakeholders such as the ○ Royal College of Physicians and Surgeons of Canada (Royal College) ○ College of Family Physicians of Canada (CFPC) ○ Medical Council of Canada (MCC) ○ Association of Faculties of Medicine of Canada ○ Resident Doctors of Canada ○ Canadian Federation of Medical Students ○ Canadian Resident Matching Service (CaRMS) ○ Canadian Forces Health Services (CFHS) ○ International Association of Medical Regulatory Authorities (IAMRA) ○ Federation of State Medical Boards (FSMB; US)	• extension of the "COVID-19" license to the 2021 cohort • licensure for candidates who had previously failed the Royal College or CFPC exams • postponements or cancellations of the 2021 exams, including the Royal College oral exam, the CFPC SOO (simulated office orals) and the MCC Qualifying Examination Part II • academic certification • recognition of certification in family medicine in other countries • practice-eligibility routes to certification • changes in the timing of the CaRMS Match due to the pandemic • FMRAC Statement on Military Physicians (April 2021) In addition to IELTS-Academic, two other **ENGLISH LANGUAGE PROFICIENCY EXAMS** were added to the Model Standards for Medical Registration in Canada, pending approval by each MRA • Occupational English Test (Medical) or OET-Medical • Canadian English Language Proficiency Index Program or CELPIP **THE MEDICAL COUNCIL OF CANADA** – recent decision to award the LMCC based on the MCCQE Part I • the preferences of FMRAC and its Members on the cohorts who would be eligible were heard and incorporated into the MCC's decisions	P4 P4, P6 P3, P6 P4, P6 P3, P4 P3, P6 P6 P3, P4, P6 P2, P3 P3, P6

C5	anti-racism in medical practice and medical regulation FMRAC identified the need to focus first on Indigenous-specific racism	• The Working Group on Anti-racism is chaired by Dr. Lana Potts, an Indigenous physician working in Calgary and Siksika, AB • Three documents are in the draft stage: ○ FMRAC Statement on Anti-racism ○ FMRAC Statement on Anti-Indigenous Racism in Medical Care ○ FMRAC Framework on Wise Practices in Medical Regulation – Towards an equitable and meaningful experience for Indigenous people	P1,
C6	FMRAC Annual Meeting and Conference – ongoing planning process	The 2021 conference on **ARTIFICIAL INTELLIGENCE AND VIRTUAL CARE: MEDICAL REGULATION FOR HIGH QUALITY CARE** was held virtually over five days, featuring a two-hour webinar each day with 100 to 125 attendees 14-16 June – Artificial Intelligence 21-22 June – Virtual Care	P1, P4, P2

SURVEYS OF MEMBERS (on behalf of FMRAC, its members or other stakeholders) (P5, P1, P6)

- Honoraria for preparation time (August 2020)
- Candidate requirements for licensing the 2020 graduating cohort (October 2020)
- Requirement for physicians to have an email address (November 2020)
- Cultural safety – mandatory courses for physicians (December 2020)
- Governance composition (February 2021)
- Vaccination roll-out (February 2021; for the Public Health Agency of Canada)
- Virtual care (October 2020, December 2020, -January 2021)
- Medical registration – guiding principles and sample revised standards (February 2021)
- Family medicine as a specialty (March 2021)
- Endoscopic procedures (March 2021)
- Declaring criminal offenses on a certificate of professional conduct (March 2021)
- Physician Competency – Phase I (March 2021)
- Pre-screening requirements for international medical graduates (April 2021)
- Physician health (April 2021)
- CaRMS – receiving first iteration results (May 2021; for AFMC)
- Physicians with licenses in multiple jurisdictions (June 2021)

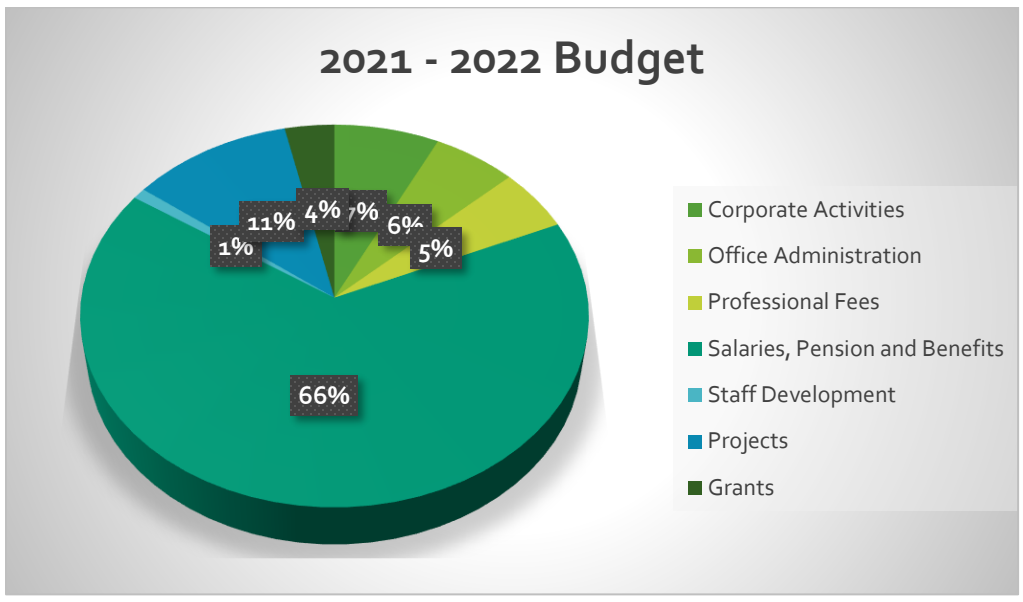
EXTERNAL ACTIVITIES AND REPRESENTATION

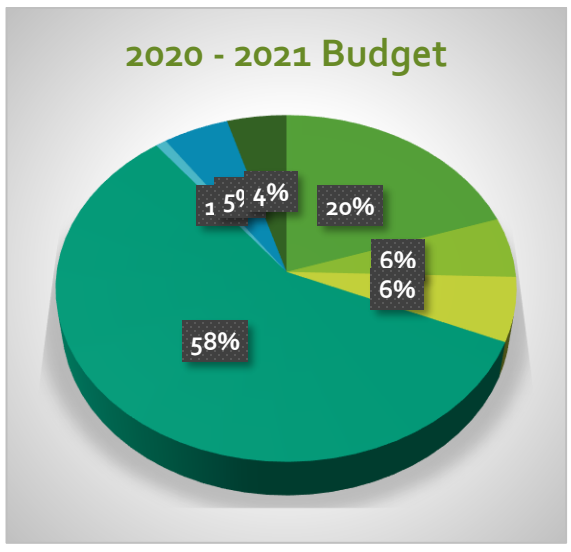
FMRAC IS ACTIVELY INVOLVED ON SEVERAL COMMITTEES, TASK FORCES, BOARDS OF DIRECTORS AND WORKING GROUPS OF STAKEHOLDER ORGANIZATIONS

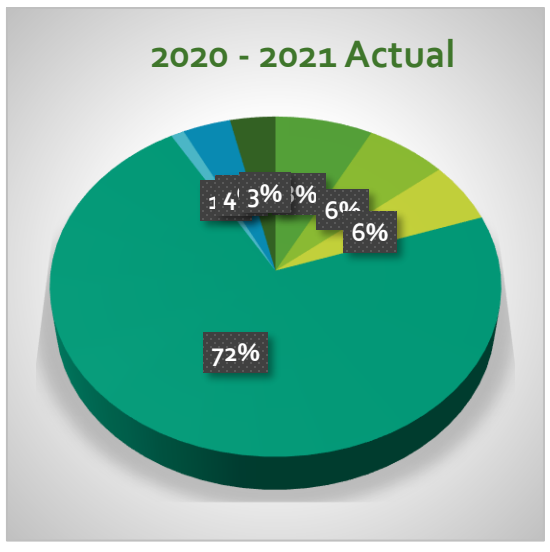
- Royal College
  - Corporate Accreditation Committee (Dr. Derek Puddester [CPSBC] and Ms. Fleur-Ange Lefebvre)
  - Residency Accreditation Committee (Ms. Lefebvre)
  - Professional Learning and Development Committee (Ms. Lefebvre)
  - Credentials Committee (Ms. Lefebvre)
- CFPC
  - Accreditation Committee (Ms. Louise Auger)
  - MainPro+ Standards Working Group (Ms. Lefebvre)
  - National Committee on Continuing Professional Development (Dr. Anna Ziomek [CPSM])
- Canadian Resident Match Service (Ms. Lefebvre – Board member)
- Committee on Accreditation of Canadian Medical Schools (Dr. Jeremy Beach [CPSA])
- Committee on Accreditation of Continuing Medical Education (Ms. Lefebvre)
- Canadian Patient Safety Institute consultations and annual general meeting (Ms. Lefebvre)
- Canadian Medical Association
  - Committee on Ethics (Dr. Ziomek)
  - National Health Summit (Dr. Scott McLeod and Ms. Lefebvre)
- Canadian Medical Protective Association Annual General Meeting (Ms. Lefebvre)
- Canadian Medical Forum (Dr. McLeod and Ms. Lefebvre)
- MINC#NIMC (Mr. Douglas Anderson [CPSO; President], Dr Yves Robert (until his retirement), Dr. Michael Caffaro and Ms. Lefebvre)
- International Association of Medical Regulatory Authorities (IAMRA)
  - Chair-elect (Dr. Heidi Oetter [CPSBC])
  - Regulatory Best Practice Working Group (Ms. Lefebvre)
  - Physician Information Exchange Working Group (Dr. Oetter, Chair)
- CFPC – Royal College – CMA Virtual Care Task Force (Dr. Oetter and Ms. Lefebvre)

2021 – 2022 BUDGET

- The only revenue is from membership dues and investment income, as there was no registration fee for the virtual Annual Conference.
- The followed costs were not incurred in fiscal year 2020 – 2021 or the first half of fiscal year 2021 – 2022: in-person meetings of the Board, committee and working group; President's activities including travel; and staff travel.
- The resulting increased percentage for salaries does not reflect an increase in actual value.







MEMBERS AND BOARD OF DIRECTORS

MEDICAL REGULATORY AUTHORITY	REGISTRAR / FMRAC DIRECTOR
College of Physicians and Surgeons of British Columbia	Dr. Heidi Oetter (FMRAC Executive Committee)
College of Physicians and Surgeons of Alberta	Dr. Scott McLeod (FMRAC President)
College of Physicians and Surgeons of Saskatchewan	Dr. Karen Shaw
College of Physicians and Surgeons of Manitoba	Dr. Anna Ziomek
College of Physicians and Surgeons of Ontario	Dr. Nancy Whitmore (FMRAC President-elect)
Collège des médecins du Québec	Dre Isabelle Tardif
College of Physicians and Surgeons of New Brunswick	Dr. Ed Schollenberg
College of Physicians and Surgeons of Prince Edward Island	Dr. George Carruthers
College of Physicians and Surgeons of Nova Scotia	Dr. Douglas A. (Gus) Grant
College of Physicians and Surgeons of Newfoundland & Labrador	Dr. Linda Inkpen
Yukon Medical Council	Ms. Stephanie Connolly
Northwest Territories	Ms. Samantha VanGenne
Nunavut	Ms. Barbara Harvey
Canadian Forces Health Services	*MGen Marc Bilodeau (Observer)*

OFFICE CLOSURE

FMRAC OFFICES CLOSED FROM 13 MARCH 2020 AND REMAIN CLOSED TO THE PRESENT DAY, WITH ALL STAFF WORKING FULL-TIME FROM HOME.

We wish to close by thanking and commending the members of the FMRAC staff for their due diligence and dedication, and for maintaining a calm, even keel throughout the pandemic. *Scott and Fleur-Ange*

COUNCIL MEETING –SEPTEMBER 29, 2021

ITEM FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met virtually on September 1. The Executive Committee reviewed the agenda and materials for Council and provided advice to the Registrar on various matters. The membership was altered slightly as Dr. Shenouda joined as President Elect and Dr. Sigurdson moved off the Executive Committee since he was no longer Past President. An Appeal Panel from the Executive Committee met once to discuss two appeals and provide direction on the course of action.

Respectfully Submitted,
Dr. Jacobi Elliott
President, CPSM and Chair of the Executive Committee

FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

Since the Council meeting in June, the Finance, Audit & Risk Management Committee has not met. Currently, there is nothing new to report. The Finance, Audit & Risk Management Committee is scheduled to meet on November 23, 2021, and at that meeting will review CPSM's financial matters.

Respectfully submitted
Dr. Nader Shenouda
Chair, Finance, Audit & Risk Management Committee

PROGRAM REVIEW COMMITTEE REPORT:

Program Review Committee (PRC) – Meeting Date: 8 September 2021

Diagnostic Facilities

MANQAP continues to conduct some remote inspections due to COVID-19 restrictions but has also resume some on-site inspections. MANQAP plans to resume on-site inspections for all facilities in the Fall, subject to Public Health directives and regulations. As decided at the last Council Meeting, PRC now has final approval of operational standards for the facility accreditation inspections. A change was made to the Diagnostic Imaging standards regarding best practice for shielding. Discussion occurred around how to keep the public aware of best practice changes. Discussion also occurred around the availability of laboratory test results and diagnostic images/reports in a patient's e-chart.

Non-Hospital Medical Surgical Facilities (NHMSF)

In order to implement the changes in the updated Accredited Facilities Bylaw (effective 9 June 2021), communication packages were sent to existing accredited NHMSFs as well as new facilities that now fall under the bylaw and will require accreditation. The Adverse Patient Outcome (APO) process and form have been updated and implemented. Medical Directors are required to sign agreements stating they are aware of their roles and responsibilities under the new Bylaw. A review of NHMSF procedures at existing accredited NHMSFs is underway and a process to approve new procedures has been implemented. Work is also being done with CPSM IT to move many of our forms (APO, new procedures, Annual Reports) to the CPSM Portal. New standards for NHMSF are being adapted for implementation in the Fall.

Respectfully submitted
Dr. Wayne Manishen
Chair, Program Review Committee

COMPLAINTS COMMITTEE REPORT:

Report forthcoming – will forward prior to meeting.

SEE END OF DOCUMENT FOR REPORT SUBMITTED

Respectfully submitted
Dr. Heather Smith
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

Since the June report, the Investigation Committee has met virtually once and reviewed 16 cases (No further action = 6, Criticism = 5, Advice = 2, Censure = 1 and Referred to Inquiry = 2). Since June 9th, 27 new investigations files have been opened and 17 have been closed.

We welcome a new Committee member, Dr. Ravi Kumbharathi, who will join us for our October meeting.

We continue to value the work of the staff in the department as well as our Committee members.

Respectfully submitted
Dr. Kevin Convery
Chair, Investigations Committee

STANDARDS COMMITTEE REPORT:

The CSC met September 3, 2021.

Quality Department Age Triggered and Referred Audits Program:

AGE TRIGGERED/REFERRED AUDITS 2021

The Quality Department Audits program total audits for the current year stands at **65** - 55 Age Triggered Audits and 9 Referred Audits all in various stages of the audit process.

16	75-year-old audits
24	74-year-old audits
15	Repeat age triggered audits
9	Referred audits

COMPLETED AUDITS 2021 OUTCOMES

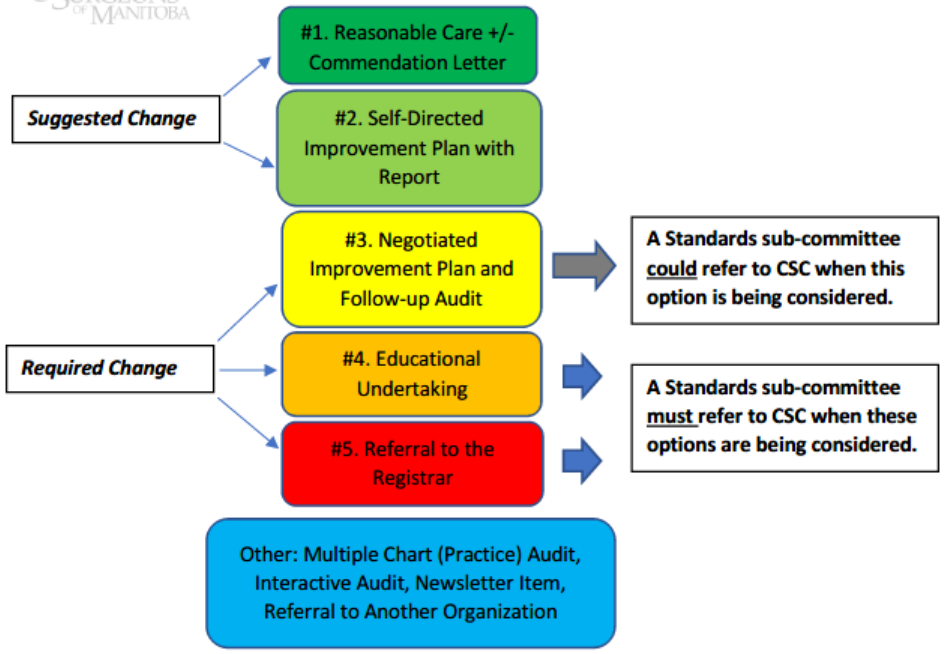
15 audits completed - 12 Age Triggered and 3 Referred

3	#1 outcomes
3	#2 Outcomes
6	#3 outcomes
1	#4 outcomes
1	#5 outcomes

To date Dr. Mihalchuk and Dr. Singer have completed 15 QI calls to all the physicians that received #3 outcomes. Please note that 11 of those calls were conducted after the February 5, 2021, CSC meeting, those physicians would have been included in the 2020 audit year.

IN PROCESS AUDITS 2021

6	Audits with confirmed audit dates
5	Waiting for auditor replies
6	Need to secure auditor (all pertinent info has been received)
9	Pre-audit questionnaire to be reviewed for further action
13	Waiting for pre-audit questionnaire to return
10	Waiting for Manitoba Health information



Standards Sub-Committees Draft Operational

At the November 6, 2020, CSC meeting, the members of the Committee approved the formation of a working group to develop recommendations for the operation and execution of its sub-committees of the CSC. The purpose of these recommendations was to facilitate consistency and standardization in approach and deliberation around the activities of Standards sub-committees as well as outcomes, data collection, and reporting, with the ultimate goal of enhancing CPSM's supervision of the Profession of Medicine.

A Standards Sub-Committee Guide to Operations has been developed to summarize the advice of the working group and will be shared with all sub-committees to set the expectation that all sub-committees will start using our required formats and consistent approaches.

The Operational Guide is intended to support an understanding of our work at the system (i.e. Share Health) level and can be used to onboard new standards committees and/or maintain operations with consistency as chairs and membership changes.

Maternal and Perinatal Health Standards Committee MPHSC and Child Health Standards Committee (CHSC)

MPHSC and CHSC has resumed meetings. CHSC meeting is scheduled for September 14. MPHSC is scheduled for October 5. Both committees also submitted their Q1-Q2 reports to Shared Health.

There were three newsletter items from MPHSC:

Escalation Protocol for Management of Severe Hypertension in Pregnancy

Interdisciplinary Collegiality Between a Consultant and the Consultee
Low Dose Aspirin in Prevention of Gestational Hypertension and Pre-Eclampsia

There was one newsletter item from CHSC:

Managing Pediatric Asthma, Croup, and Bronchiolitis in the Context of COVID-19

Respectfully submitted
Dr. Roger Suss
Chair, Central Standards Committee

QUALITY IMPROVEMENT PROGRAM

Update for September 29, 2021 Council Meeting

The QI Committee held its final meeting on April 8, 2021. Council will recall that the activities of the QI Committee have been subsumed under the Central Standards Committee effective June 9, 2021.

The Quality Improvement (QI) program continues to work with our members to assist them through to program completion during the pandemic. Operations have returned to close to normal in 2021, with flexibility for members who are more significantly affected and not reasonably able to participate when selected. The fall 2020 cohort of participants is complete except for one Category 3 review which is scheduled for October. We continue with the format of having two reviewers attend the CPSM offices to conduct the category 3 chart reviews, followed by an interactive digital (Zoom) meeting with the participant to have a chart-stimulated discussion followed by feedback from the reviewers.

A spring cohort was launched in April 2021. It includes randomly selected groups from family medicine, general surgery, pediatrics, psychiatry, and internal medicine. Category 2 chart reviews being scheduled in September and October. The Medical Council of Canada has been provided the names of the participants selected to undergo the multi-source feedback component for category 2 and 3 participants. Category 3 reviews will be scheduled once the reports are complete.

Dr. Singer presented information to members at Obstetrics and Gynecology Grand Rounds in June. A focus group has been held to help determine the optimal approach for Anesthesia, and a Grand Rounds presentation for this group will be done in September.

Of the total participants since program inception in 2019, 8 files have been brought forward to the QI Committee regarding concerns around practice deficiencies, as well as 2 files were brought forward to the Central Standards Committee at the September 3, 2021 meeting. Outcome details are as follows:

- 3 – Closed
- 5 – Pending remediation/follow-up review
- 1– Referred to Central Standards Committee – Referred to Registrar
- 1 – Referred to PHP

Of the total participants, 2 files have been brought forward to the QI Committee/Central Standards Committee for non-compliance. Both files have been/will be referred to the Registrar.

Below is a summary of initiations/participants/completions to date:

QI PARTICIPANTS

YEAR	INITIATED	PARTICIPATED	COMPLETED
2019	294	194	194
2020	251	150	149
2021 (April)	203	138	35

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 continues to work to determine the most effective way to offer a medical record keeping course to address this need.

Feedback from participants has largely been positive, including the feedback gathered via an anonymous online survey. Suggestions for program improvement continue to be collated and incorporated where reasonable and feasible.

All participants are required to submit an Action Plan for improvement as the concluding activity of their participation. They are contacted via email after one year to solicit feedback as to the success or challenges of realizing their plan. Most participants complete the plan in a thoughtful and reflective manner. The one-year feedback reveals honesty about accomplishments achieved and barriers encountered. COVID-19 affected the plans of many, and members found that they made many unanticipated changes to their processes and procedures related to this, such as incorporating virtual visits.

The QI Program has received CPD accreditation by both the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. Both have granted the program the highest credit level available of 3 credits per hour MainPro+ and Section 3 Assessment credits respectively.

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	

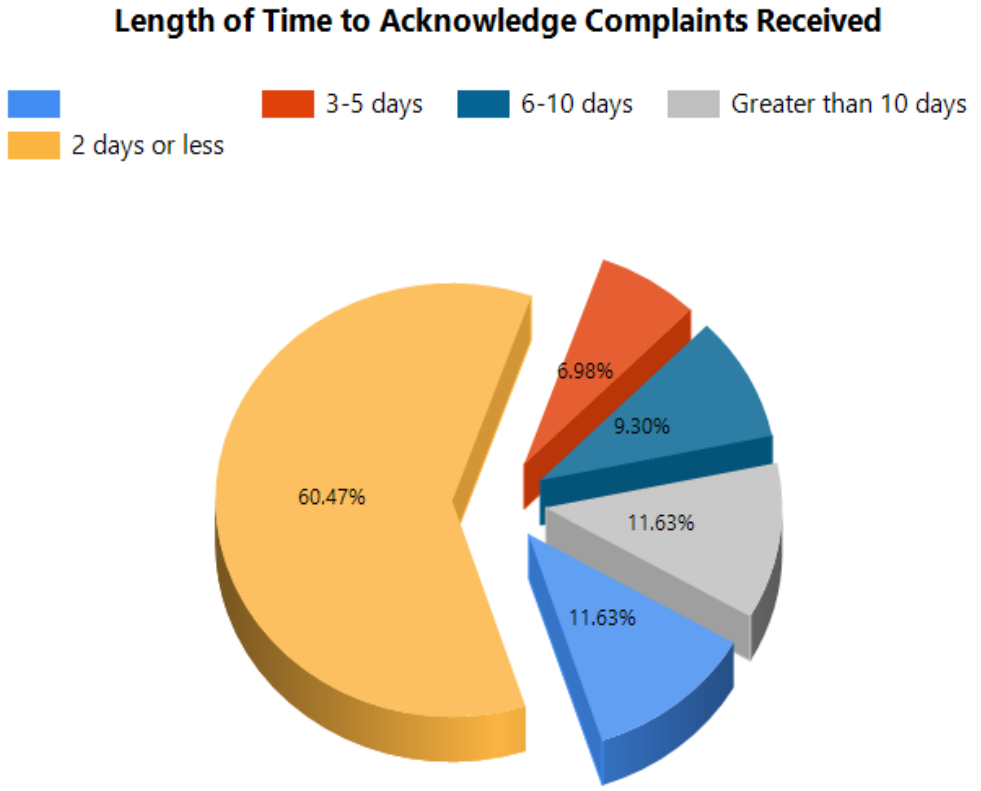
Feedback to the President				
9. The President/Chair gained consensus in a respectful and engaging manner.	1	2	3	
10. The President/Chair ensured that all members had an opportunity to voice his/her opinions during the meeting.	1	2	3	
11. The President/Chair summarized discussion points in order to facilitate 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:				

Complaints Received between
01-May-2021 and 22-Sep-2021

Complaint Received	Total Cases	
May/2021	11	
June/2021	4	
July/2021	6	
August/2021	13	
September/2021	9	
Grand Total	43	

Length of time required to acknowledge complaints received between 01-May-2021 and 22-Sep-2021

Complaints Acknowledge In	Total Cases
	5
2 days or less	26
3-5 days	3
6-10 days	4
Greater than 10 days	5
Total number of complaints cases in time period:	43



Length of time required to resolve complaints for cases closed between 01-May-2021 and 22-Sep-2021

Complaints Cases with	Total
0-60 days	4
61-90 days	15
91-120 days	12
121-150 days	3
151-180 days	2
	36