Wednesday, June 9, 2021 | 8:00 a.m. |

AGENDA

Virtual Meeting via Zoom

Time		Item		Action		Page #
5 min	8:00 am	1.	Opening Remarks		Dr. Elliott	
0 min	8:05 am	2.	Agenda – Approval		Dr. Elliott	
0 min	8:05 am	3.	Call for Conflict of Interest		Dr. Elliott	
5 min	8:10 am	4.	Council Meeting Minutes March 19, 2021	Approval	Dr. Elliott	3
50 min	9:00 am	5.	Standard of Practice Virtual Medicine	Approval for consultation	Dr. Elliott	9
45 min	9:45 am	6.	Standard of Practice Documentation in Patient Records Standard of Practice Maintenance of Patient Records	Approval for consultation	Dr. Stacey/ Mr. de Jong	16
20 min	10:05 am	7.	--Break--			
30 min	10:35 am	8.	Standard of Practice Duty to Report	Approval	Dr. Convery	48
45 min	11:20 am	9.	Standard of Practice Performing Office Based Procedures	Approval for consultation	Dr. Convery	110
10 min	11:30 am	10.	Standard of Practice Home Births	Approval	Dr. Ripstein	123
10 min	11:40 am	11.	Standard of Practice Medical Assistance in Dying	Approval	Ms Arnason	125
25 min	12:05 pm	12.	Strategic Organizational Priorities Annual Setting	Information	Dr. Elliott/ Dr. Ziomek	139
10 min	12:15 pm	13.	Standard of Practice Episodic/House Calls/Walk-in Clinic Care	Approval	Dr. Suss	143
20 min	12:35 pm	14.	--Break--			
15 min	12:50 pm	15.	Operating Budget 2021 – 2022	Approval	Dr. Elliott/ Dr. Ziomek	145
5 min	12:55 pm	16.	Appointments to Committees	Approval	Dr. Elliott	149

Time		Item		Action		Page #
5 min	1:00 pm	17.	Accredited Facilities Bylaw Amendment – PRC to approve Standard – Retinal Procedures	Approval	Dr. Mihalchuk	155
5 min	1:05 pm	18.	Registrar/CEO Report	Information	Dr. Ziomek	158
15 min	1:20	19.	COVID-19	Discussion	Dr. Elliott	
0 min	1:20 pm	20.	Meeting Dates and Attendance Record	Information	Dr. Elliott	161
15 min	1:35 pm	21.	Review of Self-Evaluation of Governance Process – In Camera		Dr. Elliott	163
5 hrs 35 min			Estimated time of sessions			

Meeting of Council – March 19, 2021

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on Friday, March 19, 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. Ira Ripstein.

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

MEMBERS:
Dr. Joshua Aquin
Ms Nasreen Merali (from 8:34 to 9:00 only)

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
Dr. Ian Wilkinson, Director MANQAP
Ms Jo-Ell Stevenson, Manager Qualifications
Ms Wendy Elias-Gagnon, Communication Officer
Ms Karen Sorenson, Executive Assistant
Ms Lynne Leah, Executive Assistant

2. ADOPTION OF AGENDA

IT WAS MOVED BY DR. ERIC SIGURDSON, SECONDED BY DR. ROGER SUSS:
CARRIED:

That the agenda be approved as presented.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

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

4. ADOPTION OF MINUTES

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY DR. MARY JANE SEAGER:
CARRIED

- That the minutes of the December 9, 2020 meeting be accepted as presented.

PRESIDENT-ELECT ELECTION RESULTS

The outcome of the election declared Dr. Nader Shenouda as the successful candidate.

5. STANDARD OF PRACTICE – SEXAL BOUNDARIES WITH PATIENTS, FORMER PATIENTS & INTERDEPENDENT PERSON

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

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

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

Council hereby approves the Standard of Practice – Sexual Boundaries with Patients, Former Patients & Interdependent Persons to be effective on March 31, 2021 and repeals Sections 6, 7, and 8 of the Good Medical Care Standard of Practice on March 31, 2021.

6. STANDARD OF PRACTICE DUTY TO REPORT SELF, COLLEAGUES, OR PATIENTS

Creating a Duty to Report Standard of Practice is a CPSM Strategic Organizational Priority. A Working Group was formed in the fall after the Terms of Reference were approved by Council in September 2020.

The Working Group chaired by Dr. Convery prepared three documents and recommended to Council that these documents be distributed to the public, stakeholders, and members for consultation:

- Standard of Practice for Duty to Report
- Contextual Information and Resources
- FAQs

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. NADER SCHENOUDA that:
CARRIED with 19 in favour and 4 objections

Council hereby approves the Draft Standard of Practice Duty to Report Self, Colleague, or Patient for distribution and consultation with the membership, the public and stakeholders.

7. PRESCRIBING PRACTICES POLICY

CPSM has embarked upon an initiative to improve the quality prescribing practices of its members. The first initiative addressed opioids. This has now been expanded to include benzodiazepines, Z-Drugs and the authorization of medical cannabis, along with polypharmacy in general. There is a need for a policy regarding the Prescribing Practices Program to establish the purpose/objectives, authority, etc.

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

Council hereby approves the Prescribing Practices Program Policy.

8. QUALITY DEPARTMENT LAUNCH

The Quality Department has as its mission statement “At the intersection of practice and patient safety”. This focus on improving members’ practice of medicine and enhancing patient safety is at the core of the many functions of the Quality Department, whether Prescribing Practices Program, Quality Improvement, Standards Committees, or accreditation of facilities. The new Quality Department’s focus is in keeping with CPSM’s regulatory mandate of regulating its members in the public interest.

The Assistant Registrar (Quality) will provide Council with a summary of the reorganization into the Quality Department, the rationale for change and highlight improvements to CPSM’s ability to deliver on our regulatory mandate for the future.

9. ANTI-INDIGENOUS RACISM MATTERS

FMRAC recently has adopted, as one of its ongoing priorities, Addressing Racism in Physician Practice. 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.

While the University of Manitoba leads the country with an 80-hour requirement for teaching indigenous cultural competence and many CPSM members might take such training through their affiliations or employment with the Health Authorities, many members have no such training if they are unaffiliated with the system etc. This is particularly important demographic to reach as some are older or are International Medical Graduates who have no background knowledge of the history and/or current state of racism.

Internally for staff, CPSM has made a course of 5 hours on Indigenous Cultural Competence mandatory. It has been followed up by discussion sessions.

CPSM is intending to work with FMRAC to determine what it can do to assist anti-Indigenous racism in the practice of medicine. Other organizations such as CFPC, Royal College, MCC and others have made commitments to address anti-Indigenous Racism in the health care system. It is important that CPSM work with others who have common goals for the medical profession. It is even more important that CPSM and other regulatory bodies listen to and be led by the Indigenous Physicians Association and other indigenous organizations on these matters.

10. MANQAP

In December 2015 Council decided to advise Manitoba Health of its intention to discontinue the operation of the Manitoba Quality Assurance Program.

Manitoba Health has been unable to transition MANQAP to either itself or another body. At the provincial government level, Shared Health has been formed with a new Quality Assurance mandate and health care transformation is well underway.

At CPSM, with the restructure of the Standards Department into a Quality Department and the new requirements for Non-Hospital Medical and Surgical Facilities Accreditation it is now recommended that MANQAP should remain with CPSM and use its expertise to assist in areas such as Non-Hospital Accreditation.

If Council is in agreement with this recommendation, then the above decision from December 2015 must be rescinded.

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

The following motion from December 2015 be rescinded and Manitoba Health Seniors and Active Living be informed:

That College of Physicians & Surgeons of Manitoba give formal notice to Manitoba Health of its intention to discontinue the operation of MANQAP, with directions as follows:

i. That the Registrar communicate with members in relation to this decision.
ii. That the Registrar work with government to ensure an appropriate transition of this important program.
iii. That the President and President-Elect approve the specific terms of the transition.

11. STANDARD OF PRACTICE FOR PRESCRIBING BENZODIAZEPINES

The Standard of Practice for Prescribing Benzodiazepines became effective November 1, 2020.

Since then, CPSM has received numerous informal complaints from patients regarding one aspect of the new Standard of Practice for Prescribing Benzodiazepines and Z-Drugs. The Standard requires monthly dispensing; accordingly, monthly dispensing fees are incurred.

Members of the Working Group were asked to review this matter and make a recommendation to Council – keep, alter, or delete this requirement.

The Working Group was unanimously in strong agreement to not alter the Standard.

Since the review, CPSM staff have put together a FAQ for the Standard of Practice. This document will be added to the end of the Standard of Practice Document as well as placed on CPSM's website as a stand-alone document in both the Prescribing Practices Program page and "For The Public" page. It will also be provided to patients who phone CPSM with inquiries.

12. STRATEGIC ORGANIZATIONAL PRIORITIES UPDATE

Councillors were presented with the Progress Chart for the Strategic Organizational Priorities and progress.

13. COVID-19 UPDATE AND DISCUSSION

The Registrars have participated in several conversations and meetings with Shared Health, Public Health, and others on pandemic regulatory matters, including the standard of care during a pandemic, duty to provide care, and withdrawing and withholding medical care.

CPSM participated in an Advisory Task Force on Delivery of COVID-19 Vaccines in Medical Clinics. From the regulatory perspective, it is important to establish and communicate the expectations of the profession in the delivery of vaccines and providing medical advice on vaccines.

CPSM participates in a meeting every two weeks with the leaders of Public Health and the CMOs to discuss matters relating to the profession and the pandemic.

14. CEO/REGISTRAR'S REPORT

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

15. COMMITTEE REPORTS

The following Reports were presented to Council for information:

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

16. IN CAMERA SESSION

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

There being no further business, the meeting ended at 12: 10 p.m.

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Dr. I Ripstein, President

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Dr. A. Ziomek, Registrar

COUNCIL MEETING – JUNE 9, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Standard of Practice – Virtual Medicine

BACKGROUND

There is a need for an updated Standard of Practice on virtual medicine for physicians in Manitoba. With the onset of the COVID-19 pandemic, members introduced virtual medicine literally overnight when a new tariff for virtual care was implemented. CPSM immediately introduced some interim guidance on virtual medicine in March 2020 to adapt to the pandemic. Members continue to practice medicine with a mix of virtual and physical care utilizing this temporary guidance. Much experience has been gained on the benefits and disadvantages of virtual medicine since then. Guidance is required on numerous aspects of virtual medicine, including what medical care can or can not be provided by virtual medicine.

At its June 2020 meeting, Council directed the Registrar to proceed with the strategic organizational priority of updating the Standard of Practice for Virtual Medicine. This is particularly timely given the immediate shift to virtual care by much of the medical profession during the COVID-19 pandemic. The Virtual Medicine Standard of Practice (and other rules) are to be updated to reflect the changes and experiences gained by the several months of extensive use by the profession. This is important and timely as crucial elements of practicing medicine changed very significantly during this pandemic, recognizing virtual medicine, new technologies, and new prescribing practices to mention just a few items. It is considered these changes will not be temporary, but permanent.

Virtual medicine has proven to be extraordinarily beneficial for many patients – there is ease of access, no requirement to take time off work/school for every medical appointment, no onerous travel requirements for those living a significant distance for their medical appointment, patients with mobility challenges can access virtual care from their homes, parents do not have to take multiple children to the appointment of one child, permitted medical care for those unable to leave their homes due to COVID-19, etc.

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. Many members are also seeing patients who have not received good medical care via virtual medicine. It is critical that virtual medicine must be balanced with in-person appointments and both must provide good medical care to patients.

Virtual Medicine has created financial opportunities in the business of medicine. Recent Initial Public Offerings in Canada of virtual medicine companies have been in the range of over one hundred million dollars.

A Working Group chaired by Dr. Jacobi Elliott met on numerous occasions, virtually, of course. Members came from the following practice areas:

- Family Medicine, General Practice (Winnipeg, other cities, and rural)
- Internal Medicine
- Pediatrics

- Neurology
- Emergency Medicine
- Psychiatry
- Cardiology
- Urology

There were three public representatives on the Working Group, two of whom are Councillors, the other with a background in ethics.

Parts of this Standard are based upon the FMRAC (Federal Medical Regulators Association of Canada) Framework for Telemedicine. Other regulators are working on the new rules for Virtual Care following the introduction of virtual care in the COVID-19 pandemic.

The Standard of Practice for Virtual Medicine includes the ethical, professional, and legal obligations for members practicing virtual medicine. The general principle is that an acceptable standard of care requires regular in-person care and it is an unacceptable standard of care to solely practice virtual medicine. The minimum requirements for assessing the appropriateness of virtual medicine for each patient encounter are included as are the minimum requirements for physical assessments and continuity of care.

CPSM previously circulated an Information Sheet to all CPSM members and public representatives on Council regarding Across Border Virtual Medicine, advising them of the legal aspects of providing medical care across provincial and international borders. It was linked to Doctors Manitoba information on tariffs for virtual medicine.

The Working Group recommends the Standard of Practice for Virtual Medicine be approved by Council for distribution to the members, public, and stakeholders for consultation.

Consultation

Upon Council approval, CPSM will launch 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 is readily accessible to the public, it will be available as an online survey with pre-determined questions and an option to provide additional comments. The actual Standard will be available too for comment. Registrants will have the opportunity to submit their feedback in written form as usual.

CPSM will communicate the consultation in several ways:

To registrants:

- Place 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:

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

- Target media outlets to have a representative on air to encourage public participation in the consultation:
  - CTV Morning Show
  - CTV News
  - CBC Radio
  - CJOB
  - Canstar Community News
  - ChrisD.ca (Winnipeg news blog)
- Invite 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)

PUBLIC INTEREST RATIONALE

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

All medical care provided, whether in-person or virtual, must adhere to all other standards of practice and to the standard of good medical care prescribed by the CPSM Standards of Practice Regulation:

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

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.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 9, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

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

Standard of Practice

Virtual Medicine

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. DEFINITION

1.1. Virtual Medicine means the provision of medical care by means of electronic communication where the patient and the member are at different locations, including but not limited to treating, advising, interviewing or examining the patient. *CPSM Standards of Practice Regulation*, s. 1.

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 mobility constraints, and in a pandemic.
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. An acceptable standard of care requires regular in-person care. It is an unacceptable standard of care to solely practice 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 insurance 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;

4.2.1.ii. Take appropriate 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.

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 arrange for 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;

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.

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

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. Referring patients to a walk-in clinic or the Emergency Department in non-emergency circumstances 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 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;

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

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.

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.

COUNCIL MEETING – JUNE 9, 2021

NOTICE OF MOTION FOR APPROVAL

SUBJECT

Standard of Practice for Documentation in Patient Records
Standard of Practice for Maintenance of Patient Records

BACKGROUND

The current Standard of Practice for Patient Records was chosen as a Strategic Organizational Priority and scheduled for review in 2020/21 and a Working Group was struck for that purpose. Several areas of improvement have been identified by CPSM and the profession.

1. Standards already prevailing in the medical profession for documentation of care in patient records and for the maintenance of patient records have outpaced the current wording of CPSM's Standard for Patient Records.
2. Modernization in the health care system and the near complete transition to digital platforms is not adequately addressed.
3. The current Standard of Practice does not always provide guidance in some situations where it should, particularly relating to:
    a. the appropriate documentation of longitudinal care,
    b. rules respecting custody and control arrangements, and
    c. mitigating the risk patient records may be abandoned.
4. Inadequate Patient Records are often associated with poor care identified in CPSM's Complaints and Investigation Department and the Quality Department. Notably, this is a common thread in the majority of recent CPSM disciplinary matters.

A priority is to declare important principles clearly and comprehensively regarding documentation in patient record and maintenance of patient records for the benefit of the public and the profession. This will greatly assist CPSM in responding to inquiries from the public.

THE WORKING GROUP

The Working Group was composed of members of CPSM, both from institutional and non-institutional settings and two public representatives. It was chaired by Dr. Brett Stacey.

The group was convened to review the current Standard for Patient Records and to develop a draft CPSM Standard of Practice for Patient Records to be presented to Council and subsequently circulated to the members, stakeholders, and the public.

The Working Group met on several occasions and reviewed numerous drafts. It determined early on 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 for Maintenance of Patient Records.

Relevant Information and Considerations in Making this Standard

The Working Group reviewed and considered the statutory framework in Manitoba relating to Patient records, including:

- The College of Physicians and Surgeons of Manitoba Standards of Practice Regulation
- The Standards of Practice of Medicine
- *The Personal Health Information Act* and *The Personal Health Information Regulation*
- *The Regulated Health Professions Act*
- The CPSM General Regulation
- The CPSM Code of Ethics

The Working Group considered all standards from other Canadian Medical Regulatory Authorities in its report. Acknowledging changes will come under Shared Health, the Working Group further considered all institutional rules in this jurisdiction from each Regional Health authority to satisfy itself there was limited need to establish revised standards for institutional settings.

Consultation

All proposed Standards of Practice must be distributed to the membership, stakeholders, and the public for consultation before they can be established by Council.

Through consultation, input will be sought respecting the proposed patient records standards and may be incorporated by Council prior to adoption. At this point, approval is being sought to distribute this Standard and seek consultation with the membership.

The Working Group was particularly alive to the highly complex nature of personal health information regulation. It looks forward to receiving input from diverse perspectives during the public consultation. Implications to Electronic Medical Records service providers, information managers and Manitoba's Digital Health will be of interest.

WORKING GROUP SUMMARY REPORT

1. Documentation Standard

Overall

Modifications to documentation standards are considered to be a reflection of already prevailing standards in the medical profession. There is significant benefit to declaring these standards, not just for the profession but also for the public. The adoption of a requirement for a cumulative

summary of patient care is considered significant, though the working group is of the view that the vast majority of the professional will already have this in place. It is a general feature of most if not all EMR systems. Numerous other Canadian jurisdictions have adopted this requirement.

Templates and macros

Serious consideration was given to requiring that members not use pre-populated templates and macros. CPSM has reviewed many instances where pre-populated data that appears in patient records is not accurate, including out-dated or inappropriate vitals, lab results, history, or physical findings. Templates used for procedures are also problematic in that some practitioners have used the same note, without modification whatsoever, for the procedures they do rendering the note essentially meaningless. Where data is not accurate or is incomplete, it is extraordinary challenging to determine the reliability of the data or what might have been missed through retrospective analysis.

To address particularly problematic categories of templates and macros, consideration was also given to prohibiting certain types of pre-populated data, for instance physical findings and history. It also considered limiting members to only using prompts rather than pre-populated responses or findings. Ultimately, it was acknowledged that the vast majority of members appropriately review and modify macros and templates that they use. The benefits to members who make appropriate use of templates and macros include efficiency and completeness in their record keeping.

Following the requirements of the Standard as worded will ensure appropriate use of templates and macros. Given the clear wording of the draft standard, if members elect to use templates and macros, heightened diligence is expected. Erroneous inclusions or omissions that result from a member's decision to use templates and macros should be considered a significant departure from the expect standard of care and treated serious when identified in any CPSM review.

Copying and pasting

It is emphasized in the draft standard that copying and pasting an entry from a prior encounter is to be avoided. This practice carries significant risk of information no longer relevant to the specific visit could be included in the new encounter note. Copying and pasting can result in important new information being lost amongst needlessly repetitive information in the patient record.

Billing related documentation

Members are required to include in their patient records information related to billing tariffs under the *Health Services Insurance Act.* CPSM has encountered instances where information is entered in patient records to meet certain billing criteria that does not actually reflect care provided. This is highly problematic for both the patient and the system. While CPSM does not

provide guidelines for professional fees, it is responsible for ensuring that members' billing practices do not compromise the integrity of patient records. The standard now specifically addresses this important issue.

Cumulative Summary of Care

Those who provide patients with longitudinal care must have an area in the patient record that reflects care over time that can be viewed at a glance to ensure the patient is properly followed. It is already considered standard of care to have this as a component of patient records and is automatically generated in some form in most if not all EMRs. Numerous other medical regulatory authorities in Canada have entrenched this standard in their written requirements. The draft Standard for documentation extends this requirement beyond primary care providers to those who are essentially acting in that capacity in light of the regularity and consistency with which a patient attends their practice.

2. Maintenance Standard

Overall

Modifications to maintenance standards are considered to be a reflection of what is already considered good practice in the medical profession. There is significant benefit to declaring these standards, not just for the profession but also for the public.

Custody and control

CPSM has encountered significant challenges associated with custody and control arrangements, particularly when members change practice locations or leave practice. Declaring standards that are clear and comprehensive in this area is highly recommended. The Working Group believe the new draft standard accomplishes that objective.

Maintenance agreements

Mandating maintenance agreements, particularly in situations where disputes regarding custody of control are known to arise, will mitigate the risk of dispute. This requirement will ensure that a clear understanding as to roles and responsibilities is established in Manitoba medical clinics.

Patient Record Abandonment

A requirement for a plan to avoid the risk of abandonment has been added.

PHIA

The working group has added far more robust reference to PHIA as compared to the current standard. This is intended to assist the membership and make clear that following PHIA is a legal and professional requirement.

3. Other authorities

It considered all standards from other Canadian Medical Regulatory Authorities.

Acknowledging changes will come under Shared Health, the working group considered all institutional rules in this jurisdiction from each Regional Health authority to satisfy itself there was limited need to establish revised standards for institutional settings.

CONSULTATION

Upon Council approval, CPSM will launch a public consultation of the draft Standard of Practice for Documentation In Patient Records and Maintenance Of Patient Records.

Registrants will have the opportunity to submit their feedback in writing. CPSM will communicate the consultation in several ways:

- Announcement on CPSM website
- An email from the Registrar
- Announcement in the CPSM June Newsletter
- An email reminder from the Registrar halfway through the consultation window

The consultation will be shared with the public in several ways:

- Announcement on CPSM website
- Distributed to CPSM stakeholder groups
- Distributed to Electric Medical Records companies (Canada)
- Distributed to Manitoba-based patient advocacy groups
- Messaging for this consultation will be included on any TV/radio/online coverage gained for the virtual medicine consultation
- An advertisement in the Winnipeg Free Press

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" (subsection 10(1) RHPA).

The section at the beginning on the Need for a Standard of Practice also forms part of the public interest discussion.

CPSM's overriding public interest mandate includes the duty to declare and uphold the standards of practice of medicine. This mandate requires that CPSM:

1. Develop, establish, and maintain standards of practice to enhance the quality of practice by members and monitor compliance with and enforce those standards.
2. Promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.

CPSM meets this mandate, in part, by establishing clear requirements in CPSM's Standards of Practice of Medicine, to which members are legally required to comply. To maintain the confidence of the profession, the requirements must be reasonable and fair.

In developing these Standards, it is recognized that good medical care and patient safety require good patient records. These Standards seek to ensure patient safety and good medical care have been paramount in their requirements.

Three aspects of the new Standards that mark a significant update from the current Standard for Patient Records that were added to address prevalent concerns in the profession for achieving good medical care are:

1. the requirement for a cumulative summary of care,
2. the requirement for maintenance agreements with specific components, and
3. the requirement that members have a plan in place to mitigate against the risk that patient records could be abandoned.

These requirements address issues frequently brought to CPSM's attention in recent time. The wording in the new Standards is focused on promoting practices that contribute to good care, protecting patients from disputes related to custody and control of patient records, and ensuring patient records are properly maintained and not abandoned.

RECOMMENDATION OF WORKING GROUP:

The recommendation of the Working Group is for Council to approve the draft Standard of Practice for Documentation in Patient Records and the draft Standard for Maintenance of Public Records, as attached, for distribution and consultation with the membership, stakeholders, and the public.

ATTACHMENTS

- Appendix A - Draft Standard of Practice for Documentation in Patient Records
- Appendix B - Draft Standard of Practice for Maintenance of Patient Records in All Settings

The Current Standard for Patient Records can be found at this link should a member be interested in comparison.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF THE COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 9,2021, DR. NADER SHENOUDA, PESIDENT-ELECT, WILL MOVE:

1. Council hereby approves the draft Standard of Practice for Documentation in Patient Records for distribution and consultation with the membership and stakeholders.

2. Council hereby approves the draft Standard of Practice for Maintenance of Patient Records for distribution and consultation with the membership and stakeholders.

Standard of Practice

Documentation in Patient Records

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.

PREAMBLE

This Standard sets out the requirements of members for documentation of medical care. It is separated into four parts:

1. Definitions
2. General requirements for all practice settings
3. Requirements specific to non-emergency department outpatient care
4. Requirements specific to inpatient care and emergency department care

The requirements in this Standard are in addition to those required in sections 5, 10 and 11 of the College of Physicians and Surgeons of Manitoba Standards of Practice Regulation ("Standards Regulation") and The Personal Health Information Act, CCSM c. P33.5 ("PHIA"). Unless otherwise stated, the requirements of this Standard are to be read in conjunction with other documentation requirements for certain clinical situations that are set out in other CPSM Standards of Practice of Medicine. Maintenance requirements for patient records and the record of appointments members must keep are dealt with in CPSM's Standard for Maintenance of Patient Records.

STANDARD OF PRACTICE

1. DEFINITIONS

For the purposes of this Standard:

1.1. **"Patient record"** means a record containing the information described at section 11 of the **Standards Regulation**. Section 11 of the **Standards Regulation** provides:

> *11(1) A member must appropriately document the provision of patient care in a record specific to each patient.*
>
> *11(2) A member must document on the patient record the medical care given to the patient containing enough information for another member to be sufficiently informed of the care provided.*

1.2. **"EMR"** means an electronic medical record or electronic patient record and includes any computer-based patient record that is created digitally or stored digitally (e.g., a patient record that has been scanned).

1.3. **"Inpatient"** means a patient to whom a member provides care while the patient is admitted in an institutional setting (e.g., hospital).

1.4. **"Institutional setting"** has the same meaning as it does elsewhere in the CPSM's Standards of Practice of Medicine, which is:

> *(a) a facility that is designated as a hospital under The Health Services Insurance Act; or*
>
> *(b) a hospital or health care facility operated by the government, the government of Canada, a municipal government, a regional health authority or CancerCare Manitoba.*

1.5. **"Outpatient"** means a patient who is not admitted as an inpatient at an institutional setting. This includes patients attending an emergency department who are not admitted and patients who have been discharged from an institutional setting.

1.6. **"Non-Emergency Department Outpatient"** means the same as paragraph 1.5, above, but excludes patients being cared for in an institutional emergency department or institutional urgent care department who are not admitted.

2. GENERAL REQUIREMENTS FOR ALL SETTINGS

Part 2 sets out requirements for documentation in patient records that apply to all members who provide care during one or more encounters to either inpatients or outpatients regardless of the practice setting in which the care was provided, whether care is provided in person or virtually or whether the documentation is paper based or digitally stored.

Overarching principles for documentation

2.1. To meet this Standard, care must be documented in the patient record in a manner that facilitates:

2.1.1. maintenance of the expected standard of care over time,

2.1.2. other members or health care professionals acting on significant information in the patient record as and when required, and

2.1.3. a meaningful review or audit of the care provided by others, including by CPSM and other authorized health authorities when required.

2.2. Sections 5 and 11 of the **Standards Regulation** establish that members:

> *Must appropriately document the provision of patient care in a record specific to each patient*.

And:

> *When a member and one or more other health care providers are involved in the health care of a patient, the member must … document, on the patient record, the member's contribution to the patient's care.*

Institutional rules and bylaws

2.3. Members who provide either outpatient or inpatient care in an institutional setting must comply with all legislation, by-laws and rules established by the institution. For members who provide care in an institutional setting:

2.3.1. where this Standard imposes requirements more onerous than those of the institution, then the more onerous requirements in this Standard must be followed, and

2.3.2. where this Standard imposes requirements less onerous than those of the institution, then the more onerous institutional requirements must be followed.

PHIA

2.4. It is a professional obligation that members be aware of and comply with PHIA's requirements for the collection, use and disclosure of personal health information.[1]

Record of Appointments for non-emergency department outpatient care

2.5. While not part of an individual patient's patient record, members must create and maintain a record of appointments for their practice in accordance with section 10 of the **Standards Regulation**, which states:

> *A member must keep a record of [their] appointments with patients and those persons seeking medical care indicating, for each day, the names persons seen and patients for whom medical care was provided.*

[1] Health, Seniors and Active Living provides useful and comprehensive information and resources, including educational materials and templates, on its website: https://www.gov.mb.ca/health/phia/

Patient identification and contact information

2.6. Members must ensure that both patient identification and reliable contact information are captured in the patient record.

2.6.1. Standard identifiers, including the patient's full name, date of birth, MHSC number, PHIN number and gender identity must be collected and documented.

i. If not available, the reason must be documented.

2.6.2. Standard contact information, including the patient's name, telephone number, address, and an emergency contact person must be collected and documented.

i. If not available, the reason must be documented.

ii. Secondary options for contact information may include an email address or contact information of an agreed upon intermediary.

Accuracy and completeness

2.7. Members must maintain accurate, up to date and complete patient records. This requires that they:

2.7.1. create entries contemporaneous with any care provided to a patient or as soon as reasonably possible thereafter, and

2.7.2. clearly indicate sources of information when it is not provided directly by the patient to the member or is not otherwise obvious by virtue of the nature of the information, and

2.8. In creating an entry, the use of templates or macros carries substantial risk that information not relevant to the specific patient's actual clinical circumstance or the specific encounter may inadvertently be included in the patient record, rendering the entry unreliable or inaccurate. For this reason:

2.8.1. Prepopulated templates should be avoided.

2.8.2. Members who use templates and macros must thoroughly review them and ensure that:

i. the content accurately reflects the care given, and

ii. the encounter is captured in a comprehensive way that does not contain inaccurate information or information not obtained during the encounter.

2.9. Members must not copy and paste an entry related to a prior encounter with a patient unless the copied entry is modified to remove outdated information and include current information which reflects the actual circumstances the encounter entry is meant to reflect.

2.10. Members must avoid the use of abbreviations that are:
  2.10.1. peculiar to only the person creating the entry such as to be confusing or unknown to other readers,
  2.10.2. known to have more than one meaning in a clinical setting, or
  2.10.3. that are otherwise not commonly used or understood in the member's area of practice.

2.11. Members must take care to ensure that any documentation made in the patient record used for the purpose of remuneration faithfully represents the care provided. Diagnoses entered for the purpose of remuneration are used for public health surveillance, policy decisions and research, thus this Standard mandates that care should be taken to ensure all patient record entries accurately reflect the care provided during an encounter.

Communication with patient

2.12. Members must include in the patient record (e.g., through document scanning, file upload, or other means) details of all communication with patients related to clinical care provided by the member that occur via telephone, or other digital means (e.g., e-mail, patient portals or other digital platforms), including the mode of communication.

Organization and intelligibility

2.13. Documentation in the medical record must be understandable, legible, and organized in an appropriate chronological and systematic manner.

2.14. Documentation in patient records must be in English.

Date and time of entries

2.15. Members must ensure that each entry in a patient record is dated and, when appropriate, timed. Members need not personally enter the date or time when that is already done by a digital system. If an entry is not made contemporaneous with the medical care given (i.e., the entry is made later), then the member must clearly indicate as part of the entry:
  2.15.1. the date and time for both the patient encounter and for the entry, and
  2.15.2. that the entry is a late entry.

Alterations

2.16. Original entries in patient records must not be altered after the entry is made.
  2.16.1. Where it is necessary to correct inaccurate, incomplete, or otherwise misleading information in the patient record, the member must date and sign off on the additions or modifications and either:

i. maintain the incorrect information in the patient record, which may be automatically done digitally, clearly label the information as incorrect, and ensure the information remains legible (e.g., by striking through incorrect information with a single line), or
ii. remove and store the incorrect information separately and ensure there is a notation in the patient record that allows for the incorrect information to be traced and readily accessible during the retention period of the patient record.

2.17. Where alterations are made, members must consider whether to notify any health care providers involved in the patient's care, particularly when the correction would have an impact on treatment decisions.

Corrections at patient's request

2.18. Members must comply with section 12 of PHIA[2, 3] respecting the patient's right to request a correction in a patient record. This includes that members must reasonably notify patients in their professional practice about their access and privacy rights, including the right to request a correction.[4]

3. REQUIREMENTS SPECIFIC TO NON-EMERGENCY DEPARTMENT OUTPATIENT CARE

This part sets out requirements for patient records for all non-emergency department outpatient care, which is most often provided in a medical clinic setting. For greater certainty, use of the term outpatient in this part (i.e., Part 3) includes care provided in an outpatient clinic within an institutional setting. Specific requirements for emergency care in an institutional emergency department or urgent care department are dealt with at Part 4 along with requirements for inpatient care.

Documentation of expectation of ongoing care

3.1. Appropriately documenting the provision of outpatient care will often depend on the nature of the professional relationship the member has with the patient and the care the patient reasonably expects from the member, including expectations for longitudinal care. In this respect, members must:

[2] *The Personal Health Information Act*, CCSM c. P33.5, at subsections 12(1) – 12(6)
[3] Helpful information about what is required when a patient requests a correction is contained in the 'PHIA Policy and Procedure Requirements' document published on the Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html
[4] Health, Seniors and Active Living has created a poster which will adequately meet this requirement when posted on a medical clinic's website and at its physical location. The poster is available on their website: https://www.gov.mb.ca/health/phia/docs/access_privacy_rights.pdf

3.1.1. ascertain the nature of the relationship, including whether there is a reasonable expectation they will continue to see the patient, and

3.1.2. ensure the patient record reflects whether the member or the member's clinic[5] are considered the patient's usual primary care provider, or, if not, whether the patient has a primary care provider and the name of that provider.

Components of a complete patient record

3.2. For non-emergency department outpatient medical care, the patient record should contain the following components as applicable:

3.2.1. Cumulative summary of care when required (see below at paragraph 3.4)
3.2.2. Encounter notes, for consultants this may be the consultant's report(s)
3.2.3. Referral letters and consultant reports
3.2.4. Requisitions (e.g., labs, diagnostics)
3.2.5. Lab and imaging reports
3.2.6. Pathology reports
3.2.7. Hospital (e.g., inpatient admission) and discharge summaries, including ER reports
3.2.8. Surgical and procedural reports
3.2.9. Tasks and communications
3.2.10. Insurance and third-party related forms (e.g., WCB, MPI, disability, etc.)
3.2.11. Other reports or documents as appropriate

Encounter note principles

3.3. All members must document, or already have in the patient record, the following for all outpatient encounters, including respecting acute or episodic care:

3.3.1. A focused subjective history, including as indicated:
i. a history of the presenting complaint,
ii. appropriate social history and risk factors,
iii. pertinent family medical history,
iv. allergies,
v. active problem list,
vi. active medications,
vii. an appropriate review of systems, and
viii. any other areas as appropriate in the clinical circumstance.

3.3.2. Relevant objective examination, including adequate positive and negative findings from focused physical examination.

[5] When a patient attends repeatedly and consistently at the same medical clinic, then they are assumed to be receiving their primary health care from that clinic. The members and medical director are collectively responsible for offering these patients longitudinal medical care.

3.3.3. An appropriate assessment, including notation of tentative, differential, working or established diagnosis or diagnoses.

3.3.4. Adequate information about the plan, including the following as applicable:

i. all tests or investigations requisitioned, including a copy of the requisition, and any associated reports and results (e.g., laboratory, diagnostic, pathology),

ii. adequate information about referrals to and consultation and collaboration with other health care providers,

iii. adequate information about the management plan for the patient such that it can be understood by another member, including respecting actions taken based on examination(s) or investigation(s) and plans for follow up,

iv. any prescriptions issued, rationale for the prescription and plan for management of same, and

v. adequate information about any treatment or therapy provided, including procedural records, and the patient's response and outcomes.

3.3.5. Any treatments, investigations, or referrals that have been declined or deferred and the reason, if any, given by the patient, and discussion of the risks.

3.3.6. Significant discussions with the patient pertinent to their care, including advice given to the patient respecting any of the above.

3.3.7. Any other areas as appropriate in the clinical circumstance.

Cumulative summary of care

3.4. Members should always maintain an up-to-date cumulative summary of care when doing so reasonably contributes to quality medical care (e.g., summary cover sheet or section in written chart or EMR summary of care). A cumulative summary of care is required as part of the patient record if one or more of the following apply:

3.4.1. the member is the patient's usual primary care provider,

3.4.2. the patient has attended the member repeatedly and consistently, irrespective of whether one or more of the individual encounters may be considered acute or episodic, or

3.4.3. the patient has repeatedly and consistently attended the health care facility (e.g., medical clinic) where the member practices for outpatient medical care either from the member or another member with whom the member practices in association (e.g., a group medical practice). In this context, the facility's medical director and all members at the facility who see the patient are collectively responsible for populating the cumulative summary of care over time.

3.5. A cumulative summary of care must include the following when the information is available and relevant (i.e., components required will be what is appropriate to the care needs of the patient and dependent upon the member's professional practice):
- 3.5.1. Past medical history
- 3.5.2. Problem List (e.g., ongoing health conditions, chronic disease, diagnoses)
- 3.5.3. Surgical history
- 3.5.4. Medications
- 3.5.5. Allergies and significant or worrisome drug reactions
- 3.5.6. Social history, including risk factors that impact health status
- 3.5.7. Family history
- 3.5.8. Immunizations

4. REQUIREMENTS SPECIFIC TO INPATIENT AND EMERGENCY CARE

This part sets out the requirements for institutional associated inpatient care provided by a member and extends to care provided in an emergency department or urgent care department setting regardless of whether the patient is formally admitted as an inpatient at the institution. It is emphasized the requirements in Part 2, above, apply to these settings.

4.1. Members must recognize that record keeping in an institutional setting is usually multidisciplinary and team-based and must document care accordingly.

4.2. Members must always be aware of their role and responsibilities respecting the continuing care of their patients and document any transfer of responsibility for continuity of care, including in compliance with CPSM's Collaborative Care Standard (i.e., Institutional Settings - Transfer of Care).

4.3. The member responsible for the care of an inpatient must complete an appropriately complete discharge summary in a timely manner consistent with the requirements of the institution.

4.4. Where a patient who has been seen by a member in an emergency department setting or has been admitted as an inpatient departs the institution against medical advice, the member responsible for continuing care must document:
- 4.4.1. that the patient left against medical advice,
- 4.4.2. the advice given to the patient prior to their leaving, if any, and
- 4.4.3. the reasons for departure, if known.

Standard of Practice

Maintenance of Patient Records in All Settings

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.

PREAMBLE

This Standard sets out CPSM's requirements for maintaining patient records. It applies to paper based and digitally stored patient records, whether care is provided in person or virtually. The requirements in this Standard are in addition to those at sections 10, 11, 13 and 14 of the *College of Physicians and Surgeons of Manitoba Standards of Practice Regulation* **("Standards Regulation")**.

This Standard is separated into five parts:

1. Defined terms, for the purpose of this standard
2. Other applicable authorities
    a. *The Personal Health Information Act*
    b. Institutional legislation, rules, and by-laws
3. Custody and control of patient records (i.e., maintenance responsibilities)
    a. Presumption of responsibility for maintenance
    b. Responsibility for maintenance in Institutional settings
    c. Transferring maintenance responsibilities
    d. Requirement for Maintenance Agreements
    e. General requirements for all maintenance arrangements
4. Requirements for maintaining patient records
    a. Security and storage measures
    b. Specific EMR system requirements
    c. Transitioning patient records management systems
    d. Retention and destruction of patient records and records of appointments
    e. Information managers
    f. Closing, leaving, or moving a medical practice

   g. Preparedness for unforeseen absence or termination of practice
5. Patient access rights and transferring patient records
   a. Patients' right to examine and copy information
   b. Transfer of patient records to third party

Note: CPSM requirements for documentation in patient records are dealt with in CPSM's **Standard for Documentation in Patient Records**.

STANDARD OF PRACTICE

Notice: The health care system shifts the standard of care in the practice of medicine over time. With this in mind, CPSM recognizes the adoption by members of Electronic Medical Records (EMRs) linked to the provincial government's electronic medical records systems (e.g., DPIN, eChart, eHealth, eHub) significantly contributes to the provision of good patient care. While working with an EMR linked to provincial systems has not yet been made a requirement in this Standard, CPSM considers this arrangement the current standard of care and it is expected that it will become a requirement for all members when the Standard is reviewed again in or around 2026. In the interim, it is expected that all members will make efforts to establish these links as soon as reasonably possible if they have not already done so.

1. DEFINITIONS

For the purposes of this Standard:

1.1. **"Maintain"** has the same meaning as it does in *The Personal Health and Information Act*, which is, "*in relation to personal health information, […] to have **custody** or **control** of the information.*" Respecting this Standard and relating to patient records, this meaning is expanded to include having custody or control of patient records.

1.1.1. **"Control"** means having full or partial authority and directorship over a patient record, including relating to how it is maintained. A patient record is under the control of a member when they have the authority to restrict, regulate, or otherwise administer its use, disclosure, or disposition.

1.1.2. **"Custody"** means having the protective care or guardianship of a patient record. Not to limit the foregoing, this includes having possession of a physical or virtual patient record. A person who has custody of a patient record will inherently have a degree of control over the patient record.

1.2. **"Information manager"** has the same meaning as it does in PHIA, which is, "*a person or body that (a) processes, stores or destroys personal health information for a trustee, or (b) provides information management or information technology services to a trustee*".

1.3. **"Medical clinic"** means a health care facility that is primarily focused on providing medical services to outpatients, including non-institutional sole and group medical practice settings, whether incorporated or unincorporated (e.g., family medicine office, cardiologist's office, etc.).

1.4. **"Ownership"** means having sole or joint proprietary rights to a patient record or patient records.

1.5. **"Trustee"** has the same meaning as it does in *The Personal Health and Information Act*, which is, "*a health professional, health care facility, public body, or health services agency that collects or maintains personal health information.*"

1.5.1. As health professionals, members of CPSM are considered trustees pursuant to PHIA respecting any personal health information they collect and maintain in patient records or appointment records.

1.5.2. Medical clinics fall under the definition of '*health care facility*' established at subsection 1(1) of PHIA and, therefore, are considered trustees respecting any personal health information collected and maintained.

2. OTHER APPLICABLE AUTHORITIES

This Standard forms only one part of the overall regulatory framework for patient records, personal health information, and other personal information in Manitoba and Canada. This Standard is not intended to comprehensively reference all enactments or rules applicable to patient records, personal health information, or other personal information established by government or institutional settings.

The Personal Health Information Act

Patient records contain the personal health information of patients and the legal requirements of *The Personal Health Information Act*, CCSM c. P33.5 **("PHIA")** are applicable to that information.[1] Provisions of PHIA are referenced and incorporated several times throughout this Standard; however, this Standard does not comprehensively describe all requirements of PHIA.

2.1. It is a professional obligation that members be aware of and comply with PHIA's requirements for maintaining personal health information.

Institutional legislation, rules, and by-laws

Institutions have legislation, rules, by-laws, and administrative services established by or for the institution to regulate and manage how personal health information and patient records are

[1] Health, Seniors and Active Living provides useful and comprehensive information and resources, including educational materials and templates, on its website: https://www.gov.mb.ca/health/phia/

maintained. As a result, members who practice in institutional settings will generally have a limited role, on an individual level, in the maintenance of patient records within the institutional practice setting.

2.2. Members who provide either outpatient or inpatient care in an institutional setting must comply with all legislation, rules and by-laws established by or for the institution respecting maintenance of patient records.

3. CUSTODY AND CONTROL OF PATIENT RECORDS

Members are required to create patient records for the medical care they provide in accordance with the **Standard for Documentation in Patient Records**. Once created, the patient record must be maintained in accordance with this Standard, either by the member who created the record or an appropriately delegated transferee.

Responsibility for maintenance in Institutional settings

3.1. Members who practice in an institutional setting must comply with institutional legislation, rules and bylaws respecting the control and custody of patient records that they create while practicing in that setting (see paragraph 2.2., above). Institutional settings usually assume responsibility for maintaining the patient records created by members who practice within the institution, though this must be confirmed by individual members.

Presumption of responsibility for maintenance

3.2. Members who practice in non-institutional settings (e.g., private medical clinics) are presumptively responsible for maintaining (i.e., have custody and control) the patient records that they create and their record of appointments. Paragraph 1.2.3. of CPSM's **Practice Environment Standard** establishes that:

> *If a member engages in medical care in a non-institutional setting, the member **must maintain full direction and control** of his or her medical practice, including:*
>
> > *… **documentation in, access to and security of patient records**, including documenting medical care provided to a patient, patient appointment schedules, patient billing and payment records for the medical care of a patient …*

3.3. Notwithstanding paragraph 3.2., subject to a written agreement to the contrary, a member practicing as locum tenens is not presumptively responsible for maintaining

the patient records that they create in their locum tenens capacity, rather the member for whom they are covering remains presumptively responsible.

Transferring maintenance responsibilities

3.4. Maintenance responsibilities for patient records, including those set out at Parts 4 and 5 of this Standard, may only be transferred by a member to another trustee (e.g., to another member or to a medical clinic where they practice) in accordance with subsection 11(5) of the **Standards Regulation**, which establishes that:

> *11(5) A member **must retain control** of all of his or her patient records unless they are maintained*
>
> *(a) by another member; or*
>
> *(b) by a person or organization that employed, engaged or granted privileges to the member and is a trustee under The Personal Health Information Act.*

3.5. For this Standard, subsection 11(5) of the Standards Regulation shall be read to include the record of appointments.

3.6. For institutional settings, transfer of maintenance responsibilities will typically be dealt with contractually or in the institution's legislation, rules, and by-laws. Members working within institutional settings are expected to be familiar with these authorities.

3.6.1. If institutional maintenance responsibilities respecting patient records are not clear, the member must negotiate an agreement that makes them clear, including rules about access to and custody of the patient records.

Requirement for Maintenance Agreement

3.7. For non-institutional practice settings, any transfer of maintenance responsibilities by a member respecting the patient records they create, or their record of appointments, must be in writing (i.e., a Maintenance Agreement)[2] and must be PHIA compliant. A Maintenance Agreement transferring maintenance responsibilities must be in place before responsibilities are transferred and must have the following components:

3.7.1. Pertinent details regarding who has ownership, control, and custodianship relating to the subject patient records.

3.7.2. Details about authority to access patient records in the practice setting (e.g., individuals who will be able to use the patient record).

3.7.3. Provisions to ensure enduring access related to both continuity of care and patient access rights and copying rights.

[2] CPSM has developed sample provisions for Maintenance Agreements. These are available on CPSM's website at: _____ (to be developed)

3.7.4. Required provisions stating that:
   i. the recipient trustee must give the member who created the patient record reasonable access to it to allow them to prepare medico-legal reports, defend legal actions, or respond to an investigation or review, when necessary, and
   ii. if relevant, the transferring member will always have reasonable access to their record of appointments and authority to copy same for the applicable retention period.

3.7.5. Details respecting:
   i. Security measures established by the recipient trustee that accord with Part 4 of this Standard.
   ii. Storage arrangements, including policies and procedures for the appropriate retention and destruction of patient records, that accord with Part 4 of this Standard.

3.7.6. Reasonable plans to ensure compliance with the **Standards Regulation** and **Practice Management Standard** for the following situations:
   i. The transferring member temporarily or permanently ceases practice, or changes practice locations.
   ii. The recipient trustee becomes unwilling or unable to continue to maintain the patient records (e.g., death, incarceration, etc.; see also paragraph 4.29., below).

3.7.7. Any custody and control implications upon termination of the Maintenance Agreement, if applicable, or termination of the employment, business, or practice arrangement, including implications respecting the transfer of patient records (see Part 5 under the heading 'Transfer of patient records at patient's request'*)*.

3.8. Regardless of whether maintenance responsibilities are transferred or not, all members who practice in a non-institutional practice setting must have a written Maintenance Agreement in place respecting patient records created in the practice setting if one or more of the following apply:

3.8.1. The member is practicing in a setting where there are multiple contributors to a patient record (e.g., a group or interdisciplinary practice setting with a shared electronic medical record ("EMR")).

3.8.2. The member is not the sole owner of the medical clinic.

3.8.3. The medical clinic is considered a group practice (i.e., multiple members practicing in association, in which case a medical director is required).

3.8.4. The member is not the sole EMR licensee relating to the patient records they create.

3.9. When a Maintenance Agreement is required under paragraph 3.7., it must be in place prior to the establishment of the practice, business, or employment arrangement, or as soon as possible afterward.

3.10. For transfers of responsibilities that pre-dated this Standard or situations when a Maintenance Agreement is required under paragraph 3.8., a Maintenance Agreement that complies with this Standard must be put in place within one year of the coming into force of this Standard.

General requirements for all maintenance arrangements

3.11. The following requirements apply to **all** patient records maintenance arrangements:

3.11.1. Members who maintain patient records, including those responsible for the operation of a medical clinic that maintains patient records (e.g., medical director), must give the member who created the patient record reasonable access to it to allow them to prepare medico-legal reports, defend legal actions, or respond to an investigation or review, when necessary.

3.11.2. Members moving to a new practice setting who do not have custody or control of the patient records of patients who choose to follow them from the former practice setting must obtain written consent from the patient or their legal representative to transfer copies of patient records to the new location. The transfer must comply with the requirements set out under Part 5, below.[3]

3.11.3. In all situations, members must prevent conflict from compromising patient care related to difficulties imposed by one member or medical clinic on another related to accessing patient records.

4. REQUIREMENTS FOR MAINTAINING PATIENT RECORDS

The requirements in this part relate to how patient records must be stored, secured, and retained over time by members who are responsible for their maintenance.

4.1. In all situations, it is an overarching ethical requirement in the practice of medicine that members protect the personal health information of their patients.

4.2. Members often rely on others such as: staff, EMR service providers, or information managers to assist in their patient record maintenance responsibilities. However, when that occurs the member always retains primary responsibility for maintenance, and the expectation is the member will reasonably satisfy themselves that the requirements of this Standard are being met when others assist in maintenance.

4.3. Members responsible for the operations of a medical clinic, including Medical Directors, are deemed to share jointly with the medical clinic all maintenance responsibilities respecting the patient records that the clinic maintains.

[3] In this scenario, the member would obtain, personally or through staff, written consent of the patient to transfer their patient records. This would then be provided to the trustee responsible for maintaining those records. The process at Part 5 would then be followed.

Security and storage measures

4.4. A member who is responsible for maintaining patient records (*i.e., sole, or joint responsibility*) must satisfy themselves that reasonable administrative, technical, and physical safeguards are in place to protect against:[4]

4.4.1. reasonably anticipated threats to the security of patient records, including unauthorized use, disclosure, modification, or access, or any other breach of confidentiality, and

4.4.2. reasonably foreseeable events or errors that may compromise the accuracy or integrity of patient records.

4.5. Part of safeguarding patient records will include ensuring they are stored in a safe location. Section 3 of PHIA's *Personal Health Information Regulation* establishes that trustees of personal health information are required to:[5]

4.5.1. Take reasonable precautions to protect it from fire, theft, vandalism, deterioration, accidental destruction, accidental deletion, loss, and other hazards.

4.5.2. Ensure that it is maintained in a designated area or areas subject to appropriate security safeguards.

4.5.3. Limit physical access to designated areas containing personal health information to authorized persons.

4.5.4. Ensure that removable media used to record personal health information is stored securely when not in use.

4.6. A member who is responsible for maintaining patient records must ensure that record management protocols are in place that regulate who may gain access to patient records and what they may do according to their role, responsibilities, and authority. Protocols must include:

4.6.1. Confidentiality agreements for all individuals who have access to patient records.[6]

4.6.2. Controls that limit who may access and use information contained in the patient records.

4.6.3. Controls to ensure that patient records cannot be used unless the identity of the person seeking to use the information is verified as a person the member has authorized to use it, and the proposed use is verified as being authorized under PHIA.

4.7. Members must ensure patient records are readily available and producible when access is required. When an EMR system is used to maintain patient records, the system must:

[4] Guidance in this regard in provided on the Manitoba Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html

[5] See 'Examples of Commonly Used Security Safeguards' on the Manitoba Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html

[6] Sample PHIA Pledge of Confidentiality available at: https://www.gov.mb.ca/health/phia/resources.html

4.7.1. Be capable of visually displaying and printing the recorded information for each patient promptly and in chronological order.
4.7.2. Be capable of displaying and creating a printed record in a format that is readily understandable to patients seeking access to their records.
4.7.3. Provide a way to access the record of each patient using the patient's name and health number, if applicable.

4.8. Where members choose to store patient record content that is no longer relevant to a patient's current care separately from the rest of the patient record, they must include a notation in the patient record indicating that documents have been removed from the active patient record and the location where they have been stored.

4.9. Section 2 of PHIA's *Personal Health Information Regulation* establishes that trustees of personal health information must establish and comply with a written policy and procedures containing the following:[7], [8]
4.9.1. Provisions for the security of personal health information during its collection, use, disclosure, storage, and destruction, including measures
i. to ensure the security of the personal health information when a record of the information is removed from a secure designated area, and
ii. to ensure the security of personal health information in electronic form when the computer hardware or removable electronic storage media on which it has been recorded is being disposed of or used for another purpose.
4.9.2. Provisions for the recording of security breaches.
4.9.3. Corrective procedures to address security breaches.

Specific EMR system requirements

4.10. Members must use due diligence when selecting an EMR system or engaging EMR service providers (see also paragraph 4.26, below, respecting Information Managers when applicable) and must only use electronic patient record keeping systems that:[9]
4.10.1. comply with privacy standards set out in **PHIA**,
4.10.2. comply with the requirements of the **Standards Regulation**, and
4.10.3. can fulfill the requirements set out in this Standard and the **Standard for Documentation in Patient Records**.

[7] Sample written policy available at: _____ (to be developed)
[8] See 'PHIA Policy and Procedure Requirements' on the Manitoba Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html
[9] This can be satisfied contractually.

4.11. When patient records are maintained electronically, a member responsible for maintaining them must ensure that (see also 4.6., above):
  4.11.1. Each authorized user has a private and unique login identity and password.
  4.11.2. Robust security features, including encryption, use of passwords, and access controls, are in place to protect against unauthorized access.

4.12. When an EMR system is used to maintain patient records, the system must have comprehensive audit capability that:
  4.12.1. Records user activity onto a permanent log, including:
    i. the date, time, and identity of the user when patient records are accessed, and
    ii. the date and time of each information entry for every patient and the identity of the user making the entry.
  4.12.2. Indicates, in a permanent log, any changes in the recorded information and the identity of the user making the change.
  4.12.3. Preserves, in a permanent log, the original content of the recorded information when changed or updated.
  4.12.4. Is capable of printing the permanent log separately from the recorded information for each patient.

4.13. Subsection 4(4) to 4(6) of PHIA's *Personal Health Information Regulation* establish that trustees of personal health information must:[10]
  4.13.1. Audit records of user activity to detect security breaches, in accordance with guidelines set by government.
  4.13.2. Maintain a record of user activity.
  4.13.3. Ensure that at least one audit of a record of user activity is conducted before the record is destroyed.

4.14. Backing-up EMRs on a routine basis and storing back-up copies in a secure environment separate from where the original data is stored is required when patient records are stored electronically.

Transitioning patient records management systems

4.15. When transitioning from one patient record keeping system to another (i.e., a paper-based to electronic system, or from one electronic system to another), members must:
  4.15.1. maintain continuity and quality of patient care,
  4.15.2. continue appropriate patient record keeping practices without interruption,
  4.15.3. protect the privacy of patients' personal health information, and
  4.15.4. maintain the integrity of the data in the patient record.

[10] 'Guidelines for Records of User Activity' are provided on the Manitoba Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html

4.16. To ensure the integrity of the patient record is maintained, members who are transitioning from one patient record keeping system to another must have a quality assurance process in place that includes:
  4.16.1. written procedures that are consistently followed, and
  4.16.2. verification that the entire medical record has remained intact upon conversion (e.g., comparing scanned copies to originals to ensure that they have been properly scanned or converted).

4.17. Members who wish to destroy original paper patient records following conversion into a digital format must:
  4.17.1. use appropriate safeguards to ensure reliability of digital copies,
  4.17.2. save scanned copies in "read-only" format, and
  4.17.3. destroy patient records in accordance with the expectations set out in this Standard.

4.18. Members who use voice recognition software or Optical Character Recognition (OCR) technology to convert records into searchable, editable files must retain either the original record or a scanned copy for the retention periods set out above.

4.19. So that complete and up to date information is contained in one central location, a member who maintains patient records and is overseeing a transition must:
  4.19.1. Set a date whereby the new system becomes the official record.
  4.19.2. Inform all health care professionals who would reasonably be expected to contribute or rely on the record of this date.
  4.19.3. And ensure contributors only document in the new system from the official date onward.

Retention and destruction of patient records and appointment records

4.20. In accordance with subsection 11(3) of the Standards Regulation, members must ensure patient records are retained for a minimum of the following time periods:
  4.20.1. Respecting adult patients, 10 years from the date of the last entry in the record.
  4.20.2. Respecting patients who are children (*i.e., minors*), 10 years after the day on which the patient reached or would have reached 18 years of age.

4.21. In accordance with subsection 10(2) of the **Standards Regulation**, members must ensure the record of appointments kept for their practice is retained for at least 10 years after the date the record was made.

4.22. Members must reasonably ensure that patient records and the record of appointments are maintained for the retention period in a manner that ensures these records remain reasonably accessible and reproducible.

4.23. Members must only destroy patient records once their obligation to retain the record has come to an end.

4.24. When destroying patient records, members must do so in a secure and confidential manner and in such a way that they cannot be reconstructed or retrieved. As such, members must, where applicable:
- 4.24.1. cross-shred all paper medical records,
- 4.24.2. permanently delete electronic records by physically destroying the storage media or overwriting the information stored on the media, and
- 4.24.3. appropriately destroy any back-up copies of records.

4.25. Members must ensure compliance with section 17 of PHIA, which establishes that:[11]

> *17(1) A trustee shall establish a written policy concerning the retention and destruction of personal health information and shall comply with that policy.*

Information managers

4.26. Section 25 of PHIA permits trustees, including members and medical clinics, to retain an information manager to assist in maintaining patient records. Many information managers are also EMR service providers. Pursuant to subsection 25(5) of PHIA, when this occurs the patient record is deemed to be maintained by the trustee (e.g., the member, the medical clinic). Arrangements with an information manager must be in writing and accord with section 25 of PHIA:[12]
- 4.26.1. A trustee may provide personal health information to an information manager for the purpose of processing, storing, or destroying it or providing the trustee with information management or information technology services.
- 4.26.2. A trustee who wishes to provide personal health information to an information manager under section 25 of PHIA must enter into a written agreement with the information manager that provides for the protection of the personal health information against such risks as unauthorized access, use, disclosure, destruction, or alteration, in accordance with PHIA regulations.

Closing, leaving, or moving a medical practice

4.27. The **Standards Regulation** and the **Standard of Practice for Practice Management** set out important CPSM requirements for closing, leaving, or moving non-institutional medical practice members must abide by. Respecting patient records, subsections 13(1)

[11] Sample written policy available at: _____ (to be developed)

[12] 'PHIA - A Trustee's Guide to Information Manager Agreements Required by *The Personal Health Information Act*' is provided on the Manitoba Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html

and 13(2) of the **Standards Regulation** and Part 3 of the **Practice Management Standard** establish that when a member intends to close their medical practice, take a leave of absence, relocate, or otherwise cease practice, they must:

4.27.1. notify patients, or their representatives, about where patient records are to be located, and

4.27.2. how the records can be transferred to another member or how copies can be obtained.

This is not required if the member's patient records are maintained by "*a person or organization that employed, engaged or granted privileges to the member and is a trustee under The Personal Health Information Act"*.

4.28. A member who closes their medical practice or takes a leave of absence must:

4.28.1. ensure the appropriate and secure storage of any patient records and record of appointments respecting which they are responsible to maintain for the remainder of the applicable retention period, and

4.28.2. must ensure subsequent destruction in accordance with this Standard.

Preparedness for unforeseen absence or termination of practice

4.29. A member who is responsible for maintaining patient records or a record of appointments must have a written plan in place to ensure the ongoing maintenance of those records in accordance with this Standard that accommodates for situations where the member becomes unwilling or unable to continue to maintain those patient records (*e.g., death, incarceration, etc.*). Plans under this paragraph must be sufficient to avoid abandonment, or the risk of abandonment, of patient records or appointment records. An appropriate successor trustee must be named in the plan.

5. PATIENT ACCESS RIGHTS AND TRANSFERRING PATIENT RECORDS

Patients' right to examine and copy information

5.1. When a member creates a patient record, the personal health information contained in the record belongs to the patient, regardless of who owns or maintains the patient record. Subsection 5(1) of PHIA establishes that, "*an individual has a right, on request, to examine and receive a copy of his or her personal health information maintained by a trustee*" subject to exceptions under which a member may refuse to provide certain information that are set out at section 11 of PHIA.[13] Respecting such requests:

5.1.1. Members shall make every reasonable effort to assist a patient, or their designate, making the request and respond to it openly, accurately, and completely.

[13] See 'Your Personal Health Information – Access and Privacy Rights at our Location' on the Manitoba Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html

5.1.2. Upon receiving a request, members must, to the extent they are authorized to do so (i.e., per access rights established for the patient record), facilitate lawful access to all requested portions of a patient record, unless an exception applies, and provide copies upon request.

5.2. In accordance with sections 6 through 7 of PHIA, members shall respond to a request from a patient, or their representative, to examine their patient record or receive a copy of it as promptly as required in the circumstances but not later than:

5.2.1. 24 hours after receiving it, if facilitating the response on behalf of a hospital and the information is about health care currently being provided to an inpatient,

5.2.2. 72 hours after receiving it, if the information is about health care the member is currently providing to a person who is not a hospital inpatient, and

5.2.3. 30 days after receiving it in any other case unless the request is transferred to another trustee (see paragraph 5.3., below).

5.2.4. In the circumstance mentioned in paragraph 5.2.1. (i.e., hospital inpatient), the member is required only to make the information available for examination and need not provide a copy or an explanation.

5.3. A member may transfer a request to examine or copy a patient record to another trustee if the information sought is maintained by the other trustee, or the other trustee was the first to collect the information. A member who transfers a request shall notify the individual who made the request of the transfer as soon as possible.

5.4. Subject to paragraph 5.3., in responding to a request, members shall do one of the following:

5.4.1. Make the patient record available for examination and provide a copy, if requested, to the individual.

5.4.2. Inform the individual in writing if the information does not exist or cannot be found.

5.4.3. Inform the individual in writing that the request is refused, in whole or in part, for a specified reason described in section 11 of PHIA and advise the individual of the right to make a complaint about the refusal under Part 5 of PHIA.

5.4.4. On request, a member shall provide an explanation of any term, code or abbreviation used in the patient record.

5.5. When a request is made for a patient record that is maintained in electronic form, the member shall produce a record of the information for the individual in a form usable by the individual, if it can be produced using the member's normal computer hardware and software and technical expertise.

5.6. A member may charge a fee as permitted under section 10 of PHIA relating to a request to examine or copy a patient record unless the member terminated the respective patient from an ongoing practice, in which case no fee may be charged. This exception

does not prohibit a member from charging a fee when the member is closing, leaving, or moving a medical practice.

5.7. For greater certainty, a member who provides a copy of a patient record to a patient must retain the original for the duration of the applicable retention period.

Transfer of patient records to third party

5.8. Members must only transfer copies of patient records when they have consent of the patient or their legal representative or are otherwise permitted or required by law to do so. Members who have custody or control of patient records must transfer copies in a timely manner, urgently if necessary, but no later than 30 days after a request is made. What is timely will depend on whether there is any risk to the patient if there is a delay in transferring the records (e.g., exposure to any adverse clinical outcomes).

5.9. Members must transfer copies of the entire patient record, unless providing a summary or a partial copy of the medical record is acceptable to the receiving person or the patient.

5.10. Members must transfer copies of medical records in a secure manner and document the date and method of transfer in the medical record.

5.11. Fulfilling a request for copying and transferring patient records is an uninsured service. As such, members are entitled to charge patients or third parties a fee. When a fee is levied, the follow rules must be followed:

5.11.1. When charging for copying and transferring medical records, members must:

i. provide a fee estimate prior to providing copies or summaries,
ii. provide an itemized bill that provides a breakdown of the cost, upon request (e.g., cost per page, cost for transfer, etc.), and
iii. only charge fees that are reasonable.

5.11.2. When determining what is reasonable to charge, members must ensure that:

i. fees do not exceed the amount of reasonable cost recovery, and
ii. correlate with the nature of the service provided and professional costs (i.e., reflect the cost of the materials used, the time required to prepare the material and the direct cost of sending the material to the requesting individual).

5.11.3. Members must consider the financial burden that these fees might place on the patient and consider whether it would be appropriate to reduce, waive, or allow for flexibility with respect to fees based on compassionate grounds.

5.11.4. Members may request pre-payment for records or take action to collect any fees owed to them but must not put a patient's health and safety at risk by delaying the transfer of records until payment has been received.

5.12. For greater clarity, a member who provides a copy of a patient record to a third party must retain the original for the duration of the applicable retention period.

COUNCIL MEETING – JUNE 9, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Standard of Practice – Duty to Report

BACKGROUND

The current duty to report provisions are scattered throughout the Standards of Practice and legislation and includes duties to report another member to CPSM and self-reporting to CPSM. There are also statutory requirements for a wide variety of reporting. There is no central document that provides all reporting requirements. The intention was to create one document containing all such requirements. Furthermore, as societal expectations change regarding public safety, so too must the Standard.

Creating a Duty to Report Standard of Practice is a CPSM Strategic Organizational Priority. A Working Group was formed in the fall after the Terms of Reference were approved by Council in September 2020.

CONSULTATION

In March 2021 the three documents were distributed to the public, stakeholders, and members for consultation:

- Standard of Practice for Duty to Report
- Contextual Information and Resources
- FAQs

A notification with a link to the Standard of Practice and supporting documents was sent to all CPSM registrants, all regulators of health professions, Government, and various other stakeholders. An advertisement was placed in two Saturday editions of the Winnipeg Free Press.

There were 37 responses provided in the feedback.

- 17 from Members
- 11 from Regulated Health Professions
- 2 from the public
- 1 each from CMPA and Doctors Manitoba

Two members reported themselves.

THEMES TO THE FEEDBACK

The overall themes of the feedback are summarized below, however, the summary certainly does not comprehensively establish the specificity, sophistication, and nuances of the feedback. This is the feedback in no order.

1. **Favourable Standard and Supporting Materials**

   Many indicated their support for the Standard, indicating it was helpful to read it as a refresher and liked the FAQs and the list of mandatory statutory reporting. The Contextual Information was appreciated by many as they indicated it provided them with an understanding for the rules and how to interpret the rules. Overall, it was received very favourably.

2. **Reporting Members or Regulated Health Professionals May Damage the Physician Patient Relationship**

   The therapeutic relationship between patient and physician which is built upon trust will be irreparably damaged if the physician is required to report another physician or regulated health professional to the regulatory authority. This was however, rarely raised in reporting patients who are not regulated health professionals.

3. **Duty to Report other Regulated Health Professionals Not Required**

   There is a statutory requirement in the RHPA to report ones' own members to the Registrar. Since there is no statutory requirement to report another regulated health profession, then CPSM should not create such a requirement. In essence, this argument is that Government was silent on this for a reason, and it is not for CPSM to change Government's intention through this Standard.

4. **Report Another Regulated Health Professional to CPSM Registrar**

   Many were perplexed why this requirement existed and why the reporting was not made directly to the other regulator. This was not widely supported, and attracted significant negative commentary.

5. **Reporting of Impairment vs. Illness**

   The draft Standard sometimes uses language of reporting illness and not impairment. It was thought that many members might not know if another member was impaired, but they might know of an illness. If CPSM knew of an illness, then CPSM could determine if there was an the impairment. An example of this is depression – one might know their colleague was depressed, but might not know they are severely depressed. CPSM would work with the treating physicians to determine if the depression was such that the member could continue working, or if the depression was severe and precluded the safe practice of medicine.

6. **Reporting of Conditions that May Impair**

   Somewhat similar to #5 above, there is concern that this is too broad and general. Furthermore, some cited studies showing the deleterious effects of reporting physicians,

including suicide, due to social and professional stigma attached to certain illnesses. Reporting of non-impairing medical conditions was seen as being an invasion of privacy and given the ability of CPSM to revoke registrations to practice, may be seen as fearful or over-reaching by some members.

7. Reporting a Patient is a Breach of Patient Confidentiality

While some commented on this directly, many made references to this. It was seen as a breach of PHIA and general principles of physician-patient confidentiality and therefore to be avoided. A further adjunct to this was that if there was such a breach of confidentiality then there should be mandatory disclosure to the patient by the member. Others state that this is not a breach of PHIA, but that CPSM should include limitations on the use of the information (this is in the Privacy Policy).

8. More Details and Guidance Requested

Even with the Contextual Information and Resources, and the FAQs, several commented that they wanted further examples, processes, and details outlined to assist members in the reporting.

9. Regulated Health Professionals will not Access Healthcare if they May be Reported

This argument was made for regulated health professionals but was not made for any of the patients that are reported under the statutory requirements. The argument is that if regulated healthcare professionals are reported to their regulator, then they will not seek health care and this discriminates against them and may imperil their health.

10. Reporting Physicians is Unduly Broad and Onerous

There is a statutory duty to report oneself for certain conditions and circumstances. The Standard has expanded this reporting for certain conditions and circumstances to other physicians. Some argues this is unduly broad and onerous and places an unreasonable burned upon physicians to evaluate the behaviours or intentions of other physicians.

11. Add Aspects of the Contextual Information to a Preamble of the Standard

The wording of the Standard creates obligations and can lead to discipline. The integration of some important context into the Standard itself ensure that certain statements can be seen as rules and not just context.

12. Non- Disclosure Agreement

Some questioned how there could be a duty to report if there was also a non-disclosure agreement. The answer to this is the reporting has to be done before the Non-disclosure agreement is signed or that the agreement includes a provision that permits disclosure to CPSM.

13. Ability to Speak to Person Prior to Reporting Them

There is no provision that prevents anyone with a duty to report from speaking with a person prior to reporting them. In fact, in most instances, failing to do so in a clinical context would

constitute bad medical care. In the Contextual Information under Physician Health matters, one is encouraged to speak to colleague, encourage their self-reporting, and then to follow up later with a report.

All feedback is provided in the attached document.

REVISIONS MADE TO THE STANDARD OF PRACTICE FOLLOWING FEEDBACK

The Working Group met to review the feedback. The Working Group recommends a revised Standard of Practice for the Duty to Report for inclusion at the meeting of the Executive Committee.

There were four main changes:

1 – **Preamble** – This was created to soften some of the rules by providing both the rationale for the rules, and how CPSM will use the information in a responsible way. Several in the feedback indicated that while the Contextual Information was of assistance, they still wanted some of those assurances in the actual Standard. There are now three paragraphs in a new Preamble section.

2 – **Reporting Other Regulated Health Professionals** - The section on reporting others was reworded to take into account the concerns voiced by many on a few aspects of this. There is another provision in the RHPA with a duty to report other regulated health professionals that are working in association with CPSM members. That language from that section of the RHPA was replicated (minus the practicing in association), and made it a CPSM duty to report - whether or not they are practicing in association with the other professional. Not only does it read better, but is more in keeping with the legislative intent.

3 – **May Be Impaired vs Is Impaired** - One of the difficulties with some of the feedback was that some wanted to report only if the person was impaired. For instance, MD Care (and others) have suggested that the "reporting requirements on the physician's **current, functional status, ie. presence or absence of functional impairment**, that than on conditions that **"may affect" or "may impair"** function at some point in the future.

However, the legislation in the Act is very clear that "a member who reasonably believes that another member … suffers from a mental or physical disorder or illness that **may affect** his or her fitness to practise" must disclose that to the Registrar. CPSM can't impose a lesser threshold for reporting in the Standard than in the legislation, though it could impose a higher threshold. In other words, the minimum threshold or test for reporting is what is in the legislation – and that is if the medical condition may affect his or her fitness to practice.

4 – **Incorporate Some Suggested Wording and Other Changes** – The new Standard incorporates and includes some of the recommended changes of CMPA, Doctors Manitoba, and MD Care and other regulators in those situations in which it improves the documents. There were some good suggestions from these groups and others that improves the Standard.

Like always, the public consultation is very helpful and the adoption of many recommendations improves the Standard in regulating the practice of medicine and ensuring good medical care and patient safety.

Attached are two copies of the Standard, one contains tracked changes as to what was changed due to the feedback and the other is a clean copy.

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 following was provided to Council in September 2020: Physicians have a legal and professional obligation to maintain the confidentiality of patient information. There are circumstances, however, where physicians are either required or permitted to report particular events or clinical conditions to the appropriate government or regulatory agency. This Standard will set out circumstances that may require or permit physicians to make a report. It is not a substitute for legal advice regarding reporting obligations.

This Standard is necessary to establish governing principles on notification of ongoing competence in practice, whether the reporting is of a colleague or of self. With respect to self-reporting or reporting of a colleague for matters of health, CPSM recognizes that a member has the right to make decisions regarding his or her health, balanced with CPSM's mandate to serve the public and ensure the safe practice of medicine by its members. Reporting a patient's medical condition to an external body is required by a wide variety of statutes which recognize the element of public safety is paramount to the confidentiality that exists between patient and physician.

The consultation assisted in ensuring a broader perspective was sought. This helps to ensure accountability and that the Standard is in the public interest and will enhance patient safety. Of particular importance was to ensure that reporting of members was required for safe practice, yet to reassure members that reporting does not equate to "losing the licence". Rather, the approach to Physician Health was explained to address such concerns and its supportive approach to physician wellness.

Similarly issues of privacy were addressed to assist in the disclosure of information and compliance with PHIA.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 9, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> The Standard of Practice Duty to Report Self, Colleagues, or Patients is approved as per attached, to be effective July 1, 2021.

Dr Mr. Comment
CPSM Members
I do not have a comment specific to your document on duty to report - it is a necessary document and essential to articulate these guidelines. No concerns. My question relates to physician reporting that a patient is no longer recommended to hold a driver licence. I feel I do not have enough direction when it is appropriate to pull a patient's driver's licence, whose responsibility is it- the Family Doc, the specialist involved or another physician not directly involved but concerned but family doc does not feel it necessary? I as a physician need guidelines or a refresher and this may fall under Duty to Disclose. thank you – this (contextual document) is helpful but still not completely clear if I as a physician have the duty to report if I feel a physician colleague the primary care provider for a pt on whom I have consulted does not report a patient to the motor vehicle branch for assessment. But not a common occurrence for sure, Cheryl
I think examples for each category would be helpful. If a physicians condition also is associated with lack of insight or reduced self awareness I am not sure it would be just to be censured for not self reporting.
Feedback on Duty to Report Self, Colleagues, or Patients I have no other concerns or observations. I believe the Standard appropriate.
When I look at the draft document it is clear that I am protected from reporting another member of CPSM if I am doing so in good faith because of the cause ***Exemption from liability for disclosure*** *138(2)* *A member who discloses information under subsection* *(1) is not subject* *to any liability as a result, unless it is established that the disclosure was made maliciously."* I am concerned that this exact clause does not follow item 2.2 where it is stipulated that now there is a duty to report members of other regulated health professions. In the absence of this clause this leaves me concerned that I would be liable if a lawsuit arose out of me making this disclosure. If this exemption clause applies to clause 2.2 as well, then it should be explicitly stated. If it doesn't then it should be explicitly stated whether CPSM assumes the liability for any legal action that arises out of following clause 2.2 in good faith or whether the physician is on their own (in which case no physician would likely ever comply with this requirement to report).

I reviewed the draft document.

I think there are two separate matters that would be better served by two separate documents:
1. Fitness to practice medicine - self and colleagues
2. Safety of patients - This could include potential for harm to self or to others (e.g. suspension of driving privileges in context of seizure or visual disability etc.; perceived threat to an individual or public safety in context of a psychiatric disorder)

I am a general hospital psychiatrist and have grappled several times with the Regulated Health Professions Act and CPSM Standards when assessing and treating impaired health professionals who are not physicians. I have previously received detailed advice from the CMPA on this matter and carefully reflected on this issue with colleagues.

My suggestion is to remove Section 2.2 because it imposes a standard of reporting that is, to my knowledge, not currently established or indemnified by the Health Professions Act. Is the CPSM entitled to confidential information about regulated professionals outside its jurisdiction? Short of amending the Act, self-reporting remains perfectly appropriate and in my field facilitates the proper assessment and care of all regulated professionals, who are typically reminded of their duty to self-report when appropriate. From that point, a signed disclosure agreement would become a much more appropriate basis on which to address clinical information to a regulator – that is, any regulator. Moreover, Section 2.2 requires proactive consideration of fitness to practice, which is a forensic matter inadvisable for non-experts to evaluate in routine clinical assessment and treatment.

I am not a legal expert but in my view, it would be preferable for the Standard to clarify that if an extraordinary duty to report another regulated professional to their own regulator arises outside the very limited provisions of the Act, this signifies a serious breach of confidentiality and may be unlawful. The general standard of reporting was established by the Supreme Court of Canada in Smith v. Jones (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1689/index.do) which stated "the standard of a “clear, serious and imminent” danger is the appropriate test for disclosure of privileged communications," and, "The chilling effect of completely breaching the privilege would have the undesired effect of discouraging those individuals in need of treatment for serious and dangerous conditions from consulting professional help. In this case the interests of the appellant and more importantly the interests of society would be better served by his obtaining treatment."

I appreciate that my viewpoint may be controversial. The overarching consideration is to eliminate discrepancies between the Standards and existing legislation that could generate double-binds and an undue burden on treating providers. If possible, I would be interested in a legal commentary on this matter if the language is upheld.

The very last scenario under FAQs is one of a cognitively declining older adult who is being abused financially. The explanation is to report to Department of Families under the vulnerable persons act. However this is incorrect. Vulnerable persons living with a mental disability are strictly defined under the act and they must have acquired the disability prior to age of 18 https://www.gov.mb.ca/fs/pwd/what_is_vpa.html In this situation while there is a duty to intervene there is actually no specific body that one is legally required to report to.
I believe Dr van Ineveld is correct. The definition of a "vulnerable person" does not include these people. Will there be safeguards to protect the person reporting? I would see there being a similar need for protection as that exists for reporting unfit drivers.
Standard of practice for Duty to Report is very thorough Well laid out and explained No further comments to add at this time
I am seeking clarification on duty to report other regulated health care providers. For example, what are the requirements for reporting of nurses, paramedics, police officers, fire fighters in situations that they may pose a risk to the public. I work in addiction medicine and am specifically interested in the process of reporting around addiction/substance use to ensure patient and public safety.
This is a difficult issue and will require lots of interpretation with potential for abuse. I think there is a need to eliminate duplicate reporting. The document indicates that ALL members have a duty to report. There are situations wherein everyone knows there is a problem, including the physician with the problem who recuses him/herself. Isolation for COVID is one example. Under the document rules all members who know that individual has an issue are mandated to report anyway. If actually complied with this may mean twenty or more redundant complaints for a situation that is not an issue that everyone knows about. If a physician is sick or has surgery and takes a week off work should all of his colleagues report him/her?

Should previous events be reported? The document is written in the present tense. If a member comes across a situation that may have affected another's practice a year ago but is no longer a potential issue, does this need to be reported?
I have few commands on the new standard for reporting. 1. When the patient discloses information leading a member to believe on reasonable grounds that a member committed sexual boundary violation. I believe that the patient herself/himself should be the one who is reporting not myself. I was not part of the conversation and I am not sure of what happened between the patient and the other physician, and the interaction differs according to the scenario. 2. Mental illnesses like depression Physicians are sometimes patients too, they should have their own privacy. IF that mental illness is not enough to impair his/her judgment or the patient interaction I believe we should respect her/his privacy.
i am aware of this rule and totaly agree with it if i need to report somebody i will definitely communicate with the college regards
I have read through the College's letter on the Standard of Practice, Duty to Report self, Colleagues, or Patients. I am in total agreement with the recommendations and will abide by then as required.
I agree with the notion of reporting as outlined in your draft report. Self reporting aids to safe and competent patient care. Reporting of a fellow colleague is a sensitive issue. I would discuss the issue at hand with the colleague first and encourage him/her to self report. This way it gives him/her a chance to resolve the issue at hand. This would reduce the associated stress to both parties. It all depends on the situation though. It is mandatory to report if the situation is posing an immediate threat to patient care and if the physician does not self report. Reporting a patient is mandatory if he/she is posing an immediate threat to himself/herself and the public. I would not hesitate to inform the authorities. It is our duty to report and protect our communities. Their is an inherent fear and stigma to reporting though.

Our duty is to follow standard of practice protocols and best practice for patient safety.

Thank you very much for the opportunity to provide feedback on the CPSM Draft Standard of Practice, Duty to Report Self, Colleagues, or Patients.

I am commenting on behalf of the MDCare service, Department of Psychiatry, University of Manitoba, which includes nine psychiatrists, a psychologist, and a psychiatric nurse. MDCare provides treatment to over 275 patients, including approximately 150 physicians. As such, we are acutely aware of the concerns of our physician patients as well as the challenges we face as treating physicians.

MDCare provides care to physicians and their families in a safe, confidential, non-judgemental environment. While we agree with and understand the need for a Standard on Duty to Report both to protect the public and to ensure the safe practice of medicine, we are concerned that some of the the proposed reporting requirements will perpetuate the stigma of mental illness and prevent physicians from seeking care. We frequently hear from physicians who are hesitant to access care due to fear of needing to report their condition or situation to CPSM, as well as fear of unnecessary disclosure of personal health information.

We suggest that the reporting requirements focus on the physician patient's **current, functional status, ie. presence or absence of functional impairment,** rather than on conditions that **"may affect" or "may impair"** function at some point in the future. The latter would likely lead to unnecessary over reporting and has the potential to breach privacy legislation.

More specifically, we'd first like to address the **Frequently Asked Questions** document:

1. **Page 1, question 1 – "What type of health conditions are reportable?"**
   The inclusion of the phrase, ***"mental health illnesses",*** in addition to more specific psychiatric diagnoses such as "substance abuse disorders" and "depression", is vague and overinclusive. This may be interpreted as needing to report any mental health condition for which a patient seeks care. As well, the answer does not take into account the patient's current functional status for either mental health or physical disorders.

2. **Page 2, question 2 – " I occasionally provide medical treatment to physicians. One of my physician patients is depressed. Should this be reported to CPSM?"**

   Our suggestion is that the wording of **paragraph 2** be modified slightly as follows:

   "As a treating physician you are not required to report your patient with depression ***unless, in your clinical opinion, it impairs their ability to practice medicine safely."***

3. **Page 2, question 2, paragraph 3** – this appears to contradict paragraph 2 above by using the term ***"potential"*** impairment rather than focusing on current impairment which paragraph 2 implies. We suggest that this answer be changed to:

   "Where you have concerns that your physician patient's illness is inadequately treated, where your physician patient is experiencing difficulty concentrating or

staying focused at work, or if their illness is of moderate to severe intensity ***such that there is evidence*** of impairment in cognition, judgment, or insight, then advise your patient that they must self-report and that you are also required to report their health issue to CPSM….."

Finally, we'd like to address the following in the **Standard of Practice, Duty to Report Self, Colleagues, or Patients** document:

Part 2, 2.2 – this requires CPSM members to report another member of a different regulated health profession ***to the CPSM Registrar,*** rather than to their own regulatory body. Our concern is that reporting to the CPSM, rather than to the other member's regulatory body would constitute a breach of privacy legislation.

Thank you again for the opportunity to submit feedback on the proposed Standard. I would be happy to provide additional comments or clarification as needed.

I send this message today on behalf of myself.

I am a psychiatrist who has an interest in the interaction between policy and mental health. I work on the MD Care team, and I sit on the executive board for the Manitoba Psychiatric Association, where I serve as the co-coordinator for the Psychotherapy Section.

I wish to provide feedback about the high likelihood of certain downstream outcomes, if the College clarifies, reifies, and enforces reporting requirements according to what is seen in the College draft. According to the draft, the "presence of a mental condition or disorder" is proposed to be reportable. This is stigmatizing and wrong for the reasons I will describe below. In summary, I believe (1) stigma will be perpetrated, (2) doctors and their patients will suffer, and (3) the College will likely face human rights complaints.

(1) To start, a note about stigma and its insinuation with regulating bodies. It is known that stigma experienced by medical professionals probably occurs most pervasively in medical licensing (Jones et al., 2018). There is substance to this perception; in a recent survey of executive directors of State Medical Boards in the USA, 37% of those surveyed indicated that the diagnosis of mental illness by itself was sufficient for sanctioning a physician (Hendin et al., 2007). But stigma can be more debilitating than mental illness itself. Consider a survey of more than 2000 female physicians that found that half of them believed that at some time in the past they have probably satisfied the criteria for a psychiatric disorder but had not sought treatment for it. A number of those physicians reported this was because of their concern over mental health licensure questions (Gold et al., 2016).

It is striking to me that regulating bodies are so invested in correlating impairment with the presence of a psychiatric disorder, because not even psychiatric institutions do so. According to the American Psychiatric Association, having a psychiatric history is NOT an accurate predictor of mental fitness. Similarly, the Canadian Psychiatric Association released an updated position paper on Physician health entitled "The Mentally Ill physician" in 2019 where they state that physicians can be mentally ill and NOT occupationally impaired. I suggest the College should not act in a manner that reveals working assumptions about mental illness that mental illness experts themselves do not endorse.

(2) When the "presence of a mental condition or disorder" is reportable, it is "dangerous" to individual physicians (personal communication with Dr Michael Myers, international physician mental health expert). A qualitative research study in which the researcher interviewed family members of physicians who had died by suicide disclosed that a significant minority (10–15%) of the decedents (34 physicians total) had killed themselves without ever receiving any treatment whatsoever. The interviewees described their physician loved ones as terrified that seeking mental health care would preclude them from being able to obtain or renew their medical licenses (Myers, 2017). In a personal communication, Dr. Myers expressed to me that "this is heartbreaking and unnecessary."

The wording ("…may impair their ability…") is far too open to interpretation. Imagine a medical culture where physicians will be mandated to report each other for any condition that "may" affect their ability to practice - this would include if a physician hears from a colleague that they take a psychiatric medication, or that they have a

well-treated current mild depression, or that they had obtained past mental health care. For example, a hospital admission for cutting in their teens - they would be mandated to report. The result of this is that colleagues will simply not talk to colleagues about their personal lives anymore. This will be to the detriment of the individuals and the medical culture in general, because people need to share openly and be vulnerable in order to truly connect and benefit from being part of a community. But, with the proposed standard for reporting, it will be just too risky to trust other physicians. A paranoid medical culture will result. And the presence of a College-affiliated PHP will not ameliorate this, for reasons I will explain.

But this is not just a physician mental health issue, this is also a public safety issue. If physicians develop greater aversion to seeking mental health support, their mental health will deteriorate, and their ability to provide safe patient care will also deteriorate. This negative consequence is still very possible - in fact, probable - despite the best of intentions at the College level. What I have presented so far is my plea from morality, grounded in research from experts in the field of physician mental health and consensus of national psychiatric associations.

(3) Furthermore, the new standard will negatively affect public perception of the College. Physicians are likely, in my opinion, to experience the new standard as an invasion of their privacy. I expect that the reporting requirements will be experienced as discriminatory on the basis of a disability, and I can conceive that the Manitoba Human Rights Code could be used to bring high-profile human rights complaints against the College. This is my warning out of a concern for the best interest of the College.

Allow me to make a few more sociological/philosophical comments. A well-described characteristic of modern society is bureaucratization. We see the “overreach of bureaucratization” when it crosses a certain threshold and it constricts the spirit of individuals living in the society. The policy makers at the College ought to personally struggle with this, and carefully consider where this threshold lies. This must be negotiated and re-negotiated, as society changes. I am providing my input today due to my faith that negotiating (or, better yet, dialogue) is the only proper way forward.

The goal for any policy is disambiguation. In the case of the draft standard for reporting, the disambiguation relates to what specific inputs will trigger specific output behaviour on the part of physicians. But my claim is that there must be space given to the individual to struggle morally. Otherwise, the territory that should belong to reflective morality will be encroached upon by policy, mandating reflexive action. When the new policy is at odds with expert wisdom, then explicit legal process itself has been prioritized over that which is supposed to be protected by the policy; in this case, the health of physicians and their patients. This is what I mean when I refer to “overreach.”

Instead of continuing down this incautious path, and in order to prioritize reverence for the human spirit, I urge that three points be considered:

Firstly, the College ought to concern itself with IMPAIRMENT ONLY, as far as mental health diagnoses, at least. When it comes to mental illness, as I stated above, impairment correlates poorly with the presence of an illness, so I strongly encourage that references to "presence of a condition or diagnosis“ as far as mental health is concerned are REMOVED (unless it specifies severity...for example "severe presentation of a condition" may be acceptable).

Secondly, and more specifically, the College should be concerned with “current impairment" only. If reportable conditions come to include any condition that “may” cause impairment, in some hypothetical future scenario, then essentially everyone should be reported. This will not help. The “human condition” is going to make us all impaired in due course - guaranteed.

Thirdly and finally, the PHP is a fraught idea because it is a conflict of interest. I considered the following quote: “Involvement with the Physician Health Program is non-punitive …” The attempt to portray the College and its components as “friendly” is lovely, but it is ultimately idealistic. And the real PHP, as it stands in Manitoba at present, may adhere to that ideal - for now.

But physicians will not ignore the brute fact that the College can revoke licenses. This is punitive. And this is the root of the primordial fear that physicians feel when they detect any evidence of College involvement. Their reputation and livelihood flash before their eyes. I suspect that the blood pressure of most physicians literally goes up even when they receive an emailed receipt from the College after paying their yearly fee. In other words, the PHP will be experienced as utterly untrustworthy to the individuals who, in course, will ultimately not be served well by it.

The insinuation of mental health stigma with regulating bodies in medicine is a reality. And the proposed draft standard of the CPSM serves as glaring evidence that stigma is at risk of being perpetuated in our province. Furthermore, if my feedback (and the feedback that I am aware that Doctors Manitoba will be providing) is not taken seriously, I am concerned it will only deepen.

I appreciate the opportunity to express my concerns about how adjusting reporting requirements may backfire, as well as a more general cultural concern; we are living in a world which is increasingly bureaucratized, which serves to further fragmentation. Though the medical profession is understood to be a “self-regulating” profession, the newly proposed reporting requirements are likely to be seen by some members as an overreaching of the regulating body, and it is liable to set doctors against their regulating body, thus setting the profession against itself. So I ask the question: do these new draft standards ultimately support unity and resolution in assisting physicians at all stages of their career to seek out assistance, advice, and treatment, or do they run the risk of having the exact opposite effect?

A report on line regarding a doctor was concerning.
I spoke to the doctor in generalities about the online report, which he brushed off as patient disgruntledness.

The person reporting did not identify themselves.

I want to be aware of reporting responsibilities regarding colleague's behavior.

When is a report a rumor? When can it be validated? Is someone venting, and if so, should they be drawn into battle, or asked to retract their report?

The electronic world makes anonymity a challenge to address. Does me providing the College with the online report constitute adequate reporting? I don't want to be seen to be spreading rumors either, as libel remains a possibility when rumors are not true. According to rumor, I have died, moved to another country, and done a variety of things that are much more exciting, (and some of them were so egregious that the person sharing the rumors actually refused to tell me what they were, knowing they were false) than in my real life, but also completely false.

Any mandated reporting on a colleague would have to be with personally known knowledge, as opposed to rumored information. If a patient wishes to remain anonymous, does the College have the authority to draw them out and force them to testify? If a patient discloses information to me regarding a colleague, and states unequivocally they will deny it if questioned by an authority, of what use is it to report, or do I report it anyway, discard my patient relationship and hope that the College can force them to spill the beans?

Does the College plan to monitor doctor review sites in the hope of identifying boundary crossing behavior? The doctor's name is mentioned. The patient's name is not.

I clearly have no answers for reporting standards, other than personal knowledge, reported with the patient's consent. Reporting without the patient's consent would trigger a legal opinion I would imagine, much above my qualifications, unless personally witnessed? Even then it amounts to a who said, who said, if the patient is not willing to testify.

SECOND RESPONSE

If I hear a rumor of something, ie a second or third person removed from the patient who claims to have a concern, to what degree am I responsible to be the detective? Am I

obligated to break PHIA in order to pursue the complainant, for example? I understand if a patient complains to me about a colleague's behavior, it is something that I then have a responsibility to address.

Is the College planning to monitor social media, like doctors' reviews for significant complaints? At the point where the complaint is in the public domain, who determines whose responsibility it is to report the doctor, when the doctor's name is mentioned? Historically the College required someone outside of the College to report an issue. In the age of electronic information sharing, is the College planning to monitor information in the public domain?

Will the College invite complainants on platforms like Doctors' reviews to come forward with their complaints to the College? Can physician members of the College not be held accountable as well, or are they exempt from reaching out to potential complainants?

Rumors versus direct patient complaints to me regarding a colleague's behavior is the gist of it. I understand the direct patient complaint. I am slightly baffled in reporting rumors.

The legal protection of the person reporting is said to be protected by the College in terms of avoiding libel charges, IF it is shown that the reporting was done in a particular manner, and not with malice, which is a difficult hinge upon which to rely. If any occurence of disagreement in the past between the accused and the reporter existed, the accused could claim bias, and the defense of the reporter would become compromised.
Very similarly to the rape victim who goes on trial in order to prove it was Snow White who was present at the time of the crime, instead of a professional exotic dancer, the reporter remains in a delicate position of having to prove their complete lack of connection to the accused, in order to be above reproach.
Very few can pick up the first stone.
I will go back and review the penalty for failing to report an incidence.

Years ago a colleague used silk to suture a facial laceration of a patient of mine, who they saw in the ER. I took them aside and stated in no uncertain terms that using silk on the face, when the option of monofilament existed, was unacceptable for my patients. Problem solved. We got along well. Never had to remove a silk suture from a face ever since. That represented a collegial solution to a problem.
The issue of boundary crossing is much more serious, and most likely training may need to occur, or worse consequences at progressive degrees of impaired decision making imposed. Reporting rumors, and making them College complaints seems a big step from witnessing an event.

THIRD RESPONSE

I was told by the College, when they were assessing a colleague who rents space at our clinic, that it was not our responsibility as a clinic to babysit them. As an IMG, they were given a full

licence. Now it would appear that I may be required to report them (notes from January not completed, b/w on patients with HT over 2 years old, etc). I am confused.
The examiners had access to the electronic charts, which had been brought up to speed for the examination time- but the date stamp on when they were last accessed would have been apparent-in some cases several months from the patient visit.
There does not appear to be a distinct penalty for not self reporting or for not reporting a colleague. Is there a reason to leave that out- to allow for flexibility on the part of the College disciplinary process? Should there be some kind of range or options set out in advance as to what to expect if in default of the guideline? The self reporting I have no issue with at all. The reporting of a colleague is a delicate matter, which is best based on facts.
If College examiners find no fault in a colleague's care of patients, who am I to say otherwise?
All the obligations to override PHIA listed are in circumstances of some type of danger, completely necessary, for sure. When safety is not an issue, the right of a patient to privacy is a more difficult bridge to destroy.
Overall the document is sound. My individual degree of confusion may not be shared by others.

Public

Thank you for inviting the public to participate in the review of this important standard of practice. I have read through the document. However I did not read through the linked documents associated with this standard. Overall it appears to be effectively comprehensive. I do have several suggestions for consideration. The content or intent of statement 1.1 would be more appropriately placed in the preamble at the beginning of the text since I believe that the ethical responsibility to report should exist for self, a colleague and for a patient; not just for self. Since a standard of practice is compulsory, the term “may” which is discretionary, needs to be exchanged for a more directive term because a breach of ethical responsibility described in a standard of practice requires consequences similar to those resulting from a failure to meet the specifics of that standard.
The term “promptly” is used throughout the standards document. As this is a subjective term, it could be problematic to comply with or enforce those aspects of the standard unless “promptly” is defined within the standard of practice document.

WHO WILL BE REVIEWING OR WORKING WITH FLAGGED DOCTOR

WHO DEALS WITH DOCTOR AND MAKES DECISIONS RE ANYTHING TO DO WITH DOCTOR

WHERE DO PATIENTS FIT IN TO SUPPORT DOCTOR OR IDENTIFY DOCTOR AS NOT APPROPRIATE TO NOT CONTINUE TO PRACTICE OR BE DISCIPLINED OR REQUIRE EDUCATION UPGRADE OR SKILL UPGRADE IF SURGEON

IF REPLY COMPLAINT PROCESS YOU ARE COMMITTING FRAUD.COMPLAINTS TO YOUR COMPLAINT DEARTMENT ARE BEING COVERED UP.

I REQUEST AN IN PERSON MEETING TO DISCUSS A MATTER I AM PERSONALY INVOLVED WITH.
Stakeholders
I have reviewed the consultation document and I am in full support of the document.
Thank you for providing us with the opportunity to review and provide feedback on your Standard of Practice – Duty to Report Self, Colleague or Patient. We noted in item 2.2 duty to report another member of a different regulated health profession – you have specified that this report should be made to the CPSM registrar. The Code of Ethics for Registered Dietitians, item 2.9, requires dietitians to bring forward concerns about unsafe practice or unethical conduct by other health care professions to their appropriate regulatory body. Have you considered requiring that these reports be made to the regulatory body of the other health care provider, rather than CPSM?
Thank you for the opportunity to review your proposed Standard on the Duty to Report. We noted that you have proposed to direct your members to report members of other regulated health care professions who may be unfit to practice, incompetent or unethical, or who may suffer from a condition that appears to be affecting their practice. We also noted that you have proposed to direct your registrants to make those reports through the CPSM Registrar, instead of directly to the regulatory body of the health care professional. We are concerned that this approach may risk delaying a report to us, if it takes time for the report to be vetted through the CPSM. We understand, from discussions with Kathy Kalinowski, that the reasons for reporting to the CPSM include providing physicians with assurances of liability protection, which might otherwise be a concern for them. We understand that rationale; however, we noted that there is liability protection in PHIA (section 62) for any disclosure made “where the trustee reasonably believed that the disclosure was authorized under the Act.” The CLPNM assumes that the CPSM has considered how section 62 would or would not apply in these circumstances and has deemed it absolutely necessary to vet these reports. Provided that CPSM feels confident it has the capacity to quickly vet and forward reports regarding other health care professionals (including LPNs), we have no comments about the proposed standard.

I reviewed the new Standard of Practice on Duty to Report. I find in very concise and easy to understand. This is a difficult topic given the conflicting professional obligation of confidentiality of patient information. I applaud the College of Physicians and Surgeons of Manitoba for creating this document and clarifying expectations for registrants.
I am writing to you on behalf of the College of Licensed Practical Nurses of Manitoba, with respect to your current consultation on the CPSM's proposed Standard respecting the Duty to Report. Our response has been sent by our Executive Director to the CPSM Registrar directly, but I am including it below as well for the working group's consideration. We noted that you have proposed to direct your members to report members of other regulated health care professions who may be unfit to practice, incompetent or unethical, or who may suffer from a condition that appears to be affecting their practice. We also noted that you have proposed to direct your members to make those reports through the CPSM Registrar, instead of directly to the regulatory body responsible for overseeing the practice and conduct of the other health care professional. We are concerned that this approach may risk delaying a report to us, if it takes time for the report to be vetted through the CPSM. We understand, from discussions with Kathy Kalinowski, that the reasons for reporting to the CPSM include providing physicians with assurances of liability protection, which might otherwise be a concern for them. We understand the rationale; however, we noted that there is liability protection in PHIA (section 62) for any disclosure made "where the trustee reasonably believed that the disclosure was authorized under the Act." Have you considered how section 62 of PHIA would or would not apply? Provided that CPSM feels confident it has the capacity to quickly vet and forward reports regarding other health care professionals (including LPNs), we have no comments about the proposed Standard.
CMPA – See attached

Thank-you for this opportunity to review and provide comment on the proposed Standard of Practice - Duty to Report Self, Colleagues or Patients	Katherine Stansfield

based on the *Regulated Health Professions Act* (RHPA) s. 138.1. The College of Registered Nurses (CRNM) agrees with this interpretation of this section of the Act and that it is the responsibility of regulated healthcare professions to report issues related to another regulated member's fitness to practice to the Registrar; in this Standard of Practice, the Registrar of the CPSM. When extrapolated to other regulated health professionals, the method of report would remain the Registrar of their own regulatory body. This seems reasonable, as it may not be immediately evident where to direct the report in all cases. There is a discrepancy between the CRNM and CPSM statements in that the CRNM encourages registrants to follow certain steps in making their decision regarding reporting a colleague, as noted in the document Duty to Report document_file_44.pdf (crnm.mb.ca): • *gather the facts* • *seek relevant information from the individual(s) involved* • *consult appropriately with others* • *work with colleagues and managers and* • *speak directly to the RN involved.* *It can be difficult to decide whether to report a RN to the College. Therefore, these steps should be taken before informing the College.* This differs from the CPSM Practice Standard: *While many members may believe it is more socially appropriate to take concerns directly to the individual involved (rather than reporting them to CPSM), in medicine the overarching obligation to patient safety creates a higher duty to report. Every member must act in ways that are transparent, accountable, and most importantly in the public interest - this protects the trust relationship between medicine and society.* *CPSM recognizes it can be difficult to report a colleague. If there is no imminent patient safety concern it may in some circumstances be acceptable to ask your colleague to start the process by self-reporting their circumstances to CPSM. To fulfill the duty to report, this must still be followed up by a timely report to CPSM.* In RN practice, there is frequently an employer who is also responsible for monitoring and responding to practice concerns, and therefore an intermediary step to consult with the manager and other colleagues may be helpful in determining whether or not to report the matter to the College. This may not be the case for physician practice. However, this is	College of Registered Nurses of Manitoba

worthy of note as it may lead to differences in reporting, particularly of registrants outside of one's own profession. I hope these comments are useful in development of this Standard of Practice.	
Thank you for the opportunity to review and comment on the proposed Standard of Practice "Duty to Report - Self, Colleagues or Patients". On behalf of the Council of the College of Physiotherapists of Manitoba, I have reviewed the Standard of Practice, Frequently Asked Questions and the Contextual Information and Resources documents and offer you the following comments. Standard of Practice Document: **"Part 2, clause 2.2. The duty of members to report in s.138 of the RHPA is expanded to include the duty to report another member of a different regulated health profession who meets the same reporting criteria described above. The report should be made to the CPSM Registrar."** Currently, any physician can make a report to the Registrar of another College, such as the College of Physiotherapists of Manitoba (CPM). In fact, we have received such complaints and dealt with them. These complaints are reported to the Registrar of CPM and are handled through our complaints process and committee. What purpose would it serve for a physician or surgeon to now be obligated to report these complaints to the CPSM Registrar? What will the CPSM Registrar do with these complaints? Your document does not specify what happens next. However, I can only foresee that the time to deal with these complaints will be increased by adding the additional reporting step. **"2.4 The duty to report a CPSM member or member of another regulated health profession arises regardless whether the member is a patient or a colleague."** This, in my opinion, defies the tenets of patient confidentiality. Members of regulated health profession will think twice about attending a physician's clinic if they think they are going to be reported. This may result in the patient, who is a health professional, not getting medical or mental health problems dealt with by an appropriate medical provider or not treated at all. This puts health care professionals at a disadvantage in the health care system. Perhaps Part 3 3.2 should be moved up earlier in the document and not saved until the last point. Otherwise, I think the document looks reasonable.	Brenda McKechnie College of Physiotherapists of MB

Thank you for the opportunity to review the draft Standard of Practice – Duty to Report Self, Colleague, or Patient. Please find CPhM's comments/feedback on this draft SOP below: **Part 1. Duty to Report Self** **Section 1.2.2** – This statement bring forward questions of what the regulator proposes to do with the collected highly sensitive personal health information of the member (such as the diagnosis of a blood borne pathogen). Is the regulator intending to or prepared to impose license conditions or react in a disciplinary manner with that information, such as removing that member from practice (through license suspension, or license conditions)? Does this have any legal ramifications? This also brings to light the member's right to maintain confidentiality of their own health status. The requirement as outlined within *CPSM General Regulation* 4.4 is more broadly termed, requiring that the member disclose if they currently are, or will be performing a procedure involving a risk of transmission of a blood borne pathogen. This still affords the member privacy of their personal health status/condition, while still protecting the public. Suggest removing the requirement for disclosure of a blood born pathogen diagnoses, and require that the member disclose any potential risk for transmission of blood borne pathogens from a given procedure. **Section 1.5 and Section 2.7** – This is an interesting statement, and brings forward questions of legality. How does this regulatory requirement prevail over an organizational/institutional confidentiality/non-disclosure agreement? Wouldn't there be potential for legal ramifications from the institution/organization? **Section 2.2** – Although it is highly important for a member to report another member of a different regulated health profession meeting the criteria, similarly as required for reporting self, priority should be given for the member to report such information directly to the other regulated health care professional's regulator/College (as outlined in subsection 57(4) of the RHPA). This removes the requirement and additional step for the CPSM Registrar to further report to the other regulated health care professional's College, with reporting being direct. Suggest including that the member report another member of regulated health care profession directly to that other College. **Section 2.9** – Suggest including further definition of what is considered "reasonable grounds". For example, from the College of Physicians and Surgeons of Alberta: CPSA - Duty to Report a Colleague: "**Reasonable grounds**" connotes a belief in a serious possibility based on credible evidence or the point where credibly-based probability replaces suspicion. It is the reasonable belief that an event is not unlikely to occur for reasons that rise above mere suspicion. **Contextual Information and Resources – Duty to Report Self, Colleagues and Patient**	Rani Chatterjee-Mehta College of Pharmacists of MB

Reporting a Colleague – Although the duty to report a colleague may be necessary in order to protect the public, it seems that the important step of open transparency with the affected colleague is missing from this direction. Perhaps this is inherent, but it is not clearly outlined in this directive. The member should be transparent with the impacted colleague upfront, encouraging that they self-report themselves. Should the impacted colleague refuse to self-report, the member has the duty to inform the colleague that a report of concern will be made to the regulator. If immediate patient safety is at risk, the impacted colleague must still be informed upfront of the concerns, with notice that a report of the concern will be made to the regulator. **Reporting of a Colleague – As a treating member of another CPSM member of regulated health professional** – Reporting of such kind is conceptually necessary to protect the public, but this direction seems to be missing particular components. What specific guidance and direction are provided to the physician treating when presented with this scenario/issue (what is defined as "reasonable grounds" for reporting?), and how will the patient (other CPSM member, or regulated health professional) be informed upfront that their personal healthcare disclosures may be reported back to their regulatory authority? **General feedback** – What are the penalties (if any) for failure to report one's self, colleague, or patient? Once again, thank you for the opportunity to review and provide feedback.	
Doctors Manitoba – See attached	Andrew Swan
	Laura Panteluk College of Registered Practical Nurses of MB

Thank you for the opportunity to provide feedback on the *Standard of Practice: Duty to Report Self, Colleagues or Patients.* The College of Registered Psychiatric Nurses of Manitoba (CRPNM) believes it is important to address the ethical duty to report any regulated health professional when there are concerns that professional may be suffering from a physical condition or mental disorder or an addiction to drugs or alcohol of a nature and to the extent that it makes it desirable in the public interest that they not practice. Of course, this reporting is not limited to fitness to practice issues as they may also include concerns about professionalism, ethical practice and safety.

We will not comment on areas that are primarily intended for physician practice, but would note that some of our registrants provide mental health and addiction services to physicians. In those cases, and where applicable, the RPN may be supporting a physician to make a disclosure to their College. Alternatively, as directed by our Standards of Psychiatric Nursing Practice and Code Ethics, they may also find themselves in a position where they have an ethical duty to report to your College. Self-report where fitness to practice issues are concerned is the most desirable, but we recognize that this is not always possible. We also recognize the moral distress that often arises as a result of having to make these kinds of reports.

We are also responding in the context of a regulator and what we would expect in terms of physician's reporting concerns about the fitness to practice of a RPN.

Part 1. Duty to Report Self

1.1. Members who may have a diminished ability to provide safe and competent medical care have an ethical responsibility to report to CPSM and restrict or withdraw from practice.

- will diminished ability be defined? Does this refer to diminished capacity in the context of an ability to use and understand information and make decisions? Or does it mean something else? A definition would provide more clarity to this statement.

Part 2. Duty to Report a Colleague – CPSM and Other Regulated Health Professionals

- There is some important information in this section but it is a bit difficult to delineate the legal and ethical reporting requirement with respect to a member of the same profession versus that of another regulated professional (which is not legally required, but may be ethically required). Have you considered addressing these separately for clarity?

2.2: The duty of members to report in s. 138 of the RHPA is expanded to include the duty to report another member of a different regulated health profession who meets the same reporting criteria described above. The report should be made to the CPSM Registrar.

- If we understand this statement correctly, you are saying that your Standard is expanding the requirement of s. 138 of the RHPA to include the

duty to report another member of a different regulated profession who meets the same reporting requirement?

- Although the RPN profession is not yet regulated under the RHPA (and as such, does not have these reporting requirement laid out in legislation in the same way), the principles are substantively the same. That said, if a physician had concerns about a Registered Psychiatric Nurse they would need to report to the Registrar at CRPNM, not CPSM. Our process to address the issue may be impacted if we did not receive the complaint/concern/report directly. In other words, we may face challenges engaging our processes if the report came via CPSM.
- Conversely, if an RPN had a concern about the fitness to practice or the professionalism, ethical practice and safety of a physician, we would direct that they report to CPSM. We currently address this obligation through the following statements in our Standards of Practice (2019):
  - Responds to and/or reports unsafe practice, professional incompetence, professional misconduct, and incapacity or fitness-to-practice issues to the appropriate authority.
  - Complies with any legal duty to warn and report, including abuse or potential harm to the public.
  - Self-reports to the regulatory body conditions that compromise their fitness to practice.

And we expect that RPNs will adhere to uphold the Standards of the registered psychiatric nurse profession.

Frequently Asked Questions:

What type of health conditions are reportable?

Anything that may impact the ability to practice of medicine – including but not limited to substance abuse disorder, cognitive decline whether due to age or other causes, neurological disorders even in the initial stages, cancer, depression, mental health illnesses, and chronic pain. CPSM takes a confidential, supportive, and rehabilitative approach to members who are experiencing both acute and chronic illness.

- This seems very broad and unspecified. In its current form, this section implies that a report is made based any diagnosis that has the potential to impact practice, even if it it's not currently impacting practice. In other words, if an physician is diagnosed with a mood disorder that is well managed and there are no concerns with respect to mood, thought or condition, that would be reportable? Is that the intent?
- This seems to deviate from the earlier mentioned reporting criteria, specified in 138(1) (b)- see underlined text below:
  A member who reasonably believes that another member of the same regulated health profession
  (a) is unfit to practise, incompetent or unethical; or
  (b) suffers from a mental or physical disorder or illness <u>that may affect his or her fitness to practise, and continues to practise despite having been counselled not to</u>; must disclose that belief to the registrar, along with the

name of the other member and particulars of the suspected disorder, illness, lack of fitness to practise, incompetency or unethical behaviour. *I occasionally provide medical treatment to physicians. One of my physician patients is depressed. Should this be reported to CPSM?* *Health issues that have the potential to impair a physician's functional ability, cognition, judgment or insight are reportable. It is advised that you have a conversation with your physician patient about the importance of self-reporting an illness to the CPSM that could result in a potential risk to patient safety and remind them the Physician Health Program takes a compassionate, non-punitive and reasonable approach to all health reporting.* - As per the previous example, the presence of the condition or illness is reportable when, in fact, the client may be well-functioning or safe and fit to practice? Would it be more reasonable to state that the condition is reportable when it has been determined that the condition is deteriorating in a manner that makes it reasonably likely that the physician's judgement, safety or competence may become or is impaired? - We anticipate that our registrants will question if making this disclosure, when there is no reasonable basis to believe that the physician is unfit to practice, is a violation of PHIA. Thank you, again, for the opportunity to provide our feedback.	
A. Preamble Thank you for the opportunity to review the draft CPSM Standard of Practice – Duty to Report Self, Colleague or Patient. We respectfully offer the following feedback. Given the significance of this proposed approach on CPSM members, other health practitioners in Manitoba and the public, it is essential that greater opportunities for review are undertaken. A one-month consultation period does not seem adequate. Though the standard is intended to guide the action of physicians and surgeons in Manitoba it has far reaching societal consequences. It is not in the public interest to potentially limit health professionals accessing necessary health services due to apprehensions of being reported to the Registrar of CPSM. The process that will be used by the Registrar of CPSM in receiving and managing the complaints they receive about regulated health professionals in Manitoba is unclear. Additionally, it is unclear how this standard is supported by legislation. The motivation to create a standard that is comprehensive on mandatory reporting for CPSM members ignores the need to support the public as a primary audience for the standard. The many requirements for mandatory reporting of patients through provincial and federal legislation is of significant value to the public. Rather than incorporate this information into a broad standard, it is recommended that it be developed as a separate resource.	Sharon Eadie College of Occupational Therapists of MB

B. Background

In order to provide this response, we have reviewed the following documents:

CPSM Consultation Document (March, 2021)
CPSM draft Standard of Practice – Duty to Report Self, Colleague, or Patient (March 2021)
CPSM Contextual Information and Resources – Duty to Report Self, Colleagues, or Patient (March 2021)
CPSM Frequently Asked Questions – Duty to Report Self, Colleague, or Patient

We also considered the following:
Health Professions Act (of Alberta), Chapter H-7 Section 127(1) and 127.(2) (https://www.qp.alberta.ca/1266.cfm?page=H07.cfm&leg_type=Acts&isbncln=9780779740772
Module 1: Introduction to *An Act to Protect Patients* – A PowerPoint Presentation on this Alberta legislation as provided by my Alberta colleague
Health Professions Act (of BC), S. 32.2 – 32.4
https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/00_96183_01#section32.2
College of Registered Nurses of Ontario Reporting Guide
Consultation with legal counsel
Review of the relevant BC and AB legislation with colleagues from the College of Occupational Therapists of BC (COTBC) and the Alberta College of Occupational Therapists (ACOT)
Government of Manitoba – Families resource The Vulnerable Persons Living with a Mental Disability Act (gov.mb.ca)

C. Detailed Review of the Draft Standard

We would like to offer these more detailed comments.

1. Part 2 Duty to Report a Colleague – CPSM and Other Regulated Health Professionals

Regarding Draft S 2.2 which reads:
The duty of members to report in s. 138 of the RHPA is expanded to include the duty to report another member of a different regulated health profession who meets the same reporting criteria described above. The report should be made to the CPSM Registrar.
The process for the reporting of colleagues is unclear. As it is currently stated, the CPSM member is reporting colleagues of other professions to the CPSM Registrar. What process will be followed by the CPSM Registrar related to that matter? It is unclear that the CPSM can expand the legislated duty to report outlined in S. 138 of The Regulated Health Professions Act via a standard that now affects all other regulated professionals in Manitoba. Your supporting Contextual Information and FAQ's speak to the presumed processes of other Manitoba regulatory organizations, for e.g. the Manitoba Dental Association.

COTM was informed that the legislation in BC is a model for this approach of reporting on a colleague. However, the reporting of a colleague has the threshold

that is “a danger to the public” which seems like a different standard than that in the CPSM draft. Further, the reporting obligations related to a health condition is specifically outlined in 32.3 of the BC Regulated Health Professions Act and is quite distinct from the approach recommended in the CPSM draft; the focus on psychiatric conditions and hospitalization.
https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/00_96183_01#section32.2

Regarding Draft S 2.4 which reads:
The duty to report a CPSM member or member of another regulated health profession arises regardless whether the member is a patient or a colleague.
It would appear that this statement in the draft standard does not have regard for the effect this reporting could have on health professionals seeking medical services. It is not in the public interest for health professionals to be reluctant to seek treatment when needed. The information does not seem to address that the reporting health professional may not be in the best position to determine the potential effect of the health condition on the patient’s practice and as such will be compelled to report. The message in the Contextual Information and Resources Document conveys that the treating professional should default to reporting. (page 2) As noted earlier, the threshold as to what should be reported in the draft standard seems quite different when compared with the “danger to the public” threshold in the BC legislation (S.32.2)

Regarding Draft S 2.9 (See consultation document for the full proposed standard on the reporting of suspected sexual misconduct.)
It is unclear if this report about another regulated professional is also being made to the CPSM Registrar.
COTM was informed that the legislation in BC is a model for this approach of reporting on a colleague. The patient consent process outlined in 32.4 of the BC Regulated Health Professions Act varies from the approach recommended in the CPSM draft.
https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/00_96183_01#section32.2

2. Part 3 Duty to Report the Medical Condition or Knowledge of Patient Information

As noted in our opening comments, it would be advisable to have a separate standard related to this Duty to Report rather than incorporate into one standard. A separate focused document addressing the content of Part 3 would be of significant benefit to members of the public to better understand the obligations of their physician.

3. Frequently Asked Questions:

We noted one example that does not appear to be accurate.

The following example was provided:
My cognitively declining elderly patient who lacks capacity is brought to appointments by a nephew who is now living at their home. The nephew may be taking advantage of the patient financially, and I have seen some

bruising that is explained away by falls. It just does not seem plausible. What should I do? You are required to report this situation to provincial Department of Families under the *Vulnerable Persons Living with a Mental Disability Act* and that Department is required to investigate. https://www.gov.mb.ca/fs/pwd/vpact_protection.html **The resource provided by the Government of Manitoba – Families outlines the following in their resource materials:** **The Vulnerable Persons Living with a Mental Disability Act (gov.mb.ca)** Who is this law for? This law applies to adults living with a mental disability who need assistance to meet their basic needs with regards to personal care or property management. To be mentally disabled means that the person has significant intellectual impairment plus impaired adaptive behaviour, both having occurred before the age of 18 years. The act does not apply to persons whose mental impairment occurred in adulthood. (underlining added by writer) Contact with the Office of the Vulnerable Persons' Commissioner confirmed our understanding of the statute and its scope regarding who is protected by this legislation.	
Thank you for providing the Manitoba Chiropractors Association (MCA) with the opportunity to review the CPSM "Standard of Practice of Medicine Duty to Report – Self, Colleague, or Patient." MCA has previously addressed during MAHRC meetings that there is a lack of parity with respect to legislative processing of complaints among regulated health professions. Those professions operating under *The Regulated Health Professions Act S.M 2009, c. 15* (RHPA) have a legislative intake process that allows the Registrar to review a complaint in order to determine whether it has merit to enter the regulatory queue. Under S. 91(2) of RHPA, the Registrar has three options in respect of a complaint: (a) encourage the complainant and the investigated member to communicate with each other and resolve the complaint; (b) refer the complaint to the complaints investigation committee; (c) dismiss the complaint if the registrar is satisfied that it is trivial or vexatious or that there is insufficient evidence or no evidence of conduct about which a finding could be made under subsection 124(2). Further to this, a complainant, when notified of a dismissal, may within 30 days apply to the registrar for a review by the complaints investigation committee in writing as per S. 92(2) of the RHPA. This appeal process is expedient for the sake of a complainant with minimized costs to both the complainant and the regulatory body.	Audrey Toth Manitoba Chiropractors

In contrast, a complaint received by MCA is processed under *The Chiropractic Act of Manitoba C.C.S.M. c.100*. The Registrar has no discretion with a complaint once received, other than to direct it to the MCA Complaints Committee (S. 32 and 33) or MCA Investigation Chair (S. 34 through 41). In fact, a dismissal of a complaint with MCA must occur under S. 40(a) and must be ratified by Board Order upon receipt of the report and recommendation of the Investigation Chair. A complainant who feels aggrieved by a Board Order under Section 40(a) is left with only an option to appeal the order of the Board under S 50. to a judge of the courts. This process additionally bears a significant financial burden to both the regulatory body to get it to a point to be dismissed as well as to a complainant who wishes to appeal the decision of dismissal. The ability of a Registrar under RHPA to encourage a complainant and investigated party to communicate with each other and resolve the complaint or to dismiss outright for appropriate reasons creates an imbalanced processing potential if CPSM members were to inundate another healthcare profession not under RHPA with complaints that are trivial or vexatious or with insufficient evidence, or with no evidence of conduct that could result in a finding of professional misconduct or conduct unbecoming. MCA will request that this amendment, "Standard of Practice of Medicine Duty to Report – Self, Colleague, or Patient" be only applicable for complaints to be received by those regulated health professions that fall under the RHPA and/or that bridging legislation or latitude be afforded to other professions not yet under the RHPA to allow similar processing as contemplated under RHPA to accept a complaint.	

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April 22, 2021

Via email: dutytoreport@cpsm.mb.ca

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

Dear Dr. Ziomek:

Re: Consultation on draft Standard of Practice, *Duty to Report Self, Colleague, or Patient*

Thank you for inviting the Canadian Medical Protective Association (CMPA) to provide feedback on the College's draft Standard of Practice, *Duty to Report Self, Colleague, or Patient.* We presume that this draft Standard is intended to replace the current Standards of Practice, *Self-Reporting to CPSM* and *Duty to Report Another Member*.

The CMPA appreciates the opportunity to comment on this important issue to physicians. We are hopeful that our comments will assist the College in clearly and fairly articulating physicians' reporting obligations in the draft Standard.

CMPA Background

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

The CMPA routinely provides advice and guidance to physicians to assist them in understanding their reporting obligations under legislation and College standards. In the event that a physician is the subject of a legal action or complaint for having made a report or failed to make a report in the course of his or her professional activities, the CMPA would generally extend assistance to the member in defending such actions or complaints related to the member's practice of medicine. It would therefore be helpful for the draft Standard to encourage physicians to contact the CMPA if they are unsure about their reporting obligations.

Duty to Report Self

Health Conditions

The CMPA remains of the view that physicians should not be required to disclose broad information concerning their health status, especially health conditions that do not currently create a genuine risk to patient safety in the circumstances of their particular practice.

We expect the draft Standard has been modified to be consistent with the revisions made to the 2020-2021 Annual License Renewal Form ("ALRF") in regards to physician health information. Similar to the ALRF, section 1.2 of the draft Standard would require physicians to report any health condition that may affect their practice of medicine, including conditions that may impair their ability to engage in the practice of medicine in a safe and effective manner and that makes it desirable in the public interest that the physician not engage in the practice of medicine. Physicians would also be required by section 1.1 to self-report when they may have a diminished ability to provide safe and competent care.

In response to concerns previously expressed by the CMPA, the College advised that the updated reporting requirement in the ALRF is based on subsections 4.4(2) and 4.10 of the *CPSM General Regulation*, which deals with information required to be disclosed upon initial registration and annual renewal. As mentioned in the context of the updated ALRF, the CMPA believes that physicians should not be required to engage in a speculative exercise about health conditions that have no likelihood of affecting their ability to practice. Simply because the language used in the ALRF and draft Standard is based on the *CPSM General Regulation* does not take away from the fact that the requirement is overly inclusive and imposes an unacceptable burden on physicians to hypothesize about an unlimited scope of health conditions and the potential impact on the public interest.

While the CMPA would prefer that the College limit reporting to conditions that are presently negatively affecting the physician's ability to practice, we are encouraged by the statement in the "Contextual Information and Resources" section of the draft Standard, which states that "reporting a health condition to CPSM must feel safe to members and be non-punitive." We therefore trust the College will be judicious and balanced in responding to any health information disclosed by physicians under this new reporting obligation.

Bloodborne Pathogens

The CMPA encourages the College to ensure the draft Standard is consistent with the legislation and other Standards of Practice in regards to the duty to report bloodborne pathogens.

Section 1.2.2 of the draft Standard states that a physician must report "being diagnosed with a bloodborne pathogen and performing a procedure that involves a risk of transmission." The *CPSM General Regulation* requires a member to self-report on an ongoing basis only when they are "or will be performing a procedure that involves a risk of transmission of a bloodborne pathogen." On the other hand, the Standard of Practice on *Bloodborne Pathogens* requires a member to self-report when they have a known active infection with HBV, HCV and/or HIV.

Wording the duty to report in divergent ways makes compliance more challenging for physicians. It is important that clear and consistent language be used to avoid any uncertainty as to when physicians are expected to report.

Protection of Physician Information

In an effort to ensure physicians are aware of the College's commitment and obligation to maintain confidentiality over information collected regarding physicians' personal health, the CMPA suggests that the draft Standard expressly state that physicians' personal health information will be treated with the utmost sensitivity and confidence, and that access to that information will be limited to a need-to-know basis.

Duty to Report a Colleague

Reporting Other Physicians

The CMPA urges the College to remove section 2.3 from the draft Standard. We are concerned that this section is unduly broad and onerous. Although section 2.1 appropriately reflects the duty to report other physicians that is mandated by subsection 138(1) RHPA, the reporting obligations listed in section 2.3 go beyond the statutory duty.

We are most troubled by section 2.3.1, which would require physicians to report physician colleagues based on the same circumstances for self-reporting in Part 1 of the draft Standard. Amongst other things, section 2.3.1 would require physicians to make reports regarding other physicians' regulatory, legal and hospital disciplinary history (section 2.3.1). This information may not be reliably known or understood by the reporting physician. The best source for this type of information should come from self-reporting, not from colleagues.

Section 2.3 also imposes an unreasonable burden on physicians to evaluate the behaviours or intentions of other physicians, including in a non-clinical context. Many physicians are not trained or equipped to appropriately assess such matters. Not only would this broad reporting obligation make it challenging for physicians to comply, it would also expose them to the risk of a complaint or legal action by the physician who is the subject of the report.

Reporting Other Regulated Health Professionals

The CMPA recommends that references to the duty to report other regulated health professionals reflect the parameters of the reporting obligation in subsection 57(4) of the RHPA. As currently written, the draft Standard provides that the duty to report other physicians under subsection 138(1) RHPA "is expanded to include the duty to report another member of a different regulated health profession who meets the same reporting criteria."

We acknowledge that subsection 57(4) of the RHPA is limited to physicians reporting other health professionals with whom they "practise in association".[1] However, it is more reasonable for the draft Standard to reference this section, rather than subsection 138(1), since it imposes a distinct reporting duty with respect to other regulated health professionals. There was clearly a legislative

[1] Subsection 57(2) of the RHPA defines "practise in association" as a practice in co-operation with another member of the same college, a member of any other college or any other person providing health care that includes one or more of the following joint advertising; sharing an office telephone number; combined client billing for health care provided by more than one person; sharing an office reception area; sharing an office or clinic expenses; sharing administrative functions or expenses; sharing ownership or use of premises, equipment, furnishings or other property; sharing employees; circumstances that the regulations describe as practising in association.

intention for subsections 138(1) and 57(4) to be worded differently and give rise to different reporting obligations depending upon which health professional is subject to the report.

We also find it curious that section 2.2 of the draft Standard states that the report should be made to the CPSM. Subsection 57(4) states clearly that the report should be made to the other health professional's College. Indeed, the CPSM would have no jurisdiction over these other health professionals.

Patient Confidentiality and Privacy

The draft Standard should remind physicians that the duty to report a colleague who is also a patient (section 2.4) must comply with the *Personal Health Information Act* (PHIA).

PHIA permits a physician to disclose a patient's personal health information without consent when authorized or required by law, such as when complying with the duty to report under subsections 138(1) and 57(4) RHPA. It also permits the disclosure "for the purpose of a body with statutory responsibility for the discipline of health professionals or for the quality or standards of professional services provided by health professionals."

However, PHIA also stipulates that "every use and disclosure by a trustee of personal health information must be limited to the minimum amount of information necessary to accomplish the purpose for which it is used or disclosed" (section 20.2) and that the disclosure can only be "to the extent the recipient needs to know the information" (subsection 22(3)). It is important that these limitations on disclosures be emphasized in the draft Standard. We are also concerned that physicians should not be discouraged from seeking required care due to the risk of overbroad reporting requirements.

Sexual Boundary Violations

It would be helpful if the reporting duty regarding a colleague's sexual boundary violation disclosed by a patient clarified what steps physicians should take if the patient refuses to file a complaint (section 2.9).

The draft Standard states that if a patient does not wish to file a complaint after disclosing a sexual boundary violation committed by another physician, then the physician must offer to file the complaint on their behalf. However, it is unclear what the physician is required to do if that offer is refused. Section 2.9.3 states only that a physician must report the colleague to the College "in the absence of confirmation that the patient has filed a complaint."

Although a physician is authorized under PHIA to disclose a patient's personal health information without consent for the purpose of a regulatory College, or to prevent a risk of harm to the patient, another individual, a minor, or the public (section 22), this is not a mandatory requirement. The RHPA also does not impose a duty to report in these circumstances. Indeed, a physician who discloses a patient's personal health information despite their refusal to consent to the disclosure, and in the absence of a statutory or regulatory duty to do so, could be exposed to a College complaint or legal action. It would be preferable if the draft Standard more clearly set out a physician's obligation to report a sexual boundary violation, including specifying that the patient's identity should not be disclosed without their consent.

Terminology

The CMPA recommends that the draft Standard clarify who is the subject of the mandatory reports. It is not always clear in the draft Standard whether the reporting duty relates to the actions or circumstances of physicians only or also other regulated health professionals.

In some cases, it is stated that the duty to report relates to "a CPSM member or member of another regulated health profession" (section 2.4), but in others the Standard only refers to the duty to report "a member" (sections 2.5 and 2.7) or "another member" (sections 2.6 and 2.9). It should be clear to physicians who they are expected to report and in what specific circumstances.

General Reporting Obligations – Duty to Report Self and Colleague

The CMPA recommends that the reporting obligations in sections 1.4 and 2.6 be removed. These sections include a broad "catch-all" duty to report that creates uncertainty as to when those duties arise.

In this regard, section 1.4 imposes a duty to self-report in situations not covered elsewhere in the draft Standard but "where there is reason to believe [the physician's] circumstances may impact their ability to practice medicine safely and competently." Section 2.6 has a similarly worded reporting duty with respect to a colleague.

These duties to report are so broad, and the other specified reporting duties are already so extensive, that it would be challenging for physicians to know what circumstances are reasonably captured. Requiring physicians to report <u>any</u> personal circumstance that <u>may</u> impact the physician's (or their colleague's) ability to practice safely and competently requires a significant degree of speculation about a hypothetical scenario. This is likely to lead to inconsistent reporting and increase the risk of College complaints and legal action against reporting physicians.

Duty to Report the Medical Condition or Knowledge of Patient Information

It would be helpful if the draft Standard referenced other types of reports that may be permitted, but not necessarily required by law.

As currently written, this part of the draft Standard focusses only on mandatory reporting obligations in relation to patients. However, there are other circumstances where the disclosure of patient information is permitted by law. For example, the PHIA permits physicians to disclose personal health information about an individual if they have reasonable grounds to believe the disclosure is necessary to prevent or lessen a risk of serious harm to the health or safety of a patient or to public health or public safety.

It would also be helpful for the draft Standard to emphasize that when making a mandatory (or permissive) report, the information disclosed should be limited to what is necessary to fulfill the reporting obligation.

To address these issues, the College may wish to amend section 3.1 as follows:

> Members may be required or permitted to disclose a patient's personal health information in certain circumstances (see Contextual Information and Resources for list of legislation). In accordance with the *Personal Health Information Act*, the disclosure must be limited to the minimum amount of information necessary to fulfill the reporting obligation.

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

Yours sincerely,

Lisa Calder, MD, MSc, FRCPC
Chief Executive Officer

LAC/ml

cc. Dr. M. Cohen
Dr. A. Ziomek
Dr. D. Johnson

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VIA EMAIL

April 30, 2021

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

Dear Dr. Ziomek:

Doctors Manitoba appreciates the opportunity to participate in this consultation on the preparation of the new Standard of Practice on the Duty to Report Self, Colleague, or Patient (the "Standard").

The effort to consolidate and codify these principles, which are currently found among various statutes and regulations, is appreciated.

1. Introduction

Doctors Manitoba agrees with the CPSM that the protection of the public is paramount. If a health care professional has a physical or mental condition or disorder which puts patient safety at risk, it must be addressed in a timely way.

Over time, CPSM and Doctors Manitoba have developed collaborative approaches to assisting members who may have a physical or mental condition or disorder which affects their ability to practice. Generally, this has represented a shift from what was viewed by many of our mutual members as a punitive model to a healing and recovery model.

Our mutual members appreciate the progress of the CPSM Physician Health Program towards best practices in assisting physicians. Doctors Manitoba offers funding support to several programs including Physicians at Risk, Physician and Family Support Program, and MD Care, intended to provide assistance to members who are concerned their issues may affect their ability to care for their patients and who want to take preventative or remedial action.

Most of our comments on the proposed Standard relate to the duty of members to report their concerns about another physician, or another health care professional, to the regulator. This is a challenging area which, as we will discuss, is not addressed fully by legislation or regulation.

Members may become aware of a potential practice issue for another member or health care professional in many ways. It can be through disclosure or observation in the course of a physician and patient relationship, the provision of formal peer support in a recognized program, or informally in a clinic or facility, or even at a social event.

While the Standard recognizes the public interest of the disclosure of concerns, there is also a benefit in permitting members to seek out advice and help without the belief they could face immediate punitive sanctions which may affect their ability to practice. The Standard must protect the public without unreasonable obligations being imposed upon members who may become aware of a colleague's situation.

The literature on physician health and wellness makes it clear that a sense of camaraderie is a key driver of physician engagement if it is present. Conversely, the absence of support is a contributor to burnout. In addition, stigma and fear are significant barriers to physicians accessing support early in a preventative way. For example:

- Almost 50% of female physicians in one study did not seek treatment despite feeling that they met the criteria for a mental disorder. "I would never want to have a mental health diagnosis on my record." (Gold, et al. in General Hospital Psychiatry, 2016);
- Residents in another study repeatedly told program psychiatrists that if not for the assurance of absolute confidentiality they would not have used the mental health services program. (Pitt et al. in Academic Medicine, 2004);
- The CMA National Physician Health (2018) revealed that "Ashamed to seek help" was the second largest barrier to physicians reaching out for support; and
- In the recent MDCare and PAR evaluation, fear of exposing their problem to CPSM was noted as *the* main barrier to physicians seeking care.

The development of this Standard is an important and timely opportunity to enhance conditions within the profession of medicine that support camaraderie and reduce stigma.

2. Legislative and Regulatory Background

We believe it is helpful to review the legislative and regulatory requirements which provide the background for the Standard.

The general obligation of a physician to report his or her own issues to the CPSM is undisputed. Section 40 and 41 of the *The Regulated Health Professions Act* (RHPA) provide the background for each member's personal obligations contained in Section 4.4 and Section 4.10 of the CPSM General Regulation. These sections obligate each member to report "that he or she does not have a physical or mental condition or disorder, including any addiction to alcohol or drugs, that may impair his or her ability to engage in the practice of medicine in a safe and effective manner, and that makes it desirable in the public interest that he or she not engage in the practice of medicine." While this is reported annually, members are obligated to update the information promptly should there be a change.

The duty of a member who learns of another member's issue is set out in Section 138(1) of the RHPA as follows:

Duty of members to report

138(1) A member who reasonably believes that another member of the same regulated health profession

(a) is unfit to practise, incompetent or unethical; or
(b) suffers from a mental or physical disorder or illness that may affect his or her fitness to practise, and continues to practise despite having been counselled not to;

must disclose that belief to the registrar, along with the name of the other member and particulars of the suspected disorder, illness, lack of fitness to practise, incompetency or unethical behaviour.

Any physician making such a report is protected from liability unless their report is "malicious".

The duty of a member to report other health care professionals to their regulator is set out in Section 57(4) of the RHPA:

Duty to report

57(4) A member who reasonably believes that a member of a different regulated health profession with whom he or she is practising in association is suffering from a physical or mental condition or disorder of a nature or to an extent that the other member is unfit to continue to practise or that his or her practice should be restricted must inform the registrar of the other member's college about that belief and the reasons for it.

There are no additional provisions in either the CPSM General Regulation or the CPSM Practice Regulation which broaden or detail the obligations set out in the RHPA.

There are other legislative provisions which either require or permit disclosure (including the disclosure of certain information respecting patients who are neither physicians nor other health care professionals). These federal and provincial statutes are listed in the Contextual Information and Resources as a "general guide" to members.

The Personal Health Information Act (PHIA) permits the disclosure of patient personal health information in certain situations required by other federal or provincial legislation, or Court order. We do note, however, that PHIA does not of itself mandate or require any disclosure (except in very limited circumstances where it is compelled by the Ombudsman).

2. Recommendations of Doctors Manitoba

The communication of a topic as sensitive as this one can benefit from additional information to guide members. Doctors Manitoba applauds CPSM's inclusion of the

Contextual Information and Frequently Asked Questions for additional clarity. However, while these resources may assist in interpretation, it is the wording of the Standard which creates obligations and could potentially lead to discipline. Accordingly, we encourage the integration of some important context into the Standard itself, in part by the addition of a Preamble.

Recommendation 1: Add the following Preamble and Definition to the Standard:

Preamble:

Self-regulation is a privilege of the medical profession which comes with responsibilities. One such responsibility is the "duty to report". This duty protects the trust relationship between the medical profession and society by showing physicians to be transparent, accountable, and acting in the public interest.

If a member is unsure if they should self-report or report a colleague they are encouraged to seek appropriate advice (e.g., the Canadian Medical Protective Association).

Definitions

Report – A report to CPSM as part of this Standard is a notification for the purpose of assessing next steps. CPSM's approach to matters related to a physician's health are viewed through a treatment and/or rehabilitation lens aimed at supporting physician wellness. Physicians with health conditions are managed independently of the complaints or discipline process whenever possible.

Part 1 - Duty to Report Self

Section 1.1 places a dual, and presumably concurrent, obligation on a physician to report to CPSM and "restrict or withdraw from practice". The circumstances requiring a report are detailed in Section 1.2.

The CPSM Physician Health Program (the "Program") is intended to be corrective and therapeutic. The required reporting to CPSM and the initial assessment of the Program may well result in a physician being advised, or directed, to restrict or withdraw from practice. However, it may not. This should be determined by the Program and not be an immediate requirement for a member.

We are concerned that the proposed wording may result in a member being less likely to make a timely report to the CPSM. A member may expect and hope to receive help, but the Standard as drafted instead suggests there could be a disciplinary action for not immediately ceasing their practice.

Recommendation 2

Amend Section 1.1 to read as follows: "Members who have a diminished ability to provide safe and competent medical care have an ethical responsibility to report to

CPSM. Where applicable and possible, the Physician Health Program will engage reporting members in a collaborative and supportive planning and monitoring process."

Section 1.2.1, following the use of the word "addiction" in the RHPA, refers to "any addiction to alcohol or drugs". CPSM may wish to consider asking government to replace the term "addiction" with "substance use disorder" as per the DSM-5. The removal of the term "addiction" was made to acknowledge and conceptualize substance use problems as occurring on a continuum of severity and because the term addiction has become loaded and lacks precision. There are people who may consider themselves to have an "addiction" but who have been in recovery and abstinent for 20 years and therefore do not have a substance use disorder.

Recommendation 3

Replace the reference to "any addiction to alcohol or drugs" with "substance use disorder". When the opportunity arises, ask government to change the term "addiction" in the RHPA to "substance use disorder".

Section 1.3 lists events which require reporting and is largely satisfactory.

However, Section 1.3.5 may have unintended consequences. Members may face the "involuntary loss or restriction of diagnostic and treatment privileges" granted by a facility or authority which is wholly unrelated to the conduct or ability of a physician. As health care restructuring continues across Manitoba, we expect this will occur many more times. We do not believe the CPSM intends to require a report from every ER physician practicing at a facility where the ER is closed, nor every surgeon in a facility where a program is being consolidated. We would suggest an amendment to require some connection to the physician's conduct or performance (as in the other sections).

Recommendation 4

Amend Section 1.3.5 to read "any voluntary or involuntary loss or restriction of diagnostic or treatment privileges granted by an administrative authority in a hospital, health authority, or university or discipline, or any resignation in lieu of further administrative action, <u>except where the loss or restriction is the result of the closure or transfer of services provided by the member</u>."

Part 2 - Duty to Report a Colleague – CPSM and Other Regulated Health Care Professionals

This is the most challenging section of the Standard, given the dynamics and complexities of disclosures to members.

Section 2.2 is stated to "expand the duty of members to report" other health care professionals. We believe this duty would go well beyond Section 138 of the RHPA, which relates only to other members. We are also concerned this obligation, which is not contained in the General Regulation nor the Practice Regulation, is actually inconsistent with Section 57 of the RHPA, for the following reasons:

- The obligation in Section 57 of the RHPA to report another health care professional is limited to those physicians practicing "in association" with the health care professional; and
- The obligation in Section 57 of the RHPA is to report to the health care professional's regulator, not to the CPSM.

Any person (including a member) *may* make a complaint at any time to the health care professional's regulator. However, mandatory reporting is limited to certain circumstances, and must be done in a certain manner.

It seems appropriate that Section 2.2 make a distinction between mandatory and voluntary disclosure.

Recommendation 5

Amend Section 2.2 to read as follows:

2.2 Where a member is aware of and reasonably believes a member of a different regulated health profession meets the same criteria described above:

2.2.1 Where a member practices in association with the member of a different regulated health profession, the member must notify the regulator of the member of the different regulated health profession.

2.2.2 In all other circumstances, the member may notify the regulator of the member of the different regulated health profession.

2.2.3 The member may provide a copy of any notification to the CPSM Registrar.

Section 2.3 requires a member to report another member based on four enumerated circumstances. It is not expressly indicated whether any, or all, of these conditions must exist to require reporting.

Section 138 of the RHPA sets out the member's obligation to report, which are not set out in any greater detail nor even mentioned in the General Regulation or the Practice Regulation.

Section 138 requires immediate reporting if a member is of the opinion that another member is "unfit to practise, incompetent or unethical".

However, Section 138 is far more nuanced where a member becomes aware of another member's mental or physical disorder or illness. Section 138 requires reporting where the member "suffers from a mental or physical disorder or illness that may affect his or her fitness to practise, and continues to practise despite having been counselled not to."

Doctors Manitoba maintains this is intended to support the modern approach and best practice in dealing with the mental and physical health issues of physicians. Section 138 appears to anticipate that a member may reach out to another member for assistance. The trigger for a mandatory report for a member is not *immediately* upon learning of the issue, but only *after* the disclosing member has been counselled to take action (presumably by the member they have disclosed to) and fails to do so. This provision also aligns with the understanding that "illness" alone is not synonymous with being "unfit" or "incompetent".

The draft Contextual Information and Resources and Frequently Asked Questions appear to reflect this, to some extent, but the Standard does not. A member who receives a disclosure from another member appears to have no discretion to offer advice, assist with a plan, and encourage the disclosing member to report without immediately taking on a duty to report to CPSM.

Doctors Manitoba expects, and hopes, that CPSM would consider a choice by a member not to report another member to be a disciplinary matter in only the most extreme situations. Given the legislative and regulatory background, we anticipate the Standard as drafted could be open to challenge by a member who delayed reporting, or chose not to report, another member who took steps to seek assistance and treatment.

Recommendation 6

Section 2.3 be divided into two sections as follows:

2.3 A member must notify CPSM promptly once they become aware of and reasonably believe that another CPSM member:

2.3.1 is unfit to practise, incompetent or unethical;

2.3.2 suffers from a mental or physical disorder or illness that may affect his or her fitness to practice, and continues to practice despite having been counselled not to;

2.3.3. has an unwillingness or inability to address behaviour that interferes with patient care or negatively impacts the ability of other members or healthcare workers to provide patient care; or

2.3.4. behaves in a manner outside of providing patient care that could reasonably be considered unprofessional conduct under the Regulated Health Professions Act, Regulations, and Standards of Practice.

In line with the information in the Contextual Information and Resources, acknowledging the ethical dilemma faced in some reporting circumstances can encourage a less stressful and more humane interaction for all involved.

Recommendation 7

Add the following after Section 2.3 as a new Section 2.4, adapted from the Contextual Information and Resources:

2.4 (new) **If there is no imminent patient safety concern and if circumstances are appropriate, a member may discuss the concern directly with the other member, assist the member in accessing support, and/or develop a plan to notify CPSM together. If circumstances are not appropriate or if this approach is unsuccessful or incomplete, the member shall report to CPSM.**

Part 3 Duty to Report the Medical Condition or Knowledge of Patient Condition

Part 3 of the draft Standard is largely satisfactory.

The various legislation referred to in the Contextual Information and Resources mandates certain disclosure, but permits others. There are numerous and varying obligations, but only where the disclosure is mandatory is the member required to comply (and, conversely, is a failure to comply a disciplinary matter).

Recommendation 8

Amend Section 3.1 to read as follows:

"Members must comply with <u>any</u> duty to report the medical condition or knowledge of patient information as prescribed by Provincial and Federal Legislation (see Contextual Information and Resources for list of legislation)."

In light of the above recommendations, we believe that minor changes to the Contextual Information and Resources and Frequently Asked Questions are warranted.

3. Annual Disclosure Form

The content of the Annual Disclosure Form is not included in this consultation. However, it appears that this Standard may require changes to the self-declaration form.

We understand the form currently requires members to answer the following two questions related to the Standard:

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

Have you ever had, or have you ever been advised that you had, a condition or disorder as described in the question above that has the potential to reoccur?

We encourage CPSM to review this form with the same evidence-based and compassionate lens used in the development of the Standard. We recommend this review include an analysis as to whether the current wording of these questions is consistent with both the Charter of Rights and Freedoms and the Manitoba Human Rights Code.

Dr. Christine Moutier's article "Physician Mental Health: An Evidence-Based Approach to Change" (2018) and Mehta and Edwards' "Suffering in Silence: Mental Health Stigma and Physicians' Licensing Fears" contain specific examples and recommendations which may be of interest. Jean Wallace (University of Calgary) also provides important context to this topic in her article, "Mental Health stigma in the medical profession" (2010).

Doctors Manitoba would welcome the opportunity to work with the CPSM on a review of the Annual Disclosure Form.

We appreciate the opportunity to provide this submission on behalf of our mutual members. Please advise if you wish more information about our submission.

Sincerely,

Andrew Swan

ANDREW SWAN
General Counsel

AS/jb

Standard of Practice

Duty to Report
Self, Colleagues, or Patients

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.

PREAMBLE

Self-regulation is a privilege of the medical profession which comes with responsibilities, including the duty to report. This duty protects the trust relationship between the profession and society by showing physicians to be transparent, accountable, acting in the public interest, and most importantly protecting patient safety.

A report to CPSM as part of this Standard is a notification for the purposes of next steps. CPSM's approach to matters of physician health are viewed through a treatment and/or rehabilitation lens aimed at supporting wellness. Members experience short term and chronic health conditions and the role of CPSM and the Physician Health Program may fluctuate over time reflective of their health condition and wellness. Members with health conditions are managed independently of the discipline process whenever possible. The personal health information of members will be treated with the utmost sensitivity and confidence and that access to that information will be on a limited need-to-know basis in accordance with the CPSM Privacy Policy and PHIA.

Any reporting and use of the information by CPSM must also be in compliance with the Personal Health Information Act which permits disclosure for the purposes of CPSM. That Act also stipulates that every use and disclosure must be limited to the minimum amount of information necessary to accomplish the purpose for which it is to be used or disclosed and only to the extent the recipient needs to know the information.

Part 1. Duty to Report Self

1.1. Members who may have a diminished ability to provide safe and competent medical care have an ethical responsibility to report to CPSM and restrict or withdraw from practice. CPSM recognizes the reporting of illness as linked to a continuum of impairment whereby CPSM in its regulatory role to protect the public must determine if a member's illness is impacting their ability to provide safe care. CPSM exercises reasonable judgement when considering the impact of an illness on the ability to practice medicine safely and does so in a respectful and dignified manner. Where required, the Physician Health Program will engage with members who self-report in a collaborative and supportive health monitoring process.

1.2. A member must notify CPSM promptly of any health condition that may reasonably affect their practice of medicine including:

1.2.1. a physical or mental condition or disorder, including any substance abuse disorder or addiction, that may impair their ability to engage in the practice of medicine in a safe and effective manner, and that makes it desirable in the public interest that they not engage in the practice of medicine. *CPSM General Regulation* s. 4.4 and 4.10

1.2.2. if they are or will be performing a procedure that involves a risk of transmission of a bloodborne pathogen. *CPSM General Regulation* s. 4.4 and 4.10

1.3. A member must notify CPSM of the following personal circumstances promptly once they become aware of:

1.3.1. being the subject of a review or finding of conduct unbecoming, professional misconduct, incompetence, or incapacity or lack of fitness to practise a health profession in Manitoba or elsewhere. *CPSM General Regulation* s. 4.4 and 4.10

1.3.2. their authority to practise medicine or any other health profession being suspended, restricted, or revoked in Manitoba or elsewhere. *CPSM General Regulation* s. 4.4 and 4.10

1.3.3. being the subject of a denial to practice a health profession or occupation in Manitoba or elsewhere. *CPSM General Regulation* s. 4.4 and 4.10

1.3.4. any breach of practice restrictions, conditions, limitations, or an undertaking imposed by CPSM or any other authority.

1.3.5. any voluntary or involuntary loss or restriction of diagnostic or treatment privileges granted by an administrative authority in a hospital, health authority, or university or discipline, or any resignation in lieu of further administrative action, except where the loss or restriction is the result of the closure or transfer of services provided by the member.

1.3.6. being charged or convicted or pleading guilty to a criminal offence or an offence under any narcotic or controlled substances legislation in any jurisdiction. *CPSM General Regulation* s. 4.4 and 4.10

1.3.7. being the subject of a claim, settled a claim, or a judgment against them in civil court respecting their professional practice or professional activities. *CPSM General Regulation* s. 4.4 and 4.10

1.3.8. a violation of sexual boundaries with a patient as defined in the Standard of Practice Sexual Boundaries with Patients, Former Patients & Interdependent Persons.

1.4. If a member finds themself in a situation that is not explicitly covered above, but there is reason to believe their circumstances impacts their ability to practice medicine safely and competently, in the interest of public safety they must report this to CPSM.

1.5. The duty to self-report is required notwithstanding any non-disclosure or other agreement regarding confidentiality signed by an institution or organization and the member.

Part 2. Duty to Report a Colleague – CPSM and Other Regulated Health Professionals

2.1. The *Regulated Health Professions Act* requires:

> ***"Duty of members to report***
> *138(1) A member who reasonably believes that another member of the same regulated health profession*
> *(a) is unfit to practise, incompetent or unethical; or*
> *(b) suffers from a mental or physical disorder or illness that may affect his or her fitness to practise, and continues to practise despite having been counselled not to;*
> *must disclose that belief to the registrar, along with the name of the other member and particulars of the suspected disorder, illness, lack of fitness to practise, incompetency or unethical behaviour.*
>
> ***Exemption from liability for disclosure***
> *138(2) A member who discloses information under subsection (1) is not subject to any liability as a result, unless it is established that the disclosure was made maliciously."*

2.2. A member must notify CPSM promptly once they become aware of and reasonably believes that another CPSM member:

2.2.1. has any of the personal circumstances listed under Part I.

2.2.2. has an unwillingness or inability to address behaviour that interferes with patient care or negatively impacts the ability of other members or healthcare workers to provide patient care.

2.2.3. behaves in a manner outside of providing patient care that could reasonably be considered unprofessional conduct under the *Regulated Health Professions Act,* Regulations, Bylaws, and Standards of Practice.

2.3. If there is not imminent patient safety concern and it circumstances are appropriate, a member may discuss the concern directly with the other member, assist the member in accessing support, and/or develop a plan to notify CPSM together. If circumstances are not appropriate or if this approach is unsuccessful or incomplete, the member must report to CPSM.

2.4. The duty to report a CPSM member or member of another regulated health profession arises whether the member is a patient or a colleague.

2.5. The duty to report a CPSM member applies to all members, whether physicians, clinical assistants, physician assistants, residents, or students.

2.6. If the member finds themself in a situation that is not explicitly covered above, but there is reason to believe that the circumstances they are aware of regarding another CPSM member impacts on that member's ability to practice medicine safely and competently, in the interest of public safety they must report this to CPSM.

2.7. The duty to report a CPSM member is required notwithstanding any non-disclosure agreement signed by an institution or organization and the colleague.

2.8. It is professional misconduct to impose repercussions upon or disadvantage any member for making a report in good faith under this Part.

2.9. When a patient discloses information leading a member to believe on reasonable grounds that another CPSM member has committed a sexual boundary violation with a patient, the member who receives the disclosure must:

2.9.1. provide the patient with information about how to file a complaint with CPSM

2.9.2. if the patient does not wish to file a complaint personally, offer to file a third person complaint on behalf of the patient;

2.9.3. in the absence of confirmation that the patient has filed a complaint, document the sexual boundary violation indicating that the patient does not wish to report to CPSM and report the member to CPSM.

2.9.4. assess and record in the patient's record whether disclosure of the patient's personal information regarding the sexual boundary violation could cause serious imminent mental, physical or emotional harm to the patient.

2.10. A member who reasonably believes that a member of a different regulated health profession is suffering from a physical or mental condition or disorder or a nature or to an extent that the other member is unfit to continues to practise should be restricted must inform the registrar of the other member's college about that belief and the reasons for it.

Part 3. Duty to Report the Medical Condition or Knowledge of Patient Information

3.1. Members must comply with any duty to report the medical condition or knowledge of patient information as prescribed by Provincial and Federal Legislation (see Contextual Information and Resources for list of legislation).

3.2. Honesty and compassion are virtues fundamental to the patient-physician relationship. To ensure a trusting physician-patient relationship, members should communicate with their patients about their reporting duties and breach of confidentiality except in rare instances when notifying the patient is not appropriate, such as where the member is concerned about the safety of the patient or another person.

Standard of Practice

Duty to Report
Self, Colleagues, or Patients

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.

PREAMBLE

Self-regulation is a privilege of the medical profession which comes with responsibilities, including the duty to report. This duty protects the trust relationship between the profession and society by showing physicians to be transparent, accountable, acting in the public interest, and most importantly protecting patient safety.

A report to CPSM as part of this Standard is a notification for the purposes of next steps. CPSM's approach to matters of physician health are viewed through a treatment and/or rehabilitation lens aimed at supporting wellness. Members experience short term and chronic health conditions and the role of CPSM and the Physician Health Program may fluctuate over time reflective of their health condition and wellness. Members with health conditions are managed independently of the discipline process whenever possible. The personal health information of members will be treated with the utmost sensitivity and confidence and that access to that information will be on a limited need-to-know basis in accordance with the CPSM Privacy Policy and PHIA.

Any reporting and use of the information by CPSM must also be in compliance with the Personal Health Information Act which permits disclosure for the purposes of CPSM. That Act also stipulates that every use and disclosure must be limited to the minimum amount of information necessary to accomplish the purpose for which it is to be used or disclosed and only to the extent the recipient needs to know the information.

Part 1. Duty to Report Self

1.1. Members who may have a diminished ability to provide safe and competent medical care have an ethical responsibility to report to CPSM and restrict or withdraw from practice. CPSM recognizes the reporting of illness as linked to a continuum of impairment whereby CPSM in its regulatory role to protect the public must determine if a member's illness is impacting their ability to provide safe care. CPSM exercises reasonable judgement when considering the impact of an illness on the ability to practice medicine safely and does so in a respectful and dignified manner. Where required, the Physician Health Program will engage with members who self-report in a collaborative and supportive health monitoring process.

1.2. A member must notify CPSM promptly of any health condition that may reasonably affect their practice of medicine including:

1.2.1. a physical or mental condition or disorder, including any substance abuse disorder or addiction, that may impair their ability to engage in the practice of medicine in a safe and effective manner, and that makes it desirable in the public interest that they not engage in the practice of medicine. *CPSM General Regulation* s. 4.4 and 4.10

1.2.2. if they are or will be performing a procedure that involves a risk of transmission of a bloodborne pathogen. *CPSM General Regulation* s. 4.4 and 4.10

1.3. A member must notify CPSM of the following personal circumstances promptly once they become aware of:

1.3.1. being the subject of a review or finding of conduct unbecoming, professional misconduct, incompetence, or incapacity or lack of fitness to practise a health profession in Manitoba or elsewhere. *CPSM General Regulation* s. 4.4 and 4.10

1.3.2. their authority to practise medicine or any other health profession being suspended, restricted, or revoked in Manitoba or elsewhere. *CPSM General Regulation* s. 4.4 and 4.10

1.3.3. being the subject of a denial to practice a health profession or occupation in Manitoba or elsewhere. *CPSM General Regulation* s. 4.4 and 4.10

1.3.4. any breach of practice restrictions, conditions, limitations, or an undertaking imposed by CPSM or any other authority.

1.3.5. any voluntary or involuntary loss or restriction of diagnostic or treatment privileges granted by an administrative authority in a hospital, health authority, or university or discipline, or any resignation in lieu of further administrative action, except where the loss or restriction is the result of the closure or transfer of services provided by the member.

1.3.6. being charged or convicted or pleading guilty to a criminal offence or an offence under any narcotic or controlled substances legislation in any jurisdiction. *CPSM General Regulation* s. 4.4 and 4.10

1.3.7. being the subject of a claim, settled a claim, or a judgment against them in civil court respecting their professional practice or professional activities. *CPSM General Regulation* s. 4.4 and 4.10

1.3.8. a violation of sexual boundaries with a patient as defined in the Standard of Practice Sexual Boundaries with Patients, Former Patients & Interdependent Persons.

1.4. If a member finds themself in a situation that is not explicitly covered above, but there is reason to believe their circumstances ~~may~~ impacts their ability to practice medicine safely and competently, in the interest of public safety they must report this to CPSM.

1.5. The duty to self-report is required notwithstanding any non-disclosure or other agreement regarding confidentiality signed by an institution or organization and the member.

Part 2. Duty to Report a Colleague – CPSM and Other Regulated Health Professionals

2.1. The *Regulated Health Professions Act* ~~provides~~ requires:

> ***"Duty of members to report***
> *138(1) A member who reasonably believes that another member of the same regulated health profession*
> *(a) is unfit to practise, incompetent or unethical; or*
> *(b) suffers from a mental or physical disorder or illness that may affect his or her fitness to practise, and continues to practise despite having been counselled not to;*
> *must disclose that belief to the registrar, along with the name of the other member and particulars of the suspected disorder, illness, lack of fitness to practise, incompetency or unethical behaviour.*
>
> ***Exemption from liability for disclosure***
> *138(2) A member who discloses information under subsection (1) is not subject to any liability as a result, unless it is established that the disclosure was made maliciously."*

~~2.2. The duty of members to report in s. 138 of the RHPA is expanded to include the duty to report another member of a different regulated health profession who meets the same reporting criteria described above.. The report should be made to the CPSM Registrar.~~

~~2.3.~~2.2. A member must notify CPSM promptly once they become aware of and reasonably believes that another CPSM member:

2.2.1. has any of the personal circumstances listed under Part I.

~~2.2.2. demonstrates an inability to provide patients with what is reasonably considered competent and good medical care.~~

~~2.2.3.~~2.2.2. has an unwillingness or inability to address behaviour that interferes with patient care or negatively impacts the ability of other members or healthcare workers to provide patient care.

~~2.2.4.~~2.2.3. behaves in a manner outside of providing patient care that could reasonably be considered unprofessional conduct under the *Regulated Health Professions Act,* Regulations, Bylaws, and Standards of Practice.

2.3. If there is not imminent patient safety concern and it circumstances are appropriate, a member may discuss the concern directly with the other member, assist the member in accessing support, and/or develop a plan to notify CPSM together. If circumstances are not appropriate or if this approach is unsuccessful or incomplete, the member must report to CPSM.

2.4. The duty to report a CPSM member or member of another regulated health profession arises whether the member is a patient or a colleague.

2.5. The duty to report a CPSM member applies to all members, whether physicians, clinical assistants, physician assistants, residents, or students.

2.6. If the member finds themself in a situation that is not explicitly covered above, but there is reason to believe that the circumstances they are aware of regarding another CPSM member ~~may~~ impacts on that member's ability to practice medicine safely and competently, in the interest of public safety they must report this to CPSM.

2.7. The duty to report a CPSM member is required notwithstanding any non-disclosure agreement signed by an institution or organization and the colleague.

2.8. It is professional misconduct to impose repercussions upon or disadvantage any member for making a report in good faith under this Part.

2.9. When a patient discloses information leading a member to believe on reasonable grounds that another CPSM member has committed a sexual boundary violation with a patient, the member who receives the disclosure must:

~~1.1.1. must:~~

2.9.1. provide the patient with information about how to file a complaint with CPSM

2.9.2. if the patient does not wish to file a complaint personally, offer to file a third person complaint on behalf of the patient;

~~1.1.2.~~

2.9.3. in the absence of confirmation that the patient has filed a complaint, document the sexual boundary violation indicating that the patient does not wish to report to CPSM and report the member to CPSM.

~~2.9.1.~~

2.9.4. assess and record in the patient's record whether disclosure of the patient's personal information regarding the sexual boundary violation could cause serious imminent mental, physical or emotional harm to the patient.

~~2.9.2.~~

2.10. A member who reasonably believes that a member of a different regulated health profession is suffering from a physical or mental condition or disorder or a nature or to an extent that the other member is unfit to continues to practise should be restricted must inform the registrar of the other member's college about that belief and the reasons for it.

Part 3. Duty to Report the Medical Condition or Knowledge of Patient Information

3.1. Members must comply with any~~the~~ duty to report the medical condition or knowledge of patient information as prescribed by Provincial and Federal Legislation (see Contextual Information and Resources for list of legislation).

3.2. Honesty and compassion are virtues fundamental to the patient-physician relationship. To ensure a trusting physician-patient relationship, members should communicate with their patients about their reporting duties and breach of confidentiality except in rare instances when notifying the patient is not appropriate, such as where the member is concerned about the safety of the patient or another person.

Contextual Information and Resources

Duty to Report
Self, Colleagues, or Patient

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.

Code of Ethics and Professionalism

CPSM has adopted the **Canadian Medical Association Code of Ethics and Professionalism.** Members' legal, ethical and professional reporting obligations relate to the following principles set out in the CMA Code of Ethics and Professionalism:

Commitment to the Well-being of the Patient

> Take all reasonable steps to prevent or minimize harm to the patient; disclose to the patient if there is a risk of harm or if harm has occurred.

Physicians and the Practice of Medicine

18. Fulfill your duty of confidentiality to the patient by keeping identifiable patient information confidential; collecting, using, and disclosing only as much health information as necessary to benefit the patient; and sharing information only to benefit the patient and within the patient's circle of care. Exceptions include situations where the informed consent of the patient has been obtained for disclosure or as provided for by law.

Physicians and Colleagues

33. Take responsibility for promoting civility, and confronting incivility, within and beyond the profession. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.

Physicians and Society

39. Support the profession's responsibility to act in matters relating to public and population health, health education, environmental determinants of health, legislation affecting public and population health, and judicial testimony.

Self Regulation and the Duty to Report

As a self-regulating profession, members have a legal and professional responsibility to report both themselves and colleagues (any CPSM registered member) when the circumstances outlined in the Standard have been met. This ensures the profession continues to regulate in the public interest and demonstrates that patient safety is paramount.

Reporting a Colleague

Even if others can or will make a report, it is each member's responsibility to report circumstances of which they are aware. While many members may believe it is more socially appropriate to take concerns directly to the individual involved (rather than reporting them to CPSM), in medicine the overarching obligation to patient safety creates a higher duty to report. Every member must act in ways that are transparent, accountable, and most importantly in the public interest - this protects the trust relationship between medicine and society.

CPSM recognizes it can be difficult to report a colleague. If there is no imminent patient safety concern it may in some circumstances be acceptable to ask your colleague to start the process by self-reporting their circumstances to CPSM. To fulfill the duty to report, this must still be followed up by a timely report to CPSM.

Concerns about possible repercussions are commonly identified as a reason why members are worried about reporting colleagues. A member who reports a colleague in good faith is protected from liability. Imposing repercussions or disadvantaging someone who reports in good faith is professional misconduct.

Other specific employment and workplace issues should be addressed through appropriate institutional and departmental processes, such as provided in medical staff bylaws.

Some members may request anonymity when they make a report. Depending upon the nature of the circumstances and the availability of other sources of information, CPSM may attempt to protect the identity of the member making the report. However, there are circumstances where, as part of the review, the identity of the member making the report may be disclosed or may become apparent.

As a treating member of another CPSM member or another regulated health professional it may be difficult to decide when a report should be made to the Registrar. The primary duty of any member is to act in the best interest of their patient, and to preserve the trust that exists in that physician-patient relationship. However, if a member becomes aware that another member or regulated health professional has a condition that may impair their ability to practice safely and competently - *even if that member is their patient* - they must report it to the Registrar in compliance with their obligations to protect the public.

Physician Health Program

CPSM recognizes that while members must report health conditions with the potential to influence the ability to practice medicine safely, the timing and nature of a member's disclosure may be influenced by fear and stigma. In the interest of patient safety, the experience of reporting a health condition to CPSM must feel safe to members and be non-punitive. CPSM will be judicious and balanced in responding to any health information disclosed under the reporting requirements. As a primary function, the CPSM Physician Health Program balances the regulatory mandate to protect the public with supporting and empowering members experiencing both acute and chronic health concerns to optimize their wellness. CPSM supports all members including physician assistants, clinical assistants, residents and medical students through the Physician Health Program. Monitoring and optimizing the health and well-being of members is critical to ensuring safe and quality patient care.

The CSPM Physician Health Program is a confidential and collegial program that aspires to treat members with respect and dignity while acknowledging the human experience of illness. When voluntary or involuntary reports about a member's health are received, the Physician Health Program encourages members to seek out and engage in appropriate therapy and/or treatment for their condition. The ability to practice safely is of primary concern and in most cases involvement with the Physician Health Program is minimal and does not impact a member's practice. A monitoring plan may or may not be required and each member's situation is reviewed individually and tailored to optimize outcomes for both patient safety and the member. In situations where an illness is severe, insight is limited, or there is a demonstrated risk to patient safety, the primary focus becomes restoring the member's health and a measured and reasonable plan is put in place to support the member in achieving wellness while not practicing medicine. Involvement with the Physician Health Program is non-punitive and is focused on rehabilitation and maintenance of or return to practice so long as the member is safe to do so. Early reporting of illness can ensure a longstanding and supportive relationship with CPSM and streamline processes in the case of an acute exacerbation and/or health crisis.

A number of health conditions may present the potential for an impact on patient safety including any condition that could impair a member's physical function, cognition, judgment and/or insight. The principle behind creating a safe and open reporting process is to encourage reporting of medical conditions prior to evidence of patient harm. It is a common misconception that reporting is only required for mental health conditions. A surgeon with Parkinson's disease, a psychiatrist undergoing chemotherapy for breast cancer, a family doctor with substance abuse disorder, and an internist who has had a stroke are all examples of members whose illness could impair their ability to perform safely and are therefore important conditions to disclose to CPSM's Physician Health Program. Where there is confusion about whether a condition is reportable members should contact the Physician Health Program for more information.

For residents and students with health issues, the Physician Health Program works with the University to ensure the member's ability to learn and practice medicine safely.

Mandatory Reporting of the Medical Condition of a Patient of or Knowledge About a Patient

There are circumstances where members are required or permitted to report particular events or clinical conditions to the appropriate government or regulatory agency. When the law requires members to provide a report, that requirement overcomes the confidentiality provisions in privacy legislation.

> "A trustee may disclose personal health information without the consent of the individual the information is about if the disclosure is authorized or required by an enactment of Manitoba or Canada." PHIA, s. 22.

Some members may have ethical concerns pertaining to reporting of confidential patient information. However, by making reports which the law requires members to make, members are complying with their legal obligations. Similarly, if a member believes there is a risk of harm to another person then that overcomes the confidentiality provisions in privacy legislation.

> "A trustee may disclose personal health information without the consent of the individual the information is about if the disclosure is to any person, if the trustee reasonably believes that the disclosure is necessary to prevent or lessen
>
> (i) a risk of harm to the health or safety of a minor, or
>
> (ii) a risk of serious harm to the health or safety of the individual the information is about or another individual, or to public health or public safety;" PHIA, s. 22.

Many statutes have mandatory reporting provisions of patient's medical conditions or knowledge of certain facts requiring public protection. While not exhaustive, the legislation referred to below is provided as a general guide to members with respect to their mandatory reporting obligations.

Provincial Manitoba Legislation

1. Personal Health Information Act

There are numerous provisions throughout PHIA requiring or permitting disclosure.

2. Child in Need of Protection, Child Pornography

Child and Family Services Act

Critical Incident Reporting, s. 8.15

General Duty to Report, s. 8.16

Child in Need of Protection, s. 18(1) and 17(2)

Child Pornography, s. 18(1.0.1)

Failure to Report, s. 18.2, 18.3

https://www.gov.mb.ca/fs/childfam/child_protection.html

3. **Deaths in Certain Circumstances**

   Fatality Inquiries Act, s. 6 and 7.1 (NB section 6 requires the reporting of deaths in s. 7.1)

4. **Reportable and Communicable Diseases**

   Public Health Act, s. 39 – 42

   Schedules to Public Health Act with reportable or communicable diseases

5. **Safe Operation of a Motor Vehicle (to MPIC)**

   Highway Traffic Act, s. 157

   https://www.mpi.mb.ca/Pages/health-care-professionals.aspx

6. **Reports on Injuries, Diagnosis, and Treatment to MPIC and WCB**

   Manitoba Public Insurance Corporation Act, s. 51

   Workers Compensation Act, s. 20

7. **Still Births and Deaths**

   Vital Statistics Act, s. 9, 14,

8. **Gunshot and Stab Wounds**

   Gunshot and Stab Wounds Mandatory Reporting Act

9. **Risk of Harm to Minor or Risk of Serious Harm to Safety of Patient or Other Person and Disclosure without Consent**

   Mental Health Act, s. 36

10. **Abuse of Persons in Care**

    Protection for Persons in Care Act, s. 3

    https://www.gov.mb.ca/health/protection/#:~:text=The%20general%20public%20can%20report,%2D788%2D6366%20in%20Winnipeg .

11. **Abuse of Vulnerable Persons**

    Vulnerable Persons Living with a Mental Disability Act, s. 21

    https://www.gov.mb.ca/fs/pwd/vpact_protection.html

12. **Reports Regarding Mental Health**

    Mental Health Act, s. 27 and other sections

Federal Canadian Legislation

1. **Aviation Safety - Flight Crew Member, Air Traffic Controller, or Holder of an Aviation Document**

   Aeronautics Act, s. 6.5

2. **Railway Safety**

   Railway Safety Act, s. 35

   Canadian Railway Medical Rules Handbook

3. **Maritime Safety**

   Canada Shipping Act, s. 90

4. **Medical Assistance in Dying Reporting Requirements**

   Criminal Code, s. 241

   Regulations for the Monitoring of Medical Assistance in Dying

5. **Vanessa's Law – Serious Adverse Drug Reactions and Medical Device Incidents**

   Protecting Canadians from Unsafe Drugs Act

6. **Lost or Stolen Controlled Substances from a Physician's Office**

   Narcotic Control Regulations, s. 55(g)

   Benzodiazepines and Other Targeted Substances Regulation, s. 72(1) and 61(2)

Duty to Report

Frequently Asked Questions

What type of health conditions are reportable?

Anything that may impact the ability to practice of medicine – including but not limited to substance abuse disorder, cognitive decline whether due to age or other causes, neurological disorders even in the initial stages, cancer, depression, mental health illnesses, and chronic pain. CPSM takes a confidential, supportive, and rehabilitative approach to members who are experiencing both acute and chronic illness.

Why should I have to report criminal charges against me?

The Code of Ethics includes the following virtues exemplified by the ethical physician: honesty, integrity, and prudence. These virtues may be incongruous with the criminal charges and/or convictions.

Criminal charges or the finding of guilt may indicate that you have health issues not being addressed. For instance, a Driving Under the Influence charge may be indicative of a substance abuse disorder; or a domestic assault may indicate significant stress that requires addressing to continue to practice medicine. A charge of sexual assault may indicate patients could be at risk and unsafe in your practice.

I have been sued in court – what do I have to disclose to CPSM?

If the matter relates to the practice of medicine (sued for negligent medical care) including professional practice management (sued for non-payment of leased medical equipment), then you must disclose that to CPSM. If the matter is unrelated to medical care (for instance, being sued by a building contractor for your failure to pay for their shoddy construction of your residence) then no need to advise.

I took over the care of a patient and upon reviewing the chart and interviewing the patient, I believe the previous doctor did not meet the standard of care and failed to provide good medical care. What should I do?

While it might be tempting to address this one-on-one with the other physician, it is important that CPSM is made aware quickly in the interest of patient safety. While it might be that the physician missed something in that one patient, it might also be indicative of poor care provided to other patients by that physician. CPSM will investigate and determine whether the medical care met the required standard of care. It is the mandated role of CPSM to determine if the standard of care has been met, but it can only do so if such cases are reported and thereby brought to its attention.

I occasionally provide medical treatment to physicians. One of my physician patients is depressed. Should this be reported to CPSM?

Health issues that have the potential to impair a physician's functional ability, cognition, judgment or insight are reportable. It is advised that you have a conversation with your physician patient about the importance of self-reporting an illness to the CPSM that could result in a potential risk to patient safety and remind them the Physician Health Program takes a compassionate, non-punitive and reasonable approach to all health reporting.

As a treating physician you are not required to report your patient with depression unless in your clinical opinion, it impairs their ability to practice medicine safety. Stigma is a major barrier for physicians to get timely mental health care, however patient safety is paramount. In addition to the CPSM Physician Health Program, please ensure that the medical learner or physician is aware of the Student Services at Bannatyne Campus and MD Care program, that provide specialized mental health services (if required).

Where you have concerns that your physician patient's illness is inadequately treated, where your physician patient is experiencing difficulty concentrating or staying focused at work or if their illness is of a moderate to severe intensity such that there is impairment to cognition, judgment or insight, then advise your patient that they must self-report and that you are also required to report their health issue to CPSM. Follow-up promptly to ensure they have self-reported. You are still required to report. The Physician Health Program will in turn assist that member in placing a focused effort on their own health and well-being in order to protect patient safety and support the physician with their personal rehabilitation and recovery.

I have diagnosed a patient who is a dentist with Parkinsons, should this be reported?

Honesty and compassion are virtues fundamental to the patient-physician relationship. To ensure a trusting relationship, members must communicate with their patients about their reporting duties and breach of confidentiality. Have a conversation with your patient first and provide them with an opportunity to disclose this quickly to their regulator. Follow up promptly with the patient to ensure they have done so. You are still required to report the medical condition to the dental regulator. This is to ensure patient safety. The dental regulator, not you, will investigate and make a determination if this dentist is safe to practice.

I have diagnosed a patient who is a hobby pilot with imperfect eye-sight and a slowly deteriorating eye condition. Should this be reported?

Again, honesty and compassion are virtues fundamental to the patient-physician relationship. To ensure a trusting relationship, members must communicate with their patients about their reporting duties and breach of confidentiality. Have a conversation with your patient first and provide them with an opportunity to disclose this quickly to Transport Canada. Follow up promptly with the patient to ensure they have done so. You are still required to report the medical condition to Transport Canada. Transport Canada, not you, will investigate and determine whether this patient is safe to fly.

COUNCIL MEETING – JUNE 9, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Standard of Practice – Performing Office Based Procedures

BACKGROUND

Council included the development of a new Standard of Practice for Performing Office Based Procedures as a Strategic Organizational Priority.

This recognizes 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. The Accredited Facilities Working Group recommended to Council that CPSM create a Standard of Practice for Office Based Procedures. These procedures pose a higher risk to patient safety yet do not meet the threshold for accreditation. In general, these procedures are usually not performed for medical purposes. Furthermore, many physicians performing these procedures are financially incentivized. This provides further rationale for regulatory rules for these procedures.

A Working Group was formed led by Dr. Kevin Convery. It included physicians (both family and specialists) who perform the procedures, family physicians who do not perform the procedures, and a public representative from Council. The following areas of practice were included:

- Plastic surgery
- Dermatology
- Hematology
- Family medicine – dermatology
- Family medicine - aesthetics
- Family medicine – vasectomy
- Family medicine - platelet rich plasma
- Family medicine – small city and rural
- Family medicine – anesthesiology
- College of Registered Nurses of Manitoba

Also attached is a Contextual Information and Resources document.

The Working Group recommends that the Standard of Practice for Performing Office Based Procedures be distributed for consultation with members, stakeholders, Government, and the public.

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.

PUBLIC INTEREST RATIONALE

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

All medical care provided, whether in-person or virtual, must adhere to all other standards of practice and to the standard of good medical care prescribed by the CPSM Standards of Practice Regulation:

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

Some of these procedures performed by some physicians have yielded complaints and led to disciplinary actions or to criticism or advice from the Investigations Committee. CPSM has been contacted by some members seeking to understand any requirements, prior to entering a new scope of practice or business enterprise. CPSM also understands that some members have not contacted CPSM for such requirements but have merely entered into a new scope of practice or business arrangement without the required forethought. This Standard of Practice establishes the requirements for such procedures, and the Standards have been developed for the purpose of patient safety – and in the public interest, not in the interest of the practitioners.

While CPSM only governs its members, CRNM participated in the Working Group and intends to create a Practice Direction for registered nurses and nurse practitioners, many of whom are entering into these areas of practice. There are also individuals who are not regulated health professionals who may perform some of these procedures independently. It is the intention for CPSM to

recommend to Government that regulation of these procedures by non-regulated health professionals occur for patient safety. Such regulation exists in some other provinces, including most recently, in Alberta.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 9, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

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.

Standard of Practice
Performing Office Based Procedures
Including Cosmetic/Aesthetic and Minor Surgical Procedures, Platelet Rich Plasma Therapy, and Laser Devices)

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.

PREAMBLE

The College of Physicians and Surgeons of Manitoba sets standards that establish expectations for quality care for patients regardless of whether the care provided is medically required or purely elective. Many members perform various in-office procedures on their patients that are medically required or elective. Some of this care is provided in non-hospital medical or surgical facilities and is therefore governed by the Accredited Facilities Bylaw. However, many procedures are performed in non-institutional settings such as established physician offices or medical clinics. When providing this care, members must comply with this Standard.

Medical clinic is defined as a medical care facility that is primarily focussed on providing outpatient medical care by CPSM members and includes what is commonly known as a physician's office. It does not include a non-medical aesthetic clinic, medi-spa, lash bar, residence, or hospitality facility.

APPLICATION

1. This Standard applies to insured and non-insured procedures that are reserved acts under the RHPA. These procedures (referred to as "**procedures**") include:
    a. Vasectomy;
    b. Male circumcision; (for female see Standard of Practice Female Genital Cutting/Mutilation prohibiting female genital cutting/mutilation)
    c. Cosmetic/aesthetic procedures which may include, but are not limited to:
        1. Application of laser energy and light-based therapies for the removal or ablation of skin lesions and pigmentation; (See Appendix 3)
        2. Soft tissue augmentation - injection of fillers; (See Appendix 1)

3. Botulinum toxin/Neuromodulators - injectable (See Appendix 1)

d. Procedures aimed at the treatment of known pathology may include, but are not limited to:
   1. Peripheral stem cell injection as approved by Health Canada; and
   2. Platelet rich plasma injection as approved by Health Canada; (See Appendix 2)

2. This Standard applies to procedures performed in an Accredited Facility Accredited Facilities Bylaw.

3. This Standard does NOT apply to:
   a. procedures performed in a hospital or government owned or operated hospital or healthcare facility.
   b. office-based ophthalmic procedures.
   c. Acts that are not reserved acts under the RHPA (examples include facials, peels, microdermabrasions, microneedling, and laser hair removal.

1. Knowledge, Skill, and Judgment

1.1. Members must work only within the limits of their competence and scope of practice and refer a patient to another practitioner if they cannot safely meet the patient's needs.
1.2. If the procedure to be performed was not part of the member's medical or specialty education and training, before carrying out the procedure for the first time, members must ensure they have the necessary knowledge, skill, and judgment to do so. Members must ensure they can: recognize when patients are not suitable to undergo the procedure, safely perform the procedure, and manage potential complications, by undergoing significant training and/or seeking opportunities for supervised practice.
1.3. Competence must be maintained.
1.4. Members must practise evidence-informed medicine and maintain a level of understanding of the available evidence supporting the procedure as it evolves.

2. Safety and Quality of Care

2.1. Members must not perform, or cause, permit, or enable another person to perform, any procedure in a location other than in a medical clinic.
2.2. Members must only perform procedures in a medical clinic that is safe, appropriate, and sanitary, is suitably equipped and staffed, and complies with any relevant regulatory requirements, and the Infection Prevention and Control for Clinical Office Practice.
2.3. Each member must take reasonable steps to ensure a system is in place for the proper maintenance, cleaning and calibration of equipment used in the medical care they provide.

2.4. Members must be open and honest with patients in their care and disclose if there is an adverse patient outcome. Members must comply with the CPSM Standard of Practice Good Medical Care *(**Section 9. Disclosure of Harm to a Patient**)*. In the event of an adverse patient outcome, the member performing, authorizing, or most responsible for the procedure must ensure a care plan is established to mitigate the effects in a satisfactory manner.

2.5. The medical director of the clinic must notify the Assistant Registrar of Quality within one working day of becoming aware of a patient with an adverse patient outcome and provide a written report within two weeks.

2.6. An **adverse patient outcome** is defined as an unanticipated significant outcome, either by misadventure, complication, or patient reaction that requires higher level care by an alternate CPSM member and includes but is not limited to:

2.6.1. Transfer to hospital or unanticipated follow-up at a hospital related to how the procedure was performed or how the patient responded to the procedure;

2.6.2. Third degree burns, disfigurement, or impairment of vision;

2.6.3. Extreme pain or discomfort causing significant limited function in an ongoing fashion;

2.6.4. Intra-arterial injection resulting in thrombosis, tissue ischemia, necrosis, or embolism with risk of blindness;

2.6.5. Injecting or infusing the wrong material than originally intended.

3. Seeking Patients' Consent

3.1. Members must comply with the CPSM Standard of Practice Good Medical Care *(**section 5. Informed Consent**)*. Consent must be obtained in writing. Members must exercise additional scrutiny and caution when considering requests for procedures on minors or those with reduced capacity.

3.2. Members must consider the patient's psychological needs and whether referral to another member or regulated health professional is appropriate (i.e. body dysmorphic disorder).

4. Practice Management of Procedures Provided by Non-CPSM Members

4.1. There must be a member identified as most responsible for care for every procedure performed in a medical clinic.

4.2. Members most responsible for care or their delegate must assess the indications and potential contraindications for each patient and must personally assess each patient undergoing an invasive procedure.

4.3. The member most responsible for care must be available to attend at the same location as the procedure is performed should circumstances arise where they are required to assist non-CPSM member providers or to manage misadventure or complications arising

from the procedure. "Available to attend" means that in the event of an urgent or semi-urgent episode or complication that exposes the patient to increased risk of harm, the member most responsible for care must be available to attend within a reasonable time consistent with the nature of the episode or complication.

4.4. Members must ensure that anyone participating in the patient's care has the necessary knowledge, skill, judgment, training, and competence and is appropriately supervised. Members may delegate to non-CPSM member providers to perform any procedure in an accredited facility, if the delegation is specific and supervised and under the direction of that physician. This does not apply to regulated health professionals under the *Regulated Health Professions Act* acting within their own scope of practice (i.e. Nurses). (See Contextual Information and Resources).

5. Obligations of Medical Director

5.1. The medical director is responsible for all aspects of the medical clinic which can affect the quality of patient care and is responsible to ensure:

- 5.1.1. the enforcement of this Standard and appropriate standards of care, including the safe, effective, and good medical care of patients in the medical clinic;
- 5.1.2. adequate quality assurance and improvement programs, including the monitoring of infection and medical complications, are in place;
- 5.1.3. a procedures manual is available and maintained for guidance;
- 5.1.4. if procedures are performed at the medical clinic that carry a risk of cardiac arrest or allergic reaction, ensure the availability of appropriate resuscitation equipment and medications and the presence of staff who are appropriately trained to utilize the equipment and medications;
- 5.1.5. a policy is in place for emergent complications, including but not limited to anaphylaxis, allergic reaction or acute embolic event, and the authorized non-physician providers present must be appropriately trained to recognize emergent complications;
- 5.1.6. that all medical devices, equipment, drugs, and other substances utilized in medical care are Health Canada, CSA, or FDA approved.

5.2. The medical director must be in attendance in-person at the medical clinic for sufficient time to ensure that all their obligations are discharged satisfactorily to ensure patient safety.

5.3. The medical director must ensure that the medical clinic, or members or other persons performing procedures do not function to increase profit at the expense of good medical care.

5.4. Members must only be medical directors of medical clinics in which they actively practice. Members must not be medical directors of non-medical clinics or other entities.

6. Liability coverage

6.1. Any member performing procedures or who is involved in authorizing non-CPSM member providers to provide or assist in procedures must ensure they have appropriate professional liability protection.

7. Communicating Information about Procedures Offered

7.1. When advertising or promoting procedures, including through the use of social media, members must follow the applicable provisions in the Standard of Practice Advertising, Standard of Practice Conflict of Interest, and the Code of Ethics and Professionalism.
7.2. Members must ensure information being communicated is responsible, factual, does not exploit patients' vulnerability or lack of medical knowledge, is not capable of misleading or misinforming the public, and does not minimise or trivialize the risks of procedures or claim that procedures are risk free.
7.3. Members must not mislead about the likely results of a procedure. They must not falsely claim or imply that certain results are guaranteed from a procedure.

8. Honesty in Financial Dealings

8.1. Members offering procedures must be open and honest with patients about financial or commercial interests that could be seen to affect the way they care for patients.
8.2. Members must not allow financial or commercial interests to affect good medical care.
8.3. Members must be comply with the Standard of Practice on Conflict of Interest and Code of Ethics and Professionalism.

APPENDIX 1 – INJECTION OF FILLERS – SOFT TISSUE AUGMENTATION AND BOTULINUM TOXIN/ NEUROMODULATORS

1. In addition to complying with the above Standard of Practice requirements, members who provide, authorize, delegate, or enable injections of botulinum toxin, dermal fillers, fillers of any sort injected below the dermis, or neuromodulators, controlled products, of other injectable cosmetic substances (all defined as substances) must comply with this Appendix.
2. Members must ensure only substances approved by Health Canada are injected.
3. Members who inject substances must have completed relevant and significant procedure specific medical education and training prior to performing such procedures.

4. Members must not themselves, nor may they permit or enable any other person to inject these substances in a location other than their medical clinic and then only as part of good medical care.
5. Members may permit a regulated health professional acting within their scope of practice to inject these substances in their medical clinic. Members must not permit or enable any other persons to inject these substances.
6. Members must not authorize the purchase, distribution, or dispensing of these substances, for use by other persons outside their medical clinic, whether regulated health professionals or not.
7. Members must perform an assessment and provide a client specific order for *Schedule 1 drugs under the Controlled Drugs and Substances Act* when collaborating with a regulated health care professional to administer the drug where that regulated health care professional is not authorized to prescribe.
8. Members must have appropriate antidotes present when performing these injections.

APPENDIX 2 – PERFORMANCE OF AUTOLOGOUS PLATELET RICH PLASMA THERAPY

Platelet rich plasma (PRP) therapy is based on the theory that the use of patient's own blood factors may improve tissue repair and healing. The validity of any potential beneficial effects of RPR therapy continues to undergo further definition and evaluation. This also includes the variability with: technique, number and spacing of injections, number/concentration/exogenous activation of platelets, with/without leukocytes and a definition of the appropriate candidate.

1. The PRP procedure involves multiple steps requiring handling blood products. Members must pay special attention to maintaining the sterility of technique and product to ensure patient safety. The risk of contamination reflects the number of steps within the PRP procedure. Contamination can easily occur during venipuncture, selection/handling of collection devices, separation containers, multiple centrifugation runs to isolate the PRP layer and the injection of the concentrated aliquot. Members must ensure the critical ability to perform all steps of the PRP procedures without contamination due to the inability to filter-sterilize the end product prior to injection. The entire procedure must take place at one patient visit.
2. Members must ensure compliance with the Standard of Practice Good Medical Care. ***(Section 11. Non-Traditional Therapies)***
3. Members who offer and perform platelet rich plasma services must comply with the College of Physicians and Surgeons of Alberta's Guideline "Performance of Autologous Platelet Rich Plasma Therapy in Unaccredited Settings: A Guideline for Physician Office/Clinic Setting".

APPENDIX 3 – LASER SAFETY

1. In addition to complying with the above Standard of Practice requirements, members who use a laser device for patient care and/or treatment must comply with this Appendix.
2. Members who use a laser device for patient care and/or treatment must have completed relevant and significant specific laser operation education and training prior to performing procedures with a laser.
3. Members must ensure that unregulated health care workers or technicians applying laser in their clinics have documented relevant and significant specific training and possess the requisite knowledge, skill and competence to safely perform the laser procedure. Members must define the degree of medical supervision required and must perform, at a minimum, annual competency assessments of each individual performing laser treatments that include observed procedures with feedback and must maintain a record of those assessments.
4. Members utilizing regulated health professionals who require additional education to authorize performance of the reserved act must ensure the additional education received meets requirements as outlined by that regulated health professional's College.
5. Members must use lasers in compliance with existing standards and occupational health and safety regulations and must keep current with the standards as they are updated from time to time. Members must refer to CSA Z386-2014 *Safe Use of lasers in health care*, and ANSI Z136.3-2018 *Safe use of lasers in health care*, and both are current at the time of this standard in 2021.
6. In addition to the above-mentioned standards, members must comply with CPSBC's CPSBC's Practice Direction on Laser Safety for Physician Practice and the CPSBC's Laser Safety for Member Practice Summary.

Contextual Information and Resources Performing Office Based Procedures

Initial Approval: **Effective Date:**

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.

Relevant and Significant Training

Patients are entitled to receive safe medical care by knowledgeable, skillful, and competent medical practitioners. Many procedures are performed by plastic surgeons or dermatologists, or family physicians with an added competency. While many years of training is not required for every procedure, a weekend course(s) is not sufficient for family physicians, other regulated health professionals or staff in the medical clinic performing or participating in the procedures.

It is incumbent upon members to ensure their knowledge, skill, judgment, and competency prior to performing any procedures. This is an objective, not subjective standard. Members should take numerous courses and perform a number of procedures under supervision prior to performing procedures independently to ensure they will provide good medical care to their patients.

CPSM can not establish what is the exact training or courses required for each member to determine knowledge, skill, judgment, and competency. The training is dependent upon the procedure to be performed, the education, scope of practice, specialization, and experience of each physician. CPSM can only say that the training must be relevant and significant and that members should seek to invest both the time and cost to establish the required knowledge, skill, judgment, and competency.

Medical Director and Purchasing

Members may be asked by non-physicians to purchase substances or medical devices which can only be sold to a physician by law. For clarity, CPSM members are not permitted to purchase injectables or other substances or medical devices for any person, clinic, or entity other than their own medical clinic in which they actively practice. This means no purchasing of substances or medical devices for nursing or other aesthetic clinics.

Performance of Procedures By Other Than CPSM Members

Many medical clinics utilize nurses (NP, RN, LPN) and non-regulated health professionals to perform a variety of health care services on patients. Members must understand the implications, responsibilities, and processes for having other regulated professionals and non-regulated health professionals perform procedures in a medical clinic prior to permitting them to do so.

The Regulated Health Professions Act sets out a way of regulating who does what in the provision of health services based on the concept of controlling potentially dangerous acts. Those activities, known as reserved acts, pose a significant risk of harm or possible harm to the health, safety or well-being of the public. Reserved acts may be performed in the course of providing health care by competent, regulated health care professionals that have been granted specific legislative authority to do so, based on their competence and skills. There are 21 categories of reserved acts and CPSM members can perform all 21 reserved acts subject to their knowledge, skill, and judgment and being within the member's scope of practice. Examples of reserved acts are – prescribing drugs, cutting into tissue, applying a form of energy for diagnosis (ex: x-rays, CT scans). Many of the reserved acts can be performed by more than one profession, and most notably, members of College of Registered Nurses of Manitoba, including Nurse Practitioners, can perform many reserved acts.

This approach supports enhanced inter-professional and multidisciplinary practice while maintaining patient safety and public protection. It also ensures that members of each regulated health profession can practice to the maximum level of their scope of practice.

Delegation

There are circumstances where it is necessary for a member to delegate tasks to unregulated care providers in order to provide access to care. Delegation is the extension of authority by a member to another regulated health care professional or health care provider who does not have the authority to perform the reserved act. Delegation is always patient-specific and the task cannot be further delegated or transferred to another patient.

There is no need to delegate tasks to a regulated health professional acting within their profession's authorized scope of practice. Regulated health professionals may or may not be able to accept delegation outside their legislated scope of practice depending upon the direction provided by their respective regulatory college. Members should be aware of other regulated health profession regulations pertaining to accepting delegation prior to delegating a task.

Making the Decision to Delegate

In delegating a reserved act, the member should:

1. Confirm that the employer (if any) supports this delegation and follow applicable policies and procedures.

2. Be competent and authorized to perform the task they are delegating.
3. Assess the competence of the person in relation to the delegated task on the specific patient.
4. Identify the risk to the patient through an assessment of the patient, task, person providing the care and environment.
5. Be satisfied that the decision to delegate is appropriate in the context of the specific patient, task, person being delegated to provide the care, and environment.
6. Include information about the decision to delegate and process of delegation when obtaining informed consent from the patient for the task.
7. Document the decision to delegate.

Engaging in the Process of Delegation

While engaging in the process of delegation the member should:

1. Provide patient-specific teaching to the person providing the care until the member is satisfied that the person providing the care is competent to perform the task in the context of the task, patient and environment.
2. Ensure that support and consultation is available during the performance of the task.
3. Provide periodic monitoring and evaluation of the competence of the person providing the care.
4. Remain responsible for the decision to delegate and the ongoing assessment of the patient's health status and plan of care.
5. Determine appropriate monitoring and evaluation of the plan of care based on assessment of the patient, task, environment and person providing the care.
6. Terminate the delegation if a change in patient status or the competence of the person providing the care indicates that the delegation is no longer appropriate or acceptable to the patient.

RESOURCES

The College of Licensed Practical Nurses has a Practice Direction on Aesthetic Nursing to assist in understanding their responsibilities and legal obligations and enabling them to make safe and ethical decisions within their practice.

CPSM gratefully acknowledges the College of Registered Nurses of Manitoba for the use of its materials in the Making the Decision to Delegate and Engaging in the Process of Delegation sections, and the College of Physicians and Surgeons of Saskatchewan for the use of some of its materials in the Standard.

COUNCIL MEETING – JUNE 9, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Standard of Practice – Home Births

BACKGROUND

CPSM is reviewing the Standards of Practice of Medicine over a four-year cycle. This is the current Standard of Practice on Home Births.

1. Members must not have planned involvement in a home birth (i.e. outside of a hospital with obstetrical care)
2. When a member is consulted by a pregnant woman who intends to give birth at home, the member must:
   (a) Encourage appropriate prenatal and postnatal care for the mother and baby;
   (b) Identify to the patient the risks of home delivery for both mother and infant, and issues of postnatal care (e.g. Vitamin K prophylaxis, eye care, metabolic screening);
   (c) Familiarize the patient with emergency services available in the community; and
   (d) Document discussions with the patient on the foregoing points.

CPSM requested feedback from the following: Department Head OB/GYN, University of Manitoba Chair, Maternal & Perinatal Health Standards Subcommittee Registrar, College of Midwives of Manitoba Registrar, College of Registered Nurses of Manitoba Chief Medical Officers of Shared Health and all Regional Health Authorities Head, Neonatal-Perinatal Medicine CPSM Medical Staff.

As many of you may recall, Council reviewed the feedback in March 2020 Council meeting. 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. Councillors had conflicting views on whether the current Standard of Practice should remain as is, be rescinded or completely re-done. Council directed that a Working Group be formed to recommend a new Standard of Practice – Home Births to Council.

A Working Group was formed consisting of the leading experts in the province: University Department Head - OB/GYN, Chair – Maternal & Perinatal Health Standards Committee, and Head – Neonatology/Perinatal Medicine, and chaired by Dr. Ripstein.

The Working Group met and recommends to Council that the Standard of Practice on Home Births be rescinded for the following reasons:

- The Society of Obstetricians and Gynecologists of Canada provides Clinical Practice Guidance on how physicians are to offer supportive medical care for patients that make such decision. CPSM Standards try not to be in contravention of the national clinical guidelines formulated by the experts in the clinical practice and academia.
- It is unnecessary in other jurisdictions.
- A newsletter article will be prepared to indicate the need to offer supportive medical care to the patient.
- Midwives have appropriate criteria to screen high risk patients to hospitals.
- No physicians participate in out of hospital births and have not for many years.
- A physician would not likely meet the standard of good medical care if they were to participate in a planned home birth of a patient and this is covered indirectly in other regulations and standards (ie a physician must have the necessary knowledge, skill, judgment, competence, and practice within their scope of practice).
- There are very few procedures that CPSM advises physicians on where they must occur (other than the Accredited Facilities).
- Changing times and greater acceptability in society of home births and midwifery as a regulated health profession.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 9, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Council rescind the Standard of Practice Home Births.

COUNCIL MEETING – JUNE 9, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Standard of Practice Medical Assistance in Dying (MAiD)

BACKGROUND

CPSM has established requirements of its members in relation to providing assistance to patients seeking assistance with dying from their physicians since 2015. Those requirements were developed after the now well known decision of the Supreme Court of Canada found that denial of MAiD was unconstitutional but prior to the enactment of the Criminal Code provisions permitting MAiD under strict conditions. It was a very significant undertaking at the time as there was no legislation within which to create those requirements. Since then, the existing Standard of Practice on MAiD was developed in 2016, when the Criminal Code was amended to create a legislative framework for MAiD.

Recent amendments to the Criminal Code of Canada necessitate an updating of the MAiD Standard of Practice to ensure compliance. The required amendments reflect and incorporate the following changes to the Criminal Code that were enacted in late March 2021:

1. It has always been an eligibility requirement for MAiD that not only must a patient have a serious + incurable illness, disease or disability (excluding mental illness), be in an advanced state of irreversible decline in capability, and have enduring suffering that is intolerable, their "natural death" had to be reasonably foreseeable. The reasonably foreseeable natural death requirement has now been removed an eligibility requirement.
2. The Criminal Code now contemplates two pathways, one where the patient's death is reasonably foreseeable, the other where the patient's death is not reasonably foreseeable.
3. Where the patient's death is reasonably foreseeable, the 10-day wait period following consent has now been removed and the patient can still receive MAiD if they previously consented and meet certain criteria but are unable to provide final consent on the day MAiD is scheduled to be administered.
4. Where the patient's death is not reasonably foreseeable, there are now additional safeguards which include a 90-day wait period, additional input from a qualified expert' and steps taken to ensure that the patient has given 'serious consideration' to ALL options to alleviate their suffering.
5. In relation to the witnesses to the signed consent, it is now only necessary to have one witness and that witness can now be a paid care provider.

It is also noteworthy that since 2016, the Provincial Maid Clinical Team has become well established in Manitoba. It is a valuable resource available to all Manitobans as part of insured services. Shared

Health now maintains a website about MAiD and accessing MAiD through its Provincial MAiD Clinical Team. This team has developed an expertise in MAiD and has established protocols for assessing eligibility for and providing MAiD.

An informal Working Group has been convened to review the legislative amendments to the Criminal Code and revise the Standard 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.

Members of the Working Group include representation from the Provincial MAiD Clinical Team and the Palliative Care Program and a public representative from Council. Lynne Arnason, legal counsel who has provided all legal services to CPSM and its working groups in relation to CPSM's requirements since 2015 provided the necessary legal assistance and drafted the attached revised Standard with substantial and invaluable input and guidance from the members of the Working Group.

Changes in the Standard

The Working Group's proposed changes in the Standard are reflected in the attached draft, which has been highlighted in yellow to illustrate where the necessary changes have been made.

No Consultation Required

There is a duty to consult with members, stakeholders, and the public when making a Standard of Practice. However, there is no duty to consult when revisions are made. Council may of course exercise its discretion and mandate a consultation period. However, given that the revisions to the existing Standard of Practice arise from a need to ensure compliance with the amended legislation, it is recommended that no consultation be undertaken as no useful purpose would be served through the consultation. The new recommended Standard has been drafted by CPSM legal counsel with knowledge and experience with the Standard and with input from two physicians with expertise in the area and input from a public representative. The Working Group and legal counsel are satisfied that the recommended changes to the Standard accurately reflect the legislative amendments to the Criminal Code and that the changes will ensure that all CPSM members who are involved with MAiD and who meet the revised Standard will be in compliance with the requirements of the Criminal Code.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 9, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> The Standard of Practice for Medical Assistance in Dying as attached is approved, to be effective immediately.

Standard of Practice

Medical Assistance in Dying (MAiD)

Initial Approval: January 1, 2019
Updated: March 26, 2021

Effective Date: January 1, 2019

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.

Background

CPSM's first Statement governing what was then known as physician assisted dying was approved in December 2015. At the time, there was no legislative framework. Medical assistance in dying (MAiD) has been permitted in Canada since 2016 as result of amendments to the Criminal Code which set out the framework for the provision of MAiD by medical practitioners and nurse practitioners.[1] Nothing in the legislation compels an individual to provide MAiD.

Following the implementation of MAiD, CPSM created this Standard of Practice and Manitoba established a provincial clinical team to provide MAiD. Shared Health now maintains a website about MAiD and accessing MAiD through its Provincial MAiD Clinical Team. This team has developed an expertise in MAiD and has established protocols for assessing eligibility for and providing MAiD. The link to its website is: https://sharedhealthmb.ca/services/maid/ The team can be reached by email at maid@sharedhealthmb.ca or by phone at 204-926-1380 or toll-free at 1-844-891-1825. All physicians who receive a request for MAiD are strongly encouraged to consult with and consider referral of patients to the Provincial MAiD Clinical Team.

On March 17, 2021, the eligibility requirements and safeguards for MAiD were expanded to include patients whose natural death is not reasonably foreseeable. The amendments created new safeguards for the provision of MAiD to those patients whose natural death is not reasonably foreseeable. They also changed the consent provisions to allow for the provision of MAiD to patients whose death is reasonably foreseeable and who consented to MAiD but lost capacity before it was scheduled to be provided. The new legislation also made clear that while mental illness is not currently considered to be an illness, disease or disability, it will be after two years and following a mandatory independent review and recommendations by experts (March 2023).[2]

[1] ***An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*** **SC 2016, c. 3**

[2] ***An Act to amend the Criminal Code (medical assistance in dying)*** SC 2021, c. 2

The legislation requires that MAiD be provided with reasonable knowledge and skill in accordance with any applicable provincial laws, rules or standards. This makes clear that anyone in Manitoba who provides or assists a practitioner who provides MAiD must work within the legal framework created by the federal legislation and follow all of the legal requirements and that physicians must comply with this Standards of Practice.

This Standard establishes the standards of practice and ethical requirements of physicians in Manitoba in relation to MAiD. It is subject to existing legislation and regulations governing any aspect of MAiD which come into force and effect while this Standard is in force and effect. Any such legislation and regulations take priority over the requirements of this Standard where there is any inconsistency.

Definitions

Medical Assistance in Dying (MAiD) is defined in s. 241.1 of the Criminal Code to mean:

a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

Medical Practitioner - is defined in s. 241.1 of the Criminal Code to be a person who is entitled to practice medicine under the laws of a province.

Physician - a medical practitioner who is a member of CPSM and is both registered on the Manitoba Medical Register and licensed to practice medicine. This definition excludes a member who is only practicing within a residency training program.

Patient - the person requesting MAiD and whose well-being must be the primary concern of any physician involved with responding to such a request.

Administering Physician –the physician who provides or administers the pharmaceutical agent(s) intended to cause the patient's death. The administering physician is responsible for confirming that all the requirements of this Standard have been met before the pharmaceutical agent(s) that intentionally cause the patient's death can be provided or administered. There can only be one administering physician for each patient.

Member – a member of CPSM who is registered on the Manitoba Medical Register, Educational Register, Physician Assistant Register or Clinical Assistant Register.

Requirements

1. Minimum Requirements of All Members and Physicians

1.1. A member must not promote their own values or beliefs about MAiD when interacting with a patient.

1.2. On the grounds of a conscience-based objection[3], a physician who receives a request about MAiD may refuse to:
- 1.2.1. provide it; or
- 1.2.2. personally offer specific information about it; or
- 1.2.3. refer the patient to another physician who will provide it.

1.3. A physician who refuses to refer a patient to another physician or to personally offer specific information about MAiD on the grounds of a conscience-based objection must:
- 1.3.1. clearly and promptly inform the patient that the physician chooses not to provide MAiD on the grounds of a conscience-based objection; and
- 1.3.2. provide the patient with timely access to a resource[4] that will provide accurate information about MAiD, including how a patient can make a request for MAiD or to be assessed for eligibility for MAiD; and
- 1.3.3. continue to provide care unrelated to MAiD to the patient until that physician's services are no longer required or wanted by the patient or until another suitable physician has assumed responsibility for the patient; and
- 1.3.4. make available the patient's chart and relevant information (i.e., diagnosis, pathology, treatment and consults) to the physician(s) providing MAiD to the patient when authorized by the patient to do so; and
- 1.3.5. document the interactions and steps taken by the physician in the patient's medical record, including details of any refusal and any resource(s) to which the patient was provided access.

1.4. A member who is not a physician and has a conscientious-based objection to MAiD who receives a request for MAiD, information about MAiD or a referral to a physician who will provide MAiD must advise the patient making the request that the member has a conscientious-based objection and must communicate the request to the member's supervising physician in a timely fashion.

2. Specific Requirements for Assessing Patient Eligibility for MAiD

[3] See s. 10 of the Standards of Practice for Good Medical Care, where conscience-based objection is defined as an objection to participate in a legally available medical treatment or procedure based on a member's personal values or beliefs.

[4] Acceptable resources may include but are not limited to other members, health care providers, counsellors and publicly available resources which can be accessed without a referral and which provide reliable information about MAiD. In Manitoba, Shared Health maintains a website about MAiD and accessing MAiD through its Provincial MAiD Clinical Team, which has developed an expertise in MAiD and has established protocols for assessing eligibility for and providing MAiD. The link to the website is: https://sharedhealthmb.ca/services/maid/ The team can be reached by email at maid@sharedhealthmb.ca or by phone at 204-926-1380 or toll-free at 1-844-891-1825. All physicians who receive a request for MAiD are strongly encouraged to consult with or consider referral of patients to the Provincial MAiD Clinical Team.

2.1. Federal legislation requires that to be eligible for MAiD, the patient must meet ALL of the following criteria:
  2.1.1. be eligible for publicly funded health services in Canada[5];
  2.1.2. be at least 18 years of age and capable of making decisions with respect to their health;
  2.1.3. have a grievous and irremediable medical condition;
  2.1.4. make a voluntary request for medical assistance in dying that is not the result of external pressure; AND
  2.1.5. provide informed consent to receive MAiD after having been informed of the means that are available to relieve the patient's suffering, including palliative care.

2.2. According to the federal legislation, a person has a grievous and irremediable medical condition only if **all** of the following criteria are met:
  2.2.1. they have a serious and incurable illness, disease or disability (note: mental illness is NOT considered an illness, disease or disability)[6];
  2.2.2. they are in an advanced state of irreversible decline in capability; and
  2.2.3. that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

2.3. CPSM requires that:
  2.3.1. any physician who conducts an assessment for the purpose of determining if a patient is eligible for MAiD pursuant to these requirements must:
    2.3.1.i. be satisfied that the patient seeking MAiD has a grievous and irremediable medical condition which the physician has verified by:
      2.3.1.i.1. a clinical diagnosis of the patient's medical condition; and
      2.3.1.i.2. a thorough clinical assessment of the patient which includes consideration of all relevant, current and reliable information about the patient's symptoms and the available medical treatments to cure the condition or alleviate the associated symptoms which make the condition grievous, including, where appropriate, consultation with another qualified physician;
    2.3.1.ii. be fully informed of the current relevant clinical information about the patient and his/her condition;
    2.3.1.iii. be qualified to render a diagnosis and opine on the patient's medical condition or be able to consult with another physician with relevant expertise for the limited purpose of confirming the diagnosis, prognosis or treatment options;
    2.3.1.iv. use appropriate medical judgment and utilize a reasonable method of assessment;

[5] This includes people who would be eligible but for any minimum period of residence or waiting period.

[6] See section 241.2(2.1) of the Criminal Code.

2.3.1.v. when assessing whether a patient's illness, disease or disability or state of decline causes the patient enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that the patient considers acceptable, ensure that:

2.3.1.v.1. the unique circumstances and perspective of the patient, including his/her personal experiences and religious or moral beliefs and values have been seriously considered;

2.3.1.v.2. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and

2.3.1.v.3. treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous or, if the patient is terminal, palliative care interventions; and the patient adequately understands the:

2.3.1.v.3.a. current and anticipated course of physical symptoms, ability to function and pain and suffering specific to that patient; and

2.3.1.v.3.b. effect that any progression of physical symptoms, further loss of function or increased pain may have on that specific patient; and

2.3.1.v.3.c. available treatments to manage the patient's symptoms or loss of function or to alleviate his/her pain or suffering.

2.3.2. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements of any assessment related to the patient's eligibility for MAiD.

3. Specific Requirements for Assessing Medical Decision Making Capacity

3.1. Any physician who conducts an assessment of a patient for the purpose of determining if the patient is capable of making decisions with respect to their health pursuant to the federal requirements must be:

3.1.1. fully informed of the current relevant clinical information about the patient and his/her mental and physical condition; and

3.1.2. qualified to assess competence in the specific circumstances of the patient whose capacity is being assessed or be able to consult with another physician with relevant expertise for the limited purpose of assessing the patient's medical decision making capacity.

3.2. In the event that a physician has a reasonable doubt as to the patient's competence, an additional independent assessment must be conducted by another physician who is enrolled on the Specialist Register as a psychiatrist.

3.3. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements of any assessments of a patient's medical decision making capacity.

4. Requirements for Obtaining Informed Consent and Mandatory Safeguards

4.1. The federal legislation requires that before a physician provides MAiD to a patient, whether that patient's natural death is reasonably foreseeable or not, the physician must:

- 4.1.1. ensure that the request for MAiD was:
  - 4.1.1.i. made in writing and signed and dated by:
    - 4.1.1.i.1. the patient; or
    - 4.1.1.i.2. where the patient is unable to sign and date the request, by another person (proxy) at the express direction of and in the presence of the patient. The person who serves as the proxy must:
      - 4.1.1.i.2.a. be at least 18 years of age;
      - 4.1.1.i.2.b. understand the nature of the request for MAiD;
      - 4.1.1.i.2.c. not know or believe that they are a beneficiary under the will of the patient or a recipient in any other way of a financial or other material benefit resulting from the patient's death; and
  - 4.1.1.ii. signed and dated after the patient was informed by a physician or nurse practitioner that the patient has a grievous and irremediable medical condition.
- 4.1.2. be satisfied that the request was signed and dated by the patient or by the patient's proxy before an independent witness, who then also signed and dated the request;
- 4.1.3. ensure that the patient has been informed that they may, at any time and in any manner, withdraw their request;
- 4.1.4. ensure that another physician or nurse practitioner has provided a written opinion confirming that the person meets all of the eligibility criteria and be satisfied that they and the other physician or nurse practitioner providing the opinion are independent in that each of them:
  - 4.1.4.i. is not a mentor to the other practitioner or responsible for supervising their work;
  - 4.1.4.ii. does not know or believe that they are a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or other material benefit resulting from that patient's death, other than standard compensation for their services relating to the request; or
  - 4.1.4.iii. does not know or believe that they are connected to the other practitioner or to the patient in any other way that would affect their objectivity; and
- 4.1.5. immediately before providing MAiD, give the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive MAiD,
- 4.1.6. If the patient has difficulty communicating, take all necessary measures to provide a reliable means by which the patient may understand the information that is provided to them and communicate their decision.

4.2. The federal legislation also provides that any person who is at least 18 years of age and who understands the nature of the request for MAiD may act as an independent witness, except if that person:

4.2.1. knows or believe that they are a beneficiary under the will of the patient, or a recipient in any other way of a financial or other material benefit resulting from the patient's death;

4.2.2. are an owner or operator of any health care facility at which the patient is being treated or any facility in which patient resides;

4.2.3. are directly involved in providing health care services to the patient or are directly provide personal care to the patient, subject to the following exception:

4.2.3.i. a person who provides health care services or personal care as their primary occupation and who is paid to provide that care to the patient requesting MAiD may act as an independent witness, except for:

4.2.3.i.1. the physician or nurse practitioner who will provide MAiD to the patient: and

4.2.3.i.2. the physician or nurse practitioner who provided an opinion regarding the patient's eligibility for MAiD.[7]

4.3. CPSM requires that:

4.3.1. Physicians who obtain informed consent for MAiD must have sufficient knowledge of the patient's condition and circumstances to ensure that:

4.3.1.i. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and

4.3.1.ii. the treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous and/or palliative care interventions where the patient is terminal; and

4.3.1.iii. the patient is offered appropriate counseling resources; and

4.3.1.iv. the patient fully understands that:

4.3.1.iv.1. death is the intended result of the pharmaceutical agent(s); and

4.3.1.iv.2. the potential risks and complications associated with taking the pharmaceutical agent(s).

4.3.2. Each physician who obtains informed consent from the patient for MAiD must:

4.3.2.i. have either conducted his/her own assessment or be fully informed of the assessments conducted by other physicians of the patient's medical condition and the patient's medical decision making capacity; and

4.3.2.ii. meet the legal requirements for informed consent, including informing the patient of:

4.3.2.ii.1. material information which a reasonable person in the patient's position would want to have about MAiD;

4.3.2.ii.2. the material risks associated with the provision/administration of the pharmaceutical agent(s) that will intentionally cause the patient's death; and

[7] This exception will allow most members of the health care team to act as an independent witness, but makes clear that family member or friends who are directly involved in providing medical or personal care to the patient are excluded.

4.3.2.iii. meet with the patient alone at least once to confirm that his/her decision to terminate his/her life by MAiD is voluntary and that the patient has:
- 4.3.2.iii.1. made the request him/herself thoughtfully; and
- 4.3.2.iii.2. a clear and settled intention to end his/her own life by MAiD after due consideration;
- 4.3.2.iii.3. considered the extent to which the patient has involved or is willing to involve others such as family members, friends, other health care providers or spiritual advisors in making the decision or informing them of his/her decision; and
- 4.3.2.iii.4. made the decision freely and without coercion or undue influence from family members, health care providers or others.

4.3.3. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements for obtaining informed consent.

5. Specific Exceptions to Consent Requirements for Patients Whose Death is Reasonably Foreseeable[8]

5.1. subject to the following exception as it relates to patients whose death is reasonably foreseeable, but have lost the capacity to consent:

5.1.1. a substance to cause a patient's death may be administered to a patient who has lost the capacity to consent to receiving MAiD without giving the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive MAiD if ALL of the following circumstances apply:

5.1.2. BEFORE the patient lost the capacity to consent to receiving MAiD:
- 5.1.2.i. the patient met all of the criteria set out in Section 2 of this Standard and all other safeguards set out in this Section of the Standard were met,
- 5.1.2.ii. the patient entered into an arrangement in writing with the physician or nurse practitioner that the physician or nurse practitioner would administer a substance to cause their death on a specified day,
- 5.1.2.iii. the patient was informed by the physician or nurse practitioner of the risk of losing the capacity to consent to receiving medical assistance in dying prior to the day specified in the arrangement,
- 5.1.2.iv. in the written arrangement, the patient consented to the administration by the physician or nurse practitioner of a substance to cause their death on or before the day specified in the arrangement if they lost their capacity to consent to receiving medical assistance in dying prior to that day;

5.1.3. the substance is administered to the patient in accordance with the terms of the arrangement; AND

[8] For greater certainty, this exception does NOT apply to patients whose death is not reasonably foreseeable.

5.1.4. the patient does not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration[9].

5.2. Once a person demonstrates, by words, sounds or gestures a refusal to have the substance administered or resistance to its administration, MAiD can no longer be provided to them on the basis of the consent given by them under this Standard.

6. Specific Additional Safeguards for Patients Whose Death is NOT Reasonably Foreseeable

6.1. The following additional requirements must be met before MAiD can be provided to a patient where the natural death of the patient requesting MAiD is not reasonably foreseeable:

6.1.1. In addition to the requirements described in Section 4.1.4 of this Standard, if the physician or nurse practitioner referred to in that Section does not have expertise in the condition that is causing the patient's suffering, another physician or nurse practitioner who has that expertise must be consulted and share the results of that consultation with the physician or nurse practitioner who provides MAiD before MAiD can be provided:

6.1.2. The patient must have been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care; and

6.1.3. The physician and the medical practitioner or nurse practitioner referred to in Section 4.1.4 above must have discussed with the patient the reasonable and available means to relieve the patient's suffering and they and the medical practitioner or nurse practitioner referred to in Section 4.1.4 above agree with the patient that the patient has given serious consideration to those means; AND

6.1.4. there are at least 90 clear days between the day on which the first assessment under Section 2 of this Standard as to whether the patient meets the criteria set out in that Section begins and the day on which MAiD is provided to the patient or — if the assessments have been completed and they and the medical practitioner or nurse practitioner referred to in Section 4.1.4 are both of the opinion that the loss of the person's capacity to provide consent to receive medical assistance in dying is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances.

[9] For greater certainty, involuntary words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance for the purposes this paragraph.

7. Specific Requirements of the Administering Physician

7.1. In all cases, whether the patient's natural death is foreseeable or not, the administering physician must:

7.1.1. have appropriate knowledge and technical competency to provide/administer the pharmaceutical agent(s) in the appropriate form and/or dosage that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent; and

7.1.2. be qualified to provide appropriate instructions to the patient as to how to administer the pharmaceutical agent(s) that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent in circumstances where the patient elects to administer the pharmaceutical agent(s) to him/herself; and

7.1.3. be readily available to care for the patient at the time the pharmaceutical agent(s) that intentionally brings about the patient's death is administered by the administering physician or taken by the patient until the patient is dead; and

7.1.4. provide reasonable notice to the Office of the Chief Medical Examiner that the patient is planning to die by means of MAiD where the location is not a health care institution; and

7.1.5. certify, in writing[10], that they are satisfied on reasonable grounds that all of the following requirements have been met:

7.1.5.i. The patient is at least 18 years of age;

7.1.5.ii. The patient's medical decision making capacity to consent to receiving medication that will intentionally cause the patient's death has been established in accordance with the requirements of the Criminal Code and this Standard;

7.1.5.iii. All of the requirements of the Criminal Code and this Standard in relation to assessing eligibility for MAiD and obtaining and documenting informed consent and all relevant additional safeguards have been met; and

7.1.5.iv. Ensure that the requirements of physicians set out in all relevant federal and provincial legislation, including the Criminal Code, The Fatality Inquiries Act, C.C.S.M. c. F52 and The Vital Statistics Act, C.C.S.M. c. V60 in respect to reporting and/or registering the cause and manner of the patient's death, including completing all required forms specified by the legislation or regulations, are met in a timely fashion.

[10] Please see Appendix A for an example of an acceptable form of written confirmation or contact the MAiD team at Shared Health for more information..

8. Additional Requirements of the Federal Legislation

8.1. The federal legislation also:

8.1.1. Sets out detailed requirements for the filing of information by physicians who carry out assessments or preliminary assessments as to whether patients meet the criteria for MAiD and those who receive a written request for MAiD[11];

8.1.2. requires that physicians who, in providing MAiD, prescribe or obtain a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose;

8.1.3. requires physicians to comply with guidelines established for the completion of certificates of death for patients to whom MAiD is provided;

8.1.4. creates criminal offences for knowingly failing to comply with the eligibility and safeguard requirements set out in Criminal Code and destroying documents with the intent to interfere with a patient's access to MAiD, the assessment of a request for MAiD or a person seeking an exemption related to MAiD.

8.2. CPSM requires that physicians comply with the federal and provincial regulations and guidelines described above as they come into force and effect.

[11] These requirements are subject to specific regulations and input from Health Canada and may change over time. See section 241.31 of the Criminal Code and the related regulations for a detailed description of the information to be provided and to whom.

Appendix A – Certification by the Administering Physician

PATIENT INFORMATION		
Last Name	First Name	Second Name(s)
Personal Health Identification No. (PHIN) and/or Manitoba Health No (MHSC)	Birthdate	Gender: ☐ Male ☐ Female ☐ Other - specify:
Medical Condition(s) Relevant to Request for MAiD		
Independent Practitioner(s) who conducted their own review for patient eligibility and provided a written opinion in that regard:		

ADMINISTERING PHYSICIAN CERTIFICATION	
By initialling and signing below, I confirm that:	
Initials	I am the administering physician who has provided/administered the pharmaceutical agent(s) for MAiD to the patient named above for the intended purpose of causing the patient's death at the patient's request.
Initials	I am familiar with and have satisfied all of the requirements for providing MAiD to the patient as set out in the *Criminal Code of Canada,* R.S.C, 1985, c. C-46 (the "Criminal Code"), and the Standard of Practice of College of Physicians & Surgeons of Manitoba ("CPSM") for MAiD and am satisfied that all requirements have been met, including the following: • The patient is 18 years of age; • The patient had the capacity to make medical decisions at all relevant times; and • All requirements in relation to eligibility for MAiD have been met and all mandatory safeguards were implemented before MAiD was provided.
Initials	A written request for MAiD was signed and dated by the patient (or their proxy as directed by the patient) before an independent witness who then also signed and dated the request.
Initials	If the patient had difficulty communicating, all necessary measures were taken to provide a reliable means by which the patient may understand the information that was provided to them and communicate their decision.
Initials	I ensured the patient was informed that they may, at anytime and in any manner, withdraw their request for medical assistance in dying.
Initials	I informed the pharmacist that dispensed the pharmaceutical agent(s) that the substances were intended for medical assistance in dying.
Initials	Immediately before providing MAiD, I provided the patient with the opportunity to withdraw their request and ensured the patient gave their express consent to receive medical assistance in dying OR
Initials	The patient had completed a *Waiver of Final Consent* then lost capacity to consent to receiving MAiD and after ensuring the patient did not by words, sounds or gestures, demonstrate refusal or resistance to having the substance administered, I provided MAiD in accordance with the terms of the *Waiver of Final Consent*.

Signature of Physician	Print Name	Date Signed
Signature of Witness	Print Name	Date Signed

COUNCIL MEETING – JUNE 9, 2021

BRIEFING NOTE

TITLE: Strategic Organizational Priorities

BACKGROUND

Council has adopted Strategic Organizational Priorities for CPSM. The idea behind identifying these Strategic Organizational Priorities is that by establishing organizational and operational priorities CPSM can successfully plan and utilize its resources for future initiatives in a disciplined manner and provide accountability for work undertaken through the quarterly review by Council of the Progress Tracking Table. Once a year, Council reviews the various proposed initiatives and then directs the CPSM Registrar to pursue these.

The COVID-19 pandemic caused some disruption and delay in achieving every Strategic Organizational Priority last year, but notwithstanding this, the following were completed and are in effect now.

- Standard of Practice for Prescribing Benzodiazepines
- Standard of Practice for Authorizing Medical Cannabis
- Accredited Facilities Review and Bylaw Amendment
- Standard of Practice Maintaining Boundaries

Four Strategic Organizational Priorities from 2020-2021 will be continued into 2021/22. These were not completed within the calendar year and were not expected to be completed. The Working Groups meet monthly in general and multiple drafts are reviewed and considered prior to a recommendation made to Council. The feedback from consultation may also be extensive and may require several meetings of the Working Groups to review the feedback and then revise the Standard accordingly. Each of these has been reviewed by Council or will be reviewed by Council in this meeting, so they are all well underway.

- Standard of Practice Patient Records
- Standard of Practice Virtual Medicine
- Standard of Practice Duty to Report
- Standard of Practice Office Based Procedures

Although not formally Strategic Organizational Priorities, two other items resulted in significant work with outputs that are important for CPSM and the regulation of the practice of medicine:

- Cardiac Exercise Stress Testing Standard of Practice
- Standards Subcommittees Review, Report, and Creation of Direction Manual

These two initiatives had Working Groups and produced documents to assist in regulation.

All Standards of Practice are to be reviewed on a four year cycle, though with COIVD-19, this has been slightly delayed. Additionally, a four year cycle has proved to be rather ambitious given the many Standards that are outdated and essentially require a completely new version. An example is the Virtual Medicine Standard which was drafted for the occasional pre-COVID virtual medicine call through the health care system.

Proposed initiatives are derived from various sources, including the cycle of reviewing the Standards and Practice Directions., recommendations made from Committees, informal recommendations from Councillors, matters that the Registrar/President considers of strategic importance, and FMRAC strategic priorities to ensure cross-Canada uniformity if possible.

For 2021-2022 new possibilities for Strategic Organizational Priorities are:

- Standard of Practice and Practice Directions Prescribing Practices & M3P**
- Indigenous Anti-Racism Initiatives**
- Standard of Practice Episodic Care / House calls / Walk-in clinics (new)**
- Standard of Practice for Prescribing Gabapentin (new)
- Standard of Practice Advertising
- Standard of Practice UGME/PGME Professional Responsibilities
- Standard of Practice Practice Environment (including Medical Director)
- Standard of Practice Collaborative Care
- Standard of Practice Conflict of Interest
- Practice Direction Medical Corporations
- Practice Direction Qualifications and Registration *

** These are likely high priority for 2021-2022

It is important to note that this is just a list of possible strategic organizational priorities and not all can be accomplished or initiated in the upcoming year. These are all listed for discussion purposes for the Executive Committee to consider. Council will be asked in June to provide direction on their choice of the upcoming Strategic Organizational Priorities. There is limited capacity and CPSM is unlikely to accomplish three major Strategic Organizational Priorities in 2021/22, noting that CPSM must still complete the 2020/21 Strategic Organizational Priorities. Perhaps two major and one or two minor Strategic Organizational Priorities are suggested for the current capacity in 2021/22.

Attached is a Chart outlining the Proposed Strategic Organizational Priorities for Consideration and the Progress Tracking Chart for a visual view of the Current Strategic Organizational Priorities.

Proposed Strategic Organizational Priorities 2021/22

Strategic Organizational Priority	Document Type	Comments	Amount of Review	Origin
Prescribing Review	Standard, Practice Directions, M3P Program, Regulations	With the move to virtual medicine and the pandemic, temporary measures were put in place to alter many aspects of prescribing. It is the intention to retain some innovations post-pandemic. Discussion on the continued use of M3P has arisen several times and requires a decision. Joint with the Colleges of Pharmacy and Registered Nursing.	Major	Need and cycle
Indigenous Anti-Racism	Registration Requirements, other unknown	Working with and led by Indigenous Physicians. Discussed at the March Council meeting.	Major	National Prominence
Episodic Care, House Calls, Walk-in Clinics	Standard	See separate agenda item	Major	Central Standards Committee Motion
Gabapentin	Standard	Gabapentin continues to be a drug of abuse, is overprescribed anecdotally, and contributes to overdose deaths. Reconvene Benzodiazepines Working Group to consider rules for gabapentin prescribing.	Medium	Need
Advertising (including Social Media Use)	Standard	There are currently no rules on social media use by members (other than for COVID).	Major	Need and Cycle
UGME/PGME Professional Responsibilities	Standard	The rules governing medical education and the supervision of residents and student have been in place for 7 years. Much of the work can be undertaken by the university.	Medium	Cycle
Practice Environment (including Medical Director role)	Standard	The role of the medical director in a non-institutional setting requires significant review and updating as CPSM intends to expand their duties and responsibilities as issues have arisen in recent years. Rules are also in place for the member to be responsible to safe premises, equipment, and supplies.	Major	Cycle
Collaborative Care	Standard	Very Low Priority since only three years old	Minor	Cycle
Conflict of Interest	Standard		Minor	Cycle
Medical Corporations	Practice Directions, Regulations	Many of the rules are set out in the regulations, but there are some details in the Practice Directions.	Minor	Cycle
Qualifications and Registration	Practice Directions, Regulations	Many of the rules are set out in the regulations, but there are some details in the Practice Directions. Most of what is in the Practice Direction are items that either Council or the Registrar has the discretion to set rules and criteria for.	Minor	Cycle

CPSM
ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	FMRAC Working Group	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Virtual Medicine within Manitoba - Standard of Practice		Sep-20	Jun-21		Jun 21	Jul 21	Sep 21	Oct 21	On Track	June Council for approval for consultation
Patient Records - Standard of Practice		Sep-20	Mar 21		Jun 21	21-Jul	Sep 21	Oct 21	On Track	June Council for approval for consultation
Duty to Report - Standard of Practice		Sep-20	Jun-21		Mar 21	Apr 21	Jun 21	Jul 21	On Track	June Council for approval
Office Based Procedures - Standard of Practice		Jan-21			Jun 21	Jul 21	Sep 21	Oct 21	Not Started	First Mtg scheduled for April 2021
Standards of Practice Ongoing Review - 4 Year Cycle		Jan-20	Dec-24						On Track	
Streamlined Registration - Fast Track Application	FMRAC-Started								Not Started	
Streamlined Registration - Portable Licence	FMRAC-Started								Not Started	Amendments to Acts Required in many jurisdictions
Artificial Intelligence	FMRAC-Started								Not Started	
Telemedicine Across Jurisdictions	FMRAC-Started								Not Started	

Last revised: April 19, 2021

EXECUTIVE COMMITTEE MEETING
MAY 12, 2021
BRIEFING NOTE

TITLE: Standard of Practice for Episodic Care/House Calls/Walk-In Clinics

BACKGROUND

The Central Standards Committee reviewed the practice of a member whose sole practice is house calls. The member has no computer connectivity, so does not undertake a search of eChart or other medical records to determine the prescribing history or medical history of the patient. These patients are generally seen for episodic care and are often elderly patients with a significant medical history, those living with disabilities, or are single mothers with multiple children who find it difficult to travel to a medical clinic to seek care for either themselves or a child.

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

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.

The Central Standards Committee identified a gap in the standard of care – namely that there are no rules for the expected standard of care for house calls, nor for episodic care or walk-in clinics. Central Standards Committee considered the possibility of a Standard of Practice being drafted to provide CPSM's expectation for the profession in delivering house calls.

The Central Standards Committee has made a recommendation for Council to consider adding to its Strategic Organizational Priorities a separate Standard of Practice for Episodic Care/House Calls. The Central Standards Committee has also made a recommendation for Council, in the alternative, to include in an existing Standard of Practice a requirement that every member review e-Chart if providing episodic care/ house calls / walk in clinic care.

A jurisdictional scan indicated no other specific standards for house calls by other colleges.

CPSM has been advised from eHealth:

- Number of total physicians listed on CPSM directory who have access to eChart: 3077
- Number of total physicians listed on CPSM directory with no match to UAD/eChart account: 961

Stated another way, 76.2% of all physicians currently listed on the CPSM directory have access to Manitoba eChart.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 9, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

1. Council includes in the 2021/22 Strategic Organizational Priorities the development of a Standard of Practice for Episodic/House Calls/Walk-In Clinics Care.

2. In the alternative, include in an existing Standard of Practice, a requirement that every member review e-Chart if providing episodic care, house calls, or walk in clinic care unless internet connectivity is not possible (such as in some rural and remote areas.)

COUNCIL MEETING – JUNE 9, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: CPSM 2021 - 2022 Operating Budget

BACKGROUND:

While it is the responsibility of the Registrar to prepare an annual operating budget and manage the operations of the College to that budget, the Finance, Audit and Risk Management Committee has responsibility to review the annual operating budget and recommend its approval to Council. Based on key parameters established - the operating budget for the 2021-2022 fiscal year projects revenues of $8,412,354, expenses of $8,955,864 for a projected deficiency of revenues over expenses in the amount of $543,510. The budgeted forecast for the future fiscal year 2022-2023 indicates a deficiency of revenue over expenses of $382,129 and a deficiency of revenue over expenses in 2023-2024 of $180,469.

Human Resource Adjustments in 2020/2021 to facilitate the achievement of the quality enhancements were necessary to meet the mandate of self-regulation. Any future increases in staffing requirements will be considered only after many of the described efficiencies have been achieved and in the context of **increased output or value to the regulatory function of CPSM**. This will follow a **strategic alignment with CPSM and Council priorities** as well as to address any **emerging risk or quality and safety issues** identified in the practice of medicine.

- The **Quality Department** at CPSM was launched in late 2020 in an effort to consolidate all similar activities within CPSM that are focused on practice competence, quality of care and monitoring of the profession unrelated to complaints and investigations.
- This resulted in the realignment of work formerly done in the Registration department and brought the Prescribing Practices Program under the direction of the Assistant Registrar (Quality).
- The Quality Department now consists of the following CPSM programs:
    - **Physician Health Program**
    - **Quality Improvement Program**
    - **Audits and Monitoring**
    - **Standards Committees**
    - **Prescribing Practices Program**
    - **Manitoba Quality Assurance Program**
    - **Non-Hospital Medical Surgical Facilities**

Goals of this reorganization are to:

- Enhance CPSM's ability to meet their regulatory mandate including additional and improved monitoring of the competence and quality of the practice of medicine
- Standardize processes, communication and experiences for members with CPSM audit and monitoring activities to permit the measuring of outcomes

- Create efficiencies through team integration, broader leveraging of skills, improved coordination of activities and knowledge
- Improve processes and monitoring of Non-Hospital Medical Surgical Facilities
- Develop and track metrics to demonstrate how each program contributes to CPSM's regulatory mandate
- Permit enhanced annual reporting and identification of continuous quality improvement opportunities within CPSM's monitoring of the profession
- Improvements in the Standards Subcommittees to assist them in meeting their mandate to supervise competent medical care
- Reduce risks identified in existing operations including lack of standardization and gaps in accreditation processes

Highlights of the enhancements or improvements planned in 2021:

- Managing increasing number of physicians with connections to the Physician Health Program
- Decreasing the age of an Age-Triggered Quality Audit to 74 from 75
- The addition of Registration Audits including Provisional Registration and RHPA mandated reviews of Physician Assistant and Clinical Assistant practice
- Increased outreach, education and intensive case management for Prescribing Practices Program
- Launch of new Accredited Facilities By-Laws and oversight of increased numbers of Non-Hospital Medical Surgical Facilities accredited facilities using standardized processes and practices consistent with Manitoba Quality Assurance Program
- Development of improved Metrics and Reporting (outcome measures)
- Creation of transparency in process, alignment of tone and messaging in communication using language of quality improvement across programs as appropriate
- Promotion of the CPSM Quality Department to the profession and its key stakeholders
- Launch of the Quality Department SharePoint Site (internal) and website enhancements (external)

"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 2021 - 2022 Operating Budget is sufficient for CPSM to fulfill its statutory mandate and to serve and protect the public interest.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 9, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Council approve the 2021 - 2022 annual operating budget as presented

College of Physicians & Surgeons of Manitoba

Budget Statement of Operations - Direct Costing

FY's 2021-22 to 2023-24

	2019-20 Actual	2020-21 Actual	2021-22 Budget	2022-23 Estimate	2023-24 Estimate
Revenues					
Physician & Resident License Fees	5,898,381	6,025,030	6,089,434	6,239,410	6,475,610
Educational Register Fees	91,975	82,100	78,737	78,134	78,000
Clinical Assistant License Fees	31,350	34,950	30,450	29,700	29,700
Physician Assistant License Fees	40,500	41,100	41,850	43,950	46,650
Medical Corporation Fees	370,461	376,975	371,825	371,300	371,300
Other Fees and Income	451,482	442,463	369,980	360,380	360,380
Interest Income	82,413	23,837	22,275	21,729	22,104
Change In Market Value	91,346	205,268	101,802	103,490	105,246
Government Funded Program Revenues	1,417,204	1,332,430	1,306,000	998,409	896,000
	8,475,112	**8,564,153**	**8,412,354**	**8,246,502**	**8,384,990**
Expenses					
Governance	158,252	138,677	141,635	155,845	156,495
Qualifications	918,511	885,559	686,403	696,679	727,409
Complaints and Discipline	1,436,654	1,509,985	1,822,265	1,491,466	1,525,748
Quality	927,900	998,626	1,263,897	1,324,055	1,517,755
Operations and General Administration	2,420,208	2,517,345	2,594,022	2,795,480	2,908,103
IT	842,104	906,385	1,037,453	1,037,891	915,350
Government Funded Program Expenses	1,288,367	1,281,632	1,410,189	1,127,215	814,779
	7,991,997	**8,238,208**	**8,955,864**	**8,628,631**	**8,565,638**
Excess (Deficiency) of Revenue Over Expenditures	**483,115**	**325,944**	**(543,510)**	**(382,129)**	**(180,649)**

College of Physicians & Surgeons of Manitoba

Budget Statement of Operations

FY's 2021-22 to 2023-24

	2019-20 Actual	2020-21 Actual	2021-22 Budget	2022-23 Estimate	2023-24 Estimate
Revenues					
Physician & Resident License Fees	5,898,381	6,025,030	6,089,434	6,239,410	6,475,610
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Government Funded Program Revenues	1,417,204	1,332,430	1,306,000	998,409	896,000
	8,475,112	**8,564,153**	**8,412,354**	**8,246,502**	**8,384,990**
Expenses					
Employee Costs	5,514,558	5,925,684	6,066,231	6,097,184	6,288,452
Committee Meetings	402,732	223,420	375,040	383,637	384,032
Professional Fees	445,338	477,801	606,623	388,325	273,883
Service Fees	190,096	193,460	287,240	225,373	229,641
Legal	141,303	125,885	147,000	42,000	42,000
Building & Occupancy Costs	421,668	443,942	545,138	594,049	600,264
Office Expenses	614,295	613,660	610,951	570,610	576,927
Capital Assets	262,007	234,358	317,642	327,452	170,440
	7,991,997	**8,238,208**	**8,955,864**	**8,628,631**	**8,565,638**
Excess (Deficiency) of Revenue Over Expenditures	**483,115**	**325,944**	**(543,510)**	**(382,129)**	**(180,649)**

COUNCIL MEETING – JUNE 9, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Appointments to Committees

BACKGROUND

With the election of a new President Elect the presidency appointments automatically rotate as many of the committee seats are ex officio for the Presidents – Elect, Current, and Past. Also with the QI Committee being absorbed into the Central Standards Committee new appointments are required.

The Executive Committee is responsible for making a recommendation to Council for Committee membership, as per governance procedures. Below are the recommendations of the Executive Committee for Committee membership for 2021 - 2022. For complete committee membership see the attached charts.

- Dr. Jacobi Elliot to Executive Committee Chair, ex officio on Finance, Audit & Risk Management Committee, Central Standards Committee, and Program Review Committee
- Dr. Nader Shenouda to Executive Committee, to Finance, Audit & Risk Management Committee Chair, Ex officio on Central Standards Committee and Program Review Committee; removed from Investigations Committee Chair
- Dr. Kevin Convery to Investigations Committee Chair
- Dr. Ravi Kumbharathi to Investigation Committee; remains on Program Review Committee
- Dr. Eric Sigurdson removed from Executive Committee and Inquiry; remains on Central Standards Committee
- Mr. Chris Barnes (Associate Representative) to Central Standards Committee
- Dr. Ira Ripstein to Inquiry Committee Chair, to Central Standards Committee
- Leanne Penny to Finance, Audit & Risk Management Committee; remains on Complaints Committee
- Ray Cadieux removed from Finance, Audit & Risk Management Committee

- Dr. Norman McLean to Complaints Committee
- Dr. Shaundra Popowich removed from Complaints (2015 appointment)
- Dr. Boshra Hosseini to complaints committee

Council is required to approve the Committee memberships, including the Inquiry Committee members for 2021 – 2022.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF THE COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 9, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> Council appoint membership in Committees as per the attached lists for Committee Membership 2021 - 2022.

Committee Membership 2021 - 2022

Council Members	Executive	Finance, Audit & Risk Mgmt	Central Standards	Program Review	Complaints	Investigation	Inquiry
Agger, Leslie				Pub Rep			
Albrecht, Dorothy			Pub Rep				
Blakley, Dr. Brian					Councillor		
*Convery, Dr. Kevin						Chair	
Elliott, Dr. Jacobi (President)	Chair	Ex O-NV	Ex O-NV	Ex Officio			
Fineblit, Allan	Pub Rep						
Kumbharathi, Dr. Ravi				Councillor		Councillor	
Lindsay, Dr. Daniel				Councillor			
Magnus, Lynette		Pub Rep				Pub Rep	
Manishen, Dr. Wayne				Chair			
McLean, Dr. Norman					Councillor		
McPherson, Marvelle	Pub Rep		Pub Rep				
Penner, Dr. Charles		Councillor					
Penny, Leanne		Pub Rep			Pub Rep		
Postl, Dr. Brian	Councillor	Councillor					
Ripstein, Dr. Ira (Past-President)	Councillor		Councillor				Chair
Seager, Dr. Mary-Jane			Councillor				
Shenouda, Dr. Nader(President-Elect)	Councillor	Chair	Ex O-NV	Ex O-NV			
Sigurdson, Dr. Eric			Councillor				
Smith, Dr. Heather					Chair		
Stacey, Dr. Brett					Councillor		
Suss, Dr. Roger			Chair				
Barnes, Mr. Christopher (Associate Member)			Councillor				
Ziomek, Dr. Anna (Registrar)	Ex O-NV	Ex O-NV	Ex O-NV	Ex O-NV			

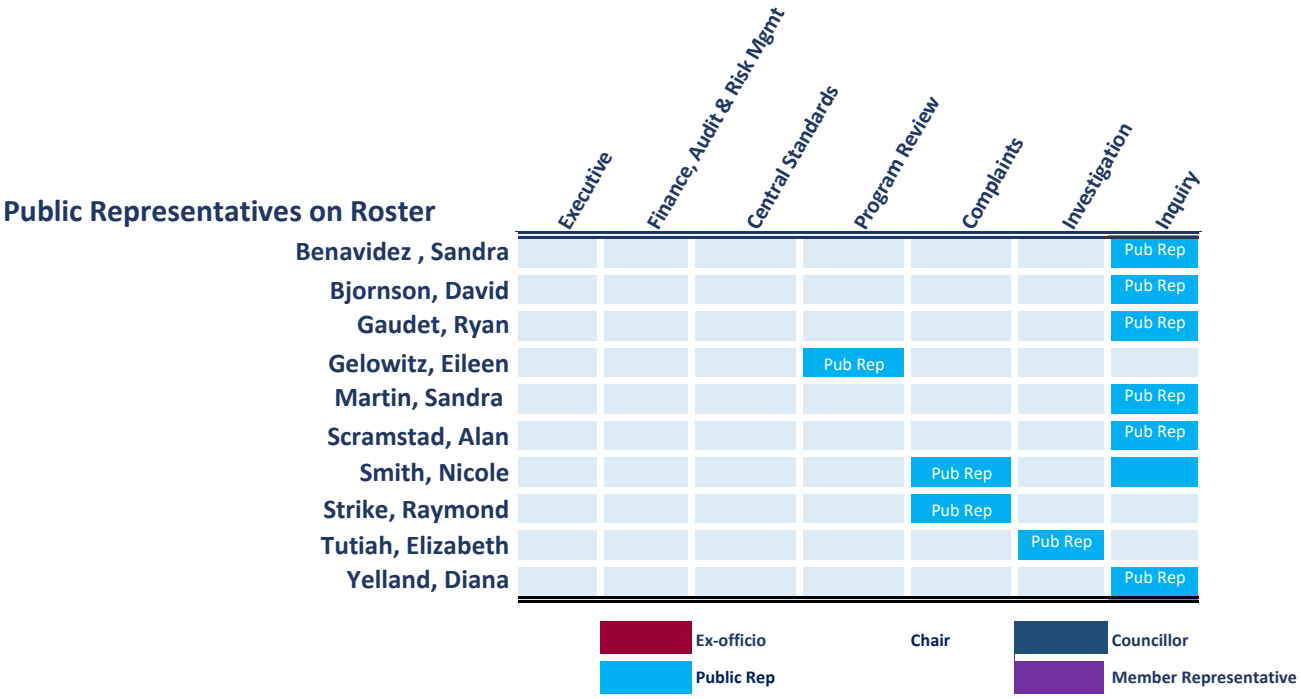
External Members	Executive	Finance, Audit & Risk Mgmt	Central Standards	Program Review	Complaints	Investigation	Inquiry
Anderson, Dr. Brent				Member Rep			
Cabel, Jennifer				Gov't Rep			
Hosseini, Boshra					Member Rep		
Kabani, Dr. Amin				Member Rep			
Kirkpatrick, Dr. Iain				Member Rep			
Kvern, Dr. Brent						Member Rep	
Naidoo, Dr. Jenisa				Member Rep			
Polimeni, Dr. Christine			Member Rep				
Reitmeier, Dr. Shayne					Member Rep		
Stansfield, Katherine			Pub Rep				

* Two Year Term

Updated May 20, 2021

Ex-officio | Councillor | Public Rep | Member Representative

Committee Membership 2021 - 2022



CPSM Members Appointed to the Inquiry Panel 2020-2021

Sal	Last Name	First Name
Dr	Ahmed	Munir
Dr	Andani	Rafiq
Dr	Basta	Moheb Samir Samy
Dr	Bello	Ahmed Babatunde
Dr	Bernstein	Keevin Norman
Dr	Bhangu	Manpreet Singh
Dr	Buduhan	Gordon
Dr	Butler	James Blake
Dr	Campbell	Barry Innes
Dr	Cham	Bonnie Paula
Dr	Corbett	Caroline
Dr	Derzko	Lydia Ann Lubomyra
Dr	Dyck	Michael Paul
Dr	Ghorpade	Nitin Namdeo
Dr	Goldberg	Aviva
Dr	Grocott	Hilary Peter Thomas
Dr	Hanlon-Dearman	Ana Catarina de Bazenga
Dr	Harris	Kristin Renee
Dr	Henderson	Blair Timothy
Dr	Herd	Anthony Michael
Dr	Hynes	Adrian Francis Mary
Dr	Jellicoe	Paul Arthur
Dr	Jones	Jodi Lynn Plohman
Dr	Kakumanu	Ankineedu Saranya
Dr	Kean	Sarah Lynn
Dr	Kettner	Joel David
Dr	Knezic	Kathy Ann
Dr	Lane	Eric Stener
Dr	Leonhart	Michael Warren
Dr	Manji	Rizwan Abdulmalik Samji
Dr	Martens-Barnes	Carolyn
Dr	McCammon	Richard James
Dr	Nair	Unni Krishnan
Dr	Nashed	Maged Shokry
Dr	Peterson	John David
Dr	Porhownik	Nancy Rose

CPSM Members Appointed to the Inquiry Panel 2020-2021

Sal	Last Name	First Name
Dr	Price	James Bryan
Dr	Ross	Timothy K.
Dr	Roux	Jan Gideon
Dr	Samuels	Lewis
Dr	Scott	Thomas Jason Paul
Dr	Shah	Ashish Hirjibhai
Dr	Simmonds	Reesa
Dr	Singh	Harminder
Dr	Sommer	Hillel Mordechai
Dr	Spencer	Mandy Lee
Dr	Stephensen	Michael
Dr	Swartz	Jo Stephanie
Dr	Tagin	Mohamed Ali Mashhoot
Dr	Taraska	Vincent Aloysius
Dr	Thompson	Susan Bomany
Dr	Van Dyk	Werner Willem Adriaan
Dr	Weiss	Elise Collette
Dr	Yaffe	Clifford Stephen
	Public Reps	
Mr.	Bjornson	David
Ms	Benavidez	Sandra
Mr.	Gaudet	Ryan
Ms	Martin	Sandra
Mr.	Scramstad	Alan
Ms	Yelland	Diana

COUNCIL MEETING – JUNE 9, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: Accredited Facilities Bylaw – Procedures Requiring Accreditation and Approval of Technical Standards

BACKGROUND

1 - Procedures Requiring Accreditation

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.

All non-hospital medical or surgical facilities in which procedures that have a sufficient risk of potential harm to a patient must apply for, obtain, and maintain accreditation from CPSM prior to providing any such diagnostic or treatment services or procedures.

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

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

A list of procedures that have a sufficient risk of potential harm to the patient to require accreditation was revised to include “cataracts and retinal procedures”. An ophthalmologist was part of the Working Group, their input was sought, and they advised that retinal procedures as a category should be included in the list. Accordingly, “cataract and retinal procedures” was included on the list of procedures requiring accreditation. Also included on the list was Lasik therapeutic procedures”.

The ophthalmologist has since consulted with peers and advises that not every retinal procedure meets the threshold of sufficient risk of potential harm to a patient and the criteria. The retinal procedures that do meet this level of risk include:

- Scleral Buckling
- Vitrectomy (including but not limited to open sky, anterior, and pars plana)

Other retinal procedures do not meet the required level of risk, including intravitreal injections. By volume intravitreal injection is the most common retina procedure performed. Prior to Covid about 22,000 were performed annually in the province. 1/3 were done at the Misericordia and 2/3 were split between the offices of the Manitoba and Winnipeg Clinics. Topical anaesthesia is used. The risk of complications such as Endophthalmitis is around 1 in 3000 to 1 in 10,000. Given the high volumes only disposable equipment is used so no reprocessing of medical devices and infection risk. The drugs

are compounded at a central WRHA facility and distributed. No other province requires Intravitreal injections to be done in an Accredited Facility.

Cataract procedures are required to be performed in accredited facilities due to the risk criteria. No change here is required.

Corneal laser procedures will require accreditation since incisions are made; whereas retinal laser procedures require no incision and therefore do not meet the criteria for accreditation from a risk perspective. Lasers for Retina procedures have been around since the 60s and 70s and have been done in offices and do not need to be done in an accredited facility. As mentioned above, Lasik is already included in the Accredited Facilities Bylaw list of procedures.

The new wording proposed for this provision of the bylaw in light of this additional information is:

"The following procedures must be performed in an accredited facility:

- Cataract Surgical Procedures
- Corneal Laser Procedures
- Retinal Procedures limited to scleral buckling and vitrectomies "

2 - Technical Standards Approval

There are technical standards created for different types of diagnostic and laboratory facilities to comply with to obtain and remain accredited. Currently, Council approves these technical standards. It is recommended that the Program Review Committee be the body that approves these technical standards. The Program Review Committee has specific expertise with membership drawn from the specialties of laboratory medicine, radiology, anesthesia, and surgery.

Should you wish to review the nature of these technical Standards here are the links:

Manitoba Laboratory Standards
Manitoba Patient Service Centre Standards
Manitoba Diagnostic Imaging Standards
Manitoba Diagnostic Imaging Standards – Mammography

In the motion the reference is to the Committee – which is defined in the Bylaw as the Program Review Committee.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 9, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

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.”

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – JUNE 9, 2021

ITEM FOR INFORMATION

SUBJECT: Registrar/CEO's Report

COVID-19

CPSM Work Continues – In Office and Remotely

The staff at CPSM have been both working from home and in the office. With the rising COVID cases and new Public Health Directives more staff have elected to work from home at this time. We continue to monitor the situation.

Guidance to the Profession

With the rising COVID numbers in Manitoba and the strain it is placing on our hospital system CPSM sent a reminder to the non-hospital surgical facilities regarding the current strain on our hospital system and that they monitor the procedures they are providing.

With the explosion of virtual medicine during COVID, and the travelling and moving of patients notwithstanding the pandemic, physicians sometimes found themselves practicing medicine worldwide – often without the realization. CPSM was also contacted daily by physicians wanting to know the "rules" of practicing virtual medicine across borders – whether into or outside of Manitoba. CPSM worked with stakeholders from Manitoba Health, Doctors Manitoba, and Shared Health to issue an Information Sheet on Virtual Medicine Across Provincial and International Borders. The document is available on the CPSM web site.

CPSM continues to be a valuable resource on the standard of care and the practice of medicine during this pandemic. CPSM is contacted daily with unique situations the CPSM members encounter due to COVID-19. Advice is provided by telephone or by email on an individual basis.

CPSM is not infrequently contacted by individuals from the public seeking medical opinions or directives on what can be called controversial or unproven treatments for COVID-19. CPSM's position is that all members must practice evidence-based medicine and follow Public Health and/or Shared Health directions. CPSM does not engage with these individuals.

Manitoba Chiropractors Association Lawsuit

In 2019 MCA filed a Statement of Claim against CPSM alleging breach of an Agreement and defamation for an opinion the College provided in 2016 to the provincial RHPA Health Advisory Panel on high velocity neck manipulations. Our insurer covered the defence as part of CPSM's coverage, so there are no legal costs for CPSM.

CPSM has been successful and the legal action has been formally dismissed with consent of the MCA by the Court of Queen's Bench. Furthermore, the Agreement between the MCA and CPSM stemming from previous litigation launched by the MCA is now null and void and of no legal effect. That Agreement required ongoing meetings between the two organizations amongst other requirements.

Meetings with Government Officials

Ministers of Health Meeting

Dr. Marina Reinecke(CPSM Prescribing Practices Program and an Addictions Doctor) and I met with both Minister Stefanson (Health) and Minister Gordon (Mental Health) to discuss overdose deaths that have increased significantly since COVID-19. Recommendations were provided to the Ministers for their review.

Public Health Orders Meetings

CPSM was invited to attend biweekly meetings and either Dr. Mihalchuk and/or myself have attended these meeting. The meeting attendees consist of Health Region Chief Medical Officers, Public Health leaders, Department Heads and Shared Health. The meetings are to discuss and collaborate on the next steps required during the pandemic.

Committee Work by the Registrar

As part of my duties as the Registrar I sit on several committees and attend the committee meetings. Some of these committees meet monthly, biweekly, quarterly or biannually. Below is a list of committees of which I am a member:

- Max Rady College of Medicine Professionalism Subcommittee on Admissions
- Max Rady College of Medicine - College Executive Council
- Max Rady College of Medicine Fellowship Committee
- Rady Faculty of Health Sciences Senate Committee – Application under Section 181 of the RHPA
- Rady Faculty of Health Sciences Medicine Subcommittee of the Joint Council
- PGME Accreditation Steering Committee
- PGME Executive Committee
- Rady Faculty of Health Sciences PGME External Review Committee
- WRHA Medical Advisory Committee
- Shared Health Medical Advisory Committee
- Manitoba Clinical Leadership Council
- Manitoba Health Home Clinics

- Manitoba Monitored Drug Review Committee
- Provincial Chief Medical Officers/Special Lead Meeting
- College of Pharmacists of Manitoba Extended Practice Pharmacist Advisory Committee

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

Other National Committees

- National Committee on Continued Professional Development – FMRAC Representative
- National Assessment Collaboration Practice Ready Assessment - FMRAC Representative
- Canadian Patient Safety Institute Policy, Legal & Regulatory Affairs Advisory Committee
- Canadian Medical Association Committee on Ethics

MEDIA

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

Most recently, CPSM was mentioned in an article from an Alberta publication reporting on Alberta's medical exception letter requirement for those unable to wear a mask. Dr. Deena Hinshaw, Chief Medical Health Officer, credited using resources developed by CPSM (Medical Notes for Exemptions) for developing their model.

Media had not contacted CPSM for comment on any other matters.

COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

2021-2022 MEETING DATES

MONTH	MEETING DATE		COMMITTEE	OTHER DATES
Jun-21	Tue 29		Complaints Committee	
Jul-21				1st : Canada Day - CPSM Closed
Aug-21	Tue 10		Complaints	2nd : Civic Holiday - CPSM Closed
Sep-21	Wed 1	8:30	Executive Committee	6th : Labour Day - CPSM Closed
	Fri 3	8:30	Central Standards Committee	
	Wed 8	08:00	Program Review	
	Wed 8		Investigation Committee	
	Wed 29	08:00	Council	
Oct-21	Tues 5	8:30	Complaints	11th : Thanksgiving Day - CPSM Closed
	Wed 13		Investigation Committee	
	Fri 22	8:30	Central Standards Committee	
Nov-21	Wed 17	08:00	Executive	11th : Remembrance Day - CPSM Closed
	Wed 17		Investigation Committee	
	Tue 23	8:30	Audit & Risk Management	
	Tue 23		Complaints	
	Wed 24	08:00	Program Review	
Dec-21	Wed 8	08:00	Council	24th Dec - 31st Dec: CPSM Closed
	Fri 17	8:30	Central Standards Committee	
	Wed 15		Investigation Committee	
Jan-22	Tues 18	08:00	Complaints	1st : New Years Day - CPSM Closed
Feb-22	Wed 2		Investigation Committee	21st : Louis Riel Day - CPSM Closed
	Fri 4	8:30	Central Standards Committee	
	Tue 22	8:30	Audit & Risk Management	
	Tue 22	08:30	Complaints	
	Wed 23	8:00	Program Review	
Mar-22	Wed 2	08:30	Executive Committee	22: Associate Member Nominations Out
	Wed 9		Investigation Committee	
	Wed 23	08:00	Council	
	Tue 29	08:00	Complaints	
Apr-22	Fri 8	8:30	Central Standards Committee	15th : Good Friday
	Wed 13		Investigation Committee	12: Associate Member Nominations Closed
				19: Associate Member Ballot Out
May-22	Tue 3	08:30	Complaints	03: Ballots In - Associate Member Election Day
	Wed 11		Investigation Committee	23rd : Victoria Day - CPSM Closed
	Wed 18	08:00	Program Review	
	Wed 25	8:30	Executive Committee	
	Tue 31	08:30	Audit & Risk Management	
Jun-22	Fri 3	08:30	Central Standards Committee	FMRAC: 09 - 11 (not confirmed)
	Tue 7	08:30	Complaints	
	Wed 15		Investigation Committee	
	Wed 22	08:00	AGM	
	Wed 22	10:00	Council	

Council Meeting
Attendance Record
2020-2021

		Meeting Date			
Councillor	Electoral District	**20-Jun-20**	**25-Sep-20**	**9-Dec-20**	**19-Mar-21**
Ms L. Agger	Public Councillor				
Ms D. Albrecht	Public Councillor				
Dr. B. Blakley	Winnipeg				
Dr. K. Convery	Central				
Dr. J. Elliott	Parklands				
Mr. A. Fineblit	Public Councillor				
Dr. R. Kumbharathi	Winnipeg				
Dr. D. Lindsay	Interlake				
Ms L Magnus	Public Councillor				
Dr. W. Manishen	Winnipeg				
Dr. N. McLean	Winnipeg				
Ms M. McPherson	Public Councillor				
Dr. A. Nguyen	Associate Member				
Dr. C. Penner	West				
Ms L. Penny	Public Councillor				
Dr. B. Postl	University of Manitoba				
Dr. I. Ripstein	University of Manitoba				
Dr. M.J. Seager	Winnipeg				
Dr. N. Shenouda	Eastman				
Dr. E. Sigurdson	Winnipeg				
Dr. H. Smith	Winnipeg				
Dr. B. Stacey	Northern				
Dr. R. Suss	Winnipeg				

In Attendance
Not In Attendance

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:				