March Council Meeting

Friday, March 19, 2021 | 8:00 a.m. |

AGENDA

Virtual Meeting via Zoom

Time		Item		Page Number
5 min	8:00 am	1.	Opening Remarks	-
0 min	8:05 am	2.	Agenda – Approval	-
		3.	Call for Conflict of Interest	
5 min	8:05 am	4.	Council Meeting Minutes December 9th, 2020 - For Approval President-Elect Election Results – For Information	3 8
15 min	8:10 am	5.	Standard of Practice - Sexual Boundaries with Patients, Former Patients & Interdependent Persons – For Approval	9
30 min	8:25 am	6.	Standard of Practice - Duty to Report – Self, Colleagues, or Patients – For Approval	20
15 min	8:55 am	7.	Prescribing Practices Program Policy – For Approval	35
45 min	9:10 am	8.	Quality Department Launch - For Information	38
15 min	9:55 am	9.	--Break--	
30 min	10:10 am	10.	Anti-Indigenous Racism Matters	46
15 min	10:40 am	11.	Standards Subcommittees – Child Health & Maternal/Perinatal – For Information	51
15 min	10:55 am	12.	MANQAP	52
5 min	11:10 am	13.	Standard of Practice – Prescribing Benzodiazepines & Z-Drugs Revisit	55
5 min	11:15 am	14.	Strategic Organizational Priorities Progress Tracking - For Information	64

15 min	**11:20 am**	**15.**	**COVID-19 Update and Discussion – For Information**	**66**
20 min	**11:35**	**16.**	**CEO/Registrar's Report**	**67**
15 min	**11:55 am**	**17.**	**Committee Reports (written, questions taken) – For Information** **i. Executive Committee** **ii. Audit & Risk Management Committee** **iii. Complaints Committee** **iv. Investigation Committee** **v. Program Review Committee** **vi. Quality Improvement Committee** **vii. Central Standards Committee**	**73**
15 min	**12:10 pm**	**18.**	**Review of Self-Evaluation of Governance Process – In Camera**	**80**
4 hrs 25 min			**Estimated time of sessions**	

Meeting of Council - December 09, 2020

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on Wednesday December 09, 2020 via ZOOM videoconference.

1. CALL TO ORDER

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

COUNCILLORS:
Ms Leslie Agger, Public Councillor
Ms Dorothy Albrecht, Public Councillor
Dr. Brian Blakley, Winnipeg
Dr. Kevin Convery, Morden
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor
Dr. Ravi Kumbharathi, Winnipeg
Dr. Daniel Lindsay, Selkirk
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

REGRETS:
Dr. Brett Stacey, Flin Flon

MEMBERS:
Dr. Maged Nashed

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
Ms Karen Sorenson, Executive Assistant
Ms Lynne Leah, Executive Assistant
Dr. Ian Wilkinson, Director MANQAP*

(*) departed the meeting after Item 5
(**) recused for item 8 due to conflict of interest

2. ADOPTION OF AGENDA

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

- That the minutes of the September 25, 2020 meeting be accepted as presented.

5. ACCREDITED FACILITIES BYLAW

A Review of the Criteria for Accredited Facilities is a Strategic Organizational Priority set by Council. In June, Council reviewed the initial recommendations of the Working Group and approved their distribution for consultation. Council reviewed the feedback from the consultation in September. The Working Group further modified the draft Bylaw to reflect feedback and re-write it to improve and enhance patient safety.

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

Council approves the Accredited Facilities Bylaw effective the date of the Annual General Meeting on June 9, 2021.

6. STANDARD OF PRACTICE FOR OFFICE BASED PROCEDURES

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

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY MS MARVELLE MCPHERSON that:
CARRIED

Council approves the Standard of Practice for Office Based Procedures Working Group Terms of Reference.

7. MAINTAINING BOUNDARIES STANDARD OF PRACTICE

The 60 day period for the Report and Draft Standard of Practice for consultation feedback to members, the public, and stakeholders is still underway. The Working Group will be re-convened to consider the feedback and provide its recommendations to Council.

8. ADDITIONAL SPECIALIST FIELDS OF PRACTICE FOR ASSESSMENT

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

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

2. IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY MR. ALLAN FINEBLIT that:
CARRIED with 14 in favour, 5 opposed, 3 abstentions.

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

The discussion continued and a third motion was presented.

3. IT WAS MOVED BY DR. BRIAN POSTL, SECONDED BY DR. AUDREY NGUYEN that:
CARRIED with 9 in favour, 8 opposed, 6 abstentions

Section 2.2.2 of the Qualifications and Registration Practice Direction be amended by adding: "section 2.2.2.g. in exceptional circumstances, an assessment that is satisfactory to the Registrar, is deemed equivalent to the above assessments by the Registrar, and is endorsed by two other Manitoba specialists practicing in the same area of practice. Any decision by the Registrar is to be reported to the Executive Committee at the earliest opportunity."

4. IT WAS MOVED BY DR. ROGER SUSS, SECONDED BY MS. MARVELLE McPHERSON, that

CARRIED with 10 in favour, 7 opposed, 3 abstentions.

The second motion (#2 above) is rescinded.

9. AGE TRIGGERED QUALITY AUDIT POLICY

CPSM may audit any of its members to ensure competence. The Age Triggered Quality Audit Policy establishes the authority for the continuation of what was previously known as the elderly physician audit. A hallmark study on age as a physician risk factor concluded that advancing age negatively impacts the individual's competence in practicing medicine. To ensure patient safety, upon reaching age 75 (to be decreased to age 70 in five years) every member must participate in an audit to determine professional competence.

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

The Age Triggered Quality Audit Policy of Council be approved as presented.

10. STRATEGIC ORGANIZATIONAL PRIORITIES UPDATE

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

11. 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 issued a direction to the profession in the recent Code Red advising they must refrain from providing care that is not medically indicated (e.g. aesthetic services, non-insured procedures).

A wide-ranging discussion on COVID-19, the extraordinary impacts on the health care system, the role of individual physicians, and CPSM's role in the pandemic was undertaken.

12. ELECTION OF PRESIDENT ELECT

The Executive Committee nominated Dr. Heather Smith for the position of President-Elect from June 2021 and to be President from June 2023 to June 2025.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. ROGER SÜSS that:
(no vote taken on motion)

Dr. Heather Smith be nominated as President-Elect of CPSM Council for a two-year term commencing June 2021, immediately following the 2020/21 Annual General Meeting.

IT WAS MOVED BY DR. DANIEL LINDSAY, SECONDED BY DR. HEATHER SMITH that:
CARRIED

Dr. Nader Shenouda be nominated as President-Elect of CPSM Council for a two-year term commencing June 2021, immediately following the 2020/21 Annual General Meeting.

Councillors will vote in an election for President-Elect of CPSM Council for a two-year term commencing June 2021, immediately following the 2020/21 Annual General Meeting. The nominated candidates are Dr. Heather Smith and Dr. Nader Shenouda in accordance with Article 39 of the Affairs of the College Bylaw.

13. QUALITY DEPARTMENT LAUNCH - Moved to March 2021 Meeting

14. COMPLAINTS/IC ALTERNATIVE DISPUTE RESOLUTION

Councillors were advised to review this item and no discussion occurred.

15. 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.

16. 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

17. IN CAMERA SESSION

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

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

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Dr. I Ripstein, President

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Dr. A. Ziomek, Registrar

COUNCIL MEETING – MARCH 19, 2021

FOR INFORMATION

SUBJECT: President-Elect Election

BACKGROUND:

An election was held for the position of President-Elect of CPSM Council for a two-year term commencing June 2021, immediately following the 2020/21 Annual General Meeting between the nominated candidates, Dr. Heather Smith and Dr. Nader Shenouda, in accordance with Article 39 of the Affairs of the College Bylaw.

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

COUNCIL MEETING - MARCH 19, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: **Standard of Practice Sexual Boundaries with Patients, Former Patients & Interdependent Persons**

BACKGROUND

Council approved as a Strategic Organizational Priority to review Maintaining Boundaries – Sexual Involvement with a Patient and prepare a new Standard of Practice. The Working Group met and prepared a Report and Recommendations for a Standard of Practice which were distributed to the public, stakeholders, and members for consultation. This report and recommendations were provided to Council in September 2020. The feedback was shared with Council in December, though the consultation period was not quite complete at the date of the Council meeting.

The Working Group has met and considered all of the feedback that was received. Based on the feedback provided, it made some changes to the version that was circulated. The most significant changes relate to chaperones and the feedback regarding confusion as to that aspect of the Standard. The Working Group, chaired by Mr. Fineblit, is now in a position to recommend that Council approve the attached Standard of Practice in its revised form to be effective on March 31, 2021. Please note that the attached version has the portions that have been changed highlighted in yellow for the benefit of Council.

Currently, the provisions on boundaries are contained in the Good Medical Care Standard of Practice at sections 6, 7, and 8. These provisions must be repealed if the recommended Standard is passed by Council.

All members will be informed of this new Standard of Practice.

PUBLIC INTEREST RATIONALE:

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

The following was provided to Council in September 2020 and remains pertinent:

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

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

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 19, 2021, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

> 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.

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

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. Purpose

This standard of practice:

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

1.2. prohibits sexual contact and sexualized interactions of any kind between members and their patients;

1.3. identifies the spectrum of conduct and behaviours which are considered to be sexual contact and sexual interactions;

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

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

1.6. complements all other relevant standards of practice and the *CMA Code of Ethics and Professionalism*.

2. Foundation of the relationship

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

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

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

2.1.2. Never exploit the patient for personal advantage.

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

2.3. Patients are by definition vulnerable when seeking medical care because:

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

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

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

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

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

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

2.7. Good communication is essential to the relationship. Clear communication by a member with their patient as to what to expect during a clinical encounter, including the physical

examination and taking a history, is the most effective way to avoid misunderstandings as to the purpose and scope of the clinical encounter.

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

3. Scope of this Standard of Practice

3.1. To Whom and in what circumstances does it apply?

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

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

3.2. Who is a patient for the purposes of this Standard?

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

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

3.2.2.i. gathering clinical information to assess the person;

3.2.2.ii. providing a diagnosis;

3.2.2.iii. providing medical advice or treatment;

3.2.2.iv. providing counselling;

3.2.2.v. creating or contributing to a medical record;

3.2.2.vi. charging or receiving payment for providing medical services; and

3.2.2.vii. prescribing a drug for which a prescription is needed.

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

childhood are patients. In determining what is a reasonable period, the following factors are relevant:

3.2.3.i. whether there was a reasonable expectation that care would extend beyond a single encounter;

3.2.3.ii. the number of encounters;

3.2.3.iii. the length of time over which the encounter(s) occurred;

3.2.3.iv. the length of time in between the encounters;

3.2.3.v. the duration of the encounter(s);

3.2.3.vi. the degree to which the encounter(s) involved intimate examinations and/or the exchange of sensitive information;

3.2.3.vii. whether care has been transferred to another member;

3.2.3.viii. the nature and extent of the patient's vulnerability in relation to the member;

3.2.3.ix. the nature of the care sought from or provided by the member;

3.2.3.x. the understanding of the patient in terms of the member's role in their medical care;

3.2.3.xi. the circumstances that led to the termination of the member-patient clinical relationship following one or more encounters, including whether sexual contact between the member and the patient was contemplated by either of them before the clinical relationship ended;

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

4. Sexual Boundary Violations – the Spectrum of Prohibited Conduct

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

4.1. Member-patient Sexual Contact

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

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

4.1.2.i. sexual intercourse;

4.1.2.ii. genital to genital, genital to anal, oral to genital, or oral to anal contact;

4.1.2.iii. masturbation of a member by, or in the presence of, a patient;

4.1.2.iv. masturbation of a member's patient by that member;

4.1.2.v. encouraging a member's patient to masturbate in the presence of that member;

4.1.2.vi. the member fondling or sexually touching of any part of a patient's body, including the genitals, anus, breasts or buttocks of the patient. This does not include performing an appropriate physical examination of these body parts that is clinically indicated as part of an encounter for the purpose of providing medical care to the patient;

4.1.2.vii. kissing of a romantic or sexual nature with a patient; and

4.1.2.viii. sexual acts by the member in the presence of the patient.

4.2. Sexualized Interactions

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

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

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

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

4.2.5. In the context of an encounter for the purposes of obtaining medical care, the patient is in a particularly vulnerable situation having put their trust in the member to limit the interaction during that encounter to what is reasonably expected to provide the care they are seeking. A member must limit physical examinations of their patient to what is clinically indicated and such that it only includes that to which the patient has provided their informed consent.

4.2.6. It is often in the best interests of both the patient and the member to have a chaperone/attendant present for sensitive examinations. A member must give the individual needs of the patient priority over their own. They must consider whether the patient may be more comfortable with the presence of a chaperone/attendant or whether the specific circumstances of the patient and/or the nature of the encounter indicate that the offer should be made.

4.2.7. Depending on the circumstances, prohibited conduct may include, but is not limited to one or more of the following:

4.2.7.i. not providing privacy while the patient is undressing or dressing;

4.2.7.ii. assisting with undressing or dressing, unless the patient is having difficulty and expressly consents to such assistance;

4.2.7.iii. providing inadequate draping;

4.2.7.iv. not offering the presence of a chaperone/attendant before conducting a sensitive examination or proceeding with a sensitive examination in the absence of a chaperone/attendant where the circumstances of the patient and/or the encounter indicate that such an offer should have been made;

4.2.7.v. making remarks about a patient's sexual orientation, gender identity or activities that could reasonably be perceived as being judgmental or discriminatory;

4.2.7.vi. making comments or gestures that could reasonably be construed as flirtatious, seductive or sexual by a patient, including reference to the patient's appearance or clothing;

4.2.7.vii. requesting details of the sexual history or sexual behaviour of a patient when not medically indicated or without explaining why it is relevant to their medical care;

4.2.7.viii. discussing a member's own or others sexual preferences or activities with a patient;

4.2.7.ix. not explaining the scope of or need for intimate or sensitive examinations or not obtaining informed consent before conducting intimate or sensitive examinations;

4.2.7.x. not providing the patient with an opportunity to question or refuse an intimate or sensitive examination or to withdraw consent;

4.2.7.xi. using unorthodox examination techniques, including inappropriate touching of the breasts, genitalia, or anus;

4.2.7.xii. intentional touching of the breasts, genitalia, or anus during an otherwise clinically indicated examination where the touching is not clinically indicated;

4.2.7.xiii. failing to use gloves when examining genitalia or anus;

4.2.7.xiv. sexualizing body contact, which can include hugging in some circumstances. This does not prohibit hugging in appropriate circumstances where there is no sexual aspect to the physical contact; and

4.2.7.xv. unnecessarily scheduling appointments for examinations outside normal office hours for any reason not related to providing medical care.

4.2.8. In the context of encounters between a member and their patients outside of the clinical setting, sexualized interactions also include:

4.2.8.i. socializing with a patient or former patient in the context of developing an intimate romantic or sexual relationship;

4.2.8.ii. responding sexually to advances made by a patient or former patient; and

4.2.8.iii. initiating any form of sexual advance toward a patient or former patient;

4.2.8.iv. sending sexually explicit emails or text messages; and

4.2.8.v. making inappropriate advances on social media.

These lists are provided as guidance and are not exhaustive.

5. Persons Interdependent with the Patient

A member often communicates with a person who is interdependent with their patient in the context of providing care to their patient and may develop a relationship with that person. An

interdependent person may be as vulnerable as the patient. This is particularly so for the adult parents or guardians of patients who are minors.

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

5.2. A member must never use their professional relationship with a person who is interdependent with a member's patient to establish or pursue sexual contact with or sexualized interactions with that person. The factors to be considered in determining whether sexual contact or sexualized interactions with a person who is interdependent with a member's patient is a boundary violation include but are not limited to:

5.2.1. the duration, frequency and type of care provided to the patient;

5.2.2. the degree of emotional dependence of the patient and or the interdependent person to the member;

5.2.3. the extent to which the member used any knowledge or influence obtained from providing medical care to the patient to establish or pursue sexual contact with or sexualized interactions with the interdependent person; and

5.2.4. the extent to which the patient is reliant on the person who is interdependent with them.

6. Former Patients

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

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

6.2. The onus is on a member to satisfy the College that a "reasonable period" has elapsed in accordance with section 3.2.3 above before engaging in what is otherwise prohibited conduct as defined in this Standard of Practice with a patient.

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

7. Psychotherapeutic Relationships

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

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

7.1.1. a psychiatrist and their patient;

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

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

8. Consequences of Breaching this Standard of Practice

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

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING - MARCH 19, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: **Standard of Practice Duty to Report Self, Colleague, or Patient**

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

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

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.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 19, 2021, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

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.

Standard of Practice

Duty to Report Self, Colleague, or Patient

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.

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.

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

1.2.1. a physical or mental condition or disorder, including any addiction to alcohol or drugs, 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. being diagnosed with a blood borne pathogen and performing a procedure that involves a risk of its transmission. *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.

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. LINK will be inserted if when approved by Council

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 impact 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:

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

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

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

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.

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, Bylaws, and Standards of Practice.

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.

2.5. The duty to report a 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 member may impact 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 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 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.

And the member must 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.

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

3.1. Members must comply with 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. 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)

Frequently Asked Questions

Duty to Report
Self, Colleague, or Patient

The Frequently Asked Questions (FAQs) are provided to support members in implementing this Standard of Practice. The FAQs 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 FAQs may be edited or updated for clarity, new developments, or new resources at any time.

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 mild depression – but you should still have a conversation with them about talking to the Physician Health Program if symptoms worsen or if there is recurrence. However, if your physician patient has more than mild depression, then you must report the physician patient.

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 with potential 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.

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 COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – MARCH 19, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: **Prescribing Practices Program Policy**

BACKGROUND

With the informal support of Council, CPSM has embarked upon an initiative to improve the quality prescribing practices of its members. While this first addressed opioids, it has been expanded now to include benzodiazepines and Z-Drugs and the authorization of medical cannabis, along with polypharmacy in general. The Prescribing Practices Program is led by Dr. Marina Reinecke, a medical consultant with additional competency in Addictions Medicine and is within the Quality Department at CPSM.

There is a need for a policy regarding the Prescribing Practices Program to establish the purpose/objectives, authority, etc. This is a high level policy. This Policy should be approved by Council – similar to the Age-Triggered Quality Audits and Physician Health Policies. Further documentation will be prepared for the processes, policies, and procedures. That subsequent documentation does not need to be approved by Council.

Attached is the Prescribing Practices Program Policy.

PUBLIC INTEREST:

Duty to serve the public interest

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

Prescribing drugs is a fundamental competence required by members whose practice requires this treatment modality. Diligence is required for prescribing all drugs, and in particular for those with a potential for substance abuse. Individual patient safety and wider public safety require CPSM to promote quality prescribing practices.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 19, 2021, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

Council hereby approves the Prescribing Practices Program Policy as per attached.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

POLICY

Prescribing Practices Program

Initial Approval: **Effective Date:**

1. Establishment

1.1. A Prescribing Practices Program is established by Council and administered by Medical Consultants in the Quality Department under the Assistant Registrar.

2. Authority

2.1. CPSM regulates the practice of medicine, governs its members, maintains standards of practice to enhance the quality of practice of medicine, and monitors compliance with and enforces those standards. CPSM is responsible for ensuring its members practice good medical care as established in the CPSM Standards of Practice Regulation.

2.2. Participation of members in the activities of the Prescribing Practices Program is voluntary.

3. Purpose and Objectives of the Prescribing Practices Program

3.1. The purpose and objective is to promote prescribing practices that are informed by current evidence and reflects best practice.

3.2. The Prescribing Practices Program utilizes a quality improvement approach that strives to promote prescribing practices that balances patient safety and the needs of the patient with the member's duty to be a guardian of public safety.

3.3. The Prescribing Practices Program is to monitor and improve prescribing quality, including but not limited to prescribing for substances of abuse (including the authorization of medical cannabis), drugs that may put patients at an elevated risk of harm, and polypharmacy.

3.4. The primary approach of the Prescribing Practices Program is educational.

4. Policies and Processes

4.1. Members who do not wish to participate in the Prescribing Practices Program may have their prescribing practices reviewed by either the Central Standards Committee or at the discretion of the Registrar, by the Investigations Committee.

4.2. Notwithstanding a review undertaken by the Prescribing Practices Program, the matter may be referred to the Central Standards Committee, or at the discretion of the Registrar, to the Investigations Committee.

5. Report to Council

5.1. The Assistant Registrar responsible for the Prescribing Practices Program shall provide a report annually to Council containing a summary of its activities, statistical data, policy recommendations for consideration, and any other matters of importance.

COUNCIL MEETING – MARCH 19, 2020

FOR INFORMATION

SUBJECT: CPSM Quality Department

BACKGROUND:

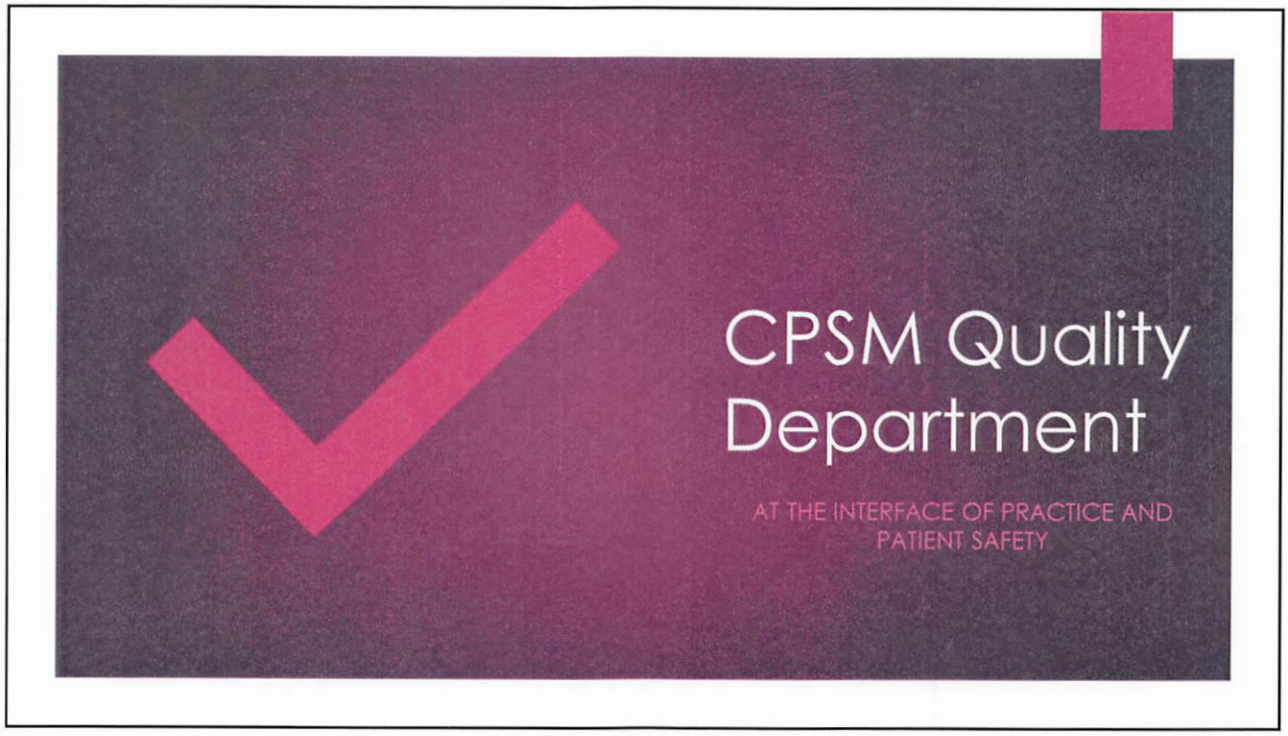
At the last meeting of Council, due to time constraints, the item regarding the launch of CPSM's Quality Department was deferred. Since that time, the Quality Department has been launched and there are several key activities underway. The Assistant Registrar (Quality) will provide Council with a summary 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.

Attached is the slide deck for the presentation by Dr. Ainslie Mihalchuk.

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 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.

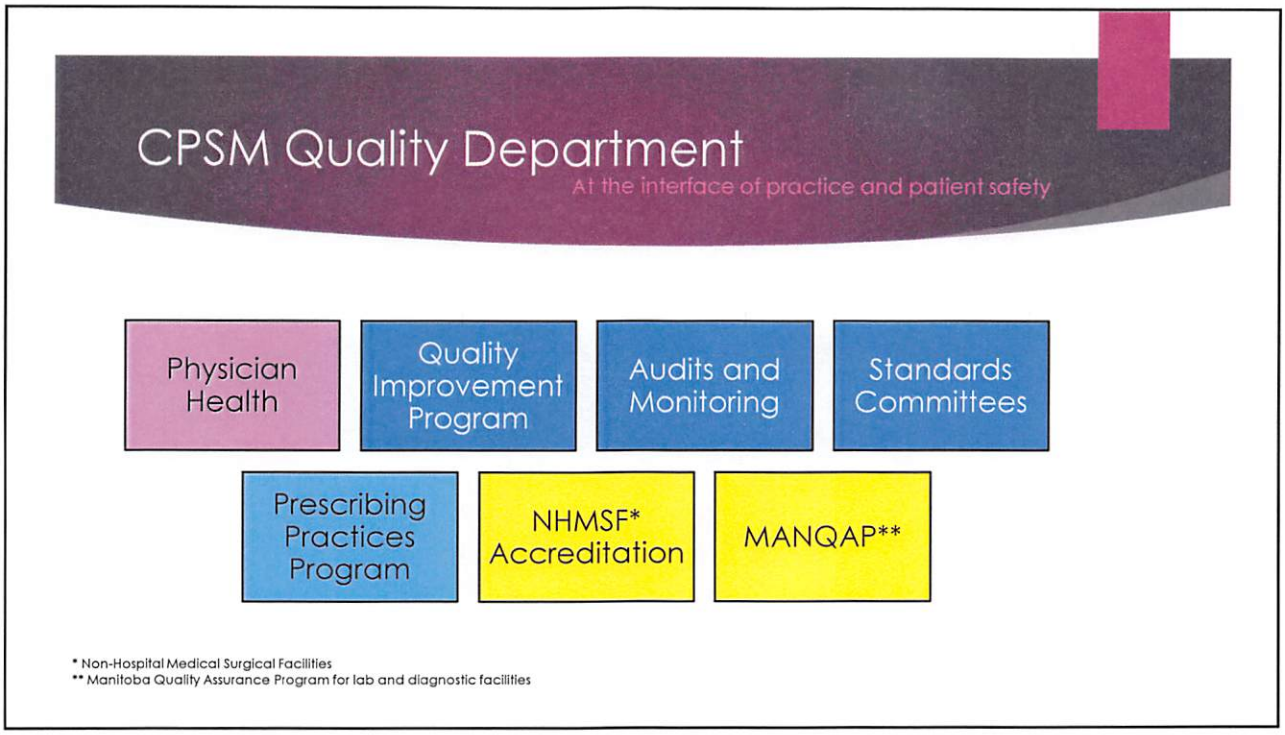


1

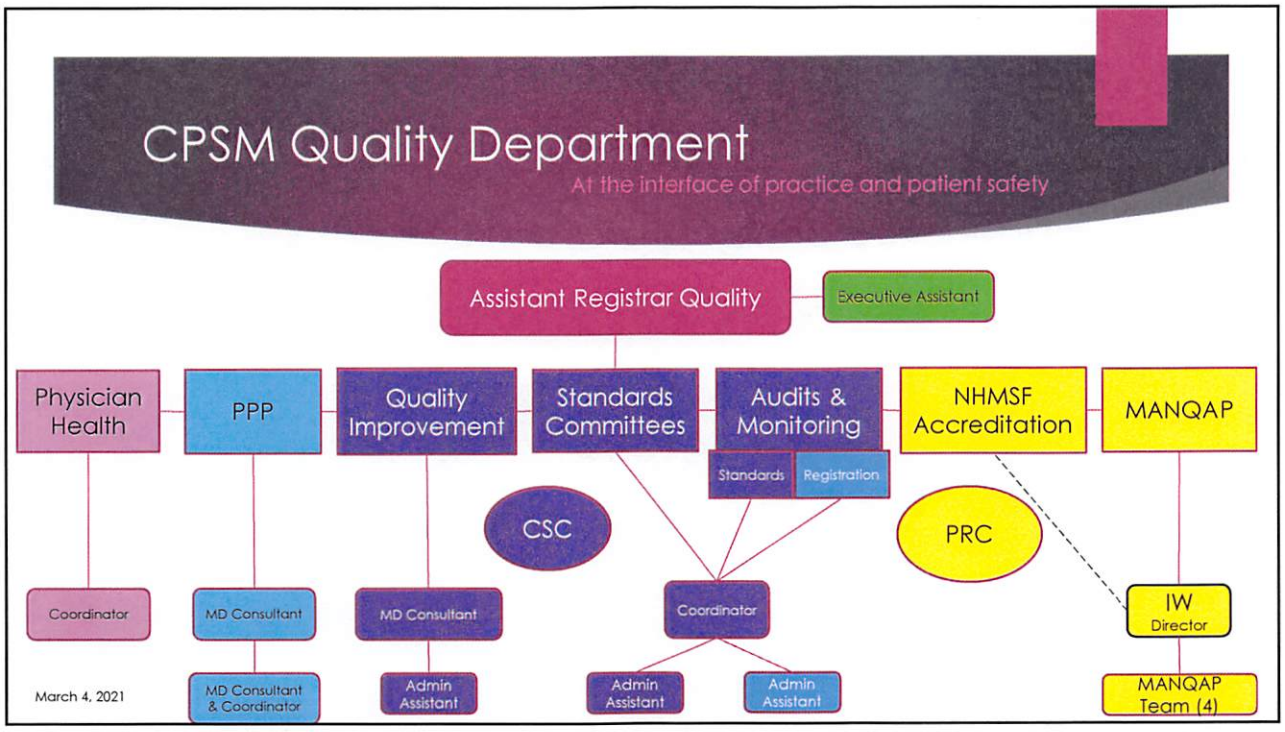
Time to Rebrand and Grow

- Jan 2020 Department of Standards - in need of a refresh
- Reflection on opportunities for **efficiency and risk mitigation** prompted a revisioning of our scope, identity and future direction for growth
- The team has expanded and become more **integrated** to **leverage skills**, **efficiency** and permit **standardization**
- The **impact** on regulation will be more significant
- **Member experience** with standards, audits and monitoring will be more uniform
- The Quality Department will become **data and outcome focused** with improved reporting

2


CPSM Quality Department
At the interface of practice and patient safety
Physician Health
Quality Improvement Program
Audits and Monitoring
Standards Committees
Prescribing Practices Program
NHMSF* Accreditation
MANQAP**
* Non-Hospital Medical Surgical Facilities
** Manitoba Quality Assurance Program for lab and diagnostic facilities

3


CPSM Quality Department
At the interface of practice and patient safety
Assistant Registrar Quality
Executive Assistant
Physician Health
PPP
Quality Improvement
Standards Committees
Audits & Monitoring
NHMSF Accreditation
MANQAP
Standards
Registration
CSC
PRC
Coordinator
MD Consultant
MD Consultant
Coordinator
IW Director
March 4, 2021
MD Consultant & Coordinator
Admin Assistant
Admin Assistant
Admin Assistant
MANQAP Team (4)

4

Key Changes: Prescribing Practices Program

- **New affiliation** with The Quality Department and other internal programs like Quality Improvement and Standards Audits
- **Common purpose with education and supporting practice change** in key areas linked to patient safety (opioids, benzodiazepines & Z-drugs, cannabis)
- Core element of **patient safety in practice**
- Value of **enhanced working relationships between internal teams** with sharing of knowledge and expertise
- Enhanced **reporting of outcomes**

5

Key Changes: Audits & Monitoring

- **Audits**
  - Enhanced focus on **continuous quality improvement and engagement of members in ongoing learning**
  - **Continue with Standards Audits:**
    - Evidence-Act Protection
    - Chief Medical Examiner
    - Age-Triggered Quality Audit
    - For Cause Audits
    - CPD Audits
  - **Addition of Registration Audits:**
    - Quality Monitoring audits
      - Provisional Registration
      - Physician and Clinical Assistants
  - Opportunity to **standardize processes** across all audit types

6

Key Changes: Standards Committees

- **Standards Committees**
  - **Execution of key deliverables** from enhancements to standards processes and practices for all committees (working group recommendations)
  - Support for **transition to new standards model provincially** with relationship between Shared Health and CPSM – Bill 10
  - Increased **support and communication** between CPSM and Standards Committees
  - Improvements in **reporting and outcome measurements**

7

Key Changes: MANQAP and NHMSF

- Leveraging **staff knowledge and expertise** to create efficiencies
- **Standardizing processes and reporting** for both accreditation of lab/diagnostic and clinical facilities
- Improvements in quality of NHMSF accreditation process to align with **implementation of the new By-Law for Accredited Facilities**
- Alignment of areas reporting to **Program Review Committee**

8

Risk Mitigation

FIRMS analysis

- Quality Assurance of Medical Practice
- Facility Accreditation/Quality Review Programs

CPSM identified **Risk Exposure** on:

- Standardization of processes and transparency
- Use of tools/decision aids (accreditation)
- Reliability
- Monitoring (data collection)

9

CPSM Quality Department Timeline 2021

Quality Department

- Addition of an **Executive Assistant** to the Assistant Registrar and Quality Department (Jan 2021)
- **Website** update and enhancements (Summer 2021)
- **Promote** CPSM Quality Department to the profession and stakeholders (Fall 2021 – Annual Report)
- Document all **core business processes** (end of 2021)
- Development of **metrics and reporting structure** (outcome and impact measures) (end of 2021)
- Improve transparency of process, align tone and messaging with **quality improvement language** across all programs (end of 2021)

10

CPSM Quality Department Timeline 2021

Audits and Monitoring

- Addition of **Registration Audits**, transfer of **one staff** from Registration (Jan 2021)
- **Standardize audit process** across Department of Quality (Spring 2021)
- Decrease the age of the **Age-Triggered Quality Audits** to 74 (Summer 2021)
- Build and implement process for **CPD audits** through CFPC and RCPSC (Fall 2021)

NHMSF Accreditation and MANQAP

- Begin roll-out of new **Accredited Facilities By-Law Part B** with standardization of process and procedures aligned with MANQAP (Summer 2021)

Standards Committees

- Enhance clarity of process, coordination and **output of Standards Committees** (end of 2021)

11

CPSM Quality Department Timeline 2021

Physician Health Program

- Transition in **new Coordinator** (March 2021)
- Promote and manage **increased reporting** and routine case management (continuous)

Quality Improvement Program

- **Transition from Quality Improvement Committee** to Central Standards Committee (June 2021)
- Research project with medical students on inter-rater reliability (Summer 2021)
- Advancement of the program into identified specialties (continuous)

Prescribing Practices Program

- Increased outreach, education and intensive case management (continuous)

12

Key Deliverables for CPSM Quality Department by End of 2021

- Execution of **Core Operational Changes** as outlined
- **Integration** of operations, staff, processes and communication
- Documentation of **Business Processes**
- Development of **Outcome Measures** and **Standard Reporting**
- **Website** Improvements
- Address current **Gaps and Risk**
- **Identify opportunities for 2022**

13

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
MARCH 17, 2021

TITLE: Anti-Indigenous Racism Matters

BACKGROUND

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

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

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

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

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

Backgrounder: National Consortium for Indigenous Medical Education
From: Health Canada

> Indigenous Peoples in Canada continue to experience serious health inequities. Changing the status quo requires introducing new approaches to medical education that are respectful of Indigenous knowledge, cultures, values and beliefs.

In support of this goal, the Government of Canada will provide $4 million to a National Consortium for Indigenous Medical Education. The creation of an Indigenous-led National Consortium on Indigenous Medical Education will allow for a better understanding of the culturally-sensitive issues faced by Indigenous Peoples, as well as an improved medical education environment that takes these issues and cultural aspects into consideration.
The Consortium will also provide leadership and implement Indigenous-led projects that reform and update the education of physicians to contribute to ensuring Indigenous Peoples have access to care that is culturally safe and free from discrimination.

The Consortium will be led by the Indigenous Physicians Association of Canada, in partnership with the Association of the Faculties of Medicine of Canada, the College of Family Physicians of Canada, the Medical Council of Canada and the Royal College of Physicians and Surgeons of Canada, with leadership from Indigenous physicians. The National Consortium for Indigenous Medical Education was developed by Indigenous physicians working with health care organizations who recognized the need for collaboration to advance work for Indigenous medical education across the country.

The Consortium will advance the following areas:

- Reform and update the assessment and education of physicians, including the development of anti-racism curricula and resources on cultural safety;
- Create anti-racism tools and resources, including but not limited to, guidelines and training modules that support anti-racism policies and processes;
- Support the recruitment and retention of Indigenous physicians and medical faculty; and
- Support wellness for Indigenous physicians.

Funding this initiative demonstrates the Government of Canada’s commitment to advancing Indigenous-led solutions that foster access to appropriate and effective healthcare services for all Canadians through the identification, development, and implementation of culturally-safe approaches to medical education.

The Manitoba Government has included an Indigenous partnership framework within the current health care transformation, is mandating obligatory cultural competence and humility training for all civil servants, requiring Shared Health to mandate a similar course tailored for all health care workers, and has accepted Jordan’s principle.

Jordan's Principle makes sure all First Nations children living in Canada can access the products, services and supports they need, when they need them. Funding can help with a wide range of health, social and educational needs, including the unique needs that First Nations Two-Spirit and LGBTQQIA children and youth and those with disabilities may have.

Jordan's Principle is named in memory of Jordan River Anderson. He was a young boy from Norway House Cree Nation in Manitoba. In 2016, the Canadian Human Rights Tribunal determined the Government of Canada's approach to services for First Nations children was discriminatory. Since the ruling, the CHRT has issued a number of follow-up orders about Jordan's Principle and ordered

that the needs of each individual child must be considered, to ensure the following is taken into account under Jordan's Principle:

- substantive equality
- providing culturally appropriate services
- safeguarding the best interests of the child

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.

At this point, it would be helpful to have an open discussion on these matters including:

- Whether CPSM should consider mandatory cultural competence for all CPSM members as an initial step.
- Should CPSM/FMRAC partner with the Royal College/CFPC/MCC on their Indigenous Medical Education?
- Should CPSM also consider an Indigenous physician voice on its Council by designating a seat, similar to how seats are allocated by geography and an associate seat to ensure those positions are heard too? A bylaw change would be required.
- Should Addressing Anti-Indigenous Racism be made an Ongoing Strategic Organizational Priority?
- How can the Complaints and Investigations process be made more available to Indigenous patients?
- Should CPSM consider a standard of practice for anti-racism?

It is recommended that any action taken by CPSM would have to be informed by and led by indigenous physicians.

FMRAC Anti-Indigenous Racism Initiative

The written brief provides participating organizations and jurisdictions an opportunity to share past, ongoing and planned actions to address anti-Indigenous racism in the health care system. Actions should be concrete, specific and have measurable objectives. Actions may include, but are not limited to legislation/policy, programming, commitments and investments.

This may include measures to address recommendations from key reports such as the Truth and Reconciliation Commission's Calls to Action and the Final Report on the National Inquiry into Missing and Murdered Indigenous Women and Girls Calls for Justice.

Briefs will be assembled into a package that will be shared with participants in advance of the meeting.

Organization / Jurisdiction	Actions to Address Anti-Indigenous Racism in the Health Care System	Theme/Area of Focus	Outcome/Impact (including deliverables and milestones)	Timeline (*)
Federation of Medical Regulatory Authorities of Canada ***Mandate*** Working with its members, the 13 provincial and territorial medical regulatory authorities, FMRAC aims to advance medical regulation on behalf of the public through collaboration, common standards and best practices.	N.B.: a) Wherever the word Indigenous is used by FMRAC in this document, it is understood to mean First Nation, Inuit and Métis. b) There is an underlying assumption in this document that the current system for complaints does not work for Indigenous people, based on the fact that racism is ongoing and yet there are almost no complaints received by the medical regulatory authorities.			
	Planned / Proposed Action #1 To develop relationships with Indigenous partners and recognize Indigenous rights to self-determination, including health care.	Build processes that are specific to the needs of Indigenous communities based on ongoing leadership and guidance by Indigenous partners.	Participation and buy-in on the part of the Indigenous partners.	two years
	Planned / Proposed Action #2 To develop recommendations for each medical regulatory authority to improve its own corporate culture and infrastructure (including recommendations regarding,	1) Human Resource policies and tools, including ongoing training on anti-Indigenous racism, cultural safety and humility, anti-oppression and Equity Diversity and Inclusion (EDI).	1) Staff, Council/Board and committees have undergone cultural awareness and active listening training rooted in the context of the Indigenous communities they serve; staff are more aware of the issue of anti-Indigenous racism and its consequences, and the need to	1) one year 2) one year

	governance, staffing, and operations).	2) Governance policies and tools, including training and a commitment to anti-racism, anti-oppression and EDI.	ensure Indigenous people feel heard and valued. 2) Appropriate representation on the Council / Board, committees and staff by Indigenous people and Indigenous physicians.	

	Planned / Proposed Action #3 To develop recommendations for each medical regulatory authority to improve its complaints processes to specifically empower the Indigenous complainant, to have a positive impact on the Indigenous complainant and community, and to maintain fairness to all.	Investigative and adjudicative processes that are culturally safe, responsive and accessible to Indigenous people, while working within the existing legal and legislative frameworks.	1) Greater access to medical regulation by Indigenous people, with more complaints from Indigenous people. 2) A quality assurance for monitoring outcomes data, promptly addressing identified concerns and continuously improving the complaints process. The desired outcome is a high level of satisfaction among Indigenous complainants with the complaints process.	1) two years 2) two years 3) two years

Additional Information:
(*) The timelines are two-fold: a) how long it will take for the recommendations to be finalized; and b) how long it will take each medical regulatory authority to follow up on the recommendations. The timelines shown in the table above only address (a).

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Executive Director and CEO, Federation of Medical Regulatory Authorities of Canada
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email: falefebvre@fmrac.ca website: www.fmrac.ca telephone: 1 613 738-0372 x2602 cell: 1 613 796-0372

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
MARCH 19, 2021
FOR YOUR INFORMATION

TITLE: Standards Subcommittees – Child Health and Maternal Perinatal

BACKGROUND:

The information for this agenda item contains confidential information and therefore will only be made available to Council Members and not the public.

COUNCIL MEETING – MARCH 19, 2021

NOTICE OF MOTION FOR APPROVAL

TITLE: MANQAP (Manitoba Quality Assurance Program)

BACKGROUND

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

> ***MANQAP***
> *The President asked that all staff members and guests leave the room in order to proceed with this agenda item in-camera. Following a very lengthy discussion:*
>
> *IT WAS MOVED BY DR. B. KVERN, SECONDED BY DR. H. AZZAM, AND CARRIED WITH 15 IN FAVOUR AND 3 OPPOSED:*
>
> *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.*

However, since then 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.

MANQAP's Role

MANQAP inspects and accredits specified types of laboratory and diagnostic imaging facilities according to operational and technical standards set under the Accredited Facilities By-Law. CPSM uses its authority over physicians to restrict physicians from practicing in facilities which require accreditation and do not hold accreditation. Further, CPSM uses its authority over physicians to require that each facility have a physician as a facility director, and CPSM holds that facility director

accountable for adherence to the standards which govern the services provided by that facility. MANQAP does not review the quality of the physicians' work in the facilities.

In the existing model, there are many modalities which are not subject to the accreditation process. The specific work done by MANQAP for publicly funded facilities is as set out in a Service Purchase Agreement (SPA) between the government and CPSM. The government requires the DSM (now Shared Health) facilities to participate in the accreditation process and funds the MANQAP work. As well, MANQAP accredits a small number of privately owned facilities, and the cost of these accreditations is billed to the facility itself.

Historical Involvement with MANQAP

CPSM first became involved in the operation of MANQAP in the 1960s. In the early 2000's concerns arose that the CPSM membership was subsidizing some of the government funded programs as some of the programs operated at a deficit. Council closely examined each of the government funded programs at that time, and decided that MANQAP was the least in keeping with CPSM's mandate. This was presented to government, but government wanted CPSM to continue to operate MANQAP. CPSM has since administered the MANQAP program at the direct request of Manitoba Health, specifically at the request of the Deputy Minister. At that time, there did not appear to be any good options to Manitoba Health for accreditation of laboratory and diagnostic imaging facilities, and the government requested that CPSM continue its work with MANQAP. As a result, the program was externally reviewed and reformed in 2005.

Other Colleges

The B.C., Alberta and Saskatchewan Colleges operate programs similar to MANQAP. The remaining Colleges do not operate similar programs. Recently, there was agreement that the Alberta standards will be adopted by Saskatchewan and Manitoba and an annual cost be paid for the maintenance of those standards. BC is a member of the group but uses its own standards.

Recent Developments

The strategic vision of CPSM continues to evolve to reflect the changing environment in which CPSM operates. Part of this evolution has resulted in the creation of a new Department of Quality at CPSM.

A review of Non-Hospital Medical and Surgical Facilities accreditation and the revision of the Accredited Facilities Bylaw has been completed. This has resulted in the need to implement a new accreditation system for these facilities. The systems and process developed by MANQAP for diagnostic facilities inspections and accreditation can be adopted and adapted for Non-Hospital Medical and Surgical Facilities accreditation. This will leverage the knowledge, expertise, and resources of MANQAP resulting in economies of scope and of scale.

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 general public has the right to assume that any diagnostic testing which they undergo will be trustworthy and safe for patients. Physicians rely on accurate, reliable, and timely laboratory and diagnostic imaging test results to assist in the diagnosis of disease and in the care of their patients. Reliable test results depend upon the complementary interaction between laboratory physicians, radiologists, and non-medical biomedical scientists/technologists in the diagnostic facility. The Accredited Facilities Bylaw ensures that a specialist physician must be in control of any medical diagnostic facility. Without this direct control by CPSM there would be no mandated role for a physician as facility director.

MANQAP is the operational arm of the Program Review Committee through which CPSM serves the public interest directly by ensuring that its members are ultimately responsible for safe diagnostic facilities.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 19, 2021, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

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.*

Frequently Asked Questions

Prescribing Benzodiazepines & Z-Drugs Medical Purposes

The Frequently Asked Questions (FAQs) are provided to support members in implementing this Standard of Practice. The FAQs 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 FAQs may be edited or updated for clarity, new developments, or new resources at any time.

The College of Physicians & Surgeons of Manitoba (CPSM) has received calls from healthcare providers and patients about the new Standard for prescribing benzodiazepines and z-drugs. In this document we hope to address some of the common questions received.

What is the Standard of Practice about?

This Standard of Practice sets out the requirements related to prescribing benzodiazepines and z-drugs. The Standard exists to ensure quality care and to ensure *patient* and *public* safety. While your doctor applies clinical judgment and discretion to your individual care, your doctor is also expected to follow this Standard to ensure all patient care is safe and ethical. The Standard of Practice for Prescribing Benzodiazepines & Z-Drugs came into effect on November 1, 2020.

Why does CPSM get to make decisions that affect my medications?

To protect the public

CPSM's job is to protect the public and ensure quality in the practice of medicine. The Standard of Practice for Prescribing Benzodiazepines & Z-Drugs is evidence-informed and promotes safe and ethical care of all patients. The Standard outlines the expectations that doctors must follow to balance individual care and public safety.

Standards are created by a group of experts in the relevant field of practice, often including doctors, nurses, pharmacists, lawyers, and members of the public. Feedback is also sought from the public prior to finalization.

To promote current and quality medical care

As medicine evolves, new information is discovered. After decades of prescribing benzodiazepines and z-drugs, we know more about the risks of these medications today,

especially when it comes to long-term use and higher doses. As the evidence of the risks compared to benefits of these drugs evolves, doctors must adapt their prescribing to align with current medical knowledge. These drugs are helpful for many patients, but they also pose risks for some patients and the public. The Standard tries to strike the best balance possible between the benefits and the risks.

What are benzodiazepines and z-drugs? What are their effects?

Benzodiazepines are sedative medications often prescribed to treat anxiety and sleep disorders. Commonly prescribed benzodiazepines include, but are not limited to, alprazolam (Xanax®), lorazepam (Ativan®), temazepam (Restoril®), clonazepam (Rivotril®), and diazepam (Valium®). Z-drugs, like zopiclone or zolpidem, are chemically similar to benzodiazepines and have similar effects and risks associated with their use. These sedatives essentially slow-down the activity of the brain and this slows bodily functions like heart rate and breathing, which can make you feel more calm or sleepy.

While these medications may be effective to decrease anxiety or improve sleep at first, regular use leads to tolerance and physiological dependence. With regular, longer-term use, the brain and body become accustomed to the effect. For some people, escalating doses are needed for relief of symptoms. Similarly, cutting back or missing doses can create rebound symptoms (including anxiety), often reinforcing the perceived need for the medication. Long-term use, and/or higher-dose use, increases the likelihood of side-effects and risk of harm.

Why are benzodiazepines and z-drugs considered so harmful?

For the same reason benzodiazepines and z-drugs make you feel calm or sleepy (by slowing some brain and body functions), they have associated side-effects and risks of harm. See the list of side-effects and risks below. These harmful effects are worsened by long-term and/or high-dose use. Some patients can develop addiction to these medications and experience serious repercussions. Misuse, overuse, or combining these medications with other sedatives increases the risk of overdose and death. In Manitoba, benzodiazepines and z-drugs have become significant drugs of abuse and are known to be sought after by substance users. The likelihood of diversion (sharing, selling, stealing) of these medications is very high and this has had a profound impact on public safety. Benzodiazepines and z-drugs are responsible for an increasing number of deaths in Manitoba, regardless of whether these drugs are prescribed alone or with painkiller medications like opioids or other prescription drugs.

What are the side-effects and risks of benzodiazepines and z-drugs?

Common side-effects and risks of benzodiazepines and z-drugs include:

- Sedation, confusion, drowsiness, and instability when standing/moving that can add to risk of falls and subsequent fractures.
- Impairment of psychomotor skills, judgment, and coordination that can increase the risk of motor vehicle accidents.
- Negative effects on cognition and memory, delirium, drug-related pseudo-dementia and a possible link to cognitive decline and Alzheimer's disease.
- Tolerance and physiological dependence, leading to withdrawal with abrupt cessation, or large dose changes.
- Sedative-Hypnotic Use Disorder (addiction).
- Risky interaction with medications or herbals.
- Risk of sleep automatism (in the case of z-drugs), similar to sleepwalking, when a person acts out scenarios when sleeping or dreaming.

Benzodiazepines and z-drugs are also particularly problematic in older adults. The risk of motor vehicle accidents, falls, and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or z-drugs.

Does my doctor have to taper my medication?

The Standard provides evidence for doctors to consider and discuss with patients *before* starting benzodiazepines and z-drugs, as well as guidelines to manage patients *already* taking these medications. Good clinical judgment and an evidence-informed approach are key to safe and appropriate prescribing. Your doctor should discuss the reason for taking these medications, their potential side-effects and risks, and reasonable expectations for their effect. This is part of the clinical judgment applied to continuing or changing medications. **Given the overwhelming evidence of the harm these medications can cause (see above), the Standard recommends your doctor attempt slow dose reductions, also known as step-downs or tapering**. This is particularly important if the harm outweighs the benefit of taking the medication, especially if benzodiazepines and z-drugs have been prescribed for a long time and/or at a high dose.

Do I have to get my dose down to zero?

The Standard asks your doctor to partner with you to attempt tapering. It asks that your doctor help you make informed decisions about your care by evaluating the risks of continuing the medication compared to the benefits. With slow and steady dose reductions (tapering), over weeks to months, over even years, you may eventually take your dose down to zero. However, all taper attempts are worthwhile, and even small dose reductions can improve cognitive function (things like memory, concentration, range of affect) and improve safety. It is not

mandatory to taper off your medication completely; with incremental step-downs your doctor may find the lowest dose that allows you wellness, function, and minimizes side-effects/risks.

Why am I being tapered off benzodiazepines and z-drugs if they work for me?

The Standard **does not** recommend your doctor stop prescribing or "cut off" these medications. It recommends that your doctor take a closer look at why they are prescribing them. The Standard promotes a discussion about the benefit versus harm benzodiazepines and z-drugs carry for you and how to improve safety around use. In the past two decades, clinical guidelines have recommended against long-term use of benzodiazepines and z-drugs. Their effectiveness to treat conditions like anxiety and insomnia is debated by doctors. They may work well for some patients, but it is important to be aware of the risk they carry to both individuals and the public. While they can have important therapeutic uses, the supply of these medications needs to be clinically safe and appropriate.

Can my doctor cut off my medications?

CPSM and the Standard encourage communication and collaboration between you and your doctor. However, based on clinical judgment and safety, a doctor may need to proceed with a taper when a patient may not agree. A doctor may also limit the amount dispensed to a patient at a time if safety concerns arise (e.g. medications may need to be dispensed weekly or daily from the pharmacy in some situations). There are times when safety, either individual, public, or both, takes precedence over the therapeutic relationship between doctor and patient. If a doctor learns that the medications they prescribe are being misused, abused, or diverted, rapid tapers or sudden cessation of prescribing may be necessary to manage risk of overdose or death, and for public safety.

What can I expect if my dose is reduced?

Because benzodiazepines and z-drugs are drugs of physiological dependence, which means the brain and body become used to them, changes in the dose can create rebound or withdrawal symptoms. **This is normal for anybody who takes these medications over time**.

With dose reductions, you may *temporarily* experience more worry or anxiety, mild sleep disturbances, heightened emotions, shakiness, sweating, twinging or restless limbs, or digestive upset. This does not mean your anxiety or insomnia will become uncontrollable; with small changes, these symptoms will settle and pass with time. Ideally, dose step-downs should be small, with enough time in between each change for you (your brain and body) to adjust to the decrease. These symptoms will settle with time; many people start to feel "normal" or back to baseline within two to four weeks of a change. Your doctor may wait until you feel closer to baseline function, or more like yourself again, before making the next change. **This is a highly individualized process**

and should be discussed regularly with your doctor. Rapid tapers or changing medications yourself is not recommended.

What is a reasonable timeframe to taper?

There is no one-size-fits-all approach to tapers. The process is individualized and considers starting dose, length of use, and concurrent medical conditions, as well as your life circumstances. Slow and steady step-downs tend to be more successful, as this allows your brain and body time to adjust to changes. If tapers progress too quickly, they can feel overwhelming and unmanageable. However, remember that even small changes can create discomfort, and it is important to know that this is a normal experience for many and that it will pass. You may need to draw on extra support during these changes. With the guidance of your doctor, you may also need to take **tapering breaks** and remain on a stable dose for a while, before taking the next steps in a taper. Psychological work done during such tapering breaks can increase your success with future taper attempts. Conversely, for safety reasons, your doctor may initiate a taper or the next step-down before you feel ready.

Why change my medication if it took years to find this balance?

Given the risks described (see page 2-3), being stable on a dose of a medication for years is not a reason to forgo reexamination. As bodies and lives change over time, medications should also be reevaluated over time. Particularly since **the risks associated with benzodiazepines and z-drugs increase with age**. However, if taper attempts are unsuccessful over time and there is a documented benefit of continuing a stable dose of medication that outweighs the harm, doctors and patients may choose to continue the benzodiazepines and z-drugs.

I've never abused my pills - why can't I have more than a month at a time?

While it may not feel like the risks, harms, or concerns apply to you, CPSM and doctors must set parameters to promote public safety. That means *drawing a line* between safe and unsafe amounts of medication that can be available at one time. This line must balance the needs and lifestyles of both well and unwell community members. CPSM has made similar prescribing rules for benzodiazepines and z-drugs, as with opioid pain medications, because of the known risks of these medications. The Standard makes firm recommendations, or rules, for prescribing and dispensing intervals to limit the supply of these drugs in the community and promote safety. These recommendations are also to ensure that doctors are taking a frequent and active role in managing the use of these medications.

What are the new rules? Are there any exceptions?

Specifically, the prescribing and dispensing rules in the Standard are that:

- Benzodiazepines and z-drugs prescriptions can only be written for a **maximum of three months at a time**; and
- **Only a one-month supply** can be dispensed at a time. Exceptions to this rule apply only if use is [1)] infrequent (as in, taking a single dose for travel or having a CT scan), [2)] you live in a remote community, or [3)] for travel if you have been on a stable long-term prescription. For these exceptions of remote living and travel, your doctor may allow a dispensing interval of up to three months only. This limit also applies if you leave the country for longer than three months at a time; still only a maximum of three months' supply of benzodiazepines and z-drugs may be prescribed and dispensed at one time.

This means that simply fewer pills are available in a home and within the community at a given time. For example, even if you have never misused or lost your medications and always got 90-days at a time, what would happen if someone stole all your medication? What if someone who has never tried them before, such as a minor, gets access, takes them, and overdoses? These are the types of risks doctors and CPSM must balance with the needs of patients who take their medications as prescribed. One-month of medication has been determined to be an amount of pills that balances community risk with patient need. When safety concerns arise, doctors can choose to further limit dispensing intervals to ensure patient and public safety (e.g. medications may need to be dispensed weekly or daily in some situations). It is a good idea to lock up medications in your home.

Are there resources to help me?

The symptoms or reasons you started these medications may still exist and can feel distressing. Evidence shows that other non-medication treatments, such as Cognitive Behavioural Therapy (CBT) for anxiety or CBT for insomnia, sleep hygiene techniques, mindfulness, and healthy exercise, are all effective ways to manage mental health issues, often with longer-term benefits than benzodiazepines and z-drugs. You can discuss optimizing non-medication and other medication-based treatments with your doctor. Ask for a referral to counselling or specialized services. If your distress becomes overwhelming, call or present to local crisis services. There are also peer-lead support groups that have helped many people recover from mental health issues, such as the Anxiety Disorders Association of Manitoba, the Mood Disorders Association of Manitoba, 12-Step programs, and other self-help groups that can offer more support.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING –MARCH 19, 2021

ITEM FOR INFORMATION

SUBJECT:

Strategic Organizational Priorities Update

BACKGROUND:

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

The Strategic Organizational Priorities for the Standard of Practice Sexual Boundaries with Patients, Former Patients & Interdependent Person is marked "Achieved". Council is being asked at this meeting to approve this Standard and if not approved the progress tracking chart will be amended.

The Strategic Organizational Priorities for Virtual Medicine, Patient Records, and Duty to Report are marked as "On Track" as all working groups are continuing to meet virtually. Office Based Procedures is listed as "Not Started" but the first meeting of the group is scheduled for April 2021.

Some of the Priorities are "on hold" until FMRAC provides a framework or national level agreement and direction.

PUBLIC INTEREST RATIONALE

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

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

CPSM
ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	FMRAC Working Group	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Maintaining Boundaries - Sexual Involvement with a Patient		Sep-19		Started Sept 2019	Sep-20	Oct-20	Dec-20	Dec-20	Achieved	Subject to Approval at March Council
Accredited Facilities Criteria		Sep-19		Started Oct 2019	Jun-20	July/August 2020	Sep-20	Jan-21	Achieved	Council Approved Dec 2020 - Effective June 9, 2021
Virtual Medicine within Manitoba - Standard of Practice		Sep-20	Jun-21		Jun 21	Jul 21	Sep 21	Oct 21	On Track	2 more Mtgs in March
Patient Records - Standard of Practice		Sep-20	Mar 21		Jun 21	21-Jul	Sep 21	Oct 21	On Track	Next Mtg March 10th
Duty to Report - Standard of Practice		Sep-20	Jun-21		Mar 21	Apr 21	Jun 21	Jul 21	On Track	
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: March 2, 2021

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING –MARCH 19, 2021

FOR INFORMATION

SUBJECT: COVID-19 Pandemic

BACKGROUND:

At the invitation of Public Health, 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 issued FAQs on the administration of vaccines and vaccine hesitancy and sent the following message to all CPSM registrants:

> The province today has released the COVID-19 Vaccine Program Registration eForm for Medical Clinics and The Program Requirements. CPSM has issued FAQs on COVID-19 Vaccine Rollout to establish its expectations of the profession in administering the vaccine in medical clinics and providing advice on vaccine hesitancy.
>
> The Provincial Government, Doctors Manitoba, Manitoba College of Family Physicians, and CPSM have worked together on a plan to deliver the vaccines in medical clinics. Doctors Manitoba and the Provincial Government have information on their websites for applying.
>
> Thank you for your continued hard work and dedication to patient care.

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.

A general discussion on COVID-19 is anticipated at the Council meeting.

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 FAQs have been drafted with a lens on public and patient safety while expediting the vaccine delivery by practitioners.

Registrar's/CEO's Report

Media

CPSM was quoted in the media (radio, TV, and print) regarding the development of private testing facilities for COVID-19 that are unregulated.

There was significant media coverage announcing that medical clinics would be partners in administering vaccines and that CPSM participated in the planning.

Exams/Qualifications

The Medical Council of Canada Qualifying Examination Part II (MCCQE Part II), one of the requirements for issuance of a full certificate of practice, was postponed as a result of COVID-19.

In March 2020 the Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada and Medical Council of Canada postponed the Spring 2020 sittings of their respective examinations due to the COVID-19 crisis in Canada. The impact of this means that the graduating cohort of residents expected to complete their training in June were not permitted to sit the qualifying examinations, and therefore ineligible for a full certificate of practice.

The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada re-scheduled and completed their 2020 examinations by early fall as anticipated. These Colleges also agreed to accept alternate means for achieving certification (completed virtually and successful completion without requirement of the Objective Structured Clinical Examination in-person component).

The Medical Council of Canada, however, did not offer an alternate means for completing their examination and intended to proceed with a face-to-face in person examination at the end of October. Due to COVID-19 wave 2, the Medical Council of Canada again postponed the Qualifying Examination Part II, to an anticipated February 2021 date, which was later cancelled. The Medical Council of Canada has now recently announced that it will conduct virtual exams over 20 days in May and June 2021 and in-person exams are not required.

However, CPSO Council will meet to review the recommended proposal to permit full registration without the MCC Qualifying Examination Part II. An update will be provided on the CPSO decision which will be made prior to CPSM Council meeting on March 19. Nova Scotia has already implemented such a policy and New Brunswick did not have this requirement. Most other regulators including CPSM have submitted statements to CPSO indicating their firm opposition

and that they intend to retain the requirement. In Manitoba, this requirement is in the CPSM General Regulation so would require Cabinet approval for amendment.

CPSM Personnel

To fulfill its mandate CPSM has recently hired several individuals, including a Communications Officer and an Administrative Assistant for the Assistant Registrar in Quality. After 45 years at CPSM the Director of Qualifications, Maxine Miller, retired. Jo-Ell Stevenson has been appointed the Manager of Qualifications (there will be no Director). After 23 years at CPSM Carol Chester McLeod will retire at the end of March. A new coordinator of Physician Health Program has been hired and is being trained.

Office Premises

The CPSM office lease at 1661 Portage Avenue has been renewed for a further term on favourable terms. Additional space has been taken on the second floor and is currently under renovations.

Electronic Document Records Management System (EDRMS)

The CPSM EDRMS Project – formally named the "DOCing Station" continues. The consulting partner Gravity Union is working with CPSM to roll this out across all departments of CPSM in an effort to reduce the volume of paper while introducing the electronic capture of all information content at CPSM. Benefits anticipated include:

- Reduced manual effort through streamlined business processes
- Faster and more accurate retrieval of documents
- Greater security and access control over sensitive information; comprehensive audit trails

A timeline for transition of all CPSM departments and support services has been developed toward a completion date of April 2021. Some departments already have been successful in their transition to the new system. This IT project has been smooth, within budget, and on time!

COVID-19 Pandemic

CPSM issued FAQs regarding the vaccine. CPSM staff continue to mix working at home and working at the office. Some staff prefer to work in the office and so attend daily, other staff attend on an as needed basis, and some staff completely work at home. The decision to do so is based on the individual and their manager ensuring work is completed. Safety protocols are in place for those attending at the office.

CPSM 150th Anniversary

2021 marks the 150th year of CPSM. To mark this CPSM will create a display case to showcase exhibits from medical history. For instance, the family of a Manitoba doctor donated his World War II Army medical surgical kit which is fascinating. There are other archival materials that could be displayed as well. A piece of artwork will be purchased to honour all members playing a crucial role in the midst of the COVID-19 pandemic and past pandemics including Spanish Influenza, TB, Polio, and the two World Wars.

FMRAC Conference

The FMRAC (Federation of Medical Regulatory Authorities of Canada) Annual Educational Conference is devoted to two topics - Virtual Medicine and Artificial Intelligence in Medicine. The conference will take place virtually, spread over a number of days in two hour slots per day to combat Zoom fatigue. Last year the conference was cancelled due to COVID.

MAID (Medical Assistance in Dying)

The Federal Government has introduced legislation that has passed in the House but is now in the Senate. Bill C-7 seeks to amend the Criminal Code of Canada MAID provisions. I attended a webinar offered by our insurer – the Healthcare Insurance Reciprocal of Canada. Several slides from the power point are attached outlining the Bill C-7 amendments.

Excerpts from HIROC Presentation

Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)

- If passed, the law will allow medical assistance in dying for eligible persons, whether their natural death is reasonably foreseeable or not
- would retain all other existing *eligibility* criteria, but existing *procedural* safeguards would be reduced for persons whose death is reasonably foreseeable ("Track One")
- New and stricter safeguards would be applied to eligible persons whose death is not reasonably foreseeable ("Track Two")

1

Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)

It remains the case that to be eligible, a person must have:

- a serious and incurable illness, disease or disability*
- be in an advanced state of irreversible decline in capability
- be experiencing physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable

*The Bill specifies that a mental illness is not [yet] considered to be an illness, disease or disability for the purpose of these eligibility requirements. Previously, it was thought that this didn't need to be specified because of the requirement that the person's *natural* death be reasonably foreseeable

2

Excerpts from HIROC Presentation

Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)

Where the person's natural death is reasonably foreseeable:

- The request for MAID is made in writing, signed by one independent witness* (rather than two), and made after the person is informed that they have a "grievous and irremediable medical condition";
- *No longer the case that the witness cannot be directly involved in the provision of health care or personal care services to the individual, as long as this is their primary occupation for which they are paid.
- The person is informed of the means available to relieve their suffering, including palliative care

3

Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)

Where the person's natural death is reasonably foreseeable: (cont'd)

- Two independent physicians or nurse practitioners provide an assessment and confirm that all of the eligibility requirements were met
- The person is informed that they can withdraw their request at any time, in any manner;
- No longer a 10 day "reflection period"
- The person is given an opportunity to withdraw consent and is required to expressly confirm their consent immediately before receiving MAID
  - With one exception: waiver of final consent

4

Excerpts from HIROC Presentation

Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)

Where the person's death is NOT reasonably foreseeable:

Same, PLUS:

- If neither of the two practitioners who provide the assessment of eligibility has expertise in the medical condition that is causing the person's suffering, a third practitioner who does have that expertise must be consulted and the results of that consultation shared between the two; (this recognizes that specialists may be willing to consult but not provide MAiD assessments)
- The person must be 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;
- It must be ensured that there has been discussion and the person has given serious consideration to those means to relieve suffering

5

Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)

Where the person's death is NOT reasonably foreseeable (cont'd):

- There must be at least 90 clear days between the request and the provision of MAiD; this period can be foreshortened only if the person's loss of capacity to provide consent is imminent;
- The person must again give express consent to MAiD immediately before it is provided

6

COUNCIL MEETING –MARCH 19, 2021

ITEM FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The full Executive Committee met on February 17, 2021. Most of the matters dealt with by the Executive Committee are included on the agenda for this meeting of Council, so will not be reiterated.

Cancellation of Certificate of Registration
The Executive Committee held a hearing to consider the cancellation of the certificate of registration of Dr. Amir Houshang Mazhari Ravesh. The Executive Committee directed the Registrar to cancel his certificate of registration because he was convicted of an offence that is relevant to his suitability to practice medicine. Dr. Ravesh was convicted in the Manitoba Court of Queen's Bench on six counts of sexual assault respecting six different women, all of whom were his patients, and all convictions arising out of clinical encounters with these patients.

Appeals of Investigation Committee Decision Hearing
There were four appeals of the decisions of the Investigation Committee heard by a panel of the Executive Committee. The decisions of the Investigation Committee were confirmed.

Respectfully Submitted,
Dr. Ira Ripstein
President, CPSM and Chair of the Executive Committee

AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

1. January 31, 2021 Quarterly Financial Statements

- Management reviewed the CPSM Statement of Operations for the nine months ended January 31, 2021 and discussed the actual results versus budget.
- Discussion highlights included the net surplus of $334 thousand which is an increase from the original budget of $75,000.
- This positive variance has resulted from lower than anticipated expenses for this period due to the timing of when these expenditures will actually be realized.
- With just three months remaining in the fiscal year, Management indicated they expect that CPSM will be in net surplus position at year end.

2. Risk Management update

- The committee received a risk management update from management. The FMRAC Integrated Risk Management System (FIRMS) was discussed as CPSM's strategy for risk management. It was emphasized that this was considered best practice among the other Colleges.

- The added benefit was the sharing and peer-benchmarking of risk management practices among MRA's. Management presented the 11 risk management standards included in FIRMS and elaborated on the risk reports provided.
- Management and the Committee exchanged ideas on how to further identify the key risks to the organization and how and when these should be presented/reported on to Council. Further discussions will occur at the May Committee meeting.
- Management also discussed CPSM's Emergency Response Plan which is in development to formalize the lessons learned and positive experience during the recent pandemic where CPSM was fully operational in a remote working environment within two weeks of the decision to close the office.
- The Committee was also updated on the adequacy of CPSM's comprehensive insurance coverage. CPSM insurance is provided for by the Health Insurance Reciprocal of Canada (HIROC).

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

PROGRAM REVIEW COMMITTEE REPORT:

MANQAP continues to work with stakeholders during the COVID-19 Pandemic. Remote inspections have already taken place for some Patient Service Centres. Remote inspections of other diagnostics facilities are scheduled to begin soon. Discussion has occurred at Program Review Committee to recommend removing the requirements for lead shielding for patients during diagnostic imagining procedures. This is based upon expert opinions and current publications in the field. MANQAP continues to investigate complaints as they arise.

The Non-Hospital Medical Surgical Facilities Program is currently revising their existing processes in order to implement the changes to the Accredited Facilities Bylaw which come into effect in June 2021. CPSM has received a number of queries regarding the changes to the Bylaw and is working to respond to each specific question.

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

COMPLAINTS COMMITTEE REPORT:

Business continues in the COVID environment. We reviewed complaints or other matters that have been referred to the Committee. From the start of this fiscal year, May 1, 2020, we have opened 95 new cases. Our last meeting was held on March 2, 2021.

Complaints Received between 01-May-2020 and 22-Feb-2021

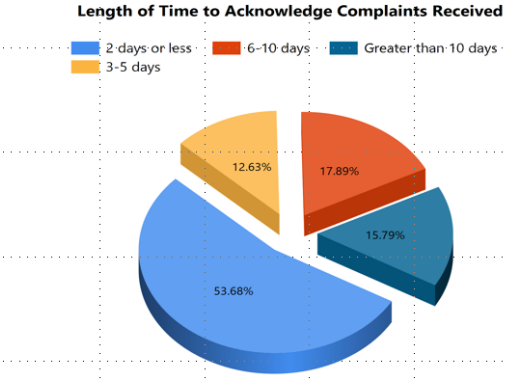
Complaint Received	Total Cases
May/2020	9
June/2020	5
July/2020	10
August/2020	16
September/2020	10
October/2020	18
November/2020	5
December/2020	8
January/2021	6
February/2021	8
Grand Total	95

Complaints Received between 01-May-2019 and 30-Apr-2020

Complaint Received	Total Cases
May/2019	16
June/2019	10
July/2019	11
August/2019	8
September/2019	3
October/2019	18
November/2019	11
December/2019	7
January/2020	11
February/2020	8
March/2020	10
April/2020	1
Grand Total	114

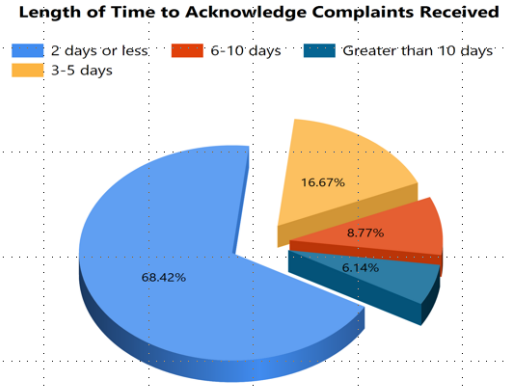
Length of time required to acknowledge complaints received between 01-May-2020 and 22-Feb-2021

Complaints Acknowledge In	Total Cases
2 days or less	51
3-5 days	12
6-10 days	17
Greater than 10 days	15
Total number of complaints cases in time period:	95



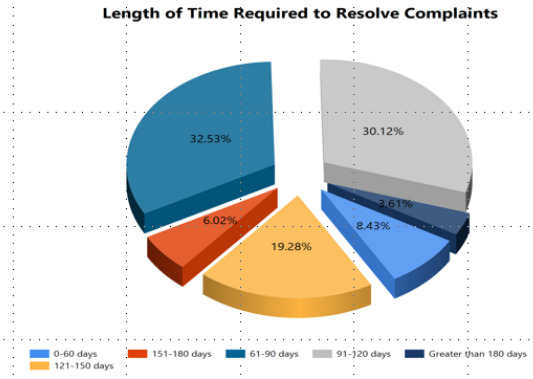
Length of time required to acknowledge complaints received between 01-May-2019 and 30-Apr-2020

Complaints Acknowledge In	Total Cases
2 days or less	78
3-5 days	19
6-10 days	10
Greater than 10 days	7
Total number of complaints cases in time period:	114



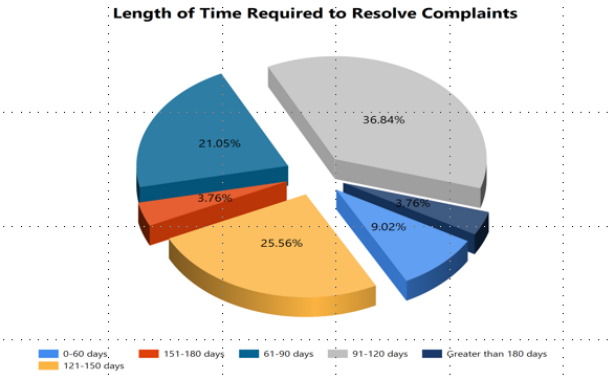
Length of time required to resolve complaints for cases closed between 01-May-2020 and 22-Feb-2021

Complaints Cases with	Total
0-60 days	7
61-90 days	27
91-120 days	25
121-150 days	16
151-180 days	5
Greater than 180 days	3
	83



Length of time required to resolve complaints for cases closed between 01-May-2019 and 30-Apr-2020

Complaints Cases with	Total
0-60 days	12
61-90 days	28
91-120 days	49
121-150 days	34
151-180 days	5
Greater than 180 days	5
	133



Respectfully submitted,
Dr. Heather Smith
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

The Investigation Committee continues to meet monthly over a virtual platform.
In January and February 2021, twenty new investigations were opened, with most being “appeals” of the Complaints Committee decisions. Twelve cases were closed.
There will be two Inquiry hearings held between March and June 2021.

Our new lawyer, Jocelyne Ritchot, began work in our department in January 2021.

We continue to value the work of all staff in the department and appreciate their flexibility in being able to adapt processes to allow for work to continue during the pandemic.

Respectfully submitted,
Dr. Nader Shenouda
Chair, Investigations Committee

QUALITY IMPROVEMENT COMMITTEE REPORT:

The Quality Improvement Committee has not met since the last Council Meeting. The Committee will have a final meeting on April 8, 2021. Council will recall that the activities of the QI Committee will be subsumed under the Central Standards Committee after the June 9, 2021 Council Meeting.

The Quality Improvement Program activities resumed after a pause in the spring related to the COVID-19 pandemic. The program re-engaged with participants in early June. Participants were offered the option of resuming their program activity at that point or deferring to the fall. A cohort had been launched January 2020, comprising 159 participants. The participants from January 2019 to June 2020 had all been family physicians. We began involving specialists in the program in June 2020, beginning with psychiatry and general surgery. Members were offered the option of participating then or in the fall. Uptake was low, so the full cohorts were launched in October, as well as the first cohort for pediatrics. Dr Singer presented to the Department of Internal Medicine Grand Rounds on February 9th, in anticipating of launching an Internal Medicine cohort in 2021. She will present to Obstetrics and Gynecology Grand Rounds June 23rd, looking to launch a cohort in the fall.

The program is showing sensitivity and flexibility during these extraordinary times and accommodates reasonable requests from members for extensions or deferrals. Most participants to date have been able to complete their process.

As a reminder, some participants undergo an off-site chart review (normally done at the CPSM offices), multisource feedback, and/or an on-site office visit. The processes for these functions have been reviewed in light of the pandemic, and alternate means of providing the reviews in a remote manner have been developed, so that the program can remain operational through the next year.

Of the total participants, 9 files have been/are being brought forward to the QI Committee regarding concerns around practice deficiencies. Outcome details are as follows:

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

Below is a summary of initiations/participants/completions for the 2019 and 2020 cohorts:

QI PARTICIPANTS

YEAR	INITIATED	PARTICIPATED	COMPLETED
2019	294	194	194
JANUARY 2020	157	88	80
OCTOBER 2020	94	62	0

In the January 2020 cohort, 41 participants were deferred. 28 of those participants chose to participate in the October cohort. Of the 94 participants in the October 2020 cohort, 16 have been deferred and 16 have been moved to the fall 2021 cohort due to their increased responsibilities during the Covid-19 pandemic.

Based on chart reviews completed to date, it appears that medical record keeping is a challenging area of practice for some physicians and that there is a need for refresher training in medical record keeping.

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

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

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

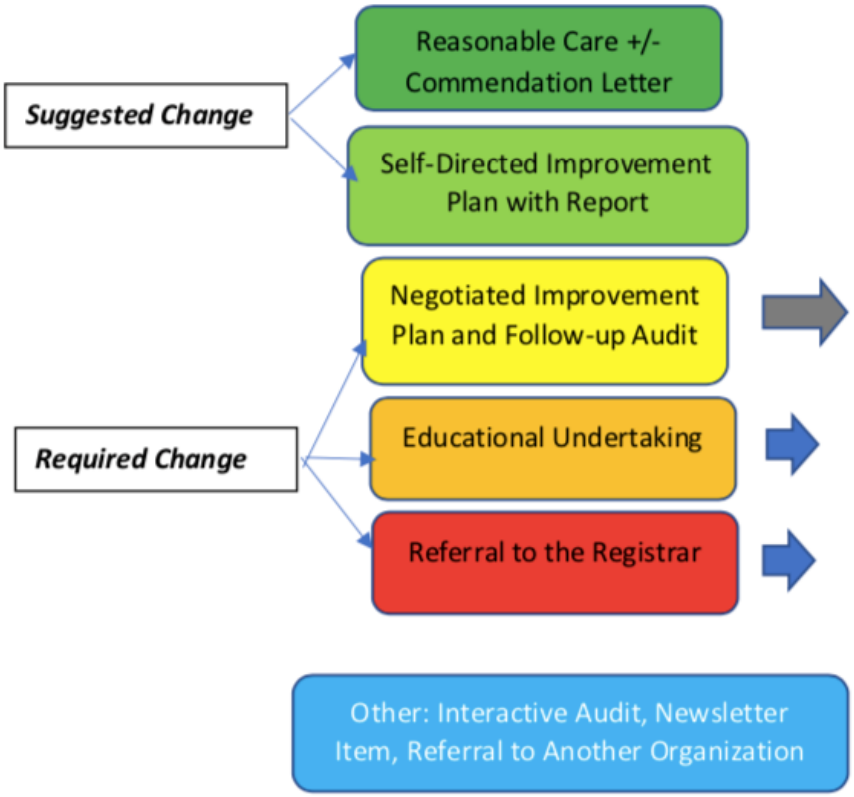
The QI Program has received CPD accreditation by both the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. Both have granted the program the highest credit level available of 3 credits per hour MainPro+ and Section 3 Assessment credits respectively.

Respectfully submitted,
Dr. Christine Polimeni
Chair, Quality Improvement Committee

STANDARDS COMMITTEE REPORT:

Standards Sub Committee Working Group
The working group continues to prepare a document to guide Standards Subcommittees in their work and their reporting, so that a summary of College Standards activities across the province can be provided to Council. The recommendations of this working group should be ready for the June meeting of Council.

Central Standards Committee Activities
The Committee has been working on more consistently applying the framework of the Central Standards Bylaw by using the following decision tool in responding to audits:



CSC has had one meeting since December with the following decisions:

There were a total of 23 outcomes.

10 physicians received letters of commendation for providing reasonable care.
1 physician received a letter for suggested change, provide the CSC with a self-directed improvement plan and follow-up within 1 year.
9 physicians received letters requiring change with a negotiated improvement plan and follow-up audit between 6 months to 2 years.
1 physician was referred to the Registrar
2 physicians are required to have interactive audits as soon as possible.

Suggested guidelines and protocols for consideration by Council.

One audit raised questions about whether episodic care physicians should be expected to have access the long-term patient record such as eChart. This arose in the context of an audit of a physician practicing as part of a house call service, but the Committee felt that the question also applied to walk-in clinics. The Central Standards Committee would like to suggest that Council clarify expectations of episodic care and communicate those expectations to the membership.

Respectfully submitted,
Dr. Roger Suss
Chair, Central Standards Committee

0077

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:				