Wednesday, December 13, 2023 | 8:00 a.m. |

AGENDA

CPSM Office – Brown Room
1000 – 1661 Portage Avenue

Time		Item		Action		Page #
5 min	8:00 am	1.	Opening Remarks		Dr. Shenouda	
0 min	8:05 am	2.	Agenda – Approval			
0 min	8:05 am	3.	Call for Conflict of Interest			
5 min	8:05 am	4.	Consent Agenda i. Council Meeting Minutes Sep 27, 2023 ii. Council Policy Registration of Clinical and Physician Assistants and Physician Assistant Students iii. Practice Direction Practice Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students iv. Council Policy Specialist Register v. Practice Direction Qualifications and Registration	For Approval	Dr. Shenouda	4
20 min	8:10 am	5.	Quality Prescribing Rules Review WG i. Standard of Practice Prescribing Requirements ii. Practice Direction Electronic Transmission of Prescriptions	For Approval	Dr. Shenouda	66
10 min	8:30 am	6.	Standard of Practice Medical Assistance in Dying (MAiD)	For Approval	Dr. Ziomek/ Ms Arnason	185
5 min	8:40 am	7.	IMG Working Group	For Information	Dr. Ziomek	218
5 min	8:45 am	8.	Board of Assessors	For Approval	Dr. Ziomek/ Mr. de Jong	221
20 min	8:50 am	9.	Registrar Deliverables (2023/24)	For Information	Dr. Shenouda/ Mr. Fineblit	225
20 min	9:10 am	10.	Performance Metrics Reporting – Registration Department	For Information	Ms St. Vincent	227
30 min	9:30 am		-- Break --			
40 min	10:00 am	11.	Prescribing Practices Program Expansion Presentation	For Information	Dr. Mihalchuk /Dr. Reinecke	228

Time		Item		Action		Page #
10 min	10:40 am	12.	Committee Report (written, questions taken) Executive Committee Finance, Audit & Risk Management Committee Complaints Committee Investigations Committee Program Review Committee Central Standards Committee	For Information	Dr. Shenouda	234
10 min	10:50 am	13.	Registrar's Report	For Information	Dr. Ziomek	241
60 min	11:00 am	14.	In Camera – Succession Planning and Self-Evaluation of Governance Process			
	noon		4 hrs - Estimated time of sessions			
			Photos to be taken throughout the afternoon			

Regulated Health Professions Act

Duty to serve the public interest

s. 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.

CPSM Mandate

10(2) A college has the following mandate:

(a) to regulate the practice of the health profession and govern its members in accordance with this Act and the regulations and by-laws;
(b) to develop, establish and maintain standards of academic or technical achievement and qualification required for registration as a member and monitor compliance with and enforce those standards;
(c) to develop, establish and maintain standards of practice to enhance the quality of practice by members and monitor compliance with and enforce those standards;
(d) to develop, establish and maintain a continuing competency program for members to promote high standards of knowledge and skill;
(e) to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues;
(f) to work in consultation with the minister towards achieving access for the people of Manitoba to adequate numbers of qualified and competent members of the regulated health profession;
(g) to develop, establish and maintain programs that provide information about the health profession, and that assist persons in exercising their rights under this Act and the regulations, by-laws and code of ethics;
(h) to promote and enhance the college's relations with its members, other colleges, key stakeholders and the public;
(i) to promote inter-professional collaboration with other colleges;
(j) to administer the college's affairs and perform its duties and carry out its powers in accordance with this Act and the regulations and by-laws.

CPSM Governance Policy – Governing Style and Code of Conduct:

1.1 General

Council recognizes its accountability to the people of Manitoba to carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest. To that end, Council will govern with an emphasis on strategic leadership, including a commitment to obtaining public and membership input, encouragement of diverse viewpoints, and clear distinction of Council and staff roles.

COUNCIL MEETING – DECEMBER 13, 2023
CONSENT AGENDA
NOTICE OF MOTION FOR APPROVAL

SUBJECT: **Consent Agenda**

BACKGROUND:

In order to make Council meetings more efficient and effective the consent agenda is being used. Routine and non-contentious business has been consolidated into a 'consent agenda'. Many organizations and their committees use consent agendas. Below is how the consent agenda works:

1. The President decides which items will be placed on the consent agenda. The consent agenda appears as part of the normal meeting agenda.
2. The President authorizes the consent agenda and associated documents distribution in time for members to read and review.
3. At the beginning of the meeting, the President asks members if any of the consent agenda items should be transferred to the regular discussion items.
4. If a member requests an item be transferred, it must be transferred. Any reason is sufficient to transfer an item. A member can transfer an item to discuss the item, to query the item, or to vote against it.
5. Once the item has been transferred, the President may decide to take up the matter immediately or transfer it to a discussion item.
6. When there are no items to be transferred or if all requested items have been transferred, the President notes the remaining consent items.

The President Elect can move to adopt the consent agenda, and a seconder is required. A vote will be called on approving the items in the consent agenda. There will be a single (en bloc) motion for all the items included in the consent agenda.

The following items on this consent agenda are for approval. See attached for details on each item.

i. Council Meeting Minutes – September 27, 2023
ii. Council Policy Registration of Clinical and Physician Assistants and Physician Assistant Students
iii. Practice Direction Practice Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students
iv. Council Policy Specialist Register
v. Practice Direction Qualifications and Registration

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2023, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

All items on the consent agenda are approved as presented.

1000 – 1661 Portage Avenue, Winnipeg Manitoba R3J 3T7
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Website: www.cpsm.mb.ca

MINUTES OF COUNCIL

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on September 27, 2023, at the CPSM Office with an option to join virtually via Zoom.

1. CALL TO ORDER

The meeting was called to order at 08:04 a.m. by the Chair of the meeting, Dr. Nader Shenouda.

COUNCILLORS:
- Ms. Leslie Agger, Public Councillor - Virtually
- Ms. Dorothy Albrecht, Public Councillor
- Mr. Chris Barnes, Associate Member
- Dr. Kevin Convery, Morden
- Dr. Jacobi Elliott, Grandview
- Mr. Allan Fineblit, Public Councillor
- Ms. Lynette Magnus, Public Councillor
- Dr. Norman McLean, Winnipeg
- Ms. Marvelle McPherson, Public Councillor
- Dr. Lisa Monkman, Scanterbury
- Dr. Charles Penner, Brandon
- Ms. Leanne Penny, Public Councillor
- Dr. Nader Shenouda, Oakbank
- Dr. Heather Smith, Winnipeg - Virtually
- Dr. Roger Süss, Winnipeg - Virtually

MEMBERS:

STAFF:
- Dr. Anna Ziomek, Registrar
- Dr. Ainslie Mihalchuk, Assistant Registrar -Virtually
- Dr. Karen Bullock Pries, Assistant Registrar
- Mr. Mike Triggs, General Counsel
- Mr. Paul Penner, Chief Operating Officer
- Ms. Karen Sorenson, Executive Assistant
- Ms. Wendy Elias-Gagnon, Communications Officer
- Ms. Jo-Ell St. Vincent, Director Registration
- Mr. Jeremy de Jong, Legal Counsel
- Ms. Barbie Rodrigues, Admin Assistant
- Ms. Lauren Phoutthavongsin, Admin Assistant

REGRETS:
- Dr. Caroline Corbett, Winnipeg
- Dr. Peter Nickerson, Winnipeg

2. ADOPTION OF AGENDA

IT WAS MOVED BY MR. ALLAN FINEBLIT, SECONDED BY MS LEANNE PENNY:
CARRIED:

That the agenda be approved as presented.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

Dr. Shenouda 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. CONSENT AGENDA

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY MS MARVELLE MCPHERSON:
CARRIED

That the following items on the consent agenda be approved as presented.

i. Council Meeting Minutes – June 28, 2023
ii. Standard of Practice – Research
iii. Council Policy – Supervision of Provisional Registrants

5. STRATEGIC PLAN AND ANNUAL WORK CYCLE

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY DR. KEVIN CONVERY that:
CARRIED

Council approves the Strategic Plan and Annual Work Cycle as presented.

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY MR. ALLAN FINEBLIT that:
CARRIED

Council approves changing the wording in the CPSM mandate to replace “physicians” with “registrants”.

6. REGISTRAR DELIVERABLES

As per request at the June 2023 council meeting, Dr. Ziomek presented further details of the deliverables for the past year.

7. PERFORMANCE METRICS REPORTING TEMPLATE

Mr. Penner spoke on the Performance Metrics Reporting score card and Dr. Mihalchuk updated Council on the Quality Department Performance Metrics.

8. QUALITY PRESCRIBING RULES REVIEW WORKING GROUP UPDATE

Dr. Shenouda provided an update and noted the public consultation deadline is Friday, September 29. The feedback received will be reviewed and presented to the working group for discussion. The working group’s assessment and the consultation feedback will be presented to Council at a future meeting.

9. COMMITTEE REPORTS

The following Committee 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

10. CEO/REGISTRAR'S REPORT

Dr. Ziomek provided the Council with a written report for information outlining the matters currently being dealt with at CPSM.

11. IN CAMERA SESSION

An in-camera session was held, and the President advised that council discussed succession planning for CPSM staff.

There being no further business, the meeting ended at 12: 15 p.m.

_____

Dr. N. Shenouda, President

_____

Dr. A. Ziomek, Registrar

COUNCIL MEETING
DECEMBER 13, 2023

CONSENT AGENDA ITEM

SUBJECT: Council Policy - Registration of Clinical Assistants, Physician Assistants, and Physician Assistant Students

BACKGROUND:

A review of Council Policies, Registrar's Policies, and registration Practice Directions is ongoing. As indicated at previous meetings of Council, the goal of this project is to revise and update these documents, and then compile and organize them into a single source to be referred to in future as CPSM's Compiled Registration Policies and Practice Directions. This will be an indexed and easy to navigate document that supports transparency and accessibility.

THE PROPOSED COUNCIL POLICY:

Registration requirements and processes for Clinical Assistants (ClAs), Physician Assistants (PAs), and PA Students are contained in the *CPSM General Regulation* as well as the *Practice Direction Registration and Qualifications*. Part of the current work involves determining whether certain requirements are best described as policies, or if they should be contained in a Practice Direction.

The Regulated Health Professions Act states that Practice Directions are in respect of the practice of the regulated health profession. It is therefore not appropriate to set registration requirements and processes in a Practice Direction. How individuals are registered is not in respect of how they practice.

Upon approving this motion, the registration processes for ClAs, PAs, and PA Students contained in the *Practice Direction Registration and Qualifications* will be removed. They will appear in a new Council Policy entitled *Registration of Clinical and Physician Assistants and Physician Assistant Students.* This policy also reproduces relevant portions of the *CPSM General Regulation* so that the reader does not need to look at multiple sources to understand our registration requirements.

Attached is a redline version of the amended Practice Direction Registration and Qualifications, and a copy of the proposed 'Council Policy - Registration of Clinical and Physician Assistants and Physician Assistant Students'.

For the most part, this action constitutes a reorganization of information and does not change eligibility requirements. Additional commentary is provided in the Council Policy for guidance. However, there is one change respecting the registration of PAs. It is proposed that Council require that, "*practicing PAs hold the PA-C or CCPA designation*". The proposed Council Policy includes (at section 5.2) that:

> *In accordance with subsection 3.37(a) of the CPSM General Regulation, Council requires that the applicant must have passed one of the following examinations to be initially registered in the Physician Assistant (Full) Practicing Class:*
> *5.2.1.1. the Physician Assistant Entry to Practice Certification Examination ("PA Certification Examination"), or*
> *5.2.1.2. the examination set by the NCCPA.*

For reference, the Physician Assistant Certification Council of Canada ("PACCC") is an independent Council of the Canadian Association of Physician Assistants ("CAPA"). The Physician Assistant Entry to Practice Certification Examination (PA Certification Examination) is recognized by the PACCC. "CCPA" means Canadian Certified PA. The CPAP website includes, "*PACCC aims to reassure the public that there is a national standard of care from PA providers who successfully complete the PA Cert Exam.*" All currently registered PAs meet this requirement. Other Canadian MRAs that license PAs have this requirement.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2023, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> The Council Policy - Registration of Clinical and Physician Assistants and Physician Assistant Students be approved as presented to be effective immediately.

AND FURTHER MOVED THAT:

> The Practice Direction Registration and Qualifications be amended as presented to be effective immediately, including by deleting sections 2.19 and 2.20.

COUNCIL POLICY

Registration of Clinical and Physician Assistants and Physician Assistant Students

Initial Approval: DATE **Effective Date:** DATE

PREAMBLE:

Clinical Assistants (ClAs), Physician Assistants (PAs), and Physician Assistant Students (PA Students) may be registered as Regulated Associate Members in one of the following classes:[1]

- Educational (Physician Assistant Student),
- Educational (External or Visiting Student),
- Educational (Non-Practicing),
- Physician Assistant (Full),
- Physician Assistant (Restricted Purpose),
- Physician Assistant (Academic – S. 181 Faculty),
- Physician Assistant (Non-Practicing),
- Clinical Assistant (Full),
- Clinical Assistant (Non-Practicing),
- Retired (Physician Assistant), and
- Retired (Clinical Assistant).

ClA, PA, and PA Student applicants must satisfy the following registration requirements found in the *CPSM General Regulation*:[2]

- the common requirements for all registrants of CPSM at s. 3.2,
- the non-exemptible requirements for all Regulated Associate Members at s. 3.37,[3] and
- the specific provisions that apply to the class for which they are applying.[4]

Specific provisions of the *CPSM General Regulation* that apply to ClA, PA and PA Student classes of registration are reproduced in this Policy for ease of reference. The purpose of this Policy is to set out additional registration requirements approved by Council.

[1] See s. 2.4 of the *CPSM General Regulation*.
[2] The RHPA at s. 33 states, "*an application for registration as a regulated associate member must be considered and decided upon in accordance with the regulations.*"
[3] As an exception, an applicant for registration in the physician assistant (academic — section 181 faculty) class must provide satisfactory evidence that they meet the requirements at ss. 181(1)(b) of the RHPA.
[4] See subsection 3.2(1) of the *CPSM General Regulation* at point 9(b).

This Policy only relates to the issuance of certificates of registration. It does not deal with the requirements for certificates of practice established at Part 4 of the *CPSM General Regulation*.[5] Certificates of practice and other practice requirements for ClAs, PAs, and PA Student are also addressed in the 'Practice and Supervision Requirements for ClAs, PAs, and PA Students' Practice Direction and at Part 8 of the *CPSM General Regulation*.

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[5] Part 4 of the *CPSM General Regulation* establishes the requirements for issuing a certificate of practice. Of note, s. 4.1 states, "*A certificate of registration does not entitle a member to practise medicine. To do so, a member must also hold a certificate of practice. This Part adds to the requirements in the* [RHPA] *for a certificate of practice.*" Additional requirements for ClAs and PAs are set out at s. 4.5.

1. APPLICABLE PRACTICE LIMITATIONS

1.1. Although not registration requirements, it is important to note that the ability of ClAs and PAs to engage in their professional practice is limited by the following regulations:

1.1.1. Part 8 of the *CPSM General Regulation* concerning practice description and contract of supervision requirements for PAs and ClAs,

1.1.2. Part 6 of the *CPSM General Regulation* concerning title restrictions, and

1.1.3. sections 4, 5 and 6 of the RHPA, section 6 of the *CPSM Practice of Medicine Regulation*, and Part 5 of the *CPSM General Regulation* respecting the performance and delegation of reserved acts.

1.1. PA Students do not require a practice description and contract of supervision. Their scope of practice is limited to practice under the supervision of the teaching staff in a particular department or departments of their educational program. Other conditions may be imposed, depending upon the circumstances. Sections 5.18 and 5.19 of the *CPSM General Regulation* limit the performance of reserved acts by all students, including PA Students.

2. EDUCATIONAL (PHYSICIAN ASSISTANT STUDENT) CLASS

2.1. Specific requirements for registration:

2.1.1. The specific requirements for the Educational (Physician Assistant Student) Class are set out at section 3.50 of the *CPSM General Regulation*:

> *3.50 An applicant for registration as an educational (physician assistant student) member must establish that he or she is confirmed by the Manitoba faculty to be enrolled as a physician assistant student.*

2.2. Terms and Conditions on registration:

2.2.1. Section 3.51 of the *CPSM General Regulation* states:

> *3.51 As a condition of registration, a member must continue to be enrolled as a physician assistant student in the Physician Assistant Education Program at the University of Manitoba.*

2.3. Cancellation of Registration:

2.3.1. Pursuant to section 3.93 of the *CPSM General Regulation*, a PA Student's registration is cancelled if they cease to be enrolled as a PA Student with the Physician Assistant Education Program, or if their registration in the Physician Assistant (Full) Class is approved by the Registrar, in which case they are converted to that class.

3. EDUCATIONAL (EXTERNAL OR VISITING STUDENT) CLASS

3.1. Specific requirements for registration:

3.1.1. The Educational (External or Visiting Student) Class is intended for students or graduates of approved faculties of medicine (i.e., medical students) or physician assistant training programs (i.e., PA Students) outside Manitoba who are also enrolled in the Manitoba faculty for a limited period. Disclosure requirements apply to these applicants; however, given the special nature of registration as an external or visiting student, the applicant must meet all the following requirements instead of other usual registration requirements:

3.1.1.1. submit a signed application in the approved form,

3.1.1.2. submit the fees provided for in the by-laws,

3.1.1.3. establish that they are a graduate or a student of an approved physician assistant training program outside Manitoba,

3.1.1.4. establish that they are in good standing with the regulatory authority in the jurisdiction in which they are currently authorized to practise medicine, and

3.1.1.5. the specific requirements at section 3.57 of the *CPSM General Regulation*.

3.1.2. The specific requirements for registration in the Educational (External or Visiting Student) Class are set out at section 3.57 of the *CPSM General Regulation*:

> *3.57 An applicant for registration as an educational (external or visiting student) member must*
>
> *(a) establish that he or she is a graduate, or an undergraduate or post-graduate student in good standing, of either*
>
> *(i) a nationally approved faculty of medicine located outside Manitoba, or*
>
> *(ii) an approved physician assistant training program located outside Manitoba;*
>
> *(b) if applicable, establish that he or she is in good standing with the regulatory authority in the jurisdiction in which he or she is currently authorized to practise medicine; and*
>
> *(c) provide written confirmation from the dean of the Manitoba faculty (or the dean's designate) that*
>
> *(i) he or she has been accepted by the Manitoba faculty as an external or visiting student in a specified department,*
>
> *(ii) he or she is legally entitled to study in Manitoba,*
>
> *(iii) he or she meets the approved English language fluency criteria,*

(iv) a specified regulated member from the department in which the external or visiting student will be studying has been designated to supervise the student, and
(v) he or she has obtained a criminal record check from the jurisdiction in which the applicant is currently authorized to practise medicine, or is enrolled in the faculty or program, that is satisfactory to the Manitoba faculty.

3.2. Approved PA training programs located outside of Manitoba:

3.2.1. For the purposes of ss. 3.57(a)(ii) of the *CPSM General Regulation* (see above), Council has approved the following physician assistant training programs located outside of Manitoba:

3.2.1.1. the Canadian Armed Forces,
3.2.1.2. University of Toronto,
3.2.1.3. McMaster University, and
3.2.1.4. a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States.

3.3. Terms and conditions on registration:

3.3.1. Section 3.58 of the *CPSM General Regulation* provides that "*A person may be registered as an educational (external or visiting student) member for a time period of not more than six consecutive months, which may be extended in accordance with sections 3.71 to 3.73.*"

3.3.1.1. The Registrar may extend registration for up to twelve (12) additional months. An extension can only occur if the student provides a written request from the dean of the Manitoba faculty, or the dean's designate, for an extension before the initial registration expires and sets out the reasons for the extension request. Written reasons must be given by the Registrar and the student has a right of appeal.

3.3.2. Section 3.59 of the *CPSM General Regulation* provides that "*As a condition of registration, an educational (external or visiting student) member must continue to be enrolled as an external or visiting student with the Manitoba faculty or the Physician Assistant Education Program at the University of Manitoba, as the case may be.*"

3.4. Cancellation of registration:

3.4.1. In accordance with section 3.93 of the *CPSM General Regulation*, an external or visiting PA Student's registration is cancelled if they cease to be enrolled with the

Physician Assistant Education Program or the specified period for which the registration was issued expires.

4. EDUCATIONAL (NON-PRACTICING) CLASS

4.1. This class is for PA Students who are on leave of absence approved by the Manitoba faculty. Section 3.60 of the *CPSM General Regulation* provides:

> *An applicant for registration as an educational (non-practising) member must establish that*
>
> *(a) he or she was registered or was qualified to be registered as an educational member in good standing immediately before applying for educational (non-practising) membership; and*
>
> *(b) his or her leave of absence has been approved by the Manitoba faculty.*

5. PHYSICIAN ASSISTANT (FULL) CLASS

5.1. Specific requirements for registration:

5.1.1. The specific requirements for registration in the Physician Assistant (Full) Class are set out at section 3.61 of the *CPSM General Regulation*:

> *3.61 An applicant for registration as a physician assistant (full) member must*
>
> *(a) establish that he or she has satisfactorily completed an approved clinical training program; and*
>
> *(b) establish that he or she meets one of the following criteria:*
>
> *(i) he or she is a graduate of the Physician Assistant Education Program at the Manitoba faculty,*
>
> *(ii) he or she*
>
> *(A) is a graduate of a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States,*
>
> *(B) has passed the examination set by the NCCPA, and*
>
> *(C) holds the designation "PA-C",*[6] [or]
>
> *(iii) he or she is a graduate of another approved physician assistant training program.*

[6] Per section 1.4 of the CPSM General Regulation, “PA-C" means the "Physician Assistant – Certified" designation granted by the NCCPA. "NCCPA" means the National Commission on Certification of Physician Assistants in the United States.

5.2. Examinations required by Council:

5.2.1. Council requires that practicing PAs hold the PA-C or CCPA designation. In accordance with subsection 3.37(a) of the *CPSM General Regulation*, Council requires that the applicant must have passed one of the following examinations to be initially registered in the Physician Assistant (Full) Practicing Class:

5.2.1.1. the Physician Assistant Entry to Practice Certification Examination ("PA Certification Examination")[7], or

5.2.1.2. the examination set by the NCCPA.

5.3. PA training programs approved by Council:

5.3.1. In addition to the PA training programs identified at ss. 3.61(b) of the *CPSM General Regulation*, the following training programs have been approved by Council for the purposes of ss. 3.61(b)(iii):

5.3.1.1. the Canadian Armed Forces,

5.3.1.2. University of Toronto, and

5.3.1.3. McMaster University.

6. PHYSICIAN ASSISTANT (RESTRICTED PURPOSE) CLASS

6.1. Specific requirements for registration:

6.1.1. As with the restricted purpose class for Regulated Members, the Physician Assistant (Restricted Purpose) Class is for the purpose of enabling a PA to engage in practice in Manitoba for a restricted purpose approved by Council. Examples include a public emergency or military service.

6.1.2. The specific requirements for registration in the Physician Assistant (Restricted Purpose) Class are set out at section 3.62 of the *CPSM General Regulation*:

> *3.62 An applicant for registration as a physician assistant (restricted purpose) member must*
>
> *(a) establish that he or she is authorized to practise medicine as a physician assistant in another jurisdiction in Canada or elsewhere and is in good standing in that jurisdiction;*
>
> *(b) submit to the registrar a signed declaration that he or she will engage in the practice of medicine only for one or more of the following purposes:*
>
> *(i) to provide medical services on a temporary basis at a specified location or facility,*

[7] The Physician Assistant Certification Council of Canada ("PACCC") is an independent Council of the Canadian Association of Physician Assistants ("CAPA"). The Physician Assistant Entry to Practice Certification Examination (PA Certification Examination) is recognized by the PACCC. "CCPA" means Canadian Certified PA.

(ii) to conduct a training course or clinical presentation related to his or her professional practice,

(iii) to conduct or engage in a research program related to his or her professional practice,

(iv) to demonstrate equipment or techniques to be used in clinical care related to his or her professional practice,

(v) to provide medical services during a public health emergency as authorized under subsection 56(1) of the Act,

(vi) for any other approved purpose; and

(c) establish that he or she has met any other approved requirements for physician assistant (restricted purpose) membership.

6.2. Terms and conditions on registration:

6.2.1. Section 3.63 of the *CPSM General Regulation* provides:

3.63 A person may be registered as a physician assistant (restricted purpose) member for a time period, geographical area or practice setting specified by the registrar.

6.3. Cancellation of registration:

6.3.1. Cancellation will occur on the earliest of:

6.3.1.1. expiry of the specified period of registration,

6.3.1.2. receipt by CPSM of written notice that the purpose or purposes for which the registration was granted have been fulfilled, or

6.3.1.3. the registrant ceasing to be registered and in good standing as a PA in another jurisdiction in Canada or elsewhere.

7. PHYSICIAN ASSISTANT (ACADEMIC – S. 181 FACULTY) CLASS

7.1. Specific requirements for registration:

7.1.1. The specific requirements for registration in the Physician Assistant (Academic – S. 181 Faculty) Class are set out at section 3.64 of the *CPSM General Regulation*:

3.64 An applicant for registration as a physician assistant (academic — s. 181 faculty) member must

(a) submit to the registrar a written request to approve the applicant's registration from the dean of the Manitoba faculty (or the dean's designate) that contains the following:

(i) a confirmation that the applicant is or will be legally entitled to work or study in Manitoba before engaging in his or her professional practice,
(ii) a confirmation that the applicant meets the approved English language fluency criteria,
(iii) a description of the applicant's most recent professional practice and proposed professional practice; and

(b) establish that he or she has been granted a section 181 certificate.

7.2. Terms and conditions:

7.2.1. Section 3.65 of the *CPSM General Regulation* provides:

3.65(1) A person may be registered as a physician assistant (academic — s. 181 faculty) member for as long as he or she holds a section 181 certificate.

3.65(2) As a condition of registration, a physician assistant (academic — s. 181 faculty) member must continue to hold a section 181 certificate.

7.3. Cancellation

7.3.1. The PA (academic – s. 181 faculty) registrant's membership is cancelled if the member's s. 181 certificate is revoked or lapses.

8. PHYSICIAN ASSISTANT (NON-PRACTICING) CLASS

8.1. The Physician Assistant (Non-Practising) Class is intended for those registrants who take a leave of absence from practice in Manitoba but intend to return to practice in Manitoba. This may occur when a Contract of Supervision is terminated. This class may also be used for those who no longer practice in Manitoba but whose registration has not been cancelled or surrendered. PAs without an approved Contract of Supervision may be placed in this class at the time of initial registration pending authorization of a contract.

8.2. This non-practicing class of registration is to be distinguished from the Retired (Physician Assistant) Class, which is intended for those registrants who have retired from practice. Public registry requirements are lessened in respect to those in the retired class, which is the main difference between the two classes.

8.3. To convert to the Physician Assistant (Non-Practising) Class, the registrant must meet the specific requirements set out at subsection 3.66(1) of the *CPSM General Regulation*:

3.66(1) An applicant for registration as a physician assistant (non-practising) member must establish that he or she was registered or was qualified to be registered as a physician assistant (full) member in good standing immediately before applying for physician assistant (non-practising) membership.

8.4. Council has extended subsection 3.66(1) to include those registered in the Physician Assistant (Academic – S. 181 Faculty) Class.

8.5. As an exception to the usual requirement for an application to convert between classes of registration, section 3.79 of the *CPSM General Regulation provides*:

3.79 If a member fails to renew or voluntarily surrenders his or her certificate of practice, the registrar may change the member's registration to the applicable non-practising class.

8.6. Conversion to the Physician Assistant (Non-Practising) Class will be the usual default for registrants who no longer hold a valid certificate of practice (e.g., if it was not renewed or their Contract of Supervision is terminated), have not expressly indicated an intention to retire, and have not otherwise had their registration cancelled.

9. Retired (Physician Assistant) Class

9.1. Section 3.69 of the *CPSM General Regulation* provides:

3.69 An applicant for registration as a retired (physician assistant) member must establish that he or she was registered in good standing in one of the following classes immediately before applying for retired membership:
(a) physician assistant (full);
(b) physician assistant (academic — s. 181 faculty);
(c) physician assistant (non-practising).

10. Clinical Assistant (Full) Class

10.1. Specific requirements for registration:

10.1.1. The specific requirements for registration in the Clinical Assistant (Full) Class are set out at section 3.67 of the *CPSM General Regulation*:

3.67 An applicant for registration as a clinical assistant (full) member must
(a) complete an approved assessment; and
(b) establish that he or she meets one of the following criteria:

(i) he or she holds

(A) a degree in medicine granted from a nationally approved faculty of medicine, or

(B) a Doctor of Osteopathic Medicine degree from a school in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation,

(ii) he or she is a graduate of an approved and accredited physician assistant or clinical assistant training program that is restricted to a field of practice,

(iii) he or she is a member in good standing of a regulated health profession in Manitoba, [or]

(iv) he or she is certified in the highest level of emergency medical attendant certification at the time of application.

10.2. Approved Assessments for ClAs:

10.2.1. ClA assessments approved by Council for the purposes of ss. 3.67(a) of the *CPSM General Regulation* are as follows:

10.2.1.1. For ClAs with no field of practice restriction on their registration:

i. Registered Clinical Assistant assessment offered by the Manitoba faculty.
ii. National Assessment Collaborative OSCE (NAC-OSCE).
iii. Hold the LMCC.

10.2.1.2. For ClAs with registration restricted to practice in a specific field of practice:

i. Satisfactory completion of a program accredited by the Royal College of Physicians and Surgeons of Canada in a Canadian University teaching hospital in the applicant's intended field of practice.

11. Clinical Assistant (Non-Practicing) Class

11.1. The Clinical Assistant (Non-Practising) Class is intended for those registrants who take a leave of absence from practice in Manitoba but intend to return to practice in Manitoba. This may occur when a Contract of Supervision is terminated. This class may also be used for those who no longer practice in Manitoba but whose registration has not been cancelled or surrendered. ClAs without an approved Contract of Supervision may be placed in this class at the time of initial registration pending authorization of a contract.

11.2. This non-practicing class of registration is to be distinguished from the Retired (Clinical Assistant) Class, which is intended for those registrants who have retired from practice. Of note, public registry requirements are lessened in respect to those in the retired class.

11.3. To convert to the Clinical Assistant (Non-Practising) Class, the registrant must meet the specific requirements set out at subsection 3.68(1) of the *CPSM General Regulation*:

> *3.68(1) An applicant for registration as a clinical assistant (non-practising) member must establish that he or she was registered or was qualified to be registered as a clinical assistant (full) member in good standing immediately before applying for clinical assistant (non-practising) membership.*

11.4. As an exception to the usual requirement for an application to convert between classes of registration, section 3.79 of the *CPSM General Regulation provides*:

> *3.79 If a member fails to renew or voluntarily surrenders his or her certificate of practice, the registrar may change the member's registration to the applicable non-practising class.*

11.5. Conversion to the Clinical Assistant (Non-Practising) Class will be the usual default for registrants who no longer hold a valid certificate of practice (e.g., if it was not renewed or their contract of supervision is terminated), have not expressly indicated an intention to retire, and have not otherwise had their registration cancelled.

12. Retired (Clinical Assistant) Class

12.1. Section 3.70 of the *CPSM General Regulation* provides:

> *3.70 An applicant for registration as a retired (clinical assistant) member must establish that he or she was registered in good standing in one of the following classes immediately before applying for retired membership:*
> *(a) clinical assistant (full);*
> *(b) clinical assistant (non-practising).*

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
DECEMBER 13, 2023

CONSENT AGENDA ITEM

SUBJECT: Practice Direction - Practice Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students

BACKGROUND:

A review of Council Policies, Registrar's Policies, and registration Practice Directions is ongoing. As indicated at previous meetings of Council, the goal of this project is to revise and update these documents, and then compile and organize them into a single source to be referred to in future as CPSM's Compiled Registration Policies and Practice Directions. This will be an indexed and easy to navigate document that supports transparency and accessibility.

Registrants and institutional actors have raised concerns about the length of contracts of supervision used in the process of approving the professional practice of Clinical Assistants (ClAs) and Physician Assistants (Pas). This context supports transporting provisions of standardized contracts to a Practice Direction. If that is done, then contracts can be significantly shortened.

Supervision requirements for ClAs and PAs are very complex, as are the general restrictions that apply to their professional practice and that of all regulated associate registrants. This circumstance is confounded by the fact that these requirements appear in multiple authorities.

The Proposed Practice Direction:

Practice requirements for ClAs, PAs, and PA Students are contained in the RHPA, the *CPSM General Regulation,* the *Practice of Medicine Regulation,* as well as the *Practice Direction Registration and Qualifications*. The proposed Practice Direction brings these requirements together and adds additional explanatory language and expectations. Many of the requirements set out in the Practice Direction are not new and reflect already prevailing expectations.

The Practice Directions deals with:

1. Certificates of practice.
2. General requirements for practice descriptions and contracts of supervision.
3. Supervision of ClAs and PAs.
4. Title restrictions.
5. Performance of reserved acts and delegation of reserved acts.
6. Collaborative care.
7. Continuing professional development.

The Practice Direction adds criteria for approval to supervise a ClA or PA and contains detailed information about the role, responsibilities, and duties of physicians who supervise.

The requirements respecting the role, responsibilities, and duties of supervisors and ClAs and PAs are largely derived from current, standardized contracts of supervisor and advice and guidance on CPSM's website.

As contextual information, the Practice Direction appends guidance for billing when a ClA or PA is involved in the delivery of care.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2023, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves the attached draft Practice Direction Practice Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students to be sent out for consultation.

PRACTICE DIRECTION

Practice and Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students

Initial Approval: DATE **Effective Date: DATE**

Practice Directions set out requirements related to specific aspects of the practice of medicine. Practice Directions are used to enhance, explain, or guide registrants with respect to the subject matter relevant to the practice of medicine. Practice Directions provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, Bylaws, and Standards of Practice issued by CPSM. All registrants must comply with Practice Directions, per s. 86 of *The Regulated Health Professions Act*.

This Practice Direction is made under the authority of s. 85 of the RHPA and represents requirements of CPSM registrants in so far as appropriate.

This Practice Direction sets out requirements that must be followed in practice by Clinical Assistants (ClAs), Physician Assistants (PAs), Physician Assistant Students (PA Students), as well as all supervising physicians. It also includes requirements for obtaining a certificate of practice and compliance with Part 8 of the *CPSM General Regulation.* Registration requirements and policies for ClAs, PAs, and PA Students may be found in the 'Council Policy – Registration of Clinical and Physician Assistants and PA Students'.

Please see attached Contextual Information for Clinical and Physician Assistant billing considerations.

Contents:

1. **Certificates of practice: 2**
2. **General requirements for practice descriptions and contracts of supervision: 2**
3. **Supervision of ClAs and PAs: 5**
4. **Title restrictions: 15**
5. **Performance of reserved acts and delegation of reserved acts: 16**
6. **Collaborative care: 18**
7. **Continuing professional development 18**

1. Certificates of practice:

1.1. ClAs, PAs, and PA Students require a valid certificate of practice issued by CPSM to engage in practice.[1, 2] Certificates of practices are issued in accordance with Part 4 of the *CPSM General Regulation*.[3] Pursuant to section 4.5 of the *CPSM General Regulation*, ClAs and PAs must have an approved practice description and contract of supervision before they may be issued a certificate of practice:[4]

> *4.5(1) An applicant for a certificate of practice who is or will be registered as a physician assistant (full), (restricted purpose) or (academic — s. 181 faculty) or clinical assistant (full) must also submit a practice description and contract of supervision to the registrar for approval.*
>
> *4.5(2) For the purpose of clause 41(1)(f) of the* [RHPA]*, a certificate of practice may be issued only if the registrar approves the practice description and contract of supervision.*

2. General requirements for practice descriptions and contracts of supervision:

2.1. Part 8 of the *CPSM General Regulation* establishes the requirements for practice descriptions and contracts of supervision for ClAs and PAs. Sections 8.1 and 8.3 state:

> *8.1 A physician assistant or clinical assistant may practise only under a contract of supervision with a regulated member and a practice description approved by the registrar. …*
>
> *…*
>
> *8.3(1) A physician assistant or clinical assistant may engage in his or her professional practice only if he or she has entered into a contract of supervision approved by the registrar.*
>
> *8.3(2) A physician assistant or clinical assistant may engage in his or her professional practice only in accordance with a contract of supervision, and a practice description, approved by the registrar.*

[1] See sections 4.1 and 4.2 of the *CPSM General Regulation*.
[2] Subsections 4.3(1)(d), (e) and (f) of the *CPSM General Regulation* include that certificates of practice may be issued to ClAs, PAs, and PA Students. This includes PAs in the restricted purpose and academic classes as well as visiting PA Students. Note that certificates of practice are not issued to registrants in a non-practicing class.
[3] Common requirements and non-exemptible requirements for all regulated registrants are found at section 4.4 of the *CPSM General Regulation*.
[4] This requirement does not apply to PA Students.

8.3(3) A physician assistant or clinical assistant may be supervised by a regulated member who has signed the assistant's contract of supervision and meets the requirement in section 8.7.

2.2. Practice descriptions:

2.2.1. Sections 8.4 and 8.5 of the *CPSM General Regulation* describe general requirements for practice descriptions:

8.4 A practice description must
(a) be in writing;
(b) describe the duties and the services that the physician assistant or clinical assistant will provide; and
(c) be approved by the registrar.

8.5 Before expanding the scope of his or her professional practice, the physician assistant or clinical assistant must first obtain the registrar's approval of a new practice description.

2.3. Contracts of supervision:

2.3.1. Section 8.6 of the *CPSM General Regulation* describes general requirements for contracts of supervision, including that a Primary Supervisor must be designated:

8.6(1) A contract of supervision must
(a) be in the approved form;
(b) designate by name the regulated member who will supervise the applicant as the primary supervisor and indicate the primary supervisor's role and responsibilities;
(c) designate by name one or more regulated members who will supervise the applicant as an alternate supervisor and indicate
(i) the period during which, or the circumstances under which, the alternate will assume the duties and responsibilities of the primary supervisor, and
(ii) any substantive alteration in the physician assistant's or clinical assistant's duties or responsibilities while supervised by the alternate supervisor;
(d) include a term of the contract stating that each regulated member who signs the contract agrees to supervise the physician assistant or clinical assistant;

(e) set out the terms and conditions for performing the duties described in the practice description;
(f) be signed by
(i) the applicant for registration as a physician assistant or clinical assistant,
(ii) the primary supervisor,
(iii) each designated alternate supervisor, and
(iv) in the case of a physician assistant or clinical assistant practising in a departmental or program setting, each additional regulated member who agrees to supervise the applicant; and
(g) be approved by the registrar.

8.6(2) With prior approval of the registrar, a contract of supervision for a clinical assistant need not meet the requirement in clause (1)(c) if the contract states that the assistant may work only when the supervisor is also working.

2.4. Section 8.14 of the *CPSM General Regulation* places limits on the number of contracts of supervision a regulated registrant may enter as the Primary Supervisor:

8.14(1) At any one time, a regulated member may not be the sole primary supervisor for more than three physician assistants and clinical assistants in total.

8.14(2) As an exception to subsection (1), the registrar may permit a member to be the supervisor for more than three physician assistants and clinical assistants. The permission must be granted before the contracts of supervision are entered into.

2.5. Pursuant to section 8.15 of the *CPSM General Regulation*, ClAs and PAs may enter multiple contracts of supervision:

8.15(1) A physician assistant or clinical assistant may enter into a contract of supervision with two or more regulated members who are not associated in a group practice or department or program setting if each of them requires the services of the assistant on a part-time basis.

8.15(2) Each regulated member under subsection (1) is a primary supervisor and must enter into a contract of supervision with the physician assistant or clinical assistant.

2.6. Any addition of an Alternate Supervisor or Additional Supervisor to a contact of supervision must be approved by the Registrar. This can be done by the execution of a new contract or by way of an addendum in the approved form to the original contract of supervision.

3. Supervision of ClAs and PAs:

3.1. Interpretation:

3.1.1. Three categories of supervisors are established under Part 8 of the *CPSM General Regulation,* Primary Supervisors, Alternate Supervisors, and Additional Supervisors. In summary:

3.1.1.1. **Primary Supervisor**'s role and responsibilities:

i. The **Primary Supervisor** has ultimate and overarching responsibility for directing and reviewing the ClA's or PA's professional practice under an approved practice description and contract of supervision.

ii. The Primary Supervisor's role and responsibilities can be transferred to an **Alternate Supervisor** designated under the contract of supervision at times when the Primary Supervisor is unavailable or unable to act in this regard.

3.1.1.2. Immediate supervision:

i. The **Primary Supervisor** may assign, direct, and supervise the duties and services performed by the ClA or PA while actively engaged in their practice. This is referred to as '**immediate supervision**'. When acting, the **Alternate Supervisor** may also perform these general supervisory duties.

ii. **Additional Supervisors** may be appointed under a contract of supervision in departmental or program settings to fulfill certain supervisory duties, particularly relating to the immediate supervision of the ClA or PA in delivering patient care.[5]

iii. While they may assign, direct, and supervise the duties and services performed by the ClA or PA, **Additional Supervisors** cannot assume the Primary Supervisor's role and responsibilities.

3.1.1.3. Primary Supervisors, Alternate Supervisors, and Additional Supervisors must comply with the general duties for all supervisors when acting in these capacities. The role and responsibilities of the Primary Supervisor as well as the general duties for all supervisors of ClAs and PAs are further explained below.

[5] For clarity, Additional Supervisors are intended to extend the supervisory capabilities of the Primary Supervisor or Alternate Supervisor. The do not assume ultimate responsibility for directing the work of the ClA or PA or for providing regular reviews.

3.1.2. For the purposes of this Practice Direction, the supervisor immediately responsible for supervising the ClA or PA while actively engaged in their practice is referred to as the '**responsible supervising physician'**. The responsible supervising physician must remain readily available for consultation when the ClA or PA is engaged in practice under their supervision.

3.1.3. The clinical activities and reserved acts that may be **assigned** to a ClA or PA are set out in their approved practice description.

3.2. Requirements to be a supervisor:

3.2.1. Section 8.7 states:

> *8.7 A regulated member who meets the approved criteria may be a supervisor for a physician assistant or clinical assistant if the member has signed a contract of supervision approved by the registrar.*

3.2.2. Approved criteria for supervisors include that they must:[6]

3.2.2.1. be a fully or provisionally registered physician who is experienced in the system,[7]

3.2.2.2. recognize the importance of their need to demonstrate effective communication and interpersonal skills and knowledge and understanding of cultural differences and values and beliefs that affect performance in a Canadian practice environment, and

3.2.2.3. be approved by the Registrar, who may consider:

i. the proposed supervisor's scope of practice,
ii. professional conduct history, and
iii. potential and actual conflicts of interest

in determining whether they should be approved as a supervisor.

3.2.3. Section 8.18 relates to a supervisor acting through a health profession corporation:

> *8.18 To avoid doubt, subsections 64(1) to (3) of the Act apply to a supervisor in respect of his or her duties and responsibilities under this Part eve n if the supervisor is practising through a health profession corporation.*

[6] In accordance with section 8.7, the Registrar still has discretion to refuse to add a supervisor even when these criteria are met.

[7] The candidate should have a minimum of two (2) years of independent practice, particularly if there fulfilling the role and responsibilities of the Primary Supervisor.

3.3. Supervision in departmental or program practice setting:

3.3.1. Section 8.8 of the *CPSM General Regulation* establishes supervision criteria that must be met before a ClA or PA is permitted to work in an institutional departmental or program setting:

> *8.8 A physician assistant or clinical assistant may provide services within a department or program setting if each of the following requirements is met:*
>
> *(a) one regulated member who works in the setting*
>
> *(i) signs the contract of supervision designating the member as the primary supervisor, and*
>
> *(ii) agrees to be responsible for the physician assistant or clinical assistant even when the assistant is acting under the immediate supervision of any other regulated member in the setting who has signed the contract of supervision;*
>
> *(b) at least one of the regulated members who works in the setting signs the contract of supervision and agrees to act as an alternate supervisor;*
>
> *(c) every regulated member of the department or program who agrees to supervise the physician assistant or clinical assistant signs the contract of supervision.*

3.4. Primary Supervisor's role and responsibilities:

3.4.1. Section 8.9 of the *CPSM Geneal Regulation* states, *"A primary supervisor is responsible for giving direction and providing regular reviews concerning the performance of the physician assistant or clinical assistant while he or she engages in professional practice."*

3.4.2. The Primary supervisor has ultimate responsibility for the ClA or PA's practice under an approved practice description and contract of supervision. This includes supervising the ClA or PA in accordance with the terms and conditions of the contract of supervision and practice description, as well as all regulations, Standards of Practice, Practice Directions, and the Code of Ethics.

3.4.3. Except where arrangements are in place for supervision by an Alternate Supervisor[8], the Primary Supervisor shall:

3.4.3.1. direct and review the work, records, and practice of the ClA or PA on a continuous basis to ensure appropriate and safe care is provided to each patient cared for by the ClA or PA; and

[8] See section 8.13 of the *CPSM General Regulation*.

3.4.3.2. always be reasonably available to fulfil their supervisory role when the ClA or PA is practicing, even when the ClA or PA is practicing under the immediate supervision of an Additional Supervisor in a departmental or program setting.

3.4.4. The Primary Supervisor shall contact each Alternate Supervisor named in the contract of supervision to review performance and workload issues in accordance with the evaluation provisions set out in the practice description.

3.4.4.1. This responsibility cannot be assigned or delegated.

3.4.5. In accordance with subsection 8.12 of the *CPSM General Regulation*, the Primary Supervisor must send periodic reports to CPSM that are satisfactory to the Registrar regarding the performance of the ClA or PA in accordance with the evaluation provisions set out in the practice description.[9]

3.4.5.1. This responsibility cannot be assigned or delegated.

3.5. General duties of all supervisors of ClAs and PAs:

3.5.1. Section 8.10 of the *CPSM General Regulation* outlines requirements for on-site supervision by Primary Supervisors, Alternate Supervisors, and/or Additional Supervisors:[10]

> *8.10(1) For a physician assistant, a supervisor must*
> *(a) provide personal on-site supervision for at least the number of hours each month as specified in the contract of supervision;*
> *(b) subject to subsection (2), be available to supervise the physician assistant for at least the number of hours each week as specified in the contract of supervision; and*
> *(c) comply with any requirement set out in the practice description concerning the supervision of physician assistants.*

[9] CPSM reporting obligations are integrated into the Practice Description under the heading 'Evaluation and Assessment of Performance'. For the vast majority of ClAs and PAs, the Primary Supervisor will be required to send periodic reports to the Registrar that are satisfactory to the Registrar regarding the ClA or PA's performance. Absent exceptional circumstances, for example evidence that the ClA or PA has worked with the Primary Supervisor within the previous few months under a similar Practice Description, reporting will occur on the following schedule: once per month for the first three months, every three months for the following 9 months, and every 12 months thereafter.

[10] The usual requirement will be that the Primary Supervisor, an Alternate Supervisor, an Additional Supervisor, or any combination of the foregoing must provide on-site, personal supervision for a cumulative total of at least 8 hours per month, or the total time worked by the ClA or PA if it is less than 8 hours.

8.10(2) The supervisor is not required to be physically present for the weekly supervision if the physician assistant is engaged in his or her professional practice in a location separate from the supervisor's regular practice location.

8.10(3) For a clinical assistant, a supervisor must

(a) provide personal on-site supervision in accordance with the contract of supervision; and

(b) comply with any requirement set out in the practice description concerning the supervision of clinical assistants

3.5.2. In supervising ClAs and PAs, Primary Supervisors, Alternate Supervisors, and/or Additional Supervisors must ensure that the ClA or PA does not practice beyond the safe limits of their skills, knowledge, and judgement, or their authorized scope of practice. Supervisors are expected to be aware of the ClA's or PA's Level of Competence, as described in their practice description, and related limits arising therefrom. Section 8.11 of the *CPSM General Regulation* states:

8.11(1) A supervisor must not permit a physician assistant or clinical assistant to engage in professional practice beyond the scope of the supervisor's professional practice.[11]

8.11(2) The supervisor must not permit or require a physician assistant or clinical assistant to engage in professional practice, including the performance of a reserved act, if the supervisor determines that the physician assistant or clinical assistant is not competent to do so.

8.11(3) The supervisor must not permit a physician assistant or clinical assistant to independently assume some or all of the supervisor's duties or responsibilities.

3.6. <u>The role and responsibilities of ClA's and PA's:</u>

3.6.1. ClAs and PAs are expected to faithfully, and to the best of their knowledge, skill, and judgment, assist the Primary Supervisor in their professional practice in accordance with their approved practice description and the terms and conditions of the contract of supervision.

[11] In other words, the ClA or PA is limited by the scope of practice of the responsible supervising physician.

3.6.2. ClAs and PAs shall comply with all proper directions of the Primary Supervisor and perform only those duties and responsibilities that are assigned by the Primary Supervisor or an Alternate Supervisor (when acting) who has signed the contract of supervision and is acting in accordance with the contract of supervision.

3.6.3. ClAs and PAs shall cooperate with performance evaluations in accordance with their practice description.

3.6.4. In engaging in their professional practice pursuant to the contract of supervision, the ClA or PA shall:

3.6.4.1. Solely practice under the supervision of the Primary Supervisor, or an Alternate Supervisor or Additional Supervisor designated in the contract of supervision.

3.6.4.2. Limit their practice solely to what is described in the practice description, including,

i. practicing only at practice settings named in the practice description, and
ii. refraining from the performance of any reserved act that is not listed in the practice description.

3.6.4.3. Never practice beyond the professional scope of the responsible supervising physician's professional scope of practice, including by not performing any reserved act which the responsible supervising physician is not competent to perform.

3.6.4.4. Comply with all rules and regulations of CPSM governing ClAs and PAs, including the *CPSM General Regulation*, the Standards of Practice of Medicine, and the Code of Ethics.

3.6.4.5. Refrain from engaging in professional practice pursuant to a contract of supervision when the Primary Supervisor is unavailable or unable to fully fulfil their supervisory role - unless an Alternate Supervisor has assumed Primary Supervisor's role and responsibilities under the contract of supervision.

3.6.5. Section 8.17 of the *CPSM General Regulation* provides:

> *8.17(1) A physician assistant must clearly identify himself or herself as such when engaging in professional practice.*
>
> *8.17(2) A clinical assistant must clearly identify himself or herself as such when engaging in professional practice.*

3.6.6. An overriding principle in terms of documentation and communication is that everyone in the circle of care or multidisciplinary environment must understand the ClA or PA's class of registration. This is because they are not in independent

practice and must be supervised by a responsible supervising physician. This circumstance must also be understood in the context of peer review, including by a health professional regulatory authority. Information about the ClA or PAs class of registration must be reasonably reflected in the patient record, prescriptions, orders, requisitions, etc. Content in these records must also accord with institutional documentation requirements and CPSM expectations, including requirements established under the *CPSM General Regulation*.

3.7. Alternate Supervisor's role and responsibilities:

3.7.1. The Primary Supervisor is expected to designate an Alternate Supervisor in accordance with section 8.6 of the *CPSM General Regulation* to assume their role and responsibilities during any period when the Primary Supervisor is unavailable or unable to fully fulfil the role of Primary Supervisor and the ClA or PA is practicing.[12] The role of the designated Alternate Supervisor is described at section 8.13 of the *CPSM General Regulation*:

> *8.13(1) The role of a designated alternate supervisor is to assume some or all of the duties and responsibilities of the primary supervisor under the contract when he or she is absent or otherwise unable to act.*
>
> *8.13(2) If an additional or substitute alternate supervisor in a department or program is proposed,*
>
> *(a) the designation of that supervisor must be confirmed in writing by the additional or substitute alternate supervisor and by the physician assistant or clinical assistant by either adding the additional designation to the contract of supervision or entering into a new contract of supervision; and*
>
> *(b) the amendment or the new contract approved by the registrar.*
>
> *8.13(3) If the primary supervisor is absent or unable to act for any reason, he or she must take reasonable steps to ensure that the designated alternate supervisor supervises the physician assistant or clinical assistant.*

3.7.2. Only those individuals who have signed the contract of supervision as an Alternate Supervisor may act as an Alternate Supervisor for the ClA or PA.

[12] The exception is that responsibility for evaluation of performance and related CPSM reporting obligations cannot be assigned or delegated by the Primary Supervisor.

3.7.3. The role and responsibilities of the Primary Supervisor may not be held concurrently by Primary Supervisor and an Alternate Supervisor. Only one Alternate Supervisor may assume the role and responsibilities of Primary Supervisor at any time.

3.7.4. Where the Primary Supervisor is unavailable or unable to fully fulfil their supervisory role and no alternate supervising physician is available and designated, the ClA or PA must cease practicing until either:

3.7.4.1. the Primary Supervisor can resume their supervisory role; or

3.7.4.2. an alternate supervising physician is designated in accordance with subsection 8.6 of the *CPSM General Regulation*.

3.7.5. To be clear, where an Alternate Supervisor assumes the Primary Supervisor's role and responsibilities, they and the ClA or PA are bound by the same terms and conditions as would apply as between the Primary Supervisor and the ClA or PA, including that the Alternate Supervisor will:

3.7.5.1. direct and review the work, records, and practice of the ClA or PA on a continuous basis to ensure that appropriate and safe care is provided to each patient cared for by the ClA or PA,

3.7.5.2. always be reasonably available to fulfil their supervisory role when the ClA or PA is practicing.

3.7.6. Where an alternate supervisor identifies any concerns about the competence or fitness to practice of the ClA or PA, they must bring them to the attention of Primary Supervisor.

3.7.7. When not acting in their capacity as an Alternate Supervisor, any person who signs the contract of supervision as an Alternate Supervisor will also have authority to act as an Additional Supervisor in a departmental or program setting.

3.8. <u>Additional Supervisor's role and responsibilities (departmental or program setting):</u>

3.8.1. In accordance with subsection 8.8 of the *CPSM General Regulation*, the ClA or PA may provide services under the contract of supervision within an institutional department or program setting if each of the following requirements are met:

3.8.1.1. the Primary Supervisor works in the setting,

3.8.1.2. at least one of the regulated members who works in the setting has signed the contract of supervision as an Alternate Supervisor, and

3.8.1.3. every regulated registrant in the department or program who agrees to supervise the ClA or PA has signed the contract of supervision as an Additional Supervisor.

3.8.2. When working in an institutional departmental or program setting, the ClA or PA may be assigned certain medical duties or undertake medical responsibilities

under the supervision of a regulated registrant who works in the setting and is named in the contract of supervision as an Additional Supervisor. When this occurs, the Additional Supervisor will supervise the ClA or PA in relation to the medical services they perform. In this context, the Additional Supervisor will be considered a responsible supervising physician in respect to the work they supervise. However, the Primary Supervisor, or Alternate Supervisor when designated, retains ultimate responsibility for the ClA's or PA's practice. Section 8.8. of the *CPSM General Regulation* provides that:

> *8.8 A physician assistant or clinical assistant may provide services within a department or program setting if each of the following requirements is met:*
>
> *(a) one regulated member who works in the setting*
>
> *(i) signs the contract of supervision designating the member as the* ***primary supervisor****, and*
>
> *(ii)* ***agrees to be responsible for the physician assistant or clinical assistant even when the assistant is acting under the immediate supervision of any other regulated member*** *in the setting who has signed the contract of supervision".*
>
> *(emphasis added)*

3.8.3. Ultimately responsibility, as referred to under section 8.8. of the *CPSM General Regulation,* concerns direction and oversight of the ClA or PA's practice and performance. Part of this responsibility requires that the Primary Supervisor, or a designated Alternate Supervisor reasonably satisfy themselves that the ClA or PA is appropriately taking direction and is being adequately observed in their professional practice in accordance with the approved practice description and contract of supervision.

3.8.4. In accordance with the general duties of all supervisors, the ClA or PA may perform medical functions that are within the scope of their practice description and the scope of the Additional Supervisor's practice when acting under the supervision of the Additional Supervisor.

3.8.5. Where an Additional Supervisor identifies any concerns about the competence or fitness to practice of a ClA or PA, they must bring them to the attention of Primary Supervisor.

3.9. <u>Information sharing:</u>

3.9.1. Contracts of supervision are to include appropriate information and confidentiality provisions. This includes the following:

3.9.1.1. All supervisors named in a contract of supervision are expected to speak to each other freely and to exchange any information relevant to the ClA's or PA's work and in particular the Clinical Assistant's workload and ability to manage that workload. Any supervisor named in a contract of supervision would also be expected to communicate such information to the Medical Director or Chief Medical Officer of the Regional Health Authority where they work, if applicable.

3.9.1.2. ClAs and PA are expected to notify Primary Supervisors of any investigation or proceeding related to their conduct, competence, or fitness to practice that is initiated by CPSM or any other body with statutory authority to regulate a health profession in Manitoba or Canada or elsewhere. Notice must be provided within ten (10) days of the initiation of the investigation or proceeding.

3.9.1.3. Primary Supervisors and Alternate supervisors are expected to promptly notify CPSM if they are permanently unable to fulfil their supervisory role under a contract of supervision.

3.9.1.4. PAs and ClAs are expected to promptly notify CPSM if they cease to practice at a listed practice location.

3.10. Termination of contract of supervision:

3.10.1. Contracts of supervision may be terminated by either the Primary Supervisor or the ClA or PA by giving thirty (30) days' notice of the fact in writing to the other and to CPSM. Contracts of supervision can be otherwise cancelled in accordance with subsection 8.16(1) of the *CPSM General Regulation*. Upon termination of the contract of supervision, the Primary Supervisor and ClA or PA must advise CPSM of the circumstances which led to termination.

3.10.2. Those named in a contract of supervision as an Alternate Supervisor, or an Additional Supervisor may have their name removed by giving thirty (30) days' notice of the fact in writing to both the Primary Supervisor and to CPSM.

3.10.3. Under subsection 8.16(1) of the *CPSM General Regulation*, a contract of supervision is automatically cancelled if the Primary Supervisor is unable to fulfil their role and responsibilities under the contract and none of the designated Alternate Supervisors can fulfil their responsibilities under the contract.

3.10.4. The Registrar further has discretion to cancel a contract of supervision if one or more of its terms are breached.

3.10.5. In the event a ClA or PA can no longer work at the practice location(s) listed in a contract of supervision, for example due to loss of employment, the Primary Supervisor or Alternate Supervisor would consequently no longer be able to fulfil their supervisory role at the listed practice location(s) and therefore the contract would be cancelled. Thus, employment issues can have implications respecting the ability of the parties to fulfil the terms of a contract of supervision.

3.11. Breach of contract of supervision:

3.11.1. Breach of a contract of Supervision may result in the following:

3.11.1.1. the imposition of conditions on the ClA's or PA's certificate of practice by the Registrar,

3.11.1.2. removal of an Alternate Supervisor or Additional Supervisor from the contract of supervision, or

3.11.1.3. cancellation of the contract of supervision.

4. Title restrictions:

4.1. Part 6 of the *CPSM General Regulation* establishes title restrictions for registrants.

4.1.1. For PAs, section 6.8. of the *CPSM General Regulation* provides:

> *6.8(1) A member who is registered in any physician assistant membership class (including the physician assistant (retired) class) is permitted to use the title "physician assistant" and the abbreviation "PA" or any variation of them or equivalent in another language.*
>
> *6.8(2) No person — other than a member described in subsection (1) — shall use the title or abbreviation described in that subsection or any variation of them or the equivalent in another language alone or in combination with other words in a manner that states or implies that the person is a physician assistant.*

4.1.2. For ClAs, section 6.9. of the *CPSM General Regulation* provides:

> *6.9(1) A member who is registered in any clinical assistant membership class (including the clinical assistant (retired) class) is permitted to use the title "clinical assistant" and the abbreviation "Cl. A." or any variation of them or equivalent in another language.*
>
> *6.9(2) No person — other than a member who is registered in a clinical assistant membership class — shall use any titles or abbreviations listed in subsection (1) or any variation of them or the equivalent in*

another language alone or in combination with other words in a manner that states or implies that the person is a clinical assistant.

5. Performance of reserved acts and delegation of reserved acts:

5.1. Reserved acts are listed at section 4 of the RHPA. Subsection 5.20(1) of the *CPSM General Regulation* restricts ClAs and PAs to performing only those reserved acts they are authorized to perform by their practice supervisor where the practice supervisor is legally permitted and competent to perform the reserved act.[13]

5.2. Delegation:

5.2.1. Delegation by a regulated health professional allows the recipient of the delegation to perform a reserved act they would not otherwise be permitted to perform under the RHPA. Delegation is a regulated process under the RHPA and requires assessment and monitoring on the part of the delegator.[14] Pursuant to ss. 5.16(1) of the *CPSM General Regulation*, ClAs and PAs are not permitted to delegate reserved acts.

5.2.2. A PA may provide direct, onsite supervision for a PA student in accordance with section 5.19 of the *CPSM General Regulation* if they themselves are legally permitted and competent to perform the reserved act. This is not equivalent to delegation.

5.3. Prescribing Drugs or Vaccines

5.3.1. When involved in prescribing, ClAs and PAs must comply with all relevant CPSM Standards of Practice and Practice descriptions as well as ss. 5.8(3) and ss. 5.12 of the *CPSM General Regulation*.

5.3.2. Section 5.12 of the *CPSM General Regulation* provides for specific restrictions on prescribing a drug of vaccine by a ClA or PA:

5.12(1) A physician assistant or clinical assistant may prescribe a drug or vaccine only if

(a) his or her supervisor has determined that the assistant

[13] See s. 4, 5 and 6 of the RHPA and s. 6 of the *CPSM Practice of Medicine Regulation* which govern the performance of reserved acts and the delegation of the performance of reserved acts.

[14] Delegation differs from collaboration or authorization. For example, a ClA or PA can write an order to another health care professional requesting that person perform a reserved act. However, for the recipient of the order to perform that act, they would have to be entitled to do so in their own right under the RHPA. In this scenario, the recipient is being asked to do something they can do; it is not a delegation.

is qualified to prescribe that drug or vaccine; and
(b) the prescribing is done in accordance with the assistant's practice description.

5.12(2) A prescription issued by a physician assistant or a clinical assistant must include
(a) his or her name and the designation "PA" or "Cl. A", as the case may be;
(b) the name of his or her supervising physician;[15]
(c) his or her telephone or paging number; and
(d) one or more of the following:
(i) the patient's clinical indication,
(ii) the patient's diagnosis,
(iii) the treatment goal for the patient.

5.3.3. Prescribing M3P schedule drugs adds additional requirements. ClAs and PAs can only prescribe M3P drugs when they are both expressly authorized to do so by:
5.3.3.1. the Registrar as part of their Practice Description, and
5.3.3.2. in accordance with section 5.12 of the *CPSM General Regulation*.

5.3.4. M3P prescription contents are strictly regulated, including in terms of required contents. Section 5.8 of the *CPSM General Regulation provides*:

5.8(1) A member who is authorized under the Controlled Drugs and Substances Act (Canada) to prescribe the drugs listed on the M3P schedule must
(a) use an approved form to issue the prescription; and
(b) prescribe only one drug on each form.

5.8(2) The prescription must
(a) include the patient's name, address, date of birth and personal health information number on the approved form;
(b) clearly and accurately set out the name and dosage form of the drug, the quantity to be dispensed, and the directions for use, including the intervals at which the drug is to be taken; and
(c) be dated and signed by the member.

[15] Prescriptions prepared by ClAs or PAs must include the name of the responsible supervising physician respecting the care provided to the specific patient. It is noted that in some institutional scenarios, the 'responsible supervising physician' may not be the physician who is considered the 'most responsible physician' for that patient's care (e.g., the admitting physician/MRP).

5.8(3) Subject to the regulations under the Controlled Drugs and Substances Act (Canada) and section 5.12 of this regulation, physician assistants and clinical assistants are not authorized to prescribe drugs listed on the M3P schedule.

5.3.5. The Registrar will only consider authorizing M3P prescribing by ClAs and PAs in departmental or program practice settings that are within an institutional practice setting.

6. Collaborative care:

6.1. Depending on the wording of the practice description, participating in team-based or collaborative care is generally acceptable and encouraged. The work in this sense would be considered collaborative rather than a supervisory relationship. It remains the case that the ClA or PA would be required to be under supervision by a responsible supervising physician in accordance with the terms of their contract of supervision while practicing.[16]

7. Continuing professional development

7.1. ClAs and PAs must remain current in their area of practice, including through compliance with:

7.1.1. the performance and evaluation provisions of their practice description, and

7.1.2. Part 10 of the *CPSM General Regulation* and the Continuing Professional Development Practice Direction.

[16] For example, a PA working in a health care facility under the remote supervision of their Primary Supervisor can work with other physicians or allied health care providers in that setting in a collaborative way. Physicians who are not named as supervisors in the contract of supervision are not able to act as their "responsible supervising physician".

Contextual Information and Resources

Practice and Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students

The Contextual Information and Resources are provided to support registrants in implementing this Practice Direction. The Contextual Information and Resources do not define this Practice Direction, 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.

Clinical & Physician Assistant Billing Considerations

The Health Services Insurance Act (HSIA) and the Manitoba Physician's Manual set out clear expectations surrounding claims for insured medical services. CPSM's understanding about these expectations when Clinical Assistants (ClAs) or Physician Assistants (PAs) are involved in care follows. Registrants are advised to seek any further clarification or guidance they require about the proper use and interpretation of the Physician's Manual directly from Manitoba Health or Doctors Manitoba.

1. Manitoba Health provides coverage for insured medical and hospital services to Manitoba residents in accordance with the HSIA and its regulations. Coverage for medical services insured under the provincial health services insurance plan is provided on the basis that the services are provided by a medical practitioner (physician). *The Medical Services Insurance Regulation* defines insured medical services as follows:

   > *… all personal health care services provided to an insured person by a medical practitioner that are medically required and are not excluded under the Excluded Services Regulation made under the [HSIA].*

2. Payments for insured medical services are made in accordance with the rules of application and subject to the terms and conditions set out in the Physician's Manual. CPSM understands that Manitoba Health expects claimants (medical practitioners/physicians):
   1. to be aware of and comply with the rules of application and terms and conditions set out in the Physician's Manual, which are published on Manitoba Health's website,
   2. to conduct themselves honourably and in good faith when deciding whether criteria are met for the tariffs they claim, and
   3. are making appropriate clinical decisions relating to the medical services underlying each of the tariffs they claim.

   Physicians are not to cause or permit bills to be submitted to Manitoba Health if applicable terms and conditions are not met.

3. Claimants are expected to be able to provide information for the assessment of claims under the HSIA. CPSM understands that this is interpreted by Manitoba Health to require sufficient information in the patient record based on the terms and conditions of the tariff as described in the Physician's Manual. In addition, section 2.12 of the Documentation in Patient Records Standard of Practice provides:

   > *Registrants must take care to ensure that any documentation made in the patient record used for the purpose of remuneration faithfully represents the care provided. …*

4. Claimants cannot submit claims under the HSIA relating to medical services with which they had no personal involvement. Manitoba Health has stated that it will pay for services only if the services are actually provided by a physician. It is noted that page CLMST-1, under Claims Submission and Payment Procedures, under Part I of Billing and Provision of Services in the Physician's Manual, states that, "*Insured service claims may only be made for services rendered personally by the physician*." Furthermore, various tariffs have specific "*patient/physician contact*" time requirements (e.g., 8734, 8529).

5. Clinical Assistants (ClAs) and Physician Assistants (PAs) are not medical practitioners (physicians), and therefore they do not provide insured medical services. Per section 17 of *The Interpretation Act*:

   > … "*physician" or "duly qualified medical practitioner" or a similar expression indicating legal recognition of an individual as a member of the medical profession means a physician who holds a valid certificate of practice issued by the College of Physicians and Surgeons of Manitoba under The Regulated Health Professions Act*.

6. Medical practitioners (physicians) may use ClAs or PAs to assist with care of patients, but they remain responsible in fulfilling the expectations and boundaries of the Physician Manual in making claims for insured services. Where ClAs or PAs participate in care the billing medical practitioner would remain responsible for the care to the individual patient and would be expected to have seen the patient and assessed their needs in accordance with the tariff billed. In certain appropriate circumstances, this may be accomplished through attending to a patient in order to review and validate the work of the ClAs or PAs.

While registrants should confirm the following with Manitoba Health or Doctors Manitoba, it is CPSM's understanding that a responsible supervising physician/medical practitioner would not be entitled to submit claims under the HSIA in the following example scenarios:

1. A ClAs or PAs sees a patient (e.g., history and physical examination) with no direct involvement of the responsible supervising physician. The visit is in the nature of a

Regional Basic Visit (8509). The responsible supervising physician does not personally see the patient, virtually or in-person. However, the supervising physician does subsequently review the patient record to satisfy themselves that good care was provided. As services were not provided personally by the physician, they cannot claim the tariff.

2. A ClAs or PAs authorizes the refill of a patient prescription. The responsible supervising physician is not directly involved with the refill. The responsible supervising physician cannot properly submit a claim using the 8005 tariff. It is noted that the commentary includes, "*No claim may be made for communications in which only a physician proxy, e.g., nurse or clerk, participates*". This remains the case even if the responsible supervising physician subsequently reviews the refill that was authorized to ensure it was appropriate (i.e., after the communication occurs).

COUNCIL MEETING
DECEMBER 13, 2023
CONSENT AGENDA ITEM

SUBJECT: Council Policy - Specialist Register

BACKGROUND:

One avenue for provisional registrants to be added to the Specialist Register is by way of successful completion of a PRA through the Manitoba Faculty. The current wording requires that the applicant submit at least three letters from assessors attesting in writing to the specialty competence of the applicant. The Manitoba Faculty has communicated to CPSM that this appears redundant given a report to CPSM already flows from the PRA process.

Council recently endorsed changes to the *CPSM General Regulation* respecting the full registration of applicants with SEAP affiliate status. As a follow-up, ensuring a mechanism for them to be added to the Specialist Register needs to be addressed.

PROPOSED COUNCIL POLICY:

Attached is a redline version of the amended Practice Direction Registration and Qualifications, and a copy of the proposed 'Council Policy – Specialist Register'. Upon review of the current requirements for the Specialist Register in the Practice Direction Qualifications and Registration, it is recommended that Council simply revise them to allow for all those in the provisional (specialty-limited) class to be added. Members of the public would have little insight into the distinction. The proposed Council Policy also adds those with SEAP affiliate status.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2023, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves the attached Council Policy Specialist Register to be effective immediately.

AND FURTHER MOVED THAT:

> The Practice Direction Registration and Qualifications be amended as presented to be effective immediately, including by deleting section 2.14.

COUNCIL POLICY

Specialist Register

Initial Approval: DATE **Effective Date:** DATE

1. A Specialist Register is established under section 2.7 of the *CPSM General Regulation* and is maintained by the Registrar. The Specialist Register must include the registrant's name and the field or fields of practice[1] in which they are registered.[2] Section 2.9 of the *CPSM General Regulation* establishes the eligibility criteria for registration as specialist:

> *2.9(1) A member in good standing who is a certified specialist of the Royal College is entitled to be registered on the specialist register if the member submits to the registrar the following:*
>
> *(a) a signed application in the approved form;*
>
> *(b) the fees provided for in the bylaws;*
>
> *(c) satisfactory evidence of the member's qualifications as a specialist.*
>
> *2.9(2) In special circumstances, the council may direct the registrar to enter on the specialist register the name of a member in good standing who is not a certified specialist of the Royal College but who submits to the registrar a signed application in the approved form and pays the fees provided for in the by-laws.*

2. In accordance with subsection 2.9(2) of the *CPSM General Regulation*, Council has provided the Registrar with authority to register regulated registrants in the Specialist Register who are not Royal College certified specialists if they meet the following requirements:

   2.1. The applicant must apply for entry on the Specialist Register in the approved form and pay the prescribed fee. They must meet all requirements for full registration other than holding Royal College certification.

   2.2. The applicant must meet one or more of the following eligibility criteria:

      2.2.1. They have successfully completed MPAP, in which case they would be registered in accordance with the outcome of that process.[3]

      2.2.2. They hold affiliate status with the Royal College in a subspecialty and have successfully completed a Royal College subspecialty examination through

[1] See section 2.10 of the CPSM General Regulation.
[2] See section 2.8 of the CPSM General Regulation.
[3] See The Manitoba Practice Assessment Program ("MPAP") Council Policy.

the Royal College — Subspecialist Examination Affiliate Program, in which case they would be registered in accordance with their affiliate status.

2.2.3. They were registered pursuant to section 64 of *The Medical Act* or section 181 of the RHPA in a specialty field of practice.

2.2.4. They are registered in the provisional (speciality-limited) class, in which case they would be registered in accordance with their area of practice.

3. Section 6.6. of the *CPSM General Regulation* provides:

> *6.6(1) A member who is registered on the specialist register is permitted to use the designation "specialist" or any variation or abbreviation of it or equivalent in another language to describe his or her professional practice or to hold himself or herself out as a person who is qualified to practise medicine as a specialist.*
>
> *6.6(2) No person — other than a member described in subsection (1) — shall use the designation "specialist" or any variation or abbreviation of it or equivalent in another language alone or in combination with other words in a manner that states or implies that the person is a member qualified to practise medicine as a specialist.*

4. Section 6.7. of the *CPSM General Regulation* provides:

> *6.7(1) A regulated member who is not registered on the specialist register is permitted to use the phrase "special interest in" or "practice restricted to", or both, when referring to the member's professional practice if*
>
> *(a) the member's field of practice is not one that is listed in clause 2.10(2)(b) as a specialty field of practice; or*
>
> *(b) the member's field of practice is listed in clause 2.10(2)(b) as a specialty field but the member's registration does not indicate that he or she is qualified to practise as a specialist in that specialty field.*
>
> *The phrase must appear immediately before the member's field of practice.*
>
> *6.7(2) As an aid to the reader, the following are examples of such phrases:*
>
> *(a) a member with a special interest in sports medicine;*
>
> *(b) a family practitioner with a special interest in psychiatry;*
>
> *(c) a member with a special interest in and practice restricted to oncology.*

PRACTICE DIRECTION

Qualifications and Registration

Initial Approval: November 22, 2018

Effective Date: January 1, 2019

Reviewed with Changes
June 21, 2019, December 9, 2020
March 23, 2022, September 29, 2022
March 22, 2023, June 28, 2023
September 27, 2023, December 13, 2023

Practice Directions set out requirements related to specific aspects of the practice of medicine. Practice Directions are used to enhance, explain, or guide registrants with respect to the subject matter relevant to the practice of medicine. Practice Directions provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, Bylaws, and Standards of Practice issued by CPSM. All registrants must comply with Practice Directions, per s. 86 of *The Regulated Health Professions Act*.

This Practice Direction is made under the authority of s 85 of the RHPA with specific reference to Parts 3, 4, 7, and 8 of the CPSM General Regulation.

1. REGISTRATION AND CERTIFICATE OF PRACTICE

Types of Certificates of Practice

1.1. Regulated registrants may apply for a certificate of practice in one of the following categories:

1.1.1. full annual certificate of practice;

1.1.2. full monthly certificate of practice, which is available only on a calendar month basis;

1.1.3. limited certificate of practice applicable to the restricted purpose class of registration;

1.1.4. resident annual certificate of practice;

1.1.5. resident reduced term certificate of practice, which is available only for a period of fewer than 8 consecutive months.

1.2. Regulated associate registrants may apply for a certificate of practice in one of the following categories:

1.2.1. resident annual certificate of practice;

1.2.2. resident limited certificate of practice;

1.2.3. external or visiting student certificate of practice;

1.2.4. medical student certificate of practice;

1.2.5. physician assistant annual certificate of practice;

1.2.6. clinical assistant annual certificate of practice;

1.2.7. assessment candidate specialty practice limited;

1.2.8. assessment candidate family practice limited;

1.2.9. assessment candidate re-entry; and

1.2.10. limited certificate of practice applicable to the restricted purpose class of registration.

Resident Qualified for Registration as Regulated Registrant - Full class

1.3. A resident who meets the qualifications for registration in the full practising class and who wishes to practise medicine outside of his or her approved residency program must apply for a full annual certificate of practice or full monthly certificate of practice. Fees collected by CPSM for the resident's annual certificate of practice are applied against the full annual certificate of practice fee.

Renewal of Monthly Certificate of Practice

1.4. A regulated registrant seeking to renew a monthly certificate of practice during a certificate of practice year in which he or she has already met the renewal requirements must pay the fee prescribed and declare to CPSM whether there have been any changes in the information provided by the individual at the time of his or her last renewal declaration, provided that each certificate of practice year all regulated registrants must comply with the annual renewal disclosure requirements.

1.5. On request at the time of an application for monthly certificate of practice, CPSM may issue monthly certificates of practice for consecutive months, but only for calendar months during the same certificate of practice year. When a regulated registrant who held one or more full monthly certificates of practice during a certificate year applies for a full annual certificate of practice in that same certificate year, the fees collected by CPSM for the full monthly certificates of practice are not applied against the full annual certificate of practice fee.

1.6. A registrant who opts for monthly or other reduced term certificates of practice will not be issued any reminder of the requirement for renewal and is solely responsible for ensuring that he or she has a valid certificate of practice at all times when practising medicine in Manitoba by renewing his or her certificate of practice and paying the fee before the expiry date of the monthly or other reduced term certificate of practice.

Application and Renewal of Certificate of Practice

1.7. When applying for, or renewal of, a certificate of practice, in addition to complying with the requirements set out in s. 4.4 and 4.7 of the CPSM General Regulation, the Registrar requires a registrant to provide evidence satisfactory to the Registrar that the registrant has professional liability coverage and will maintain such coverage while holding a certificate of practice in accordance with s 4.12 of the CPSM General Regulation.

2. QUALIFICATIONS

Approved Assessment Requirements

2.1. Clinical assistant assessments approved by Council for the purposes of CPSM General Regulation s. 3.67(a)

The following assessment processes are approved for registration as a clinical assistant:

2.1.1. with no field of practice restriction:

2.1.1.a. Registered Clinical Assistant assessment offered by the Rady Faculty of Health Sciences, Max Rady College of Medicine, University of Manitoba.

2.1.1.b. National Assessment Collaborative OSCE.

2.1.1.c. Satisfactory completion of the MCCQE1 exam.

2.1.2. with practice restricted to a specific field of practice: satisfactory completion of a program accredited by the Royal College of Physicians and Surgeons of Canada in a Canadian University teaching hospital in the applicant's intended field of practice.

2.2. Provisional Registration Assessments approved by Council

The following assessment processes are approved for provisional registration in:

2.2.1. Family Medicine Assessments approved for the purposes of CPSM General Regulation s.3.19 (1)(g)(i):

2.2.1.a. Western Alliance for Assessment of International Physicians.

2.2.1.b. Practice Ready Assessment - Family Practice (PRA-FP), formerly known as the Assessment for Conditional Licensure for Family Medicine ("ACL"), excluding anaesthesia.

2.2.1.c. Family practice including anaesthesia

2.2.1.c.i. PRA-FP; and

2.2.1.c.ii. the anaesthesia assessment annexed hereto as Schedule A.

2.2.1.d. The practice ready assessment for family medicine used by the College of Physicians & Surgeons of Alberta.

2.2.1.e. An assessment conducted elsewhere in Canada certified by the Dean of the Faculty of Medicine as equivalent to the competencies for family medicine/practice ready assessment.

2.2.2. Specialty Practice Assessments approved for the purposes of CPSM General Regulation s. 3.16 (1) (g) (i):

2.2.2.a. Satisfactory completion of a program accredited by the Royal College of Physicians and Surgeons of Canada in a Canadian university teaching hospital.

2.2.2.b. Participation in the Practice Ready Assessment- Specialty Practice ("PRA-SP"), formerly known as the Non-Registered Specialist Assessment Programs, limited to those specialty programs offered by the Rady Faculty of Health Sciences, Max Rady College of Medicine at the University of Manitoba.

2.2.2.c. An assessment conducted elsewhere in Canada certified by the Dean of the Faculty of Medicine as equivalent to the competencies for Royal College certification in that specialty, limited to those specialty fields of practice where a training program in that field is not offered by the Rady Faculty of Health Sciences, Max Rady College of Medicine.

2.2.2.d. Limited to those candidates who have completed fellowship at the Rady Faculty of Health Sciences, Max Rady College of Medicine:

2.2.2.d.i. Certification by the Program Director that in the fellowship the candidate successfully completed an equivalent assessment to specified components of the PRA-SP, and

2.2.2.d.ii. Participation in the remaining components of the PRA-SP not covered by the fellowship, as certified by the Program Director.

2.2.2.e. The Western Alliance for Assessment of International Physicians, limited to general surgery or internal medicine candidates.

2.2.2.f. The Canadian practice ready assessment for specialty practice in psychiatry or internal medicine.

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 made under this clause must be reported to the Executive Committee at the earliest opportunity.

2.3. REPEALED – MARCH 22, 2023 – See Policy – Assessment Candidate (Re-Entry to Practice) Class

Family Practice Registration – Fields of Practice for the purposes of CPSM General Regulation section 2.5(1)(c) and 2.10(2)

2.4. REPEALED – JUNE 28, 2023 – See Practice Direction – Professional Practice and Inactivity

2.5. REPEALED – JUNE 28, 2023 – See Practice Direction – Professional Practice and Inactivity

2.6. REPEALED – JUNE 28, 2023 – See Practice Direction – Professional Practice and Inactivity

Provisional Registration

2.7. REPEALED – SEPTEMBER 27, 2023 – See Policy – Supervision of Provisional Registrants

2.8. REPEALED – SEPTEMBER 27, 2023 – See Policy – Supervision of Provisional Registrants

2.9. Requirements for the use of extension of registration

2.9.1. The Registrar has authority to permit an extension of registration for the classes listed in s. 3.71 of the CPSM General Regulation. In any application, the onus is on the physician to demonstrate that the extension should be granted, and the following conditions must be met:

2.9.1.a. The applicant must be eligible to receive a satisfactory certificate of good standing.

2.9.1.b. The physician must undertake to attend the earliest dates of the examination sittings and to cease registration if the physician is unsuccessful in the examinations.

2.10. Time for Completion of Orientation

2.10.1. A candidate is not eligible for movement from the assessment class to registration in the specialty limited or family practice limited class until orientation for provisional registration in specialty and family practice has been completed.

Temporary Registration Restrictions (Locum) – Approved Requirements for the purposes of CPSM General Regulation section 3.30(e).

2.11. The Registrar must restrict the use of temporary - locum registration to register only those physicians who meet the requirements set out below.

2.12. A locum physician is a physician who will be carrying out the practice of medicine in place of another physician with a valid certificate of practice, for a fixed time period approved by the Registrar. A physician who wishes to practice medicine in Manitoba as a locum physician must establish that he or she:

2.12.1. has satisfactory locum agreement with a regulated registrant; and

2.12.2. meets any other requirements set by Council.

2.13. The Registrar must approve the time interval for the locum and the locum physician may act in place of the other physician only when written CPSM approval is received. The recommended time frame is 12 months. The Registrar has the discretion to extend this time period only in exceptional circumstances.

~~Applications for Registration on Specialists Register under section 2.9(2) of the CPSM General Regulation (non-Royal College specialists)~~

2.14. REPEALED – DECEMBER 13, 2023 – See Policy Specialist Register

~~2.14. The Registrar has the authority to register physicians in the specialist register who do not have a certificate of specialty issued by the Royal College of Physicians and Surgeons of Canada, but who:~~

~~2.14.1. meet all requirements for registration other than holding Royal College certification,~~

~~2.14.2. apply for entry on the specialist register,~~

~~2.14.3. pay the prescribed fee, and~~

~~2.14.4. meet one or more of the following criteria:~~

~~2.14.4.a. holds examiner status in the Royal College of Physicians and Surgeons of Canada examinations.~~

~~2.14.4.b. was registered pursuant to s. 64 of *The Medical Act or s. 181 of The Regulated Health Professions Act* in a specialty field of practice.~~

~~2.14.4.c. possesses current certification from a registrant board of the American Board of Medical Specialties in a specialty field of practice set out in the CPSM General Regulation clause 2.10(2)(b).~~

~~2.14.4.d. has recognized and established specialist skills acceptable to CPSM, with review based on the skills of the applicant. Minimum requirements to meet these criteria are:~~

~~2.14.4.d.i. hold the qualifications to engage independently in the practice of medicine in a specialty field of practice in a jurisdiction outside Canada in which the applicant trained.~~

~~2.14.4.d.ii. have satisfactorily completed post-graduate clinical training in the specialty that took place in one or more facilities that provide health care and are recognized by a national post-graduate training authority, was accredited by a national post-graduate training authority and is approved by the Registrar.~~

~~2.14.4.d.iii. successful completion of an on-going on-site assessment acceptable to CPSM. This assessment must:~~

- ~~be done by the Department or Specialty Division of the Rady Faculty of Health Sciences, Max Rady College of Medicine, University of Manitoba or another Canadian University acceptable to CPSM.~~
- ~~include direct observation of the applicant's knowledge, skills and attitude.~~
- ~~for physicians who practise in interventional specialties, include evaluation and clear documentation of procedures performed by the applicant.~~

~~submit at least three letters from assessors attesting in writing to the specialty competence of the applicant. Where possible, one letter must be from the Department Head or Section Head.~~

~~2.14.4.e. have recognized clinical excellence acceptable to CPSM. Minimum requirements to meet these criteria are:~~

~~2.14.4.e.i. Must have been in practice in Canada in the specialty for a minimum of two years.~~

~~2.14.4.e.ii. must provide at least three letters of support, one of which must be from a peer who has direct knowledge of and who has worked with the applicant and who can attest to the applicant functioning as a specialist. Where possible, one letter of support must come from a supervisor.~~

~~2.14.4.f. Successful completion of the Manitoba Practice Assessment Program.~~

Approved Fields of Specialty Practice for Assessment for the purposes of CPSM General Regulation section 3.38(b)

2.15. For the purposes of the CPSM General Regulation s. 3.38(b), the following are the approved fields of specialty practice eligible for registration for assessment:

- Anesthesia;
- Anatomical Pathology;
- Cardiac Surgery;
- Cardiology;
- Community Medicine;
- Dermatology;
- Diagnostic Radiology;

- Endocrinology;
- General Surgery;
- Gastroenterology;
- Infectious Diseases;
- Internal Medicine;
- Medical Oncology;
- Neonatal Perinatal Medicine;
- Nephrology;
- Neurology;
- Neurosurgery;
- Nuclear Medicine
- Obstetrics and Gynecology;
- Ophthalmology;
- Orthopedic Surgery;
- Otolaryngology;
- Palliative Care;
- Pediatric Hematology/Oncology;
- Pediatric Orthopaedic Surgery;
- Paediatric Surgery;
- Pediatrics;
- Plastic Surgery;
- Psychiatry;
- Radiation Oncology;
- Respirology;
- Rheumatology;
- Thoracic Surgery;
- Urology;
- Vascular Surgery.

Approved Special Designation Registration for the purposes of CPSM General Regulation s.2.10(2)(c)

2.16. Council approves special designation registration of physicians holding one of the following special designations:

2.16.1. A Certificate of Added Competence (CAC) from the College of Family Physicians of Canada in one of the following areas:

- Care of the Elderly
- Palliative Care
- Emergency Medicine
- Family Practice Anesthesia
- Sport and Exercise Medicine
- Enhanced Surgical Skills

2.16.2. From the Royal College of Physicians and Surgeons of Canada:

- A Diploma in Areas of Focused Competence (AFC).
- A Diploma of the Royal College of Physicians and Surgeons of Canada (DRCPSC).

2.16.3. Those physicians previously registered and licensed under *The Medical Act i*n the following areas are grandfathered in and may continue to show as their designated area of practice the applicable area listed below**:**

- Adult Surgical Pathology
- Chemical Pathology
- Eye Physician
- Foot & Ankle Diabetic Foot Care
- Hair Restoration Physician
- Neuro-ophthalmology
- Pediatric and Adult Nephropathology

Approved Speciality Field of Practice for the purposes of - CPSM General Regulation section 2.10(2)(c) 45

2.16a Council approves the following specialty field of practice:

- Molecular Genetic Pathology

Approved English Language Fluency Criteria for the purposes of - CPSM General Regulation section 3.7(d)

2.17. CPSM adopts the Federation of Medical Regulatory Authorities of Canada's national standard for English Language testing, as amended from time to time.

Approved Resident Prescribing Educational Program for the purposes of CPSM General Regulation section 5.4(3)(b)(ii)

2.18. The approved pharmacology course for resident prescribing is the "Prescription Writing Course" offered through the Max Rady College of Medicine PGME core curriculum on limited resident prescribing.

~~Approved Physician Assistant Training Program for the purposes of CPSM General Regulation section 3.61(b)(iii)~~

2.19. REPEALED – DECEMBER 13, 2023 - See Council Policy Registration of Clinical and Physician Assistants and Physician Assistant Students~~In addition to the physician assistant training programs identified in CPSM General Regulation clauses 3.61 (b)(i) and (ii), the following are approved physician assistant training programs for the purposes of clause 3.61(b)(iii):~~

~~2.19.1. Canadian Military~~

~~2.19.2. University of Toronto~~

~~2.19.3. McMaster University~~

~~Approved Physician Assistant Training for External or Visiting students – CPSM General Regulation section 3.57(a)~~

2.20. REPEALED – DECEMBER 13, 2023 – See Council Policy Registration of Clinical and Physician Assistants and Physician Assistant Student~~For the purposes of registration as a Physician Assistant Educational (External or visiting student) class an applicant must establish he or she is a graduate or undergraduate or post-graduate of:~~

~~2.20.1. the Physician Assistant Education Program at the Manitoba faculty;~~

~~2.20.2. a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States;~~

~~2.20.3. another approved physician assistant training program set out in 2.19 above.~~

Approved Criteria for Supervisor of Physician Assistants or Clinical Assistant for the purposes of CPSM General Regulation section 8.7

2.21. A regulated registrant who meets the following criteria may be a supervisor of a clinical assistant or physician assistant:

2.21.1 holds a current certificate of practice; and

2.21.2 whose scope of practice is approved by the Registrar as being substantially similar to the scope of practice of the clinical assistant or physician assistant being supervised.

Certificate of Professional Conduct

2.22. CPSM form of Certificate of Professional Conduct used for registrants and former registrants as required by the RHPA s.144 is set forth in Schedule "B" annexed to and forming part of this policy.

2.23. Upon receipt of the written consent of the registrant or former registrant and payment of

the fee for issuance of a certificate, the Registrar shall issue a certificate of professional conduct concerning the registrant.

Approved Fields of Practice for Resident Limited for the purposes of CPSM General Regulation section 3.54(b)

2.24. For residents who have completed a minimum of two years training in the applicable field and who have their Licentiate of the Medical Council of Canada (LMCC), the following are the approved fields of practice for registrants to be registered in the resident limited class:

2.24.1. Neonatal and Perinatal Medicine

2.24.2. Obstetrics and gynecology

2.24.3. Anaesthesia; and

2.24.4. Emergency medicine

Approved liability Insurance for the purposes of CPSM General Regulation section 4.12(1)(a)

2.25. In addition to the Canadian Medical Protective Association, for the purposes of the CPSM General Regulation s. 4.12(1) (a), the following are approved types of liability insurance or liability coverage:

2.25.1 Lloyds of London;

2.25.2 Healthcare Insurance Reciprocal of Canada (HIROC);

2.25.3 Canadian University Reciprocal Insurance Exchange (CURIE)

Restricted Purpose Class: Approved Purposes

2.26. The following are approved as Restricted Purpose classes:

[To Be Approved by Council at a later date]

2.27. The following are additional requirements for registration in a restricted purpose class:

[***To Be Approved by Council at a later date]***

Schedule A – Anesthesia Assessment

LOW RISK ANESTHESIA ASSESSMENT PROGRAM
Department of Anesthesia
University of Manitoba

PREAMBLE

The College of Physicians and Surgeons of Manitoba recognizes two levels of Anesthesia practice. Unlimited practice requires Royal College certification. Low-risk anesthesia requires either completion of a College of Family Physicians of Canada Certificate of Added Competence program, or an equivalent. Candidates with the latter, whether from a Canadian non-standard program or from an International program, require an assessment in low risk anesthesia. This Low Risk Anesthesia Assessment (LRA), will be conducted within the Department of Anesthesia, under the governance of the Division of Continuing Professional Development in the College of Medicine.

GOALS AND OBJECTIVES

The overall goals and objectives of this program are to assess the skills, knowledge, and ethical behaviour of candidates for licensure. This is not a training program, and there is no intention to provide for remediation of any discovered deficiencies within the limits of this assessment program. The clinical standard against which candidates shall be assessed is the same as that for trainees within our own program. The full standard is the same as that for Family Practice Anesthesia residents. They will therefore need to demonstrate proficiency in Pediatric, Obstetrical and adult anesthesia. Specific goals and objectives for each of these components are attached. Thus, for each section the minimum standard shall be to fulfill the PGY2 goals and objectives.

PROGRAM ADMINISTRATION

A designated supervisor shall be appointed for each component. A committee consisting of all three supervisors, and the Anesthesia Program Administrator and the Associate Head for Education in Anesthesia shall be the governing body for the LRA. This committee shall formulate the specific outline and requirements of the program, as well as collaborate on each final evaluation report. The Chair shall report to the Anesthesia Department Head, and to the Faculty LRA Coordinator.

DURATION OF ASSESSMENT

The LRA in Anesthesia is organized into three rotations over two four-week periods. The minimum duration of the assessment will include one four-week period of adult anesthesia and a second four-week period comprising two weeks each of pediatric and obstetrical anesthesia. As outlined below, any individual rotation may be extended by 100 % if it is deemed that the candidate's performance is neither clearly acceptable nor unacceptable. This extension will not be used to remediate any deficiencies exposed during the first portion of the assessment.

EARLY TERMINATION OF ASSESSMENT

The LRA reserves the right to terminate an assessment after a period of one month if, in the opinion of the assessing department, the candidate is clearly unsuitable to continue the assessment period. The criteria for such unsuitability may include inadequate anesthesia skills or knowledge, the inability to work with colleagues, nursing and/or allied health professional staff, or any other pattern of behaviour that is felt to preclude competent practice. In the case of early termination, the LRA will have no further responsibility to the candidate or to the sponsoring institution.

FACULTY/SUPERVISION

For each component of the LRA within the department of anesthesia, there will a supervisor assigned. This supervisor will have the responsibility of collecting the input from staff with whom the candidate works. This data will be used as the basis of the interim and final evaluations.

DAILY RESPONSIBILITIES

The candidate shall have a graduated increase in responsibility in each of the components of the program. On initial exposure, it will be necessary for the purposes of safety to regard the candidate as a PGY1 resident. It is anticipated that candidates qualifying for this program will in fact be functioning at a level above that. By the mid-rotation evaluation, they will be expected to function at the same level as a Family Practice Anesthetist.

Candidates shall be assigned to daily slates in the same manner as FPA residents. In addition, they will be expected to do four calls per month, to allow assessment of emergency performance. These will be done according to the same rules established for residents on Scholarly activity, in the Anesthesia Postgraduate Program.

EVALUATIONS AND FORMS

There will be an evaluation at the midpoint and the end of each of the components. At the midpoint evaluation, if possible an indication will be made of the potential for extension. There may be formative feedback given in the process of this interim assessment, but this implies no commitment by the department to provide any necessary remediation. The assessment at the end of the component will serve as the final assessment for that component. The designated supervisor for the respective component shall perform these assessments.

The evaluation forms used shall be the same as those used for the resident ITAR. Daily forms will not be required, as they are intended primarily for formative, as opposed to summative evaluation. The Anesthesia Associate Head for Education shall compile a summary of the individual component evaluations, which will then be discussed the by the LRA committee to create an overall FITER for the LRA.

In addition to the clinical assessment, the LRA candidate shall complete the exam used by the department for family practice anesthesia. This is not required of full-program PGY2 residents because they will ultimately be assessed by the Royal College exam process. However, it is necessary in order to fulfill the first level of the assessment's goals, which is Family Practice Anesthesia equivalence.

REPORTING

Results of this assessment shall be reported to the Anesthesia Department Head and the LRA Coordinator for the Faculty of Medicine, as well as directly to the candidate. There will no other report provided directly to any other party.

ACCESSING THE PROGRAM

The Faculty LRA Coordinator shall refer candidates to the Anesthesia LRA committee for consideration. Eligible candidates for the program must have

- A conditional license from the College of Physicians and Surgeons of Manitoba
- Certification of Non-Specialist training from a program acceptable to the CPSMB

Schedule B – Certificate of Professional Conduct

THIS IS SCHEDULE "B" ANNEXED TO AND FORMING PART OF THE QUALIFICATIONS AND REGISTRATION POLICY OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA.

PRIVATE & CONFIDENTIAL

CERTIFICATE OF PROFESSIONAL CONDUCT

1. Identification and contact information for recipient of COPC[1].

2. Information about the applicant.
    a. Personal Identifiers
        i. Full legal name
        ii. Practice Location in Manitoba
        iii. Office telephone number
        iv. Name of the Medical Corporation (shareholder or director)
        v. Medical Identification Number for Canada/NIMC #
        vi. Date of birth
        vii. Name changes

3. Qualifications and credentials
        i. Medical Degree
        ii. Name of medical school
        iii. Country of medical school
        iv. Year of graduation
        v. LMCC
        vi. Date of LMCC
        vii. Specialty qualifications
        viii. Any other qualifications
        ix. Source verification – Yes or No

4. Registration / Certificate of Practice information
        i. Registration number
        ii. Date of registration
        iii. Certificate of Practice expires(d)
        iv. Registration/licensure history
        v. Registration Expiry, if any
        vi. Membership class
        vii. Field(s) of practice
        viii. Specialist Register
        ix. Terms conditions, and restrictions on Certificate of Practice
        x. Actively practising in the jurisdiction – Yes or No
        xi. If applicable, authorized/no authorized to perform a reserved Act

[1] Disclosure is based upon the best information available to the CPSM as of the date of this certificate.

5. Complaints[2] [3]

6. Investigations[4]

7. Disciplinary actions, except dismissals after a hearing
    i. Date of the disciplinary action
    ii. Particulars of the disciplinary actions
    iii. Findings arising from disciplinary action
    iv. Any remedy or sanction whether imposed or by consent

8. Current information of a non-disciplinary nature[5]
    i. Conditions on Certificate of Practice or registration;
    ii. Consent agreements or undertakings;
    iii. Consent withdrawal from practice or a register; and if known, reasons for withdrawing;
    iv. Restriction or cancellation of hospital privileges, if known.

9. Findings of guilt, criminal or otherwise[6]
    a. Findings of guilt or pardoned offences and pending charges:
        i. In Canada;
        ii. Elsewhere if known.

    b. Other; including;
        i. Findings under the *Controlled Drugs and Substances Act*;
        ii. Findings under the *Food and Drugs Act* (Canada);
        iii. Fraud findings;
        iv. Restraining orders.

[2] A complaint means any initiating communication which:
a) is an expression of concern about the conduct, competence or capacity of the registrant or former registrant, about which the registrant or former registrant is aware;
b) identifies a registrant or former registrant of the issuing medical regulatory authority;
c) is made by any person (including the Registrar of the issuing medical regulatory);
d) meets the legal criteria or procedures in the jurisdiction in question; and
e) does not necessarily have to lead to an action.

[3] Open complaints and any past complaints for the current year and the 10 previous calendar years are included.

[4] Open Investigations and any past investigations for the current year and the 10 previous calendar years are included.

[5] CPSM does not collect information about hospital privileges.

[6] CPSM began collecting information about court findings of guilt from other jurisdictions, fraud findings, restraining orders, and pardoned offences on July 15, 2015. Only matters for the current year and the 10 previous calendar years are included.

10. Professional litigation history against registrant or former registrant[7]
    i. Settlements[8];
    ii. Civil suit finding;
    iii. Statements of claim.

11. Any other information the Registrar deems relevant

DATE OF ISSUE: REGISTRAR

Not official without signature of Registrar and impression of College seal
No further entries below

[7] CPSM began collecting information about medical malpractice court judgments issued against the registrant by a court in Canada within the previous 10 years on July 4, 2005. On July 15, 2015, CPSM began collecting information about registrants' professional litigation history including pending civil actions and settlements of civil action. The registrant's professional litigation history involving a patient for the current year and the 10 previous calendar years is included.

[8] Settlement means any resolution of a lawsuit involving a patient at any time during the proceeding, which included any payment of money in relation to a registrant's medical practice and/or any admission of liability in relation to a registrant's medical care.

COUNCIL MEETING
DECEMBER 13, 2023
NOTICE OF MOTION FOR APPROVAL

SUBJECT: Quality Prescribing Rules Review

i. Standard of Practice - Prescribing Requirements
ii. Practice Direction - Electronic Transmission of Prescriptions

RECOMMENDATION:

That Council approve the attached:

- Standard of Practice - Prescribing Requirements (attached)
- Practice Direction – Electronic Transmission of Prescriptions (attached)

That Council rescind:

- Standards of Practice – Prescribing Requirements
- Practice Directions – Dispensing Physicians
- Practice Directions – Facsimile Transmission of Prescriptions
- Practice Directions – Manitoba Prescribing Practices Program (M3P)
- Practice Directions – Prescribing Practices: Doctor/Pharmacist Relationship

BACKGROUND:

On June 28, 2023, Council approved a draft Standard of Practice Prescribing Requirements and a draft Practice Direction Electronic Transmission of Prescriptions be distributed for consultation. The consultation period was from August 24 to September 29, 2023. An executive summary of the consultation results prepared for the Quality Prescribing Rules Review Working Group is attached as well as all 227 consultation responses.

Based on the consultation, the Quality Prescribing Rules Review Working Group recommended amending the drafts of the Standard of Practice Prescribing Requirements and Practice Direction Electronic Transmission of Prescriptions as follows:

- There be a recommendation that either the diagnosis, clinical indication, or treatment goal or a combination thereof be included in the prescription. A Contextual Information and Resource document be added to the Standard of Practice to provide guidance on this matter.
- Clarification be provided on the direct patient contact requirement for issuing a prescription as well as exceptions to this requirement.
- Minor editorial changes to provide clarification.

Changes to the documents distributed for consultation are attached.

The Working Group also recommended CPSM and CPhM jointly approach government to amend the Pharmaceutical (General Matters) Regulation to permit verbal prescription of M3P medication in limited circumstances.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2023, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves:

i. The Standard of Practice Prescribing Requirements as presented to be effective March 1, ,2024.
ii. The Practice Direction Electronic Transmission of Prescriptions as presented to be effective March 1, 2024.

Council rescinds effective March 1, 2024:

- Standards of Practice – Prescribing Requirements
- Practice Directions – Dispensing Physicians
- Practice Directions – Facsimile Transmission of Prescriptions
- Practice Directions – Manitoba Prescribing Practices Program (M3P)
- Practice Directions – Prescribing Practices: Doctor/Pharmacist Relationship

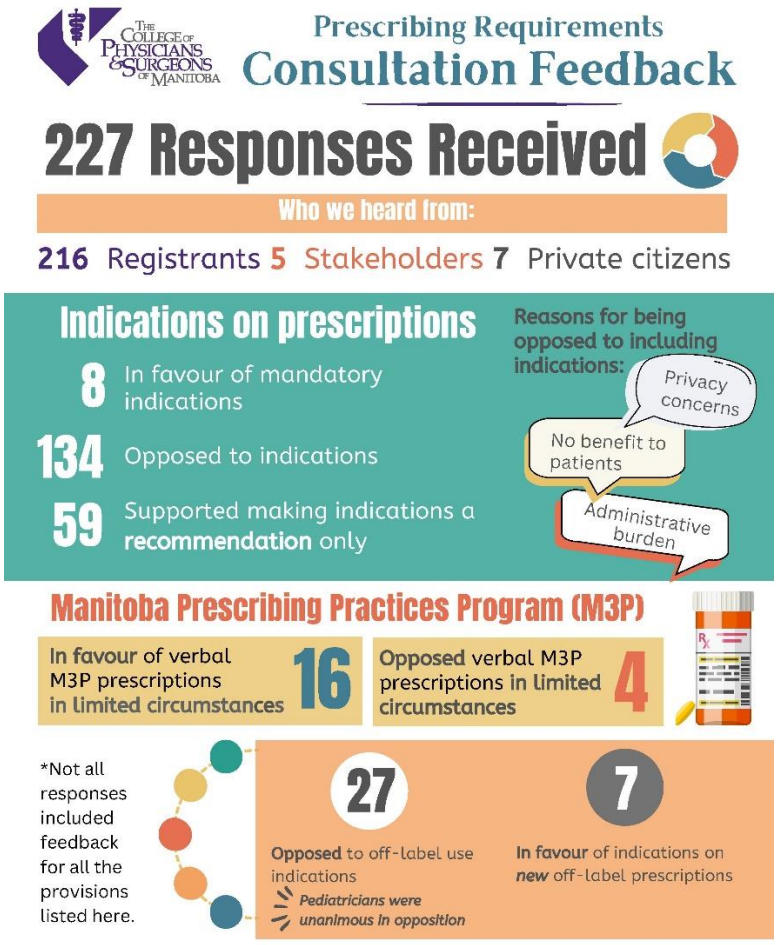
Executive Summary of Consultation Responses

227 responses to the consultation on the draft Standard of Practice and draft Practice Direction were received.

Comments were from:

- 216 registrants (11 submitted more than one email and 14 submitted a joint response)
- 7 members of the public
- 5 Stakeholders:
    - Doctors Manitoba
    - College of Pharmacists of Manitoba
    - College of Mid-wives
    - College of Medical Laboratory Technologists
    - Joint Task Force on Reducing Administrative Burdens for Physicians

The comments should be reviewed in their entirety; however, to assist in the review, the following executive summary is provided.



Indications Mandatory on all Prescriptions

Most submissions (96%) were opposed to the mandatory requirement to include the indication on all prescriptions. Opposition can be summed up as "a lot of work for little or no benefit." Physicians believe this would add significant administrative burden to those currently struggling with excessive administrative work, burnout, and the inability to see their patients in a reasonable time.

Eight individuals were in favour of this mandatory requirement. One member of the public (a pharmacist) provided a detailed explanation as to why they are in favour of the recommendation.

> *"I think diagnosis' on all RX's would help with clarification calls to doctors, especially if the dose is out of normal range. Also, it would help with deciding if the part 2 drugs should be covered with EDS as very few physicians document coverage.*
>
> *The November 2022 practice direction regarding z-drugs and benzos to have doctors re-evaluate usage every 90 days isn't happening in most cases. All it does is make patients wait for a new RX every 90 days with discontinuation and changes rarely made. We send for refills and make the patient wait for it to be signed. We understand that sleeping is not considered a life threatening condition, however it is very disruptive for the patient to be told that we cannot continue the RX and they will have to go a few days without if not singed and returned to pharmacy. We, as pharmacists, can hold patients to refills on time if we went back to more refills. I had a doctor accuse pharmacy of bringing in the direction so we could charge a fee every month which is absolutely not the case.*
>
> *The Mp3 program had its place before DPIN, but now that all RX's are entered into DPIN we can see if a patient is double doctoring or over filling a narcotic. The change to Mp3 requirements with Covid has made for a lot of questions from physicians as to how to write these RXs. Bringing them into line same as all schedules would help with confusion.*
>
> *I also feel that some physicians do not realize we have our own licenses to protects as well. Our questions and clarifications are not to waste the Doctor's time or do too much, it is in the best interest of the patient."*

One physician commented that based upon their practice they would spend approximately 70 minutes a day inserting indications to every prescription they issue. Whether the calculation is typical, the logic is sound to estimate the potential administrative burden added to physicians' workload:

> *Average time to include indication multiplied by number of prescriptions written/renewed. A range can be established by assigning time to complete the task (30 seconds or 1 to 2 minutes) multiplied by the number of prescriptions written each day (plus existing refills). For example, if the physician wrote/refilled 30 prescriptions a day and the range of time it takes to add an indication is 30 seconds to 2 minutes per prescription, the additional work would be from 15 minutes to 2 hours of additional administrative work.*

A corresponding increase in administrative burden will also be placed upon pharmacists to read and comprehend the indication. Assuming this requires an additional 15 to 30 seconds per prescription, what will be the total impact upon a pharmacist's daily workload?

As stated above the overall sentiment is “a lot of work for little or no benefit”. There is a range of opinions on what value pharmacists bring to the process and there is a significant amount of skepticism related to the benefit achieved for this additional work. A summary of some comments is:

- If pharmacists have a question now, they phone, and the process works.
- Are pharmacists now having to approve my prescriptions.
- This will just add delays in processing prescriptions.
- Complex indications can’t be succinctly recorded.
- Where is the data there is a problem and that this is a fix to that problem.
- Sometimes there is no clear diagnosis at the time of prescribing.
- Many specialists (ex. oncologists, dermatologists, ophthalmologists) believe that pharmacists will not have the knowledge of the conditions they treat and how various drugs are used. This requirement will lead to confusion and delays.
- Pharmacists are not involved in the care/treatment of the patient; how do they know the appropriateness of the medication.

Privacy concerns were raised by both physicians and members of the public. This requirement will increase the risk of improper disclosure of personal health information. Since more people than the pharmacist will see the indication there are concerns related to sensitive and stigmatized diagnosis (sexually transmitted disease/gentile herpes, erectile dysfunction, therapeutic abortions, panic disorder, schizophrenia, benzodiazepine dependence, HIV, delusional disorder, transgender treatments) being viewed by persons who do not need to see the prescription. This was considered a significant concern in small rural communities. It was also raised as a concern if prescriptions are lost, stolen, or viewed by people who may otherwise get access to the prescription.

Concerns were expressed about additional personal health information coming into the possession of large corporations – Walmart, Costco or Loblaws.

Physicians treating patients with mental health disorders or geriatric patients with cognitive issues expressed concerns that these patients will not take the medication if they see the indication written on the prescription.

Indications Required for Off-label Use

Concerns were raised by several specialists (pediatricians, obstetricians, dermatologists) that a significant amount of the prescriptions they write are for off-label uses and that many pharmacists may not have sufficient knowledge of their specialties use of the medications. There is concern that this will lead to increases in time spent justifying/explaining the prescription to the pharmacist in addition to the administrative burden of including the indication. Concern was expressed that this is an unjustified increase of administrative burden placed upon certain classes of physicians merely because of how off-label use medication is predominately prescribed in their area of practice.

Recommendation to Include Indication

Fifty-nine comments were in favour of a Standard of Practice that recommended including indication in the prescription. 16 comments were opposed. It is unclear whether the support for making this a recommendation was based on being in favour of the concept or that it was the lesser of 3 evils to choose from.

Drafter's Note: If the Standard of Practice is to make it a recommendation to include the indication, the Standard of Practice should provide guidance on when it should be included, why it is beneficial to be included, and when not to include it as per any legitimate concerns referred to above.

M3P Changes

There were 16 comments (including Doctors Manitoba and the College of Pharmacy) in favour of the proposed changes to M3P requirements. 4 individuals were opposed to the proposed M3P changes, but none provided a rational for their position except for one person who said "I see more risk with verbal narcotics orders than benefits." Statistically interesting - 2 of the 4 individuals opposed to the M3P changes were among the 8 in favour of the requirement for all prescriptions to include the indication.

Comments related to the provision of "knowing the drug and your patient"

No one disagreed with the concept that prescribers must only prescribe a drug when they have the knowledge, skill and judgment to do so for a patient they appropriately know. However, a number of practical issues were identified related to applying this concept. These concerns are copied in full:

> *"The draft standard of practice (2.1) suggested that prescribers must only prescribe the drug if they have the knowledge, skill and judgement to do so safely and effectively. I will admit that often as family physicians we are placed in a compromising position for ongoing care from specialists/other care providers. (ie. Specialists- ccmb/specialists/Hosp) to provide ongoing prescriptions that we did not ever initially start- I am often told from the specialist that this is an expectation of continuation of care. In another instance, the specialist will prescribe medications and expect that I need to do bloodwork to monitor for the medication that they're prescribing as my responsibilities as the family doctor. The standard of practice for prescribing certainly highlights my concern that I initially had and still have to this day. Perhaps CPSM will look further into this."*

> *"re: section 6 on direct patient care. Is the College saying that the patient needs to be seen/contacted every time a prescription is renewed? What about patients who live in remote areas with insufficient physicians available and no primary care provider. Are physicians able to write prescriptions to provide bridging for patients until they are able to find a physician? In some rural areas, there is a severe shortage of physicians. Many patients are not able to afford gas to drive into larger centres where there may be more physicians available."*

"I am concerned that this standard of practice as outlined will significantly exacerbate physician shortages as they exist, and worsen effective availability of care to patients in rural and remote areas. Where I work in Western Manitoba, I have been doing my best to make care available to patients particularly based on assessments by nurses who then document the details of the conversation and medication decisions, even in an outpatient setting such as hemodialysis or mobile RAAM clinic. If these regulations were to be followed to the letter, the expectation of a thorough discussion of risks and benefits of a given medication, obtaining informed consent for every prescription and documenting this will significantly increase the time required to engage with a patient and render very legally dubious the practice of providing care at a geographic remove from a patient. I am currently working with Prairie Mountain health that makes use of the new ability to provide virtual care to expand access to physician assessment facilitated by assessment of nurses and mental health counsellors. I will have to strongly reconsider my attempts to provide care to multiple small communities simultaneously, as the wording of the standard implies to me that in person assessment will be the only valid means of writing a legal prescription in most cases, and that adjusting these prescriptions based in input from nurses or the patients themselves via their own written communication will be unacceptable.

I do not see how the volume of care necessary can be provided if these regulations are followed to the letter, which is implied to me by the word "must." It implies a lack of trust in the judgment of physicians, the confidence of patients in their physicians, and imposes a burden of documentation that will make physicians choose between following the regulations exactly or breaking the regulations to allow people to access care.

I am generally in favour of high standards of practice. However, the standards of practice must, in my opinion, reflect the reality of medical practice at a given time. I am concerned we are in fact in a situation where the volume of need will require a considered reducing of the standards of care, particularly in documentation and other time consuming but non-patient-centred domains. I feel this draft proposal moves towards increasing the standards of documentation and communication, which will necessarily reduce the available care at a time of crisis."

"Thank you for taking my concerns previously raised seriously. I had a very fruitful conversation with Dr Reinecke that may help clarify my concerns.

- *The current standard refers to "sufficient direct dialogue ... regarding treatment options and the risks and benefits"*
- *The draft standard says a prescriber MUST document informed consent*

My concern is for situations where care is mediated by a nurse, pharmacist or other appropriate health care professional in an outpatient setting, such as a RAAM clinic, dialysis unit or the model I am trying to set up in which I communicate with psych nurses about their outpatient clients. If a change needs to be made to a patient's prescription, the way I read the standard says there must be direct contact between the prescriber and patient and informed consent must be obtained before a prescription is written. This would not allow medication changes to occur based on information obtained from a nurse or pharmacist.

A common example is in the care of patients on opioid agonist therapy, when a patient feels nauseous with suboxone. A common practice is for the patient to inform the pharmacist or the

nurse for the program and then a non-sedating anti-emetic such as metoclopramide or ondansetron is prescribed when the other professional informs the physician. Per this standard, this would be unacceptable because the patient has not undergone informed consent.

In my clinic I am trying to develop, I am hoping to make an environment where an appropriately qualified professional, such as a registered psychiatric nurse, can provide a summary of a patient's issues, I can ask appropriate clarifying questions, and then change medication to suit the patient's needs, such as adding a low dose antipsychotic for augmentation of treatment of depression, or adjust stimulant therapy to better suit a patient's changing needs. My concern is this would be prohibited by the requirement for informed consent.

I think this could be rectified if it's made explicit that the qualified health care provider discussing with the patient is able and expected to communicate relevant risks and benefits.

Similarly, I am concerned about this section in part B:

9.2. Before prescribing a drug, prescribers must: 9.2.1. document in the patient's medical record a diagnosis or differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information (as reasonably appropriate)

This would significantly alter the flow of patient care in small rural emergency departments where coverage is provided off site. A common scenario is a patient arriving with a painful condition that nevertheless can wait until morning for full in person assessment by a physician, such as renal colic. A verbal prescription for pain control while awaiting comprehensive assessment is common and reasonable. This would not be possible when receiving a phone call at midnight while covering a rural emergency department that uses paper charts.

Again, perhaps this could be addressed by changing the requirement so that the interlocutor can legally document the reason for the rx (not a normal practice currently but I could see value in its institution).

In principle, I would much prefer to see a standard of practice that is supportive of the reality of care delivered with doctors providing guidance and prescription of medication based on the information provided by competent health care professionals, and the expectation of the other professionals to establish informed consent and document this. If the documents could be reviewed with a view to maximizing safe, effective, timely interprofessional care it would be appreciated."

"As a family physician I have one more concern that may not apply to all of my colleagues. It seems to me to potentially add to the burden of family dots. I have had patients see consultants who prescribe meds for a given concern in their area of expertise, not mine, who then want the family doc to do the refills. Will this increase? Maybe. I have also had pharmacists send me requests for refills on a Tried that I never prescribed, obtained from emergency or a walk in clinic, with no documentation as to who the original prescriber was or what the issue was. My answer to this is usually to make an appointment to discuss, but why does the pharmacy even ask us. Surely if they have the clinical expertise to decide if we are prescribing the right drug for a given goal, they have the expertise to tell the patient no, you should see your doctor."

"Our clinic has primary care nurses who may assess our patients in various capacities, eg. For STI care, OAT, LTBI and so forth. A nurse might perform a telephone or in-person assessment and relay this to a prescriber, eg. A complete assessment based on an algorithm for uncomplicated acute cystitis to determine whether empiric antibiotics are appropriate, or a home visit to examine a wound. In designing our workflows, would it be possible for a prescriber to provide a prescription in a case like this based on a nurse's assessment, or does the prescriber need to have "direct" contact, eg. Meet the patient by phone/video/in person prior to prescribing, even when no physical exam is medically indicated (eg. Some cases of uncomplicated acute cystitis)?"

"Another area of concern surrounding this standard of practice is what happens currently in my practice. Another physician may write a prescription for the patient (whether they are discharged from the hospital ER, or under specialist care). I am expected to thereafter assume the prescription going forward however, despite using diligence, I am often spending much time trying to obtain records to review the rationale of the rx and why a medication was started. The pharmacist often does not exercise any due diligence, in terms of looking for where the prescription came from because often the prescribing doctor/health practitioner may not be reachable, and as such finds the easiest target- my office, as I am the 'physician on record' (the family md). This is becoming more common and increasingly frustrating. This is not only time-consuming, but just adds to the ever increasing administrative burden."

Editing comments/observations:

Some comments identified potential grammatical editing and observations related to specific matters which are copied below:

"In the Prescribing Requirements document:

- *pg 5 ends with the word "and", but p6 does not pick that up and continue*
- *The standard does not allow for the remote supervising physician (but on the same EMR, so pt notes can be reviewed) of and NP to co-sign prescriptions.*
- *section 7.3 second I is unclear and likely not needed as verbal M3P rxs are dealt with below*
- *3.1.6 I think the wording "is recommended" should be used. I think physicians should be encouraged to do this, but that prescriptions should not be denied or returned if they don't have it. Physicians are already dealing with so much paperwork and so many hassles, that they do not need that added stress.*
- *9.2.3 another example would be creatinine or eGFR*

On the Electronic Prescriptions standard:

2.3.1.a. they should also be entered into echart. Not all of us have access to DPIN.

3.1.6 again, I recommend the wording that it is recommended that the diagnosis be on the rx – for reasons noted above.

3.1.13.c I am not sure that Accuro does this (make it not possible to send the original rx again).”

“This step may be necessary with controlled/MP3 medications, but not for non controlled/MP3 medications.

- *Pharmacists prescribe and dispense some medications (ie for UTI), and there is room for error in that there is no assessment documented or communicated to the Physician, and no documented medical record of this interaction. Any professional prescribing any medications, should have to meet the criteria/standards listed in 6.3. Pharmacists should be required, if prescribing without Physician prescription, to also “demonstrate that there has been: 6.3.1 a documented patient evaluation by the registrant signing the prescription, including history and physical examination, adequate to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indications; 6.3.2 sufficient direct dialogue between the registrant and patient regarding treatment options and the risks and benefits of treatment(s); 6.3.3 a review of the course and efficacy of treatment to assess therapeutic outcome, as needed; and 6.3.4 maintenance of a contemporaneous medical record that is easily available to the registrant, the patient, and the patient’s other healthcare professionals” and this documentation should be forwarded to the patients primary Physician.*”

“6.1 I assume a phone conversation is considered to be direct patient contact. Perhaps this should be stated.

6.3.1 Since it is not possible to conduct a physical examination via a phone call I think this point should be modified.

6.3.4 I don’t think any medical records are “easily” available to patients or other health care providers other than those working in a group practice with access to the same EMR.

8.1.4 &.5 I strongly agree that all written orders on a hospital chart should include the date, time , clearly printed name and signature but in my experience this has rarely been done.

9.3.4 The mandatory signing of verbal orders was stopped at Boundary Trails Health Centre a number of years ago. I understand this is not required at the Grace and St. Boniface Hospitals as well.”

<u>CPSM Standard of Practice on Prescribing Requirements</u>

- *The contents listed in section 8.1.2 are not current standard requirements for orders written in a facility. Is this an intended change?*

- *The definition of hospital and residential health care facilities would benefit from having further clarity and broadening the definition to encompass facilities such as outpatient IV, palliative care, dialysis units, and emergency response services.*

Joint Statement on Electronic Transmission of Prescriptions

- *CPhM Council is supportive of including a diagnosis/clinical indication/treatment goal on all prescriptions.*

- *In section 3.2 where it states, "Prescribers **must** use their professional judgment to determine whether it is necessary to include any additional information on the prescription (e.g., the patient's weight or date of birth where this information would affect dosage).", CPhM Council has recommended to update that section to state, "Prescribers must include any additional information on the prescription as required such as, the patient's weight or date of birth where this information would affect dosage."*

"I am a new fellow in Manitoba, working out of Winnipeg. I would like to provide input into the prescribing requirements for residents and fellows. The additional requirements (treatment/diagnosis and supervising physician) as well as restriction from prescribing restricted substances seems to be unique to Manitoba compared to the rest of the country.

While the in-hospital pharmacists are well-versed in the standards of practice regarding learners (they understand that residents/fellows can write prescriptions if they include all the necessary information), unfortunately the community pharmacists are not, and very frequently reject these prescriptions (even when all requirements are met). This results in residents being unable to write outpatient prescriptions and places the burden on staff physicians. In the two months I have been here, I have seen this delay patient discharges from hospital countless times, further contributing to ongoing bed shortages (for example, if the residents are discharging the patient in the morning but the staff physician will not be available until the end of the day to sign the prescription).

In summary, my input into this draft is to remove restrictions from residents and fellows for writing outpatient prescriptions in the following ways:

- *Remove the requirements that are placed on residents for writing non-controlled prescriptions (treatment goal and/or diagnosis and/or clinical indication; and name of supervising physician)*
- *Allow residents to prescribe controlled substances*
- *Increase education to community pharmacists regarding resident outpatient prescription writing*

A review of other provincial practices regarding resident prescription writing would likely provide reassurance to the safety of this practice."

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CPSM Registrant Feedback			
Comment	**Should indication, and/or treatment goal, and/or clinical indication be:**		
	required on all prescriptions	required on all new and "off-label"* prescriptions only	be recommended only on all prescriptions
A) Clinical indication, and/or treatment goal, and/or diagnosis on prescriptions: hard NO B) Verbal prescriptions for M3P drugs: hard YES It should be noted that most faxes are in fact email equivalents and faxed from computers are stored electronically and subject to the same IT concerns.	No		
I would be opposed to having a provision that mandates the inclusion of a diagnosis or other justification on a M3P prescription. This is going to be just another time consuming piece of work for physicians that are already overburdened with paper work Additionally I don't see that there would be any clinical benefit to having this extra work load. Certainly, in the 40 plus years that I have been in practice I have not included this extra information and have not seen any deleterious effect on patient care			
I do not feel that indication, and/or treatment goal, and/or clinical indication should be required for prescriptions of any kind. It may be recommended, but I do not feel this should be required. There are many reasons I feel this way. Some include the potential of delay for release of medications (potential harm), the self-evident nature of many medications (frequent lack of need), and the fact that increased barriers to treatment and added details are unlikely to succinctly relay accurate complexity of indication. For example, some medications are used for multiple purposes, e.g. a biologic/leukotriene inhibitor/other medication that treats eosinophilic asthma, eosinophilic esophagitis, allergic rhinoconjunctivitis, and atopic dermatitis concurrently. This is unlikely to benefit patients or improve their care except in rare circumstances. Often a busy physician would only write one of several indications or the most important indication, choosing one indication may be misleading--i.e. patients with concurrent conditions might have another physician discontinue a needed medication not understanding the complex multiple reasons for that medication. Patients are more complex than a prescription allows, that's why physicians write a note of their assessment; sometimes the indication that allows coverage is not the most important. For example, before a supervised medication challenge, I one physician may opt to have a patient stop a betablocker with a listed indication for migraine headaches on a DPIN, only to learn that it was concurrently indicated for difficult to control afib with RVR or for secondary MI prevention. Physicians already explain the indication to their patients, often fill forms to EDS and to patient support programs, they already write notes describing their conditions and their rationale, it seems we have to write separate notes to the pharmacist, separate notes to patient support programs, separate notes to EDS, and often written notes for patients in addition to handouts (all uncompensated time), we even have EMRs that allow/require diagnoses in non-communicating fashion, and additional software on which we are to add diagnoses/allergies for inpatient (e.g. EPR), then outpatient, then alternate outpatient locations: it's difficult to believe that this would	No		

adequately or appropriately summarize appropriate care for a patient. It seems that adding further to the physician workload would be a major frustration. If such an update is truly needed, the government needs to create a central documentation system that can be accessed by pharmacists, EDS, and physicians throughout the province -- a centralized EMR (such as that being implemented in Alberta) would allow for accurate and shared diagnostic information including indications for medications. The lack of a central system in our province (especially a province so well suited for a centralized EMR) should not be the burden of the physician, but the burden of the system. Thank you for considering some of my thoughts outlined above.			
Thanks for the opportunity to provide feedback on draft / proposed prescribing practices changes. I would recommend against mandating the inclusion of indication and / or treatment goals on prescriptions. I feel it would be unnecessarily burdensome and may also lead to further confusion, miscommunication, and friction between pharmacists / physicians.	No		
Diagnosis /indication should be only on NEW rx Verbal for MP3 ONLY for refills, not for new. My other feedback is that on MP3 prescriptions we should not be putting the address. One of my pain clinic colleagues advised me of this several years ago because if someone loses their prescription, the person that finds it will know that there are narcotics at that address.		Yes (new only)	
1. Should indication, and/or treatment goal, and/or clinical indication be required on all prescriptions? No 2. Should indication, and/or treatment goal, and/or clinical indication be required on all new and “off-label”* prescriptions only?No 3. Should indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions? Yes	No	No	Yes
Further to your request for an opinion on three options regarding additional information on prescriptions: 1. Should indication, and/or treatment goal, and/or clinical indication be required on all prescriptions? No. This would further increase administrative burden on physicians at a time when reducing this burden has become a focus of healthcare policy [1, 2]. The accuracy of the new information is undermined from the start by the fact that physicians will attempt to preserve their practice volume and standard of care while complying with additional documentation requirements. Furthermore, such requirements would disproportionately affect specialties such as Family Medicine and Internal Medicine, where the number of medications prescribed and the frequency of prescribing are high. There is already a Family Medicine crisis in Canada [3], and mandating additional requirements that disproportionately impact Family Medicine will not help to alleviate it. Furthermore, since no other province has such a requirement, mandating it would uniquely reduce the attractiveness of Manitoba for practicing physicians. 2. Should indication, and/or treatment goal, and/or clinical indication be required on all new and “off-label”* prescriptions only? No. In addition to the burdens imposed by option 1, this option adds an additional decision-making step to the new documentation requirement. It also imposes new continuing education requirements, particularly for new medications the approved indications for which are evolving. For every	No	No	Yes

drug, physicians would need to know precisely which indications have been officially approved and which have not. In practice, this would devolve into the equivalent of option (1), where many physicians would list additional information for every drug in order to avoid non-compliance. Therefore, this option does not represent a true middle ground between a blanket requirement for new information and no requirement at all, and should not be considered. The reality of this is reflected in the Environmental Scan within the Public Consultation request, which shows that only Quebec has such a requirement in place. 3. Should indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions? Yes. This option represents a satisfactory compromise between the CPhM request and the practice realities faced by physicians. "Dispensing a prescription without an indication noted and confirming with the prescriber afterwards" in cases where the pharmacist has concerns that are not urgent in nature represents appropriate and non-objectionable interprofessional communication. References: 1. https://doctorsmanitoba.ca/news/reduceadminfocusoncare 2. https://www.cma.ca/our-focus/administrative-burden 3. https://www.cfpc.ca/en/news-and-events/news-events/news-events/news-releases/2023/urgent-action-needed-to-address-the-family-medicin			
This could be very intrusive, for example prescribing medication for a therapeutic abortion, STD etc. Not sure pharmacist or pharmacy technician fall into the " need to know" category.			
With regards to the proposed possible amendment to include a clinical diagnosis/indication/treatment goal on prescriptions, I strongly feel that mandating any such inclusion would significantly add to paperwork and time burden for physicians without significantly impacting patient care. It has never come up in my outpatient practice that a pharmacist has rightfully recommended a changed dose after clarifying indication. Before making such changes, I would be interested to know if there is actual data outlining the frequency of medication errors which occur because a prescriber prescribed the wrong dose for a particular indication, which a pharmacist would have caught and helped correct if they had known the correct indication. I agree that any back-and-forth communication is likely to only lead to delays in patient care. I do not actually support any of the proposed phrasing, but would support something to the effect of “clinical indication, and/or treatment goal, and/or diagnosis is recommended for new or off-label prescriptions”. Should any mandatory reporting go forward (which again I do not support), I also think it would be essentially to work with the major EMR vendors PRIOR to implementation, to allow the systems to flag prescriptions missing an indication, similar to how a prescription cannot be sent without dosing instructions or route of administration. Furthermore, available indications should be linked to diagnoses on the chart and favourites should be able to be saved (neither of these appear available on Accuro at present). The latter would be helpful even if the softer “recommend” proposal is passed. Again, to ensure safe patient care, such EMR changes should be made before the standard is changed. I would also be concerned about unintended consequences where patient’s insurance providers could decline payment for medications due to indications which are phrased slightly differently from what they are expecting. In summary, I worry that this proposed change will significantly and permanently add to prescribers’ workload and burden, both with the initial prescribing and with the inevitable added communication back and forth to between a prescriber and pharmacist, delay patients’ access to medicine on a regular basis (pharmacists’ professional judgement about what medications can wait for diagnosis clarification and prescriber	No	No	Yes

judgement about the same are very likely to differ at times), all in order to prevent a small percentage of medication errors whose frequency has not even been defined.			
I understand the request for prescriptions to have additional detail, but as a family doctor with patients on many medications, often with many refill requests coming in on a daily basis, I feel that this is just additional paperwork. I am already inundated with paperwork and red tape. The fact that I need to apply for eds for drugs, NIHB for drugs and now need to add on additional time to provide a diagnosis, indication and then make sure it is not considered an off lable but widely accepted use for every prescription that I write is a very demanding task that I do not see a benefit from. It is adding paperwork and administrative burden in a job where I already spend a disproportionate amount of time on admin tasks instead of taking care of patients. I do not support these changes. Additionally if I am expected to renew medications from a specialist (which is a regular occurence), it shifts even more work on to myself. I see the value in this, but it just feels like one more thing that disproportionately affects family doctors as we are expected to see more patients, provide more prescriptions and follow up more issues than specialists. We have less time to do so and are compensated less. To add an additional burden is frustrating and thr exact opposite of the previous stayed goals of decreasing additional paperwork requirements.	No		
I strongly disagree with any requirements for writing indication/clinical info or anything more than is currently done on any prescriptions (new or otherwise). What would be the purpose other than to waste the physician's time and delay initiating treatment for the patient. One would suppose that as physicians, we are the ones with the education to make clinical decisions and appropriate medication prescriptions. We should not have to justify this, or discuss this, with a pharmacist. The pharmacists have an important role in identifying possible medication interactions and ensuring quality of medication chemistry dispensed (the latter is typically forgotten/omitted, unfortunately).	No	No	
I see the additional information that may be required on prescriptions as an added burden of documentation without any impact on improving the care of the patient.			
1. Should indication, and/or treatment goal, and/or clinical indication be required on all prescriptions? - NO 2. Should indication, and/or treatment goal, and/or clinical indication be required on all new and “off-label”* prescriptions only? - NO 3. Should indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions? - NO	No	No	No
In regards to the Draft revision for prescribing requirements: A. The potential requirement to include either a clinical indication, and/or treatment goal, and/or diagnosis on all prescriptions. Should indication, and/or treatment goal, and/or clinical indication be required on all prescriptions? Should indication, and/or treatment goal, and/or clinical indication be required on all new and “off-label”* prescriptions only? Should indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions?			Yes

I believe that #3 is best. Indication on prescriptions should be recommended only. Now is not the time to be adding a labour burden to our healthcare system. I had already recently started to write indications, and if it is recommended I will likely do it more often, but it would be a terrible waste of resources to make it required.			
I did manage to look over the drafts. I am concerned about the added documentation. This seems cumbersome and I'm not sure it actually will improve safety or patient care. Some prescriptions have multiple medications. I'm thinking specifically of patients discharged from the hospital when there may be over ten medications. Doctor's Manitoba is looking at the the burden of administrative work on physicians, and how it can be reduced. CPSM seems to be working in the opposite direction. I submitted an email regarding the above, but I had another thought I would like to bring up. It is in regards to putting diagnoses on prescriptions. Currently, a doctor diagnoses, prescribes, and a pharmacist dispenses. The third step is already a safety check. Recent changes, however, have made it so, to my understanding, for certain conditions a pharmacist can diagnose, prescribe, and dispense. I don't see any safety check. So on one hand, prescribing medications has been made easier so it can have fewer safeguards/steps (for pharmacists) and yet we want more safeguards/bureaucracy (for physicians). I don't understand this dichotomy.			
Here is my feedback on the draft prescribing requirements: Re: writing the treatment goal/indication on the prescription - I am not in favour of requiring this, as it further increases already large paperwork demands on physicians, without any clear benefit. re: section 6 on direct patient care. Is the College saying that the patient needs to be seen/contacted every time a prescription is renewed? What about patients who live in remote areas with insufficient physicians available and no primary care provider. Are physicians able to write prescriptions to provide bridging for patients until they are able to find a physician? In some rural areas, there is a severe shortage of physicians. Many patients are not able to afford gas to drive in to larger centres where there may be more physicians available.			
Thank you for proposing the changes reflected in the above document. My request would be to only revise the standard such that it would be recommended, not required, to provide one of a diagnosis, a treatment goal, or a clinical indication on ALL prescriptions. I believe it would be counterproductive to make this a requirement for all prescriptions. My concerns include that: • The potential risk to patients without this information being included on all prescriptions has not been sufficiently (or at all) demonstrated or proven. Even if there is an intuitive risk, it is not clear that provision of this information will mitigate the risk. It may seem to be a logical conclusion, but reality and intuitive logic are often far apart. Has there been some sort of study to demonstrate that provision of this information does, in fact, mitigate some type of risk?	No	No	Yes

• There is a risk of a potential compromise to patient privacy. Some prescriptions are still printed. If I print a prescription for Cefixime and the patient inadvertently drops the prescription, all that is compromised is that I have prescribed cefixime. If I also put Dx: Syphilis and the patient drops that prescription or leaves it in a place where it can be seen, there is a whole other level of privacy compromise. Consider if I prescribe an antiretroviral and I now need to put Dx: HIV and that prescription is seen by an unintended recipient. Or perhaps a prescription for hormones in a transitioning patient and I now need to write Dx: gender identity disorder. The potential compromises are numerous. And pharmacies are not perfect places. A patient may have complete comfort entrusting their privacy to their pharmacist, but perhaps not the pharmacy tech that also may serve a role in managing the prescription. • If this information is required, and it is omitted in error, there is a risk to patient safety if a prescription must be delayed in its dispensation while pharmacy contacts me back to request completion of the requirement. Friday afternoon on a long weekend – likely won't be seen until the following week. Pharmacists had long since refused to pick up the phone and call with a request for clarification. Instead, they all rely on old fashioned fax machines. A request for clarification is subject to an open phone line – something that is often busy. It must then be processed by staff and allocated to an activation pathway that may not be efficient. There are so many ways that communication by these methods is delayed. The more requirements you put on a prescription, the more mistakes there will be, and therefore the more delays there will be. This will carry a risk of compromising patient safety. As an additional comment, section 6.3.1 seems to suggest that all prescriptions require physical examination of a patient. This would preclude prescribing in a setting of virtual care provision. I doubt this was the intent of this section and perhaps I am not interpreting it correctly, but it suggests to me that all prescription provision must be accompanied by physical examination.			
"Should indication, and/or treatment goal, and/or clinical indication be required?"--->my vote is NEVER. This would just add to the heavy administrative burden physicians endure each and every day.	No	No	No
The requirement for indication on all prescriptions or all new prescriptions is just an example of one of the many hundreds of small administrative tasks which reduce the overall amount of time physicians have to actually care for their patients. It's a small ask, but one of an ever growing number of small asks. I would agree that it would be useful for cases of off label use, but would argue that it would only really be useful for cases where the off label use is an uncommon one.	No	No	
1. Should indication, and/or treatment goal, and/or clinical indication **be recommended only on all prescriptions?** This is what I recommend. Perhaps the patient does not want the pharmacy team to know diagnosis. Perhaps also in pediatrics the diagnosis for this not "off label" use will be onerous as many of the medications in the pediatric age group are considered "off- label" .			Yes
keep prescriptions to the present standards and not make it more time consuming.			

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To be honest it makes no difference at all wrt patient safety to add diagnosis, indication, etc on the prescription. It only adds to the already excessive administrative burden as physicians already spend (unpaid) up to 40% of their time on these tasks. If this requirement is added then when we add e.g. gabapentin for off label use that is well known I can guarantee that Pharmacists will i) not dispense, ii) counsel against, iii) add to the administrative burden somehow. Health care in Canada is on the verge of collapse. The practice of Pharmacists sending repeat faxed script requests for medications should not be allowed as often the medication requested has not been prescribed by the receiving FP or the patient was seen in a walk in for a one off visit and the patient has not been to the FP's clinic for months if not years. If the College really cared about patient care it would be easier for doctors to register, i.e. more doctors would be available, who could spend more time with patients, examining, counselling, advising, etc.. More resident places would be allowed. Polypharmacy would be discouraged by specialists especially in the elderly. Just a few of my thoughts.			
I think it would be a burden on the physicians to write an indication on all prescriptions I can understand reasoning behind off label uses for writing an indication As for verbal orders in MP3 meds, I think it is vital that this should remain possible. Specifically in my practice as one of the few docs in Brandon working in PCH. In order to provide effective and time sensitive pain relief and palliative care, it is vital to be able to give verbal orders of all meds. It is also relevant to expect orders to be signed in a reasonable timeframe	No		
I would not support mandatory need for indication on prescriptions. Pharmacists may contact prescriber if there is a concern regarding the medication prescribed.	No		
I strongly agree that diagnosis or clinical indication or goal of therapy should be included on a prescription, especially a new prescription or a new diagnosis. I don't think that verbal prescriptions for M3P drugs are a good idea. Fax prescriptions for M3P drugs has been a very helpful change in prescribing practices.	Yes		
Electronic scripts All scripts has to be electronic. No written scripts should be allowed, to prevent mistakes and fraud. Interaction checker essential to be safe. Consider automatic inclusion of eGfr We find many days that e- script malfunctioning. Therefore fax has to be a backup Goal and diagnosis Not feasible from a time and practical perspective. It will add too much time on scripting . We are already under so much time pressure	No		

Patients does not always want the pharmacy personal to know their medical history. Not just the pharmacist sees the script. They use assistants. In smaller community settings, it will be a mayor problem. Patients from these communities already choose to get , for example their viagra script at a city pharmacy. Off label use could be a possibility. However for example nortrypteline is the drug of choice for IBS, also used for headaches and migraines. So it is not quite off label. It is accepted practice The rest of the recommendations should already be standard practice			
I have no comment on item B. My order of preference for item A is 3,2,1, with 3 being my most preferred option.	no		yes
A. The potential requirement to include either a clinical indication, and/or treatment goal, and/or diagnosis on all prescriptions. I believe it should be: 1. Should indication, and/or treatment goal, and/or clinical indication be required on all prescriptions? I think it would make it easier in practices such as mine where we cross cover a lot, rather than having to read a whole patient chart to figure out why they are on something. I think it would also increase the chances that a pharmacist might catch a mistake. I also think it could make more physicians critically assess why a patient is on something when they have to put an indication. I think making it only necessary on 'off label' or 'new' medications will result in a lot of back and forth between pharmacists and physicians, as there are many medications that physicians think are 'on label' but they are actually 'off label' B. The Implementation of verbal prescriptions for M3P drugs under limited circumstances when timely fax or electronic transmission is not possible AND may otherwise lead to a delay in access to urgently needed medication. I believe this amendment should go ahead. It will allow for better patient coverage by physician groups such as ours that provide 24/7 call coverage. We do 1 week on call at a time, so cannot always be at a computer to send a prescription.	yes		
Regarding providing indication on prescriptions: I am most supportive of option #2. However, for Paediatricians and Paediatric subspecialties, so many medications we prescribe are "off-label" for children. Therefore, I suggest that the indication only be required for "new" Rx's and not refills for "off-label" medications. Option #2 Should indication, and/or treatment goal, and/or clinical indication **be required on all new and "off-label"* prescriptions only**? (with suggested revisions as above).		yes	
A few things, some minor, that I noticed: In the Prescribing Requirements document: - pg 5 ends with the word "and", but p6 does not pick that up and continue			

- The standard does not allow for the remote supervising physician (but on the same EMR, so pt notes can be reviewed) of and NP to co-sign prescriptions. - section 7.3 second sentance is unclear and likely not needed as verbal M3P rxs are dealt with below -3.1.6 I think the wording "is recommended" should be used. I think physicians should be encouraged to do this, but that prescriptions should not be denied or returned if they don't have it. Physicians are already dealing with so much paper work and so many hassles, that they do not need that added stress. -9.2.3 another example would be creatinine or eGFR On the Electronic Prescriptions standard: 2.3.1.a. they should also be entered into echart. Not all of us have access to DPIN. 3.1.6 again, I recommend the wording that it is *recommended* that the diagnosis be on the rx - for reasons noted above. 3.1.13.c I am not sure that Accuro does this (make it not possible to send the original rx again).			
I am concerned that this standard of practice as outlined will significantly exacerbate physician shortages as they exist, and worsen effective availability of care to patients in rural and remote areas. Where I work in Western Manitoba, I have been doing my best to make care available to patients particularly based on assessments by nurses who then document the details of the conversation and medication decisions, even in an outpatient setting such as hemodialysis or mobile RAAM clinic. If these regulations were to be followed to the letter, the expectation of a thorough discussion of risks and benefits of a given medication, obtaining informed consent for every prescription and documenting this will significantly increase the time required to engage with a patient and render very legally dubious the practice of providing care at a geographic remove from a patient. I am currently working with Prairie Mountain health that makes use of the new ability to provide virtual care to expand access to physician assessment facilitated by assessment of nurses and mental health counsellors. I will have to strongly reconsider my attempts to provide care to multiple small communities simultaneously, as the wording of the standard implies to me that in person assessment will be the only valid means of writing a legal prescription in most cases, and that adjusting these prescriptions based in input from nurses or the patients themselves via their own written communication will be unacceptable. I do not see how the volume of care necessary can be provided if these regulations are followed to the letter, which is implied to me by the word "must." It implies a lack of trust in the judgment of physicians, the confidence of patients in their physicians, and imposes a burden of documentation that will make physicians choose between following the regulations exactly or breaking the regulations to allow people to access care. I am generally in favour of high standards of practice. However, the standards of practice must, in my opinion, reflect the reality of medical practice at a given time. I am concerned we are in fact in a situation where the volume of need will require a considered reducing of the standards of care, particularly in documentation and other time consuming but non-patient-centred domains. I feel this draft proposal moves towards increasing the standards of documentation and communication, which will necessarily reduce the available care at a time of crisis.	No		

I strongly disagree with the proposal to have the requirement to include clinical indication and or treatment goals and or diagnosis on any prescriptions. This will significantly increase the workload of the prescriber. I fail to see how providing this information would improve care. Who is this information intended for? Who if anyone would be acting on the information? Presumably anyone who did would likely be considerably less knowledgable about the patient and their condition than the prescriber, and should not be policing patient care.	no	no	
Main concern will be the extra time required for physicians and pharmacists. I would suggest 6-12 months of recommended before moving to required. Also, can residents now prescribe? (Section 3.3). That would be great if they could. Manitoba is lagging on this and it delays our residents taking on this responsibility. Draft Practice Direction on Electronic Transmission of Prescriptions This seems good. I would just want to clarify if an electronic signature is accepted or it a signature in ink and then faxed is necessary. There is no definition of what defines a signature, except that a rubber stamp is not appropriate.			
Rather than mandating MD's write indications for medications on all prescriptions ad infinitum, it would be far more useful if the DPIN or eChart could include the patient's diagnoses, as is done for allergies. This could be done by the MD giving the patient a problem list to share with the pharmacy if the patient agrees. Any new medications for short term treatment for conditions like a UTI would not need to be entered onto the list. Longer term, new medications for new diagnoses should indicate the diagnosis, for the first prescription only. Other subsequent new or current medications for the same condition would not require the diagnosis. Problem solved and minimal additional administrative burden of pharmacy/MD telephone/faxing delays with this alternative. This policy would also benefit ER's when patients show up with multiple vials that don't have any diagnostic information. If the DPIN or eChart can't be modified to include the patient's diagnoses, then I would hold off mandating changes in listing the prescribing indications until it can be made to do so. This would also incentivize Shared Health/eHealth to finally show some progress on its long-overdue electronic health record system initiatives rather than placing the administrative burden on busy MD's and pharmacies. I don't think we should accept a half-baked, partial solution to a solvable problem. I do like the patient-focused option of allowing MD's to offer verbal MP3 prescribing where electronic or paper communication isn't possible.			
I am a Family Physician and am responding to the request for feedback on the Draft Standard of Practise for Prescribing requirements . I am very concerned about there being a requirement or a recommendation for a diagnosis to be written with each medication. The amount of time this will add to my day is significant . I have a large practise of 2200 patients, and receive multiple fax refill requests each day from pharmacies . I provide comprehensive care to my patients, and many of them have multiple comorbid conditions . Many have prescription refill requests for more than 10 medications at a time, for various diseases.			

If I am required to spend extra time listing a reason for each medication, I will need to see less patients during the day , which reduces my access . I see Family Physicians being negatively impacted by this more than anyone . An Endocrinologist advised me yesterday she will have to get a stamp that says " Diabetes" if this goes through . A Family Physician does not have a short list of diseases , and cannot find short cuts to speed them up like the specialist in this example . Overall, I do not see a significant benefit with this initiative and do not see one listed in the proposal . I have asked several pharmacists who agree , and who were also quick to point out the significant administrative burden this would add for physicians. Please reconsider this proposal.			
I am a new fellow in Manitoba, working out of Winnipeg. I would like to provide input into the prescribing requirements for residents and fellows. The additional requirements (treatment/diagnosis and supervising physician) as well as restriction from prescribing restricted substances seems to be unique to Manitoba compared to the rest of the country. While the in-hospital pharmacists are well-versed in the standards of practice regarding learners (they understand that residents/fellows can write prescriptions if they include all the necessary information), unfortunately the community pharmacists are not, and very frequently reject these prescriptions (even when all requirements are met). This results in residents being unable to write outpatient prescriptions and places the burden on staff physicians. In the two months I have been here, I have seen this delay patient discharges from hospital countless times, further contributing to ongoing bed shortages (for example, if the residents are discharging the patient in the morning but the staff physician will not be available until the end of the day to sign the prescription). In summary, my input into this draft is to remove restrictions from residents and fellows for writing outpatient prescriptions in the following ways: • Remove the requirements that are placed on residents for writing non-controlled prescriptions (treatment goal and/or diagnosis and/or clinical indication; and name of supervising physician) • Allow residents to prescribe controlled substances • Increase education to community pharmacists regarding resident outpatient prescription writing A review of other provincial practices regarding resident prescription writing would likely provide reassurance to the safety of this practice.			
In theory I support the idea of adding a diagnosis to the prescriptions as an added measure of safety. However I am more concerned about access to medications for patients when this is forgotten or the pharmacist disagrees with the medication for the diagnosis and cannot get ahold of the prescriber at the time of patient presents for the medication (at night or on a weekend for example). If there is a way to allow for the pharmacist to dispense the medication and add the diagnosis later, to avoid the patient missing out on picking up the medication they need in a timely fashion, then I could support it.			
I would like to lodge my following comments / recommendations.	No	No	No

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Draft change to Prescribing Requirements and Electronic Transmission of Prescriptions: The proposed change "3.1.6" is in my evaluation entirely unnecessary, will increase administrative burden and reduce time with patients, thereby reducing quality of care. While this additional step has been recommended by the CPhMB, it is an unnecessary extra step as this is already covered under Item 2.2.2 of the Prescribing Requirement Standard of Practice "2. Before Prescribing". I advocate "no" is the most appropriate response to the following questions posed by the CPSM in your call for feedback: 1. Should indication, and/or treatment goal, and/or clinical indication **be required on all prescriptions**? - No 2. Should indication, and/or treatment goal, and/or clinical indication **be required on all new and "off-label"* prescriptions only**? - No 3. Should indication, and/or treatment goal, and/or clinical indication **be recommended only on all prescriptions?** - No			
Thank you for the opportunity to provide feedback . I would like to specifically address the proposal to add an indication to every prescription issued. I work in a rural family medicine practice, with a large component of chronic disease management. I am opposed to adding any type of indication. It would add an **extraordinary amount of time** to filling prescriptions. I timed it : for every medication, it would add 35 seconds . On an average day in-clinic, I fill 120 prescriptions. That does NOT include the prescriptions I fill when patients are in the office with me . That equals 70 minutes of extra work daily - time in which I could see patients. In my practice, it would take years to " catch-up " and have every prescription populated with an indication. Furthermore, I would **find a shortcut** for future prescriptions . I would update my " favourite " (electronic) list with vague indications, in an effort to save time . I agree that pharmacists are **part of the patient team**, and that is in the best interest of the patient if the pharmacist has information. What would be truly meaningful is pharmacist accessing the patient's electronic chart (e-chart) to acess the patients' weight, renal (kidney) function, liver function, HbA1c (test to check for diabetic control) and so forth. I don;t believe an indication is going to add information that makes patient care better or safer. Pharmacists are **providers too**. Much as I have to look at a new patient's medication list and " piece together " what the meds are for, so do pharmacists ! In fact, I often look at the med list first, to populate the patient's problem list . In most cases , it is very obvious. If **patient education** is to be enhanced, we would be better off advocating for patients to have access to their electronic chart ., such as Alberta and Saskatehewan . Then patients could view their medication and their problem lists/cumulative patient profiles . I am nervous about adding **sensitive diagnoses**. A good example is the antivirals we prescribe for genital herpes. I already tell patients that these types of meds have many different indications, such as cold sores , and shingles, in an effort to make it slightly less awkward for the patient to fill the prescription. An indication would Lastly, It's concerning that there is **only one other province doing this**.	No	No	
I am writing today in response to your request for feedback on possible new prescribing guidelines. As a member who has practised Family Medicine for over 3 decades and worked as a pharmacist prior to that, I can see some significant pitfalls to the idea of requiring a diagnosis , indication or treatment goal on every prescription . I have concerns that having the diagnosis right on the prescription will be a problem for some patients. I can imagine that there will be patients who	No	No	Maybe

do not want their mental health issues written on the prescription. As it is sometimes very difficult for patients to bring these problems up to get help, it may feel like a betrayal to them to put their diagnosis in writing for anyone in the pharmacy to see. Likewise for sensitive issues like HSV or erectile dysfunction. Just because the pharmacist will surmise what it is for, does not mean the patient will be happy to see it in writing. Will patients see this as another layer of protection for them, or as a potentially concerning increase in the circle of professionals with more access to their medical information than they would like? A big issue from a practical perspective is the impact on administrative burden both for prescriber and pharmacist, and the potential for delays for patients in receiving their medications. We are struggling to keep up with the paperwork load, and the pandemic has increased that burden substantially. Is the concept that for every prescription written we must add a comment about the usage of the med? For new prescriptions a case could be made, but for every repeat? I can envision patients going without meds as they often do not allow enough time for communication and repeat generation already, let alone delays if the required documentation is not there. If pharmacists do not have the diagnosis will they then provide a "continuation of care" prescription to add it themselves, increasing costs for the patient? Do pharmacists really want this? As regards your three questions: 1. Required on ALL prescriptions. This seems like a logistical nightmare for physicians, pharmacists and patients alike. Meds that have been used by patients for years suddenly requiring this information or they cannot be filled will result in unnecessary delays for patients, and increased workloads for both professions. 2. Required on off label and new prescriptions only. This is probably more doable although I think a recommendation is probably adequate, not a requirement. And again the patient privacy concerns above could be an issue. 3. Recommendation for ALL prescriptions. Maybe. This would leave room for some professional judgment. As a family physician I have one more concern that may not apply to all of my colleagues. It seems to me to potentially add to the burden of family dots. I have had patients see consultants who prescribe meds for a given concern in their area of expertise, not mine, who then want the family doc to do the refills. Will this increase? Maybe. I have also had pharmacists send me requests for refills on a Tried that I never prescribed, obtained from emergency or a walk in clinic, with no documentation as to who the original prescriber was or what the issue was. My answer to this is usually to make an appointment to discuss, but why does the pharmacy even ask us. Surely if they have the clinical expertise to decide if we are prescribing the right drug for a given goal, they have the expertise to tell the patient no, you should see your doctor.			
Hi, sharing the following thoughts on the Standards/practice directions below **1. DRAFT Revised CPSM Standard of Practice: Prescribing Requirements (the Standard)**		Yes	

- A. The potential requirement to include either a clinical indication, and/or treatment goal, and/or diagnosis on all prescriptions. I think the best route is requiring indication on all new or off-label prescriptions. Off label prescriptions would also benefit from having treatment goal included. (ie. Potassium citrate with indication of prevention of recurrent nephrolithiasis would nullify the need to check if potassium chloride products would be substitutable). It is likely not of significant value to be included on re-fill prescriptions of the same drug, but qualifying that changing of dosing/interval should be acknowledged on the prescription to avoid inadvertent dosing errors. **B. The Implementation of verbal prescriptions for M3P drugs under limited circumstances when timely fax or electronic transmission is not possible AND may otherwise lead to a delay in access to urgently needed medication.** I strongly believe this is necessary to close a gap in pain and palliative medicine. Being able to give verbal prescriptions for M3P for a limited supply would allow me to be able to function more effectively by being able to refill or initiate M3P scripts when mobile or even on vacation where there may not be adequate on-site coverage available due to overstretched practices and demands. This is particularly sticky with methadone refills as there is not always someone physically present to do an original script that is able to prescribe methadone for analgesia. The other situation where it would be tremendously handy is when doing call coverage for Medical Oncology. Not infrequently metastatic patients run into issues on a weekend when I may not be able to readily fax an original M3P until Monday, but are in significant pain requiring a change in management, and even though it may be manageable as an outpatient with access to oral M3P drugs and follow up, they end up possibly having to go to ER or Urgent Care because of the time needed to get drug to them.			
1. Should indication, and/or treatment goal, and/or clinical indication **be required on all prescriptions**? -No. This is another unnecessary administrative burden on physicians. I suspect it was recommended to allow pharmacists to continue to bill additional counselling tarrifs. Should I just cut and paste my entire clinical assessment and note onto the prescription as well? Do I need to change all of my Rx macros on my EMR to facilitate this pointless administrative requirement? Will we create Rx's with so much 'noise' that the important information is lost? 2. Should indication, and/or treatment goal, and/or clinical indication **be required on all new and "off-label"* prescriptions only**? -No. Sometimes this information can be helpful, at the discretion of the prescribing physician to assist the pharmacist and can be included in a personal and discretionary basis. 3. Should indication, and/or treatment goal, and/or clinical indication **be recommended only on all prescriptions?** -No. My job at it's core is conducting a consultation to determine indication/treatment goal, and documenting them in my EMR. It is an unnecessary duplication of my work to now have to include the same information in the prescription as well. Will I be audited by the College of Pharmacists? Will my records be requested to review my clinical judgement and assessments? This is a poorly thought out proposed change and I sincerely hope the college changes direction.	No	No	No
Thanks for allowing me to participate in this survey. I found the information very useful & helpful. Regarding my basic practice is in a private clinic. I am using paper prescription. I don't work in the hospital although I am sharing every day with our colleagues working thee through phone consultation. I do though talk with the pharmacist for clarifications whenever needed			Yes

hence **1. Draft Revised Standard of Practice: Prescribing Requirements** I would choose Should indication, and/or treatment goal, and/or clinical indication **be recommended only on all prescriptions?** **2.Draft Revised CPSM Practice Direction: Electronic Transmission of Prescriptions** although i am not currently using but i read all the recommendation i will work on it for future using or electronic prescriptions all the other information for prescription drugs & cooperating with the pharmacist for best care I got it & i will do my best to use it in my practice according to the recommendations			
Thank you for taking my concerns previously raised seriously. I had a very fruitful conversation with Dr Reinecke that may help clarify my concerns. - The current standard refers to "sufficient direct dialogue ... regarding treatment options and the risks and benefits" - The draft standard says a prescriber MUST document informed consent My concern is for situations where care is mediated by a nurse, pharmacist or other appropriate health care professional in an outpatient setting, such as a RAAM clinic, dialysis unit or the model I am trying to set up in which I communicate with psych nurses about their outpatient clients. If a change needs to be made to a patient's prescription, the way I read the standard says there must be direct contact between the prescriber and patient and informed consent must be obtained before a prescription is written. This would not allow medication changes to occur based on information obtained from a nurse or pharmacist. A common example is in the care of patients on opioid agonist therapy, when a patient feels nauseous with suboxone. A common practice is for the patient to inform the pharmacist or the nurse for the program and then a non-sedating anti-emetic such as metoclopramide or ondansetron is prescribed when the other professional informs the physician. Per this standard, this would be unacceptable because the patient has not undergone informed consent. In my clinic I am trying to develop, I am hoping to make an environment where an appropriately qualified professional, such as a registered psychiatric nurse, can provide a summary of a patient's issues, I can ask appropriate clarifying questions, and then change medication to suit the patient's needs, such as adding a low dose antipsychotic for augmentation of treatment of depression, or adjust stimulant therapy to better suit a patient's changing needs. My concern is this would be prohibited by the requirement for informed consent. I think this could be rectified if it's made explicit that the qualified health care provider discussing with the patient is able and expected to communicate relevant risks and benefits. Similarly, I am concerned about this section in part B: 9.2. Before prescribing a drug, prescribers must: 9.2.1. document in the patient’s medical record a diagnosis or differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information (as reasonably appropriate)			

This would significantly alter the flow of patient care in small rural emergency departments where coverage is provided off site. A common scenario is a patient arriving with a painful condition that nevertheless can wait until morning for full in person assessment by a physician, such as renal colic. A verbal prescription for pain control while awaiting comprehensive assessment is common and reasonable. This would not be possible when receiving a phone call at midnight while covering a rural emergency department that uses paper charts. Again, perhaps this could be addressed by changing the requirement so that the interlocutor can legally document the reason for the rx (not a normal practice currently but I could see value in its institution). In principle, I would much prefer to see a standard of practice that is supportive of the reality of care delivered with doctors providing guidance and prescription of medication based on the information provided by competent health care professionals, and the expectation of the other professionals to establish informed consent and document this. If the documents could be reviewed with a view to maximizing safe, effective, timely interprofessional care it would be appreciated.			
I am a consultant practicing in Winnipeg. I believe the correct path forward is: **" Should indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions?"** Requiring indications on all prescriptions puts an undue burden on an already struggling physician population, particularly for family physicians who we will lose if we continue down this path.			Yes
I don't see any issues with the proposed draft documents. I think having the diagnosis on all prescriptions for controlled substances provides another safety check Having said that a lot of chronic pain prescriptions tend to be off label use for things such as neuropathy. I'd be curious to know how this information on the prescription is being utilized ie. Is it a check the pharmacist does or is it simply a check box? I would not want my off label scripts being rejected by a pharmacist that was perhaps not familiar with their use in specific chronic pain situations			
I am a paediatric ophthalmologist. The majority of the medication's that I prescribe have not been explicitly tested on children and therefore are considered off label. It would be a considerable burden to continuously make comments about drugs that are commonly used in my practice. I would hope that this entire requirement be dropped as it would be cumbersome and non productive and just add more unnecessary potential delay in instituting appropriate treatment			
I wish to comment on the new draft standards regarding prescriptions and in particular the proposal to include clinical indications on prescriptions. I am opposed to this for several reasons: 1. Increased workload 2. While my EMR has a space for "indication" it does not transmit onto the faxed prescription - this would take an IT fix 3. Several medications I use	No	No	No

serve multiple indications (tacrolimus for immune suppression and proteinuria in nephritis) 4 Refill requests that involve a dozen or more medications will be somewhat nightmarish 5. Pharmacists don't know enough about the off-label use of some indications to properly explain to patients. I already have enough of an issue with them giving patients the wrong information In short I don't believe the problem you're trying to fix is worth the headache or workload			
Overall it seems reasonable. I prefer option C as patients may not want to share the indication for the medication. If there is a contraindication or concern from pharmacy, they can contact the MD.			Yes
I am commenting on the proposed requirement to include a diagnosis on prescriptions. I am AGAINST this recommendation as it places an undue increased administrative burden on the prescribing MD. If the pharmacist needs this information, they can contact the prescribing MD. For most meds the indication is obvious. Regarding the need for direct pt contact to renew medications (section 6). This is NOT PRACTICAL for some meds such as those chronic meds that are used continuously. These meds should be able to be prescribed/renewed between clinic visits providing the needed monitoring is done and the pt is assessed clinically at scheduled visits. Given extreme capacity restrictions on clinic visits it is not practical to contact each pt each time a renewal is requested	No	No	No
I do not feel the indication or diagnosis should be required on all prescriptions. I am concerned this will lead to a delay in patients receiving their medication if the indication is not written on the prescription and the prescribing doctor cannot be reached.	No		
Diagnosis/medical indication information should **not be required** on **any** prescription. This is private and confidential information that does not need to be disclosed to a pharmacist when the pharmacist's role is limited to filling and dispensing a prescription provided by another health care provider. If the pharmacist has any questions, they can and should contact the prescriber with their concerns.	No	No	No
I can see this being problematic for more sensitive information. Has there been a problem where not including this information has caused harm? In other words, if it ain't broke what are you fixing? What if someone loses their prescription? It now has their name, date of birth and sensitive information (eg panic disorder, schizophrenia, erectile dysfunction, benzodiazepine dependence).			

What does including this information add to the dispensing? Why does the pharmacist need to know? Is the pharmacist going to confirm the diagnosis or if they disagree not fill the prescription? I would review the number of times not having this information has caused a critical incident and see if there are certain categories of diagnosis where this may be relevant If someone is prescribed Risperidone and they have schizophrenia why do you need to put the diagnosis on the Rx. I fail to see what it adds. And, what of the patient with diminished capacity - say a delusional disorder. They would not agree that they have a delusional disorder, may agree to taking a Rx and then refuse when they see delusional disorder written			
I think the prescribing requirement should either be for all prescriptions (which I am opposed to for many reasons) or for none. The proposal that off-label prescriptions would need an indication worries me a lot since many of our pediatric medications are used off-label, as are medications in some other patient groups, like pregnant women. That would increase the burden for specific groups of physicians. In general, I think it's not a good idea for us to mention the indication. The pharmacist can't judge why I prescribe a particular drug in most cases, and giving the indication wouldn't change that. And this practice may actually cause PHIA violations, and keep patients from filling their prescriptions. Many of our patients may not want the pharmacy to know why they are prescribed their medication, and that's understandable. Monitoring appropriate care is important, but I don't think is the way to do it.			
I would like to submit my feedback as requested for prescribing patterns. I would like it to be RECOMMENDED and not required. It would be so much more paperwork per patient to add indication. Especially for multiple prescriptions. Especially since accuro already requires so many steps to create a prescription. It's one more decision we have to make that overall adds to the risk of prescribing errors due to decision fatigue. I also see it causing a lot of back and forth communication thus delaying treatment for patients. I am in favor of consolidating m3ps, I find this to be a lot of admin burden. I'm not in favor of verbal consent of certain m3ps like opiates and benzos.			Yes
This is bad idea. More admin work. Requires yet more writing and documentation. For instance if I prescribe drops to lower IOP - now I have to write my goals or a diagnosis. This is ridiculous. 3.1.6. one of: diagnosis, and/or clinical indication, and/or treatment goal, is required on all prescriptions OR is required on new and off-label prescriptions only OR is recommended on all prescriptions. 9 (Refer to consultation document)			

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For the Draft Standard of Practice – Prescribing Requirements, my preference would be that indication be 'recommended only' on all prescriptions. I am concerned that it would be impossible to always know the Health Canada approved indications, especially for old drugs, to know if it is off-label. I am further concerned that requiring it on all prescriptions will unduly increase workload. I understand that changes were requested by CPhM, but there was no indication as to what the actual problem was they are hoping to solve. It is not clear to me how the pharmacist would be expected to determine appropriateness with or without an indication listed, given the requirements on prescribers to have fully assessed the patient before prescribing. Anything more than recommending we state an indication does not seem reasonable. Please allow for verbal prescriptions for M3P drugs as this would help considerably when providing after hours coverage. Regarding the Draft Practice Direction on Electronic Transmission of Prescriptions, please allow for electronically signed prescriptions to be valid. I understand that some EMRs can print an image of the physician's signature and as I understand it this is considered a valid signature. However, in our EMR (at CancerCare) we can only print a prescription while logged in as ourselves and using our password, but instead of showing an image of my signature the prescription says 'electronically signed by'. This has not been considered valid, to my knowledge, which has resulted in excessive work to get the prescription completed and sent in. This is a particularly large problem with virtual visits as we cannot always print based on our location. The end result is both extra work, frustration, and delays in getting prescriptions sent in. We would highly value the ability to have our electronically signed prescriptions considered valid.			Yes
I'm writing this email to provide my feedback on new requirement for prescription. The new requirement to document indication for prescription is not only necessary but would also create a significant new administrative burden on physicians and may affect patient centred care. I would appreciate considering this feedback.			
In response to the following draft change: " . one of: diagnosis, and/or clinical indication, and/or treatment goal, is required on all prescriptions OR is required on new and off-label prescriptions only OR is recommended on all prescriptions.9 (Refer to consultation document)" These are unnecessary changes to prescribing. They do nothing for patient safety and add to physician administrative burden. Physicians are the gold standard prescribers and document in great detail their diagnoses and how they came to them. We are able to decide on the correct treatment and prescribe the appropriate therapy. That is our job and what we train for. The pharmacists job is not physician oversight. That is your job. I think the college needs to get real as to why pharmacists are suggesting this. Their college is doing this in order to allow pharmacists to cherry pick patients they feel the are able manage in community and make changes that benefit their business. This is the definition of conflict of interest and is			

a significant threat to patient safety. You need to look no further than the most recent PC party announcements staying their goals are for pharmacists to prescribe more. As soon as there are complications they will kick the patients (with poor documentation and lack of follow up) back to their primary care providers or ERs to clean up the mess. If you proceed with these changes I do believe you will ultimately do nothing for patient safety and will allow a group motivated by self interest rather than patient care to advance their agenda. If you are ok with this then really you may as well allow MDs to prescribe and dispense. I would encourage you to look at the CMA data and you would see that we as a profession are burned out and trying still to recover from the damage of the pandemic. By adding more administrative burden and allowing this scope creep by pharmacy you will not only further erode physician trust in the college/system but you will end of complicating delivery of care to patients ultimately leading to patient harm. Please listen to your members. We care about patient safety. Show us you care about both your members and the public.			
My comments regarding the proposed standards: • Physicians already spend a significant amount of time reviewing history, signs and symptoms with a patient, assessing past medical history, reviewing current medications, possible interactions, and then reviewing all of this/the medication/side effects/risks/benefits with the patient. All of this is already expected and understood in a Physician-patient interaction that meets present standards. Creating another step for documenting indication/treatment goal/or diagnosis on new or existing or off label prescriptions, is unnecessary and an added burden for Physicians who are already struggling to balance the needs of patients with the admin burden we face. Pharmacists can review with the patients, and if patients are uncertain pharmacists can direct the patient to discuss with their physician – which they likely already did. If pharmacists are concerned re a significant interaction, they can discuss with the patient – to follow up with the Physician, or can call/or send a note to the physician, as is already the process. Adding this label/indication on the prescription, should not/and is not going to impact/dissuade the Pharmacist reviewing with the patient, nor stop the Pharmacist from bringing/noting their concern to the Physician, and as such is an unnecessary step that is significantly cumbersome in the amount of times Physicians will be required to do this daily, repeatedly. This step may be necessary with controlled/MP3 medications, but not for non controlled/MP3 medications.			

• Pharmacists prescribe and dispense some medications (ie for UTI), and there is room for error in that there is no assessment documented or communicated to the Physician, and no documented medical record of this interaction. Any professional prescribing any medications, should have to meet the criteria/standards listed in 6.3. Pharmacists should be required, if prescribing without Physician prescription, to also "demonstrate that there has been: 6.3.1 a documented patient evaluation by the registrant signing the prescription, including history and physical examination, adequate to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indications; 6.3.2 sufficient direct dialogue between the registrant and patient regarding treatment options and the risks and benefits of treatment(s); 6.3.3 a review of the course and efficacy of treatment to assess therapeutic outcome, as needed; and 6.3.4 maintenance of a contemporaneous medical record that is easily available to the registrant, the patient, and the patient's other healthcare professionals" and this documentation should be forwarded to the patients primary Physician. Further to my previous comments: If CPSM's role is to advocate for patients why is CPSM not speaking out against increasing pharmacy scope, including already being able to prescribe some medications and now the PC party's platform of Pharmacist's being able to prescribe numerous medications, and how this is a major conflict of interest being that Pharmacists clearly have financial gain in these interactions in the care of a patient. The entire premise of the conflict of interest standards are breached when Pharmacists are placed in the role of Physician. If CPSM's role is to advocate for patients, it should be advocating against Pharmacists practicing medicine as it does not comply with numerous standards of Practice of Medicine.			
I am writing to provide my feedback on the electronic transmission of prescriptions draft statement. My preference would be to limit the requirement for clinical indication or diagnosis to "recommended on all prescriptions" in the statement. Requiring diagnosis and / or clinical indication on every prescription will require physicians spending even more time writing prescriptions and replying to faxes and phone calls from pharmacies when they forget to do so, resulting in less time spent with patients. This requirement seems redundant to me. I work in an episodic care department and have to look up medication lists frequently on echart and there are only extremely rare circumstances where I do not know why a patient is taking a current medication as most often the clinical indication is obvious, or I can simply ask the patient. Furthermore, will prescriptions without the required diagnosis/ indication not be dispensed? This will result in delays in patients obtaining medications prescribed by their physicians, who bear the ultimate responsibility for the patient's care. Also, will the pharmacists decline to fill medications prescribed if there is a disagreement on off label or other use? At that point who bears responsibility for the patients care, the MD who prescribed the medication or the pharmacist who refuses to fill it? Ultimately, in this circumstance the patient will be left confused, probably frustrated, and unfortunately caught in the middle.			Yes
To Whom it May Concern, I have reviewed the proposed standard of practice prescribing requirements. Specifically pertaining to 3.1.6 - this is grossly unnecessary, would significantly and inappropriately increase, administrative burden when it is already at an all-time high, and I am tremendously in opposition to having to indicate diagnosis / goals/ indications on prescriptions.			

Additionally, since the majority of prescriptions in my section are off label, it would pertain to the overwhelming majority of my prescriptions!! Infuriating! Furthermore, it would require a reduction in patient volume to accommodate the additional work associated with this task. If physicians are now required to communicate, patient care, goals, and/or diagnoses to pharmacists, perhaps we should now have a separate fee code for sending prescriptions. It would seems appropriate if there is this degree of workload associated with sending prescriptions and it may offset the reduction in patient workload required. Unquestionably, such a change would increase patient waitlist due to an increase in administrative burdens and unquestionably negatively impact on physician burnout.			
I have a simple comment regarding the proposed changes to prescribing requirements. I would suggest this be a recommendation rather than a requirement for a trial period of 1 year and reassess at that point with a view to making it mandatory as necessary based on low uptake and stakeholder feedback.			Yes
1. I feel that the requirement for a diagnosis or treatment plan should be an OPTION, not a requirement, when applied to all prescriptions. This is additionally onerous on the prescriber, may result in resistance of prescriber to complete prescriptions; will result in prescriptions that are incompletely filled out and denied by pharmacist and then resulting in prolonged delays for the patient getting the rx filled. 2. Many times an prescription will include more than one rx, which are for different diagnoses; it raises the question of whether the goal is to make the pharmacist a “gatekeeper” who can approve or deny the physician’s order for medication to be received by the patient. I feel this is inappropriate. Pharmacists already have means in place to communicate with physicians if they have questions about the rx. 3. I also feel that the requirement that every rx include the prescribers practice address and licence number is too much information, and not consistent with current practice. In hospitals, generic rx pads are used to create post-operative and discharge prescriptions for patients, and they do not contain space or room on pads to include this information. This information is easy to apply to electronic Rx’s, but not to handwritten ones. This should not be a requirement, since it will- if enforced- dramatically reduce Rx’s completed.			
These experiences and roles have led to my involvement as a member of the Task Force for Administrative Burden here in Manitoba, wherein our goal is to reduce the administrative burden that is leading to these tragic statistics of burnout, depression, and suicidality. My goal in giving up the little free time that I have to be a part of these committees and organizations is truly because I care. I care about my patients, I care about my colleagues, and I care about the parts of me that are left over for my kids at the end of my work day. As a dermatologist in Manitoba, I cannot see as many patients as I need to in a day, to support the long wait lists, largely due to the administrative burden that exists for me in my practice. If the proposed standard of practice is approved, this will further add to my workload in a substantial way, with profoundly negative impacts.			

As a dermatologist, I write many prescriptions per day, the majority of which in my specialty are off label. If I am to write the diagnosis and or treatment goals on the prescription I will likely be spending significant time per day writing the names of lengthy rare diagnosis that are not recognizable to the pharmacist. Today for example I wrote prescriptions to treat Keratosis Pilaris Atrophicans faceii, Confluent and Reticulated Papilomatosis of Gourgerot and Carteaud, and Frontal Fibrosing Alopecia variant of Lichen Planopilaris. This is not effective use of my limited time, nor is it a helpful exercise to communicate these pieces with pharmacists who more likely than not, are not familiar with the majority of the conditions that I treat. These requirements will only result in me cutting down the numbers of patients that I am seeing in clinic each day, increasing my already lengthy waitlist in an underserviced part of the country. If by chance this standard is mandated, a billing fee code should be created to compensate my time for this additional requirement and use of my expertise. In my clinic when I prescribe medications I do so through conversations with the patient on the appropriate use of the therapy, the potential side effects, and the anticipated results. These conversations are always done either via a hand out provided to the patient or via visuals online that we review together. It is my responsibility to ensure my patient is educated and informed. It is not my responsibility to have to repeat this exercise again to the pharmacy. I do my best to provide thorough care, evidence-based medicine, in a clear and concisely communicated way. My patients deserve my time. My own burnout and stress from ever increasing demands on me in my practice are an imperative consideration with regards to this new standard suggestion which I adamantly oppose.			
I think putting a diagnosis, etc on RXs should be only a recommendation and never a requirement. Thanks			Yes
I would vote to implement that a diagnosis, clinical indication and/or treatment goal be recommended to be written on all prescriptions (and electronic ones). This would be best practice, but mandating that all prescriptions have this to be valid will undoubtedly cause a great number of scripts to be invalid as uptake and practice change for many will take time. Also, EMRs at various sites may not easily allow for this, which would greatly inconvenience many clinicians and patients. Implementing this as a recommendation gets things moving in the right direction, but does not put the pharmacist in an awkward position where they cannot fill an Rx because the indication/Dx/treatment goal is not on the Rx.			Yes
I feel we are trying to fix something that is not broken . I personally have not experienced any difficulties or problems with the current method . Imagine a patient with 12 medications requiring 12 diagnoses inserted to each medication , 12 aims of treatment etc - there will be so much confusion for the prescriber and it will take so much more time (which I do not have already enough of) typing all of this My computer server will have to amend his prescription format and templates all over at more cost to me .. As it is , I have to concentrate on what I am typing while trying to listen to the patients multiple problems at the same time and then completing typing his visit for the day - this is too complicated and too stressful . I do not see any advantage in including all the details as in the draft and it might cause more confusion to the dispensing pharmacist . I prefer leaving things as they are . The pharmacist can always call the prescribing doctor if he notices any errors , which they do already now.			

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I am writing with regards to the proposed prescribing requirements pertaining to 3.1.6. I as most physicians do not have enough time in my work day to see the number of patients that need to be seen given our long wait lists. I was under the impression that the college is aware of the administration burden, and documentation requirements that is extremely time consuming, and therefor taking physicians away from being able to care for our patients in a timely manner. As such, I am quite dismayed that I would now have to take the time to write an email to completely disagree with the proposal 3.1.6. This would increase all of our workloads and have a significant burden on my ability to care for patients. I'm not just talking about the time to write the diagnosis or reasons for prescribing. I'm also referencing the number of calls to clarify my prescription by pharmacist who are not trained in treatment of dermatologic diseases. I already get calls for appropriately prescribed prescriptions that the pharmacist were not aware of. I can't imagine how many I would get if I had to write a diagnosis on the prescription in which they likely have not even heard of the condition I am treating. Furthermore, I think it would be a breach of PHIA. Can you imagine a patient leaving their prescription or their medication that is labelled on their desk at work, or on a kitchen counter at home, with a diagnosis of "genital herpes" valtrex 500 mg bid for 3 days or imiquimod for "extensive genital warts". For all these reasons and so many more I am entirely opposed to guideline 3.1.6	No	No	No
I do not think that including the indication or treatment goal on any prescription, whether off-label or not, is necessary. This will contribute to unnecessary administrative burden on physicians. Please do not go forward with this change.	No	No	No
Thank you for the opportunity to comment on your DRAFT Standard of Practice - Prescribing Requirements. Specifically, I would like to comment on the following three options you offer to choose from: **Any prescription must** contain an indication or therapy goal **1** **Any new or off-label prescription must** contain an indication or therapy goal **2** **It is recommended** that any prescription contain an indication or therapy goal It is my opinion that options 1 and 2 will unduly increase physician admin burden and are not acceptable. In addition, no other jurisdiction in Canada, except Quebec, has such a requirement. The only viable option in my opinion is option #3.	No	No	Maybe
Regarding the Draft Standard of Practice - Prescribing Requirements, three options were supplied. *I would advise the implementation of C) indication/treatment goal be* ***recommended*** *on all prescriptions.* Reasoning - in a hospital setting, as we admit new patients, we often do not have access to the Family Physician's reasoning for the use of any of the currently prescribed medications. If supplying a treatment goal/indication were *mandatory* for all orders in hospital, this would mean holding some			Yes

or all of the patient's home medications until such time as the indications could be clarified. this could take days, or even weeks if the FP is away. Holding a patient's regularly prescribed medications could represent a significant risk to the patient.			
If the plan is to expand the scope of treatment for other practitioners (ie pharmacy) which I have my own separate comments about, then we physicians have no choice but to write starting the diagnosis on the rx. But yes, it is an extra step that will take more time and ADD to our administrative charting burden, which is the opposite direction we are trying to move in. In our current archaic system (sadly often relying on faxes) that gives pharmacists NO access to patient charts and NO means of reliable direct communication with doctors, it would be completely irresponsible to allow them to expand their scope of prescribing without some understanding of why patients are on the medications that they are. The better solution that these proposed changes is to create ONE accessible patient chart that is accessible to all allied health and allows communication back and forth. This would NOT require us to “double document” why we are prescribing something (it would be in the chart notes and medical history), and would result in better communication and patient care all around. However if the PCs are re-elected and they take the typical cheaper, easier and heading-towards-privatization approach that they are known for then I highly doubt that they would invest in that work to create a comprehensive chart. Perhaps you should delay discussion on these changes until after the election…			
I would like to voice my vehement opposition to a requirement of including an "indication or therapy goal" on prescriptions. This is an absolutely idiotic idea, no other jurisdiction in Canada uses this tactic. Who is going to police these indications? The pharmacists? What if they don't agree? The administrative burden, confusion, barriers and obstacles to delivering patient care by implementation of this insane rule would jeopardize Manitoban's health.			
In regards to the new prescribing requirements consultation, my strong preference is #3 (recommended that any prescription contains an indication or therapy goal). There is such a large burden of administrative work on physicians right now. Options 1&2 will not be feasible for physicians and will result in delays for patients receiving prescriptions.			Yes
I feel that the indication for a prescription should be optional. When multiple prescriptions are being written it will be very time consuming.			
While in principle writing an indication for any meds on the prescription is good idea, it does put significant burden and unnecessary burden on the physicians/providers. It is also unclear if there is any clear evidence that this practice provides better patient care(except communication to pharmacists). Therefore I would suggest option #3 to make it as a recommended but not mandatory.			Yes

I strenuously object to the proposal to **require** indication or treatment goal to all prescriptions. It will add a huge administrative burden for physicians, and add absolutely nothing to patient outcomes. This proposal would fall squarely within the realm of useless administrative work required of physicians. Please rethink this.	No	No	
HI all ! I work in a small rural town where my patients are often related and or know the workers in clinic and pharmacy. The majority of my patients will be OK with this. However some of my patients will not want a diagnosis written on their prescription if someone other then me will see it including pharmacists and techs. Can i write on RX patient does not consent to sharing diagnosis? This would usually be a vulnerable group of patients and maybe they have finally mustered up the courage to come see me for a delicate reason - this will not be the time for me to try to convince them that their info will be safe. In general I am uncomfortable writing a diagnosis on any information leaving my domain without my patients consent due to past experience with vulnerable patients. I also do not want patients avoiding seeing me or having to drive to a far away pharmacy to fill Rxs. It is possible that we will need to document consent on patients chart for this in general. What type of PHIA like protection will be in place at the pharmacists end to reassure patients that this info is protected ? I believe we have always erred on the side of caution with PHIA and really have to prove that the persons receiving info need it to provide safe patient care. I work very collaboratively with my pharmacist team and certainly understand the value to sharing information.			
The requirement that the indication for the medication/condition/treatment goal be provided is unnecessary and will add substantial administrative resources, it should be removed. Has any other jurisdiction done this? Why are we considering this?			
This is in respond to your last e mail regarding prescription medication. It is consuming a lot of time to do this step. It is not logic to do it to my own patients May be to apply to Walk-in clinic			
3.1.6. one of: diagnosis, and/or clinical indication, and/or treatment goal is required on all prescriptions OR is required on new and off-label prescriptions only OR Is recommended on all prescriptions; (Refer to consultation document) In my opinion, the only viable option is the last one: a recommendation (but not a requirement) to write the indication or Rx goal on the prescriptions. The other two options unequivocally increase our admin burden without adding any significant improvement to patient care. Thank you for counting my vote!			Yes

Reasons for opposing the requirement for a diagnosis to be noted on a prescription: From a rheumatology perspective, I can't see how noting a diagnosis on a prescription is going to reduce prescribing errors. In rheumatology practice, the same medication at the same dose can be trialled for various different conditions. What determines the medication type/dose is the disease severity and patient tolerance/ side effects rather than the diagnosis itself. There are also several instances where we don't know the exact diagnosis. If anything, having to write a diagnoses on a prescription would create more chance for errors and confusion for our patients, in addition to the totally unnecessary admin burden.			
There is no way physicians have the time to write the indication for every prescription. Although I think this would be reasonable for individual prescriptions, I work in kidney transplant where we routinely discharge patients taking 10 or more medications. Every patient sits down with a pharmacist and reviews each medication with them prior to discharge and these are re-reviewed at the initial outpatient visits. I don't see this as a necessary step in our practice.			
Could we all understand why these proposals have been generated? What problems are being addressed? How will these proposals help? In the absence of understanding what the motivations for these documents are it's difficult for anyone to comment intelligently. Questions: 1 Who needs a diagnosis on a Rx? Where did this requirement come from? Will there be a policing function to ensure that the diagnosis/indication is correct? If so, how will that work? Basically, who cares? Is this not a privacy violation between patient and physician? 2 How does a prescriber ensure that a Rx has been invalidated? How is such vigilance obtained? Basically, I wonder what issues led to this proposals? Who needs them? For what purpose? Are the issues related to the use of specific medications? Narcotics? Non-narcotics? Etc.			
I'd like to add my voice to those objecting to these Draft Standards. <u>Mandatory</u> inclusion of a treatment indication is over-exacting and an unnecessary administrative burden to doctors. Guidelines should only include a recommendation it be included in select circumstance (eg. new medication only, one for which the indication may not be singular or obvious). Anything more is over-reach. I'm surprised and disappointed this is where CPSM would start with a Draft policy. It lacks common sense.			

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I often include the indication on prescriptions, but **I strongly feel that this should be optional and not mandatory**. I am concerned that forcing the inclusion of indication will be: a) misleading – for instance I prescribe Tylenol for pain AND for fever relief. Would I need to include all indications including pain location? Would only including one make it confusing for the other. I also often RXN drugs eg ACEI for HTN AND proteinuria reduction. b) a huge administrative burden c) out of keeping with other jurisdictions as this is not required anywhere else in English speaking Canada.			
RE prescriptions: I favor option 3 – indication/treatment goal should be RECOMMENDED only on prescriptions.			Yes
In my opinion requiring an indication to be placed on prescriptions will place an undue burden on physicians without the resultant improvement in patient care. There is no evidence for this practice. We can continue to rely on our pharmacists to have appropriate dialogue with us if the indication for the prescription is not clear.			
I would like to strongly voice my disagreement and concerns with this proposal. It: 1) adds unnecessary administrative burden, 2) contributes nothing to care, 3) creates potential medicolegal risk if inconsistent indications are discovered in court and misconstrued in a narrative, 4) may affect patient access to medication through insurance coverage for off label indications.			
Thank you for reaching out for feed back on prescription practices. While the idea that prescriptions must contain the indication sounds good on paper, it would add a large burden to physicians that are already struggling with a large burden of paper work. It would likely lead to a lot of prescriptions being delayed while further verifications are requested from pharmacy. I would suggest, at most, that including the recommendation be recommended.			Yes

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Please see my feedback regarding prescribing requirements. I personally believe that requiring an indication on all Rx , or any new or off label Rx will unduly increase physician admin burden and is not acceptable. In addition, no other jurisdiction in Canada, except Quebec, apparently has such a requirement. This should be optional or recommended only.			Yes
I vehemently disagree with the proposal to include “indications” or “treatment goals" on routine prescriptions so pharmacists can feel comfortable that the medical practitioners are doing “the right thing". The huge administrative burden that would be added to the daily practice of medicine is completely unacceptable. As a practicing rheumatologist for more than 4 decades, I write numerous prescriptions for highly specialized medications, based on a deep and thorough understanding of the literature in my discipline, and on a wealth of clinical practice experience. Any pharmacists that I have known have only a very superficial knowledge of these medications, their indications, how to balance risk/benefit, etc. The pharmacists are though very quick to let my patients know about the evils of these drugs, and the potential disasters that have been reported with their use in one in a hundred thousand patients who take them. Over the last number of years, I have witnessed a tidal wave of new administrative requirements for prescribing medications. I have seen virtually nothing to suggest that these cumulative administrative requirements have actually improved healthcare delivery in any tangible way. The proposed new prescribing requirements are purportedly based on pharmacists "acting in the best interests of the patients”. Unfortunately, I believe that this is ultimately in the best interest of the College of Pharmacists not the patients, and is a thinly veiled attempt to gain more control over healthcare delivery. There is virtually no precedent for this anywhere else in Canada (except Quebec). I am also not aware of these requirements in any other developed country. As I approach imminent retirement, I can’t help but feel sorry for my younger colleagues and medical trainees who will have to shoulder the burden of these onerous administrative requirements for years to come. Moreover, these parochial requirements will serve as a significant disincentive for new physicians to come to (or stay in) Manitoba and help fill the compelling gaps in healthcare delivery that we have in this jurisdiction.			
It is very rare that pharmacists will ask for clarification. In my opinion, this just increases the already high demands of physicians in the city. I vote for not including indications on prescriptions but to send gentle reminders to physicians to include this as a courtesy to pharmacists if a prescription isn’t a typical one.			

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I am writing to strongly oppose the proposed changes to the standards of practice requiring physicians to include an indication on every prescription they right. This will unduly increase my administrative burden in my practice, and is an unacceptable replacement for broader action towards centralizing the charting system in Manitoba to allow all healthcare providers to have access to equal information on their patients. I don't think increasing the burden yet again on physicians is the correct way to build a team-based approach to medicine in Manitoba. Please reconsider this.			
1. Indication: Good idea, all EMR's should be required to make a spot for this to be easily filled 2. M3P: Agree with verbal Rx in exceptions. Also PLAESE can we remove current requirement/understanding that EACH drug needs seperate M3P. Adds to work load.			
I agree with Option 1 that every prescription should have an indication or therapy goal. I believe that this will improve patient care, by facilitating education by pharmacists, allowing patients to be more empowered in managing their health, reduce polypharmacy, and facilitate de-prescribing.	Yes		
I am opposed to having to provide indication for treatment. Reasons below. 1. Onerous and unnecessary paperwork 2. The overwhelming majority of the time, the indication is clearly understood by anyone who studied pharmacy. Not worth my extra work time to address the minority where multiple uses exist. 3. In my practice, I cannot identify a drug where the safety/management of the patient would in some way be improved whether the pharmacist was aware or unaware of the objective of therapy. I have thought long and hard and cannot identify even one. 4. Invasion of personal privacy. Does the pharmacy or pharmacy clerk really need to know whether my patient takes a drug for sleep, pain, diarrhea control or neuropathy ie amitriptyline. Some health problems remain stigmatized even amongst health care workers. I feel the need to advocate for patient privacy. 5. Inconsistent with any other provincial jurisdiction other than Quebec. I could accept "recommended" to state the objective of treatment. But overall, this seems like a well-intentioned, ill-conceived idea.			
The first two options will impose a massive administrative burden on physicians and be very hard to implement into busy clinics, hospital discharges etc. I would strongly favor this as a recommendation ONLY (option 3). 1. **Any prescription must** contain an indication or therapy goal **2. Any new or off-label prescription must** contain an indication or therapy goal **3. It is recommended** that any prescription contains an indication or therapy goal	No	No	Yes
Thank you for soliciting feedback on writing prescriptions. I feel that writing indications / goals routinely on prescriptions increases unduly the admin burden on Manitoba physicians. I would agree with recommending writing indication/treatment goal for new/off label use of meds.		Yes	

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I have reviewed with concern the proposed CPSM prescribing requirements. These are ill conceived and would already add to the administrative burden faced by physicians in their daily practice. I fail to see the purpose or logic of such a change. To my knowledge no other province outside of Quebec has such a requirement and it is not clear to me how this is going to advance patient care' I do not support any of the options suggested including option #3 which encourages physicians to add a justification/reason for the medication. This simply adds more administrative burden with no definable benefit.	No	No	No
I would suggest option "c". Requiring an indication to be written on each prescription would represent an additional administrative burden for physicians and not result in improved patient care/outcomes. There is a documentation standard that already exists within the medical record regarding the indications for prescription drugs. The medical profession is currently in crisis. A large contributor to burnout is the burden of administrative tasks, many of them are "non value added tasks". Doctor's Manitoba and government have committed to finding ways to reduce this burden. The proposed options "a" or "b" would add yet another unproductive administrative chore.			Yes
I am strongly opposed to the proposed mandatory requirement to list treatment goals/diagnosis/indication on prescriptions. There is no supporting evidence given as to why this is needed, no indication of how it will be monitored, nor what constitutes a sufficient annotation. In fact, I would point out the great irony that the College's own "prescription' here for physicians has no diagnosis, no indication, and no treatment goal! What problem is being solved? And this will certainly add to physician workload at the worst possible time, with no clear benefit.			
I am not in favour of a standard where a prescription must contain and indication or therapy goal. I think it would be fine to leave that as a recommendation rather than a requirement.			Yes
I feel that needing to write an indication or goal on a prescription will significantly increase my administrative burden with no real improvement to patient care. If a change needs to be made I would go with option 3.			Yes
I feel that writing diagnosis and treatment goals on all prescription and hospital orders as a requirement adds extra work without benefit.			

We should be documenting these things in electronic chart, patient letters, and hospital records appropriately. Writing it again with the prescription is just a duplication of efforts			
On the issue of providing the indication for prescribed drugs, the concept is reasonable but the application is likely to be problematic: 1. Prescribers will use many different terms and abbreviations for conditions, e.g heartburn, GERD, reflux, dyspepsia. On handwritten prescriptions these may be illegible. Would there be an expectation that this should be standardized? 2. Any requirement to provide indication for off-label use requires an unreasonable expectation for prescribers to know all specific labelled indications. Many drugs, especially older drugs, are widely used for conditions not included on the label. As an example azathioprine is used to treat ITP, hemolytic anemia, inflammatory bowel disease etc. but is only approved for transplant rejection and rheumatoid arthritis. If prescribing is done in an electronic record system there should in principle be the possibility to code all approved indications so that the prescriber could pick from a list at the time of generating the prescription (though the EMR I use at CCMB does not have this capability at present) 3. Members may have concern that these indications will be used to monitor the appropriateness of their practice. If this is the intent, it must be discussed fully and consensus reached that it is appropriate. Otherwise such use must not be permitted. I feel these issues would need to be addressed before such a standard is implemented. On electronic transmission: the world of carbon paper duplicates and fax machines is obsolete. The preferred way any prescription should be transmitted is from an electronic record directly to the pharmacy via secure software linkage. The College has a duty to advocate that the necessary investments be made for this to become the reality.			
My recommendation is that: Diagnosis, and/or clinical indication, and/or treatment goal is **recommended** on all prescriptions. This option minimizes physician administrative burden while also providing the option to make note of the indication for a drug under special circumstances. Both of the other options (mandatory inclusion of diagnosis/indication for *all*, or *new*, prescriptions) will significantly increase the amount of time required to complete prescriptions and will not notably improve patient safety or patient outcomes from my perspective.	No	No	Yes
I am concerned that needing to put diagnosis in the prescription will increase admin burden and will delay rx dispensing until I can respond. I think pharmacists should have access to pts chart if verification of indication is indicated.			
Re: Draft standard of practice -Prescribing Requirements I do not support the requirement for prescriptions (new , renewal, or off-label) to include an indication and/or goal of therapy (options #1 and 2) Not only is this unnecessary, it will add an unsustainable burden of time and energy on the physician (or other health care worker) prescriber.	No	No	Yes

Of the three options, if I have to vote for one of the three, the only one I vote for is #3, which makes a recommendation but not a requirement for including an indication/goal (although I think that a case has not been made for any such recommendation).			
In general I support the changes. I don't believe the verbal prescribing of MP3 prescriptions would apply to my practice so I have no comment My opinion on adding indication to all prescriptions would be that the indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions			Yes
Re requirement for indication / therapy goal on prescription While this may be recommended, I believe making it a requirement (as opposed to a recommendation) will unduly burden prescribers I am not aware that this is required in other provinces			
Regarding the ***CPSM Standard of Practice - Prescribing Requirements***, I understand the CPhM would appreciate having more information on prescriptions, especially with the ongoing discussion about an expanded scope of pharmacists. However, my vote (between the three options), would be for option 3 (indication, and/or treatment goal, and/or clinical indication be **recommended** only on all prescriptions). Requiring an indication and/or treatment goal and/or clinical indication on all prescriptions, or all new/off-label prescriptions, would be a significant increase in administrative burden to physicians. It is suggesting that physicians do more administrative work to make up for the inadequacies of our system (i.e., not having a province-wide electronic medical record). I would suggest that rather than increasing the administrative burden on physicians, the government look to other ways to improve communication between physicians and pharmacists (ex. a province-wide electronic medical record, or Imprivata Cortext extended to all pharmacists, etc.). I also think requiring an indication and/or treatment goal and/or clinical indication is going so far beyond what is required in other provinces that it will just further drive physicians away from Manitoba and/or the practice of medicine. I strongly support allowing verbal prescriptions for M3P medications (in the exceptional circumstances described in the draft). Working in medical oncology, and with a lot of patients with significant cancer-related pain and taking calls from patients while on call (evenings, weekends and statutory holidays), it is not uncommon that I have needed to provide a small supply of M3P medication to patients over the weekend or statutory holidays. Often, the only alternative, is to send patients to the emergency department. In the past, I have had to spend an hour of my time driving a physical M3P prescription to CCMB MacCharles for pick-up by the patient or have dropped off a physical M3P prescription directly to an agreed-upon pharmacy. This has become more difficult as I am now a mother with young children, and this is not always possible. If there is a safe way to give verbal prescriptions for M3P medications (in the exceptional circumstances described in the draft), I think this would be beneficial to both patients and physicians (and pharmacists). Regarding the ***CPSM Practice Direction - Electronic Transmission of Prescriptions***, I have no concerns regarding this document, other than preferring the option 3 (indication, and/or treatment goal, and/or clinical indication be **recommended** only on all prescriptions) as described above. I believe electronic transmission of prescriptions is a necessary change as a result of the permanent availability of virtual visits.			Yes

This new standard places a significantly higher burden on physicians with no demonstrable benefit to patients.			
I think to make it mandatory to have an indication written on prescriptions will add undue burden to our already cumbersome paper work. Given that there is no evidence to show that this impacts patient outcomes, making it mandatory is not evidence based. I suggest keeping this as a RECOMMENDED and NOT mandated requirement for prescriptions.			Yes
Because of the unnecessary increase in the already very high administrative burden I do not support the options 1 and 2 listed below and that opinion appear to be in agreement with most physicians in Canada as these options are only used in Quebec now. 1. Any prescription must contain an indication or therapy goal 2. Any new or off-label prescription must contain an indication or therapy goal I think that option 3 is reasonable 3. It is recommended that any prescription contains an indication or therapy goal	No	No	Yes
I would prefer not to be required to have to add indications, treatment goals, or diagnoses on prescriptions. a) Should indication, and/or treatment goal, and/or clinical indication **be required on all prescriptions**? NO b) Should indication, and/or treatment goal, and/or clinical indication **be required on all new and "off-label"* prescriptions only**? NO c) Should indication, and/or treatment goal, and/or clinical indication **be recommended only on all prescriptions?** NO	No	No	No
I have reviewed the proposed standards and kindly find my comments below each statement. **Any prescription must** contain an indication or therapy goal I believe this will unduly increase physician admin burden which is not small by any means today. In addition no other jurisdiction in Canada except Quebec has such a requirement. **Any new or off-label prescription must** contain an indication or therapy goal Again this will unduly increase physician admin burden and is not acceptable especially for new prescription. It can be recommended for an off label indication but most physicians would document an off label indication in their charts.			Maybe

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It is recommended that any prescription contains an indication or therapy goal This is reasonable.			
I have reviewed the draft documents I would strongly favor options 3 - that this change be recommended. There is always an indication for prescribing drugs and these are included in the patient record. Forcing physicians to put this on all prescription is a duplication of work and only serves to increase paperwork of the the busy clinician who writes many prescription per day. We need to find ways to simplify paper work, not amplify it			Yes
I practice as an Infectious Diseases and Internal Medicine provider in Manitoba, and am an Assistant Professor at the U of Manitoba. I vote for option a).	Yes		
I am an Interventional Cardiologist at SBGH. I have reviewed the documents and am familiar with the CPSM process as I served on the Virtual Care Working Group. I have great respect for the Colleges, the work they do, and the balance involved in the system of Professional self governance particularly related to Physicians. I always feel that we should err on the side of public safety in these issues. Having read the documents I don't see a reasonable case has been demonstrated for the addition of Clinical indication, and/or treatment goal, and/or diagnosis on prescriptions. This will provide Pharmacists with additional information but it has not been shown that this information will improve patient care. Perhaps the CPSM or working group has been provided with such information to indicate the additional requested information will improve patient safety. I think adding this information to prescriptions will not improve patient care and increase physician workload unnecessarily.			
I personally see the downside more that the upside in this proposal. Two things to consider: 1. **administrative burden:** 1. the physical act of adding indications will be a bother over time. Accuro is not the most efficient programme and every key stroke consumes time, or if writing physical prescriptions, an other line or two will add time 2. the countless phone calls/faxes that will follow when a pharmacist calls to "clarify" what an expert in the field is suggesting. Most of my prescriptions will say "osteomyelitis" but will that percipitate a discussion about therapeutic options with a pharmacist? or "Blastomycosis" where			

there different durations of therapy based on extent of invasion. Will this now lead phone calls about whether we are treating for 6 mo or a year? Every phone call/fax takes away from important tasks and we all already receive many phone calls 2. **PHIA:** a patient leaves their prescription for "valacyclovir-indication: herpes simplex virus" on their desk at work and co-workers see it, or if on a counter at home and children see it. Will a prescription stating "HIV", "herpes virus", "genital warts", "anal warts" "chlamydia", "syphilis", "gonorrhoea", "sexually transmitted infection" written on it be a source of embarrassment /shame for the patient and a potential deterrent to take to pharmacy? I do not support the proposal			
I am very concerned about the practice change options with wording of 'required' statement of the indication for each drug being present on the prescription for a few reasons: 1. Physician administrative burden increase with added time to complete this 'one more task', and unnecessary increase in phone calls from pharmacist if they forget to write it on one drug on a prescription or if it is for a relatively new indication for use. 2. Shortages of physicians are too high to increase the workload on those we have with this new requirement - and burnout and stress are at an all time high. I think this might be the death by a thousand cuts that pushes more MD's to close practice and leave the profession early. 3. PHIA risk to patients should they inadvertently lose their prescription with their diagnoses written on the prescription. I would suggest the 'recommend' that the indication be listed on the prescription is a better wording to proceed with.			
I consider that option 3 is the best one, that **is recommended** that any prescription contains an indication or therapy goal, but not mandatory. How are we going to protect the confidentiality of the patient when his diagnosis is in the prescription, what if he is a person living with HIV or have genital herpes and he leaves his prescription at home, in the car, at his office and he is discriminated for the diagnosis he has. Administrative burden is already a huge issue in Manitoba and making this mandatory will only increase our burden of work, forcing us to do this in any prescription will represent more work and will represent more call backs from pharmacist asking us for clarification "It's estimated Manitoba physicians spend nearly 600,000 hours on unnecessary administrative tasks annually, a heavy burden that not only diverts doctors away from patient care, but is also a top contributor to physician burnout" https://news.gov.mb.ca/news/?archive=&item=58526#:~:text=%E2%80%9CIt%27s%20estimated%20Manitoba%20physicians%20spend,top%20contributor%20to%20physician%20burnout.			Yes

I am against requiring physicians to write indication for prescription. This will result in delays in patients getting prescriptions which could adversely effect outcomes in some situations like prescriptions for antibiotics. What would a pharmacist consider an adequate indication? For example: if the rx is for an antibiotic would writing 'infection' suffice or would we be expected to write 'pneumonia' ? This will not improve patient care and has to potential to harm			
This initiative may have some benefits; however, the costs to an already overburdened healthcare system make this unacceptable. The few considerations that follow are examples of these unwanted consequences. 1. What is the hypothesis for the initiative? The intended objective for this initiative presumably is to reduce medication errors. If this is correct, then there must be some methodology to determine if the initiative has, in fact, resulted in a significant reduction in medication errors. There must be a quality control process. This, I expect, would require resources not previously budgeted by the College or Shared Health Manitoba. It is unclear how the value added of this initiative will be assessed. For example, a prescription for amoxicillin may be accompanied by the indication "pneumonia". There is no process to verify that diagnosis let alone the microbiological aetiology. 2. The initiative will add a significant cost for the additional time required for physicians to perform the function. How is this cost to be remunerated to the physicians? 3. One might predict that written prescriptions containing indication information may be difficult to decipher or understand by a pharmacist. This would likely lead to a request for clarification with additional cost in time for the pharmacist and the physician. 4. Electronic prescription applications may not be able to accept additional information fields without further re-programming. This will add a substantial cost to the initiative. 5. Is there a risk for breaching PHIA? A prescription containing the indication may be seen by others not entitled to have this information.			
I am writing to provide comments on the recent Draft to changes to the SOP for Prescribing Requirements. Specifically, I am concerned about the changes to the new proposed requirement to include 'indication or therapy goal' on prescriptions. I strongly believe this should not be a mandatory requirement for all prescriptions because: 1. It adds an undue administrative burden. Physicians are already burdened by the use of electronic medical records and the numbers of 'clicks' or additional information required to approve any orders. I specialize in the treatment of cancer. Our prescriptions are complex as they include drugs to treat the cancer and drugs to address anticipated side effects. Do we need to justify the purpose of every drug in the prescription even though the prescribing of these drugs and protocols are tightly regulated by CCMB policies? 2. This information is redundant. We already document the reason for therapy in the medical record. Should we therefore copy pharmacists on all progress notes as well?			Yes

3. It invades patient privacy. Prescriptions follow varying journeys from prescriber to pharmacy especially with more vulnerable patients. There is a risk that their health privacy may be violated in the process as patient diagnoses may be visible to more 'eyes'. 4. May lead to gaps in patient care. Due to current health care provide shortages, particular in primary care, patients are often reliant on specialist involved in their care to 'bridge' prescriptions until they can be seen by their PCP. The greater administrative burden of these requirements may force more specialists to abstain from renewing vital prescriptions. I do appreciate the need in certain circumstances where this including prescribing information would be important for patient care. Two examples that come to mind: 1. Narcotic prescriptions – I agree it is important to note the reason for the prescription to avoid abuse. E.g. I routinely write on my narcotic prescriptions that it is for cancer pain to communicate the intent and reduce potential stigma for the patient. 2. Abuse of off-label use – a particular example that comes to mind is Ozempic use for weight loss as opposed to DM2 treatment. To address this issue, the college should have specific indication requirements for certain drugs, rather than a blanket requirement for all prescriptions. In summary, of the options available the only one that seems reasonable is options C. '**be <u>recommended only</u> on all prescriptions?'**			
Concerning the above consultation I would advocate for an approach similar to that which has been taken in Quebec as you had noted in the consultation document. I believe this would foster better team communication with community pharmacists.			
I have reviewed the DRAFT Standard of Practice - Prescribing Requirements, and I would like to provide my feedback on 3.1.6. I am opposed to requiring physicians to write a diagnosis/clinical indication/treatment goal on prescriptions, as 1) the general purpose of the prescription can usually be deduced from the nature of the medication; 2) it adds an additional time/administrative burden, particularly to FPs who may be prescribing multiple medications at each visit; and 3) it creates potential for PHIA violations/stigmatization of patients who have conditions that they may not want others to know about (e.g. HIV and other STBBIs).			
Please find below my comments regarding the draft Standard of Practice for Prescribing Requirements. 1. I would like to see the indication or treatment goal as a requirement on all new prescriptions. However, I'm concerned that a requirement for "off-label" prescriptions will be difficult to apply as prescribers may not readily know when some medications are being used in a common but technically off-label manner. 2. The draft makes reference to a faxed prescription form for M3P medications. Will the CPSM continue to accept M3P prescriptions generated by/faxed directly from an EMR, provided they contain the required details eg. total qty and indication? Adding a required fax form/template to the workflow would have a major impact on some practices (especially OAT) and I doubt would add much in the way of patient safety. I also have a question pertaining to the standard which I'm hoping someone could provide guidance on:			

3. Our clinic has primary care nurses who may assess our patients in various capacities, eg. for STI care, OAT, LTBI and so forth. A nurse might perform a telephone or in-person assessment and relay this to a prescriber, eg. a complete assessment based on an algorithm for uncomplicated acute cystitis to determine whether empiric antibiotics are appropriate, or a home visit to examine a wound. In designing our workflows, would it be possible for a prescriber to provide a prescription in a case like this based on a nurse's assessment, or does the prescriber need to have "direct" contact, eg. meet the patient by phone/video/in person prior to prescribing, even when no physical exam is medically indicated (eg. some cases of uncomplicated acute cystitis)?			
In addition to Dr. Renner's comment; to add, any of these options will add considerable administrative time to our already heavy administrative workload.			
I don't support the proposal of writing the diagnosis and goals of therapy on the prescriptions. This will result in unnecessary confusion and more frequent calls between pharmacists and physicians and may delay the dispensing of the necessary medications because of that. Sometimes, there is no clear diagnosis at the time of the prescriptions. In addition, this will increase the administrative time burden which is already heavy and I understand the province health authorities are working on minimize this burden.			
Please accept our prescriptions from ARIA directly as it will be more efficient. Current process is very cumbersome.			
I understand that it can be helpful to pharmacists to have a prescription indication for safety reasons and to facilitate appropriate patient education. However, I have some concerns about the proposal to require an indication for every prescription. These include: • Increased workload – this may seem limited but over the course of multiple prescriptions adds up to a considerable increase in time, at a period when administrative workload demands are already very high • My current experience when I do write detailed indications is that this does not address issues as expected. For example we prescribe high dose (1250 mg prednisone/day orally) on some occasions. Knowing that community pharmacists will query the dose I write out indication, as well as the bioequivalent dose to the IV steroid that they may have heard more about. Despite this at least one third of pharmacists will still hold the prescription and ask if I really mean it before they fill it. • Medication dose/type are highly variable depending on the needs of the patient • Sometimes the precise diagnosis is unclear, or we are treating multiple symptoms with drug – this is common when working as a specialist with complex conditions, where we need to really on experience to allow us to make a choice about how to try to improve someone's quality of life – this may impede that • Even if I write a diagnosis, that does not prevent errors in choice of therapy, dose etc. I would favor stating that adding an indication is a recommendation.			Yes

I favor the option to recommend, rather than require, an indication for prescriptions. I don't think there is enough potential gain in patient safety to outweigh the extra time taken by physicians in writing prescriptions, or answering the potential follow-up questions.			Yes
I am concerned that the requirement to add further information, such as diagnosis or indication will add significant and unnecessary administrative burden. The following will be a specialists' perspective: It is unclear to me how this will add to patient care. For example, why should it matter if an oral contraceptive pill is prescribed for contraception, for menorrhagia, or for acne, as long as the prescriber is diligent in assessing suitability when they prescribe? Should this come to pass, please provide and communicate a convincing explanation of how care will be improved, as CPSM will not get buy-in if it is "recommended", and will escalate physician disengagement if it is "required" without convincing benefits. I am concerned that this will lead Canada towards the negative direction of the US, where medications are essentially not available for "off label" use, even where there is solid evidence to support use for indications not included in drug companies' initial studies and applications. Finally, as you know our administrative burden is extreme. If we are to be required to add this information to prescriptions there must be an effort made to minimize other burdens; my biggest burden related to prescriptions is pharmacists' repetitively sending me rx renewals for patients who are no longer under my care. This requires me to open their chart, review when I last saw them, review my notes and prescription history and often reply that the patient is no longer under my care. Despite this I often get a second or a third request, doubling or tripling the work. This is especially frustrating when I never prescribed the medication in the first place (this occurred exactly as described this week). I would suggest adding a box that can be checked indicating if we are willing to receive requests for refils for this rx. If not checked, we should not receive these requests. Care will be enhanced by avoiding delays from sending to an incorrect physician.			
For paragraph A I prefer option C For paragraph B - I think it would be sufficient to allow using regular prescription, I see more risk with verbal narcotics orders than benefits.			Yes
The new prescribing requirements proposed would place an additional administrative burden on our already overburdened physicians and will especially impact family physicians. In my 25 years of working as a family physician I have never encountered a situation where a pharmacist would contact me regarding the indication for a medication, queries have always been regarding dosing, interactions etc. and on occasion with a medication review by specialized pharmacist they have requested additional medical information that was provided with the patient's consent. I have an extensive elderly practice and adding a diagnosis to every single medication prescribed would easily add another hour to my day, time that could be better spent caring for my patients. It would be a a lot more efficient for a pharmacist to request more information from me via fax or phone. In my opinion the best option would be "c) Should indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions?"			Yes

Given that we're trying to streamline the amount of paper work for family docs, the only reason for including indication should be for a)off label, b) controlled drugs or c) new prescriptions. This potentially improves patient care with the least amount of added burden for docs. I agree with verbal M3P under conditions of extreme need ie for palliative patients after hours, or on weekends, or the physician is away from their computer.			
Thanks for allowing input into the DRAFT Revised Standard of Practice: Prescribing Requirements and the DRAFT Revised Practice Direction: Electronic Transmission of Prescriptions. I make these comments as a physician with 35 years of practice, in rural Manitoba, performing several roles. I prescribe for inpatients and outpatients. My practice has shifted from paper prescribing to almost entirely prescribing in electronic format. I work extensively with CancerCare and Palliative Care, and as such am a high opioid prescriber, for patients with significant health issues, many of whom are close to end-of-life. Regarding the DRAFT Revised Standard of Practice: Prescribing Requirements, the need for the added diagnosis could become more complicated. Will a diagnosis of "cancer pain" be enough, for example, or will it need to be "breast cancer pain?" Or perhaps for the prescribing of tamoxifen, "Stage 3A ER pos PR neg HER-2 neg?" How specific will a diagnosis need to be? And is the rationale that the pharmacist can become involved in the clinical decision-making? I also worry about those patients receiving multiple medications, needing to document the indication for each. Aren't some obvious? My suggestion would be that the document makes it a **RECOMMENDATION**, especially for medications that have multiple indications, or for controlled drugs, or drugs that require more clarity. I would hope then, that when I write a prescription for prochlorperazine, for example, and state that it's indication is for post-chemotherapy nausea, that the pharmacy stops providing patients with handouts that concentrate on the treatment of psychosis. Regarding the DRAFT Revised Practice Direction: Electronic Transmission of Prescriptions: I have a specific question regarding the ARIA medical record, used extensively throughout the province by CancerCare. I feel all prescriptions should be marked with a patient's PHIN, but prescriptions generated through CancerCare's ARIA do **NOT** have a PHIN number on them (apparently some kind of privacy decision). Would a faxed prescription without a PHIN still be valid? (They are routinely accepted now.) If an EMR (such as ARIA) is unable to fax directly from that EMR, is a faxed prescription of a controlled drug (e.g. opioid for pain) from a fax machine in a cancer clinic valid? If the prescription contains the identifiers, the correct instructions, etc., will there still be need for a cover page stating all of that again, as is currently mandated? It would seem to be reasonable for a pharmacist to take a verbal prescription, especially if a faxed prescription is to follow. It should be important to note that the pharmacist could ***release*** the medication prior to having received the written confirmation. Thanks for your work on these standards as we all evolve in our practices around prescribing.			
I am writing in regard to the potential change in standard of practice for prescribing medications in Manitoba. I am a surgical Ophthalmologist practicing in the Province for 27 years. I oppose the pending change in which physicians would have to include a diagnosis, treatment goal or indication on **any** prescription. Pharmacists are not physicians and are not trained in the diagnosis of medical or surgical conditions. Pharmacists do			

not need information about the diagnosis made by a physician for his or her patient in order to fill a prescription. The history and examination as well as laboratory or imaging investigations that lead to a diagnosis are made within the doctor patient relationship and is privileged. In today's pharmacies there are several people who were involved in filling the prescription including pharmacy technicians and students. Patients have the ultimate right to privacy of their diagnoses. In most cases, medications are dispensed in a large public setting where their diagnosis could be discussed where others could overhear. This is entirely unacceptable. There is no reason that a pharmacist needs to know the diagnosis, treatment goal or indication in order to dispense a drug. If a pharmacist has a concern he or she can contact the prescribing physician as is currently the case. Patients would have to sign a release of information document if the diagnosis has to be listed on the prescription. This would be just another layer of work for physicians. Information such as diagnosis would also then be listed in the database of the pharmacy. Most pharmacies are large corporations. Who would have access to this information? Would companies such as Walmart, Costco or Loblaws be selling this information, perhaps to pharmaceutical companies? Patients need to be protected and ensured that their medical information, which is privileged, would not be shared with or sold to third parties including government agencies. There would also have to be an option for patients to opt out of having their medical information disclosed on a prescription to a pharmacy In my experience I have been contacted by pharmacists who question the doses of certain medications that I have prescribed. When I explain why the dose is beyond what is normally prescribed because of a specific diagnosis (bacterial keratitis) they simply go along with my initial prescription as they have no idea about what type of disease I am treating. This is a waste of time for me, and especially for the patient who has had to wait longer to get an eye saving drug. In my opinion this is about getting pharmacists more power to diagnose and prescribe and also a way to collect more information about patients. Information is a huge commodity and can be bought and sold. It can also be hacked and misused. Please do not allow this amendment to how physicians prescribe medications for their patients. There is no benefit to the patient. There is only harm as their personal information would be transmitted to people who were not involved in the diagnosis or evaluation of their conditions. It also opens up patients to having their medical information given or sold to third parties.			
In regards to section 3.1.6 I feel that the third option of diagnosis indication or clinical goal is recommended on all prescriptions makes the most sense to me . Although I really don’t see the need for this change and don’t think it should be changed at all.			Yes
Thank you for requesting feedback from the community regarding the proposed **CPSM Standard of Practice - Prescribing Requirements** document. I can appreciate CPhM's goal of improving patient safety in their recommendation to require a clinical indication/treatment goal/diagnosis on all prescriptions (herein called the "Recommendation"). A change of this magnitude should come with supporting evidence from either CPhM or CPSM indicating the frequency of adverse events associated with the current Standard of Practice (i.e., how often does harm arise when prescriptions do			

not include clinical indications/treatment goals/diagnoses). Additionally, in jurisdictions where this Recommendation has already been adopted, how frequently does the inclusion of a clinical indication/etc lead to the Pharmacist identifying an issues that alters management? At this time, I **do not support** this update to Prescribing Requirements. Physicians across the country are already overburdened by administrative tasks. I worry that this Recommendation duplicates steps already required in the Standard, and will increase the clinician's administrative burden. In the current CPSM Standard of Practice - Prescribing Requirements, sections 2.1 and 2.2 stipulate that the prescriber must be knowledgeable and skilled in the prescription of a given medication, and must have appropriately assessed the patient and documented a clinical indication (or other relevant information). Should a pharmacist believe a prescription does not address a patients' needs fully, they already have the ability to request timely feedback or clarification from the prescriber. Hence the Recommendation appears to duplicate existing steps. One of the offered options describing only including clinical indications/etc when prescribing "new and "off label" [medications]". I do not think this is a helpful compromise either, as a huge number of medications used in daily practice are done so in an "off label" manner. As an example, topical moxifloxacin eye drops are routinely prescribed after any intraocular surgery (such as cataract surgery, corneal surgery, or glaucoma surgery) in order to prevent serious post-operative intraocular infections (i.e. endophthalmitis). This is considered a strong standard of care amongst the ophthalmic community across North America. However, the strict clinical indications for moxifloxacin are for the treatment of bacterial conjunctivitis only (not prevention of endophthalmitis). Hence the vast majority of prescriptions for topical moxifloxacin would be considered "off label". In the case of the ophthalmic community, this would mean that one of the most commonly prescribed medications we have would always require the extra documentation of the Recommendation.			
I will like to advise that we keep the indication for treatment or diagnosis - as recommended for all prescriptions and NOT required. Making this a requirement will increase all of our work which will lead to a lot of back and forth Rx faxes with pharmacists asking for clarifications. We already have a tonne of these to deal with on a daily basis and this will be a nuisance and not help our patients since there will be longer delays in getting the medications they need.			Yes
I would like to respond to the recent e-mail requesting our voice for the DRAFT Standard of Practice - Prescribing Requirements document. I disagree with all three options as presented below copied from the CPSM website. The three options below are being considered. In your response, we ask that you provide your feedback on your preference regarding the use of indications. a) Should indication, and/or treatment goal, and/or clinical indication be required on all prescriptions? My answer is NO.	No	No	No

b) Should indication, and/or treatment goal, and/or clinical indication be required on all new and "off-label"* prescriptions only? My answer is NO. c) Should indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions? My answer is NO. I think the above requests are unnecessary and only add to the additional administrative burden that is being placed on physicians. The current standards of prescribing (drug, dose, refills, etc.) has been in place for many generations and I do not feel that the above requirements would improve patient safety at all. There is already too much administrative "red tape" that physicians and their offices must comply with in order to serve patients. This change would go in the opposite direction of improving patient care and improving physicians efficient delivery of patient centered care.			
Regarding the draft Standard of Practice for prescribing requirements, I am in opposition to prescriptions requiring a diagnosis, clinical indication, or treatment goal. In my practice in sleep medicine, we previously had several patient complaints about breach of their privacy when we included related diagnoses on CPAP prescriptions. Although at first glance in our practice, it seemed this was benign information to include to related care providers on CPAP prescriptions, but we quickly removed that information once we received the patient feedback that this was unnecessary sharing of their personal health information. Patients highly value the protection of their health information. The additional information on prescriptions will also add additional administrative burden to physicians.			
I strongly oppose this proposed requirement to include a clinical indication and/or treatment goal, and/or diagnosis on all prescriptions. 1. this will impose a significant administrative burden, that is unequally distributed to specialties that already have a high administrative burden, such as primary care physicians, as well as physicians such as myself who work in HIV clinics that often act as surrogate primary care clinics for patients who have no family doctor or whose family doctor recently retired 2. this proposal will further stigmatize conditions that already are significantly stigmatizing, such as mental health diagnoses, HIV, and sexually transmitted infections. The HIV medications I prescribe are very clearly known to be for HIV based on what they are - asking me to write "FOR HIV" on these prescriptions will further stigmatize my patient population. Similarly, I may send antibiotic prescriptions for doxycycline, or azithromycin, or cefixime, to treat syphilis, chlamydia, or gonorrhea - I don't think it improves a patient's care in the slightest for me to write the name of the STI I am treating on the script - I've made the diagnosis and if I need pharmacy guidance I will ask for it ahead of time; writing the diagnosis only contributes to stigma for the patient. I know why I am prescribing the drug; my patient knows why I am prescribing the drug, and if for some reason the pharmacist has a question they can call me.			
I am responding to the consolidation of prescriptions. I do NOT think putting the diagnosis is a good idea for the following reasons. 1. Is this acceptable from a patient confidentiality perspective? Will patients have to sign a release? What if the patient doesn't want the diagnosis released?			

2. This will create extra paperwork in clinics that have a high patient volume with alot of prescriptions, such as routine post op prescriptions after cataract surgery. 3. In my ophthalmology practice, initial prescriptions may initially be for symptoms and not a diagnosis, for example, uveitis. I may prescribe in a certain way and then change what I do based on the progression of the condition or the discovery of the diagnosis. I don't want to be taking calls from a pharmacist questioning why I am using drops a certain way or changing them when they don't know the clinical situation of the diagnosis or symptoms that I am treating. That would be counterproductive and a waste of everyone's time. I appreciate when I am notified of drug interactions that I have missed, but for the reasons mentioned above I do not think that putting the diagnosis on a prescription will improve patient care.			
This proposal is a poor idea adding burden to our practice. It will result in much more admin work. We need to decrease the documentation burden of physicians, not increase it. Requires yet more writing and documentation, and can be another source of error. For instance if I prescribe drops to lower eye pressure - now I would have to write my goals or a diagnosis. This proposal is unacceptable and in the wrong direction of efficiency with no benefit to patient care. 3.1.6. one of: diagnosis, and/or clinical indication, and/or treatment goal, is required on all prescriptions OR is required on new and off-label prescriptions only OR is recommended on all prescriptions. 9 (Refer to consultation document)			
I am writing this email to express my complete lack of support for the mandatory requirement of providing an indication or goal of therapy for prescriptions written. I will be brief but very clear. A mandatory policy will significantly increase administrative burden on physicians in both clarifications by fax and phone call. It may also delay access to necessary medication. The burden to reduced medication errors should not be put solely on the physicians related to an antiquated paper dependent system. The burden should be on the province to produced a province wide EMR with electronic prescription submissions. The proposed policy is not justified. I also believe providing the indication or goal of therapy is a **PHIA violation**.			
1. There would need to be a clear scientific justification for doing any of these changes. What data do we have that this is required? This should be shared in a transparent way with CPSM. 2. What is the expectation if the pharmacist disagrees with the indication? Are they (pharmacist) now acting in the capacity of a consultant on our prescriptions? Are they taking on more liability if they fill the prescription if the indication is there? Are physicians now going to have to answer phone calls/communications from pharmacy to discuss the indications for the prescriptions? If so how will that extra time be accounted for/ remunerated? 3. How would the added burden of work to the physician be addressed? This can me much more time over the week/month/ year of administrative duties for the physician.			

4. How much information is required for an indication? Will pharmacist reject a prescription if only a word in included, what is the standard? Do they want a copy of the clinic note for each prescription? 5. Will this apply to refills? Without more information I cannot support this.			
I previously sent my feedback regarding the additional prescribing requirement. I have one further comment. I work at CCMB and use ARIA as the electronic record and prescribing system. It would markedly improve efficiency and patient privacy to allow prescriptions that say "electronically signed by…" without needing a hand-drawn signature. This would then open the door for some kind of direct e-prescribing system between ARIA and pharmacies. Our current system wastes many hours of healthcare workers time dealing with faxes. Fax transmission is also inherently unreliable (it is frequent that faxes don't go through) and unsecure (fax has the potential to go to the wrong fax number which is a significant privacy issue).			
Thank you for the opportunity to provide feedback regarding the proposed changes to prescribing standards. I am very concerned regarding the proposal of mandatory inclusion of indications for prescriptions of any sort. This places a considerable burden on physicians, without a case of any strength being made for the purported patient safety benefits. Even a *recommendation* to include diagnosis/indication/treatment goals is not substantiated. While there may be scenarios for some classes of drugs that are a higher risk, this is not part of the proposal. I would be concerned if pharmacists are attempting to apply treatment goals without being able to assess clinical endpoints, or be involved in laboratory ordering/monitoring. If there was information from other jurisdictions or pilot studies that demonstrated a positive impact, a proposal to recommend inclusion of this information might be more reasonable. I think that establishing a infrastructure for other forms of electronic communication of prescriptions would have a greater impact on patient safety, and this infrastructure could conceivably support inclusion of the clinical information that apparently has been missing.			
We are reaching a point that physicians cannot keep up on documentation in Manitoba. This is well known and well documented. Mandating anything that requires additional documentation is not in the best interested of the college if you are hoping to minimize physician burn out and preventing premature retirement or stress leaves due to work load. Given this my feeling is that there should be a recommendation that any prescription contain and indication or therapy goal, and should not be required. Which I agree is important and in fact do myself not infrequently. I would also like to request the college consider accepting electronic signatures on prescriptions. This would improve work flow for physicians at CCMB and help to decrease some of our work load.			

I am writing with regard to my concerns about the Standard of Practice Prescribing Requirements, specifically 3.1.6. one of: diagnosis, and/or clinical indication, and/or treatment goal is required on all prescriptions OR is required on new and off-label prescriptions only OR Is recommended on all prescriptions; I am quite concerned about the initial suggestion "diagnosis, and/or clinical indication, and/or treatment goal is required on all prescriptions" for multiple reasons as listed below 1. It remains unclear to me the additional value it will provide. I do not believe that it will decrease medication errors and it is not the standard of practice across Canada. We are an evidence based medicine and I have not been provided with any evidence to support this policy, so how can this be the "standard"? Rather, I see it is an additional administration burden without significant value in an already admin heavy practice. 2. I am concerned that it will lead to delays in patients receiving their medications. Take for example an antibiotic written for a dialysis patient… and the indication is missed. What happens then? Does the pharmacist contact the physician or send it back to the dialysis unit with a request for clarity? If it's the latter, it may be a day or two before the physician sees it, so potentially this patient might go an additional 1-2 days without medications they really need. This is not safe or acceptable. 3. There is potential breach of confidentiality, as pharmacists are not necessarily privy to the indication for a medication, nor do they necessarily handle the information confidentially. Take for example a patient prescribed valacyclovir for genital herpes.. is it appropriate that diagnosis be written on a prescription? Absolutely not! Prescriptions are most certainly not handled confidentially at all pharmacies, and I will provide a personal example of this. I recently dropped off a paper prescription at my own pharmacy, but when I went to pick it up it was not filled. Then when they went to look for it, they could not find it. They looked all around the pharmacy in MULTIPLE paper prescription piles splayed all around the pharmacy, which is not the way confidential information should be handles. So unless processes are FIRST implemented to guarantee patient confidentiality at all pharmacies, I do not support providing clinical diagnoses on their prescriptions.			
Regarding the DRAFT Standard of Practice - Prescribing Requirements, Specifically on the following three options. 1. **Any prescription must** contain an indication or therapy goal 2. **Any new or off-label prescription must** contain an indication or therapy goal 3. **It is recommended** that any prescription contains an indication or therapy goal FEEDBACK It's a bit difficult to provide feedback without knowing what issue is being addressed. It says that this would "Allow pharmacists to determine prescription appropriateness in a timely manner." Is determining prescription appropriateness in a timely manner an issue? Are pharmacists searching for indications, and is that the cause of the delay? If there is a more detailed quality improvement type analysis that shows that (a) pharmacists are having difficulty determining appropriateness AND (b) that writing an indication would effectively address the problem, it would be helpful to hear.			

In the absence of such data, I'm not sure why any change is being proposed. CONCERNS 1. It seems like this change would just introduce a new place for medication errors to occur, like writing the wrong indication by accident 2. It seems like this introduce an area of confusion for pharmacy and patients. 3. It would be a large administrative burden that would fall on physicians and likely the pharmacists in clinic as well. Especially in internal medicine where patients are on 10+ medications. 4. An indication for medications is often written in the note from the subspecialist to the GP, so this would be duplicate work. (eg. Dear GP, thank you for referring patient X for hypothyroidism. I have started Synthroid) 5. As above, I'm not sure what this change is going to help with. I would like more info on that if it were to move ahead. Also how much detail would be needed? Eg metoprolol 25 mg PO BID – for afib and HTN, dose increase b/c high BPs but HR at target, goal BP 120/80 etc. etc.			
I am a medical oncologist who treats patients with a variety of cancers, including situations where patients are near the end of their life. They often require frequent medication adjustments/changes. have the following concerns with the current draft: 1. I don't understand why a diagnosis/clinical indication/treatment goal needs to be placed on a prescription. Medications are used for a variety of reasons and I foresee this requirement creating more work without fixing any underlying problem. It is not reasonable for a pharmacist to interpret the needs of a complex patient by using one (or a few word summary) for that medication. I think it may ultimately cause more confusion. 2. Our electronic medical record prints out prescriptions with an "electronically signed" by xxxx on it. A significant proportion of the prescriptions I write are done when the patient is not right in front of me. This means I am writing the prescriptions in my emr, printing/saving them to add a signature, emailing the prescription to my clerk who has to prints it off (again) and fax it to the pharmacy. Requiring a hand-written signature is a burdensome extra step in this process. There seems like there should be an easier way to send validated prescriptions and would advocate for allowing the "electronically signed by" xxxx generated by an EMR. I am not convinced that making someone sign the prescription decreases the risk of forgery. Ideally, prescriptions should be able to be sent from the EMR. 3. I don't see the value of requiring only 1 electronic M3P prescription on each sheet of paper. I have numberous examples of prescriptions that are lost by the pharmacy when faxing multiple M3P prescriptions at the same time. It ends up causing extra work for everyone involved. EMR M3P prescriptions already have clearly laid out info, so I don't see the value of requiring only 1 per sheet of paper. 4. M3P require a PHIN number: I have been told that the College of Pharmacy doesn't allow the PHIN to be automatically added to electronic prescriptions. Right now this means we have to manually add the PHIN number to each M3P prescription done in our EMR. It would be ideal if this was not a requirement. 5. I support allowing verbal M3P prescriptions in specific situations.			

My preference is: Indication, and/or treatment goal, and/or clinical indication **be <u>recommended only</u> on all prescriptions**. This should not be a mandatory requirement.			Yes
I am submitting requested feedback regarding documentation of an indication for prescribed medications. I view this as just another step that will add to excessive administrative burden which detracts from patient care and physician mental health. I appreciate that pharmacists feel pressured for time however patients have the option of changing pharmacies. It is far more difficult for patients to find a new doctor if wait time is excessive. Hence saving our time is probably of greater importance with respect to patient well being and safety.			
My recommendation would be a variation of choice 2 and 3. Diagnosis or indication be required for any off label use and recommended for new diagnoses.		Yes	Yes
I am a hematologist working at CancerCare MB. I write a lot of prescriptions for benign hematologic conditions (eg. Immune thrombocytopenia, thrombosis etc) as well as for malignant hematologic conditions (eg. Lymphoma). I have my reservations about having to write indication for treatment on call prescriptions (Section 3.1.6). This has huge implications not only for the physician but also patients as well as pharmacists. I have tried to summarize these implications below: 1. For Physicians a. This will increase our work load substantially. We are already thin in manpower, our clinics are overbooked, we are short of nursing and clerical staff. Having to write diagnosis or clinical indication on all prescriptions will take a lot of our valuable time b. Some prescriptions are for rare hematologic conditions with small case series (eg Off label use); I am afraid a physician will have to provide lengthy explanation to pharmacist as in their books a drug may not be approved for that indication 3. Some diagnosis are rare so even if I spent time writing about it in the prescription, the pharmacist may not have the knowledge of what that is which has the potential to delay treatment for patients (if the pharmacist doesn't fill it 2. For patients a. May delay them getting drugs on time if pharmacist has no knowledge of medical indication written on the prescription and are waiting for clarification b. May get conflicting information (eg a physician chats with patient about disease outcome but pharmacist who may not know prognosis data for cancers could provide them with conflicting information). The would cause patient anxiety which in turn would lead to patient dissatisfaction with treating physician (including mistrust in health care being provided to them!) c. Implication on patient confidentiality and impact in their life (eg. A patient diagnosed with sexually transmitted infection due to extra marital affair who gets a prescription for antibiotics whose spouse finds that prescription with a diagnosis saying "syphilis").	No	No	Yes

d. Medications will become more expensive as pharmacy may increase their dispensing fee due to their increased workload of having to check diagnosis/indication on every prescription 3. For pharmacists a. Increase in their work load b. May not have good understanding of diagnosis/clinical indication c. Frustration of having to contact physician every time there is missing diagnosis or clinical indication etc. I personally think Section 3.1.6 needs great thought. I vote AGAINST having to write diagnosis/clinical indication or treatment goal on ALL prescriptions or NEW prescriptions. I would favor "is recommended but NOT mandatory"			
I vote against the requirement of writing the diagnosis for any medication we prescribed. Extra work for no reason. We have been granted medical degree to be able to write those prescriptions.	No	No	No
indication, and/or treatment goal, and/or clinical indication should be required on all prescriptions indication, and/or treatment goal, and/or clinical indication should be required on all new and "off-label"* prescriptions a grace period, lots of communication and mitigation strategies to avoid barriers or inefficiencies to develop as a result of this change must be considered			
I would favor Section 3.1.6 to read that clinical indication/diagnosis is recommended on new prescriptions only. Our electronic system is not set up to continually revise diagnoses and put them on electronically generated prescriptions and it is a huge administrative burden to expect physicians to write this on every prescription that they generate in clinical practice. Similarly, there are many medications that are in general use in practice that are technically an "off-label" indication and again it would be a huge administrative burden for physicians to recognize this every time and to indicate it on every prescription. For the occasional time that the pharmacist has question about this, I understand that I would be called by that pharmacist. I am also strongly in favor of being able to electronically generate prescriptions and fax them directly to the pharmacy with electronic signature. Again, it would be a huge administrative burden to expect the clinical diagnosis/indication to always be on the prescription and to indicate whether it is on-label or off-label use. In order to facilitate communication between physicians and other health care providers we should all be on the provincial Cortext system which would help pharmacists and us communicate in a expedient manner.			

I have issues with the new proposal to require diagnosis/indication for all off-label prescriptions. As a pediatrician many of our drugs are off-label and many of these are used so ubiquitously that we don't even realize they are off-label. in fact this can be said for many vulnerable populations such as pregnant women, the elderly, etc. I worry this proposal will demand increased work from prescribers, especially when we are inevitably challenged by the pharmacies, resulting in significant delays in medication delivery. It seems like a unnecessary burden, especially in an era when physician administrative work-load, work-force shortages, and delayed patient care are under significant scrutiny.			
I am emailing to say that I don't think we as MDs should have to add in prescribing indication for medications on prescriptions. I have several concerns for this. 1. There are often times that there are multiple reasons to prescribe a specific medication that would make this meaningless. Such as using enalapril for hypertension, renal preservation and albuminuria – some times all exist in one patient. Not sure why writing this would add value and the pharmacist would not be privy to this other medical information to help decide if the treatment is indicated. 2. If this was only for off label use – as a pediatrician that would mean most of my prescriptions will need this since most of the time we are using things off label – or honestly I don't know if they are off-label usage but would assume so since very rarely studied and approved in children. This will create more burden on those of us prescribing to children. 3. I'm not sure how this would be incorporated into EMRs which are complex enough to send accurate prescriptions on – especially using liquid medications in children. 4. If this wasn't filled out or the pharmacist didn't agree with the indication – I would worry that this would cause delays in medications being filled. While I understand the safety of this – not using medications inappropriately – perhaps a better system would involve – high alert medications that you do need to put an indication of why this is being used – that would somehow automatically incorporate in to our EMR – or that pharmacy would have an automatically form that came back for an MD to fill out if a drug required this step to confirmed appropriate indication – similar to NIHB approval forms.			
I would like to provide my feedback regarding your email about the Draft SoP for Prescribing Requirements. For context, I am a PID physician long involved locally and nationally in antimicrobial stewardship, for which many of the themes are similar. There is literature from the ASP world to show that having prescribers put an indication for abx use in the EMR when generating an abx Rx, can help nudge them into more appropriate prescribing behavior. That being said, many of those findings have also been paired with other ASP initiatives.			

Especially for pediatric prescribers, I feel the proposal of having requirement of a diagnosis or clinical indication for any new or off-label prescription would dramatically increase the workload for practitioners prescribing to peds and other vunerable groups like pregnant women, the elderly etc. In peds many of the Rx we use are "off-label", and this would put an inappropriate burden on pediatricians and other Rxers for children. Also, many of the prescribers don't know which are on or off label. There would easily be issues for pharmacies with increased paperowrk and therefore potential delays in appropriate therapy. Overall, I could see the benefit having at least a diagnosis included on any new Rx for a patient, especially where medications for totally different uses have similar spelling and could be accidently mis-clicked in the EMR while ordering. (e.g nevirapine (HIV med) vs nifedipine (Ca ch blocker)			
I am writing to provide feedback on your proposed changes to prescribing requirements. Of the three options listed in your consultation document, I strongly favor c) Should indication, and/or treatment goal, and/or clinical indication **be recommended only on all prescriptions?** Mandating that this information must be on every prescription seems unnecessary and will, on a combined basis, waste an unacceptable number of physician hours for the whole province when we have a significant shortage of physicians to begin with. I can imagine that it rare cases this information may be beneficial, but by taking time away from physicians so that they complete this step with every prescription written, you are going to reduce the number of patients seem which likely will cause as much or more harm. It might be reasonable to do this for a limited subset of medications but for the majority of medications, it seems an unnecessary step.			Yes
I have significant concerns re the CPSM Draft Standard of Practice Prescribing requirements, section 3.1.6 as follows: 1. This would represent a potential leak in patient medical confidentiality outside of physician control 2. What are the measures of purpose and outcome that will be undertaken to know if this improves patient care in any way? Will this be re-examined to determine efficacy? 3. Improvements in communication are already available and should be used (Physician access to DPIN) but remain inaccessible to physicians. E-chart is not available to physicians working outside a medical clinic which, in this day and age, is ridiculous. These areas of improved communication should be undertaken first and immediately. 4. Improvements in communication should include modern compatible computer systems (not fax as we are currently forced to use from physician offices to pharmacies). 5. This creates an additional burden of administrative work on physicians who are already unable to meet the needs of our client population. Infrastructure should be the task of the government and the health system and this should not be offloaded to individual physicians.			

After reviewing the possible prescribing requirement changes, and discussing with colleagues. On the balance of pros and cons I don't think requiring an indication on prescriptions is a good idea. I think it will result in more faxes/clarifications from pharmacists, confusion in patients, and won't reduce medication errors substantially.	No	No	No
I suggest no changes to the present prescribing methods by pediatricians for the following reasons: The requirement to add a diagnosis or clinical indications for off-label medications will have a huge impact on pediatrics. Many of the medications we prescribe especially for mental health diagnoses are off-label. They are safe & effective when prescribed approp. & pts. are monitored. Moreover, most pediatricians are unaware that many of the medications they prescribe are off-label! This will create an inappropriate burden to those physicians willing to follow & prescribe medications for these pts. This change in prescribing practices will increase paperwork, cause delays in therapy, consume valuable time in already overburdened pediatricians & pharmacists.			
I am writing to express my profound concern about the proposed standard of practice pertaining to prescription requirements. Having reviewed the proposal in meticulous detail, I wish to offer my insights and reservations on this matter. The proposal states, "Prescribers must only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively." While I appreciate the importance of ensuring patient safety, I believe that the current format of the proposal grants pharmacists the authority to make the final determination regarding the indication and appropriateness of treatments prescribed by qualified physicians or healthcare providers. It is important to emphasize that pharmacists, although highly skilled in their field, do not possess the clinical training and qualifications necessary to assess the clinical indications of proposed treatments, particularly in the realm of medications. Their educational background typically does not include medical school, residency training, or any formal clinical training. I am deeply concerned that the implementation of the proposal in its present form may jeopardize patient care by potentially causing delays in treatment and, in worst-case scenarios, harm to patients. Furthermore, such a policy could lead to confusion among patients as to who their primary care provider truly is, and it raises questions about the authority of individuals who may not have access to the full spectrum of their medical history, yet are tasked with evaluating the validity of a prescription and potentially rejecting it. I believe that this issue is of paramount importance and should not be allowed to become an official policy and standard. It is essential that we find a balanced approach that ensures patient safety while respecting the expertise and roles of both prescribers and pharmacists.			
It is hard to have a fully informed opinion without knowing the reasons behind the proposed changes - is this because pharmacists are receiving prescriptions for medications that seem risky/off-label /etc.?			Yes

I think adopting a standard which recommends including diagnosis would be appropriate. I don't think making it mandatory on all prescriptions is an effective use of physician time. Perhaps the pharmacy college could also adopt a standard that where something is not clear or risky, they could contact the prescriber for clarification.			
Currently at CancerCare Manitoba, we electronically sign the prescription. The clinic clerk brings this to us for physically signing and after that it is faxed to the pharmacy. This puts in additional workload implications for the clerks and physicians. In the current system if we could eliminate the requirement of physical signature when its electronically signed and explicitly says so, it would help with the workload and make things easier. Ideally, in future we need a system where an electronically signed prescription at CancerCare automatically is faxed to the pharmacy without need to print; currently we don't have this capability. Also, given the significant staffing and workload issues; I would not be in favour of putting in the diagnosis or indication for the medication prescribed.	No	No	No
I am writing to provide feedback on the proposed change to prescribing requirements. I am currently a PGY-4 Psychiatry resident. I have some concerns regarding the vague nature of the preamble meant to describe the purpose of the Standard. While it is true that pharmacists and physicians often have minimal to no direct contact with one another, it is not clear to me how this practice in general actually "improves this liaison" between the two. In my experience when clarification is required on either side of this relationship, this is relatively painless to obtain via phone call or cortext. I don't think adding additional administrative burden - and only on one end of this relationship, mind you - will improve or build on this relationship in any substantial way. Furthermore, I am unsure what is meant by "the two individuals [...] may not totally understand each other's responsibilities" is meant to convey. As medical students we receive frequent teaching sessions and opportunities to work alongside allied health, including pharmacists and pharmacy students. As a resident, I have received several teaching sessions from pharmacists, as well as worked directly with pharmacy students/pharmacists on a variety of clinical rotations. I feel that these experiences have given me a solid foundation with respect to the responsibilities of my pharmacist colleagues, and I do not believe that the changes outlined in this Standard would build on this foundation in any significant or frankly helpful way. **With respect to the proposed changes to the content of prescriptions, I do not think that writing indications for medications should be required on any prescriptions.** I believe this will have a negative impact on patient outcomes and patient care, particularly with respect to patients receiving treatment for mental health conditions. Though there have been improvements in recent years, there continues to be a significant stigma associated with mental health diagnoses. Having to write diagnoses on papers that patients must carry from the office/clinic and then hand to another individual - likely a	No	No	

pharmacy tech, not the pharmacist themselves - could lead to increased negative interactions. Patients with mental health concerns already face significant hurdles with respect to medication adherence, and adding additional barriers to this process seems harmful. I also have what I believe are legitimate safety concerns with respect to having to explicitly write this information on prescriptions specifically for transgender individuals seeking hormone replacement therapy and/or puberty blockers. Given the escalating and aggressive targeting of trans issues across Canada, I strongly believe that this will put an already vulnerable minority at increased risk of discrimination and potentially very real violence. It may also significantly impact their ability to receive medically necessary treatment depending on where they are attempting to fill prescriptions. My final concern is the increased administrative burden that this adds to the physician workflow, in a time when the focus has (at least superficially) been on reducing administrative burden and burnout in healthcare professionals.			
I am writing in response to the consultation on Prescribing Requirements. Thank you for the opportunity to engage on this issue. I am a consultation-liaison psychiatrist, which refers to a practice focus on the interprofessional care of complex patients. I frequently have gratifying interactions with excellent pharmacists in my day-to-day work, which often involves acute and/or complex pharmacologic problems. Regarding the preamble and subsection 3.1.6, I do not think that an enhanced requirement on all prescribers is the “right touch” intervention, to borrow a term from the College of Physicians and Surgeons of Ontario. The proposed changes all serve to increase paperwork and administrative time for a problem that I do not find adequately defined or quantified in the proposed standard. Prima facie, this suggests to me that further study and consultation is required. The application of the proposed new rules to psychiatric prescribing also brings up special issues. Although not my usual experience, pharmacists have at times needlessly increased my patients’ anxiety or even paranoia with warnings about a carefully selected treatment, for which informed consent was my responsibility to ensure. Patients in my practice not infrequently defy a diagnosis or may only have an “unspecified” or provisional diagnosis. Labelled indications (as opposed to symptoms, behaviours, and formulations) are often poor representations of psychiatric problems and are not a good nexus at which to meet multidisciplinary colleagues where terminology can be antiquated and stigmatizing (e.g. schizophrenia, dysthymia, etc.). A treatment may be used for more than one indication (e.g. a mood stabilizer selected for both Bipolar disorder and epilepsy). It is also not unusual that the provision of certain treatments may fit into a plan that frankly is beyond a brief comment to the pharmacist but may conversely stigmatize the patient carrying the prescription out of the office. A reference for this is the book "Psychodynamic Psychopharmacology" by David Mintz, published by the American Psychiatric Association. To borrow his language, the proposed changes do not enhance the person-centreredness of the prescriber-patient relationship, but may counterproductively amplify the patient’s perception of disorder and may serve as a distraction from shared treatment goals which I know you can appreciate are sometimes very challenging to establish. In my view, the proposed rules are a change that few psychiatric patients, including many health professionals who receive psychiatric care, would themselves want. I would strongly prefer the disclosure of indications in all cases be left to professional discretion and situation-specific judgment.			

Public Consultation – Prescribing Requirements
August 24- September 29, 2023

Thank you for the opportunity to respond to the proposal under consideration to require a clinical indication on prescriptions. We, the twelve urologists identified below, are totally opposed to any clinical indication being required on any prescription. It is completely unnecessary and would represent yet another barrier to patient care and only serve to delay it. It would needlessly increase workload and be an administrative burden for already over worked physicians. Important medications will be missed and therapy interrupted. The responsibility of determining the appropriateness of a medication lies with the prescribing physician, not the pharmacist. The pharmacist, who will have not seen, examined or assessed the patient in any manner (or gone to medical school or completed a residency), is going to be the arbiter as to whether a medication is being prescribed correctly? This is completely inappropriate and should be rejected. This goes far beyond the practice of a pharmacist notifying a physician of an allergy or drug interaction. We do not believe this measure will improve patient care in any tangible way. The reason why only one jurisdiction in Canada has this requirement is because it is misguided. Physicians and surgeons should not permit their responsibilities, duties, and authority to be eroded in this fashion. The medical community in our province needs to have the courage to stand up and deny such an improper request.	No	No	
In regards to the three options, While I laud the working groups goal of improving patient safety, transparency, and improved communication, I do have concerns that this standard would cause increased administrative burden to make it mandatory rather than recommended. Finally, I have concerns CPSM would be too restrictive regarding putting the treatment goals on the prescription or the diagnosis. The question that arises for me is, "who is the reader of the diagnosis on the prescription?". If it is the patient, then "Blood pressure pill" might be the diagnosis, and more appropriately it might be in the language of preference for the patient, if it is the pharmacist then "hypertension," and in English, as is our charting standard language. I have already written to the College regarding the colonial legacy of requiring all charting in English, with no room for patient expressions of language of choice, has on some patients. More specific guidance re: readership would be needed regarding this requirement should it become policy.			
I don’t agree with the idea needing a dx on every prescription. I can live with it if it is added to a completely new use or off label use.			
Thank you for your request for comments on the draft Standard of Practice regarding prescribing requirements. Please find attached a letter from the members of the Section of Pediatric Emergency Medicine regarding the proposal.			

Children's Hospital
Health Sciences Centre Winnipeg

DEPARTMENT OF PEDIATRICS AND CHILD HEALTH
PEDIATRIC EMERGENCY MEDICINE

September 26, 2023

Dr. Nader Shenouda, Council President
The College of Physicians and Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg, MB R3J 3T7

Re: CPSM Consultation – Proposed Requirement for Documenting Indication on Prescriptions

Dear Dr. Shenouda:

The following comments regarding the above consultation are submitted on behalf of the group of physicians providing care at the HSC Children's Emergency Department. The consensus of this group is to **strongly discourage** a requirement to add indication/treatment goal on all or on all new/off-label prescriptions. This requirement presents significant privacy issues, adds an administrative burden, and will impede patient flow.

1. Summary of Privacy Concerns

- A medical indication written on a prescription suggests or reveals a diagnosis. This is information that the patient may wish to (and has the right to) not share with others. In the case of children and youth, prescriptions are provided to their guardians, including parents, Child and Family Services, and other delegated guardians. This presents a unique and important consideration for children and youth, as adults need not share their prescriptions (with documented indications/diagnoses) with others. We feel strongly that privacy for youth must be protected. Sharing certain diagnoses/indications on a prescription is inappropriate, particularly when the guardian does not have a close personal relationship with the patient.

- Youth rely on guardians to fill prescriptions and may choose to not to fill or provide prescriptions to their guardian to avoid sharing personal health information. This could result in harm to the patient. The prescriber may not be aware that the prescription was not filled.

- Youth who do provide a prescription to a guardian to fill are forced to share personal health information and without informed consent (unless the prescriber takes that step).

- The patient also may not want to share diagnoses/indications with pharmacy staff. The pharmacist has a legitimate therapeutic relationship and may ask the patient for the indication to ensure that the prescribed medication is appropriate, but the patient decides how much to share in that conversation. Other pharmacy staff do not need to know this level of detail and

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personal health information (e.g., Rx for GC/Chlamydia/STI, HIV prophylaxis after sexual assault).

- There are significant patient privacy concerns if the prescription is lost and when it is handled/viewed by others (e.g., CFS support worker, group home staff, foster parent, parent, sibling, delegate guardian).

- Sending prescriptions via facsimile presents additional privacy concerns when protected health information such as diagnosis or indications/treatment goals is added.

2. Summary of Administrative Burden and Patient Flow Concerns

- This will result in additional documentation in a very busy practice setting (Emergency Department) in which patient flow will be impacted. As we frequently work with trainees who need close mentorship in the fundamentals of prescription writing, this is one more element that would need to be discussed and documented.

- Getting informed consent from the patient/family to add this personal health information to prescriptions is an added step that will impact patient flow.

- In our practice setting we handwrite all prescriptions. Adding the proposed requirements is both time-consuming and an added cognitive burden. The inclusion of a written required diagnosis or indication, legibility, and use of abbreviations may add to phone calls from pharmacies to clarify.

- Some patients have multiple medications on one prescription, such as asthma, eczema, and infected eczema. The proposed requirement implies that each would need an indication or treatment goal documented.

- Many of our prescriptions are for products that are for obvious indications (acetaminophen, ibuprofen, antibiotics, asthma medications, eczema medications, antiepileptics, etc.), so adding a diagnosis or indication adds no information that is not already apparent. Including diagnostic information generally provides no added benefit to the patient and is unnecessary.

-There may be benefit to the patient/pharmacist for certain clinical conditions where dosage recommendations for common antibiotics vary by diagnosis, such as amoxicillin dose for otitis media vs. pneumonia vs. Group A Strep pharyngitis. In these cases, we would support wording that 'suggests' listing a diagnosis to clarify appropriate dosing.

We have the utmost appreciation for our pharmacy colleagues and their valuable contributions to the joint medical care of our shared patients. Calls for clarification regarding medication doses and frequency are welcomed. Ultimately, physicians are responsible as prescribers to make the diagnosis and know the indications, limitations, complications, and dosing parameters of any prescribed therapy. While we understand that this proposal is suggested to improve patient safety, the risks and burden associated are too great.

In summary, we are concerned that the requirement to add an indication/treatment goal to prescriptions is a threat to privacy, reveals personal health information, does not benefit the patient, and is an unnecessary administrative burden.

Sincerely,

Karen E. Gripp, MD, FAAP, FRCPC
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Assistant Professor, Rady Faculty of Health Sciences
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My responses are based on my experience working in Manitoba as an epileptologist, which offers a sample of the clinical dysfunction that is very likely to come if these requests from the CPhM are implemented. Specifically, I am referring to my experience with just one medication that requires an indication for prescription: Clobazam. Although the requirement to state that Clobazam was being prescribed for the indication of "EPILEPSY" seemed simple and innocent enough, the actual implementation has been both disastrous and painful for patients and physicians alike. I am not infrequently subjected to seemingly random Clobazam prescription rejections for epilepsy patients who depend on this medication to prevent a seizure from suddenly incapacitating them, or even worse, killing them - simply because Clobazam has somehow become maligned and stigmatized into a "dangerous" medication "of abuse". Even patients who have successfully been on this medication for decades (without side effects or abuse) can suddenly have their prescription interrupted and accompanied by questions of if and why Clobazam - somehow now a "dangerous evil substance" - should be used in the treatment of their epilepsy. This continuous sporadic unpredictable to-and-fro drains not only my time and energy - but also the time and energy of the entire HSC Epilepsy Clinic - from the poor overworked clinic clerk who receives the fax stamped "URGENT" rejecting Clobazam who then has to drop what they're doing to convey this information urgently - to the poor overworked clinic nurse who receives a frantic phone call from a patient desperately pleading for support from the clinic to have their prescription honoured. Naturally, the frenzy inevitably makes its way to me such that I also need to drop whatever that I am doing to deal with something completely unnecessary and trivial. Keep in mind that this is just the ongoing normalized chaos stemming from an indication requirement change made years ago for just one medication. I shudder to think about the scale and enormity of the potential damage to our provincial health care system if similar restrictions are rolled out for all prescriptions, new prescriptions, or off-label prescriptions. Therefore, I am writing these comments out of a sense of a "duty to protect" all of us from going down this same traumatic path - multiplied a thousand-fold - if at all possible.	No	No	No
I think adding a diagnosis or indication to a Rx opens another path for a patient's personal information breach similar to what happened multiple times in the past, that could be used by pharma and more importantly other hackers to use against patients and providers. I do not support this idea and would strongly vote against it Please leave Rx as before without any further compromise to our already exhausted health system.	No	No	No

Public Consultation – Prescribing Requirements
August 24- September 29, 2023

I am writing to voice my strong rejection regarding 3.1.6 of the proposal and it's equivalent in the electronic prescription proposal. What exactly is this supposed to achieve? Is this change supposed to improve patient care and outcomes? If so no strong empiric evidence is cited in support. Is the purpose to afford pharmacists to comment on appropriateness of drug prescribed, if so I would hope the pharmacist be required to perform a history and physical with review of test results as is expected of physicians. Few patients I serve have single medical problem and are on 1 or 2 medications. Furthermore although my practice is not primary care, more and more of my patients have no primary care practitioner and little prospect of obtaining one in the foreseeable future. I am frequently requested to provide prescriptions for conditions that are unrelated to the condition I am managing. I often accede to the request if it is reasonable. In my opinion this change to prescribing requirement would add considerable time to writing a prescription without an obvious improvement in patient outcome. In the current trying environment of too few physicians perhaps the College might consider trying to reduce bureaucratic burdens of physicians unless changes have strong evidence of improving patient outcomes.			
Thank you for inviting feedback from CPSM members on the recent draft Standards of Practice. I would like to provide feedback regarding one section of the recent draft Standard of Practice – Prescribing Requirements. A similar section is also included in the draft SOP for Electronic Prescriptions; my feedback similarly applies. The section of interest is: 3.1.6. one of: diagnosis, and/or clinical indication, and/or treatment goal is required on all prescriptions OR is required on new and off-label prescriptions only OR Is recommended on all prescriptions; (Refer to consultation document) I am a pediatric neurologist. I have a few concerns. 1. Many of the medications I and other pediatric physicians prescribe are off-label. I do not always know if a specific medication is off-label—I am aware of its indications, potential side effects, appropriate dose and monitoring. 2. Definitive diagnosis/indication is not always available at the time of treatment – a patient's physician and/or team may still be working through a differential diagnosis. At times, the reason for using a medication covers more than one diagnosis/indication (e.g., clonazepam may have dual benefit for seizures and for spasticity, in a patient with epilepsy and spastic cerebral palsy).			

3. I am concerned that the requirement of a diagnosis/indication (first/second options above) may create delays in patients' access to medication, related to increased paperwork and processing time. 4. I am also concerned that this requirement will place an added paperwork burden on physicians and pharmacists. We know that paperwork/administrative work contributes to health care provider burnout, which is currently widespread. We also know that burnout reduces safety, can lead to leaving the profession, and that our system needs us to recruit and retain physicians.			
In regards to what appears to be an amendment as indicated in section 3.1.6, I find it rather redundant that prescribing physicians should be required to document the diagnosis, clinical indication, or goal of treatment on the prescription when written. This should be documented in the patient's medical record. There is little merit to including this information on a prescription, except to either educate the pharmacist or have them vet the indication. While pharmacist education is an admirable goal, this seems to be a strange way to go about doing this. Additionally, it does open the door to the pharmacist changing a prescription entirely or in part, perhaps without understanding the patient's overall medical condition or the clinical scenario. A more appropriate amendment to prescription writing would be for all prescribing physicians to ensure an indication is documented within the patient's medical record as to why a prescription was written, specifically the indication, rather than having this included on a prescription which itself is not a part of the patient's medical record and instead goes only to the pharmacy where it is stored within the patient's record there. This information is proprietary to the pharmacy and the pharmacy alone, and not shared across platforms. If the pharmacy has questions as to the indication for a prescription, they should have a duty of care to contact the prescribing physician with their concerns.			
I am writing to provide feedback on the proposed changes to prescribing requirements from the perspective of Family Practice. In my opinion, the requirement to include the diagnosis or treatment goal on prescriptions would add a significant administrative burden to a Family Doc with no benefit to patient or pharmacist in the majority of situations whether it be long term management of chronic conditions or short term acute illness. It may seem like a small thing to add, but when you multiply that by a busy day seeing 30 patients some of whom may have multiple prescriptions, it becomes a significant burden. For example a patient with diabetes & IHD may have 6 medications. They will be managed over many years with no change in the diagnosis & perhaps no change in the medications. Where is the benefit of being required to include the diagnosis on each of these prescriptions? Even in short term care e.g. prescription of antibiotics for a short term illness, is it really of benefit for the diagnosis to be included on the prescription? I think there is a danger that it becomes something that the doctor can be criticised for if it has been omitted when it is not really necessary.			

In situations where the pharmacist has questions about the prescription it would be more productive to discuss it with the patient & when necessary to contact the doctor's office. If the goal is enhanced communication between pharmacist & prescriber then rather than requiring every prescription to have a diagnosis , it would be more useful to work on prompt & respectful communication between pharmacist & prescribers. Perhaps the pharmacists see this from a different perspective & do see a value in requiring a diagnosis on every prescription, but to me it appears to be an unnecessary additional piece of work which will not assist in the majority of situations where additional discussion between prescriber & pharmacist will still be needed anyway. Perhaps a recommendation of addition of diagnosis on off label prescriptions would be reasonable. I do agree that limited use of verbal prescriptions for M3P prescriptions would be helpful in certain circumstances.			
I am a practicing PA and all of my prescriptions require an indication/dx/goal of treatment. I'm somewhat unclear what the hope for this additional layer of administration will be for MDs (and for PAs, honestly) as I have never, in 10 years of practice, had a prescription returned or questioned due to the indication. Nor have I regularly had a Pharmacist give suggestions for alternatives when there has been a recall, shortage, or interaction of medication, despite the Pharmacy having the indication for the prescription. Similarly, I'm unsure what level of further burden this may put on Pharmacists, such as if there is no indication on the prescription, will they be faxing a clarification notice back in order to have it put on the prescription? Will this delay the filling of the prescription? If there will be no delay, what is the purpose of the proposal? Also, what consultations have been done with the EMR vendors to allow ease of applying an indication to a prescription directly from the medical record? Who will be checking the indications on the Pharmacy end, and for what purpose will this be done? What is the aim or goal of this proposal from a known safety endpoint perspective? What is the purpose of having a standard that then only "recommends" this action when it will likely be ignored by the membership? How direct are the indications needing to be defined? I could prescribe a statin, fibrate, neuropathic agent, and antihypertensive medication all with the indication of diabetes OR peripheral vascular disease. Would there be pushback or clarification requested? What if one month the medication is prescribed with one indication and the next month another? All that being said, if this is absolutely going to be pushed through in one form or other, then the wording which only <u>recommends</u> the indication on the prescription would be the most reasonable unless you can adequately answer the above questions.			
As a long time practicing pediatric specialist I worry about the increased burdens on pharmacies and pediatricians and other prescribing for children if there is a need to add a diagnosis for prescription in general and especially for those with off-label uses. Many of the medications we used in pediatric practice that are in common usage (and even recommended), are actually used off-label, because there has not been adequate testing in pediatric patients. The need to add a diagnosis would also place an undue burden on those practicing with other vulnerable and understudied populations such as those with disabilities, pregnant women and people of any age with disabilities. Therefore, I would hope for a status quote in the prescribing requirements that do not require a diagnosis when prescribing a medication.	No	No	No

The following are my comments of the draft standard of practice - prescribing requirements: 3.1.6 The diagnosis and/or clinical indications should be recommended on all prescriptions but not required. At a time when many physicians are feeling stressed by the burden of administrative work and many patients having difficulty accessing medical care the mandatory requirement to include this information on all prescriptions would lead to a deterioration in patient care. 6.1 I assume a phone conversation is considered to be direct patient contact. Perhaps this should be stated. 6.3.1 Since it is not possible to conduct a physical examination via a phone call I think this point should be modified. 6.3.4 I don't think any medical records are " easily" available to patients or other health care providers other than those working in a group practice with access to the same EMR. 8.1.4 &.5 I strongly agree that all written orders on a hospital chart should include the date, time , clearly printed name and signature but in my experience this has rarely been done. 9.3.4 The mandatory signing of verbal orders was stopped at Boundary Trails Health Centre a number of years ago. I understand this is not required at the Grace and St. Boniface Hospitals as well. I hope you will find my comments useful when finalizing the Standard of Practice.			Yes
While I fully appreciate the intent of wanting documentation of medication indication on the prescription there are many situations in clinical practice in geriatrics where this may lead to unintended negative consequences Many patients have cognitive issues and as a consequence poor understanding of why they are on medication or need for prescribing. In such a case further explanations and discussion are not always helpful and potentially harmful to the patient and burdensome for the family/ pharmacist/ prescriber if the patient does see the prescription. Dementia and paranoia would be typical situations. I recommend 3.1.6 be left as "recommended on all prescriptions'			Yes
In response to the proposed changes to prescriptions - I can see that pharmacists want to play more of a collegial role in patient care. if that is the case - then we need to completely change our culture - pharmacists are no longer private with pharmacies - they practice in clinics with physicians and all the medications are provided by the provincial or federal government.			

Or how about pharmacists have access to electronic medial records. Instead - physicians are overburdened with paper work and administrative jobs they are not paid for. We are being pressured to see more and more patients because of a lack of physicians. We have no option but for multiple prescribers to be providing care to the same patient because of the lack of family physicians. So now the idea is to increase our paperwork burden to make up for the lack of provider resources in the province? I can't even imagine the burden it will be to the specialists whose entire realm of practice exists with "off label" prescribing. Or for physicians in rural or northern communities who are prescribing outside of their scope of practice based on recommendations from specialists in Winnipeg.			
I strongly disagree with having a requirement to include a clinical indication, and/or treatment goal, and/or diagnosis on all prescriptions. In a time that we are trying to reduce unnecessary paperwork for physicians, this seems to be an unreasonable addition and would add a significant amount of time to the patient visit. For example, if a ICD code is required, it would mean either looking the code up or memorizing various codes that our billing staff currently complete for us. For doctors who use voice recognition software, it would increase likelihood of additional errors in descriptive words indicating diagnoses. In my opinion, I am qualified to write the prescription and have rarely had a pharmacist question a prescription I have written. Do we need a pharmacist to verify our diagnosis? With respect to MP3 prescriptions, I believe that verbal orders should not be used.	No	No	No

Rady Faculty of Health Sciences | University of Manitoba

Department of Pediatrics & Child Health

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September 27, 2023

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

Dear Dr. Ziomek,

I received the notice from your office that the College of Physicians and Surgeons of Manitoba (CPSM) is proposing changes to the Standard of Practice – Prescribing Requirements and is asking for our input.

In my role as Department Head of Pediatrics and Child Health, I am concerned about the impacts of the second option; indication or diagnosis to be added for every off-label prescription. Many of our patients receive drugs off-label. The same is true for many other prescribers to pediatric patients.

Unfortunately, we are not always aware of the labelling status of the drugs we prescribe because we follow (inter)national (often evidence-based) guidelines for dosing, age ranges, indications, and dosage forms.

I am concerned that this may create complexity with pharmacies, increase paperwork, potential delays, and even drug coverage shortfalls. This option puts a large burden on pediatricians and other practitioners prescribing for children, as well as pharmacists.

Sincerely,

Patricia E. Birk, MD, FRCPC (she/her/elle)
Professor and Head, Department of Pediatrics and Child Health
Max Rady College of Medicine, University of Manitoba
Provincial Medical Specialty Lead-Child Health, Shared Health Manitoba
Medical Director-Pediatric Kidney Program, Transplant Manitoba
Executive Leadership in Academic Medicine (ELAM)

Cc: Dr. Geert 't Jong

PB/ah

Public Consultation – Prescribing Requirements
August 24- September 29, 2023

Thank you for your email requesting feedback on the proposal around prescription changes for family practice. I appreciate the opportunity to give some open and honest opinion in this regard. I've consulted with several of my colleagues in formulating my opinion. Taken directly from the document regarding prescription requirements: The three options below are being considered. In your response, we ask that (you) provide your feedback on your preference regarding the use of indications. a) Should indication, and/or treatment goal, and/or clinical indication be required on all prescriptions? b) Should indication, and/or treatment goal, and/or clinical indication be required on all new and "off-label"* prescriptions only? c) Should indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions? Given the current state of the medical system with respect to administrative burden and the overall spirit of ensuring efficient and safe continuity of care in prescription writing, I think that the suggested requirements of recommendations for prescriptions will put an undue burden on physicians as a whole and create a roadblock for access. I certainly am concerned that this requirement or recommendation set will result in some physicians choosing to delay script writing and therefore to cause potential harm to patients both new to a practice or patients who have been accessing a practice for years. I am also concerned about potential PHIA violations which could become challenging if a fax or e script reaches an unintended target at the pharmacy and has identifiers written on it and very personal and sensitive information with respect to diagnoses and plan written as well. Therefore, I feel that none of the three options are written in a fashion that I can support at this time. I look forward to future iterations of the document though!	No	No	No
I am writing in response to your request for feedback on the proposed revisions of the Standard of Practice: Prescribing Requirements and Practice Direction: Electronic Transmission of Prescription. In both cases, I am only providing feedback regarding the proposal to require a clinical indication, and/or treatment goal, and/or diagnosis on prescriptions. I do not think that you have provided adequate time or sufficiently detailed information for feedback on what can be a complex proposed change. It appears that the motivation behind this proposal is entirely based on the College of Pharmacy's request for more information on a prescription to allow pharmacists to determine the appropriateness of the prescription. There is no information on what this actually means, how a pharmacist determines appropriateness, or what the outcome would be. It is also not clear what the action of the CPSM would be if a physician does not include this information on a prescription or what constitutes a reasonable attempt at conveying this information. I find this potentially more disturbing than being requested to add this to a prescription.			

Currently, the only access a physician has to what medications are being prescribed to a patient is through the DPIN which is available through eChart. Both pharmacists and physicians know that the DPIN was not designed to assist in provision of health care rather than allowing Manitoba PharmaCare to determine what medication has been dispensed. Any change in prescribing requirements should be preceded by a change in eChart to allow all information on a prescription to be summarized and available to prescribing physicians. This would be of value in all settings, including emergency departments, urgent care or walk-in clinics, specialist consults, and even primary care since many patients have several prescribers. For physicians using an electronic medical record for generating prescriptions, it would not be particularly onerous to include a primary and, if appropriate, secondary indication for a prescribed medication as it would automatically be included on any prescription renewals. This seems like something for which Doctors Manitoba could advocate rather than an issue for CPSM. Although there certainly could be a benefit in the management of patients if physicians had access to the added information that a clinical indication provides, I am not sure how this pertains to pharmacists (drug interactions occur independent of the clinical indication). I do not think that you have provided a clear rationale for making this a standard of practice or demonstrated any evidence of harm by not including this information. I think it would be premature to make the proposed changes.			
I am writing with respect to feedback requested on whether diagnoses need to be entered on prescriptions. I have obviously a number of different concerns. CPSM is seeking feedback and has given three choices based on what the college of pharmacists have recommended. The preference would be that they should be quired on new or new office label prescriptions only and not four medication's in general. The difficulty I find lies within the scope of practice of the pharmacist. While I welcome the additional review from the pharmacist, reviewing and determining prescription appropriateness, unfortunately, the pharmacist may not necessarily be directly involved in care, and as such not know any of the background and surrounding the appropriateness of the medication. This results in more time I would have to spend to further explain the rationale for the medication. I also took an informal pole of patience with recently sold your prescriptions, and most have said that no pharmacist has actually taking the time to review the side effects, etc. of medication, rather simply gave them the handled with the side effects and asked if there are "any questions". Often, this was handled by the pharmacy assistant, and not the pharmacist them selves. Another area of concern surrounding this standard of practice is what happens currently in my practice. Another physician may write a prescription for the patient (whether they are discharged from the hospital ER, or under specialist care). I am expected to thereafter assume the prescription going forward however, despite using diligence, I am often spending much time trying to obtain records to review the rationale of the rx and why a medication was started. The pharmacist often does not exercise any due diligence, in terms of looking for where the prescription came from because often the prescribing doctor/health practitioner may not be reachable, and as such finds the easiest target- my office, as I am the 'physician on record' (the family md). This is becoming more common and increasingly frustrating. This is not only time-consuming, but just adds to the ever increasing administrative burden. I agree that having a pharmacist on the team is very important as it in enhances patient safety. We have demonstrated that through our "my health team" in ft Garry-river heights, where we have a clinical pharmacist who is able to spend the time to actually review meds and to give information		Yes	

to provide input re appropriateness of the medication and medication choices. That would make more sense as opposed to trying to write a diagnosis on a prescription which makes less sense. The draft standard of practice (2.1) suggested that prescribers must only prescribe the drug if they have the knowledge, skill and judgement to do so safely and effectively. I will admit that often as family physicians we are placed in a compromising position for ongoing care from specialists/other care providers. (ie. specialists- ccmb/specialists/Hosp) to provide ongoing prescriptions that we did not ever initially start- I am often told from the specialist that this is an expectation of continuation of care. In another instance, the specialist will prescribe medications and expect that I need to do bloodwork to monitor for the medication that they're prescribing as my responsibilities as the family doctor. The standard of practice for prescribing certainly highlights my concern that I initially had and still have to this day. Perhaps CPSM will look further into this.			
This is my Public Consultation Prescribing Requirements feedback: I think that indication, and/or treatment goal, and/or clinical indication should only be **recommended** on prescriptions. I myself already write indication and treatment goals sometimes even though it is not required. I am wondering if CPhM has requested this because they think it is a solution for inappropriate prescriptions. I do not think this is the solution. I think the majority of doctors write appropriate prescriptions. The ones who do not will continue to do so even with this requirement. Requiring indications will only cause more work and punish the doctors who are already writing appropriate prescriptions. I think if a pharmacist questions the appropriateness they can contact the doctor. I feel like requiring doctors to write indications is like making the doctor do the pharmacists' work for them as they are always welcome to clarify with the doctor via phone or fax. It is also frustrating that this has been requested because I do feel that often my extra writing in the "sig" section is ignored by the pharmacist - but I recognize, like doctors (and all humans), there will be both diligent and non-diligent pharmacists. As doctors, we already have a lot of documentation and charting work that we have to do, it would be nice not to have this extra requirement.			Yes
My preference would be that indication, and/or treatment goal, and/or clinical indication be recommended on all prescriptions. I worry about the potential for delays in care for patients if the indication is a requirement on all prescriptions, and also about how this would be actioned specifically for discharge from hospital (ex. discharge med recs would require an additional space added, which would take substantial efforts for change and implementation, putting those being discharged from hospital at even higher risk for interruptions in care). **Feedback for Prescribing Requirements draft** Section 6 - direct patient contact. I believe it would be important to add an exception for registrants working with other regulated health professionals to provide service in rural/remote areas...ex. a trained nurse does an assessment with a patient and connects with a prescriber for a new prescription or dose adjustment of OAT...in that situation the prescriber doesn't have direct patient contact themselves, and if this is not allowable it would significantly limit service in underserved areas.			Yes

Section 7.5 Now that the majority of M3P drugs are being prescribed by EMR, is it necessary to specify that they must be on separate forms? Practically this means that when I see a patient for follow-up of OAT, who is also prescribed other medications that I review and renew at the same time (ex. benzo taper, SSRI, etc.) I have to refill and fax those medications separately, which adds a fax burden on both the clinic and pharmacy side, and adds risk that medications are missed on either side. Renewing them together doesn't change any of the information actually included on the prescription, but with this wording many pharmacies will require the OAT prescription to be refaxed separately (so that it doesn't end up on the same sheet as other medications), presenting a possibility for delay of critical medication, without actually adding any clarity (at least any that I can perceive). It seems like a rule for the sake of being a rule. Section 9. Please clarify whether this applies to M3P drugs, as well as to OAT specifically, as previously verbal orders for OAT medications have not been accepted in hospitals. If we're moving toward acceptance of verbal outpatient OAT prescriptions in urgent situations (which I highly support), replicating this option for inpatient situations would be reasonable and beneficial. **Feedback for Electronic Transmission draft** While the most common EMR for clinics run by the SDOs is Accuro, there are many others. It would be prudent to refer simply to EMR generated prescriptions, rather than specifically Accuro. There is a superscript labelled 5, after the statement 2.1.1.b, but there is no description of it. It would be helpful to specify whether the 'computer-to-facsimile machine' description of electronic transmissions supports the use of facsimile technology that does not have a land-line on the sending end (ie. a fax machine that scans and transmits electronically to a traditional fax on the pharmacy end), as this is increasingly the technology being used in prescribers' home offices, given the transition away from land-lines in general. The requirement for direct confirmation of a CDSA regulated medication with a prescriber has the potential to delay care for vulnerable people (ex. those just released from prison who are receiving OAT but do not have an active health card, and who already have significant systemic barriers to receiving care). Even if the prescriber/clinic contact info is provided on the prescription, there is no guarantee that they can answer the phone immediately when the client is in the pharmacy (ex.RAAM clinic is unable to return a phone call immediately due to being busy seeing clients during drop-in) and may result in patients disconnecting from lifesaving care due to frustration with systemic barriers. It may be worthwhile to consider additional caveats to this requirement (ex. if the prescriber indicates in advance that there is no PHIN it does not need to be verified again; in the event that the prescriber is not available in a timely manner to confirm, the pharmacist may dispense an interim amount until it can be confirmed...).			

September 28, 2023

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

Dear Dr. Ziomek:

Thank you for your notification regarding the drafts related to Standard of Practice Prescriber Requirements and Practice Direction of Transmission of Prescriptions.

In regards to the draft revised Standard of Practice Prescriber Requirements and the clinical indication and/or treatment goal and diagnosis of prescriptions, I think that this will confuse and delay prescriptions rather than facilitate anything. I don't think there is a need for us to indicate why we are treating a patient because the diagnosis may not be definitive and tests could be pending. We believe the medication is indicated and should be given to the patient for the problem. No one is going to randomly prescribe medications without good reason. There are a lot of factors that are involved with prescribing including the physical exam, the family history of the patient and the past history with the patient and what the patient may be taking over the counter and other extenuating circumstances and information the Pharmacist will not have. The Pharmacist will not have the lab work up or diagnostic work up which may be instrumental in determining what the prescription will be. I cannot believe any one really thinks having a second person determine the choice of medication based on the diagnosis which they may or may not be familiar with could in any way be considered practical. It is not a good idea to have the person selling the medication make those choices either. I have had prescriptions renewed on patients whose meds were being changed and a short course was only prescribed for that reason. Then more meds are dispensed by the Pharmacist for " continuity of care " when the plan was to have a change of medication or dose titration.

As far as verbal prescriptions and M3P drugs, I think this is quite reasonable. I think the pharmacists play an incredibly important role with respect to providing care to our patients. Having a good working relationship and speaking with pharmacists regarding

medications cannot help but be a great enhancement to this program. Sometimes having to go through the triplicate process and having patients pick up the prescriptions and/or fax them in can be a bit of an impediment timewise. Certainly, the faxing of prescriptions has been helpful.

I would have to say, however, that the pharmacists should have no need for input with respect to certain refills, repeats, and part fills. These are for different drugs and controlled substances and there are are guidelines there we all need to follow. One must understand that the decision is at the top of the patient care pyramid with respect to patient care. Trying to bring in another layer would only complicate matters.

I do not believe that the clinical indication and/or treatment goal and diagnoses should be included on all prescriptions as this will add another layer of time and is really not, in my view, the purview of the pharmacist to monitor and tell physicians what to do.

Pharmacists are indispensable with respect to providing advice and guidance and also clarifying if errors have been made. However I don't think that it is appropriate to have the pharmacist reviewing our work and diagnoses to tell us how we should be prescribing. It will add another layer of time as well as complications and if you think that this will alleviate friction, I do strongly believe it will cause more friction.

With respect to the 3 options which you had provided:

1a) Should indication and/or treatment goal and/or clinical indication be required on all prescriptions? The answer would be categorically "no"; that is unnecessary.

1b) Should indication and/or treatment goal and/or clinical indication be required on all new and off label prescriptions only? Again, I would have to state that it is at the discretion of the physician to decide what is best for the patient. The physician has examined the patient. The physician has likely tried other medications with the patient. The patient has usually had treatment options such as therapies, and other over-the-counter prescriptions as well as knowledge of the family history to consider. There is certainly no time for a physician to totally and fully explain every nuance of what they're doing with respect to the prescription.

1c) This looks to me to be repeat of part a). Same reasoning applies as to why it is inappropriate

With respect to the implementation of verbal prescriptions for M3P drugs, I think that this could be useful. I do note that not all physicians have access to the faxing process relative to Accuro, for example which is used in the WRHA. So certainly, a verbal prescription I think would be totally appropriate in many circumstances and would facilitate patient care.

With respect to the electronic prescription transmission of prescriptions, I think that certainly faxing of the M3P prescriptions is certainly detailed enough.

I would note that not all of my colleagues have access to e-chart and therefore would not know whether somebody was prescribing something in a different manner for the patient necessarily and interactions could occur. I note that there was a portion on the College of Pharmacists submission that would state that it would speed up the process of prescribing medications for patient if all of the indications were put on the prescription form. I would counter that with saying that it would actually add another layer of delay. There was the comment prescriptions need to be prescribed and dispensed in a timely fashion and this is without question in every case not just simple cases.

I don't think that anyone other than the physician themselves should be prescribing the medication for the patient and I do not think that it is necessary to include all of the extra diagnostic information as I would question who is going to be taking the time to read all of that and research all of that and I think this will add to more delays.
I hope this information is of use to you and your panel.

Yours sincerely,

James Langridge, MD
Sport Medicine Clinic
Pan Am Clinic

JL/mc

Attention: Working Group on CPSM Proposed Revised Standard of Practice, Prescribing Requirements – Feedback from Prescribers. Re: Draft Revised Standard of Practice: Prescribing Requirements Clinical indication, and /or treatment goal, and/or diagnosis on prescriptions. Dear Working Group. I am writing in opposition to all of the above proposed changes considered to become the current Standard of Practice. Though commendable for the Colleges to liaise in an attempt for 'better prescribing practices', with the CPhM requesting above noted clinical indication, treatment goal and diagnosis to be included in all prescriptions in order for it to 'be beneficial for patients in allowing pharmacists to determine prescription appropriateness in a timely manner', and prevent 'delays whilst pharmacists confirm indications before dispensing medications', I am concerned that little logical thought was given to a wide variety of consequences which will follow such decision making. The administrative burden, to start with, in the already over extended daily practise of any physician, would be incalculable. One can only imagine what the list length would look like in many patients with multiple diagnoses on multiple drugs should a diagnosis, clinical indication and treatment goal(s) have to be written down for each medication prescribed. What would the additional time consumption per patient be to physician and pharmacist, if accumulated, even with 2 drugs on the list, which we all realize to be a minimalistic number as to what many patients are on? Would the pharmacist still be accepting the benefit suggested if inundated by a multitude of data, where mostly a cholesterol lowering agent is used for dyslipidemia, and various anti-hypertensives used for hypertension, and granted, under some circumstances for congestive heart failure, and issued for a variety of other off label conditions, very few of which have standard researchable doses or dose and frequency increases? Would either pharmacist or patient still benefit if there are for instance little or no information in the literature about certain antibiotics used to good effect at certain doses for a specific medical condition due to the knowledge base within a specific specialty prescribing it?	No	No	No

Or, would it all eventually contribute to a completely useless and uncontrolled mass of information clogging up the system and the physician's time, being duplicated over years, with minimal benefit in safely for only a small percentage of cases? One would also need to ask the question, that should noted changes become mandatory, how pharmacists would process this information. Surely indications, treatment goals, and diagnoses will have to be entered manually into their patient computer records which will again be a time consuming effort. How long will it take before time pressured pharmacists start suffering from data overload, missing serious drug interactions or warning signs which could lead to a catastrophe which could have been averted, were they less strapped for time. The purpose of a direction/ Standard of Practise change should not be to burden the system further with a massive data input, to the expense of physicians, and probably also to pharmacists involved, where the true need for change, and benefit, is minimal. A large number of the prescriptions in my practise are off label. A large number of diagnoses are extremely complex and treated with a variety of individually dosed drugs. Information on many of these are not freely available. It appears highly unlikely that any of the suggested changes to the Standard of Practise would benefit the patient or prevent confusion. In fact, it may actually increase confusion, may lead to more time spent through telephonic discussion between physician and pharmacist, who may find it prudent to ensure themselves of the specifics of the diagnosis and the reason as to the drug prescribed and dose documented. Patients my become more confused as to whether they can trust the prescription, the physician and the physician decision-making process, potentially leading to a breakdown in the physician-patient relationship, leading to second opinions, longer waiting lists, more time wasting, and eventually - receiving the same prescription. It is a concern that our governing body appears to be seemingly unaware of the stressors that are present in its members' medical lives. Surely the statistics regarding a rapidly retiring and highly stressed group of professionals, many of whom quit medicine due to the ongoing, ever increasing barrage of stipulations and stressors, are very visible. Depression, anxiety, burnout, substance abuse and suicidality in the medical fraternity are significant. There is no question that there may be consequences to continue on a path unchanged just because it "has always been done this way", but the benefit of a new approach should prove to provide a significant betterment in a large majority, and not just a few. Definitely not to the detriment of an already embattled group of highly trained individuals who are acutely aware of the significant responsibility entailed in prescribing medication.			

The question that needs to be answered is: how many prescriptions are being questioned for "prescription appropriateness" or "indication confirmation"? Would that be the majority of concerning incidents? Or is it true, as I understand, that most commonly the concerns are regarding illegibility, dose, frequency and duration of treatment mistakes.

If that is indeed the case, suggestions currently advised as Revision of Standard of Practise would completely fail.

Patient confidentiality, and violation thereof, is a significant concern, especially the effects of which have been highlighted over the past 4 years, which would be jeopardised when writing a diagnosis, clinical indication and a treatment protocol down on a script, where a co-worker, family member, pharmacy cashier (e.g. who is also incidentally your neighbour), or pharmacy assistant gain insight not just into an otherwise generic prescription drug written down, but also now realizing what the script was issued for. This can lead to embarrassing and potentially damaging personal information becoming common knowledge, with devastating effects.

Would you, member of the Working Group, for example, appreciate that your neighbourhood or your colleagues become aware that you are being treated for genital warts? I would certainly not.

Since phycisians were consulted to contribute and remark on the DRAFT Revised Standard of Practise: Prescribing Requirements, I have had discussions, personally, telephonically and by email, with at least 15 colleagues who confirm their significant concerns with any benefits the DRAFT presentation would provide, and therefore would not support the draft.

I therefore advise the College that, due to what I feel are valid abovementioned concerns, I **DO NOT SUPPORT** The Revised Standard of Practice Requirement where the clinical indication, and/or treatment goal, and/or diagnosis should be required on **any** prescription, **NOR** should it be recommended on any prescriptions(which would not serve any purpose whatsoever).

I thank the College for allowing me to contribute to this process.

Sincerest regards.

Dr. Robert W. Mouton

1.I believe this is a breach of patient privacy as a diagnosis is disclosed to unnecessary parties. 2.The EMR is unable to extract or do this and the physician workload will increase unnecessarily. To manually do this will further prevent excellence in patient care.			
I would just like to advocate that there should be considerations for pediatric patients within the new standards. Many if not most of our medications are off-label given the nature of studies done. Most drug companies exclude children from studies and as such, we don't have the same evidence available for use as in adult medicine. If the requirement is to add a "clinical diagnosis or indication" for each off-label prescription, this will add a significant workload to pediatric practitioners that is disproportionate to our adult colleagues. We are all invested in writing appropriate, safe prescriptions, but I hope there can be a reasonable alternative to a general statement indicating all off-label prescriptions need this additional information.			
i think we are all famelier with electronic prescription of controlled substance and its much easier that using paper format we should keep it as its now			
1.No diagnosis for chronic prescriptions 2.Diagnosis for new and change in prescription 3.No telephone prescriptions for M3P			
I am joining the overwhelming number of physicians who are in disagreement with the purposed change of including a diagnosis, treatment goal etc on the prescriptions. We are trying to reduce paperwork and burden on this over stressed healthcare system, not increase it. This adds more work. Most of my prescriptions are off label and I don’t need to educate many pharmacists as to why a medication is needed and this may have PhIA breaches. Please don’t add to our burden.			

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Dr. Margaret E. Abell abellmedclinic@shaw.ca Dr. W. Robert Abell

September 20th 2023

Re Requirements To Include Clinical Indication
Treatment goals
&/or Diagnosis For All Prescriptions

Three options are being considered none of which we feel are appropriate, although #3 may be more acceptable than the first two to many physicians.

Our major concern is for the patient's privacy. This may not be as serious a situation in the cities but in the rural areas, prescription scripts many times are taken into the nearby town by a friend or member of the family and the medications brought back in a similar way. With clear documentation as has been suggested, the patient's confidential information may well be all over town before the patient has received the pills. This also is a major factor when a rural pharmacy has a clerk working there who would now have much easier access to information for which they have no right. Probably even more likely is the fact that the medication bottles are frequently left on a table, placed in a food cupboard or medicine cabinet which can then be read by friends or family members, again causing a breach in confidentiality.

Not all patients will be negatively affected by this but what little we gain for some patients by this documentation, unfortunately many others will realize an immense loss in the way of privacy. With regards to medications prescribed as "Off Label" this certainly could be put on the script as "OL" If the pharmacist has concerns, the telephone is at hand and is a more appropriate way of dealing with confidential matters between pharmacist and physician.

And last, but not least we are increasing yet again the paperwork for our physicians, is it really beneficial for all concerned and worth the risks?

Respectfully submitted,

Margaret E. Abell W. Robert Abell

Public Consultation – Prescribing Requirements
August 24- September 29, 2023

PUBLIC FEEDBACK			
I've recently had the chance to review the proposed changes to the prescribing requirements. As a patient, I am extremely troubled by the proposed changes. I submit this email to express my serious opposition to the proposed changes. My doctor is responsible to prescribe the medications that I need. The pharmacist is responsible to provide the medication prescribed by my doctor and to provide minimal counsel on how to properly take those medications. It is not the place of the pharmacist to meddle in my medical treatment and to change what my doctor and I have discussed. This approach waters down and in deed jeopardizes my safe care, under the direction of a qualified physician. While there is an important role for the pharmacist, it is not to prescribe me medications, or to change or even consult on the medical care being provided to me by my physician. Further this approach may further jeopardize care and puts patients in the terrible position of now having to justify care to a pharmacist who doesn't have all the information necessary, the information shared PRIVATELY between patient and doctor. I do not want to be placed in the position of having to share protected personal health information in a crowded store to a pharmacist when filling prescriptions. Moreover, it is NOT the place of the college to make decisions releasing my protected personal health information. My diagnosis is protected information and it should NOT be shared without my expressed consent. I would NOT consent to my diagnosis being shared with any pharmacist or anyone. This information is very personal and it does not belong to the college to determine how it will be shared. It is my information and it is protected under legislation. I urge you to both reconsider these standards, that jeopardize patients, but also to authentically consult with patients.	No		
I appreciate the opportunity to provide feedback on matters that concern healthcare. However, the language used to provide background on prescribing requirements and revised drafts 1 and 2 is not appropriate for the general public. This public consultation is inaccessible to the public. I ask that this consultation request be revised and written in language that is simple for the average person to understand. Neglecting to do so will result in primarily receiving feedback from those in the healthcare field and those with higher education which is not an accurate representation of public opinion.			
I was alerted to the request for feedback on prescribing requirements as shown here: http://www.cpsm.mb.ca/news/public-consultation-prescribing-requirements My first thought is why is this not more public since this ultimately involves patient information? That is a major oversight. Second, the treatment goal, diagnosis, or indication being put on a prescription should be a discussion had between the physician and patient as it involves the disclosure of personal health information. Prescriptions, whether written on paper or on the bottle or medication pack, already			

includes an individual's name and the medication information. This is susceptible to being lost, stolen, or viewed by people without PHIA training. This includes general public, pharmacy employees, delivery drivers, family members, friends, or anyone who may somehow come in contact with an individual's medications, whether by choice or accident. I work in a front-line health care setting and see many patients who have stated that their prescriptions have been lost or stolen. This alone can be quite upsetting. Now for them to know that their private medical diagnosis or reason for needing the medication is also out "in the world" is akin to leaving a patient chart in a waiting room or outside. This is terrible. Many diagnoses come with stigmas. I am appalled this is even up for discussion without a concerted effort for open feedback from the public.			
The three options below are being considered and you have asked for public input. Unfortunately unless the public goes to The College of Physicians and Surgeons website to search for a doctor etc., I'm not sure if you can expect a fair response from the public as the questions are not in a survey format, in an easily or often visited public forum. a)Should indication,and/or treatment goal, and/or clinical indication be required on all prescriptions? Response: No I have read the draft with respect to the proposed Revised Standard of Practice: (Prescribing Requirements) and I absolutely do not agree that any information regarding a diagnosis, clinical indication or treatment goal should be provided to the pharmacy when a prescription is ordered. Many pharmacies do not have in place sufficient policies, procedures and other safeguards to meet its obligations under PHIA. Presently most prescriptions, faxed or provided to a pharmacy employee at the pharmacy may go through a number of people prior to it being filled by the actual pharmacist and the staff plus the actual pharmacy do not qualify as trustees. While they may sign an NDA or some other confidentiality agreement, it is impossible to monitor disclosure of information within the building or outside of the workplace. Many illnesses unfortunately have a stigma or a sense of embarassment attached to the illness. For example, HIV/Aids, VD, mental illness such as schizophrenia, borderline personality, colon and other cancers, liver diseases, IBS, ED, HPV, fertility, obesity, depression, substance issues, etc. Having a diagnosis or clinical indication or treatment goal evident on the prescription may deter a client from reporting to a physician their symptoms and in some cases a client may even be hesitant to see a doctor if the private information is being released to a pharmacy. More often than not, the clinical indication reflects the diagnosis, assumed or not. PHIA is already a rather tenuous concept and relies, for the most part, on staff in all positions, regardless of their signature on an NDA, to not expose to others any knowledge they may gain about a patient's condition. However, humans are curious and conversations in lunch rooms, at home and in clinical environments often center around a patient, client or family issues encountered through their positions.	No	No	No

Future generations should not be placed in a position where their personal information travels from their physician to a pharmacy considering a pharmacist generally knows their business so well that they can make a fairly accurate assumption as to why a medication is being prescribed. They have an area to discuss with their client, in private, if there are any concerns and according to the pharmacist I discussed this with, he has no problem placing a call to the client or doctor if he feels the treatment is in question regarding dosage, allergy, interactions etc. Also for some age groups this can be particularly devastating if they have their backpack with a prescription stolen, accidently left somewhere or lost. I was a nurse and have overheard conversations as well as having my had my own private information compromised in the past, in a hallway, lunch room and outside of the workplace. While I have not yet found myself in need of any medication I feel awkward about having to take, I believe it would make it very difficult for others suffering from medical conditions they do not want to risk having exposed. Presently the electronic system is already fragile. Add to that audits done to ensure information within a hospital is not being compromised, they are seldom catching those that overstep. The ability to monitor the "gossip" in lunch rooms and other areas outside of the workplace is zero. b)Should indication, and/or treatment goal, and/or clinical indication be required on all new and “off-label”* prescriptions only? No, for the reasons stated above. I would assume my primary physician would inform me if they were prescribing an off label drug. If this is not being done it should be required. "*Off-label is defined as the use of a medication that has not been approved for the treatment of a specific disease by Health Canada, as listed in the Canadian drug product monograph." c)Should indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions? NO, for the reasons stated above. If one looks as far back as 2012 and the survey done by Fair Warnings Inc. you can note the concerns facing patients and the general public at that time and very little, if anything, has changed in terms of privacy concerns. Further to that by increasing the stream of private information being released it will more likely than not impact the desire of a patient to withhold information impacting care. In the previous survey: 43.2% of Canadian patients stated they have withheld or would withhold information from their care provider based on privacy concerns 31.3% stated they have or would postpone seeking care for a sensitive medical condition due to privacy concerns More than 2 out of 5 Canadian patients, 42.9% indicated they would seek care outside of their community due to privacy concerns, with 33.7% indicating they would travel substantial distances, 50 kilometers or more, to avoid being treated at a hospital they did not trust, in order to keep sensitive information confidential, and 61.9% of Canadian patients reported that if there were serious or repeated breaches of patients’ personal information at a hospital where they received treatment, it would reduce their confidence in the quality of healthcare offered by the hospital.			

Many, in fact most, do not report a breach they are aware of nor are they aware they can report it to the Ombudsman. The hospital or organization deals with it internally, often in private and in fact in one of my situations I was told the offender had been talked to and moved to another department, however when questioned further, I was told they could not divulge any further information as that would be considered a privacy breach with respect to the offender. In a pharmacy situation it would be impossible to determine who leaked private information and unfortunately by the time one is made aware it has happened to them, the damage in terms of trust, confidence and sometimes reputation has been done.			
a) Should indication, and/or treatment goal, and/or clinical indication be required on all prescriptions? I was under the assumption that what I discuss with my doctor is private. To have staff in a pharmacy or anywhere else be given any information as to my condition is not appropriate. b)Should indication, and/or treatment goal, and/or clinical indication be required on all new and “off-label”* prescriptions only? That is something my primary would tell me or a pharmacist might ask directly if I have any questions if it is off label and if side effects are a concern you often receive a sheet on possible side effects. c) Should indication, and/or treatment goal, and/or clinical indication be recommended only on all prescriptions? They should not be on any prescriptions. Only the prescription unless you have little faith in the doctors that you certify??			

Public Consultation – Prescribing Requirements
August 24- September 29, 2023

STAKEHOLDERS FEEDBACK			
The College of Medical Laboratory Technologists of Manitoba has reviewed the two documents out for public consultation. We find them comprehensive and clear and feel that they provide guidance to your registrants on proper and safe prescribing practices. We did note one small omission in the Practice Direction for electronic submission and have added our comment to this document. *On page 2, section 2.1.1.b. There is a footnote (5) at the end of the sentence but footnote #5 is missing at the bottom of the page. The footnotes jump from #4 to #6.*			
Thank you for seeking feedback regarding the CPSM proposed changes to the prescribing requirements. I read them with interest. As outlined in your memo many of the changes provide clarity and avoid duplication of information. You did indicate that you were specifically seeking feedback on two issues. 1. Requiring an indication on all or some prescriptions. I appreciate that this is a complex decision. Although I am aware some professions already require this, our college does not yet - though I imagine it will be on our agenda soon. I recognize that many resources identify that including an indication as a key area to reduce medication errors. From a public protection perspective, on first glance it would seem that if it reduces medication errors it should be required. However as your memo pointed out the benefits could be reduced by the logistics of implementation, and enforcement. I think if the CPSM decides not to implement the requirement then it should be clear to you how public protection was considered. The draft Standard of practice is very specific regarding all other required content of prescriptions. In this case I am leaning towards option 3 (ie it being recommendation only), with a little hesitation. If option 3 is chosen hopefully it could be understood that including an indication is best practice, and therefore physicians should be implementing best practice unless there is rationale otherwise, ie. it should (somehow) be understood that not including an indication should be rare. The CPSM may also want to consider what to do in complaints cases where an indication was not included but there was no reason why that was so. I didn't see the benefit of only requiring it for off label use. It seems to me the risks for medication error exist in either case. 2. Verbal prescriptions for MP3 drugs. I support this change and agree that a request for regulation amendment should be made.			Maybe
Just a few comments on the practice directions and issues with pharmacy. I think diagnosis' on all RX's would help with clarification calls to doctors, especially if the dose is out of normal range. Also, it would help with deciding if the part 2 drugs should be covered with EDS as very few physicians document coverage. The November 2022 practice direction regarding z-drugs and benzos to have doctors re-evaluate usage every 90 days isn't happening in most cases. All it does is make patients wait for a new RX every 90 days with discontinuation and changes rarely made. We send for refills and make the			

patient wait for it to be signed. We understand that sleeping is not considered a life threatening condition, however it is very disruptive for the patient to be told that we cannot continue the RX and they will have to go a few days without if not singed and returned to pharmacy. We, as pharmacists, can hold patients to refills on time if we went back to more refills. I had a doctor accuse pharmacy of bringing in the direction so we could charge a fee every month which is absolutely not the case. The Mp3 program had its place before DPIN, but now that all RX's are entered into DPIN we can see if a patient is double doctoring or over filling a narcotic. The change to Mp3 requirements with Covid has made for a lot of questions from physicians as to how to write these RXs. Bringing them into line same as all schedules would help with confusion. I also feel that some physicians do not realize we have our own licenses to protects as well. Our questions and clarifications are not to waste the Doctor's time or do too much, it is in the best interest of the patient. If you have any further questions or comments for me please feel free to reach me at the number below.			
Signature: the changes should include what a valid signature is and must indicate: Stamps to sign a prescription are not valid and are not acceptable since they do not satisfy legislative requirements. Photocopied templates including signature are not valid and do not meet legislative requirements. Digital images of a signature. cut and pasted into a prescription , are not valid Tenneille Metz Pharmacist Out of province I commend Manitoba Colleges for addressing this national problem of invalid prescriptions issued by registrants. I have sent this to the College of Physicians and Surgeons and College of Pharmacists in B.C. since the same problems exist here.			

Public Consultation – Prescribing Requirements
August 24- September 29, 2023

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September 27, 2023

Dear College of Physicians and Surgeons of Manitoba (CPSM),

The College of Pharmacists of Manitoba (CPhM) Council has considered the items and recommendations from the Quality Prescribing Review Working Group and the CPSM consultation.

As it relates to verbal orders and pharmacist extensions of M3P medications, Council would like CPhM, CPSM, and the College of Registered Nurses of Manitoba (CRNM) to jointly approach the Manitoba government to pursue a Pharmaceutical Regulation amendment to permit the Health Canada subsection 56(1) exemptions in Manitoba that would allow for verbal orders and pharmacist extensions of M3P prescriptions.

CPhM Council has also reviewed the drafts of the following documents:
- CPSM Standard of Practice on Prescribing Requirements
- Joint Statement on Electronic Transmission of Prescriptions

CPhM Council would like to provide the following feedback:

1. CPSM Standard of Practice on Prescribing Requirements
- The contents listed in section 8.1.2 are not current standard requirements for orders written in a facility. Is this an intended change?
- The definition of hospital and residential health care facilities would benefit from having further clarity and broadening the definition to encompass facilities such as outpatient IV, palliative care, dialysis units, and emergency response services.

2. Joint Statement on Electronic Transmission of Prescriptions
- CPhM Council is supportive of including a diagnosis/clinical indication/treatment goal on all prescriptions.
- In section 3.2 where it states, "Prescribers **must** use their professional judgment to determine whether it is necessary to include any additional information on the prescription (e.g., the patient's weight or date of birth where this information would affect dosage).", CPhM Council has recommended to update that section to state, "Prescribers **must** include any additional information on the prescription as required such as, the patient's weight or date of birth where this information would affect dosage.".

Kind Regards,

Jane Lamont
President

College of Pharmacists of Manitoba Mission:
To protect the health and well being of the public by ensuring and promoting safe, patient-centred and progressive pharmacy practice.

Member of the National Association of Pharmacy Regulatory Authorities

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VIA EMAIL

September 29, 2023

Dr. Anna Ziomek, Registrar
The College of Physicians & Surgeons of Manitoba
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Dear Dr. Ziomek:

Thank you for the opportunity to provide a submission on behalf of Doctors Manitoba respecting the public consultation by the College of Physicians and Surgeons of Manitoba (the "College") respecting the updating of prescribing requirements.

Introduction

Doctors Manitoba appreciates the ongoing efforts of the College to consolidate the requirements now contained in various Standards of Practice and Practice Directions. The thoughtful consolidation of these requirements allows our mutual members to find the guidance they require more easily. As well, we appreciate the ongoing efforts by the College to update the wording of the various Standards of Practice and Practice Directions.

We are aware that a substantial number of our mutual members have shared their views on this consultation, either directly to the College or to us. We acknowledge that we have invited members to provide us with their views if they do not feel comfortable providing them directly to the College. We do not do this to restrict or limit feedback, but to support our mutual members who advise us that they do not feel comfortable providing their position on challenging issues directly to the College. By allowing members to provide us with their thoughts, we can increase the diversity of opinions received by the College. We have also been copied with some of the many submissions the College has received directly from members.

Proposed Prescription Requirements

The only issue in this consultation which has generated significant concern from our mutual members is the potential requirement for physicians to include either a clinical indication, and/or treatment goal, and/or diagnosis on all prescriptions. Most of our submission will focus on this issue.

We acknowledge the College's advice that this proposed requirement did not originate within the College, but instead was requested by the College of Pharmacists of Manitoba ("CPhM"). We further appreciate the College's environmental scan of other Canadian jurisdictions, which found only Quebec requires a similar requirement (and even then only in certain situations).

The feedback we have received directly from our mutual members, and we have seen in member submissions to the College, is that a requirement of this type is almost universally opposed. We would like to summarize the reasons provided by our mutual members to support the rejection of this proposed obligation.

1. Increased Regulatory Burden

We believe the College is very aware of the tremendous administrative burdens placed on physicians. These burdens are created by the College as regulator, Manitoba Health as the payor for all insured medical services, as well as other parties with which physicians engage (including insurance companies, Manitoba Public Insurance, and the Workers' Compensation Board, etc.). Administrative burden is regularly reported by our members as an increasing concern, and it has been identified as a major reason for physician stress, burnout, and even the choice to reduce or closing their practices.

Not long ago, the College consulted on new requirements respecting episodic care. The draft Standard of Practice proposed a requirement to provide a summary of each episodic care visit to be sent to the patient's primary care physician. This would have created a significant administrative burden for both the sending and the receiving physician. The College listened to mutual members and Doctors Manitoba, and this new obligation was limited to those episodic visits where it would be medically beneficial for the primary care physician to know about the visit. The willingness of the College to listen was appreciated by our mutual members. We believe the resulting Standard of Practice balanced the best interests of patients without adding unduly to physicians' administrative burdens.

Similarly, the proposed requirement to require physicians to provide the indication, and/or treatment goal, and/or clinical indication to be required on all prescriptions, required for all new and off label prescriptions, or recommended on all prescriptions will create an additional administrative burden on all physicians in Manitoba. Our mutual members are strongly of the view that this burden outweighs any potential benefit to patients from this requirement.

A physician's prescription is based on that physician's judgment, developed from their experience and training. Their choices are always reviewable by the College. The College holds physicians to a very high standard commensurate with the nature of the profession.

More concerns about the increased administrative burden will be the focus of another submission coming to the College from the Joint Task Force to Reduce Administrative Burden for Physicians. Doctors Manitoba is a participant in that Task Force.

2. Privacy and Confidentiality

Several of our mutual members have raised questions about privacy, should physicians be required to provide more information with the prescription.

The confidentiality of prescription information is highly protected, with good reason.

We note that at present the College is not considering the transmission of prescriptions by email because of concerns of confidentiality. We support the College's caution on this issue, and acknowledge this issue may be reconsidered should security concerns be resolved.

Our mutual members have told us very clearly that including the additional information proposed by the CPhM will put patients' personal health information at risk, and is not beneficial to patient care.

This information will be included in a prescription which might be taken to the pharmacist by someone other than the patient. The information might be printed on the bottle or other packaging accessible to anybody who picks up the prescription, including family, members, or delivery staff. It will be much easier for staff other than a pharmacist to see this additional health information of the patient.

These are all examples of how the privacy and confidentiality of the patient's personal health information could be affected. This proposed obligation would greatly increase the risk of the improper sharing of personal health information in a way which may be embarrassing or even damaging to the patient. We do not believe that most patients would want, the reasons for their prescription to be transmitted to the pharmacy; we submit that in most situations patients want the pharmacist to fill the prescription, describe the proper administration of the medication, and review any concerns about interactions with other medication without knowing about their underlying condition. At any time, the patient is free to disclose their personal health information to the pharmacist if they choose.

Some of our members have asked whether they would require separate informed consent from each patient in order to comply with the proposed requirements.

We have also noted the concerns of pediatricians about the particular impact this would have on minors, especially those in care.

3. Unauthorized Use or Access of Personal Health Information by Pharmacists

Some members have raised concerns about the uses pharmacists could make of this information. When a physician prescribes a specific drug or medication, they have a reason for doing so. Unless there is a compelling reason otherwise, which would warrant the pharmacist contacting the physician, the pharmacist should not question the decision of the physician. Obviously, if the pharmacist is aware of potential interactions with other medication that the patient is taking, that is an entirely valid reason for communication between the pharmacist and the physician. However, the choice by a pharmacist to counsel a patient to take a different medication, dispense a different quantity or dosage, or make some other change to what the physician has prescribed, must be reviewed with concern, and, in certain cases, suspicion.

Pharmacists are important partners in the delivery of care to Manitobans. However, it well understood that some pharmacists are very interested in expanding their scope of practice. We are also aware that some pharmacists would welcome the ability to change and manage prescriptions, in order to generate additional revenue for themselves or the large companies for whom they may work or may otherwise be engaged. The College should not concern itself with maximizing pharmacists' revenue without any meaningful enhancement to the benefit or care of patients.

Some mutual members have expressed concerns that requiring physicians to include this information before the pharmacist will lead to greater second-guessing of their decisions by health care professionals with far less training and expertise in treating illness, and far les familiarity with the patient's condition. This could lead to confusion by patients, more complaints, and more time taken away from physicians' other duties.
Finally, our mutual members have raised a multitude of concerns about the mechanics of adding this information.

There is a simple solution to any questions or concerns about a prescription, which has been around since before the regulatory colleges were created: a pharmacist can contact the physician to discuss these questions or concerns.

4. Conclusion respecting the proposed new obligations

For these reasons, it is the position of Doctors Manitoba that none of the three options should be included in the new Standard of Practice and Practice Direction.

We note (in addition to the common sense solution of a pharmacist contacting the physician to discuss any questions or concerns) there are certain protections for patient safety already contained in the proposed documents. Section 3.2 of the proposed Standard of Practice provides as follows:

> 3.2 Prescribers must use the professional judgement to determine whether it is necessary to include any additional information on the prescription (e.g., The patient's weight or date of birth where this information would affect dosage).

Similar provisions are contained in Section 3.2 of the proposed Practice Direction respecting the electronic transmission of prescriptions.

Accordingly, the College's draft documents already include an obligation to provide additional information where there is a medical reason to do so. It is strongly submitted that this is sufficient.

Other Provisions

We have considered the other changes to the proposed Standard of Practice and Practice Direction on prescribing requirements.

With respect to the Manitoba Prescribing Practises Program (M3P drugs), we believe the repeal of the Practice Direction and the inclusion of the requirements in the Standard of Practice is reasonable and beneficial for ensuring physicians understand their responsibilities.

The consolidation of the verbal private prescribing expectations from the Practice Direction into the Standard of Practice is reasonable and makes the obligations easier to review.

The proposed Section 3.1.8 of Standard of Practice respecting the statutory requirements for pharmacist dispensing is prudent. The clarification that the Standard of Practice applies to

prescribing in both the community and in a hospital, but clearly specifying which prescribing rules do not apply in a hospital, personal care, home, or other institutional settings, is useful.

The implementation of verbal prescriptions for M3P drugs, under limited circumstances and only when timely, fax or electronic transmission is not possible and would otherwise lead to a delay in access to urgently need medication, is reasonable with these prudent limitations. The College's clear direction that this is not intended to be a "workaround", but instead an extraordinary measure to protect patients who may be at risk if the prescription cannot be renewed, is appropriate. Doctors Manitoba's support of this change is on the understanding that an amendment to the General Regulation of the College of Pharmacists of Manitoba will be required.

Finally, subject to the comments we have made respecting the content of electronic prescriptions, we believe the draft Practice Direction is acceptable.

Conclusions

Our position that the additional requirements being requested by the CPhM should be rejected by the College at this time does not mean there cannot continue to be discussions among various health regulators about enhancing patient care. As technology advances, there may be ways to share additional information among health care professionals without raising concerns about administrative burden, privacy, and the other concerns raised by our mutual members.

We understand that the Task Force noted above will seek to bring together physicians and pharmacists to discuss ways to reduce the administrative burden without impacting (or perhaps even enhancing) patient care. CPSM's involvement would be welcomed by Doctors Manitoba and appreciated by our mutual members.

At the present time Doctors Manitoba submits the College would best serve the interests of its members and the public by rejecting the request by the CPhM.

Thank you once again for the opportunity to provide this submission on behalf of our mutual members.

Yours truly,

Andrew Swan

ANDREW SWAN
General Counsel

AS/cb

Manitoba | Doctors Manitoba

Joint Task Force on Reducing Administrative Burdens for Physicians

September 29, 2023

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

Subject: Submission in Response to Public Consultation on New Prescribing Requirements

Dear Dr. Ziomek,

We are writing on behalf of the Joint Task Force to Reduce Administrative Burdens for Physicians in response to the public consultation on potential new prescribing requirements. Specifically, we are responding to the proposed new documentation requirements for prescriptions, as requested by the College of Pharmacists.

Our Joint Task Force was established jointly by the Minister of Health and President of Doctors Manitoba, with a mandate to assess and reduce the administrative burdens for physicians (learn more about our mandate and work here). We acknowledge the critical role that the College of Physicians and Surgeons of Manitoba (CPSM) plays in ensuring the highest standards of patient care and safety, and we appreciate the opportunity to submit a response to your consultation.

The Joint Task Force is very concerned about the introduction of significant administrative burden on physicians that would result from the proposed new requirements for prescribing medications, such as adding the clinical indication, treatment goal, or diagnosis to prescriptions.

As you know, there is a shortage of physicians in Manitoba, significantly influenced by high levels of physician burnout. Extensive administrative burden has been identified as a major contributor to burnout. Our research reveals that physicians already dedicate an average of 10.1 hours per week to administrative tasks, with 44% of that time deemed unnecessary. Given that the CPSM's mandate includes supporting work to ensure an adequate number of physicians to achieve access for the people of Manitoba, we are confident you share our concern about new measures that could negatively affect the supply and well-being of physicians at this time.

We recommend a stringent evaluation process of the administrative burden that would result before considering the implementation of any new requirements, as you have initiated through your public consultation. The potential introduction of additional burdens warrants thorough examination of the overall administrative burden impact on the healthcare system. In fact, the Joint Task Force has developed practical tools aimed at reviewing and mitigating administrative burdens on physicians that could be of assistance. We are happy to share these resources with the College, fostering a collaborative effort to streamline processes and avoid new administrative burdens on physicians.

Of note, one of our current initiatives relates to the administrative burdens associated with prescribing and prescription renewals. We are actively facilitating collaborative dialogue among pharmacists and physicians, including Pharmacists Manitoba, Doctors Manitoba, and the College of Pharmacists. We invite the College of Physicians and Surgeons of Manitoba to participate in this cooperative endeavor.

In summary, the Joint Task Force strongly advocates for a cautious and prudent approach when contemplating the introduction of new administrative or documentation requirements for prescribing medications. We emphasize the critical importance of considering physician burnout and administrative burden while considering any new requirements for prescriptions.

Thank you for considering our submission and collaborating towards a more efficient and sustainable healthcare system for the people of Manitoba. We would be happy to meet with you to discuss this further.

Sincerely,

Paul Pierlot Keir Johnson

Paul Pierlot and Keir Johnson
Co-Chairs
Joint Task Force to Reduce Administrative Burdens for Physicians

cc: Scott Sinclair, Deputy Minister of Health
Theresa Oswald, CEO of Doctors Manitoba
Joint Task Force Members

Public Consultation – Prescribing Requirements
August 24- September 29, 2023

Hi! I know that I missed the deadline for feedback about the prescribing guidelines and faxing prescriptions. But just wanted to send my input anyways. I feel that all prescribers should be required to put a diagnosis on all prescriptions. As an NP, I do it with every Rx – it does not take any extra time or impact workflow in any way. In my opinion, it is safer – the pharmacist is aware of the diagnosis and can ensure that the prescribing of the medication matches (ie- especially since some medications are dosed differently depending on the diagnosis).	Yes		

Standard of Practice

Prescribing Requirements

DRAFT

Initial Approval: **Effective Date:**

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

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

PREAMBLE

Medicine and Pharmacy are two professions that are often jointly involved in the management of the same patient. Unfortunately, the pharmacist and physician often have very little direct contact with each other on a matter. The two individuals may never have met each other and may not totally understand each other's responsibilities. This Standard of Practice attempts to improve this liaison and ensure better access to quality safe prescribing for Manitobans.

1. Application and Definitions

1.1. Prescribe[1] and Prescription[2] includes both prescriptions in the community and what are commonly called “orders” in hospital and residential healthcare institutions. Only the requirements in Part B apply to prescribing for hospital inpatients and residential health care institutions.

1.1.1 Hospitals include healthcare facilities owned and operated by the Government or a Health Authority (including Personal Care Homes and other Government-run residential care facilities).

1.1.2 Residential healthcare institutions are defined as privately-owned residential care settings.

[1] Prescribe is defined as, “to issue a prescription for a dental appliance, drug, vaccine, vision appliance, or wearable hearing instrument.” *RHPA,* s. 3

[2] Prescription is defined as, “in respect of a drug or vaccine, a direction to dispense a stated amount of a drug or vaccine specified in the direction of the individual named in the direction.” RHPA, s. 3

Part A – Prescribing in the Community

2. Before Prescribing

2.1 Prescribers **must** only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively.

2.2 Before prescribing a drug, prescribers **must** meet the following requirements. These requirements are subject to the limited exceptions specified in Section 6.3:

- 2.2.1 complete an appropriate clinical assessment of the patient;
- 2.2.2 document in the patient's medical record a diagnosis or differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information;
- 2.2.3 consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs, and the risks and benefits when providing long-term prescriptions; and
- 2.2.4 obtain informed consent.

3. Content of Prescriptions

3.1. Prescribers **must** ensure the following information is included on every written or electronic prescription:

- 3.1.1. the prescriber's printed name, signature[4], practice address, and CPSM registration number;
- 3.1.2. the patient's name and either date of birth or Personal Health Identification Number (PHIN) (for M3P drugs, the patient's address, date of birth, and PHIN must be included);
- 3.1.3. the name of the drug;
- 3.1.4. the drug strength, quantity, and formulation (tablet, liquid, patch);
- 3.1.5. the dose and directions for use;
- 3.1.6. the full date the prescription was issued (day/month/year);
- 3.1.7. the total quantity and interval between part-fills must be specified for:
  - 3.1.7.a any medication on the M3P drug list
  - 3.1.7.b any medications that are classified federally as a narcotic or a controlled substance (refer to the appendix for a complete listing of these medications);
- 3.1.8. for all other medications, refill instructions must be specified;
- 3.1.9. a method to contact the prescriber (telephone number[5], email address, or facsimile number).

[4] Paper prescriptions handed to the patient must be **signed in ink** by the prescriber. Electronically transmitted prescriptions may be signed electronically. Rubber stamped signatures are not permitted.

[5] This can be the hospital, clinic, or institutional phone number. If desired, a prescriber may also include a personal phone number on prescriptions intended for electronic transmission (i.e., faxed directly to pharmacy and not handed to the patient).

3.2. Prescribers **must** use their professional judgment to determine whether it is necessary to include any additional information on the prescription (e.g., the patient's weight or date of birth where this information would affect dosage). It is recommended that either the diagnosis, clinical indication, or treatment goal or a combination thereof be included on the prescription. See the Contextual Information and Resources document following this Standard for guidance on this matter.

3.3. If the prescriber is an associate registrant (Resident, Physician Assistant, Clinical Assistant), the prescription must also include:
- 3.3.1. their designation (e.g., PA or Cl.A);
- 3.3.2. the treatment goal and/or diagnosis and/or clinical indication; and
- 3.3.3. the name of their supervising physician.

4. Format of Prescriptions including Verbal Prescribing

4.1. Prescriptions may be handwritten (legibly), electronically generated in accordance with the Practice Direction Electronic Transmission of Prescriptions, verbally relayed, or in the physician's order sheet in a hospital, Personal Care Home, or residential healthcare institution as per Part B of this Standard.

4.2. Verbal prescriptions for all drugs must include all information included in section 3.1 above other than the signature and prescription issue date.

4.3. Verbal prescriptions are permitted for all drugs and substances, subject to section 7 of this Standard and any institutional policies.

5. Sample Medication

5.1. A registrant must:
- 5.1.1. keep sample medication in a secure location;
- 5.1.2. dispose of sample medication in a safe and environmentally acceptable manner;
- 5.1.3. not offer to sell or barter sample medication for any purpose whatsoever; and
- 5.1.4. not have any form of material gain from distributing the sample medication.

5.2. A registrant must ensure if a sample drug is provided to the patient it is provided with clear instructions for its use, including any precautions, and it is not expired.

6. Direct Patient Contact

6.1 In most cases, prescribing medication or counter-signing a prescription without direct patient contact does not meet an acceptable standard of care. The requirements of section 2 and this section must be met for most prescriptions. These requirements are subject to limited exceptions specified in section 6.3. There is no direct patient contact when the registrant only relies upon a mailed, faxed or an electronic medical questionnaire.

6.2 The registrant **must** demonstrate there has been:

- 6.2.1 a documented patient evaluation by the registrant signing the prescription, that includes an adequate history and physical examination (subject to the requirements of the Standard of Practice – Virtual Medicine), to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indications;
- 6.2.2 sufficient direct dialogue between the registrant and patient regarding treatment options and the risks and benefits of treatment(s);
- 6.2.3 a plan for follow-up to review the course and efficacy of treatment to assess therapeutic outcome, as needed; and
- 6.2.4 maintenance of a contemporaneous medical record that can be accessed by the registrant, and be made available to the patient, and the patient's other healthcare professionals.

6.3 Exceptions exist to the direct patient contact requirement when the registrant:

- 6.3.1 is fulfilling responsibilities as part of a call group, true group practice or healthcare institution. In these scenarios registrants must reasonably satisfy themselves that:
  - 6.3.1.a. the healthcare professional who conducted the assessment has the appropriate knowledge, skill, and judgment to do so, and
  - 6.3.1.b. the prescription is clinically sound and in the patient's best interest;
- 6.3.2 treats their own patients after normal office hours;
- 6.3.3 works in an academic teaching environment;
- 6.3.4 is providing naloxone as part of a harm reduction strategy and overdose prevention.;
- 6.3.5 prescribes prophylaxis as part of a Public Health Program;
- 6.3.6 prescribes for the sexual partner of a patient with a sexually transmitted infection;
- 6.3.7 prescribes anti-retroviral medication within the context of the Provincial HIV program; or
- 6.3.8 prescribes a medication available in Manitoba without requiring a prescription (e.g., an over-the-counter medication such as acetaminophen).

7. Manitoba Prescribing Practices Program (M3P Drugs)

7.1. Physicians **must** prescribe the drugs listed on the M3P schedule in the manner prescribed in the Regulation and this Standard.

7.2. Section 7 of this Standard does not apply to:

7.2.1. prescriptions for drugs administered in a personal care home as described under the Manitoba Health Services Insurance Act;

7.2.2. prescriptions for drugs administered in a hospital or institutional residential healthcare facility; and

7.2.3. the direct administration of a designated drug to a patient by a prescriber.

7.3. All prescription drugs on the M3P Schedule must be written on a prescription form as is approved by CPSM.

7.4. The treatment goal, and/or diagnosis, and/or clinical indication(s) must be included for all M3P prescriptions.

7.5. The prescription **must** contain only one drug per prescription form.

7.6. The prescription is only valid for three days after its issuance to the patient and the physician **must** so advise the patient.

7.7. Prescribers **must** prescribe in accordance with the Practice Direction for Prescribing Methadone or Buprenorphine/naloxone.

Part B - Prescribing in a Hospital, Personal Care Home, or Residential Healthcare Institution (Orders)

8. Prescribing

8.1 Prescribers in the facilities listed in sections 1.1.1. and 1.1.2 **must** ensure the following:

Content of prescription orders:

8.1.1. the name of the drug;

8.1.2. the drug strength and formulation (tablet, liquid, patch);

8.1.3. the dose and directions for use (for example the exact time of administration, if applicable);

8.1.4. the full date and time the prescription was issued (hour/day/month/year); and

8.1.5. the prescriber's printed name and signature.

9. Before Prescribing in a Hospital, Personal Care Home, or Residential Healthcare Institution

9.1. Prescribers **must** only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively.

9.2. Before prescribing a drug, prescribers **must:**

9.2.1. document in the patient's medical record a diagnosis or differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information (as reasonably appropriate);

9.2.2. consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs, and the risks and benefits when providing long-term prescriptions; and

9.2.3. use their professional judgment to determine whether it is necessary to include any additional information on the prescription (e.g., the patient's weight or date of birth where this information would affect dosage).

9.3. For verbal prescribing/orders, in addition to the requirements under section 9.1 and 9.2, prescribers **must**:

9.3.1 provide the verbal order to a nurse or pharmacist, including all required content;

9.3.2 ensure if a voice message is left that a direct callback number is included to facilitate the nurse or pharmacist calling back and verifying the verbal order directly with the prescriber. A verbal order is not considered valid until a nurse or pharmacist speaks directly with the prescriber to verify the order; and

9.3.3 sign the order within a reasonable timeframe, if required by the institution's operating policy.

Contextual Information and Resources

Prescribing Requirements

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

Importance of Pharmacists as Part of the Health Care Team

Pharmacists are important members of a patient's health care team. Their knowledge, skill, and judgement contribute to improving health care of patients.

However, without knowing the diagnosis, clinical indication, or treatment goal(s) associated with a prescription, the pharmacist's ability to optimize patient outcomes is limited.

It is important for registrants to understand that pharmacists aim to work collaboratively with prescribers to ensure the patient receives good medical care. Pharmacists have expertise in navigating complex drug therapy, in-depth knowledge about pharmacology, and specialized training in hundreds of medications and how these may interact with one another.

The Role of the Pharmacist

Patient safety and quality medical care are optimized when pharmacists know the diagnosis, clinical indication, or treatment goal for medications.

Patient Safety

Good medical care requires safety checks along the care path to prevent inadvertent errors from occurring. Unintended prescribing errors do occur. Pharmacists provide a safety check to catch these errors. However, they may not be able to identify an error if they are unaware of the diagnosis, clinical indication, or treatment goals. For example, a pharmacist would not be able to identify an error if the registrant inadvertently prescribed hydroxyzine when the intention was to prescribe hydralazine. Additionally, there is also a need to verify the correct dose for the intended indication. Verifying doses, formulations, or directions for use can be difficult without knowing the therapeutic indication.

There will also be occasions when a drug prescribed needs to be changed, whether it be due to a drug shortage, interaction, cost concerns, or other reasons. If the pharmacist understands the therapeutic indication, they can effectively and efficiently advise on appropriate alternatives based upon what is available and covered by third-party payors.

Quality Patient Care

Often the community pharmacist will be the last health care provider the patient speaks with prior to taking a new medication. Although the registrant has provided the patient with counselling regarding the appropriate use of the medication, this information may be complex and new to the patient. It is often beneficial for the pharmacist to ensure that the patient understood this important information and will be able to follow through on taking the medication appropriately.

Proper patient counselling requires that the patient understands the purpose and desired therapeutic effect of the medication, and that any safety concerns are addressed. It is also important for the patient to have an opportunity to have their questions answered. However, without knowing the diagnosis, clinical indication, or treatment goals it can be more challenging for the pharmacist to provide effective counselling. If the pharmacist is unable to answer the patient's questions, this may result in delays in patient care while the pharmacist verifies the appropriateness of the prescription by contacting the prescriber. Providing specific information on a prescription can enhance patient care. For example, listing treatment goals will allow the pharmacist to reinforce care goals when counselling the patient, particularly when managing medication titrations, transitions, or changes.

Resource for the Health Care Team

Pharmacists should be viewed as a valuable resource for the health care team. Pharmacists have expertise evaluating the effectiveness and safety of medications and the appropriateness of medication regimens in general. This is especially true for the management of chronic conditions and complex or high-risk medication regimens.

Pharmacists can suggest medication options that are optimal for the patient in the context of their current conditions and medications. They can assist in developing care plans to achieve the patient's treatment goals through optimal medication therapy and support of chronic disease management and prevention. Keeping pharmacists informed about the therapeutic intent of medications prescribed can maximize their effectiveness as a key resource to the care team.

Best Practice

It is considered best practice and recommended to include appropriate clinical information on the prescription. While CPSM recognizes that including the diagnosis, clinical indication, or treatment goal on every prescription can add time or administrative burden for prescribers, this must be balanced with the benefits of doing so. There may be situations when doing so is deemed unnecessary or inappropriate by the prescriber. The latter may occur in rare circumstances when sensitive psychosocial or ethical considerations prevail. When writing a prescription, the registrant may identify a valid reason to omit the diagnosis, clinical indication, or treatment goal (e.g., when the harm of information sharing outweighs the benefit). Otherwise, it remains best practice.

Considering Prescription Drug Costs

Effective prescribing involves consideration of efficacy, safety, convenience/burden, and cost. Available research shows that a failure to consider prescription drugs costs at the point of care can have a variety of unintended negative consequences, including:

- many prescriptions going unfilled because the patient is unable to afford the medication;
- many patients do not take their medications as prescribed due to cost; and
- high prescription drug costs are associated with increased clinic and emergency room visits, and hospitalizations.

For this reason, prescribers should consider the following on a proactive basis:

- the cost of the drugs they prescribe, and
- whether there is a therapeutically equivalent alternative that is available at a lower price.

This analysis will be particularly important when a prescriber has reason to believe that their patient may struggle to afford or be unable to pay for the medication being prescribed.

CPSM recognizes that physicians may not be aware of up-to-date resources regarding the cost of prescription drugs in Manitoba. Consultation with a pharmacist may be helpful. Additionally, the MEDS (Medications, Evidence, & Decision Support) Conference site is a source of current, convenient, and up-to-date information, specifically the list of Price Comparisons of Commonly Prescribed Medications in Manitoba (2023).

Reporting Adverse Drug Reactions or Medication Incidents

Registrants can help support the ongoing evaluation of prescription drug safety by reporting adverse drug reactions, suspected adverse drug reactions, and medication incidents to the relevant organizations/authorities, especially those that are:

- unexpected, regardless of their severity;
- serious, whether expected or not; and
- related to recently marketed health products (on the market for less than five years).

Registrants can report adverse drug reactions to Health Canada's Vigilance Program and medication incidents through the Institute for Safe Medication Practices Canada.

Prescription Drug Disposal

Because most community pharmacies have procedures in place to safely dispose of patients' returned medications (also called post-consumer waste), it is generally best practice for registrants to direct patients to their local pharmacy to return unused medication.

In circumstances where a registrant takes possession of the patient's drugs directly or is in possession of any other types of medications (e.g., unused or expired medication samples), registrants can contact a drug disposal company to set up their own contract for safe disposal. Registrants may further consider arranging for the disposal of unused/expired/returned drug samples directly through the pharmaceutical representative or company that has provided them.

Suspected Prescription Forgery

What Physicians Can Do

Report Forgeries. Physicians should notify CPSM, CPhM, and the pharmacies involved upon becoming aware of forgeries. Likewise, pharmacies should alert prescribers of forgery attempts and notify CPhM.

Notify Police. If impersonated, physicians can report to local police authorities. If a patient's information was fraudulently used, the physician may review this with their patient and involve police if safety concerns arise.

Safeguard Practice. Reduce risk of theft and forgery by locking up all prescription pads, letterhead, and fax templates. Pharmacists may contact prescribers to verify prescriptions for opioids, benzodiazepines, or other potential products of abuse, particularly if they seem unusual or concerning.

What Pharmacists Can Do

Verify Suspected Forgeries. Pharmacists should contact the prescriber to confirm any unusual or concerning prescriptions prior to dispensing.

Report Forgeries. Pharmacists should notify the prescriber, CPhM, and see Forgery of Narcotics and Controlled Substances on CPhM's website for details of reporting to Health Canada.

Notify Police. Pharmacists should report prescription forgeries to the local police authorities. Whenever possible, this should be done while the individual(s) are waiting in the pharmacy. If the individual requests the forgery back, the pharmacist should take a copy, stamp the original with the pharmacy contact information and document refusal to fill on the original and in Drug Program Information Network (DPIN).

What CPSM & CPhM Are Doing

CPSM and CPhM work directly with prescribers and pharmacies involved in forgeries. The Colleges monitor situations and trends, and collaborate to raise awareness by informing registrants of identified trends, risks, and actions to take.

Resources

ADD LEGISLATION AT THE BACK

The Pharmaceutical Act of Manitoba

Practice Direction

Electronic Transmission of Prescriptions

DRAFT

Initial Approval: **Effective Date:**

Practice Directions set out requirements related to specific aspects of the practice of medicine. Practice Directions are used to enhance, explain, or guide registrants with respect to the subject matter relevant to the practice of medicine. Practice Directions provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, Bylaws, and Standards of Practice issued by CPSM. All registrants must comply with Practice Directions, per s. 86 of *The Regulated Health Professions Act.*

This Practice Direction is made under the authority of s. 85 of the RHPA and represents requirements of CPSM registrants in so far as appropriate.

This joint Practice Direction is the result of Interprofessional Collaboration between:

- College of Pharmacists of Manitoba (CPhM),
- College of Physicians and Surgeons of Manitoba (CPSM),
- College of Registered Nurses of Manitoba (CRNM),
- The Manitoba Dental Association (MDA), and
- The Manitoba Veterinary Medical Association (MVMA).

Purpose

To better serve all patient populations (urban, rural, and remote) and to leverage the benefits of modern technology, the electronic transmission of prescriptions is necessary to ensure timely access to care. The purpose of this Practice Direction is to outline the minimum practice expectations for health professionals whose scope of practice includes prescribing. The Practice Direction clarifies the expectations of safeguards for electronic transmission of prescriptions.

1. Definition and Application

"Electronic transmission" is the communication of an original prescription or refill authorization by electronic means. This includes computer-to-facsimile machine[1], facsimile machine to facsimile machine, facsimile machine to computer, or via a closed e-prescribing system[2]. It does not include verbally transmitted prescriptions or prescriptions transmitted by email at this time.

This joint Practice Direction applies to all medications prescribed for outpatients and persons receiving care in an ambulatory community practice.

[1] For instance, a prescription sent by Accuro is converted into a fax and sent to the pharmacy's fax machine.
[2] For example, the PrescribeIT prescribing system

The Manitoba Prescribing Practices Program (M3P) will supersede this process when the drug being prescribed is covered under the M3P Program. Prescribers should refer to their respective regulatory body for further guidance.[3]

2. Electronic Transmission of Prescriptions

2.1. Principles

2.1.1. In consideration of patient safety and to minimize the risks associated with drug diversion, prescribers and pharmacists **must** adhere to the following principles:

2.1.1.a. The process **must** maintain confidentiality.[4] It **must** do so by either facsimile or closed e-prescribing system. Prescribers and pharmacists are jointly responsible for maintaining the confidential nature of electronic transmission.

2.1.1.b. The accuracy and authenticity of the prescription **must** be able to be validated.

2.1.1.c. The process **must** incorporate mechanisms to decrease prescription forgery risk and minimize the risk of the prescription being transmitted to more than one pharmacy unintentionally.

2.1.1.d. The patient's choice of pharmacy **must** be protected, taking into consideration the treatment plan and drug availability.

2.2 Shared Responsibility

2.2.1. To facilitate congruence with the above principles, prescribers and pharmacists have the following responsibilities:

2.2.1.a. The prescriber **must** ensure the prescription is transmitted directly to the pharmacist in a clear, unambiguous manner and the mode of transmission is secure and maintains confidentiality.

2.2.1.b. The pharmacist **must** only accept a prescription once satisfied that it came directly from someone who has the authority to prescribe and the prescription is appropriate for the patient. A pharmacist is also responsible for verifying a prescriber's written and/or electronic signature if it is unknown to the pharmacist.

2.2.1.c. Both prescribers and pharmacists **must** ensure that prescribing is done in accordance with each profession's scope of practice (as outlined by their regulatory body).

[3] CPSM Standard of Practice Prescribing Requirements, CRNM xx, CPhM xx, MVMA xx, DVA xx
[4] Veterinary prescriptions are exempt from the confidentiality requirement.

2.3. Safeguards

2.3.1. The following additional safeguards apply to electronic prescriptions:

2.3.1.a. All prescriptions transmitted electronically (except veterinary prescriptions) **must** be entered into the Drug Program Information Network (DPIN) to enhance patient care and safety, and to restrict opportunities for potential prescription fraud.[5]

2.3.1.b. After transmission, the prescriber **must** ensure the original prescription is invalidated to ensure it is not transmitted elsewhere at another time. A prescription record **must** be retained in accordance with the prescriber's regulatory body.

2.3.1.c. Pharmacists **must** ensure the electronic and facsimile equipment at the pharmacy is under the control of the pharmacist so the transmission is received and only handled by staff in the dispensary in a manner which protects the patient's privacy and confidentiality.[6] Prescriptions, including any relevant prescription information received by electronic transmission **must** be appropriately filed by the pharmacist in accordance with CPhM's record keeping requirements.

3. Content of Electronic Prescriptions

3.1. The prescription **must** be legible and **must** include the following information:

3.1.1. The prescriber's printed name, signature, practice address, and Registration number;

3.1.2. The patient's name and either date of birth or Personal Health Information Number (PHIN) (for M3P drugs, the patient's address, date of birth, and PHIN must be included).[7]

3.1.3. The name of the drug.

3.1.4. The drug strength, quantity, and formulation (tablet, liquid, patch).

3.1.5. The dose and directions for use.

3.1.6. The full date the prescription was issued (day/month/year).

3.1.7. The total quantity and interval between part-fills **must** be specified for:

3.1.7.a. Any medication on the M3P drug list.

3.1.7.b. Any medication classified federally as narcotic or a controlled substance. (Refer to the appendix for a complete listing of these medications.)

3.1.8. For all other medications, refill instructions must be specified.

3.1.9. The time and date of prescription transmission.

[5] Should a patient request a drug that falls under the Controlled Drugs and Substance Act (CDSA) *not* be entered into DPIN under their PHIN (or if they do not have a Manitoba PHIN), a pharmacist must directly confirm prescription authenticity with the prescriber. Such drugs would include opioids, controlled medications, benzodiazepines, and targeted substances.

[6] For greater clarity, dedicated pharmacy electronic and/or facsimile equipment must not be accessed by individuals who are not authorized pharmacy staff.

[7] Veterinary prescriptions are exempt from PHIN and date of birth.

3.1.10. The name and address of the one pharmacy intended to receive the prescription.
3.1.11. The method to contact the prescriber (telephone number, email address, or facsimile number).
3.1.12. Signed certification that:
3.1.12.a. the prescription represents the original of the prescription drug order;
3.1.12.b. the addressee is the only intended recipient and there are no others; and
3.1.12.c. the original prescription will be invalidated, securely filed, and not transmitted elsewhere at another time.

3.2. Prescribers **must** use their professional judgment to determine whether it is necessary to include any additional information on the prescription (e.g., the patient's weight or date of birth where this information would affect dosage). It is recommended that either the diagnosis, clinical indication, or treatment goal or a combination thereof be included on the prescription. See the Contextual Information and Resources document following the Standard of Practice for Prescribing Requirements for guidance on this matter.

3.3. If the prescriber is a CPSM associate registrant (Resident, Physician Assistant, Clinical Assistant), a prescription must also include:
3.3.1. their Designation (e.g., PA or Cl.A);
3.3.2. treatment goal and/or diagnosis and/or clinical indication; and
3.3.3. the name of the supervising physician.

3.4. If the prescriber is a CRNM Registrant (e.g., RN(NP)), a prescription **must** include a treatment goal and/or diagnosis and/or clinical indication.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
DECEMBER 13, 2023
NOTICE OF MOTION

SUBJECT: **Standard of Practice – Medical Assistance in Dying (MAiD)**

RECOMMENDATION:

That Council approve for consultation amendments to the Standard of Practice - MAiD. These amendments provide greater guidance on how to address complex cases and improve patient safeguards in response to the legislated expansion of MAiD eligibility effective March 2024.

BACKGROUND:

The existing Standard of Practice for MAiD was developed in 2016, when the Criminal Code was amended to create a legislative framework for the provision of MAiD. At that time, eligibility for MAiD was limited to patients who had:

1. a grievous and irremediable medical condition, and
2. whose death was reasonably foreseeable.

In March 2021, federal legislation expanded the eligibility requirements for MAiD to include patients whose natural death is not reasonably foreseeable. It also changed the consent requirements to permit the provision of MAiD to patients whose death was reasonably foreseeable and who previously consented to MAiD but lost capacity to consent at the time MAiD was scheduled to be provided.

In addition, the legislation created new safeguards for the provision of MAiD to such patients. CPSM's current Standard was amended in 2021 to reflect the change in the law at that time.

The 2021 legislation also made clear that while mental illness as referenced in the legislation was not then considered an illness, disease or disability, it would be after two years and following a mandatory independent review and recommendations by experts (March 2023). The moratorium was extended by one year to March 17, 2024.

The effect of the legislation is that as of March 17, 2024, patients whose sole underlying medical condition is a mental illness/disorder (MD-SUMC) will be eligible for MAiD provided they meet all other eligibility requirements.

The proposed amended Standard of Practice ensures appropriate safeguards are in place for all patients who are eligible for MAiD as of March 17, 2024. Non-substantive formatting and structural amendments are also proposed to improve readability and understanding of the processes related to MAiD.

The following summarizes the developments which led to the recommended changes to the existing Standard:

1. An Expert Panel established by the federal government issued a report in May 2022 in which it recommended a process to facilitate the development of Standards of Practice by medical regulatory authorities such as CPSM for the assessment of MAiD requests in situations that raise questions about incurability, irreversibility, capacity, suicidality, and the impact of structural vulnerabilities. The Panel's recommendations included, but were not limited to provision of MAiD to patients for whom a mental disorder is the sole underlying medical condition (MD-SUMC). It made the following observations:
    - Cases of MD-SUMC are clinically similar to some other cases where MAiD is already permitted where natural death is not reasonably foreseeable in terms of the complexity of the questions raised, such as with respect to irremediability.
    - Patients with mental disorders already access MAiD, provided they had another qualifying condition such that having a mental disorder did not necessarily preclude them from accessing MAiD. Rather, it had to be taken into consideration during the MAiD assessment.
    - Patients seeking MAiD with histories of suicidal ideation/attempts and other patients seeking MAiD who were in situations of structural vulnerability currently access MAiD and these factors did not preclude them. Rather, they were considered in the eligibility assessment.
2. The Expert Panel concluded that unique legislated safeguards for MAiD requests by patients with MD-SUMC were **not** warranted. It observed that the concerns about MAiD in such circumstances were of a clinical nature and that what was needed was additional clinical guidance/safeguards for **all** MAiD requests that are complex because of challenges such as how to establish incurability and irreversibility, capacity, suicidality, and/or how to address the impacts of structural vulnerability upon the requests. Treating MD-SUMC differently was expressly rejected, and medical regulatory authorities were recognized as the most appropriate bodies to develop and enforce appropriate standards.
3. In response to this report, a MAiD Practice Standards Task Group was established by Health Canada. It was comprised of six individuals from across Canada with relevant expertise, including the Registrar of the CPSNS. It created resources for the use of all medical regulatory bodies, including a Model Standard that could be adopted by each regulatory body to create uniformity across Canada. The Task Group's process involved consultation with stakeholders, including CPSM and other medical regulatory bodies, representatives of MAiD providers and psychiatry. Ultimately, it both endorsed and implemented the suggested approach of the Expert Panel by not creating a unique set of additional requirements for patients with MD-SUMC seeking MAiD.
4. CPSM has been in regular communication with its counterparts across Canada about the approach being taken to the Model Standard. There was an initial interest in all adopting the Model Standard to achieve a national standard, but over time, this approach was rejected by most colleges for a variety of reasons.
5. The Registrar, the Medical Director of the Provincial MAiD Clinical Team and Lynne Arnason, legal counsel who has provided all legal services to CPSM and its working groups in relation to CPSM's requirements since 2015 have carefully considered the extensive

materials from the Expert Panel and the Task Group and materials from other sources with differing perspectives. The Standard has been modified as reflected in the attached draft to incorporate many of the recommendations of the Federal Expert Panel and the Task Group.

It is important to note that:

- The Model Standard contained much of what was already contained in CPSM's standard, which has been followed by the MAiD team in Manitoba. As such, it was not considered desirable to make unnecessary changes to the existing Standard.

- A similar approach, where existing standards have been modified as opposed to adopting the entire Model Standard without modification, has been taken by regulatory bodies across Canada. Most have made changes to their existing standard to include those additional requirements that each regulatory body felt best suited their circumstances.

Changes in the Standard

The proposed changes in the Standard are reflected in the attached draft. Unfortunately, it was not feasible to provide a red-lined comparison of the proposed changes to the current Standard. This is in part due to the fact that it was necessary to move portions around and change the numbering to accommodate new sections. That said, the format remains the essentially the same. This approach has facilitated improved flow and a more concise document. It will also be beneficial to those who provide MAiD and are already very familiar with the existing Standard to minimize the changes in the flow of the document.

A summary of the proposed changes/impact follows:

1. The proposed modifications have no impact on the existing requirements for the provision of MAiD to patients whose natural death is reasonably foreseeable.
2. The document has been updated and simplified by removing portions of the historical context that are no longer relevant and updating the language so it is consistent with CPSM's current approach.
3. A few additional definitions have been added to enhance the understanding of certain terms in the context of the Standard.
4. The primary focus of the changes are additions to the existing expectations of physicians assessing eligibility and implementing safeguards for patients seeking MAID whose death is not reasonably foreseeable. It does so by incorporating portions of the Model Standard which offer more guidance for determining whether the medical condition(s) from which a patient seeking MAiD is "grievous and irremediable". Most of these are found in section 2 of the Standard. The focus is on clearer criteria for what conditions are irreversible or incurable. Some examples include:
    a. additional assurances that physicians with appropriate expertise in the patient's underlying condition are involved in the assessment;
    b. enhanced requirements for obtaining all relevant information for the assessment;

   c. clarifying the need for there being no reasonable interventions remaining to treat the patient's condition(s) before they are eligible for MAiD; and
   d. the requirement for exploration of the patient's consistency of suffering with the patient's clinical presentation over time.
2. It includes enhanced safeguards to address issues often associated with vulnerable patients with complex chronic medical conditions which were suggested by the Expert Panel and formed part of the Model Standard. These are primarily found in section 7 of the Standard. Examples include:
   a. consideration of the means available to address suffering, including housing and income supports and other factors impacting the most vulnerable; and
   b. addressing suicidality in the context of a MAiD request,
3. Expansion of the expectations/requirements of physicians in respect to all registrants in relation to their communications with patients about MAiD and their relationships with patients who are seeking MAiD, regardless of the physician's stance on MAiD (Section 1). These changes are aimed at protecting patients seeking MAiD and encouraging open communication.

In order to identify where substantive changes have been made, the new sections have been highlighted in yellow in the proposed Standard. Where text has been simply been moved or section numbers changed to accommodate new material, the moved text has generally not been highlighted. The Standard currently in force is attached for comparison purposes. This approach is intended to give Councillors an appreciation as to what has been changed without requiring ad detailed review of a red-lined side by side comparison, which would be cumbersome to read.

Limited Consultation on Changes to Expectations and Requirements

There is a duty to consult with registrants, stakeholders, and the public when developing/updating a Standard of Practice. CPSM recognizes that MAiD for patients with MD-SUMC is controversial. The proposed revised Standard does not re-open the debate for whether MAiD should be accessible by patients with MD-SUMC. That decision has been made by parliament. If the moratorium on access to MAiD for patients with MD-SUMC is not extended, such patients will be legally entitled to access MAiD and CPSM must proceed on that basis. It cannot create barriers to such patients accessing MAiD.

It is also important to note that the revisions proposed to the Standard are warranted to address the complex cases where death is not reasonably foreseeable even if the moratorium is extended or patients with MD-SUMC never become legally entitled to access MAiD in Canada. The additional guidance and safeguards have generally been welcomed in most jurisdictions.

The revisions to the existing Standard have been drafted by CPSM legal counsel with knowledge and experience with the Standard and with input from two physicians with expertise in the area. They are satisfied that the recommended changes to the Standard are consistent with the Criminal Code and the recommendations made by the Federal Expert Panel and the Task Group.

PUBLIC INTEREST RATIONALE:

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

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2023, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

The Standard of Practice for Medical Assistance in Dying as attached is approved to be sent out for consultation.

Standard of Practice

Medical Assistance in Dying (MAiD)

Initial Approval: January 1, 2019 **Effective Date: January 1, 2019**
Updated: June 9, 2021
Updated:

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 registrants 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.

CONTEXT

Medical assistance in dying (MAiD) has been permitted in Canada in limited circumstances since 2016 as result of amendments to the Criminal Code[1]. On March 17, 2021, the eligibility requirements for MAiD were expanded to include patients whose natural death is not reasonably foreseeable[2]. Those amendments also created new legislated safeguards for the provision of MAiD to patients whose natural death is not reasonably foreseeable. They also changed the consent provisions to allow for the provision of MAiD to patients whose death is reasonably foreseeable and who consented to MAiD, but lost capacity before it was scheduled to be provided. The new legislation also made clear that while mental illnesses / disorders were not then considered to be an illness, disease or disability, they would be after two years and following a mandatory independent review and recommendations by experts (March 2023). This was later extended to March 2024.

An Expert Panel established by the federal government issued a report on May 13, 2022[3]. In that report, the Expert Panel acknowledged that its mandate referred only to mental illness. That said, it believed that its recommendations for safeguards, protocols, and guidance should apply to all clinical situations in which concerns about incurability, irreversibility, capacity, suicidality, and/or the impact of structural vulnerabilities arise, regardless of the patient's diagnoses. As such, it recommended a process to facilitate the development of Standards of Practice by medical regulatory authorities for the assessment of MAiD requests where questions about incurability, irreversibility, capacity, suicidality, and the impact of structural vulnerabilities arise, including but not limited to provision of MAiD to patients for whom a medical disorder is the sole underlying medical condition (MD-SUMC). This Standard has been modified to incorporate several of the recommendations of the Expert Panel.

[1] An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) SC 2016, c. 3
[2] An Act to amend the Criminal Code (medical assistance in dying) SC 2021, c. 2
[3] Final Report of the Expert Panel on MAiD and Mental Illness, May 2022)

This Standard establishes the standards of practice and ethical requirements of all CPSM registrants in relation to MAiD. The terms "must" and "should" are used to describe CPSM's expectations. "Must" indicates a mandatory requirement. "Should" indicates a strong recommendation for what is considered best practice, but allows for registrants to use reasonable discretion when applying such an expectation in their practice. These expectations are subject to existing legislation and regulations governing any aspect of MAiD which come into force and effect, which unless otherwise stated, take priority over this Standard where there is any inconsistency.

Shared Health's Medical Assistance in Dying website provides information on MAiD and accessing MAiD through its Provincial MAiD Clinical Team. This team has developed an expertise in MAiD and follows protocols for assessing eligibility for and providing MAiD. The team can be reached by email at maid@sharedhealthmb.ca or by phone at 204-926-1380 or toll-free at 1-844-891-1825. All physicians who receive a request for MAiD should consult with and consider referral of patients to the Provincial MAiD Clinical Team. Other recommended resources include the Canadian Medical Protective Association and the Canadian Association of MAiD Assessors and Providers.

DEFINITIONS

The following terms and phrases have specific meaning in the context of this Standard, regardless of how they are otherwise understood.

Administering Physician –the physician who provides or administers the pharmaceutical agent(s) intended to cause the patient's death. The administering physician is responsible for confirming that all the requirements of this Standard have been met before the pharmaceutical agent(s) that intentionally cause the patient's death can be provided or administered. There can only be one administering physician for each patient.

Assessing Physician(s) – the physician(s) who provide a written opinion as to whether the patient requesting MAiD meets the eligibility requirements for MAiD. There can, and in some cases must be, more than one Assessing Physician.

Medical Assistance in Dying (MAiD) is defined in s. 241.1 of the Criminal Code to mean:

a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

MAiD MD-SUMC: Medical assistance in dying where a mental disorder is the sole underlying medical condition of the patient requesting MAiD.

Medical Practitioner - is defined in s. 241.1 of the Criminal Code to be a person who is entitled to practice medicine under the laws of a province. For the purposes of providing MAiD in Manitoba and this Standard, this means physicians on the Manitoba Medical Register and excludes Regulated Associate Members (medical students, residents, physician assistants and clinical assistants).

Mental Disorder: a condition as described in standard psychiatric diagnostic classification schemes such as the DSM5-TR. The *Criminal Code* uses the term 'mental illness.' According to the federal legislative background document prepared for Bill C-7, the term 'mental illness' would **not** include neurocognitive or neurodevelopmental disorders, or other conditions that may affect cognitive abilities, such as dementias, autism spectrum disorders, or intellectual disabilities.

Nurse practitioner: a registered nurse who, under the laws of Manitoba, is entitled to practice as a nurse practitioner and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients.

Patient - the person requesting MAiD and whose well-being must be the primary concern of any physician involved with responding to such a request.

Pharmacist: a person who is entitled to practice pharmacy under the laws of Manitoba.

Physician - a medical practitioner who is a registrant of CPSM and is both registered on the Manitoba Medical Register and licensed to practice medicine. This definition excludes a registrant who is only practicing within a residency training program.

Registrant – a registrant of CPSM who is registered on the Manitoba Medical Register or the Associate Members Register as an Educational Registrant, Physician Assistant or Clinical Assistant.

EXPECTATIONS AND REQUIREMENTS

1. EXPECTATIONS AND MINIMUM REQUIREMENTS OF ALL REGISTRANTS AND PHYSICIANS

1.1. A registrant must not promote their own values or beliefs about MAiD when interacting with a patient.

1.2. On the grounds of a conscience-based objection[4], a physician who receives a request about MAiD may refuse to:
- 1.2.1. provide it; or
- 1.2.2. personally offer specific information about it; or
- 1.2.3. refer the patient to another physician who will provide it.

[4] See s. 10 of the Standard of Practice for Good Medical Care, where conscience-based objection is defined as an objection to participate in a legally available medical treatment or procedure based on a registrant's personal values or beliefs.

1.3. A physician who refuses to refer a patient to another physician or to personally offer specific information about MAiD on the grounds of a conscience-based objection must:
  1.3.1. clearly and promptly inform the patient that the physician chooses not to provide MAiD on the grounds of a conscience-based objection; and
  1.3.2. provide the patient with timely access to a resource[5] that will provide accurate information about MAiD, including how a patient can make a request for MAiD or to be assessed for eligibility for MAiD; and
  1.3.3. continue to provide care unrelated to MAiD to the patient until that physician's services are no longer required or wanted by the patient or until another suitable physician has assumed responsibility for the patient; and
  1.3.4. make available the patient's chart and relevant information (i.e., diagnosis, pathology, treatment and consults) to the physician(s) providing MAiD to the patient when authorized by the patient to do so; and
  1.3.5. document the interactions and steps taken by the physician in the patient's medical record, including details of any refusal and any resource(s) to which the patient was provided access.

1.4. A registrant who is not a physician and has a conscientious-based objection to MAiD who receives a request for MAiD, information about MAiD or a referral to a physician who will provide MAiD must advise the patient making the request that the registrant has a conscientious-based objection and must communicate the request to the registrant's supervising physician in a timely fashion.

1.5. Registrants who have existing therapeutic relationships with a patient requesting MAiD must:
  1.5.1. not discharge the patient from existing services even when there is a MAiD team or centralized process involved in their care; and
  1.5.2. continue to work with the patient with their consent in the pursuit of therapeutic goals even while a MAiD request is being explored.

1.6. Registrants must not assume that all patients who are potentially eligible for MAiD are aware that it is legal and available in Manitoba.

[5] Acceptable resources may include but are not limited to other registrants, health care providers, counsellors and publicly available resources which can be accessed without a referral and which provide reliable information about MAiD. In Manitoba, Shared Health maintains a website regarding MAiD and accessing MAiD through its Provincial MAiD Clinical Team, which has developed an expertise in MAiD and has established protocols for assessing eligibility for and providing MAiD. The team can be reached by email at maid@sharedhealthmb.ca or by phone at 204-926-1380 or toll-free at 1-844-891-1825. All physicians who receive a request for MAiD are strongly encouraged to consult with or consider referral of patients to the Provincial MAiD Clinical Team.

1.7. Unless a registrant has a conscience-based objection to MAiD, where a registrant reasonably believes that:

1.7.1. a patient is unaware that MAiD is a medical service available to patients who meet the eligibility requirements; and

1.7.2. MAiD is consistent with the patient's values and goals of care,

the registrant should inform the patient about MAiD, taking reasonable steps to ensure that the patient does not perceive the providing information as pressure to pursue or MAiD or not and must not otherwise promote the registrant's own values or beliefs and document the interactions in the patient's medical record.

2. ELIGIBILTY FOR MAiD

2.1. Legal Criteria

2.1.1. To be eligible for MAiD, a patient must meet **ALL** of the following criteria:

2.1.1.i. be eligible for publicly funded health services in Canada[6] ;

2.1.1.ii. be at least 18 years of age and capable of making decisions with respect to their health;

2.1.1.iii. have a grievous and irremediable medical condition;

2.1.1.iv. make a voluntary request for medical assistance in dying that is not the result of external pressure; AND

2.1.1.v. provide informed consent to receive MAiD after having been informed of the means that are available to relieve the patient's suffering, including palliative care.

2.1.2. A patient has a grievous and irremediable medical condition only if **ALL** of the following criteria are met:

2.1.2.i. they have a serious and incurable illness, disease or disability[7];

2.1.2.ii. they are in an advanced state of irreversible decline in capability; and

2.1.2.iii. that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

2.1.3. Only Medical Practitioners and Nurse Practitioners are legally authorized to assess eligibility and ensure that all statutory safeguards in relation to the provision of MAiD have been implemented before it is provided.

2.1.3.i. The law requires that at least two such practitioners must be of the opinion that the legal criteria has been met and that the safeguarding measures have been put into effect before MAiD can be provided

[6] This includes people who would be eligible but for any minimum period of residency or waiting period.

[7] A mental illness/disorder is NOT considered as an illness, disease or disability unless or until the amendment to the Criminal Code made in 2021 comes into effect in March 2024 or otherwise.

2.1.3.ii. Among CPSM registrants, only physicians can independently conduct the necessary assessments and ensure that the safeguards have been implemented prior to MAiD be provided.

2.2. Expectations Of Physicians Assessing Eligibility And Implementing Safeguards

2.2.1. General

2.2.1.i. For a physician to provide an opinion in relation to MAiD eligibility and the statutory safeguards, that opinion must be based on appropriate medical judgment and reasonable method of assessment, including:

2.2.1.i.1. a clinical diagnosis of the patient's medical condition whether that diagnosis has been made by that physician or, where that physician lacks sufficient expertise to render a diagnosis and opine on the patient's medical condition, a formal consultation with another physician with relevant expertise for the limited purpose of confirming the diagnosis, prognosis or treatment options. The physician who provides the consultation to that physician is acting as a consultant to either the Assessing physician or Administrating Physician and is not considered to be providing MAiD for the purposes of this Standard;

2.2.1.i.2. a thorough clinical assessment of the patient, which includes consideration of all relevant, current and reliable information about the patient's symptoms and the available medical treatments to cure the condition or alleviate the associated symptoms which make the condition grievous, including, where appropriate, consultation with another qualified physician; and

2.2.1.i.3. having been fully informed of the current relevant clinical information about the patient and his/her condition.

2.2.1.ii. Any physician who conducts an assessment for the purpose of determining if a patient is eligible for MAiD in respect to any of the clinical criteria, including whether they are of the opinion that the patient has a grievous and irremediable medical condition, must have sufficient training, experience and qualifications to safely do so in the circumstances of each case.

2.2.1.iii. Forming an opinion about MAID eligibility may require a physician to obtain health records and/or gather collateral information from a variety of sources, including from other health care professionals, family members and/or significant contacts, to ensure that all relevant information is considered in the assessment.

2.2.1.iii.1. Where a patient requesting MAiD refuses consent to obtaining health record and personal data necessary for the completion of a MAID assessment, the physician must explain that, without such information, the assessment cannot be completed and therefore the patient cannot be found to be eligible.

2.2.1.iii.2. Potential sources of collateral information include the patient's family and close connections. Physicians must have received consent from the patient prior to gathering collateral information from any source. Physicians must be mindful of the patient's privacy when considering whether it is appropriate to seek collateral information from family members and other close connections. Where a patient refuses consent to obtaining collateral information that is essential for the completion of a MAID assessment, then the physician must explain that without such information, it may not be possible to complete the assessment and explore other sources of the collateral information before concluding that the patient cannot be found to be eligible based on the limited information available.

2.2.1.iii.3. Where physicians require the involvement of medical specialists, subspecialists, and other healthcare professionals for consultations and additional expertise for the purposes of their assessment, and where a patient requesting MAiD refuses consent to the involvement of other health care practitioners the physician must explain that without such involvement, the assessment cannot be completed and therefore the patient cannot be found to be eligible.

2.2.1.iv. Each physician must document in the patient's medical record all information that is relevant to their role and findings in respect to each of the specific requirements of any assessment related to the patient's eligibility for MAiD and the statutory safeguards, including capacity, informed consent and determining that the patient has a grievous and irremediable medical condition.

2.2.2. Assessing Whether A Medical Condition Is Grievous And Irremediable

2.2.2.i. 'Grievous and irremediable medical condition' is not a clinical term associated with medical practice. It is a legal term limiting access to MAiD which is defined by the legal criteria set out in the Criminal Code and includes several components, all of which must be present.

2.2.2.ii. The criteria for having a grievous and irremediable condition can only be met if both the practitioner who conducts the assessment for MAiD eligibility and the practitioner who provides MAiD are of the opinion that all of the components, which are listed in s. 2.1.2 above, are met.

2.2.2.iii. For a physician to be of the opinion that a patient has a serious and incurable illness, disease, or disability, incurable should be interpreted as meaning that there are no reasonable treatments remaining where reasonable is determined by the physician and patient together exploring the recognized, available, and potentially effective treatments in light of the patient's overall state of health, beliefs, values, and goals of care.

2.2.2.iv. For a physician to be of the opinion that a patient is in an advanced state of irreversible decline in capability:

2.2.2.iv.1. capability refers to a patient's functioning (physical, social, occupational, and/or other important areas), not the symptoms of their condition. Function refers to the ability to undertake those activities that are meaningful to the patient;

2.2.2.iv.2. advanced state of decline means the reduction in function is severe.

2.2.2.iv.3. Irreversible means there are no reasonable interventions remaining where reasonable is determined by the physician and patient together exploring the recognized, available, and potentially effective interventions in light of the patient's overall state of health, beliefs, values, and goals of care.

2.2.2.v. For a physician to be of the opinion that a patient's illness, disease or disability or state of decline causes the patient enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that the patient considers acceptable, the physician must respect the subjectivity of suffering and ensure that:

2.2.2.v.1. they are satisfied that it is the patient's illness, disease, or disability and/or state of decline in capability that is the primary cause of the patient's enduring suffering;

2.2.2.v.2. they have explored with the patient the consistency of the patient's assessment of their suffering with the patient's overall clinical presentation and expressed wishes over time, considering the unique circumstances and perspective of the patient, their personal experiences and religious or moral beliefs and values;

2.2.2.v.3. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and

2.2.2.v.4. treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous or, if the patient is terminal, palliative care interventions; and

2.2.2.v.5. the patient adequately understands the:

2.2.2.v.5.1. current and anticipated course of physical symptoms, ability to function and pain and suffering specific to that patient; and

2.2.2.v.5.2. effect that any progression of physical symptoms, further loss of function or increased pain may have on that specific patient; and

2.2.2.v.5.3. available treatments to manage the patient's symptoms or loss of function or to alleviate his/her pain or suffering.

3. CAPACITY

3.1. Any physician who conducts an assessment of a patient for the purpose of determining if the patient is capable of making decisions with respect MAiD must be:

3.1.1. fully informed of the current relevant clinical information about the patient and their mental and physical condition; and

3.1.2. qualified to assess competence in the specific circumstances of the patient whose capacity is being assessed or be able to consult with another physician with relevant expertise for the limited purpose of assessing the patient's medical decision making capacity.

3.2. As capacity is fluid and may change over time, physicians must be alert to potential changes in a patient's capacity and, where appropriate undertake serial assessments of the patient's decision-making capacity.

3.3. In the event that a physician has reasonable doubt as to the patient's competence, an additional independent assessment must be conducted by another physician who is enrolled on the Specialist Register as a psychiatrist.

4. INFORMED CONSENT AND VOLUNTARINESS

4.1. Physicians who obtain informed consent for MAiD must have sufficient knowledge of the patient's condition and circumstances to ensure that:

4.1.1. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and

4.1.2. the treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous and/or palliative care interventions where the patient is terminal; and

4.1.3. the patient is offered appropriate counseling resources; and

4.1.4. the patient fully understands that:

4.1.4.i. death is the intended result of the pharmaceutical agent(s); and

4.1.4.ii. the potential risks and complications associated with taking the pharmaceutical agent(s).

4.2. Each physician who obtains informed consent from the patient for MAiD must:

4.2.1. have either conducted his/her own assessment or be fully informed of the assessments conducted by other physicians of the patient's medical decision-making capacity; and

4.2.2. meet the legal requirements for informed consent, including informing the patient of:

4.2.2.i. material information which a reasonable person in the patient's position would want to have about MAiD;

4.2.2.ii. the material risks associated with the provision/administration of the pharmaceutical agent(s) that will intentionally cause the patient's death; and

4.2.2.iii. meet with the patient alone at least once to confirm that their decision to terminate their life by MAiD is voluntary and that the patient has:

4.2.2.iii.1. made the request themself thoughtfully; and

4.2.2.iii.2. a clear and settled intention to end their own life by MAiD after due consideration;

4.2.2.iii.3. considered the extent to which the patient has involved or is willing to involve others such as family members, friends, other health care providers or spiritual advisors in making the decision or informing them of his/her decision; and

4.2.2.iii.4. made the decision freely and without coercion or undue influence from family members, health care providers or others.

5. SPECIFIC EXCEPTIONS TO CONSENT REQUIREMENTS FOR PATIENTS WHOSE DEATH IS REASONABLY FORESEEABLE[8]

5.1. Subject to the following exception as it relates to patients whose death is reasonably foreseeable, but have lost the capacity to consent:

5.1.1. a substance to cause a patient's death may be administered to a patient who has lost the capacity to consent to receiving MAiD without giving the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive MAiD if **ALL** of the following circumstances apply:

5.1.1.i. BEFORE the patient lost the capacity to consent to receiving MAiD:

5.1.1.i.1. the patient met all of the criteria set out in Section 2 of this Standard and all other safeguards set out in this Section of the Standard were met;

5.1.1.i.2. the patient entered into an arrangement in writing with the physician or nurse practitioner that the physician or nurse practitioner would administer a substance to cause their death on a specified day;

5.1.1.i.3. the patient was informed by the physician or nurse practitioner of the risk of losing the capacity to consent to receiving medical assistance in dying prior to the day specified in the arrangement; AND

[8] For greater certainty, this exception does **NOT** apply to those whose death is **NOT** reasonably foreseeable.

5.1.1.i.4. in the written arrangement, the patient consented to the administration by the physician or nurse practitioner of a substance to cause their death on or before the day specified in the arrangement if they lost their capacity to consent to receiving medical assistance in dying prior to that day;

5.1.1.ii. the substance is administered to the patient in accordance with the terms of the arrangement; AND

5.1.1.iii. the patient does not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration[9].

5.2. Once a patient demonstrates, by words, sounds or gestures, a refusal to have the substance administered or resistance to its administration, MAiD can no longer be provided to them on the basis of the consent given by them under this Standard.

6. LEGALLY MANDATED SAFEGUARDS AND RELATED EXPECTATIONS

6.1. Before a physician provides MAiD to a patient, whether that patient's natural death is reasonably foreseeable or not, the physician must not only be of the opinion that the patient meets all of the criteria set out in Section 2, that physician must also ensure that the following procedural requirements have been met:

6.1.1. The request for MAiD was made in writing and signed and dated by the patient or where the patient is unable to sign and date the request, by another person (proxy) at the express direction of and in the presence of the patient. The person who serves as the proxy must:

6.1.1.i. be at least 18 years of age;

6.1.1.ii. understand the nature of the request for MAiD;

6.1.1.iii. not know or believe that they are a beneficiary under the will of the patient or a recipient in any other way of a financial or other material benefit resulting from the patient's death; and

6.1.2. The request was signed and dated after the patient was informed by a physician or nurse practitioner that the patient has a grievous and irremediable medical condition.

6.1.3. The request was signed and dated by the patient or by the patient's proxy before an independent witness, who must be at least 18 years of age and understand the nature of the request for MAiD, which witness must have also sign and date the request and not:

6.1.3.i. know or believe that they are aware they are a beneficiary under the will of the patient, or a recipient in any other way of a financial or other material benefit resulting from the patient's death;

6.1.3.ii. be an owner or operator of any health care facility at which the patient is being treated or any facility in which patient resides;

6.1.3.iii. be directly involved in providing health care services to the patient or be directly providing personal care to the patient, subject to the exception that a person who provides health care services or personal care as their

primary occupation and who is paid to provide that care to the patient requesting MAiD may act as an independent witness, except for:

6.1.3.iii.1. the physician or nurse practitioner who will provide MAiD to the patient: and

6.1.3.iii.2. the physician or nurse practitioner who provided an opinion regarding the patient's eligibility for MAiD.[9]

6.1.4. The patient has been informed that they may, at any time and in any manner, withdraw their request;

6.1.5. Another physician or nurse practitioner has provided a written opinion confirming the patient meets all the eligibility criteria and be satisfied that they and the other physician or nurse practitioner providing the opinion are independent in that each of them:

6.1.5.i. is not a mentor to the other practitioner or responsible for supervising their work;

6.1.5.ii. does not know or believe that they are a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or other material benefit resulting from that patient's death, other than standard compensation for their services relating to the request; or

6.1.5.iii. does not know or believe that they are connected to the other practitioner or to the patient in any other way that would affect their objectivity; and

6.1.5.iv. immediately before providing MAiD, give the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive MAiD,

6.1.6. If the patient has difficulty communicating, take all necessary measures to provide a reliable means by which the patient may understand the information that is provided to them and communicate their decision.

7. ADDITIONAL SAFEGUARDS FOR PATIENTS WHOSE DEATH IS NOT REASONABLY FORESEEABLE

7.1. The following additional requirements must be met before MAiD can be provided to a patient where the natural death of the patient requesting MAiD is not reasonably foreseeable:

7.1.1. In addition to the requirements described in Section 6.1.5 of this Standard, if the physician or nurse practitioner referred to in that Section does not have expertise in the condition that is causing the patient's suffering, another physician or nurse practitioner who has that expertise must be consulted and share the results of that consultation with the physician or nurse practitioner who provides MAiD before MAiD can be provided.

[9] This exception will allow most members of the health care team to act as an independent witness, but makes clear that family member or friends who are directly involved in providing medical or personal care to the patient are excluded.

7.1.2. The patient must have been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care. This should include consideration of housing and income supports in appropriate circumstances and may require the involvement of other professionals with expertise in the type of services which are relevant to the patient's personal circumstances; and

7.1.3. The Administering physician and Assessor must have discussed with the patient the reasonable and available means to relieve the patient's suffering and they must agree with the patient that the patient has given serious consideration to those means. In this context, the physician should consider whether the patient has demonstrated a genuine openness to the means available to relieve their suffering, including exploring the extent to which reasonable means have been tried by the patient.

7.1.4. The Administering physician and Assessing Physician or Assessing Nurse Practitioner should ensure that the patient's request for MAiD is not only consistent with their values and beliefs, but is unambiguous and rationally considered during a period of stability, and not during a period of crisis.

7.1.5. By itself, a request for MAiD by a patient with a mental disorder should not be interpreted as suicidal ideation, even if suicidality is listed as one of the diagnostic criteria of the patient's mental disorder. In all cases, if the patient requesting MAiD has a history of or current suicidal ideation or attempts, the usual clinical approach to assessing suicidality should be taken.

7.1.6. In the context of MAiD for mental disorders (whether sole underlying medical condition or a co-morbidity), both acute and chronic suicidal ideation must be considered and evaluated to best determine whether the wishes of the patient requesting MAiD to end their life by MAiD represents a capable appraisal of their situation rather than a potentially treatable symptom of their mental disorder.

7.1.7. There must be at least 90 clear days between the day on which the first assessment under Section 2 of this Standard as to whether the patient meets the criteria set out in that Section begins and the day on which MAiD is provided to the patient or - if the assessments have been completed and they and the physician or nurse practitioner referred to in Section 6.1.5 are both of the opinion that the loss of the person's capacity to provide consent to receive medical assistance in dying is imminent — any shorter period that the first physician or nurse practitioner considers appropriate in the circumstances.

8. SPECIFIC REQUIREMENTS OF THE ADMINISTERING PHYSICIAN

8.1. In all cases, whether the patient's natural death is foreseeable or not, the administering physician must:

8.1.1. have appropriate knowledge and technical competency to provide/administer the pharmaceutical agent(s) in the appropriate form and/or dosage that will terminate

the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent;

8.1.2. be qualified to provide appropriate instructions to the patient as to how to administer the pharmaceutical agent(s) that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent in circumstances where the patient elects to administer the pharmaceutical agent(s) to themself;

8.1.3. be readily available to care for the patient at the time the pharmaceutical agent(s) that intentionally brings about the patient's death is administered by the administering physician or taken by the patient until the patient is dead;

8.1.4. provide reasonable notice to the Office of the Chief Medical Examiner that the patient is planning to die by means of MAiD where the location is not a health care institution; and

8.1.5. certify, in writing[10] that they are satisfied on reasonable grounds that all of the following requirements have been met:

8.1.5.i. The patient is at least 18 years of age;

8.1.5.ii. The patient's medical decision-making capacity to consent to receiving medication that will intentionally cause the patient's death has been established in accordance with the requirements of the Criminal Code and this Standard;

8.1.5.iii. All of the requirements of the Criminal Code and this Standard in relation to assessing eligibility for MAiD and obtaining and documenting informed consent and all relevant additional safeguards have been met; AND

8.1.6. ensure that the requirements of physicians set out in all relevant federal and provincial legislation, including the Criminal Code, The Fatality Inquiries Act, C.C.S.M. c. F52 and The Vital Statistics Act, C.C.S.M. c. V60 in respect to reporting and/or registering the cause and manner of the patient's death, including completing all required forms specified by the legislation or regulations, are met in a timely fashion.

9. Additional Requirements of the Federal Legislation

9.1. CPSM requires that physicians comply with the federal and provincial regulations and guidelines described above as they come into force and effect. This includes the following requirements:

9.1.1. There are detailed requirements for the filing of information by physicians who carry out assessments or preliminary assessments as to whether patients meet the criteria for MAiD and those who receive a written request for MAiD[11];

[10] Please see Appendix A for an example of an acceptable form of written confirmation or contact the MAiD team at Shared Health for more information.

[11] These requirements are subject to specific regulations and input from Health Canada and may change over time. See section 241.31 of the Criminal Code and the related regulations for a detailed description of the information to be provided and to whom.

9.1.2. Physicians who, in providing MAiD, prescribe or obtain a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose;

9.1.3. Physicians must comply with guidelines established for the completion of certificates of death for patients to whom MAiD is provided;

9.1.4. A physician commits a criminal offence for:

9.1.4.i. knowingly failing to comply with the eligibility and safeguard requirements set out in Criminal Code; and

9.1.4.ii. destroying documents with the intent to interfere with a patient's access to MAiD, the assessment of a request for MAiD or a person seeking an exemption related to MAiD.

Appendix A – Certification by the Administering Physician

PATIENT INFORMATION		
Last Name	First Name	Second Name(s)
Personal Health Identification No. (PHIN) and/or Manitoba Health No (MHSC)	Birthdate	Gender: ☐ Male ☐ Female ☐ Other - specify:
Medical Condition(s) Relevant to Request for MAiD		
Independent Practitioner(s) who conducted their own review for patient eligibility and provided a written opinion in that regard:		

ADMINISTERING PHYSICIAN CERTIFICATION	
By initialling and signing below, I confirm that:	
Initials	I am the administering physician who has provided/administered the pharmaceutical agent(s) for medical assistance in dying ("MAiD") to the patient named above for the intended purpose of causing the patient's death at the patient's request.
Initials	I am familiar with all of the requirements for providing MAiD to the patient as set out in the *Criminal Code of Canada,* R.S.C, 1985, c. C-46 , and CPSM's Standard of Practice and am satisfied that all requirements have been met, including the following: 1. The patient was 18 years of age; 2. The patient had the capacity to make medical decisions at all relevant times; and 3. All requirements in relation to eligibility for MAiD have been met and all mandatory safeguards were implemented before MAiD was provided.
Initials	I am satisfied the Independent Practitioner listed above is independent of me and is not: 1. A mentor to me nor responsible for supervising my work; 2. Believed to be a beneficiary under the Will of the patient or recipient in any other way of any financial or material benefit resulting from the patient's death; or 3. Connected to me or the patient in any other way which would affect their objectivity
Initials	A written request for MAiD was signed and dated by the patient (or their proxy as directed by the patient) before an independent witness who then also signed and dated the request.
Initials	If the patient had difficulty communicating, all necessary measures were taken to provide a reliable means by which the patient may understand the information that was provided to them and communicate their decision.
Initials	I ensured the patient was informed that they may, at anytime and in any manner, withdraw their request for medical assistance in dying.
Initials	I informed the pharmacist that dispensed the pharmaceutical agent(s) (the "Substances") that the Substances were intended for medical assistance in dying.
Initials	Immediately before providing MAiD, I provided the patient with the opportunity to withdraw their request and ensured the patient gave their express consent to receive medical assistance in dying **OR**
Initials	The patient had completed a *Waiver of Final Consent* then lost capacity to consent to receiving MAiD and after ensuring the patient did not by words, sounds or gestures, demonstrate refusal or resistance to having the Substances administered, I provided MAiD in accordance with the terms of the *Waiver of Final Consent*.

Signature of Physician	Print Name	Date Signed
Signature of Witness	Print Name	Date Signed

Standard of Practice

Medical Assistance in Dying (MAiD)

Initial Approval: January 1, 2019
Updated: June 9, 2021

Effective Date: January 1, 2019

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

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

Background

CPSM's first Statement governing what was then known as physician assisted dying was approved in December 2015. At the time, there was no legislative framework. Medical assistance in dying (MAiD) has been permitted in Canada since 2016 as result of amendments to the Criminal Code which set out the framework for the provision of MAiD by medical practitioners and nurse practitioners.[1] Nothing in the legislation compels an individual to provide MAiD.

Following the implementation of MAiD, CPSM created this Standard of Practice and Manitoba established a provincial clinical team to provide MAiD. Shared Health now maintains a website about MAiD and accessing MAiD through its Provincial MAiD Clinical Team. This team has developed an expertise in MAiD and has established protocols for assessing eligibility for and providing MAiD. The link to its website is: https://sharedhealthmb.ca/services/maid/ The team can be reached by email at maid@sharedhealthmb.ca or by phone at 204-926-1380 or toll-free at 1-844-891-1825. All physicians who receive a request for MAiD are strongly encouraged to consult with and consider referral of patients to the Provincial MAiD Clinical Team.

On March 17, 2021, the eligibility requirements and safeguards for MAiD were expanded to include patients whose natural death is not reasonably foreseeable. The amendments created new safeguards for the provision of MAiD to those patients whose natural death is not reasonably foreseeable. They also changed the consent provisions to allow for the provision of MAiD to patients whose death is reasonably foreseeable and who consented to MAiD but lost capacity before it was scheduled to be provided. The new legislation also made clear that while mental illness is not currently considered to be an illness, disease or disability, it will be after two years and following a mandatory independent review and recommendations by experts (March 2023).[2]

[1] ***An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*** **SC 2016, c. 3**

[2] ***An Act to amend the Criminal Code (medical assistance in dying)*** SC 2021, c. 2

The legislation requires that MAiD be provided with reasonable knowledge and skill in accordance with any applicable provincial laws, rules or standards. This makes clear that anyone in Manitoba who provides or assists a practitioner who provides MAiD must work within the legal framework created by the federal legislation and follow all of the legal requirements and that physicians must comply with this Standards of Practice.

This Standard establishes the standards of practice and ethical requirements of physicians in Manitoba in relation to MAiD. It is subject to existing legislation and regulations governing any aspect of MAiD which come into force and effect while this Standard is in force and effect. Any such legislation and regulations take priority over the requirements of this Standard where there is any inconsistency.

Definitions

Medical Assistance in Dying (MAiD) is defined in s. 241.1 of the Criminal Code to mean:

a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

Medical Practitioner - is defined in s. 241.1 of the Criminal Code to be a person who is entitled to practice medicine under the laws of a province.

Physician - a medical practitioner who is a registrant of CPSM and is both registered on the Manitoba Medical Register and licensed to practice medicine. This definition excludes a registrant who is only practicing within a residency training program.

Patient - the person requesting MAiD and whose well-being must be the primary concern of any physician involved with responding to such a request.

Administering Physician –the physician who provides or administers the pharmaceutical agent(s) intended to cause the patient's death. The administering physician is responsible for confirming that all the requirements of this Standard have been met before the pharmaceutical agent(s) that intentionally cause the patient's death can be provided or administered. There can only be one administering physician for each patient.

Registrant – a registrant of CPSM who is registered on the Manitoba Medical Register, Educational Register, Physician Assistant Register or Clinical Assistant Register.

Requirements

1. Minimum Requirements of All Registrants and Physicians

1.1. A registrant must not promote their own values or beliefs about MAiD when interacting with a patient.

1.2. On the grounds of a conscience-based objection[3], a physician who receives a request about MAiD may refuse to:
- 1.2.1. provide it; or
- 1.2.2. personally offer specific information about it; or
- 1.2.3. refer the patient to another physician who will provide it.

1.3. A physician who refuses to refer a patient to another physician or to personally offer specific information about MAiD on the grounds of a conscience-based objection must:
- 1.3.1. clearly and promptly inform the patient that the physician chooses not to provide MAiD on the grounds of a conscience-based objection; and
- 1.3.2. provide the patient with timely access to a resource[4] that will provide accurate information about MAiD, including how a patient can make a request for MAiD or to be assessed for eligibility for MAiD; and
- 1.3.3. continue to provide care unrelated to MAiD to the patient until that physician's services are no longer required or wanted by the patient or until another suitable physician has assumed responsibility for the patient; and
- 1.3.4. make available the patient's chart and relevant information (i.e., diagnosis, pathology, treatment and consults) to the physician(s) providing MAiD to the patient when authorized by the patient to do so; and
- 1.3.5. document the interactions and steps taken by the physician in the patient's medical record, including details of any refusal and any resource(s) to which the patient was provided access.

1.4. A registrant who is not a physician and has a conscientious-based objection to MAiD who receives a request for MAiD, information about MAiD or a referral to a physician who will provide MAiD must advise the patient making the request that the registrant has a conscientious-based objection and must communicate the request to the registrant's supervising physician in a timely fashion.

2. Specific Requirements for Assessing Patient Eligibility for MAiD

[3] See s. 10 of the Standards of Practice for Good Medical Care, where conscience-based objection is defined as an objection to participate in a legally available medical treatment or procedure based on a registrant's personal values or beliefs.

[4] Acceptable resources may include but are not limited to other registrants, health care providers, counsellors and publicly available resources which can be accessed without a referral and which provide reliable information about MAiD. In Manitoba, Shared Health maintains a website about MAiD and accessing MAiD through its Provincial MAiD Clinical Team, which has developed an expertise in MAiD and has established protocols for assessing eligibility for and providing MAiD. The link to the website is: https://sharedhealthmb.ca/services/maid/ The team can be reached by email at maid@sharedhealthmb.ca or by phone at 204-926-1380 or toll-free at 1-844-891-1825. All physicians who receive a request for MAiD are strongly encouraged to consult with or consider referral of patients to the Provincial MAiD Clinical Team.

2.1. Federal legislation requires that to be eligible for MAiD, the patient must meet ALL of the following criteria:
  2.1.1. be eligible for publicly funded health services in Canada[5];
  2.1.2. be at least 18 years of age and capable of making decisions with respect to their health;
  2.1.3. have a grievous and irremediable medical condition;
  2.1.4. make a voluntary request for medical assistance in dying that is not the result of external pressure; AND
  2.1.5. provide informed consent to receive MAiD after having been informed of the means that are available to relieve the patient's suffering, including palliative care.

2.2. According to the federal legislation, a person has a grievous and irremediable medical condition only if **all** of the following criteria are met:
  2.2.1. they have a serious and incurable illness, disease or disability (note: mental illness is NOT considered an illness, disease or disability)[6];
  2.2.2. they are in an advanced state of irreversible decline in capability; and
  2.2.3. that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

2.3. CPSM requires that:
  2.3.1. any physician who conducts an assessment for the purpose of determining if a patient is eligible for MAiD pursuant to these requirements must:
    2.3.1.i. be satisfied that the patient seeking MAiD has a grievous and irremediable medical condition which the physician has verified by:
      2.3.1.i.1. a clinical diagnosis of the patient's medical condition; and
      2.3.1.i.2. a thorough clinical assessment of the patient which includes consideration of all relevant, current and reliable information about the patient's symptoms and the available medical treatments to cure the condition or alleviate the associated symptoms which make the condition grievous, including, where appropriate, consultation with another qualified physician;
    2.3.1.ii. be fully informed of the current relevant clinical information about the patient and his/her condition;
    2.3.1.iii. be qualified to render a diagnosis and opine on the patient's medical condition or be able to consult with another physician with relevant expertise for the limited purpose of confirming the diagnosis, prognosis or treatment options;
    2.3.1.iv. use appropriate medical judgment and utilize a reasonable method of assessment;

[5] This includes people who would be eligible but for any minimum period of residence or waiting period.

[6] See section 241.2(2.1) of the Criminal Code.

2.3.1.v. when assessing whether a patient's illness, disease or disability or state of decline causes the patient enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that the patient considers acceptable, ensure that:

2.3.1.v.1. the unique circumstances and perspective of the patient, including his/her personal experiences and religious or moral beliefs and values have been seriously considered;

2.3.1.v.2. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and

2.3.1.v.3. treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous or, if the patient is terminal, palliative care interventions; and the patient adequately understands the:

2.3.1.v.3.a. current and anticipated course of physical symptoms, ability to function and pain and suffering specific to that patient; and

2.3.1.v.3.b. effect that any progression of physical symptoms, further loss of function or increased pain may have on that specific patient; and

2.3.1.v.3.c. available treatments to manage the patient's symptoms or loss of function or to alleviate his/her pain or suffering.

2.3.2. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements of any assessment related to the patient's eligibility for MAiD.

3. Specific Requirements for Assessing Medical Decision Making Capacity

3.1. Any physician who conducts an assessment of a patient for the purpose of determining if the patient is capable of making decisions with respect to their health pursuant to the federal requirements must be:

3.1.1. fully informed of the current relevant clinical information about the patient and his/her mental and physical condition; and

3.1.2. qualified to assess competence in the specific circumstances of the patient whose capacity is being assessed or be able to consult with another physician with relevant expertise for the limited purpose of assessing the patient's medical decision making capacity.

3.2. In the event that a physician has a reasonable doubt as to the patient's competence, an additional independent assessment must be conducted by another physician who is enrolled on the Specialist Register as a psychiatrist.

3.3. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements of any assessments of a patient's medical decision making capacity.

4. Requirements for Obtaining Informed Consent and Mandatory Safeguards

4.1. The federal legislation requires that before a physician provides MAiD to a patient, whether that patient's natural death is reasonably foreseeable or not, the physician must:

- 4.1.1. ensure that the request for MAiD was:
  - 4.1.1.i. made in writing and signed and dated by:
    - 4.1.1.i.1. the patient; or
    - 4.1.1.i.2. where the patient is unable to sign and date the request, by another person (proxy) at the express direction of and in the presence of the patient. The person who serves as the proxy must:
      - 4.1.1.i.2.a. be at least 18 years of age;
      - 4.1.1.i.2.b. understand the nature of the request for MAiD;
      - 4.1.1.i.2.c. not know or believe that they are a beneficiary under the will of the patient or a recipient in any other way of a financial or other material benefit resulting from the patient's death; and
  - 4.1.1.ii. signed and dated after the patient was informed by a physician or nurse practitioner that the patient has a grievous and irremediable medical condition.
- 4.1.2. be satisfied that the request was signed and dated by the patient or by the patient's proxy before an independent witness, who then also signed and dated the request;
- 4.1.3. ensure that the patient has been informed that they may, at any time and in any manner, withdraw their request;
- 4.1.4. ensure that another physician or nurse practitioner has provided a written opinion confirming that the person meets all of the eligibility criteria and be satisfied that they and the other physician or nurse practitioner providing the opinion are independent in that each of them:
  - 4.1.4.i. is not a mentor to the other practitioner or responsible for supervising their work;
  - 4.1.4.ii. does not know or believe that they are a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or other material benefit resulting from that patient's death, other than standard compensation for their services relating to the request; or
  - 4.1.4.iii. does not know or believe that they are connected to the other practitioner or to the patient in any other way that would affect their objectivity; and
- 4.1.5. immediately before providing MAiD, give the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive MAiD,
- 4.1.6. If the patient has difficulty communicating, take all necessary measures to provide a reliable means by which the patient may understand the information that is provided to them and communicate their decision.

4.2. The federal legislation also provides that any person who is at least 18 years of age and who understands the nature of the request for MAiD may act as an independent witness, except if that person:

4.2.1. knows or believes that they are a beneficiary under the will of the patient, or a recipient in any other way of a financial or other material benefit resulting from the patient's death;
4.2.2. is an owner or operator of any health care facility at which the patient is being treated or any facility in which patient resides;
4.2.3. is directly involved in providing health care services to the patient or is directly providing personal care to the patient, subject to the following exception:
4.2.3.i. a person who provides health care services or personal care as their primary occupation and who is paid to provide that care to the patient requesting MAiD may act as an independent witness, except for:
4.2.3.i.1. the physician or nurse practitioner who will provide MAiD to the patient: and
4.2.3.i.2. the physician or nurse practitioner who provided an opinion regarding the patient's eligibility for MAiD.[7]

4.3. CPSM requires that:
4.3.1. Physicians who obtain informed consent for MAiD must have sufficient knowledge of the patient's condition and circumstances to ensure that:
4.3.1.i. the patient is properly informed of his/her diagnosis and prognosis in relation to the current or impending associated symptoms; and
4.3.1.ii. the treatment options described to the patient include all reasonable medical treatments to cure the condition or alleviate the associated symptoms which make it grievous and/or palliative care interventions where the patient is terminal; and
4.3.1.iii. the patient is offered appropriate counseling resources; and
4.3.1.iv. the patient fully understands that:
4.3.1.iv.1. death is the intended result of the pharmaceutical agent(s); and
4.3.1.iv.2. the potential risks and complications associated with taking the pharmaceutical agent(s).

4.3.2. Each physician who obtains informed consent from the patient for MAiD must:
4.3.2.i. have either conducted his/her own assessment or be fully informed of the assessments conducted by other physicians of the patient's medical condition and the patient's medical decision making capacity; and
4.3.2.ii. meet the legal requirements for informed consent, including informing the patient of:
4.3.2.ii.1. material information which a reasonable person in the patient's position would want to have about MAiD;
4.3.2.ii.2. the material risks associated with the provision/administration of the pharmaceutical agent(s) that will intentionally cause the patient's death; and

[7] This exception will allow most members of the health care team to act as an independent witness, but makes clear that family member or friends who are directly involved in providing medical or personal care to the patient are excluded.

4.3.2.iii. meet with the patient alone at least once to confirm that his/her decision to terminate his/her life by MAiD is voluntary and that the patient has:
- 4.3.2.iii.1. made the request him/herself thoughtfully; and
- 4.3.2.iii.2. a clear and settled intention to end his/her own life by MAiD after due consideration;
- 4.3.2.iii.3. considered the extent to which the patient has involved or is willing to involve others such as family members, friends, other health care providers or spiritual advisors in making the decision or informing them of his/her decision; and
- 4.3.2.iii.4. made the decision freely and without coercion or undue influence from family members, health care providers or others.

4.3.3. Each physician must document in the patient's medical record all information that is relevant to his/her role and findings in respect to each of the specific requirements for obtaining informed consent.

5. Specific Exceptions to Consent Requirements for Patients Whose Death is Reasonably Foreseeable[8]

5.1. subject to the following exception as it relates to patients whose death is reasonably foreseeable, but have lost the capacity to consent:

5.1.1. a substance to cause a patient's death may be administered to a patient who has lost the capacity to consent to receiving MAiD without giving the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive MAiD if ALL of the following circumstances apply:

5.1.2. BEFORE the patient lost the capacity to consent to receiving MAiD:
- 5.1.2.i. the patient met all of the criteria set out in Section 2 of this Standard and all other safeguards set out in this Section of the Standard were met,
- 5.1.2.ii. the patient entered into an arrangement in writing with the physician or nurse practitioner that the physician or nurse practitioner would administer a substance to cause their death on a specified day,
- 5.1.2.iii. the patient was informed by the physician or nurse practitioner of the risk of losing the capacity to consent to receiving medical assistance in dying prior to the day specified in the arrangement,
- 5.1.2.iv. in the written arrangement, the patient consented to the administration by the physician or nurse practitioner of a substance to cause their death on or before the day specified in the arrangement if they lost their capacity to consent to receiving medical assistance in dying prior to that day;

5.1.3. the substance is administered to the patient in accordance with the terms of the arrangement; AND

[8] For greater certainty, this exception does NOT apply to patients whose death is not reasonably foreseeable.

5.1.4. the patient does not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration[9].

5.2. Once a person demonstrates, by words, sounds or gestures a refusal to have the substance administered or resistance to its administration, MAiD can no longer be provided to them on the basis of the consent given by them under this Standard.

6. Specific Additional Safeguards for Patients Whose Death is NOT Reasonably Foreseeable

6.1. The following additional requirements must be met before MAiD can be provided to a patient where the natural death of the patient requesting MAiD is not reasonably foreseeable:

6.1.1. In addition to the requirements described in Section 4.1.4 of this Standard, if the physician or nurse practitioner referred to in that Section does not have expertise in the condition that is causing the patient's suffering, another physician or nurse practitioner who has that expertise must be consulted and share the results of that consultation with the physician or nurse practitioner who provides MAiD before MAiD can be provided:

6.1.2. The patient must have been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care; and

6.1.3. The physician and the medical practitioner or nurse practitioner referred to in Section 4.1.4 above must have discussed with the patient the reasonable and available means to relieve the patient's suffering and they and the medical practitioner or nurse practitioner referred to in Section 4.1.4 above agree with the patient that the patient has given serious consideration to those means; AND

6.1.4. there are at least 90 clear days between the day on which the first assessment under Section 2 of this Standard as to whether the patient meets the criteria set out in that Section begins and the day on which MAiD is provided to the patient or — if the assessments have been completed and they and the medical practitioner or nurse practitioner referred to in Section 4.1.4 are both of the opinion that the loss of the person's capacity to provide consent to receive medical assistance in dying is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances.

[9] For greater certainty, involuntary words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance for the purposes this paragraph.

7. Specific Requirements of the Administering Physician

7.1. In all cases, whether the patient's natural death is foreseeable or not, the administering physician must:

7.1.1. have appropriate knowledge and technical competency to provide/administer the pharmaceutical agent(s) in the appropriate form and/or dosage that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent; and

7.1.2. be qualified to provide appropriate instructions to the patient as to how to administer the pharmaceutical agent(s) that will terminate the patient's life in the manner in which the patient was informed that it would terminate his/her life at the time the patient provided his/her consent in circumstances where the patient elects to administer the pharmaceutical agent(s) to him/herself; and

7.1.3. be readily available to care for the patient at the time the pharmaceutical agent(s) that intentionally brings about the patient's death is administered by the administering physician or taken by the patient until the patient is dead; and

7.1.4. provide reasonable notice to the Office of the Chief Medical Examiner that the patient is planning to die by means of MAiD where the location is not a health care institution; and

7.1.5. certify, in writing[10], that they are satisfied on reasonable grounds that all of the following requirements have been met:

7.1.5.i. The patient is at least 18 years of age;

7.1.5.ii. The patient's medical decision-making capacity to consent to receiving medication that will intentionally cause the patient's death has been established in accordance with the requirements of the Criminal Code and this Standard;

7.1.5.iii. All of the requirements of the Criminal Code and this Standard in relation to assessing eligibility for MAiD and obtaining and documenting informed consent and all relevant additional safeguards have been met; and

7.1.5.iv. Ensure that the requirements of physicians set out in all relevant federal and provincial legislation, including the Criminal Code, The Fatality Inquiries Act, C.C.S.M. c. F52 and The Vital Statistics Act, C.C.S.M. c. V60 in respect to reporting and/or registering the cause and manner of the patient's death, including completing all required forms specified by the legislation or regulations, are met in a timely fashion.

[10] Please see Appendix A for an example of an acceptable form of written confirmation or contact the MAiD team at Shared Health for more information.

8. Additional Requirements of the Federal Legislation

8.1. The federal legislation also:

8.1.1. Sets out detailed requirements for the filing of information by physicians who carry out assessments or preliminary assessments as to whether patients meet the criteria for MAiD and those who receive a written request for MAiD[11];

8.1.2. requires that physicians who, in providing MAiD, prescribe or obtain a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose;

8.1.3. requires physicians to comply with guidelines established for the completion of certificates of death for patients to whom MAiD is provided;

8.1.4. creates criminal offences for knowingly failing to comply with the eligibility and safeguard requirements set out in Criminal Code and destroying documents with the intent to interfere with a patient's access to MAiD, the assessment of a request for MAiD or a person seeking an exemption related to MAiD.

8.2. CPSM requires that physicians comply with the federal and provincial regulations and guidelines described above as they come into force and effect.

[11] These requirements are subject to specific regulations and input from Health Canada and may change over time. See section 241.31 of the Criminal Code and the related regulations for a detailed description of the information to be provided and to whom.

Appendix A – Certification by the Administering Physician

PATIENT INFORMATION		
Last Name	First Name	Second Name(s)
Personal Health Identification No. (PHIN) and/or Manitoba Health No (MHSC)	Birthdate	Gender: ☐ Male ☐ Female ☐ Other - specify:
Medical Condition(s) Relevant to Request for MAiD		
Independent Practitioner(s) who conducted their own review for patient eligibility and provided a written opinion in that regard:		

ADMINISTERING PHYSICIAN CERTIFICATION	
By initialling and signing below, I confirm that:	
Initials	I am the administering physician who has provided/administered the pharmaceutical agent(s) for medical assistance in dying ("MAiD") to the patient named above for the intended purpose of causing the patient's death at the patient's request.
Initials	I am familiar with all of the requirements for providing MAiD to the patient as set out in the *Criminal Code of Canada,* R.S.C, 1985, c. C-46 , and CPSM's Standard of Practice and am satisfied that all requirements have been met, including the following: 1. The patient was 18 years of age; 2. The patient had the capacity to make medical decisions at all relevant times; and 3. All requirements in relation to eligibility for MAiD have been met and all mandatory safeguards were implemented before MAiD was provided.
Initials	I am satisfied the Independent Practitioner listed above is independent of me and is not: 1. A mentor to me nor responsible for supervising my work; 2. Believed to be a beneficiary under the Will of the patient or recipient in any other way of any financial or material benefit resulting from the patient's death; or 3. Connected to me or the patient in any other way which would affect their objectivity
Initials	A written request for MAiD was signed and dated by the patient (or their proxy as directed by the patient) before an independent witness who then also signed and dated the request.
Initials	If the patient had difficulty communicating, all necessary measures were taken to provide a reliable means by which the patient may understand the information that was provided to them and communicate their decision.
Initials	I ensured the patient was informed that they may, at anytime and in any manner, withdraw their request for medical assistance in dying.
Initials	I informed the pharmacist that dispensed the pharmaceutical agent(s) (the "Substances") that the Substances were intended for medical assistance in dying.
Initials	Immediately before providing MAiD, I provided the patient with the opportunity to withdraw their request and ensured the patient gave their express consent to receive medical assistance in dying **OR**
Initials	The patient had completed a *Waiver of Final Consent* then lost capacity to consent to receiving MAiD and after ensuring the patient did not by words, sounds or gestures, demonstrate refusal or resistance to having the Substances administered, I provided MAiD in accordance with the terms of the *Waiver of Final Consent*.

Signature of Physician	Print Name	Date Signed
Signature of Witness	Print Name	Date Signed

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
DECEMBER 13, 2023
BRIEFING NOTE

SUBJECT: International Medical Graduates
CPSM Working Group Terms of Reference

RECOMMENDATION:

That Council receive this report as information on plans to create a Working Group to support International Medical Graduates begin practicing medicine in Manitoba.

BACKGROUND:

Medical practitioners provide care to patients across the globe through the sound application of their clinical skills, knowledge, and judgment. However, health care systems in which medical education, training and care are provided, as well as other day-to-day aspects of clinical practice, vary dramatically among different jurisdictions.

CPSM has heard from registrants in the province and from other Canadian MRAs that more needs to be done to ensure new registrants with limited or no experience in the local practice environment have appropriate supports. In this regard, CPSM considers orientation, mentorship, and access to resources essential to success and the delivery of good quality care.

Initial orientation materials are currently being prepared by CPSM staff in the following areas:

- CPSM's regulatory scheme, including Standards of Practice, Practice Directions, and the Code of Ethics.
- Fundamentals of Manitoba's healthcare system and the role of the physician in that system.
- Cultural sensitivity and trauma informed practices in delivering good care.
- The patient-centered approach to care.
- Workplace culture and team-based practice environments.
- Documentation and maintenance of patient records.
- Business arrangements and practice management in non-institutional practice settings.
- Continuing professional development expectations.

CPSM staff have also taken a critical look at registration issues specific to internationally educated medical practitioners, including policies, processes, and procedures that are in place for provisionally registered physicians and the involvement of registrants in foreign recruiting practices.

The above is considered the first step in identifying and acting upon opportunities for improvement. The Registrar believes the next step calls for the establishment of a working group to reflect on the work done and make recommendations for the work to come.

Purpose of Working Group:

The primary purpose of the IMG Working Group will be to assist in the development and establishment of a new orientation program. In this context, it will review current issues facing IMGs entering and maintaining practice in Manitoba.

The Working Group would also be tasked with developing and recommending a Standard of Practice for Patient-Centered Care and Team Based Practice. This is added as the group will be well position to do this work given the content of the orientation program.

This work is considered an important part of CPSM's Truth and Reconciliation initiatives, which is anticipated to form a significant portion of orientation.

Roles, Functions, and Accountabilities:

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

- Reporting to the Registrar:
    - Make recommendations to the Registrar on the development and establishment of an orientation program for registrants who are new to practice in Manitoba, including those who have not practiced in the Canadian health care system.
    - Review and make recommendations to the Registrar on registration issues that are specific to internationally educated medical practitioners, including policies, processes, and procedures that are in place for provisionally registered physicians.
    - Review and make recommendation to the Registrar on the adequacy of mentorship and other resources for registrants who have trained outside the country regarding acclimatizing to or synergizing with local practice environments and culture.
    - Review and make recommendations to the Registrar on issues arising from the involvement of registrants in foreign recruiting practices, including consideration as to whether CPSM has any role or responsibilities in this area and/or whether CPSM should endorse the WHO Global Code of Practice on the International Recruitment of Health Personnel.
    - Assist and make recommendations to the Registrar with respect to CPSM's obligations under subsection 8.1(1) of the *Fair Registration Practices Code*, "*to take reasonable steps to collaborate with education providers and employers to (a) identify opportunities to develop programs that may assist internationally educated individuals and unsuccessful applicants in obtaining registration …; and (b) develop programs identified …*".
- Reporting to Council:
    - Develop and recommend to Council a Standard of Practice for Patient-Centered Care and Team Based Practice. This would address:
        - the patient-centered approach to care,

- cultural sensitivity and trauma informed practices in delivering good care, and
- workplace culture and team-based practice environments.

Note: The Standard of Practice would be circulated to registrants, stakeholders, and the public for consultation and review the results of that consultation process.

- Finalize a Standard of Practice for Patient-Centered Care and Team Based Practice for approval by Council.

Chair and Membership

4.1 Chair

The Committee chair is to be determined.

4.2 Membership

Working Group Membership is to include representatives from:

- CPSM Council.
- CPSM Staff.
- Registrants in active practice (particularly IMGs).
- Public representatives.
- Representatives from the Manitoba Faculty.
- Representatives from Government (MHSAL) and/or Shared Health.
- Representative from Doctors Manitoba.
- And any other representative the Chair considers appropriate.

Meetings

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

COUNCIL MEETING
DECEMBER 13, 2023
NOTICE OF MOTION FOR APPROVAL

SUBJECT: Board of Assessors

RECOMMENDATION:

That Council commence the necessary steps to establish a Board of Assessors to consider and decide applications for registration.

BACKGROUND:

The Regulated Health Profession Act (RPHA) requires Council direct the Registrar to consider and decide applications for registration or establish a Board of Assessors to do so.

Currently, the Registrar is solely responsible for considering and deciding applications for registration. Decisions are made in accordance with the RHPA and the *CPSM General Regulation*. In most cases, approvals and rejections are performed by staff in the Registration Department as a function delegated by the Registrar. Applications involving complex issues are considered directly by the Registrar, for example if there are significant entries on the applicant's Certificate of Professional Conduct.

The volume and complexity of applications for registration are increasing. As well, more is expected by government and the public with respect to registration issues, particularly ensuring a fair, efficient, and supportive process. Significant benefits of having a Board of Assessors include:

- It will contribute to CPSM's capabilities and the maintenance of expertise and consistency in registration decision-making over-time.
- Public members will serve on the Board. Having public representation supports CPSM in meeting its public interest mandate.
- The Board will provide an additional stream for deciding registration applications which will assist the Registrar in ensuring timely processing of complex applications.
- The Board will also be responsible for advising and making recommendations to Council about CPSM's registration requirements, policies, and procedures on an ongoing basis.

Establishing a Board of Assessors will require amendments to The Affairs of the College Bylaw and The Governance Policy. The Bylaw establishes the process of creating the Board of Assessors and the Governance Policy will contain the terms of reference for the Board of Assessors.

The Governance Policy does not have to go for consultation; however, the following are proposed Terms of Reference for the Board of Assessors. Approval of the Terms of Reference are not sought at this time but are provided for context for an understanding of how the Board of Assessors will operate:

TERMS OF REFERENCE:

Procedure and Code of Conduct:

Members of the Board of Assessors must comply with the Council and Committee Code of Conduct. With necessary modifications, Council and Committee Policies apply to the Board of Assessors as if it were a committee of Council.

Meetings of the Board of Assessors are closed to the public.

Appointment to the Board of Assessors and composition:

Council must appoint the members of the Board of Assessors and its Chair. The Chair must be a member of Council. The Board of Assessors must have at least four (4) members, half of whom must be public representatives.

A member of the Executive Committee cannot be appointed as a member of the Board of Assessors.

Term of office:

The term of office of all members of the Board of Assessors is one year. Members are eligible for reappointment.

Duties of the Chair:

The chair of the Board of Assessors must:

- *preside over all meetings of the Board,*
- *report to the Council about the Board's activities, either directly or by delegation as required for time to time,*
- *submit a written annual report of the Board's activities to the Council, and*
- *carry out other duties as the Council may direct.*

Quorum for Council Committees:

The quorum for the Board of Assessors is:

- *a majority of the voting members of the Board, at least half of whom must be public representatives, and*

- *when sitting as a panel of the Board, four members, at least two of whom are to be public representatives.*

Procedural Matters Respecting the Board of Assessors

Subject to statutory requirements, the Board of Assessors must adhere to the procedural requirements of the RHPA and those established in the bylaws, as well as to this policy and other applicable registration policies established by Council or the Registrar.

The Board of Assessors may meet and conduct business in person, or by video, telephone conference, web casting, or an equivalent mechanism.

If, in the opinion of the chairperson of the Board of Assessors, a matter requires immediate attention, and if, in the opinion of the chairperson, the matter can be adequately addressed by providing information electronically or in writing, with the Board voting on a resolution included in the information by mail or by specified electronic means, the chairperson may provide such information to the members of the Board, and allow a time for response that is, in the opinion of the chairperson, sufficient to permit the Board members to respond.

In order to constitute quorum of the Board, a majority of the voting members of the committee must have voted on the resolution by specified electronic means by the time for response established by the person who called the meeting.

Authority

The Board of Assessors is established in accordance with section 31 of the RHPA to consider and decide on applications for registration under section 32 or 33.

Purpose

The functions and duties of the Board of Assessors include:

- *Upon referral by the Registrar, sitting as the full Board of Assessor or as a panel of the Board, to consider and decide on applications for registration under section 32 or 33 of the RHPA.*
- *Upon approving an application for registration, to make recommendations to the Registrar respecting conditions on a certificate of practice in accordance with subsection 40(2) or 41(2) of the RHPA.*
- *To advise and make recommendations to Council about CPSM's registration requirements, policies, and procedures on an ongoing basis.*
- *To advise and make to the Executive Committee respecting approved registration forms.*

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2023, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves the below proposed amendment to The Affairs of the College Bylaw be distributed to the public, stakeholders, and registrants for consultation.

BOARD OF ASSESSORS

The Board of Assessors is established in accordance with section 31 of the RHPA to consider and decide on applications for registration under section 32 or 33.

Terms of reference for the Board of Assessors are set out in the Governance Policy of Council, and include the Board's authority, purpose, composition, and the term of office for Board members. The Board of Assessors is required to operate within the terms of reference established from time to time by Council.

Members of the Board of Assessors shall be paid remuneration and travel expenses at such rates and in accordance with the Financial Management Policy of Council.

COUNCIL MEETING
DECEMBER 13, 2023
BRIEFING NOTE

SUBJECT: Registrar Deliverables 2023-2024

BACKGROUND:

At its September meeting Council reviewed a Briefing Note titled "Strategic Plan and Annual Work Cycle". It was agreed at the meeting that each fall a set of deliverables would be developed for the subsequent year flowing from the Mandate and the 3 Goals set out in that Briefing Note. Those deliverables would be developed by a small group in consultation with the Registrar and presented to Council for approval.

Dr. Shenouda appointed a small working group (Dr. Elliott, Dr. Penner and Mr. Fineblit) to develop the proposed set of deliverables for the Registrar for 2024. The group reviewed the Briefing Note and considered the issues that have arisen during the past year at Council that might be appropriate for inclusion as deliverables. The intent was to:

- Recognize what Council felt were important things for CPSM to be working on in order to achieve its goals and fulfill its mandate;
- Recognize that capacity is an issue and the need to set reasonable objectives that are ambitious but also reasonably achievable;
- Recognize that many of the deliverables set for the Registrar in prior years are long term in nature and will continue to occupy her time and energy in 2024;
- Recognize that simply keeping the operations of the College going in an efficient and effective manner, while not a specific deliverable, is a key component of the Registrar's responsibility;
- Make sure the deliverables align with the CPSM goals and mandate;
- Recognize that many of the issues of concern to Council are not within the direct control of the CPSM and as such, only set expectations that the Registrar herself can achieve.

With those concepts in mind the working group developed a set of 5 Registrar deliverables we are proposing to Council. These were reviewed by the Registrar and her input was considered.

The proposed deliverables are:

1. Examine the policies and practices of the CPSM to determine if there are any of those that can be changed to help alleviate the stresses on registrants created by workload and a shortage of resources, with particular emphasis on those issues in rural and northern Manitoba. Provide a report to Council on the results of that examination and any proposals for change by September 30, 2024.
2. Develop a government relations strategy that takes into account the risks and opportunities created by a new provincial government and an action plan to minimize the risks and maximize the opportunities and, present that strategy to Council by June 30, 2024.
3. Develop a package of legislative amendments that can assist CPSM in fulfilling its mandate and achieving its goals and present that package for Council's consideration before September 30, 2024.
4. Do the things necessary to effectively implement whatever succession plan Council adopts.
5. In the context of a smaller Council, develop a discussion paper for Council on the current process for electing Councillors and options for improving the process and ensuring the necessary skills and diversity are available and, presenting that paper for discussion by October 31, 2024.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
DECEMBER 13, 2023
BRIEFING NOTE

SUBJECT: Performance Metrics Reporting – Registration Department

BACKGROUND:

Important information necessary to access the Registration Department's performance was either not collected or stored in a manner that made it easily retrievable from our database. Since January 2023, the Registration Department worked collaboratively with the IT Department on collecting and reporting relevant data sets. Of particular importance was identifying areas of potential delays to applicants completing their registration.

IMPORTANT DATA:

As of 27 November 2023, there are 4703 Registrants.
In the past 12 months, 537 Registrants left the practice of medicine in Manitoba and 753 were registered, 358 of which are first-time registrants.

APPLICATION PROCESS:

April 1, 2023 to September 30, 2023 – 822 applications received, with 706 registered.

- Average time to respond to applicant after application received – 1 day.
- Average time to advise applicant of eligibility for registration – within 3 days after application received.
- Average time for applicant to provide all necessary documentation to issue registration – 10 to 14 days.

Primary reasons for applicants not obtaining registration during that time period include:

- Applicant does not have an employment offer.
- Applicant has not submitted their documents to Physiciansapply.ca.
- Applicant is determining eligibility with Royal College of Physicians and Surgeons of Canada or College of Family Physicians of Canada.
- Applicant did not pursue registration.
- Applicant did not meet requirements.

COUNCIL MEETING
DECEMBER 13, 2023
BRIEFING NOTE

SUBJECT: CPSM Prescribing Practices Program Expansion

BACKGROUND:

Further to discussions in June 2023 regarding expanding the PPP program, attached is a Regulatory Impact Assessment.

A presentation will be given at the December 13, 2023, Council meeting.

CPSM Regulatory Impact Assessment

Prescribing Practices Program Expansion

DATE: 14 November 2023

Background/Issue:

The Prescribing Practices Program (PPP) engages with registrants, other health care providers, and members of the public to provide timely and relevant guidance on prescribing-related matters. PPP's educational approach has been recognized as an organizational asset, by Council, registrants, other CPSM staff, and our many stakeholders and collaborators. In an ever-evolving landscape of high-risk polypharmacy, patient complexity, and physician shortages, the demand for PPP resources continues to rise. **To maintain our capacity for responsiveness, and develop further programming to promote safer prescribing practices, further medical consultant time is urgently needed**.

PPP was formally established in 2018 with one medical consultant and a vision. This vision was to create a responsive pathway to support registrants with prescribing concerns that was educational, remedial, and an alternative to the complaints process. Now under the Quality Department, PPP has grown to include several interdisciplinary staff, namely an analyst and coordinator supporting the medical consultant work. Over five years, PPP has operationalized many programs and projects that promote safer prescribing practices and quality improvement in medical care.

Originally, PPP had two medical consultants sharing the workload. Presently, one medical consultant at 0.6 EFT overseas work in *all* program initiatives, special projects, committees, and importantly, responds to prescribing-related inquires within 1-2 business days with the team, often taking calls outside of work hours.

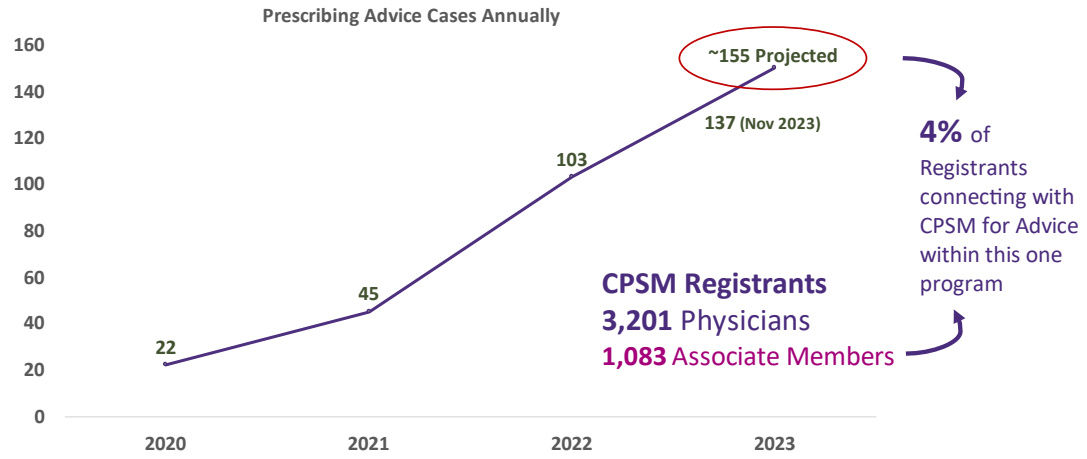
As seen in **Figure 1**, the number of community-driven inquires for prescribing advice continues to rise rapidly, from 22 cases in 2020 (when data collection began) to an *estimated 155 this year*. The same medical consultant is responding to this increasing demand, among many other duties.

A case typically involves several phone calls, emails, and varying degrees of advice and care recommendations. PPP staff inevitably support our registrants on a personal and emotional level, as these cases cause varying degrees of caregiver distress during the initial stages of the process.

Approximately 80% of cases involve clinical matters that require some oversight by the medical consultant, while 19% will clarify regulatory requirements, and <1% are escalated to the Registrar for review (if serious matters are identified). Overall, PPP has received positive feedback, cited by registrants as a timely and relevant resource for support, with repeat callers and registrants encouraging their colleagues to seek assistance.

The re-addition of a second medical consultant will help PPP maintain it's current capacity to engage with registrants and continue to develop program initiatives that align with organizational priorities, namely addressing and supporting registrants with complex patients on polypharmacy regimens within our strained health care system.

Figure 1: General Prescribing Advice Cases Annually



Near-exponential growth! **Who would take these calls if not the Prescribing Practices Program?**

Proposed Solution:

Not Applicable ☐

The hiring of a second medical consultant will:

1) Maintain responsiveness to calls/inquires for registrants seeking contemporary guidance.
2) Improve closure rates (provide more timely intervention and recommendations) for more complex clinical matters (e.g., concerns identified through calls/inquires, Registrar Referrals, or Chief Medical Examiner Death Reviews).
3) Improve the ability to operationalize other organizational and Council priorities as it relates to safer prescribing practices, namely reviewing cases identified by a recently updated DPIN dataset involving very high-dose opioid prescribing. These cases involve 23 patients prescribed doses over 900 milligram morphine equivalents (MME) per day (by 31 physicians), up to 2,167 MME per day. **Review of concerning opioid prescribing most certainly will identify patients with problematic polypharmacy (typically defined as 5 or more psychoactive and/or sedating medications prescribed concurrently)**.

   The interplay of chronic pain, mental health, and social issues is complex. These patients require skillful and intensively structured medication management over time to appropriately manage the inherent patient and public risks associated with these medication regimens.

Many prescribers on this list will have several patients under their care who would benefit from skillful clinical intervention. Engaging these prescribers in targeted education and mentoring, to ensure their prescribing is in-line with best practices and universal precautions, can have a weblike effect on their entire patient panel and help prevent future problematic polypharmacy regimens. The patient safety and overall health system benefits from this type of remediation cannot be overstated!

Accountability:

PPP aims to meet the *contemporary* regulatory needs of registrants, ensuring quality in the practice of medicine and patient safety. Maintaining responsiveness for general prescribing advice cases meets the immediate needs of registrants, however this is balanced with other time-intensive regulatory work, such as completion of Chief Medical Examiner Death Review Cases, special project research (e.g., Ketamine, Safer Supply), and committee participation (e.g., Quality Prescribing Rules Working Group), as well as implementing the many regulatory changes that arise from this work.

Staying accountable and responsive to registrants, by closing cases and providing timely recommendations is essential. Closure rates are limited by medical consultant time, spread thinly across all these initiatives. Additionally, new projects remain in the cue. **A second medical consultant would not only improve responsiveness and case closure, but create time to operationalize other high-impact regulatory projects – accountably acting on prescribing trends as they are identified**. For example, the high-dose MME dataset that awaits review and project development (as discussed above).

Timeline:

November – RIAT to Dr Mihalchuk & Dr Ziomek, finalize for Executive Committee submission.
December – RIAT to be presented to Council.
January-February – Job description review/revision, posting, recruitment, interviewing.
March-July – Training and development.

Fixed Timeframe Not Applicable ☒

On-going – Recruitment and training into 2024 Not Applicable ☐

Alignment of Organizational Priorities:

Not Applicable ☐

Maintaining PPP's capacity to engage with registrants and other key players, and target unsafe prescribing practices (e.g., polypharmacy regimens) strongly aligns with the organizational priority to rebrand CPSM's identity as Quality Care, and inherently improves patient safety. Council has recognized that PPP provides high-impact and focused education to registrants through prescribing advice, mentoring, and many collaborative initiatives. Maintaining and growing our ability to support registrants in this way continues to build capacity, proficiency, and intervenes before concerns require escalation to Complaints and Investigations.

Patient Safety:

Supporting registrants with their work, by providing practical guidance with clinical concerns (particularly for patients on complex medication regimens), has a positive impact on patient safety and can improve physician capacity to manage other complex patients, physician health, and retention in practice.

Risk Analysis:

With increasing workload demands current staff may not be able to maintain responsiveness (PPP responds to 80% of calls the same day and 96% of calls within 2 business days) or case closure rates (most cases closed within 1-2 weeks, complex cases take several months for correspondence and to see recommendations through). Other projects slated for development (that can positively impact patient care and safety) will be delayed or abandoned entirely.

Public Risk Not Applicable ☐

Delays in providing sound guidance to registrants, either those calling or by delaying other projects/intervention with registrants, may have a negative impact on patient and public safety.

Reputational Risk Not Applicable ☐

Through engagement, PPP is helping shift registrants' perception of CPSM, highlighting the focus of Quality Care. Registrants express gratitude when calls are answered and joint problem solving occurs. This work helps registrants view CPSM as a source of timely, relevant support for complex or challenging patient situations that can be distressing for registrants, who may be concerned about patient complaints. This promotes a positive organizational reputation. Delays in responsiveness may have a negative impact on this perception.

Regulatory Risk Not Applicable ☐

CPSM has valuable data on high-dose MME prescribing that is not being reviewed. Connecting with these prescribers will be high-impact regulation, not only to promote safer opioid prescribing, but in medication management and clinical skill building overall. Opioid prescribing will be a doorway to review concerning polypharmacy regimens. Overall, polypharmacy increases risk of serious adverse outcomes, including progressive cognitive impairment and accidental overdose deaths. Utilizing this data to help prevent such outcomes is paramount.

Operational Risk Not Applicable ☐

Budgetary considerations can impact CPSM and registration fees.

Regulatory Impact on Registrants:

Maintaining our ability to engage with registrants in a timely manner, particularly with complex, urgent, or precarious patient situations, will have a positive regulatory impact – building physician capacity to handle challenging cases and improving practice manageability. Additionally, closing cases with timely feedback allows registrants to implement recommendations sooner to maximize care, and provides closure for the unresolved feeling of an open matter. Comparatively, starting new projects (e.g., targeting polypharmacy) will create more contact with registrants that are not presently engaged with CPSM, which can be an uncomfortable experience. We aim to design future projects to minimize the perceived threat to registrants and optimize communication and support during the process.

Financial Impact:

Hiring another medical consultant will have human resource and financial impact on CPSM.

Human Resources: Not Applicable ☐

Current staff will allocate time and internal resources to initially recruit and train the new medical consultant. Currently, staff are strained to juggle all priorities, so investing in training a new consultant will eventually make everyone's work demands more manageable and create space to develop innovative projects.

Financial: Not Applicable ☐

Budget for additional salary and benefits would be required.

Infrastructure: Not Applicable ☐

The PPP office was designed for a future third staff member; however, additional space, furniture, and IT equipment may be required.

Transition Budget: Not Applicable ☒

Alternatives or Status Quo: Not Applicable ☐

The alternative would be to leave PPP's staffing as is. PPP will continue to prioritize prescribing-related inquires, however the volume is anticipated to rise, impacting responsiveness and the ability to provide timely follow up, intervention, and close cases. PPP will need to allocate resources for the rollout and change management of the upcoming Quality Prescribing Rules changes, which will also increase call volume. Taking calls and closing cases (of which there is presently a backlog) will delay completion of other special projects (e.g., Ketamine, Safer Supply). New initiatives will be delayed or remained shelved (e.g., addressing the high-dose MME data, intervention for complex polypharmacy cases, or the prescriber profile project).

Evaluation and Outcomes: Not Applicable ☐

PPP has been effectively collecting and sharing data to capture the work being done. The next stage is to evaluate the impact of these interventions beyond the positive feedback received from registrants. Additional staff would help to design and implement more outcome evaluation, such as feedback surveys for those engaged with prescribing advice cases.

Additional Information: Not Applicable ☐

Further program data can be presented as needed.

Recommendation:

Secure funding to hire a second (part-time) medical consultant to augment the quality-improvement work of the Prescribing Practices Program. The goal is to maintain the program's capacity for responsiveness and engagement with registrants, and develop further initiatives to promote safer prescribing practices, particularly around concerning polypharmacy. Developing a new medical consultant is also key for program succession planning.

Submitted by: Talia Carter & Marina Reinecke, Prescribing Practices Program.

COUNCIL MEETING – DECEMBER 13, 2023
COMMITTEE REPORTS
FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met in-person on November 21, 2023. Most matters discussed at the meeting appear on this Council agenda.

Two Appeal Panels were struck. One panel met on October 4 and one panel met on October 5. Both panels heard 3 investigation committee appeals.

Respectfully Submitted,
Dr. Nader Shenouda
President, CPSM and Chair of the Executive Committee

FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

The new auditor, BDO, presented their 2023-24 audit plan to the Finance, Audit and Risk Management Committee.

The first half of the year posted a net surplus of $141,000 vis-à-vis a projected budget deficit of $585,000 as both revenues and expenses yielded favorable variances. Member license fees were favorable across the board, notably regulated member certificate of practice fees (monthly-based) and volume increases in clinical assistant certificate of practice fees. Expenses saw savings principally driven by timing differences.

Management presented a draft risk registry to augment the existing integrated risk management (FIRMS) reporting. The committee tasked management with returning in February with a finalized risk registry template to be shared with Council.

Respectfully submitted
Dr. Charles Penner
Chair, Finance, Audit & Risk Management Committee

PROGRAM REVIEW COMMITTEE REPORT:

Diagnostic Facilities:

Letters were sent in November to applicable laboratory, transfusion medicine and patient service centre facilities to introduce the new Western Canada Accreditation Alliance (WCAA) Laboratory and Transfusion Medicine Standards that MANQAP will be using for accreditation inspections. These Standards have been approved for use by Council. The implementation date for the new standards is 1 January 2024.

Non-Hospital Medical Surgical Facilities (NHMSF):

The format of the Adverse Patient Outcome (APO) documents and information shared in the Committee agenda was revised to allow the Committee the opportunity to discuss the APOs in more detail and improve the Committee's options on how to respond to NHMSF regarding the reported APOs.

Discussions occurred on how best to utilize the Adverse Patient Outcome and the Annual Review Report data MANQAP receives from NHMSF. A report that details the rates of APOs for specific procedures at NHMSFs will be developed and brought back to the Committee for review and discussion in the Spring.

Respectfully submitted
Ms Leanne Penny
Chair, Program Review Committee

COMPLAINTS COMMITTEE REPORT:

The Complaints Committee met on September 14, 2023 and reviewed 13 complaints. Of those complaints considered, they were disposed as follows:

- 04 cases resulted in a letter of criticism
- 03 cases resulted in a letter of advice
- 05 cases resulted in a decision that no further action was required
- 01 cases resulted if endorsement of an informal resolution
- 00 cases resulted in a referral to the Investigation Committee

The Complaints Committee met on October 5, 2023 and reviewed 12 complaints. Of those complaints considered, they were disposed as follows:

- 01 cases resulted in a letter of criticism
- 04 cases resulted in a letter of advice
- 06 cases resulted in a decision that no further action was required
- 01 cases resulted if endorsement of an informal resolution
- 00 cases resulted in a referral to the Investigation Committee

The Complaints Committee met on November 9, 2023 and reviewed 13 complaints. Of those complaints considered, they were disposed as follows:

02 cases resulted in a letter of criticism
03 cases resulted in a letter of advice
07 cases resulted in a decision that no further action was required
01 cases resulted if endorsement of an informal resolution
00 cases resulted in a referral to the Investigation Committee

Respectfully submitted
Dr. Norman McLean
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

Dear Council Members

The Investigations Committee has met twice since our last Council meeting.

On October 4th we reviewed 12 cases with the following outcomes:

1 resulted in no further action
1 resulted in a letter of advice
3 resulted in a letter of criticism
1 case was deferred
6 cases were referred to Inquiry (all six related to the same physician)

On November 15th we reviewed another 11 cases with the following outcomes:

1 resulted in no further action
2 resulted in letters of advice
7 needed letters of criticism
1 required an undertaking

We have welcomed several new faces to our committee with a new member of the public and a new physician member starting at our November meeting. We plan to be busy for the rest of the annual cycle as we will meet monthly from December until June and we hope by adding more members to our ranks, we can continue to chip away at the outstanding cases.

Please let me know if anyone has any questions.

Respectfully submitted
Dr. Kevin Convery, Chair, Investigations Committee

STANDARDS COMMITTEE REPORT:

Central Standards Committee (CSC) Activities 2023

The CSC met January 27, March 17, June 16, and September 22, 2023.

AGE TRIGGERED/REFERRED AUDITS REVIEWED IN 2023

The CSC reviewed:

- 17 Age Triggered Audits
- 24 Referred Audits

The following outcomes were determined at CSC.

18	#1 Outcomes
12	#2 Outcomes
8	#3 Outcomes
1	#4 Outcomes
0	#5 Outcomes
2	Other – Full Practice Audit, Interactive Audit
41	Total outcomes

Standards Sub-Committee Reporting.

The Central Standards Committee has been receiving quarterly reports from the various Standards Committees within the province. Annual and Quarter 4 reports for the year 2023, will be requested in January 2024.

Scheduled reminders for any outstanding quarterly reports have gone out to the Chairs of currently active standards committees that are due.

Interlake/Eastern ASC has nominated a new Chair and approval should be given at the next Central Standards Committee meeting scheduled on December 8, 2023.

Selkirk ASC had no meetings to date in 2023. Dr. Alexander, Chair advised that they will start to meet before the end of 2023.

Cumulative Reporting by Area/Region.

Clinical Audits: Adverse Patient Occurrences (APO) have bolded numbers which reflects the core cases reviewed. All other totals/numbers with a (*) beside the numbers are other reviews and/or outcomes that are not a part of the Clinical Audits: APO totals.

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Activity	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
Interlake-Eastern	**Clinical Audits: Adverse Patient Occurences (APO)**	0					
	Referred Concern	0					
	Random Audit	0					
	Not an APO	0					
	Practice Audit or Interactive Audit	0	Committees Include: Interlake-Eastern Area Standards Committee, Selkirk Area Standards Committee, Selkirk Mental Health Centre Standards Committee.				
	Newsletter Item	0					
	Referral to Another Organization	0					
	Number of Meetings in 2023	0					

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Activity	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
Northern	**Clinical Audits: Adverse Patient Occurences (APO)**	**4**		**1**	**1**		**2**
	Referred Concern	0					
	Random Audit						
	Not an APO	0					
	Practice Audit or Interactive Audit	0	Committees Include: Northern Area Standards Committee				
	Newsletter Item	0					
	Referral to Another Organization	0					
	Number of Meetings in 2023	1					

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Activity	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
Prairie-Mountain	**Clinical Audits: Adverse Patient Occurences (APO)**	**123**	**118**	**2**			
	Referred Concern	0					
	Random Audit	0					
	Not an APO	*1					
	Practice Audit or Interactive Audit	0	Committees Include: Prairie-Mountain Area Standards Committee, Brandon Regional Health Centre Area Standards Committee, Brandon Regional Health Centre Psychiatry Standards Committee * - Not included in overall total of Clinical Audits: APO				
	Newsletter Item	*1					
	Referral to Another Organization	**3**					
	Number of Meetings in 2023	6					

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Activity	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
Provincial Committees	**Clinical Audits: Adverse Patient Occurences (APO)**	**135**	**130**	**2**			
	Referred Concern	*2	*1		*1		
	Random Audit						
	Not an APO						
	Practice Audit or Interactive Audit		Committees Include: CancerCare Standards Committee, Endoscopy Provincial Standards Committee, Orthopedic Surgery Provincial Standards Committee * - Not included in overall total of Clinical Audits: APO				
	Newsletter Item	*1					
	Referral to Another Organization	3					
	Number of Meetings in 2023	3					

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Activity	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
WRHA	**Clinical Audits: Adverse Patient Occurences (APO)**	**1741**	**1709**	**32**			
	Referred Concern						
	Random Audit	*30	*25	*5			
	Not an APO	*128					
	Practice Audit or Interactive Audit		Committees Include: Various Sub-Committees of the Winnipeg Regional Health Authority Standards Committee. * - Not included in overall total of Clinical Audits: APO				
	Newsletter Item	*1					
	Referral to Another Organization	*1					
	Number of Meetings in 2023	Unknown					

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Activity	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
All Regional Area Standards Committees	**Clinical Audits: Adverse Patient Occurences (APO)**	**2003**	**1957**	**37**	**1**	**0**	**2**
	Referred Concern	*2	*1	0	*1	0	0
	Random Audit	*30	*25	*5	0	0	0
	Not an APO	*128	0	0	0	0	0
	Practice Audit or Interactive Audit	0	* - Not included in total Clinical Audits: APO				
	Newsletter Item	*3					
	Referral to Another Organization	*1 6					
	Number of Meetings in 2023	10					

Current active Committees by Region:

Committee	RHA	Chair	Current Status
Interlake-Eastern ASC	Interlake-Eastern	New Chair Nominated.	To be approved at December 2023 Central Standards Committee
Selkirk ASC	Interlake-Eastern	Dr. Ian Alexander	No meetings held to date – Dr. Alexander confirmed meetings will resume winter 2023.
Northern ASC	Northern	Dr. Shadi Mahmoud	Q3 Reminder sent
Brandon Regional Health Centre ASC	Prairie Mountain	Dr. Nicolaas Butler	Up to date. No meetings in Q3
Prairie Mountain Health ASC	Prairie Mountain	Dr. Shannon Prud'homme	Up to date. No meetings in Q2 and Q3
Brandon Regional Health Centre Psychiatry	Prairie Mountain	Dr. Gilbert Lee	Committee is still on hold due to lack of psychiatrists in Brandon. No new update since November 2022.
Portage ASC	Southern	Dr. Jim Ross	Up to date.
Southern ASC	Southern	Dr. Shayne Reitmeier	Q3 Reminder sent
Boundary Trails Health Centre	Southern	Dr. Kevin Convery	Up to date.
C.W. Wiebe Medical Centre	Southern	Dr. Louw Greyling	Q2 and Q3 Reminder Sent
Eden Mental Health Centre	Southern	Dr. William Miller	Up to date.
CancerCare	Provincial	Dr. Catherine Moltzan	Q3 reminder sent
Endoscopy Provincial	Provincial	Dr. Ross Stimpson	Up to date. No meetings in Q3
Orthopedic Surgery Provincial	Provincial	Dr. Eric Bohm	Up to date. No meetings in Q3
Winnipeg Regional Health Standards Committee	WRHA	Dr. Elizabeth Salamon	Up to date.

Respectfully submitted
Dr. Roger Suss, Chair
Central Standards Committee

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING - DECEMBER 13, 2023

FOR INFORMATION

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

QUARTERLY REPORTING ON DELIVERABLE ACTION PLANS

At the September 29, 2023, meeting Council approved the following 3 goals for CPSM:

1. Ensuring the Qualifications of Registrants
2. Ensuring Quality Medical Care is Provided by Registrants
3. Improving the Quality of Medical Care Through Accountability and Repairing/Preventing Harm

The Registrar is responsible for achieving these goals. Several Deliverables were developed for achieving the goals and each Deliverable has various Action Plans of work to be done throughout to accomplish the Deliverables. Below is a status report on the various Action Plans.

The Deliverables and Action Plans that support the achievement of each goal are:

Goal 1: Ensuring the Qualifications of Registrants

Deliverable:

- **Creating an efficient and effective organization**
  Action Plan:
  - Website Registration Redesign

    The Registration section of the website has been updated to include all Regulation changes. In addition, working within the current structure of CPSM's website, the Registration Section has a new look with easy-to-follow information for each Class of registration.

  - Registration Stakeholder Education

    Staff have met with 3 recruiters to provide information regarding the process for registration. A webinar is scheduled for February 24, 2024, through Manitoba Start. Manitoba Start provides central registration services for all newcomers arriving in Manitoba.

    In addition, a presentation on our processes and associated programs regarding legislative changes will be made to Health Canada in November 2023.

Representatives from the Ukraine and Israel have reached out to CPSM regarding registration. Both have been extended an invitation to come to CPSM and meet with staff. At this time, no response has been received.

Continued meetings with Shared Health, Workforce Planning regarding assisting with the recruitment of physicians to Manitoba.

- Database Analysis for Registration Bottlenecks

The Registration Department commenced tracking additional information to produce performance metrics. These will be presented at the December Council meeting (see Agenda Item #9).

- **Updating RHPA/CPSM Documentation**
  Action Plan:
  - Registration Policies & Practice Direction Guide

Registration requirements are found in many different places, including the CPSM General Regulation, Practice Directions, policies, and MOUs. We are in the process of creating standalone resource that is intended to bring all the requirements together for each class of registration in one place. Once completed, the plan is to post the indexed guide on our website. This is an ongoing project with a scheduled completion date of May 1, 2024.

- **Addressing Anti-Indigenous Racism**
  Action Plan:
  - Mandatory Indigenous Specific Anti-Racism Training

TRC Advisory Circle is working with the University of Manitoba to develop training materials. Scheduled launch is June 2024. All modules development is to be completed by end of December 2023 with quality assurance testing commencing in the New Year.

Goal 2: Ensuring Quality Medical Care is Provided by Registrants

Deliverables:

- **Improving Quality Medical Care**
  Action Plan:
  - Audit Improvement

Improvements ahead of targets and moving forward. In training and testing phase. Evaluation to follow in spring/summer.

- Physician Health Program Growth and Enhancement

  Reviewing needs and developing potential solutions in terms of program design, role adjustments and human resources investment. Targeting January 30th for plan development, business case for Feb 29th and implementation for end of May 2024.

- Prescribing Practices Program Growth and Enhancement

  Updated RIAT and presentation to Council for December (see Agenda Item 11); timelines to be adjusted once a decision regarding funding has been made. In the meantime, short-staffed with one staff member on paternity leave and focused on keeping core business operating as smoothly as possible. The team should be back at full compliment by the end of January and will begin work within their existing resources to prioritize the highest risk prescribers using a recently acquired DPIN data set.

- **Updating RHPA/CPSM Documentation**

  Action Plan:

  - Cyclical Review Schedule for Standards – (Bloodborne Pathogens, Definitions, Good Medical Care)

    A team of experts was assembled on October 26, 2023, to review Standard of Practice on Bloodborne Pathogens.

    Definitions Standard of Practice is being reviewed internally.

    A Working Group is being established to review the Good Medical Care Standard of Practice.

- **Addressing Indigenous Anti-Racism**

  Action Plan:

  - Standard of Practice – Practicing Medicine to Prevent Indigenous Specific Racism

    TRC Advisory Circle retained a consultant to assist a smaller working group develop Standard of Practice. The workplan has been developed with the objective of submitting a draft Standard of Practice to Council at its March 2024 meeting.

  - Definition of Anti-Indigenous Specific Racism

    Draft definition of Anti-Indigenous Specific Racism has been prepared for inclusion in the Standard of Practice – Practicing Medicine to Prevent Indigenous Specific Racism.

- Mentorship/Leadership at CPSM (includes creating an open culture to support indigenous physicians).

  TRC Advisory Circle has established working groups to address Recommendation #6. Next step is for the working groups to develop workplans.

Goal 3: Improving the Quality of Medical Care Through Accountability and Repairing/Preventing Harm

Deliverables:

- **Applying the right-touch regulation to patient's concerns**

  Action Plan:

  - Categorizing & Assigning Complaints to an Administrative Process

    On track. Document completed and being used as a working document over the next 6 months.

  - Improve Communication & Informal Resolution Process

    On track. Interviews are being conducted for Complaints Mediator position this week, expecting to hire in near future.

- **Creating an efficient and effective organization**

  Action Plan:

  - Audit Improvement

    Improvements ahead of targets and moving forward. In training and testing phase. Evaluation to follow in spring/summer.

- **Updating RHPA Documentation**

  Action Plan:

  - Seek Legislative Amendment to sections 186 & 187 RHPA (improving Complaints & Investigation procedures).

    Request to initiate legislative amendments submitted to government in January 2022 and resubmitted on October 31, 2023.

- **Addressing Anti-Indigenous Racism**

  Action Plan:

  - Restorative Justice Approach to Complaints & Investigations

    On track – key individuals undergoing training in conjunction with the University of Manitoba under the expert leadership of individuals from Stanford University.

GOVERNMENT

A congratulatory letter was sent to Minister Asagwara extending an invitation to meet with CPSM to discuss how we can work together to address challenges and opportunities in the medical profession.

A letter was sent to Deputy Minister Sinclair outlining the Proposed Amendments to Legislation/ Regulations relating to CPSM.

CPhM has asked CPSM and CRNM to approach government with them to request making the Section 56(1) Controlled Drugs and Substances Act Exemption permanent. CPSM agrees with this suggestion.

MEETINGS ATTENDED - OTHER ORGANIZATIONS

Senate Committee on Medical Qualifications – September 20, 2023

WRHA Medical Advisory Committee – September 28,

Provincial CMO/Specialty Lead Meeting – October 5, 2023

Medicine Subcommittee of the Joint Council – October 11, 2023

Shared Health Medical Advisory Committee – October 12, 2023

College of Pharmacists of Manitoba Extended Practice Committee – October 31, 2023

PGME Executive Committee – November 28, 2023

Federation of Medical Regulatory Authorities of Canada (FMRAC)

- Audit, Finance, & Risk Management Committee – October 30, 2023
- Board Meeting – November 20, 2023

International Association of Medical Regulatory Authorities (IAMRA) 2023 International Conference on Medical Regulation – A Regulation in a disrupted world: Challenges and Opportunities (Bali) – November 6 to 9, 2023

Provincial Medical Leadership Committee – November 16, 2023

National Assessment Collaboration IMG Alliance Committee (Ottawa) – November 22, 2023

Western Registrar's Meeting – November 27, 2023

STAFF MATTERS

The information described below highlights staffing changes and additions since the September 2023 Council meeting.

Executive office – a new 0.6 EFT Communications Assistant, Michelle Fontanilla, was hired and started October 17, 2023. This new position will support the increasing demands for communications and support areas of growth driven by the strategic goals and deliverables.

Complaints and Investigation – a new full-time Legal Counsel has been hired, Mira Bokhaut, to replace Lynne Arnason who is retiring in December 2023. Mira's start date was November 13, 2023.

COMMUNICATIONS & MEDIA

Media: I was a guest on 680 CJOB with Richard Cloutier on October 31 to discuss and address myths about medical regulation and to create awareness about CPSM's role in protecting the public interest.

Registrant communications this quarter included an update on masking requirements, September and November newsletters, and a National Physician Assistant Day message to PAs distributed on Nov 27. Guidance issued was a reminder on using legal last names for practice, GLP-1 receptor risk, appropriate window times for virtual medicine, importance of sampling for endometrial cancer.

An update of the registration section of the website was completed. This includes new sections for each registration class and comprehensive information and resources on taking a leave of absence and retirement.

FINANCE

The new auditor, BDO, is currently conducting an interim audit. Please see the Finance, Audit & Risk Management Committee report for additional information.

INFORMATION TECHNOLOGY

The following items have been completed or introduced since the last report:

- **Quality Improvement Enhancement:** Phase one has been rolled out. The Pre-screening questionnaire has been sent to the selected cohort and responses are being collected in the CPSM Portal.
- **Cybersecurity:** A new vulnerability monitoring system has been rolled out. This greatly improves our cybersecurity posture as we are monitoring all managed devices.
- **Medical Corporation Renewals:** Changes to the online renewal system facilitated registrants being allowed to renew their medical corporation using the same account they use for registrant renewals. Authorized Representatives are now able to manage renewals for all medical corporations which they represent under a single account as well.

QUALITY DEPARTMENT

Physician Health Program (PHP)

- As of September 1, there have been 21 new referrals (for a total of 56 to-date this fiscal year).
- The current caseload total is 83 (caseload includes registrants with undertakings, those who require further follow-up and new referrals who are pending review or mid-review).
- There are currently 21 registrants followed by PHP who are on medical LOAs that will require PHP approval once they feel ready to return to work (RTW).

MANQAP

- Continue to implement a communication rollout for Western Canadian Accreditation Alliance (WCAA) Laboratory and Transfusion Medicine Standards October-November. At November PRC, the approval to proceed with the standards was approved. Implementation of Lab/TM standards will commence Jan 1, 2024.
- WCAA Diagnostic Imaging Standards were introduced at September PRC, the standards are in a review process with staff and provincial clinical specialists for analysis. PRC will decide on approval in February. Implementation of DI Standards are scheduled for Spring 2024.
- Collaboration continues with the Manitoba Dental College (MDA) specifically addressing anesthesia performed by CPSM members in a dental suite clinic.
- MANQAP participated in the National Non-Hospital Surgical and Medical Facilities (NHSMF) annual meeting in October for standards discussion and collaboration.
- Temporary accreditation status continues to be top of mind, addressing the backlog from Covid.
- MANQAP Continuing Service Agreement (CSA) with Manitoba Health has been signed and renewed for 2023-2024.

Quality Improvement Program (QIP)

- The program functions have moved into the CPSM Portal with the most recent cohort. Things are running smoothly so far. We anticipate that this change will alleviate staff burden, improving program efficiency.
- Mapping and work plan is in place to complete the end of the first cycle of the program December 2025. To date, 2239 registrants out of 2529 eligible registrants have been contacted by the QI Program. A total of 1351 have completed the process. There are 369 registrants in the current cohort, with the balance to be completed in 2024/2025.
- Auditor Training Workshop being held December 1 to fill anticipated gaps with new specialities coming into program 2024.
- Collaborative workshop with Concordia Hospital medical and nursing staff on Medical Record Keeping held Nov 24.

Standards Audits and Monitoring (SAM)

- Total qualifying audits for the start of 2023 was 123 as the year progressed, that number moved to 132. As the end of the 2023 approaches, we are now sitting at 102 total qualifying audits, this is the breakdown for the year 2023:
- 7 YOB: 1947 (76 yrs.) & 1946 (77 yrs.) - (Carried over, challenging to audit)
- 15 YOB: 1948 (75 yrs.) - (Newly initiated)
- 12 YOB: 1949 (74 yrs.) - (In Progress)
  - 21 YOB: 1950 (73 yrs.) - (In Progress)
  - 24 YOB: 1951 (72 yrs.) - (Initiate in the last quarter of 2023)
  - 21 Repeat Age Triggered (In progress and to be initiated throughout 2023)
  - 18 Repeat Referred (In progress and to be initiated throughout 2023)
  - 14 New Referrals (In Progress)

= 132 in total

  - 8 cancelled audits – retirements, admin only, and teaching.
  - 11 deferred to other years due to recent Quality Improvement Program participation.
  - 9 deferred to 2024 due to no auditor or unable to audit

= 102 new total

- The Age Triggered Audits (ATA) Program is currently completing cohorts 1947, 1948, 1949, and 1950. The 72-year-old physicians' cohort 1951 will begin later this fall in Q4 and carried out through the winter.

Prescribing Practices Program (PPP)

- **Registrant Advice & Support**: responded to **50 general prescribing advice** inquiries since September 1, 2023 (150 GPA cases thus far in 2023). KPI update: 76% responded within 1 business day; 86% within 2 business days; 92% within 3 business days. Number of GPA cases per quarter is higher compared to last quarter and response time has increased (last quarter: 88% responded within 1 business day; 95% within 2 business days).
- **IAMRA**: Dr Reinecke attended the International Association of Medical Regulatory Authorities conference in Bali, Indonesia, in November and presented 2 talks on PPP innovative programs.

- **Methadone & Suboxone**: Issued **12 Suboxone** & **4 Methadone** prescribing approvals for OAT since September (59 thus far in 2023). **1 methadone pain/palliative** approval. Collaborating on educational initiatives with RAAM HUB; presented on MB OAT Recommended Practice Manual at RAAM Knowledge Exchange Days on November 22 (180 registered for 1-hour session!).
- **CME Death Review**: Closed 1 complex case. Working with CME Office on Memorandum of Understanding to continue collaboration and resume CPSM consultant attendance for case review.
- **Quality Prescribing Review Working Group**: Assisting with prescribing rules documents under revision. Will assist with roll-out of prescribing rules changes and respond to inquiries.

COMPLAINTS & INVESTIGATIONS DEPARTMENT

Ms Lynne Arnason is retiring in December after more than 20 years of service to CPSM. Lynne has made valuable contributions not just to the Complaints and Investigation Department, but to the broader work of CPSM. She had key contributions in the development of multiple Standards of Practice, including Withdrawing and Withholding Life Sustaining Treatment, Medical Assistance in Dying, and Sexual Boundaries with Patients, Former Patients and Interdependent Persons. Her insight and experience have been truly appreciated through the years and we wish Lynne all the best in her retirement.

We welcome Ms Mira Bokhaut to the legal team of the department. Mira has experience in health law, and we look forward to working with her.

The department is working with IT to develop a file management system that will greatly assist with workflow and data analysis. Testing of the system is in progress. In addition, staff in the department have developed a central system to track calls from the public and from our registrants. More information will follow about the volume and nature of calls as data is collected over time.

Senior staff in the department continue to gain insight into how to bring a restorative approach to the work of complaints/investigation where possible. Formal training in restorative justice continues in conjunction with the University of Manitoba. As part of our desire to increase informal resolution we are in the process of hiring a complaints mediator.

REGISTRATION DEPARTMENT

The Registration section of the website has been updated presenting easy to follow, step by step information to all Classes of Registration. Feedback from external stakeholders and applicants has been very positive.

A Webinar has been scheduled for February 2024 for Manitoba Start. Manitoba Start provides central registration services for all newcomers arriving in Manitoba.

A presentation on our processes and associated programs regarding legislative changes was made to Health Canada in November 2023.

Continued meetings with Shared Health, Workforce Planning regarding assisting with the recruitment of family physicians to Manitoba.

Information from 1 April to 30 September 2023 with respect to performance metrics in registration will be presented at this meeting.