# September 25, 2024 Council

Wednesday, September 25, 2024 | 8:00 a.m. |

# *REVISED* AGENDA

**CPSM Office – Brown Room**
**1000 – 1661 Portage Avenue**

| Time | | Item | | Action | | Page # |
|---|---|---|---|---|---|---|
| 10 min | 8:00 am | 1. | Opening Remarks and Land Acknowledgment | | Dr. Shenouda | |
| | | 2. | Agenda – Approval | | | |
| | | 3. | Call for Conflict of Interest | | | |
| 5 min | 8:10 am | 4. | Consent Agenda<br>i. Council Meeting Minutes June 26, 2024<br>ii. Council Electronic Meeting Minutes June 28, 2024<br>iii. Council Electronic Meeting Minutes August 9, 2024<br>iv. Council Policy – Certificate of Professional Conduct<br>v. Council Policy – English Language Proficiency Requirements<br>vi. Appointment of members to the CPSM Board of Assessors and Amendment to Governance Policy<br>vii. Practice Direction Qualifications and Registration | For Approval | Dr. Shenouda | 4 |
| 10 min | 8:15 am | 5. | Accredited Facilities Bylaw Amendments | For Approval | Dr. Shenouda/ Mr. Triggs | 51 |
| 15 min | 8:25 am | 6. | TRC Advisory Committee Update | For Discussion | Dr. Monkman | 112 |
| 30 min | 8:40 am | 7. | Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism | For Approval | Dr. Shenouda/ Dr. Monkman/ Mr. Triggs | 114 |
| 30 min | 9:10 am | 8. | Restorative Practices Program | For Approval | Dr. Shenouda/ Dr. Monkman/ Dr. Mihalchuk | 126 |
| 20 min | 9:40 am | 9. | --Break-- | | | |

| Time | | Item | | Action | | Page # |
|---|---|---|---|---|---|---|
| 10 min | 10:00 am | 10. | Practice Direction – Practice Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students Contextual Information & Resources Document | For Information | Dr. Shenouda/ Mr. Triggs | 133 |
| 10 min | 10:10 am | 11. | IMG Working Group | For Information | Dr. Shenouda/ Mr. de Jong | 136 |
| 10 min | 10:20 am | 12. | National Registry – MCC | For Information | Dr. Shenouda/ Mr. Penner | 137 |
| 15 min | 10:30 am | 13. | Performance Metrics | For Information | Dr. Shenouda/ Mr. Penner | 145 |
| 10 min | 10:45 am | 14. | Registrar/CEO Report Operational Reports | For Information | Dr. Mihalchuk | 154 |
| 5 min | 10:55 am | 15. | 2023/24 Annual Report | For Information | Dr. Shenouda | 161 |
| 10 min | 11:05 am | 16. | Committee Reports (questions taken)<br>Executive Committee<br>Finance, Audit & Risk Management Committee<br>Program Review Committee<br>Complaints Committee<br>Investigations Committee<br>Central Standards Committee<br>Board of Assessors | For Information | Dr. Shenouda/ Committee Chairs | 162 |
| 45 min | 11:15 pm | 17. | In Camera Session | | | |
| 4 hours | | | Estimated time of sessions | | | |

# 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 – SEPTEMBER 25, 2024**
**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.

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

i. Council Meeting Minutes June 26, 2024

ii. Council Electronic Meeting Minutes June 28, 2024

iii. Council Electronic Meeting Minutes August 9, 2024

iv. Council Policy – Certificate of Professional Conduct

v. Council Policy – English Language Proficiency Requirements

vi. Appointment of members to the CPSM Board of Assessors and Amendments to Governance Policy

**vii.** Practice Direction Qualifications and Registration – Adding Emergency Medicine

**MOTION:**

**NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:**

Council approves all items on the consent agenda as presented.

1000 – 1661 Portage Avenue, Winnipeg Manitoba R3J 3T7
Tel: (204) 774-4344 Fax: (204) 774-0750
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 June 26, 2024, at the CPSM Office with an option to join virtually via Zoom.

## 1. CALL TO ORDER

The meeting was called to order at 08:19 a.m. by the Chair of the meeting, Dr. Nader Shenouda.

COUNCILLORS:
Ms. Leslie Agger, Public Councillor
Mr. Neil Cohen, Public Councillor
Dr. Kevin Convery, Morden
Dr. Jacobi Elliott, Grandview - Virtually
Mr. Allan Fineblit, Public Councillor
Dr. Chaitasi Intwala, Winnipeg
Dr. Wendy MacMillan-Wang, Associate Member
Ms. Lynette Magnus, Public Councillor
Dr. Rizwan Manji, Winnipeg
Dr. Jennifer McNaught, Winnipeg
Ms. Marvelle McPherson, Public Councillor
Dr. Lisa Monkman, Scanterbury–Virtual/In-person
Dr. Peter Nickerson, Winnipeg – Virtually at 11:00
Dr. Charles Penner, Brandon
Ms. Leanne Penny, Public Councillor
Dr. Nader Shenouda, Oakbank
Dr. Alewyn Vorster, Treherne

REGRETS:
Dr. Caroline Corbett, Winnipeg

MEMBERS:
Dr. Guillaume Poliquin
Ms Clara Weiss, Clinical Assistant

GUEST

STAFF:
Dr. Anna Ziomek, Registrar
Dr. Ainslie Mihalchuk, Deputy Registrar
Dr. Karen Bullock Pries, Assistant Registrar
Mr. Mike Triggs, General Counsel
Mr. Paul Penner, Chief Operating Officer
Ms. Karen Sorenson, Executive Assistant
Ms. Barbie Rodrigues, Executive Assistant
Ms. Wendy Elias-Gagnon, Communications Officer
Mr. Jeremy de Jong, Interim Director Registration
Dr. Sonja Bruin, Interim Director Quality
Dr. Marilyn Singer, Medical Consultant

## 2. ADOPTION OF AGENDA

IT WAS MOVED BY MR. ALLAN FINEBLIT, SECONDED BY DR. RIZWAN MANJI:
*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

Dr. Shenouda, the President asked if any councillors wanted to discuss any of the consent agenda items. As there was none

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 March 20, 2024
ii. Practice Direction Qualifications and Registration addition of Specialist Fields of Practice
iii. Governance Policy
iv. Appointment of CPSM Appointed Public Representative
v. Appointment of 2024/25 Committee Members
vi. Standard of Practice -Bloodborne Pathogens
vii. Financial Policy

## 5. OPERATING BUDGET

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY DR. RIZWAN MANJI:
*CARRIED*

Council approves the 2024/25 annual operating budget as presented.

## 6. FEE BYLAW – FOR INFORMATION

The Fee Bylaw sets out the following rules to be followed for fee increases.

*Increases in Fees*

3. *The fee for the annual certificate of practice shall automatically increase by an amount equal to the Manitoba Consumer Price index to cover inflationary costs.*
4. *Council may also increase the fee for the annual certificate of practice by an additional amount provided that management presents Council with a budget and a satisfactory rationale justifying an increase.*

5. *The Council may issue a special assessment on some or all classes of members to cover unexpected expenses, which were not reasonably foreseeable at the time the budget was prepared.*

With the approval of Finance, Audit, and Risk Management Committee and the Executive Committee the fees for the 2024-25 year will increase by 2% on November 1, 2024 in accordance with section 3 of the Fee Bylaw.

## 7. ACCREDITED FACILITIES BYLAW – FOR INFORMATION

Council was advised of the following potential amendments to the Accredited Facilities Bylaw

1. Section 13.3.3.vi – tumescent liposuction
2. Section 13.3.3.xi – any procedure that the Program Review Committee directs
3. Bylaw list – Intravenous ketamine administration
4. Bylaw list – MDMA (3,4-methylenedioxymethamphetamine)-Assisted Therapy (MMDA-AT)
5. Requiring anesthesiologists working in dental clinics to report Adverse Patient Outcomes

CPSM recommended advising the Minister of Health of the proposed changes and consulting on the Bylaw amendments over the summer months to bring decision an item to the September Council Meeting.

## 8. ARTIFICIAL INTELLIGENCE IN MEDICINE ADVICE TO THE PROFESSION – FOR INFORMATION

An Artificial Intelligence in Medicine Advice to the Profession document was presented to Council for review and comment. There was discussion Artificial Intelligence in Medicine, and the consensus was this document is a good start to addressing the matter.

## 9. PRESCRIBING RULES WORKING GROUP – FOR INFORMATION

The new Standard of Practice – Prescribing Requirements and the Joint Practice Direction Electronic Transmission of Prescriptions approved by Council on March 20, 2024, came into effect on June 1, 2024.

Subsequent to the March 20, 2024 Council meeting, the College of Pharmacists of Manitoba (CPhM) requested a minor amendment to the Practice Direction related to pharmacists acting as prescribers. As the amendment has no impact on registrants, the Registrar made the amendment based on the authority provided pursuant to section 84 of The Affairs of the College Bylaw.

CPhM requested that The College of Midwives of Manitoba and the Manitoba Association of Optometrists become parties to the Joint Practice Direction. This will require discussions with

these organizations at a future date to determine if they have any interest in being a party to the Joint Practice Direction.

CPhM advised they changed their procedures for their members related to notifying physicians of an out of province transfer of Controlled Drugs and Substances Act prescriptions. Initially, the CPhM procedure was to **require pharmacists to notify the physician** when a patient transferred their prescription out of province. Due to perceived administrative burden this requirement was amended to **recommend pharmacists notify the physician**. This procedure does not appear in the Standard of Practice or the Joint Practice Direction and therefore does not require any action by Council.

## 10. COLLABORATIVE CARE WORKING GROUP UPDATE – FOR INFORMATION

A new draft Standard of Practice has not yet been developed; however, the working group has agreed upon the following key concepts:

1. The Standard of Practice should apply to all circumstances in which a registrant is working with one or more health care providers.
2. The fundamental requirement behind every action or decision of a registrant, even if they are on the periphery of the care, is ensuring the patient receives good medical care.
3. Civility is mandatory.
4. In the consultation request scenario:
    a. The referring registrant and the specialist registrant will have specific responsibilities based upon a shared responsibility to the patient for timely care within available resources.
    b. The specialist registrant must have a triage process to separate urgent consult requests from non-urgent requests.
    c. There will be a requirement for closed loop communication with approximate timeframes.
5. In scenarios involving emergent care, the registrant receiving a request for assistance will have a duty to be helpful regardless of whether they are accepting the patient. At a minimum, this will require them to listen to the case and offer advice. The nature and scope of the registrant's responsibility will be dependent upon the circumstances of the case but their responsibility to the patient will continue until the registrant seeking assistance is able to make a reasonable plan for care and disposition of the patient.

Although the new Standard of Practice will rely heavily on the *Code of Ethics and Professionalism* it is anticipated that this will be viewed as a major cultural change in how registrants interact with each other in the provision of care to a patient. As a result, CPSM will have to consider communication and implementation strategies prior to releasing the draft for consultation.

## 11. TRC ADVISORY CIRCLE UPDATE – FOR INFORMATION

Dr. Monkman provided an update on the work the CPSM TRC Advisory Circle is currently working on which includes Mandatory Indigenous-Specific Anti-Racism Training, Mentorship/Leadership and creating open culture to support Indigenous physicians, and the Standard of Practice – Practicing Medicine to Prevent Indigenous Racism.

## 12. REGISTRAR REPORT – FOR INFORMATION

Dr. Ziomek provided the Council with a written report on the Registrar's activities and information outlining matters currently being dealt with at CPSM.

## 13. COUNCIL ATTENDANCE REPORT – FOR INFORMATION

The Councillor attendance report for 2023-24 was provided. Dr. Shenouda emphasized the importance of Councillors attending meetings.

## 14. 2024/25 MEETING DATES – FOR INFORMATION

A list of CPSM Council and Committee meetings for 2024-25 was provided.

## 15. 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

## 16. ACKNOWLEDGEMENT OF RETIRING EXECUTIVE STAFF AND WELCOMING INCOMING EXECUTIVE STAFF

Dr. Shenouda acknowledged the accomplishments of the Executive Staff who are retiring at the end of June and thanked them for their commitment to CPSM.

Dr. Anna Ziomek, Registrar/CEO
Dr. Karen Bullock Pries, Assistant Registrar, Complaints & Investigations
Ms. Jo-Ell St. Vincent, Director Registration Department

Dr. Shenouda welcomed the incoming Executive Staff

Dr. Ainslie Mihalchuk, Registrar & CEO

Dr. Guillaume Poliquin, Assistant Registrar, Complaints & Investigations Department

**17. IN CAMERA SESSION**

An in-camera session was held, and the President advised that there were no items discussed that are to be added to the minutes.

There being no further business, the meeting ended at noon.

_____

Dr. N. Shenouda, President

_____

Dr. A. Ziomek, Registrar

# Electronic Council Meeting Minutes June 28, 2024

At the Council meeting Wednesday, June 26, 2024, Council approved the addition of Pediatric Gastroenterology and Pediatric Respirology to the Specialist Field of Practice for Assessment. When CPSM notified the University of Manitoba, they advised they sent an updated letter requesting that Pediatric Emergency Medicine, Pediatric Infectious Diseases, and Pediatric Intensive Care also be added to the Specialist Field of Practice for Assessment. Due to an administrative error this information was not received by the Executive Office to be included in the June Council package. This is required as Practice Ready Assessments in these areas are scheduled to begin July 2, 2024, and Council does not meet again until September.

RESPONSES RECEIVED FROM:

Ms. Leslie Agger
Dr. Kevin Convery
Dr. Jacobi Elliott
Mr. Allan Fineblit
Dr. Chaitasi Intwala
Dr. Wendy MacMillan-Wang
Ms. Lynette Magnus
Dr. Rizwan Manji
Dr. Jennifer McNaught
Ms. Marvelle McPherson
Dr. Lisa Monkman
Dr. Peter Nickerson
Dr. Charles Penner
Ms. Leanne Penny
Dr. Nader Shenouda
Dr. Alewyn Vorster

**MOTION:**

Council approve Pediatric Emergency Medicine, Pediatric Infectious Diseases, and Pediatric Intensive Care be added to the Qualifications and Registration Practice Direction as a Specialist Field of Practice for Assessment for the purpose of CPSM General Regulation Section 3.38(b).

*Carried*

_____
Dr. N. Shenouda, President

_____
Dr. A. Mihalchuk, Registrar and CEO

Electronic Council Meeting Minutes August 9, 2024

At the June 2024 Council meeting Mr. Bowles was appointed to committees as a public representative subject to him being appointed to the Government Roster.

As the first meeting of the Board of Assessors is scheduled for August 14, 2024, and it will not have quorum to conduct its business without Mr. Bowles being appointed. The recommendation is that Mr. Bowles' appointment to both the Board of Assessors and the Central Standards Committee be made without it being subject to him being on the Government Roster.

CPSM will still pursue having Mr. Bowles appointment to the Government Roster after he is appointed to these two bodies.

RESPONSES RECEIVED FROM:

Ms. Leslie Agger
Mr. Neil Cohen
Dr. Kevin Convery
Dr. Carrie Corbett
Dr. Jacobi Elliott
Mr. Allan Fineblit
Dr. Chaitasi Intwala
Dr. Wendy MacMillan-Wang
Ms. Lynette Magnus
Dr. Rizwan Manji
Dr. Jennifer McNaught
Ms. Marvelle McPherson
Dr. Lisa Monkman
Dr. Peter Nickerson
Dr. Charles Penner
Ms. Leanne Penny
Dr. Nader Shenouda
Dr. Alewyn Vorster

**MOTION:**

**NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON AUGUST 8, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:**

Mr. Kingsley Bowles is appointed as a public representative to the Board of Assessors and the Central Standards Committee.

*Carried*

_____
Dr. N. Shenouda, President

_____
Dr. A. Mihalchuk, Registrar and CEO

# COUNCIL MEETING
# SEPTEMBER 25, 2024
# NOTICE OF MOTION FOR APPROVAL

**SUBJECT:** **Council Policy – Certificate of Professional Conduct**

**BACKGROUND:**

A review of Council Policies, Registrar's Policies, and Registration Practice Directions is ongoing. 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. Due to the volume of work, the focus of this project is on clarity, updating wording and organization. For the most part, limited substantive changes are being made to existing requirements.

**CURRENT COPC REQUIREMENTS:**

Section **2.22** and Schedule "B" of the Qualifications and Registration Practice Direction set out the current requirements for COPCs. This document is attached as Appendix C to Consent Agenda Item number 4.v. Council Policy – English Language Proficiency Requirements.

**PROPOSED CHANGES:**

A new draft Council Policy for COPCs is attached at Appendix B. Most changes are to add explanatory notes. Other changes include:

- The COPC will now be called a CPC (in line with other MRAs).
- Investigation and Complaints Committee matters that are resolved informally (including where no further action is taken) will not longer be noted on CPCs.
- A notation of whether the registrant is in good standing has been added.

The new draft policy has been reviewed and endorsed by the Board of Assessors.

**MOTION:**

**NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:**

- Council approves the attached Council Policy – Certificate of Professional Conduct to be effective immediately.

- Section **2.22** and Schedule “B” of the Qualifications and Registration Practice Direction are repealed.

# COUNCIL POLICY

# Certificate of Professional Conduct

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

Preamble:

Section 144 of *The Regulated Health Professions Act* (RHPA) requires that the Registrar issue a certificate of standing or conduct at the request of a registrant:

> *Upon the request of a member, the registrar must issue a letter of standing or certificate of conduct about the member, in accordance with policies approved by the council. It must include*
>
> *(a) all information about the member recorded in any register; and*
>
> *(b) a description of every matter outstanding before the complaints investigation committee or inquiry committee.*

Drafting note (will be deleted upon approval): The RHPA requires that CPCs include all registry information, which is stipulated in the *CPSM General Regulation*. The RHPA also requires a description of all ongoing matters before the Investigation Committee or the Inquiry Committee. Through policy, Council has discretion to add to these requirements.

This Policy establishes process and specific content requirements that are to be followed by the Registrar in addressing all requests made under s. 144 of the RHPA.

For the purposes of s. 144 and this Policy, a certificate issued by the Registrar under s. 144 shall be referred to as a Certificate of Professional Conduct ("CPC") and CPCs are to include necessary information about the registrant's standing and conduct as described in s. 144.

1. Requesting a CPC:

1.1. A CPC may be requested by a current or former registrant.

1.2. Upon receipt of the written consent of the registrant and payment of the applicable fee, the Registrar shall issue a CPC concerning the registrant to the designated recipient(s). The registrant may list themselves as a recipient.

Drafting note: Some Canadian MRAs also permit requests from RHAs and Accredited Facilities. These requests must be accompanied by a consent form. This option has not been reviewed.

1.3. CPCs are only considered certified by CPSM when received directly from CPSM. Information contained in the CPSM is certified as accurate to the date of the CPC.

2. Form of CPC:

2.1. The form that is used by CPSM when issuing a CPC is set forth in Schedule "A".

3. Registry information:

3.1. Subsection 144(a) refers to registry information that is listed in subsection 2.5(1) of the *CPSM General Regulation*. Accordingly, the items to be included in the registration history portion of the CPC are as follows:

3.1.1. The date of the registrant's initial registration and the date of the registrant's subsequent registration in another class, if any.

3.1.2. Notation of any undertaking or agreement by the registrant, including but not limited to an undertaking accepted under section 102 of the RHPA, that provides for one or more of the following:

i. an assessment of the registrant's capacity or fitness to practice medicine,
ii. counselling or treatment of the registrant,
iii. the monitoring or supervision of the registrant's practice,
iv. the completion by the member of a specified course of studies by way of remedial training, or
v. the placement of one or more conditions on the registrant's right to engage in the practice of medicine, including the conditions relating to reinstatement set out in section 106 of the RHPA.

3.1.3. Any voluntary surrender of the registrant's certificate of practice accepted by the Investigation Committee under section 102 of the RHPA, including any directions given to the registrant under section 105 of the RHPA.

3.1.4. Any suspension of the registrant's registration or certificate of practice as permitted by section 110 or subsection 127(3) of the RHPA.

3.1.5. Any cancellation of the registrant's certificate of practice as permitted by sections 48 and 49 of the RHPA.

3.1.6. Subject to section 104 of the RHPA, any censure accepted by the member under Section 102 of the RHPA and a notation as to how a description of the circumstances that led to the acceptance of the censure can be obtained.

Drafting note: Subsection 2.5(1) of the *CPSM General Regulation* does not mention closed Complaints Committee or Investigation Committee matters. Therefore, it is up to the Council to decide if these should be included. FMRAC's National Standard for CPCs provides guidance on this point.

4. Complaints, investigations, and disciplinary information:

4.1. For the purposes of this Policy, a complaint means any initiating communication which is an expression of concern about the conduct of a registrant or former registrant, in respect to which the registrant or former registrant is notified through the process described at Part 8 of the RHPA. Complaints may be brought by any person, including the Registrar. Complaints do not necessarily lead to an action.

4.2. The requirements at subsection 144(b) of the RHPA are interpreted to apply only to outstanding complaints that are referred to the Complaints Committee or the Investigation Committee. Complaints that are being resolved by communication ("RBC") are not recorded on CPCs.

4.3. In accordance with this Policy, dispositions of the Investigation Committee, except where no further action is directed, are to be noted on CPCs for the period defined in Schedule "A". Complaints that have been dismissed by the Registrar and complaints that are resolved by the Complaints Committee are not noted on CPCs.

4.4. Information about disciplinary hearings where no findings have been made against the registrant is to be included on CPCs.

5. CPCs issued by CPSM will indicate whether the registrant is in good standing.

5.1. Being in good standing simply means that
- 5.1.1. the registrant has kept all paperwork related to their registration and any applicable renewal applications up to date,
- 5.1.2. all fees have been paid,
- 5.1.3. their certificate of registration or certificate of practice is not suspended, and
- 5.1.4. they are meeting CPD requirements.

Drafting note: We have not included whether they are in default of any undertakings, agreements, or orders from a statutory committee established under the RHPA

5.2. For greater clarity, the term does not indicate whether the registrant has had a finding of professional misconduct made against them or whether they have terms, conditions or restrictions imposed on their certificate of registration or certificate of practice; that information can be found elsewhere on the CPC.

Drafting note: We have not listed criminal convictions, civil findings, findings form RHA proceedings, etc.

Schedule A
APPROVED FORM FOR CPSM
CERTIFICATES OF PROFESSIONAL CONDUCT

Designate recipient(s): [Name]
[contact information]

This is to certify that XX is/was registered with CPSM as indicated below.[1]
Certification of this document is valid only if this is received directly from the College of Physicians and Surgeons of Manitoba (CPSM). Information contained herein is certified only to the date of this CPC.

XX is/is not considered in good standing by CPSM.[2]

1. Identification:

| | |
|---|---|
| Registrant: | [Title] [First name] [Middle name(s)] [Last name(s)] |
| CPSM registration #: | [Enter CPSM registration number] |
| Date of birth (YYYYMMDD): | [Enter DOB as YYYYMMDD] |
| Medical ID # for Canada (MINC): | [Enter MINC] |
| Name changes (where known): | [List any known former names] |

2. Current registration information:

| | |
|---|---|
| Status: | [Active/Inactive] |
| Registration type: | [Regulated or RAM, or no longer registered] |
| Registration number: | [Enter registration number] |
| Current class of registration: | [Enter current class of registration, or N/A] |
| Conditions on registration: | [Enter any conditions on Cert. of Reg., or N/A] |
| Certificate of registration expiry: | [Enter if applicable, past, or future, or N/A] |
| Certificate of practice expiry: | [Enter if applicable, past, or future, or N/A] |
| Field(s) of practice: | [Enter field of practice, or N/A] |
| Specialist register: | [Yes/No, or N/A] |
| Inclusion(s): | [Enter inclusion(s), or N/A] |
| Exclusion(s): | [Enter exclusion(s), or N/A] |
| Special interest areas: | [Enter special interest area(s), or N/A] |
| Practice conditions: | [Enter conditions on right to engage in practice, or N/A][3] |
| Primary practice location: | [Enter if applicable] |
| Office phone number: | [Enter if applicable] |

[1] Disclosure is based upon the best information available to the CPSM as of the date of this CPC.
[2] Being in good standing with CPSM means that: the registrant has kept all paperwork related to their registration and any applicable renewal applications up to date, all fees have been paid, their certificate of registration or certificate of practice is not suspended, and they are meeting CPD requirements.
[3] This refers to conditions, terms or restrictions entered on the registrant's certificate of practice.

3. Qualifications and Credentials:

| | |
|---|---|
| Medical School: | [Name of medical school, country, and year of graduation] [Verified[4]: Yes, no, or N/A] |
| LMCC: | [Confirm holds, and date, or state does not have] |
| Certification(s): | [Royal College, CCFP, CCPA, or other] |
| Other certification(s): | [As applicable] |
| Source verification: | [Yes or No] |
| CPSM route to registration: | [FTR, labour mobility application, etc.][5] |

4. Registration history:

| | |
|---|---|
| Date of initial registration: | [Date when first registered with CPSM] |

History of actions:

- [Enter new line for each registration action (i.e., membership history)]

5. Open complaints and inquiry proceedings:[6]

| | |
|---|---|
| Complaint XX####: | [Date filed] |

6. Closed complaints:[7, 8]

| | |
|---|---|
| Complaint XX####: | [Date filed, date of disposition, and disposition] |

7. Inquiry Committee decisions:[9]

| | |
|---|---|
| Complaint XX####: | [Date of findings on liability and the date of any orders. List whether an appeal or judicial review is ongoing, and related particulars. List particulars of disciplinary actions.] |

[4] Verified by Physicians Credential Registry of Canada, EICS, or Physicians Apply.
[5] Training documents are generally not verified by CPSM for FTR and some labour mobility applicants.
[6] This does not include complaints that are referred for resolution through CPSM's information communication process. Complaints, Investigation, and Inquiry Committee proceedings are listed.
[7] This section lists decisions made by the Investigation Committee. Complaints resolved by communication or by the Complaints Committee are not included. Complaints where the Investigation Committee directed no further action are not included. Investigation Committee decision under appeal remain under the open complaints section.
[8] Only decisions from the current year and the 10 previous calendar years are included. Older decisions of the Investigation Committee are not listed.
[9] Matters where a panel of the Inquiry Committee did not make any findings against the registrant are to be included.

8. Reported findings of guilt, restraining orders, and pending charges:[10, 11]

| | |
|---|---|
| Pending charges: | [Enter if applicable, or none known] |
| Findings of guilt: | [Enter if applicable, or none known] |
| Restraining orders: | [Enter if applicable, or none known] |

9. Professional litigation history:[12]

| | |
|---|---|
| Outstanding statements of claim: | [Enter if applicable, or none known] |
| Settlements: | [Enter if applicable, or none known] |
| Civil suit findings: | [Enter if applicable, or none known] |

10. Relevant non-disciplinary information:[13]

[Enter if applicable, or none known]

11. Any other information the Registrar deems relevant:[14]

[Enter if applicable, or none]

DATE OF ISSUE:
PER THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

_____
REGISTRAR
OR

_____

[10] This includes any known findings or pending charges from Canada or elsewhere. Examples may include findings under the *Criminal Code*, the *Controlled Drugs and Substances Act*, the *Food and Drugs Act*, and fraud findings, regardless of whether there has been a pardon or record suspension. All known restraining orders, whether they arise from criminal or civil proceedings, are listed. Only matters for the current year and the 10 previous calendar years are included.

[11] CPSM began collecting information about court findings of guilt from other jurisdictions, fraud findings, restraining orders, and pardoned (or record suspension) offences on July 15, 2015.

[12] This section includes information about settlements, civil suit findings, and outstanding statements of claim that relate to the registrant's professional practice. 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.

[13] This section is for consent agreements or undertakings along with particulars, including regarding health or fitness to practice, peer review, etc., and consent withdrawals from practice or a register, and if known, reasons for withdrawing. It also may include restriction or cancellation of hospital privileges, if known. CPSM does not collect information about hospital privileges.

[14] This may include institutional actions, or anything else that should be included in the public interest.

[Name and Title of Delegate]
ON BEHALF OF THE REGISTRAR

Not official without signature of Registrar, or their delegate, and impression of CPSM seal

No further entries below

# COUNCIL MEETING
# SEPTEMBER 25, 2024
# NOTICE OF MOTION FOR APPROVAL

**SUBJECT:** **Council Policy – English Language Proficiency Requirements**

**BACKGROUND:**

A review of Council Policies, Registrar's Policies, and Registration Practice Directions is ongoing. 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. Due to the volume of work, the focus of this project is on clarity, updating wording and organization. In general, limited substantive changes are being made to existing requirements.

**CURRENT ELP REQUIREMENTS:**

Section **2.17** of the Qualifications and Registration Practice Direction sets out the current requirements for ELP:

> *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.*

The FMRAC standard is attached as Appendix A to this Notice of Motion for Approval

.**PROPOSED CHANGES:**

A new draft Council Policy for ELP is attached as Appendix B. The new policy largely recreates the FMRAC document, with additional provisions and context applicable to Manitoba.

The new draft policy has been reviewed and endorsed by the Board of Assessors.

The Manitoba Faculty was consulted on revisions relating to academic and educational registrants.

**MOTION:**

**NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:**

Council approves the attached Council Policy – English Language Proficiency Requirements to be effective immediately.

Section **2.17** of the Qualifications and Registration Practice Direction is repealed.

We have attached as Appendix C the Practice Direction for Qualifications and Registration with tracked changes to show the deletion of section **2.17**.

***Academic license***
The type of license granted to a physician for the purposes of a full-time academic appointment at a Canadian faculty of medicine. Specific elements of an academic license may vary from jurisdiction to jurisdiction. An academic license may or may not be eligible for transition to a full license, depending on the jurisdiction.

***Satisfactory practice***
A period of practice during which no intervention has taken place, either directly by the medical regulatory authority or by another agency (outside of the satisfactory completion of prescribed peer review or quality assurance activities). Such interventions may include, but are not limited to, any action intended to address concerns about the physician's conduct or competence.

***Supervision***
Oversight, with reporting to the medical regulatory authority, conducted by another physician or physicians in accordance with the approved *Expectations of Medical Regulatory Authorities Using Supervision for Provisional Licensure Purposes*.

## Part IV – Model Standards

### *1. Pre-screening Requirements*

The pre-screening requirements for physicians who may qualify for a license include the following seven components:

1.1 Language proficiency

Issues such as language proficiency testing are permissive under the Canadian Free Trade Agreement (CFTA). English language proficiency testing is beneficial and preferable.

a) Physicians trained in Canada

For physicians trained in English or French, some provincial and territorial medical regulatory authorities may require language proficiency testing if the language of the candidate's undergraduate or postgraduate medical education in Canada is in the other official language than the language of patient care in the receiving province or territory.

b) Physicians trained outside of Canada

For physicians trained outside of Canada who did not, at the time of licensure in Canada, have to demonstrate English language proficiency according to the model standard in this document, some provincial and territorial medical regulatory authorities may require language proficiency testing.

The following model standard applies to physicians who did their undergraduate medical education outside Canada:

1. French language testing (basic) in accordance with the laws in Québec.

2. English language testing (basic):
   *i. IELTS academic version within the last 24 months at the time of application, and achieved a minimum score of 7.0 in each of the four components in the same sitting; or*
   ii. *NEW: Occupational English Test - Medicine (OET-Medicine) within the last 24 months at the time of application, with a minimum grade of B in each of the four subsets in the same sitting; or*
   iii. *NEW: Canadian English Language Proficiency Index Program-General (CELPIP-General) Test within the last 24 months at the time of application, with a minimum score of 9 in each of the four skills in the same sitting.*

   **Exemptions:** Applicants trained outside of Canada (undergraduate and/or postgraduate medical education) may be exempted from English language proficiency testing if:

   A. their undergraduate or postgraduate medical education was taken in English in one of the countries that have English as a first and native language, i.e.:

   | |
   |---|
   | Australia, Bahamas, Bermuda, British Virgin Islands, Canada, Ireland, New Zealand, Singapore, South Africa, United Kingdom, United States of America, US Virgin Islands; and the Caribbean Islands of Anguilla, Antigua and Barbuda, Barbados, Dominica, Grenada, Grenadines, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent, Trinidad and Tobego |

   or

   B. they can provide satisfactory evidence that is acceptable to the medical regulatory authority of appropriate exposure to English language in trainingand practice. For example, evidence could be provided to support the following:
      - taken in their totality, the majority (>50%) of their undergraduate and/or postgraduate medical education was in English; or
      - taken in its totality, the majority (>50%) of patient care provided by the applicant was in English; or
      - others.

*It is important to note the following about the above model standard:*

- *Many Canadian medical regulatory authorities will also use this particular standard for educational licenses (not only provisional or full licenses):*
  - *once the candidate has successfully done the language proficiency test for an educational license, including an elective, the candidate will be exempt from future testing (even beyond the 24-months described in the"model standard").*
- *Where governing laws supersede the ability of a medical regulatory authorityto apply this "model standard" (at least for the time being), those jurisdictions (excluding Québec) will communicate to the new certificants / licensees that, although they may not have been required to undergo testing in that jurisdiction, they should consider taking the test, especially if they would like to move to another jurisdiction in the future. The information will be:*
  - *posted on the medical regulatory authority's website;*
  - *included in the letter of decision;*
  - *included in the new certificant / licensee package; and*
  - *shared with the relevant recruiters (e.g., HealthForce Ontario).*

# COUNCIL POLICY

# English Language Proficiency

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

Preamble:

Registrants practicing medicine in Manitoba need to be able to communicate clearly with their patients and document their involvement in care in English. Consequently, non-exemptible requirements for registration with CPSM for all classes include that the applicant must establish that they meet English language fluency criteria approved by Council.[1, 2] This Policy establishes those criteria.

1. English language proficiency testing

1.1. Unless exempt under paragraph 2 of this Policy, applicants for registration are required to complete one of the following English language proficiency tests[3]:

1.1.1. International English Language Testing System (IELTS), academic version, within the last twenty (24) months at the time of application and achieved a minimum score of 7.0 in each of the four components in the same sitting.

1.1.2. Occupational English Test - Medicine (OET-Medicine) within the last 24 months at the time of application, with a minimum grade of B in each of the four subsets in the same sitting.

1.1.3. Canadian English Language Proficiency Index Program-General (CELPIP-General) test within the last 24 months at the time of application, with a minimum score of 9 in each of the four skills in the same sitting.

1.2. Direct verification of test results may be waived for applicants who are currently in independent practice in a country where English is the first and/or native language,[4] and who were required to achieve English language proficiency prior to registration with the applicable regulatory body. Waiver under this paragraph requires the following information directly from the regulatory body:

[1] See sections 3.7 and 3.37, as well as 3.10, 3.12, 3.14, 3.57, and 3.64 of the *CPSM General Regulation*.

[2] Issues such as language proficiency testing are permissive under the Canadian Free Trade Agreement (CFTA). English language proficiency testing is beneficial and preferable.

[3] This list aligns with the FMRAC Model Standards for Medical Registration in Canada.

[4] See list at paragraph 3.

1.2.1. confirmation English language proficiency must be demonstrated to enter training or practice in the jurisdiction,
1.2.2. a description of the English language proficiency requirement (including the necessary scores on any required English language tests), and
1.2.3. a copy of the applicant's test results that were accepted when they entered training or practice in that jurisdiction.

2. English languages proficiency testing exemptions

2.1. Labour mobility applicants:
2.1.1. The requirement to demonstrate proficiency in English is fulfilled if the applicant provides proof that they currently hold an equivalent medical license in any province or territory in Canada and demonstrates they practice primarily in English.[5]

2.2. Educational registrants:[6]
2.2.1. Medical students and physician assistant students are exempt from the English language testing requirement based on confirmation of their admission into the Manitoba Faculty.
2.2.2. Visiting elective trainees and applicants who are enrolled in a residency or fellowship program at the Manitoba Faculty are exempt from English language testing requirement for the first ninety (90) days of training. They will be fully exempt from English language testing if CPSM receives confirmation from the Associate Dean or Assistant Dean of the applicable program confirming the trainee has satisfied the Manitoba Faculty's English language fluency criteria.

2.3. Provisional academic registrants:[7]
2.3.1. Applicants for the provisional (academic — s. 181 faculty), provisional (academic — visiting professor), and provisional (academic — post-certification trainee) classes are exempt from English language testing requirements if CPSM receives confirmation from the Associate Dean or Assistant Dean of the applicable program confirming the applicant has satisfied the Manitoba Faculty's English language fluency criteria.

2.4. Additional exemptions:
2.4.1. Applicants may be exempted from English language proficiency testing if one of the following circumstances apply:

[5] Satisfactory evidence may include verification from a director or supervisor at the practice setting.
[6] See sections 3.48, 3.50, 3.52, 3.54, and 3.57.
[7] See sections 3.10, 3.12, and 3.14 of the *CPSM General Regulation*.

i. Their undergraduate or postgraduate medical education[8] was taken in English in one of the countries that have English as a first and/or native language.[9]
ii. They can provide evidence that is satisfactory to the Registrar of appropriate exposure to English language in training and/or practice. For example, evidence could be provided to support the following:
    1. that they have taken the majority (>50%) of their undergraduate or postgraduate medical education in English, and/or
    2. the majority (>50%) of patient care provided by the applicant has been in English, and/or
    3. other substantially equivalent evidence of English proficiency in training and practice (e.g., significant clinical teaching, research, and/or academic experience).

Commentary: When assessing English language proficiency under paragraph 2.4.1., evidence will be evaluated by the Registrar on a case-by-case basis. Examples of satisfactory evidence include:

- Inclusion of their UGME or PGME training program in the list of English programs in FAIMER's World Directory of Medical Schools (https://www.wdoms.org/).
- Completion of a fellowship of at least two years within a country where English in the first or native language, as verified by a director or supervisor at the location of the fellowship.
- For 2.4.1.ii.2., evidence the candidate has successfully completed an English language proficiency exam beyond the expiry period, but who has been working in an English-speaking environment, as verified by a director or supervisor at the practice setting.

3. For the purposes of this Policy, the list of countries where English is a first and/or native language includes, but is not limited to: Australia, Bahamas, Bermuda, British Virgin Islands, Canada, Ireland, New Zealand, Nigeria, Singapore, South Africa, United Kingdom, United States of America, US Virgin Islands, and the Caribbean Islands of Anguilla, Antigua and Barbuda, Barbados, Dominica, Grenada, Grenadines, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent, Trinidad and Tobago.

[8] This includes residency and medical fellowship training.
[9] See list at paragraph 3.

# 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**
**March 20, 2024, June 26, 2024, June 28, 2024**
**September 25, 2024**

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

## 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
- Pediatrics
- Pediatric Emergency Medicine
- Pediatric Gastroenterology
- Pediatric Hematology/Oncology
- Pediatric Infectious Diseases
- Pediatric Intensive Care
- Pediatric Orthopedic Surgery
- Pediatric Respirology
- Pediatric Surgery
- 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. REPEALED – SEPTEMBER 25, 2024 – See Council Policy English Language Proficiency~~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 – MARCH 20, 2024 – See Council Policy Registration of Clinical and Physician Assistants and Physician Assistant Students

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

2.20. REPEALED – MARCH 20, 2024 – See Council Policy Registration of Clinical and Physician Assistants and Physician Assistant Students

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

2.21. REPEALED – MARCH 20, 2024 – See Practice Direction Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students

## Certificate of Professional Conduct

2.22. REPEALED – SEPTEMBER 25, 2024 – See Council Policy Certificate of Professional Conduct~~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. REPEALED – SEPTEMBER 25, 2024 – See Council Policy Certificate of Professional Conduct~~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 be 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 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 be 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

**REPEALED – SEPTEMBER 25, 2024 – See Council Policy 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~~

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

xi. If applicable, authorized/no authorized to perform a reserved Act

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
# SEPTEMBER 25, 2024
# NOTICE OF MOTION FOR APPROVAL

**SUBJECT:** **Appointment of Members to the CPSM Board of Assessors and Amendments to Governance Policy**

**BACKGROUND:**

Council appointed the following individuals to the first Board of Assessors:

- Dr. Alewyn Vorster, Chair
- Ms. Leslie Agger, public representative
- Mr. Kingsley Bowles, public representative
- Dr. Mohsen Khoshnam, registrant
- Dr. Brent Kvern, registrant

Having only 5 members of the Board of Assessors creates potential logistical issues associated with obtaining quorum for a panel hearing which requires a quorum of 5 members.

The Governance Policy states:

> **4.17.7.a** The quorum for the Board of Assessors is:
>
> > **4.17.7.a.ii** when sitting as a panel of the Board, five members, at least two of whom are to be public representatives and one must be the Chair of the Board of Assessors. The Chair will only vote when there is a tie.

It is recommended that Council appoint two more registrant representatives and two public representatives.

Dr. Elissa Abrams and Dr. George Gerges agreed to be members of the Board of Assessors.

In addition, Ms. Cheryl Smith and Ms. Elizabeth Tutiah agreed to be public representatives on the Board of Assessors. Both are are public representatives on the Investigation Committee.

It is also recommended that Council amend the Governance Policy to appoint the Registrar as an ex officio, non-voting member of the Board of Assessors. This will require adding the following section to the Governance Policy:

> **4.17.4.c** The Registrar, as an ex officio, non-voting member.

A typographical error was in section **4.17.2.e** of the Governance Policy should corrected by adding the word “recommendation”. The amended section would be:

**4.17.2.e** To advise and make recommendations to the Executive Committee respecting approved registration forms.

Excerpt from CPSM Board of Assessors Governance Policy is attached for reference as Appendix A.

**MOTION:**

**NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:**

Council appoints Dr. Elissa Abrams, Dr. George Gerges, Ms. Cheryl Smith and Ms. Elizabeth Tutiah as members of the CPSM Board of Assessors.

The Governance Policy be amended to read:

**4.17.2.e** To advise and make recommendations to the Executive Committee respecting approved registration forms.

**4.17.4.c** The Registrar, as an ex officio, non-voting member.

4.16.1.f Appeal Rights

4.16.1.f.i Decisions of Program Review Committee are subject to the right of appeal to Executive Committee.

**4.17. Board of Assessors Terms of Reference**

4.17.1 Authority

4.17.1.a. 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.

4.17.2 Purpose

4.17.2.a The functions and duties of the Board of Assessors include:

4.17.2.b 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.

4.17.2.c Upon approving an application for registration, placing conditions on the applicant's registration in accordance with subsection 32(2) of the RHPA.

4.17.2.d To advise and make recommendations to Council about CPSM's registration requirements, policies, and procedures on an ongoing basis.

4.17.2.e To advise and make recommendations to the Executive Committee respecting approved registration forms.

4.17.3 Procedure and Code of Conduct

4.17.3.a 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.

4.17.3.b Meetings of the Board of Assessors are closed to the public.

4.17.4 Appointment to the Board of Assessors and composition

4.17.4.a Council must appoint the members of the Board of Assessors and its Chair. The Chair must be a registrant physician. The Board of Assessors must have at least five (5) members, two (2) of whom must be public representatives. In all cases, two-fifths of the members of the Board of Assessors must be public representatives.

4.17.4.b A member of the Executive Committee cannot be appointed as a member of the Board of Assessors.

~~4.17.4.b~~4.17.4.c The Registrar, as an ex officio, non-voting member.

4.17.5 Term of office:

4.17.5.a The term of office of all members of the Board of Assessors is one year. Members are eligible for reappointment.

# COUNCIL
# SEPTEMBER 25, 2024
# NOTICE OF MOTION

**SUBJECT:** Qualifications and Registration Practice Direction - Adding Emergency Medicine Specialist Field of Practice to the List of Approved Membership Classes for Assessment

**BACKGROUND:**

Conditional and temporary registration may be granted for specialist fields of practice if the field is listed as an approved membership class. The College of Physicians and Surgeons of Manitoba General Regulation **s.2.10(2)(b) 45.** allows for the addition of "any other approved specialty field of practice". Adding this specialty field of practice requires an amendment to the Qualifications and Registration Practice Direction.

If Council approves the addition of Emergency Medicine to the Specialist Field of Practice for Assessment, a physician can be referred to the Division of Continuing Professional Development for an assessment in that area.

The Practice Ready Assessment is an alternative route to specialist registration for many, including International Medical Graduates. It is a rigorous assessment exercise over a lengthy period, rather than full residency and examinations, that is used to determine if the applicant has the competency to safely practice independently in Manitoba.

The Department Head of Emergency Medicine has confirmed their commitment to participate in the Practice Ready Assessment of physicians who seek registration with CPSM in these areas. Current request attached for reference as Appendix A.

The proposed amendment is referenced as an excerpt of page 6 of the Practice Direction – Qualifications and Registration as Appendix B, full Practice Direction can be referenced as Appendix C of Consent Agenda Item 4.v. Council Policy – English Language Proficiency Requirements.

**MOTION:**

**NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:**

> Council approve Emergency Medicine be added to the Qualifications and Registration Practice Direction as a Specialist Field of Practice for Assessment for the purpose of CPSM General Regulation Section **3.38(b)**.

University of Manitoba | Rady Faculty of Health Sciences

**Max Rady College of Medicine**
International Medical Graduate Program
260 Brodie Centre
727 McDermot Avenue
Winnipeg, Manitoba R3E 3P5
Phone: 204-975-7757
Fax: 204-789-3911

September 18, 2024

Dr. Ainslie Mihalchuk
College of Physicians and Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg, MB R3J 3T7

**Re: Practice Ready Assessment - Specialty Practice (PRA-SP) in Emergency Medicine**

I would like to report that Dr. Paul Ratana with the Department of Emergency Medicine, has confirmed their commitment to participate in the PRA-SP effective immediately.

I would therefore like to officially request that the College add Emergency Medicine to the Approved Fields of Specialty Practice for Assessment for the Purposes of CPSM General Regulation Section 3.38(b).

Please let me know if you require any additional information or documentation to process this request.

Yours sincerely,

Martina Reslerova, MD, PhD, FRCPC
Director,
International Medical Graduate Program

MR/cc

cc: Dr. Paul Ratana, Head, Department of Emergency Medicine

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

## 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
- Emergency Medicine
- 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
- Pediatrics
- Pediatric Emergency Medicine
- Pediatric Gastroenterology
- Pediatric Hematology/Oncology
- Pediatric Infectious Diseases
- Pediatric Intensive Care
- Pediatric Orthopedic Surgery
- Pediatric Respirology
- Pediatric Surgery
- Plastic Surgery
- Psychiatry
- Radiation Oncology
- Respirology
- Rheumatology
- Thoracic Surgery
- Urology
- Vascular Surgery

# COUNCIL MEETING
# SEPTEMBER 25, 2024
# NOTICE OF MOTION FOR APPROVAL

**SUBJECT:** **Accredited Facilities Bylaw Amendment**

**BACKGROUND:**

The Accredited Facilities Bylaw (Bylaw) is a two-part document that applies to:

1. All diagnostic facilities in Manitoba other than facilities operated by the provincial or municipal government and those designated as hospitals.
2. Non-hospital medical or surgical facilities in which procedures, that have a sufficient risk of potential harm to a patient, are performed.

Prior to amending the Bylaw CPSM must notify the Minister of Health of the proposed changes and provide a minimum 30-day consultation with registrants. Council is required to consider comments received when deciding to amend the Bylaw. If an amendment is of a non-substantive nature, it can be made by the Registrar without consultation.

Attached as Appendix A is an email dated July 30, 2024, to the Minister of Health advising of the proposed changes and seeking comment. This email included a red-lined copy of the proposed amended Accredited Facilities Bylaw. No comments were provided by the Minister of Health.

Attached as Appendix B is the results of the consultation with registrants.

A Bylaw amendment will come into effect once it is made but requires ratification at the next AGM meeting for the amendment to remain in effect past the date of the AGM.

There are 5 recommended Bylaw amendments:

1. Section **13.3.3.vi** – tumescent liposuction
2. Section **13.3.3.xi** – any procedure that the Program Review Committee directs
3. Bylaw list – Intravenous ketamine administration
4. Bylaw list – MDMA (3,4-methylenedioxymethamphetamine)-Assisted Therapy (MMDA-AT)
5. Requiring anesthesiologists working in dental clinics to report Adverse Patient Outcomes

**THE RECOMMENDED AMENDMENTS**

**Tumescent liposuction**

This will amend the section in Part B that lists procedures required to be performed in Non-Hospital Medical or Surgical Facilities:

> **13.3.3.vi** ~~any tumescent~~ liposcution procedure<u>s</u> ~~involving the administration of dilute local anaesthesia~~

The amendment is to the naming of the procedure in the list of the regulated procedures. Although it appears to be amending the procedure from a discrete narrow procedure to a broader number of procedures it is not. The purpose of the amendment is to remove confusion by replacing antiquated terminology with generally accepted terminology. The procedures would be governed by the same existing standards. This issue was identified in the updating of the existing standards and will not affect the procedures that are required to be performed at Non-Hospital Medical or Surgical Facilities. As such, the amendment is of a non-substantive nature and can be made by the Registrar without registrant consultation or Council approval.

**Any procedure that the Program Review Committee directs**

Part B section **13.3.3.xi** permits the Program Review Committee to add new procedures to the list of procedures that must be performed at Non-Hospital Medical or Surgical Facilities. Although it is an excellent means of reducing red tape associated with adding procedures to the list of procedures required to be performed in an accredited facility, the effect is that it bypasses legislative requirements for consultation and approval.

Council does not have the power to delegate this authority to the Program Review Committee, and therefore the Bylaw must be corrected.

**Intravenous Ketamine Administration**

Intravenous Ketamine Administration is on the list of procedures that must be performed at Non-Hospital Medical or Surgical Facilities. It was added to the procedures list pursuant to section **13.3.3.xi** above and never went to Council for approval. To require the procedure be performed in Non-Hospital Medical or Surgical Facilities a Bylaw amendment is necessary. Amending the Bylaw will require registrant consultation and notice to the Minister.

**MDMA-AT (3,4-Methylenedioxymethamphetamine)**

Health Canada has recognized the growing interest in the use of psychedelic-assisted psychotherapy and the possible psychological and physical risks to patients associated with this

type of therapy. MDMA can be procured through Health Canada's Special Access Program. There are however significant public, patient and clinic staff risks associated with MDMA-AT. If MDMA-AT is not included in the list of treatments that must be performed at an accredited facility, there will be no regulatory safeguards to protect the public. Similar to ketamine procedures, MDMA-AT use will also require a Bylaw amendment and the associated consultation and notice. The Program Review Committee has recommended Council add MDMA-AT to the list.

**Requiring anesthesiologists working in dental clinics to report Adverse Patient Outcomes**

CPSM believes anesthesiologists working in dental clinics (which are not regulated by the Accredited Facilities Bylaw) should report Adverse Patient Outcomes involving anesthetics. The purpose of the Bylaw is to govern Non-Hospital Medical or Surgical Facilities and the procedures that occur in the facility. However, the proposed amendment governs the conduct of the registrant performing a procedure outside of Non-Hospital Medical or Surgical Facilities. CPSM has jurisdiction over the registrant who is performing the treatment but does not have jurisdiction over the dental clinic where the procedure is being performed.

Amending the Bylaw to accomplish this goal will have to rely upon Section **183(3)** of the RHPA that states:

> **183(3)** The council may make by-laws
>
> (e) respecting arrangements with other colleges for accreditation of facilities at which members of those colleges perform diagnostic or treatment procedures.

A red-lined copy of the proposed Accredited Facilities Bylaw is attached as Appendix C.

**MOTION:**

**NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:**

Council approves the Accredited Facilities Bylaw as presented in Appendix C.

## Mike Triggs

**From:** Mike Triggs
**Sent:** July 30, 2024 10:35 AM
**To:** minhsltc@manitoba.ca
**Cc:** maria.gonzales@manitoba.ca; scott.sinclair@manitoba.ca; Hill, Donna; The Registrar
**Subject:** CPSM Accredited Facilities Bylaw Amendments
**Attachments:** Accredited Facilities Bylaw 2024 amendments tracked changes.pdf

Dear Minister Asagwara,

CPSM Council is proposing amendments to its Accredited Facilities Bylaw. Section 183(4) of *The Regulated Health Professions Act* requires that before making such amendments CPSM must provide you with a copy of the proposed bylaw for your review and comment, and to consider any comments received from you. Greater detail on these amendments is provided in public consultation notice https://cpsm.mb.ca/news/public-consultation-amendments-to-accredited-facilities-bylaw , which will be held July 29 to August 29.

By way of background, pursuant to *The Regulated Health Professions Act* CPSM regulates accredited facilities which are:

1. Diagnostic facilities in Manitoba that are not operated by the provincial or municipal government and those designated as hospitals, and

2. Non-hospital medical or surgical facilities in which procedures with a sufficient risk of potential harm to a patient are performed.

Two of the three proposed bylaw amendments requiring consultation relate to non-hospital medical or surgical facilities in which procedures with a sufficient risk of potential harm to a patient are performed. The bylaw lists those procedures which have a sufficient risk of potential harm that require them to be performed in an accredited facility. If a procedure is not on this bylaw list the consequence is that it can be performed without any standards on who or how the procedure is to be performed. This poses risks to patient safety.

CPSM is proposing to add two procedures to the list of procedures to be performed in accredited facilities:

1. Intravenous Ketamine Administration
2. MDMA (3,4-methylenedioxymethamphetamine) administration

The third bylaw amendment requires anesthesiologist (CPSM registrants) working in dental surgery clinics to report to CPSM any major adverse patient outcome caused by the anaesthesiology services they provide in the dental surgery clinic. Currently, adverse patient outcomes in dental surgery clinics are only reported to the Manitoba Dental Association. As such CPSM is unaware of major adverse patient outcomes that may be caused by the work of these anesthesiologist. Improved patient safety requires CPSM being aware of procedures performed by registrants that cause major adverse patient outcomes so that it can take the necessary steps to address any concerns that arise.

For your information, two additional non-substantive amendments are also being made to the bylaw.

The first relates to modernizing/updating the name of liposuction procedures which is on the list of procedures to be performed in non-hospital medical or surgical facilities. The proposed amendment replaces antiquated and confusing terminology of “any tumescent liposuction procedure involving the administration of dilute local anaesthesia” with “liposuction procedures”.

The second amendment removes a provision allowing the Program Review Committee to add to the list of procedures to be performed at accredited facilities without going through the process of amending the bylaw or notify the Minister of Health. This provision was used in the past to add Intravenous Ketamine Administration to the list of procedures. This is a provision that is beyond the jurisdictional scope of the bylaw and is being removed.

Attached is a redlined copy of all the proposed amendments to the Accredited Facilities Bylaw. (For ease of reference all proposed amendments are found on page 14 of the pdf and are tracked).

CPSM Council materials for its September 25, 2024 meeting need to be finalized by September 6, 2024, therefore it would be greatly appreciated that any comments you may have are received before that date.

If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Michael Triggs (he/him)
General Counsel
The College of Physicians and Surgeons of Manitoba
Email: mtriggs@cpsm.mb.ca
P: 204-470-9543
www.cpsm.mb.ca
1000-1661 Portage Avenue, Winnipeg MB, R3J 3T7

## Executive Summary of Consultation Responses

27 responses were received from the consultation process.

Comments were from:

- 19 registrants answering the online questionnaire
- 1 person from another regulated profession answered the online questionnaire
- 4 registrants submitting email responses
- 3 Stakeholders:
    - College of Registered Nurses of Manitoba
    - Shared Health – Provincial Emergency Medical Services
    - Canadian Medical Protective Association (CMPA)

The questionnaire asked:

> Q. Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals?
>
> 17 responded - yes
>
> 1 responded - no
>
> 2 responded - unsure

> Q. Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba?
>
> 15 responded – yes
>
> 1 responded – no
>
> 4 responded – unsure

Q. CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association. The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic. Do you support this amendment?

19 responded – yes

0 responded – no

1 responded – unsure

The College of Registered Nurses of Manitoba expressed support for the amendments as they enhance patient safety.

Shared Health - Provincial Emergency Medical Services inquired as to whether the amendment would impact paramedics use of ketamine in prehospital care of patients. Shared Health was advised that the bylaw is not applicable to this use of ketamine.

CMPA expressed it would be helpful for "major adverse patient outcome" to be defined in the Accredited Facilities Bylaw so that physicians can have a better understanding of their reporting obligations.

All written responses are attached.

Consultation Feedback – Accredited Facilities

| **Comment** |
| --- |
| These proposed amendments make good sense for the safety and health of the public |
| Good afternoon,<br><br>The request for feedback by members on "off label" Ketamine infusions is quite timely. We have been exploring including this in our therapeutic options here at Selkirk Mental Health Centre. I have reviewed the various literature/guidelines that are supportive of using IV Ketamine for treatment resistant MDD. These include our local guidelines at HSC – Adult Psychiatry, as well the CANMAT 2021 guidelines and the Cochrane Reviews on this subject.<br><br>In my landscape survey, I have read the College of Physicians and Surgeons Guidelines from both British Columbia and Saskatchewan on Ketamine infusions. Both documents are comprehensive and excellent guidelines which I am sure that the College of Physicians and Surgeons of Manitoba is well aware of.<br><br>I would ask that the CPSMB clarify what are non- hospital accredited facilities (to be able to admin IV therapy) are, as well the level of expected training for ketamine infusions, ie. Royal College Psychiatry, GP psychiatry, and the level of training expected for Physicians administering Ketamine, ie. Family Physicians, (CCFP, CCFP-EM, CCFP- Anesthesia, palliative care, etc. ). I would also ask that the guideline speak to transfer of care of this function (ie PAs or Cas) as to whether or not it is acceptable for them to deliver IV Ketamine. The guidelines between CANMAT, and the Colleges of Saskatchewan, and British Columbia vary on their opinions/guidelines of the qualifications of medical personal that are delivering IV Ketamine.<br><br>Thank you for asking for the membership's feedback on this timely topic. I look forward to reviewing the final statement/guideline. |
| Hello, I am in favor of the proposed amendments. I am also in favor of a review of any new or off-label use of a compound - particularly an injectable (aside from insulin) by the CPSM, especially if that compound may incur a risk over and above normal risks incurred by use of other substances (i.e. opioids vs. cholesterol medications, for example). |
| I agree with the proposed above regulations |
| Shared Health - Provincial Emergency Medical Services currently uses ketamine in the prehospital care of patients as per the attached medication standing order.<br>But, as you know we are not by definition an accredited facility.<br>Under the proposed CPSM amendments to intravenous ketamine administration, would we be allowed to continue to do so?<br><br>It's use as an analgesic is covered in our employer-based training / onboarding. Its administration does comply with the College of Paramedics of Manitoba practice scope for providers at the primary care (PCP), intermediate care (PCP-IC), and advanced care (ACP) registration levels, but does require a physician's order .<br>Additionally, with the expansion of advanced care paramedics into the rest of the Province, there consideration of eventually using it for the off-label indications of chemical restraint or procedural sedation in carefully selected patients.<br>This is currently practiced by other Canadian paramedic services, and is supported by the EMS scientific literature.<br>Would the CPSM consider "exempting" Shared Health ERS from the restriction to administration in accredited facilities, or CPSM-accredited Non-Hospital Medical Surgical Facilities (NHMSF)?<br><br>Thank you for your time and consideration of this matter.<br>I am available any time to discuss further if necessary. |

| Shared health Soins communs Manitoba | M17 - KETAMINE | |
|---|---|---|
| | STANDING ORDER | HIGH-ALERT MEDICATION [1] |
| Version date: 2024-04-15 | Effective date: 2024-05-15 (0700) | |

## INDICATIONS

- Moderate to severe pain from an acute illness, injury, or the exacerbation of a chronic condition:
  - As an adjunct when standard analgesic agents alone have not been effective
  - As an alternative when standard analgesic agents are contraindicated
- INTRANASAL: Short-term analgesia for extrication when vascular access cannot be obtained

## CONTRAINDICATIONS

- Uncorrectable severe hypoperfusion
- Risk of respiratory or CNS depression
- Previous emergence reaction from ketamine
- True allergy to ketamine

## DOSING

### ANALGESIA

**INTRAVENOUS / INTRAOSSEOUS (INTERMEDIATE WORK SCOPE & ABOVE):**

- 12 months & older - 0.5 mg/kg (administer by slow push over 1 - 2 min)
- Follow with 0.25 mg/kg after 10 min if necessary to achieve adequate analgesia
- Repeat 0.25 to 0.5 mg/kg every 30 min as required to maintain adequate analgesia
- Ketamine is not compatible with Ringer's lactate solution

**INTRAMUSCULAR (INTERMEDIATE WORK SCOPE & ABOVE):**

- 12 months & older - 0.5 mg/kg
- Follow with 0.25 mg/kg after 15 min if necessary to achieve adequate analgesia
- Repeat 0.25 to 0.5 mg/kg every 60 min as required to maintain adequate analgesia

### EXTRICATION WITHOUT VASCULAR ACCESS

**INTRANASAL (PRIMARY WORK SCOPE & ABOVE):**

- 12 months & older - 0.5 to 1 mg/kg
- Follow with 0.25 to 0.5 mg/kg after 10 min if necessary to achieve adequate analgesia
- Repeat 0.25 to 0.5 mg/kg every 30 min as require to maintain adequate analgesia

| NOTES |
|---|
| 1. ERS HIGH-ALERT MEDICATION: Refer to Shared Health Provincial Clinical Standard - Safety Controls for High-Alert Medications (refer to A03 - HIGH ALERT MEDICATIONS).<br>2. In a hemodynamically compromised patient who is compensating, ketamine can still cause hypotension and deterioration. Priority should be given to adequate resuscitation before administering analgesia.<br>3. Ketamine may enhance the effects of CNS depressants such as the opioid analgesics. Consider smaller dosing if given with or after opioids.<br>4. INTRANASAL ADMINISTRATION WITHOUT VASCULAR ACCESS:<br>• Should not be used for routine analgesia.<br>• Use extreme caution if administering for painful extrication, as hypotension may occur in a hemorrhaging patient who is compensating. |

| APPROVED BY | |
|---|---|
|  |  |
| Medical Director - Provincial EMS/PT | Associate Medical Director - Provincial EMS/PT |

| VERSION CHANGES (refer to X08 for change tracking) |
|---|
| • Removal of requirement for IV access with IN administration, but reminder re administration without vascular access |

College of Registered Nurses of Manitoba
890 Pembina Highway
Winnipeg, MB R3M 2M8
P 204-774-3477
F 204-775-6052
TF (Manitoba) 1-800-665-2027
crnm.mb.ca



August 8, 2024

Dr. Ainslie Mihalchuk
Registrar
College of Physicians and Surgeons of Manitoba
1000 – 1661 Portage Avenue
Winnipeg MB R3J 3T7

**VIA EMAIL**
CPSMconsultation@cpsm.mb.ca

Dear Dr. Mihalchuk,

Thank you for the opportunity to review the proposed amendments to Accredited Facilities Bylaw. We, at the College of Registered Nurses of Manitoba, are supportive of amendments that enhance patient safety. The proposed amendments to the Bylaw are clearly intended to address safety risks that may arise from new psychiatric treatment approaches. These amendments will also ensure proper reporting of Adverse Patient Outcomes by anesthesiologists working in dental clinics.

We have no concerns with the proposed amendments to the Accredited Facilities Bylaw outlined in your July 29, 2024 email. We view them as providing a benefit the public.

Sincerely,

Deb Elias RN

Deb Elias RN MN FRE *has authorized the use of electronic signature*
CEO/Registrar

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

August 15, 2024
*Via email:* CPSMconsultation@cpsm.mb.ca

Dr. Ainslie Mihalchuk
Registrar
College of Physicians & Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg, MB R3J 3T7

Dear Dr. Mihalchuk:

**Re: CPSM, Amendments to the Accredited Facilities Bylaw**

The Canadian Medical Protective Association (CMPA) appreciates the opportunity to provide feedback on the proposed amendments to the College of Physicians and Surgeons of Manitoba's Accredited Facilities Bylaw.

As you know, the CMPA delivers efficient, high-quality physician-to-physician advice and assistance in medico-legal matters, including the provision of appropriate compensation to patients injured by negligent medical care. Our evidence-based products and services enhance the safety of medical care, reducing unnecessary harm and costs. As Canada's largest physician organization and with the support of our over 111,000 physician members, the CMPA collaborates, advocates and effects positive change on important healthcare and medico-legal issues.

While it is not the role for the CMPA to set standards for the profession or comment on clinical issues, we identified one proposed amendment that could create medico-legal risk for physicians providing medical services in accredited facilities. In particular, proposed subsection 13.41.1 of the Bylaw would require CPSM registrants providing anaesthesiology services to notify the College of any "major adverse patient outcome" resulting from the anesthesiology services provided in the dental surgery clinics.

We recognize similar terminology is used elsewhere in the Bylaw (*e.g.* subsections 7.8.15, 25.4.1. vi, and 25.4.4). However, because the term "major adverse patient outcome" (or "major change in equipment" as stated in subsection 25.4.4) is not defined anywhere in the Bylaw, it will be difficult for physicians to know when the reporting obligation is triggered under this proposed subsection (and the others that use similar terminology). For example, does a "major adverse patient outcome" differ from an adverse event that physicians are generally required to disclose to patients, as set out in the College's *Standard of Practice on Good Medical Care*? Do all harmful incidents need to be disclosed to the College? Or only those of a certain significance or severity?

So that physicians can comply with their obligations under the Bylaw, it would be helpful for the College to set out criteria to assist physicians in determining whether an adverse patient outcome (or change in equipment) is “major” and triggers the relevant reporting obligation.

We trust the above comments will be of assistance to the College in finalizing the proposed Bylaw amendments.

Yours sincerely,

Lisa Calder, MD, MSc, FRCPC
Chief Executive Officer

LAC/ml

**Q1**

Are you:

**CPSM Registrant?**

**Q2**

Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals?

**Yes,**

The college needs to be proactive on this issue. Any delay on a practical approach will lead to implementation of completely private, unregulated and misuse. There is emerging evidence for IV ketamine treatment resistant depression and in a properly regulated site (ideally a standalone centre) this can be done safely and equitably for manitobans.

**Q3**

Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba?

**Yes**

**Q4**

CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment?

**Yes**

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|---|---|
| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes** |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes** |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes,**<br>There is high potential for misuse and predatory practices upselling for chronic pain treatment with minimal evidence, and definite safety concerns. Agree this should be limited to CPSM accredited facilities/hospitals to ensure transparency and trackability. |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes,**<br>There is high potential for misuse and predatory practices upselling for chronic pain treatment with minimal evidence, and definite safety concerns. Agree this should be limited to CPSM accredited facilities/hospitals to ensure transparency and trackability. |

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| **Q4** | **Yes** |
| CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | |

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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes** |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes** |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes** |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes** |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

**Q1**

Are you:

**CPSM Registrant?**

**Q2**

Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals?

**Yes,**

Risk/benefit ratio unclear but ketamine use requires monitor of both patients and drug supply.

**Q3**

Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba?

**Yes,**

As with ketamine, this is a powerful drug which can certainly be harmful. How helpful it may be is directly related to cautious, supervised use.

**Q4**

CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment?

**Yes,**

These are MEDICAL adverse events in the context of anesthesia given by CPSM registrants.

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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes,**<br>Because of the risks associated with administration only accredited facilities should administer this agent |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Unsure,**<br>It's unclear from the wording of this statement that it is a CPSM-accredited non-Hospital facility. |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes,**<br>This does not differ from reporting from a hospital (or non-hospital) setting reporting significant anesthesia-related adverse drug effects. |

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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes** |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes** |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes** |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes** |
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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Unsure** |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Unsure** |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes,**<br>This is a valuable tool in the management of depression and chronic pain. Without services in the community; patient will not be able to access these modalities in the current hospital based structure. |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes,**<br>Community access is prevalent and thus it is superior to have access to this compound in appropriate medical setting particularly as it has shown therapeutic benefit. |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

**Q5**

Do you have any other comments regarding the above three amendments to the Accredited Facilities Bylaw?

Expansion of community pain services should be a priority

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| **Q1**<br>Are you: | **Member of another regulated health profession in Manitoba?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes** |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes** |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **No** |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **No** |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes,**<br>Potential risk of misuse, drug abuse, side effects, interactions with other drugs and addiction potential is associated with ketamine, hence its use needs to be regulated and also supervised by trained personal |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes,**<br>Same reason as for ketamine |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

**Q1**

Are you:

**CPSM Registrant?**

**Q2**

Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals?

**Yes,**

Safety profile ensuring

**Q3**

Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba?

**Yes,**

Ensuring Safety profile

**Q4**

CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment?

**Yes,**

For early access to underlying failure of the procedure.

**Q5**

Do you have any other comments regarding the above three amendments to the Accredited Facilities Bylaw?

No

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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes,**<br>Ketamine, even when used as directed, can have side effects. The appropriate Resuscitation supplies and staff trained to use it, need to be on site. |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes,**<br>Needs appropriate monitoring, as per the answer above. |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes,**<br>Needs to be appropriately monitored. As per the answer in question #1. |

| | |
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| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes** |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Unsure,**<br>I do not know enough about this. |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

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|---|---|
| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Unsure** |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Unsure** |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Unsure** |

| | |
|---|---|
| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes,**<br>the potential hazards of these treatments require that adequate and consistent safety back up specific to their use be immediately available |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes,**<br>the use of this medication required highly specific training |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes,**<br>critical incidents must be reviewed by all agencies involved |

| | |
|---|---|
| **Q1**<br>Are you: | **CPSM Registrant?** |
| **Q2**<br>Do you support adding the intravenous administration of ketamine to the list of procedures permitted only in CPSM-accredited, non-hospital medical or surgical facilities or in hospitals? | **Yes,**<br>As pointed out, ketamine and MDMA require appropriate supervision by trained/experience HCPs. These are dangerous meds in the wrong hands, and need regulation to ensure safe administration. |
| **Q3**<br>Do you support adding MDMA (3,4-methylenedioxymethamphetamine) administration to be performed only within non-Hospital Medical Surgical Facilities in Manitoba? | **Yes,**<br>See above. I feel that treatment with any psychedelic medicine (MDMA, ketamine, psilocybin, DMT, LSD) should be regulated and precautions be put in place. At present, these are being given by non-medical practitioners without any certification in Manitoba |
| **Q4**<br>CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.The proposed amendment requires CPSM registrants providing these services to also notify the CPSM Assistant Registrar of Quality, within one working day of becoming aware of any major adverse patient outcome resulting from the anaesthesiology services provided in the dental surgery clinic.Do you support this amendment? | **Yes** |

**Q5**

Do you have any other comments regarding the above three amendments to the Accredited Facilities Bylaw?

I have received training from TherPsil regarding use of psilocybin, but have not been able to administer this to patients in a accredited facility. We also have no regulations (presently) at the College level that help with direction for these emerging treatments, and as such, are not remunerated within the Manitoba Health framework. Regulation should reduce the risk to the patient as well as help support proper training for us as physicians. I also see this as limiting use by non-medical practitioners without proper supervision. If a committee were to be established regarding the regulation of psychedelic medications, I would be interested in participating.

1000 – 1661 Portage Avenue
Winnipeg, Manitoba R3J 3T7
TEL: (204) 774-4344
FAX: (204) 774-0750
Website: www.cpsm.mb.ca

# Accredited Facilities Bylaw

**(Under Section 183 of *The Regulated Health Professions Act*)**

## The College of Physicians and Surgeons of Manitoba

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba on November 22, 2018 repealing and replacing Bylaw #3 and 3D under The Medical Act)

Effective Date January 1, 2019
**With revisions up to and including June 9, 2021**

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## Preamble

**Prior to making this Bylaw, the Minister must be provided with a copy of the proposed Bylaw for review and Council must review and consider any comments made, pursuant to s. 183 of the RHPA.**

# PART A – DIAGNOSTIC FACILITIES

## Article 1 – Definitions

1.1. In Part A of Bylaw:

1.1.1. "**accreditation**" means a review process conducted by CPSM to determine whether the facility being reviewed meets the standards specified by CPSM.

1.1.2. **"anatomic pathology laboratory"** means a place where human surgical tissue biopsies and specimens, cytological specimens and autopsies are examined for diagnostic purposes.

1.1.3. **"certificate of accreditation"** means a certificate issued under this Part of the Bylaw.

1.1.4. **"clinical pathology laboratory"** means a place where diagnostic testing is performed on human samples including the disciplines of chemistry, hematology, transfusion medicine, cytology, immunology, microbiology, virology, histology or pathology.

1.1.5. **"Committee"** means the Program Review Committee of CPSM.

1.1.6. **"diagnostic imaging facility"** means a place where imaging techniques are used for diagnostic purposes including radiography, ultrasound, computed tomography, magnetic resonance imaging, fluoroscopy, mammography or nuclear medicine.

1.1.7. **"facility"** means a place or a vehicle, whether privately owned or affiliated with or administered by a hospital or other health facility, which is principally equipped to perform a procedure normally performed in an anatomic pathology laboratory, a clinical pathology laboratory, a diagnostic imaging facility, or a patient service centre. A clinical pathology laboratory facility may be comprised of a primary location, which is its laboratory, and one or more patient service centres.

1.1.8. **"Facility Director"** means a physician appointed as director of a facility in accordance with this Part of the Bylaw and whose credentials are acceptable to the Committee and is synonymous with the term "medical director" used in section 183(3) of the RHPA.

1.1.9. **"patient service centre"** means a location for the collection and/or testing of specimens of blood and of body fluids for the purpose of testing in an accredited laboratory.

1.1.10. **"physician office laboratory"** means a physician's office where specimens are collected and tested by the physician or a laboratory technician/assistant qualified by training from an accredited medical laboratory technician/assistant training program and is certified or eligible for certification with the Canadian Society of Medical Laboratory Science for the diagnosis of the physician's own patients.

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

1.1.12. **"vehicle"** means a device in, upon or by which diagnostic equipment is transported upon a roadway and which is:

1.1.12.i. used primarily for the purpose of offering diagnostic services; and

1.1.12.ii. has the approval of the Government of Manitoba to offer diagnostic services in Manitoba but does not include an emergency vehicle as defined in *The Highway Traffic Act*.

1.2. In this Bylaw, words and phrases defined in *The RHPA* have the same meaning as in the *RHPA*.

## Article 2 – Application of this Part

Part A of this Bylaw applies as follows:

2.1. Pursuant to *The Regulated Health Professions Act (RHPA),* ss 183(1)[1], to all diagnostic facilities in Manitoba which are principally equipped to perform a procedure normally performed in an anatomic pathology laboratory, clinical pathology laboratory, diagnostic imaging facility, and patient service centre, in which services are performed by registrants of CPSM, other than those under the jurisdiction of the provincial or municipal governments and those designated as hospitals under *The Health Services Insurance Act,* and a facility or class of facilities exempted by Regulation from the application of s.183(1) of the *RHPA*.

[1] 183(1) This section applies to any facility in which a member performs or causes to be performed diagnostic or treatment services, such as a non-hospital medical or surgical facility or a nuclear medicine facility, other than
(a) a facility that is designated as a hospital under *The Health Services Insurance Act*;
(b) a hospital or health care facility operated by the government, the government of Canada or a municipal government; and
(c) a facility or class of facility exempted by regulation from the application of this section.

2.2. Pursuant to *s.183(15)*[2] *of the RHPA* and pursuant to the Service Purchase Agreement made between the College of Physicians and Surgeons of Manitoba and the Government of Manitoba governing diagnostic facilities, to those diagnostic facilities falling within the jurisdiction of the Government of Manitoba as specified in the Service Purchase Agreement.

2.3. Pursuant to s.12.3(1) (d) of the *CPSM General Regulation* this does not apply to a facility operated by the Canadian Blood Services, CancerCare Manitoba, St. Amant Inc., or Mount Carmel Clinic unless it is part of the Service Purchase Agreement referred to above.

## Article 3 – Facility Accreditation

3.1. A facility is required to obtain accreditation before it offers any services to the public.

3.2. Accreditation of a facility must be:
- 3.2.1. except in the case of a vehicle, for a specific address or addresses.
- 3.2.2. for the fixed period of time determined by the Committee, to a maximum of 5 years.
- 3.2.3. for the procedures specified with the certificate of accreditation.

3.3. In the case of a vehicle, the facility must provide a current mailing address for the owner and the operator of the service.

3.4. Prerequisites to full accreditation of a facility pursuant to this By-law are:
- 3.4.1. compliance with the relevant standards; and
- 3.4.2. appointment of a Facility Director acceptable to the Committee.

3.5. The Committee must establish and make available on request:
- 3.5.1. Operational/technical standards for each type of facility.
- 3.5.2. the accreditation process for each type of facility.
- 3.5.3. the Committee's policies governing the accreditation process for each type of facility.

3.6. Applications for accreditation of a facility must be made to the Committee by the Facility Director, on the forms prescribed by the Committee, and must contain the information required by the Committee.

[2] 183(15) The council may enter into agreements with the government, the government of Canada or a municipal government to make this section applicable to any facility or any part of a facility that falls within that government's jurisdiction.

**Accreditation Process**

3.7. The accreditation process will include:
- 3.7.1 completion of a pre-inspection questionnaire by the Facility Director;
- 3.7.2 an inspection by one or more persons, with knowledge in the facility's work, designated by the Committee;
- 3.7.3 review of the facility's compliance with standards;

3.8. On completion of the accreditation process, the Committee may:
- 3.8.1 grant full accreditation and issue a certificate of accreditation to a facility if the Committee is satisfied that the facility has met all the requirements of Part A of this Bylaw and there are no identified deficiencies;
- 3.8.2 grant conditional accreditation to a facility with identified deficiencies and specifying the date it will expire if the identified deficiencies are not corrected;
- 3.8.3 deny accreditation pending correction of identified deficiencies in accordance with s. 183(7) of the RHPA; or
- 3.8.4 withdraw any existing accreditation.

3.9. Where an inspection is conducted as part of the accreditation process, and deficiencies are observed, the Committee must issue a report of the inspection and must provide a copy of the report to the applicant.

**Full Accreditation**

3.10. Where a facility fully complies with the relevant standards, the Committee will grant full accreditation and will specify with the certificate of accreditation the procedures for which the facility is accredited.

**Accreditation Not Granted**

3.11. Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to the Executive Committee.

**Conditional Accreditation**

3.12. Where a facility does not fully comply with the relevant standards, but the Committee is of the opinion that it is in the public interest to permit the facility to operate while it corrects specified deficiencies, the Committee may grant conditional accreditation.

3.13. Where conditional accreditation is granted, the Committee must:
- 3.13.1. provide written notice of its decision and the reasons therefor and the information on the right of appeal to the Executive Committee.

3.13.2. state in its decision a fixed deadline for the facility to comply with all relevant standards and for the Facility Director to provide written confirmation of compliance to the Committee.
3.13.3. state in its decision whether a follow-up inspection must occur before full accreditation may be granted.

3.14. The Committee may extend the deadline for compliance with standards if, in its sole discretion, the Committee deems it appropriate to do so.

3.15. Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:
3.15.1. Extend conditional accreditation
3.15.2. direct an inspection.
3.15.3. withdraw the conditional accreditation and if the facility is publicly owned, report the matter to government with the request that the government require the facility to cease operation.

3.16. If the Committee is of the opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit registrants from using the facility.

**Accreditation Status Review**

3.17. Accreditation status may be reviewed at the discretion of the Committee.

**Temporary Accreditation**

3.18. Temporary accreditation may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.

**Role of Facility Director During Accreditation**

3.19. Facility Director and personnel who are subject to the accreditation process must cooperate fully, which includes but is not limited to:
3.19.1. permitting inspectors to enter the facility and inspect the premises and all diagnostic equipment located therein.
3.19.2. permitting inspectors to inspect all records pertaining to the provision of services and providing copies of the same if so requested.
3.19.3. providing requested samples or copies of any material, specimen, radiological image or product originating from the diagnostic service.
3.19.4. answering questions posed by the inspectors as to the procedures or standards of performance relating to examinations/procedures performed.

## Article 4 – Maintenance of Accreditation

4.1. In order to maintain accreditation, a facility must:
- 4.1.1. comply with the relevant standards.
- 4.1.2. perform only the procedures permitted pursuant to the facility's certificate of accreditation.
- 4.1.3. at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect.
- 4.1.4. cooperate with and participate in the inspection process approved by the Committee for its type of facility.

4.2. During the currency of a full or conditional accreditation the Committee may direct an inspection for the purpose of monitoring compliance, if the Committee is of the opinion that:
- 4.2.1. a facility may not meet the relevant standards and
- 4.2.2. an inspection would be in the public's best interest.

## Article 5 – Renewal of Accreditation

5.1. In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation.

## Article 6 – Variance or Withdrawal of Accreditation

6.1 A facility may apply at any time to vary its accreditation.

6.2 If the Committee is of the opinion that the facility may be unsafe, the Committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the Committee deems appropriate in the circumstances, including withdrawing accreditation and if the facility is publicly owned, report the matter to government with the recommendation that the government require the facility to cease operation. If the Committee is of the opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit registrants from using the facility.

6.3 Where a facility is no longer providing patient services, the Committee may withdraw the facility's accreditation

6.4 Council may withdraw accreditation in accordance with the RHPA

## Article 7 – Facility Director

7.1. A facility must have a Facility Director.

7.2. A Facility Director must be a physician whose credentials are acceptable to the Committee.

7.3. The Committee must establish and make available on request the qualifications for Facility Directors in each type of facility.

7.4. The Facility Director is responsible for granting privileges to any physician who wishes to work for the facility and notifying the Committee of the physicians who are granted privileges. Before granting privileges to any physician a Facility Director must:

7.4.1. define in writing the qualifications and competencies required in order to obtain privileges in each field of practice.

7.4.2. obtain written confirmation that the applicant is registered and licensed to practice medicine in Manitoba.

7.4.3. obtain full particulars of the applicant's education, training, competencies and experience.

7.4.4. take reasonable steps to ensure that the applicant has the education, training competencies and experience required, and that the applicant is otherwise a suitable candidate for privileges.

7.5. Within one year of first granting privileges to a physician, the Facility Director must review that physician's privileges. Thereafter, privileges must be reviewed by the Facility Director at least every two years.

7.6. Before granting renewal of privileges or extending the existing privileges of any physician, the Facility Director must take reasonable steps to ensure that the physician has the education, training, competencies and experience required for each field of practice for which he or she is seeking privileges within the facility.

7.7. The Facility Director must have effective control of and be responsible for the safe operation and administration of the facility, the supervision of all professional, technical and administrative activities of the facility, and for compliance with this Bylaw and with the relevant standards established by the Committee.

7.8. Without limiting the generality of the foregoing, the Facility Director must:

7.8.1. have access to all records and documents relating to the operation of the facility and the procedures performed therein.

7.8.2. communicate with any facility under his/her direction a minimum of once per year.

7.8.3. ensure that quality management system requirements and improvement programs are in place.

7.8.4. ensure that the facility has current up to date policies and manuals as required by the standards for that facility.

7.8.5. ensure that complete and accurate patient records and documentation relating to the operation of the facility and procedures performed are kept.

7.8.6. ensure that no procedure is carried out in the facility unless it is permitted by the certificate of accreditation.

7.8.7. ensure that technologists have the qualifications as provided by training from an accredited:

7.8.7.i. medical laboratory training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.

7.8.7.ii. medical radiology technology training program and are certified or eligible for certification with the Canadian Association of Medical Radiology Technologists.

7.8.8. ensure that medical laboratory technologists who are required to perform x-ray examinations and medical radiology technologists who are required to perform laboratory testing have graduated from a cross-training program.

7.8.9. ensure that laboratory technicians/assistants have the qualifications as provided by training from an accredited medical laboratory technician/assistant training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.

7.8.10. ensure that persons who provide services to the facility maintain competence to perform the procedures for which the facility is accredited.

7.8.11. ensure that work referred out of the facility is performed by persons with appropriate qualifications and competence to perform the work.

7.8.12. promptly notify CPSM of any change in the ownership or directorship of the facility.

7.8.13. promptly notify CPSM if the facility is no longer providing patient services.

7.8.14. where applicable, be available for consultation with referring physicians.

7.8.15. promptly notify the Committee if there is a major change in the following:

7.8.15.i. equipment.

7.8.15.ii. the accredited list of diagnostic imaging examinations, laboratory or transfusion medicine tests, or blood and blood products dispensed.

7.8.16. ensure that the duties and responsibilities of all personnel are written and understood;

7.8.17. ensure adequate quality assurance and improvement programs are in place

7.9. The Facility Director must submit to CPSM such information as required by the Committee.

## Article 8 – Appeal

8.1. The facility or a registrant may appeal any decision of the Committee to the Executive Committee pursuant to sections 183 and 38 of the RHPA by filing a written notice of appeal with the Registrar within thirty calendar days of being informed of the decision. The notice of appeal must specify the reasons for the appeal.

## Article 9 – Fees

9.1. A privately-owned facility shall pay all expenses, charges and fees incurred by CPSM in respect of the accreditation or inspection of the facility and the administration of Part A of this Bylaw.

## Article 10 – Physician Office Laboratory

10.1. Physicians must not operate a physician office laboratory without first obtaining the written approval of CPSM.

10.2. The Committee may direct the inspection of any facility where physician office laboratory procedures are performed.

## Article 11 – Transition

11.1. A facility that holds accreditation at the time this Bylaw comes into force continues to hold that accreditation status under this Bylaw in accordance with the terms of that accreditation.

11.2. A facility which has not undergone the accreditation process will be notified in writing by CPSM that it is exempt from the requirement of accreditation set forth in this Bylaw until the inspection process for that facility is complete and a report is issued, but the facility must cooperate with CPSM for the timely completion of its accreditation process in accordance with this Bylaw.

11.3. A physician who holds a Facility Directorship at the time this Bylaw comes into force continues to hold that status under this Bylaw.

# PART B – NON-HOSPITAL MEDICAL OR SURGICAL FACILITIES

## Article 12 – Definitions

12.1. In Part B of this Bylaw:

**“accreditation”** means a review process conducted by CPSM to determine whether the facility being reviewed meets the requirements specified by CPSM.

**"certificate of accreditation"** means a certificate issued under this Part of the Bylaw.

**"Committee"** means the Program Review Committee of CPSM.

**“direct or indirect financial interest”** means any interest owned by a registrant, by individuals connected by blood relationship, marriage or adoption to a registrant, by any corporation, proprietorship, partnership, society, business, association, joint venture, group or syndicate in which a registrant or any individual connected by blood relationship, marriage or adoption to a registrant have any interest.

**"facility"** means a non-hospital medical or surgical facility for the purposes of Part B of this Bylaw.

**“general anaesthesia”** means a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently, or to respond purposefully to physical stimulation or verbal command, produced by pharmacologic or non-pharmacologic methods, alone or in combination.

**“hospital”** means a hospital under *The Hospitals Act* or the *Regional Health Authorities (Health System Governance and Accountability) Act* when proclaimed with an operational Emergency or Urgent Care Department.

**"medical director"** means a physician appointed as director of a facility in accordance with this Part of the Bylaw and whose credentials are acceptable to the Committee and is synonymous with the term “medical director” used in section 183(3) of the RHPA.

“**oral sedation**” means an altered state or depressed state of awareness or perception of pain brought about by pharmacologic agents and with is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained. This is specific to the use of oral medication alone. An example may include oral dosing of opioids and/or benzodiazepines that produce the above states.

**"privileges"** means the authority to admit and treat patients at a facility.

**“procedural sedation”** means an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees

of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained, and

i. includes, but is not limited to, the use of any IV or intra-muscular agent for this purpose; and
ii. requires the monitoring of vital signs,

but does not include the use of oral pre-medication alone or in combination with local anaesthesia. No distinction is made between light and deep procedural sedation for credentialing or monitoring purposes.

**"procedure"** means the diagnostic and treatment procedures, both medical and surgical, as approved by the Committee to be carried out in a facility.

## Article 13 – Application of this Part – Procedures Requiring Accreditation

13.1. Part B of this Bylaw applies to all non-hospital medical or surgical facilities, subject to section 183 of the RHPA, and not included in Part A of this Bylaw. All non-hospital medical or surgical facilities in which procedures that have a sufficient risk of potential harm to a patient must apply for, obtain, and maintain accreditation from CPSM prior to providing any such diagnostic or treatment services or procedures.

13.2. The criteria for assessing sufficient risk of potential harm to a patient include:
- 13.2.1. Level of anaesthesia and/or sedation
- 13.2.2. Need for medical device reprocessing (infection risk)
- 13.2.3. Complexity of procedure and risk of complications

13.3. The following procedures have a sufficient risk of potential harm to the patient to require accreditation:
- 13.3.1. Any procedure that is carried out or should be carried out in accordance with generally accepted standards of care with the concurrent use of procedural or oral sedation including for patient comfort (pain and/or anxiety); See definitions of procedural and oral sedation in Article 12.
- 13.3.2. Any procedure that requires general anaesthesia, See definition of general anaesthesia; or
- 13.3.3. Procedures involving:
  - 13.3.3.i. deep, major, and complicated procedures that may require more resources than are commonly available in a medical office. Surgeons should make decisions as to the appropriate location for these surgical procedures in accordance with the resources necessary for unexpected complications and with generally accepted standards of care. These procedures may include:
    - 13.3.3.i.a. resection of a deep, major or complicated lesion;
    - 13.3.3.i.b. surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal

organs, and other life-threatening complications or requiring sterile precautions to prevent blood borne deep closed cavity or implant-related infections;

13.3.3.ii. flexible endoscopic evaluation of the gastrointestinal or genitourinary tract;

13.3.3.iii. assisted reproduction technology, uterine evacuation procedures, and hysteroscopy;

13.3.3.iv. the following Ophthalmological Procedures:

13.3.3.iv.a. cataract surgical procedures

13.3.3.iv.b. corneal laser procedures

13.3.3.iv.c. retinal procedures limited to scleral buckling and vitrectomies

13.3.3.iv.d. Lasik therapeutic procedures

13.3.3.v. the use of drugs by injection which are intended or may induce a major nerve block or spinal, epidural or intravenous regional block;

13.3.3.vi. ~~any tumescent~~ liposuction procedure~~s involving the administration of dilute local anaesthesia~~;

13.3.3.vii. hair transplantation;

13.3.3.viii. venous sclerotherapy;

13.3.3.ix. hyperbaric oxygen therapy;

13.3.3.x. hemodialysis;

13.3.3.xi. intravenous Ketamine administration;

~~13.3.3.x.~~13.3.3.xii. MDMA (3,4-methylenedioxymethamphetamine); or

~~13.3.3.xi. any procedure that the Committee directs, which must be performed in an approved, non-hospital medical or surgical facility, in order to meet the minimum acceptable standard of care for that procedure. (see list at end of bylaw)~~

13.4. CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.

~~13.3.4.~~13.4.1. In addition to complying with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association, CPSM registrants providing these services must notify the Assistant Registrar within one working day of becoming aware of any major adverse patient outcome resulting from the anesthesiology services provided in the dental surgery clinic.

~~13.4.~~13.5. This Part of the Bylaw does not apply to any hospital or health care facility operated by a health authority or the Governments of Canada, Manitoba, or any municipality.

## Article 14 – Registrants Must not Work in Non-Accredited Facilities

14.1. A registrant must not perform or cause to be performed any procedure in a facility that requires accreditation under this Part, but is not accredited, in accordance with s. 183(14) of the RHPA and in accordance with the transition provisions in Article 29.

14.2. A facility is required to obtain accreditation before it offers any services to the public.

## Article 15 – Facility Accreditation

15.1 The medical director of a facility seeking accreditation must apply on the form prescribed by the Committee, specifying the procedures for which accreditation is sought.

15.2 The medical director must agree to pay the fee charged for the inspection and accreditation process even if the accreditation is not completed or granted.

**Accreditation Process**

15.3 The accreditation process will include:
- 15.3.1 completion of a pre-inspection questionnaire by the medical director;
- 15.3.2 an inspection by one or more registrants, with expertise in the appropriate area of medical practice, designated by the Committee;
- 15.3.3 review of the facility's compliance with requirements including CPSM and medical or other standards; and
- 15.3.4 CPSM providing the Minister with a copy of each application and report as required by section 183(17) of the RHPA.

15.4 On completion of the accreditation process, the Committee may:
- 15.4.1 grant full accreditation and issue a certificate of accreditation to a facility if the Committee is satisfied that the facility has met all of the requirements of Part B of this Bylaw and there are no identified deficiencies;
- 15.4.2 grant conditional accreditation to a facility with identified deficiencies and specifying the date it will expire if the identified deficiencies are not corrected;
- 15.4.3 not grant accreditation pending correction of identified deficiencies in accordance with s. 183(7) of the RHPA; or
- 15.4.4 withdraw any existing accreditation.

15.5 Where an inspection is conducted as part of the accreditation process, and deficiencies are observed, the Committee must issue a report of the inspection and must provide a copy of the report to the applicant.

**Full Accreditation**

15.6 Where a facility fully complies with the relevant requirements, the Committee will grant full accreditation and will specify with the certificate of accreditation the procedures for which the facility is accredited.

**Accreditation Not Granted**

15.7 Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to the Executive Committee.

**Conditional Accreditation**

15.8 In circumstances where a facility does not comply fully with all requirements for accreditation, and if the Committee deems it adequate for patient safety, conditional approval may be granted for the operation of a facility pending the completion of the accreditation process or while it corrects specified deficiencies.

15.9 Where conditional accreditation is granted, the Committee must:

15.9.1 provide written notice of its decision and the reasons therefor and the information on the right of appeal to the Executive Committee.

15.9.2 state in its decision a fixed deadline for the facility to comply with all relevant standards and for the medical director to provide written confirmation of compliance to the Committee.

15.9.3 state in its decision whether a follow-up inspection must occur before full accreditation may be granted.

15.10 Where conditional accreditation is granted, the medical director must provide a written response to each deficiency within the time specified by the Committee, and a follow-up inspection may occur, if the Committee so directs. Full accreditation will only be granted when identified deficiencies have been corrected to the satisfaction of the Committee.

15.11 The Committee may extend the deadline for compliance with requirements if, in its sole discretion, the Committee deems it appropriate to do so.

15.12 Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:

15.12.1 extend conditional accreditation;

15.12.2 direct an inspection;

15.12.3 withdraw the conditional accreditations.

**Temporary Accreditation**

15.13 Temporary accreditation may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.

**Term of Accreditation and Renewal**

15.14 Accreditation of a facility must be for the fixed period of time determined by the Committee, to a maximum of five years.

15.15 In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation. The re-accreditation process will follow the same procedure as required for accreditation. Where an application to renew is pending, the Committee may continue the facility's accreditation until a decision is made on the renewal application.

## Article 16 – Maintenance of Accreditation

16.1 In order to maintain accreditation, a facility must:

16.1.1 comply with the relevant requirements;

16.1.2 perform only the procedures permitted pursuant to the facility's certificate of accreditation;

16.1.3 at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect; and

16.1.4 cooperate with and participate in the inspection process approved by the Committee for its type of facility.

16.2 During the currency of a full or conditional accreditation the Committee may direct an inspection for the purpose of monitoring compliance, if the Committee is of the opinion that:

16.2.1 a facility may not meet the requirements, standards of practice, or other standards for public safety and.

16.2.2 an inspection would be in the public's best interest.

## Article 17 – Renewal of Accreditation

17.1 In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation.

## Article 18 – Variance or Withdrawal of Accreditation

18.1. A facility may apply at any time to vary its accreditation.

18.2. If the Committee is of the opinion that the facility may be unsafe, the Committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the Committee deems appropriate in the circumstances, including withdrawing accreditation and ordering it to cease operation. If the Committee is of the

opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit registrants from using the facility.

18.3. Where a facility is no longer providing patient services, the Committee may withdraw the facility's accreditation.

18.4. Council may withdraw accreditation in accordance with the RHPA.

## Article 19 – Approved Procedures

19.1. Each certificate of accreditation must include a schedule listing the procedures which have been approved for the facility, and the names of the registrants who have been given privileges to perform the procedures at the facility.

19.2. The schedule of procedures may be amended from time to time upon the application of the facility and the approval of the Committee.

19.3. Only those procedures which are approved by the Committee and set out in the schedule to the facility's certificate of accreditation may be performed in the facility.

19.4. Where a facility is no longer being used for the procedures set out in Article 13, the Medical Director must inform the Assistant Registrar. The Committee may withdraw the facility's certificate of accreditation.

## Article 20 – Health Authority Agreement

20.1. Every facility must have a written agreement with a health authority pursuant to which the health authority agrees to provide emergency treatment if a patient has to be transferred from the facility.

## Article 21 – Privileges

21.1. A registrant must have privileges at an accredited facility prior to performing any of the services and procedures listed in Part B;

21.2. The Medical Director must only grant and renew privileges for a registrant to perform procedures in an accredited facility if the Medical Director is satisfied that:

21.2.1. the applicant is a suitable and competent candidate

21.2.2. the treatment services and procedures are within the privileges requested and within the knowledge, skill, and judgment of the applicant and

21.2.3. those privileges are the same as granted by Shared Health or a Regional Health Authority or are recommended through the Shared Health credentialing process and those privileges are and remain in good standing.

21.3. Where the registrant does not have Shared Health or Regional Health Authority privileges the Medical Director must only provide privileges for a specific facility if the Committee has already granted privileges under the following process:
  21.3.1. utilize the established Shared Health credentialing process to assess applicants using established specialty groups;
  21.3.2. implement a non-refundable assessment fee paid to Shared Health or the Regional Health Authority payable by the registrant seeking credentials for the credentialing process;
  21.3.3. seek and obtain an assessment from Shared Health regarding the granting of privileges; and then
  21.3.4. the Committee shall decide whether to grant privileges.

21.4. Within 15 calendar days of granting or renewing privileges the Medical Director must provide the Assistant Registrar with the particulars of the privileges granted in the facility.

21.5. Any registrant who performs services and procedures without obtaining privileges in the facility and any Medical Director who permits a registrant to perform services and procedures without privileges in the facility may be found guilty of professional misconduct.

## Article 22 – Standard of Care

22.1. An accredited facility and those registrants performing procedures must meet appropriate standards for the quality and safety of those treatments and procedures performed in that facility. To receive and maintain accredited status, a facility must:
  22.1.1. demonstrate compliance with appropriate standards for quality and safety of treatments and procedures performed;
  22.1.2. provide patient care in a manner consistent with good medical care as defined in the CPSM Standards of Practice Regulation and elaborated on in the Standards of Practice, Practice Directions, and Code of Ethics and Professionalism; and
  22.1.3. engage in ongoing processes of self-review and quality improvement.

## Article 23 – Patient Care

23.1. Anaesthetic Care

23.1.1. All patients proposed to undergo anaesthesia in a facility must be assigned an American Society of Anaesthesia risk score and only patients with ASA I, II and III Risk scores may have a procedure performed unless otherwise indicated in the accreditation approval.

23.1.2. General anaesthesia must not be given to infants under the age of twenty-four months.

23.1.3. A patient who receives general anaesthesia or procedural sedation should only leave the facility in the care of an adult.

23.1.4. Procedural sedation must be administered by or under the direct supervision of a registrant with appropriate training acceptable to CPSM to provide procedural sedation.

23.1.5. A patient who receives procedural sedation must be attended by a registered nurse or a registrant who is not assisting in the surgical procedure and who is trained to monitor patients under procedural sedation.

23.1.6. There must be at least two personnel who are certified in basic cardiopulmonary resuscitation within the facility while patients are receiving care.

23.1.7. All equipment for the administration of anaesthetics must be readily available, clean and properly maintained.

23.2. A registrant who has been granted privileges must:

23.2.1. be in the room at all material times during the performance of a procedure in the facility.

23.2.2. ensure that following any procedure, patients receive an adequate recovery period under supervision before leaving the facility.

23.2.3. be responsible for the post-operative care of the patient within the facility.

23.2.4. ensure qualified support staff are on duty during and after a procedure in the facility.

23.2.5. maintain accurate information concerning the medical condition of patients in a clinical record which meets the expected standards of medical record-keeping, including documentation related to the informed consent of the patient for the procedure(s) performed in a facility.

23.2.6. perform procedures in a facility only if the facility is adequately equipped and has maintained operating and post-operative rooms and all equipment is safe, well maintained and compliant with applicable federal, provincial, and municipal legislation.

23.3. A registrant shall not perform a procedure in an accredited facility unless the procedure is one that should safely allow the discharge of a patient from medical care in the facility within 23 hours of the day cycle (no overnight).

## Article 24 – Infection Control

24.1 A facility must:
- 24.1.1 use sterilization techniques,
- 24.1.2 store medical and dental supplies, and
- 24.1.3 use waste handling and disposal procedures

consistent with the standards applicable to hospitals.

24.2 A facility must comply with all guidelines CPSM may require the facility to comply with to meet best practices on infection control practices in a facility setting, including the Ontario Public Health Infection Prevention and Control for Clinical Office Practice.

## Article 25 – Medical Director

25.1 The facility shall appoint a medical director, who is a registrant acceptable to the Committee, and who must:
- 25.1.1 enforce the standards of care in the facility, which include the safe and effective care of patients in the facility;
- 25.1.2 be responsible for the administration of the facility; and
- 25.1.3 provide required reporting to CPSM.

25.2 In enforcing the standards of care in the facility which includes the safe and effective care of patients, the medical director must ensure that:
- 25.2.1 procedures and equipment are appropriate and safe;
- 25.2.2 procedures are performed in accordance with current good medical care and practice;
- 25.2.3 sufficient numbers of appropriately trained personnel are present during procedures;
- 25.2.4 procedures approved by the Committee as set out in the certificate of accreditation are only performed at the facility by registrants with privileges;
- 25.2.5 persons who provide services to the facility have appropriate qualifications and maintain competence to perform the procedures for which the facility is accredited;
- 25.2.6 registrants with privileges have current basic life support skills and other skills appropriate to the clinical settings (such as advanced cardiac support, pediatric advanced life support, and airway management skills);
- 25.2.7 all direct patient care personnel have life support skills and there must be two such qualified personnel present at any time patients are receiving care;
- 25.2.8 adequate quality assurance and improvement programs, including the monitoring of infection and medical complication rates, are in place.

25.3 In being responsible for the administration of the facility, the medical director must:

25.3.1 have access to all records and documents relating to the operation of the facility and the procedures performed therein;

25.3.2 develop appropriate and up-to-date policy and procedure manuals, including acceptable staff health policies;

25.3.3 ensure the duties and responsibilities of all personnel are written and understood;

25.3.4 ensure complete and accurate confidential patient records and documentation relating to the operation of the facility and procedures performed are kept current and up to date;

25.3.5 ensure the requirements for granting privileges are met with necessary approvals and complete records kept of all registrants who obtain privileges at the facility, including their applications;

25.3.6 ensure documentation, fees and a complete reporting of all required information to CPSM is submitted when and as required;

25.3.7 meet annually with each registrant who has privileges to review those privileges and document the review; and

25.3.8 attend at the facility at least one day per month or more if prescribed by the Committee to inspect the facility, and meet with other staff to review operations, the facility, standards, and quality assurance;

25.4 In providing required reporting to CPSM, the medical director must:

25.4.1 Ensure that the Assistant Registrar is notified within one working day of becoming aware of any of the following circumstances and provide a report within two weeks of any of the following:

25.4.1.i death that occurs within 10 days of the procedure;

25.4.1.ii transfers from the facility to a hospital regardless of whether or not the patient was admitted;

25.4.1.iii unexpected admission to hospital within 10 days of a procedure performed;

25.4.1.iv clusters of infections among patients treated in the facility; or

25.4.1.v procedure performed on wrong patient, side, or site or wrong procedure; or

25.4.1.vi any other major adverse patient outcome.

25.4.2 notify the Assistant Registrar of any change in ownership of the facility within one month;

25.4.3 promptly notify the Assistant Registrar if the facility is no longer providing patient services within one month;

25.4.4 promptly notify the Assistant Registrar if there is a major change in equipment or renovations to the facility or the accredited list of procedures within ten days; and

25.4.5 advise the Assistant Registrar of resignation, revocation, suspension, or restriction of privileges of staff immediately.

## Article 26 – Audit and Quality Control

26.1 All certificates of accreditation are subject to the following conditions:

26.1.1 all procedures and all clinical records must comply with the requirements of standards of care set by CPSM.

26.1.2 quality assurance and improvement programs are in place sufficient to demonstrate that standards of care set by CPSM and required for good medical care are met in the facility.

## Article 27 – Annual Report

27.1. The medical director must review the facility's quality assurance and improvement programs at least annually.

27.2. Within 30 days of each calendar year end, the medical director must forward an annual report in the prescribed form to the Assistant Registrar outlining:

27.2.1 the exact number and types of procedures performed in the facility;

27.2.2 the exact number and type of adverse outcomes and events, including infections and complications, arising from procedures done in the facility;

27.2.3 exact number of events such as needlestick, incomplete sterilization, breaks in technique, medication errors, each of which must be investigated and documented;

27.2.4 assurance that quality assurance and quality improvement program initiatives in the facility sufficient to demonstrate the standards of care set by CPSM and required for good medical care;

27.2.5 the number of transfers to hospital from the facility

27.2.6 list of registrants with privileges and health care staff

27.2.7 List of registrants whose privileges were not renewed, or suspended, or revoked with details;

27.3. Included with the annual report, the medical director must review, sign, and return to the Assistant Registrar an annual declaration in a form prescribed by the Committee confirming that they are aware of their responsibilities as set out in law, this Bylaw, Standards of Practice, and Practice Directions.

## Article 28 – Inspections and Audits

28.1. At any time and without notice, a facility is subject to inspection and audits by registrants or other persons with expertise (the latter designated by the Assistant Registrar) to conduct inspections and audits, including, but not limited to if there is:

28.1.1. a change in or addition to procedures offered at the facility;

28.1.2. renovations in the facility;

28.1.3. an adverse patient outcome;

28.1.4. a possible failure to comply with this Bylaw or the approval accreditation;
28.1.5. a possible failure to meet appropriate standards;
28.1.6. a possible risk to patient care and safety.

28.2. The facility will be required to pay the costs of any such inspection/audit and any required follow-up expenses.

28.3. If access to the facility for any inspection is refused, the Committee may take such action it deems necessary including, suspending, revoking or amending the facility's certificate of accreditation.

28.4. The Committee may appoint an investigator with powers under s. 183(6) of the RHPA.

## Article 29 – Appeal

29.1 The facility or a registrant may appeal any decision of the Committee to the Executive Committee pursuant to sections 183 and 38 of the RHPA by filing a written notice of appeal with the Registrar within thirty calendar days of being informed of the decision. The notice of appeal must specify the reasons for the appeal.

## Article 30 – Administration Fees for Facilities

30.1 The facility shall pay all expenses, charges and fees incurred by CPSM in respect of the accreditation or inspection of the facility and the administration of Part B of this Bylaw.

## Article 31 – Transition

31.1 All accreditations and approvals of facilities, procedures, medical directors, conditions, and privileges granted at the time this Bylaw comes into force continues to be valid.

31.2 To permit the orderly accreditation of new facilities under Article 14 effective the date of the Annual General Meeting, June 9, 2021, registrants must not perform these procedures at a facility unless the facility:
31.2.1 has applied for accreditation by December 1, 2021,
31.2.2 has been granted at least conditional or full accreditation by December 1, 2022,
31.2.3 is actively working on obtaining full accreditation as determined by the Committee, and
31.2.4 is seeking to comply with all requirements of this Part of the Bylaw as if it were a fully accredited facility.

31.3 The Committee may determine whether the facility is compliant with the provisions in 31.2.3 and 31.2.4.

# COUNCIL MEETING
# SEPTEMBER 25, 2024
# BRIEFING NOTE

**SUBJECT:** TRC Advisory Circle Update

**BACKGROUND:**

At its September 29, 2022 Meeting, Council adopted the 7 recommendations of the TRC Advisory Circle:

1. Apology and Statement by CPSM on Indigenous-Specific Racism
2. CPSM Land Acknowledgement
3. Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism
4. Restorative Justice Approach to Complaints and Investigations/Create a Culture for Receiving and Addressing Complaints by Indigenous Patients
5. Mandatory Indigenous-Specific Anti-Racism Training
6. Mentorship/Leadership & Create Open Culture to Support Indigenous Physicians
7. Definition of Anti- Indigenous Racism and Gather Examples of Racism by Medical Professionals

The Apology and Statement by CPSM on Indigenous-Specific Racism has been posted on CPSM website since January 2023. In-person apologizes have been made to the Assembly of Manitoba Chiefs and the Manitoba Inuit Association. CPSM has been unsuccessful in its attempts to arrange an in-person apology with the Manitoba Metis Federation.

The CPSM Land Acknowledgement is posted on CPSM website and is stated prior to CPSM Council and Committee meetings.

The Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism will be presented to Council on September 25, 2024, for approval to be released for public consultation (see Agenda Item 7). The definition of Anti-Indigenous racism is included in the Standard of Practice. The Contextual Information & Resources document which will accompany the Standard when it is published will include examples of racism by medical professionals.

The University of Manitoba Rady Faculty of Health Sciences expects to go live on October 3, 2024, with a ten-module program on Indigenous Cultural Safety that was developed specifically for health care professionals in Manitoba. CPSM had envisioned that this program would be mandatory training for all registrants.

The University's plan is for 3,000 individuals across the health care system to take the training in the first year. This is envisioned as a "gentle launch" to allow for identification and fixing of issues during the initial rollout. The various partners (UofM, Shared Health, SDOs) who participated in the program development are currently prioritizing 2,700 individuals/roles who will take the training in the first year. For the partners, the University's ten-module program will replace the current Manitoba Indigenous Cultural Safety Training (MICST) with the goal to have more people trained within the same budgetary allotment.

The University's initial role-out plan has space for 300 individuals paying for spots to take the training. There is potential to expand the number of paid training spots in future years once logistical issues from the "gentle launch" are identified and corrected.

CPSM will have to coordinate with stakeholder organizations to determine reasonable expectations for all registrants receiving this training and determine whether alternative training may have to be identified.

Agenda Item number 8 – Restorative Practices Program will address TRC Advisory Circle Recommendations 4 and 6.

# COUNCIL MEETING
# SEPTEMBER 25, 2024
## NOTICE OF MOTION FOR APPROVAL

**SUBJECT:** **Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism**

**RECOMMENDATION:**

That Council approve for consultation the draft Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism.

**SUMMARY:**

A working group of the TRC Advisory Circle led by Dr. Lisa Monkman created a draft Standard of Practice – Practicing Medicine to Prevent Indigenous Racism (attached Appendix A) to guide and inform Registrants on how to practice medicine in a manner that prevents Anti-Indigenous racism and the harm that Indigenous patients experience from that racism.

The Standard establishes 3 steps to practicing medicine to prevent anti-Indigenous racism:

1. Understand and acknowledge that racism exists, and results in negative health impacts.

2. Understand and identify acts and omissions of anti-Indigenous racism in the health care system and the practice of medicine.

3. Take action to address acts and omissions of anti-Indigenous racism.

The 3 steps are based upon and leverage existing obligations set out in the Canadian Medical Association Code of Ethics and Professionalism.

This Standard is fundamentally different from other CPSM Standards of Practice in that it is focusing on self-awareness and personal behaviour as opposed to detailed discrete actions to be taken or avoided. The Standard is focused on education and self-awareness about learning Indigenous issues. The end goal of Registrants actively practicing medicine to prevent anti-Indigenous racism will not be achieved by the creation of a Standard of Practice. Practicing medicine to prevent anti-Indigenous racism will be achieved through a cultural shift in how the medical profession approaches anti-Indigenous racism.

The cultural shift can be achieved through the operationalization of the 7 recommendations of the TRC Advisory Circle which is discussed in greater detail in Agenda Items number 6 and number 8.

**BACKGROUND:**

At its September 29, 2022 Meeting, Council adopted the 7 recommendations of the TRC Advisory Circle:

1. Apology and Statement by CPSM on Indigenous-Specific Racism
2. CPSM Land Acknowledgement
3. Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism
4. Restorative Justice Approach to Complaints and Investigations/Create a Culture for Receiving and Addressing Complaints by Indigenous Patients
5. Mandatory Indigenous-Specific Anti-Racism Training
6. Mentorship/Leadership & Create Open Culture to Support Indigenous Physicians
7. Definition of Anti- Indigenous Racism and Gather Examples of Racism by Medical Professionals

The Working Group had preliminary consultations with Indigenous individuals and organizations representing Indigenous People. The discussions were based upon 4 questions:

i. What do we need to consider in creating this Standard of Practice?
ii. What kind of actions are required to ensure Racism doesn't happen in caring for our Relatives?
iii. What do we need to consider so our relations feel comfortable in reporting acts of Racism?
iv. What consequence should be considered for Physicians that are found to acting in a Racist manner?

The following are the consistent themes from the various focus groups.

- Registrants need awareness of the harm Indigenous Peoples are experiencing in the health care system.
- Registrants need to understand and be able to identify acts or omissions of anti-Indigenous racism.
- Registrants need to know their patients.
- Registrants need to take action to address acts or omissions of anti-Indigenous racism that they witness. Failure to act when anti-Indigenous racism is witnessed is enabling its continuance.

The Standard of Practice uses the Code of Ethics and Professionalism to address these themes. The Standard of Practice will compel Registrants to direct their attention and apply their Code of Ethics and Professionalism to the issues of racism in the practice of medicine that are experienced by Indigenous Peoples.

A Contextual Information and Resources document will be provided as part of the materials being circulated for consultation.

**MOTION:**

**NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:**

> Council approves the attached Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism to be sent out to registrants, stakeholders, and the public for consultation.

# Standard of Practice

# Practicing Medicine to Prevent Anti-Indigenous Racism

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

**DRAFT**

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

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

**This Standard of Practice will guide and inform Registrants on how to practice medicine in a manner that prevents Anti-Indigenous racism and the harm that Indigenous patients experience from that racism.**

## PREAMBLE

It is an undeniable fact that racism exists in the provision of health care to Indigenous Peoples via personal interactions and systemic contexts. Racism against Indigenous Peoples in the health care system has been researched, reported, and acknowledged both regionally and nationally. (see Contextual Information and Resources Practicing Medicine to Prevent Anti-Indigenous Racism).

Racism in health care causes harm that has both short and long-term impacts, and in the worse cases results in patients' death.

In its Apology and Statement on Indigenous-Specific Racism, CPSM apologizes for its historical and current failure to regulate the medical profession in the public interest by failing to adequately address Indigenous-specific racism by medical practitioners, whether in their clinical practice or administrative roles.

CPSM's responsibility extends to the racist actions and inactions of physicians, residents, medical students, clinical assistants, and physician assistants against Indigenous persons. We accept this responsibility, and we apologize.

CPSM apologizes to First Nations, Métis and Inuit children, families, and Elders for the racism that has occurred in their medical care, whether it was in the care they received, or should have received but did not. We apologize for the intergenerational trauma, suffering, poor health outcomes, and death that this has caused.

Apologies are not enough, CPSM pledges to take action against Indigenous-specific racism and to support and guide Manitoba physicians, residents, students, clinical assistants, and physician assistants to recognize and call out acts of racism against Indigenous persons and medical practitioners.

CPSM will take this journey, knowing that it is difficult but necessary and fully aware that it takes more than a pledge to end racism. Recognizing racism in ourselves will neither be comfortable nor easy. However, with knowledge, awareness, and a positive obligation to "*consider first the well-being of the patient*"[1] Registrants can practice medicine to prevent Anti-Indigenous racism and harm to their patients.

## CONCEPTS THAT MUST BE UNDERSTOOD BY REGISTRANTS

The term **"Indigenous" or "Indigenous Peoples"** is used throughout the Standard of Care to reference First Nations, Inuit, and Métis people of Canada. It is understood that in Manitoba the Métis are referred to as Red River Métis and First Nations linguist groups include Anishinaabe, Cree, Anish-Ininew, Dene, and Dakota.

**Racism** has many definitions. It is simultaneously simple and complex to understand. At its core it results in harmful acts or omissions against an identifiable race of people. At a societal level it is the systems, policies, and practices that oppress, undervalue, and diminish a worldview, culture and spiritual practices based on race. At the individual level it is the prejudices and discrimination that treat people differentially because of their race. It is the impacts of these acts or omissions that need to be recognized and addressed, whether they were intended or not.

**Indigenous-specific racism** is the ongoing race-based discrimination, negative stereotyping and injustice experienced by Indigenous Peoples that perpetuates power imbalances, systemic discrimination and inequitable outcomes stemming from colonial policies and practices. Racism is a form of harm.

**Systemic Racism in Health Care** –When one is working as a registrant in Manitoba, despite one's personal views, we are working within a racist system and that has consequences for those we are serving. This type of racism is often found deeply entrenched in institutional policies and practices that were developed without consideration to the impact of Indigenous Peoples. We

[1] Words appearing in italics in this Standard are direct quotes from the Canadian Medical Association Code of Ethics and Professionalism.

must work to identify, remove, prevent, and mitigate racially inequitable outcomes and power imbalances. We must work to change the structures that sustain inequities in our practices. It is upon the registrant to become culturally competent and reduce instances of anti-Indigenous racism in their practice. This means being aware of cultural values, micro aggressions and barriers Indigenous Peoples may face with medical compliance, medical trauma or being listened to by other providers when articulating their needs for care.

**Anti-racism** is more than just being "not racist". It is an explicit stance, process and a systemic method of analysis requiring a proactive course of action for individuals, institutions, and societies to undertake change that prevents the perpetuation of racism. It is actively eliminating racism from our policies and institutions, understanding how the present exists upon colonial and racist foundations, and committing to educate oneself and take action to create conditions of greater inclusion, equality, and justice.

**Privilege** – It is important to acknowledge and understand registrants have a position of privilege in this context. Registrants have social, economic, and a power imbalance in their relationships with patients. Registrant's acts or omissions have tremendous impacts upon their patients.

**Unconscious Bias** - Is when we make judgments or decisions based on our prior experience, our own personal deep-seated thought patterns, assumptions, or interpretations, and we are not aware that we are doing it. Unconscious biases prevent us from seeing fairly and accurately the information or the people in front of us.

## THREE STEPS TO PRACTICING MEDICINE TO PREVENT ANTI-INDIGENOUS RACISM

1. Understand and acknowledge that racism exists, and results in negative health impacts.

2. Understand and identify acts and omissions of anti-Indigenous racism in the health care system and the practice of medicine.

3. Take action to address acts and omissions of anti-Indigenous racism.

## RACISM NEGATIVELY IMPACTS HEALTH

The most extreme consequence of anti-Indigenous racism is death. Two public inquiries into the deaths of Indigenous patients are examples of Indigenous-specific racism in the health care system - Brian Sinclair (Manitoba) and Joyce Echaquan (Quebec) (see Contextual Information and Resources Practicing Medicine to Prevent Anti-Indigenous racism). These are examples of situations where anti-Indigenous racism directly resulted in death; however, the health impacts of this racism are diverse and widespread.

The report In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C. Health Care found extensive profiling and widespread stereotyping of Indigenous patients. They were described as less capable, less worthy; as drug seekers or alcoholics; as people who are non-compliant, are bad parents, and "get stuff for free." The report reveals that an additional layer of discrimination against Indigenous women exists in health care settings, where Indigenous women, girls, Two-Spirit, and gender-diverse people are subject to misogynistic stereotyping, child apprehensions, and forced sterilization.

CPSM recognizes the collective role of the medical profession in providing medical care to Indigenous Peoples which is impacted by systemic colonial values, individual biases, and racist attitudes. These continue to result in inequitable access to health care and poor medical outcomes including a compounding affect over time and the suffering and deaths of a disproportionate number of Indigenous patients.

**The mere exposure to racism causes psychological strain on the individual**. Psychological strain can lead to stress, feelings of loss of control, insomnia, fatigue or exhaustion, sadness or tears, concentration or memory problems, irritability, or aggression. It can also lead to physical manifestations of increased blood pressure and a higher risk of heart disease, gastrointestinal problems, headaches, and back or neck pain. Despite this Indigenous Peoples demonstrate significant resilience by continuing to be vulnerable within the medical systems that often causes or retriggers trauma.

**Denial of access to health care**. Systemic racism sets up barriers limiting Indigenous Peoples access to health care ranging from racist institutional policies, geographic access to health care, and resource inequities including poverty, food insecurities, and lack of safe housing. In addition, the psychological strain resulting from racism received from other institutions and/or during medical treatment creates a deterrent to seeking health care when it is needed. CPSM recognizes current examples of Indigenous-specific racism in treating Indigenous Peoples which leads to substandard care including, but not limited to:

- Failing to respect traditional Indigenous health care practices as complementary to Western scientific medicine.
- Accepting or advancing stereotypical perceptions of alcohol and illicit drug consumption or socioeconomic status.

- Inadequate treatment of pain based upon racial profiling.
- Failing to demonstrate interest, respect, and humility to understand the context of patients' Indigenous teachings, communications, lived experiences, and circumstances.
- Failing to adapt medical treatment plans to the reality of the person's social circumstance. For example, advising care while knowing there may be a lack of access to that care in the community or refusing to provide care based on patients missed appointments which may be out of their control.
- Committing outright acts of racism, including derogatory comments to Indigenous Peoples.

## UNDERSTAND AND INDENTIFY ACTS AND OMISSIONS OF ANTI-INDIGENOUS RACISM

To understand and identify an act or omission of anti-Indigenous racism the registrant must understand the impact of the act or omission on the patient. The intent of a particular act or omission may be *bona fide* but if the impact on the patient is racist it is harmful. It is the harm that must be prevented.

Based on the Code of Ethics this section provides guidance on how registrants are to gain knowledge and understanding of anti-Indigenous acts and omissions.

**Know Yourself / Self Reflection**

The *Code of Ethics* lists humility as a virtue exemplified by an ethical physician.

*Humility*

*A humble physician acknowledges and is cautious not to overstep the limits of their knowledge and skills or the limits of medicine, seeks advice and support from colleagues in challenging circumstances, and recognizes the patient's knowledge of their own circumstances.*

Registrants must have a sound understanding of self, be aware of limits in their knowledge of Indigenous history and culture.

An important part of self-reflection will be recognizing racism in ourselves. This will neither be comfortable nor easy, but it is necessary for improvement.

Registrants must self-reflect on their interactions with Indigenous patients, including:

- possible barriers to patient-centered care and patient participation such as support to navigate unfamiliar systems, access to resources such as transportation, interpreters, escorts, family support etc.

- understanding the individual patient's expectations and needs from Western Medicine and recognize their need for traditional Indigenous health care and practices.
- Whether the patient feels safe in the health care facility.

(See Contextual Information and Resources Practicing Medicine to Prevent Anti-Indigenous racism).

**Know Your Patient**

Knowing your patient is foundational to your *Code of Ethics*. The first Virtue of an Ethical Physician in the *Code of Ethics* is Compassion.

*A compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient's suffering, and accompanies the suffering and vulnerable patient.*

The *Code of Ethics* specifically sets out a *commitment to the well-being of the patient*:

- *Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient.*
- *Provide appropriate care and management across the care continuum.*
- *Take all reasonable steps to prevent or minimize harm to the patient; disclose to the patient if there is a risk of harm or if harm has occurred.*

Registrants have a *commitment to respect for persons*:

- *Always treat the patient with dignity and respect the equal and intrinsic worth of all persons.*
- *Never participate in or support practices that violate basic human rights.*

Patients of differing race, ethnic or religious backgrounds will be impacted differently by a particular act or omission. In Manitoba there are 63 First Nations comprised of 5 distinct linguistic groups, Inuit, and Métis. These Indigenous Peoples are culturally distinct.

To meet your ethical obligations towards your Indigenous patients requires a Registrant to be aware of:

- Indigenous cultural values
- Indigenous history
- colonization
- impacts of trauma
- micro aggressions
- systemic racism
- unconscious bias

- barriers

Registrants will not know the culture and history of every Indigenous person. However, as a compassionate physician you seek to understand the unique circumstances of each patient and to alleviate their suffering. This means in a dignified and respectful manner seeking culturally important factors that impact your patient's individual care.

(See Contextual Information and Resources Practicing Medicine to Prevent Anti-Indigenous racism).

**Education**

The *Code of Ethics* requires a *commitment to professional integrity and competence*, specifically:

- *Practise medicine competently, safely, and with integrity; avoid any influence that could undermine your professional integrity.*
- *Develop and advance your professional knowledge, skills, and competencies through lifelong learning.*

Registrants practicing in Manitoba must ensure an **ongoing** education, awareness, and understanding of Indigenous Peoples, culture, history including trauma informed care. **Continuous learning** in this area is considered important and akin to the *Code of Ethics* in which Registrants are expected to regularly enhance their professional knowledge, skills, and competencies.

(See Contextual Information and Resources Practicing Medicine to Prevent Anti-Indigenous racism).

## TAKE ACTION TO ADDRESS ACTS OR OMISSIONS OF ANTI-INDIGENOUS RACISM

The *Code of Ethics* requires:

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

The *Code of Ethics* also requires that registrants have a commitment to justice and society:

- *Never participate in or support practices that violate basic human rights.*

- *Promote the well-being of communities and populations by striving to improve health outcomes and access to care, reduce health inequities and disparities in care, and promote social accountability*.
- *Contribute, individually and in collaboration with others, to improving health care services and delivery to address systemic issues that affect the health of the patient and of populations, with particular attention to disadvantaged, vulnerable, or underserved communities.*

When an Indigenous person receives differential medical care because they are Indigenous their basic human rights are being violated. This is a serious failing in the provisions of good medical care and needs to be addressed. The most important perspective to consider is that of the patient and their health.

The acts or omissions of anti-Indigenous racism can be blatant, subtle, discrete events and/or systemic. They can take many different forms; most are either unintentional or done out of ignorance that can be corrected through proper education or direction.

**Take Action**

If you witness racist behaviour or become aware of systemic racism you are expected to take action to address it if you can. The action you take will depend upon the situation. If you are a registrant to whom an act or omission is brought to your attention, your duty of care is to your patient when determining appropriate response to address an issue. You also have a corresponding ethical duty to treat your colleague with dignity and as a person worthy of respect. Your behavior when taking action, whether as someone who witnessed it or to whom the matter was raised to, is governed by the *Code of Ethics* – Physicians and colleagues:

> *31. Treat your colleagues with dignity and as persons worthy of respect. Colleagues include all learners, health care partners, and members of the health care team.*
>
> *32. Engage in respectful communications in all media.*
>
> *33. Take responsibility for promoting civility, and confronting incivility, within and beyond the profession. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.*
>
> *34. Assume responsibility for your personal actions and behaviours and espouse behaviours that contribute to a positive training and practice culture.*
>
> *35. Promote and enable formal and informal mentorship and leadership opportunities across all levels of training, practice, and health system delivery.*
>
> *36. Support interdisciplinary team-based practices; foster team collaboration and a shared accountability for patient care.*

**Report**

If you are unable to remediate it or feel uncomfortable doing so on your own, you are required to report the matter to the Restorative Practices Program. The Restorative Practices Program will report to the Central Standards Committee as a specialized program to address matters of anti-Indigenous racism through restorative practices emphasizing education and improved medical practice for registrants.

As stated above, the most important perspective is that of the patient and their health. **Your duty to remediate and report applies to the racist behaviour or systemic racism regardless of whether the act or omission was caused by a registrant or someone else or some organization.** Report what you observe to the Restorative Practices Program they will determine how the matter is best addressed.

**Advocate**

Allyship has been described as the actions, behaviors, and practices that leaders take to support, amplify, and advocate with others, most especially with individuals who don't belong to the same social identities as themselves. As a privileged leader in the health care profession, you have a responsibility to advocate for your Indigenous patients to ensure that they receive good medical care.

Advocacy can take many forms.

- Empowering Indigenous patients with knowledge of their rights within the health care system, and their right to file a complaint (including the process for doing so).
- Assisting Indigenous patients when you observe racism/barriers which includes systemic racism.
- Inquiring of Indigenous patients if they are experiencing any racism/barriers and take positive action when advised of such events.
- Recognition to allow others (family, friends, or other health care providers) which could facilitate a sense of safety for Indigenous patients.
- Sharing with colleagues your experiences of anti-Indigenous racism and finding solutions to overcome it.
- Taking a leadership role on the health care team to promote the practice of medicine to prevent anti-Indigenous racism.
- Educating and training learners to the profession on the importance of practicing medicine to prevent anti-Indigenous racism.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

# COUNCIL MEETING
# SEPTEMBER 25, 2024
## NOTICE OF MOTION FOR APPROVAL

**SUBJECT:** CPSM Restorative Practices Program

**BACKGROUND:**

At its September 29, 2022 Meeting, Council adopted the 7 recommendations of the TRC Advisory Circle:

1. Apology and Statement by CPSM on Indigenous-Specific Racism
2. CPSM Land Acknowledgement
3. Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism
4. Restorative Justice Approach to Complaints and Investigations/Create a Culture for Receiving and Addressing Complaints by Indigenous Patients
5. Mandatory Indigenous-Specific Anti-Racism Training
6. Mentorship/Leadership & Create Open Culture to Support Indigenous Physicians
7. Definition of Indigenous Racism and Gather Examples of Racism by Medical Professionals

The end goal of these recommendations is the active practice of medicine so that Indigenous Peoples receive quality medical care without being subjected to racism.

Achieving this goal will require the operationalization of these recommendations.

CPSM believes that the best way to operationalize these recommendations is through the centralized, dedicated, expertise of a Restorative Practices Program.

The various recommendations are intertwined and dependent upon each other for success. A coordinated holistic approach to operationalizing these recommendations is required to achieve the end goal of practicing medicine to prevent anti-Indigenous racism.

**PROPOSED SOLUTION**:

The Restorative Practices Program will be modeled after the Prescribing Practices Program (PPP). The 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, CPSM staff, and our many stakeholders and collaborators.

The draft Standard of Practice - Practicing Medicine to Prevent Anti-Indigenous Racism is based upon education enabling registrants to practice medicine in a manner that addresses anti-Indigenous racism. Similarly to how the PPP is designed to bring about improved prescribing practices through education, the Restorative Practices Program will be an educational resource for registrants.

The first step will be the hiring of a Program Director (ideally a medical consultant) with expertise in anti-Indigenous health related racism and restorative practices. A Coordinator will also be hired to assist the Program Director.

The Program Director will develop a multi-year action plan to determine how to address the following major issues:

- Restorative practices
- Mentoring Indigenous registrants
- Responding to calls/inquiries from registrants seeking guidance
- Continual education
- Creating a culture to support Indigenous patients and Indigenous physicians

## ACCOUNTABILITY:

CPSM is the voice and leader of the self-regulated medical profession. Through the adoption of the 7 TRC Recommendations, CPSM has said the culture of the practice of medicine must change. The new Standard of Practice - Practicing Medicine to Prevent Anti-Indigenous Racism is a fundamental statement on how the culture will change but it needs to be implemented. The Restorative Practices Program will be accountable to registrants and the public for implementing the required cultural change.

## TIMELINE:

**October- December 2024** – Job description created, posted, recruitment, interviewing, hiring.

**January – March 2025** – Position starts (coordinates with launch of Standard of Practice), training and development.

**Fixed Timeframe** Not Applicable ☒

**On-going** – program development multi-year Not Applicable ☐

**ALIGNMENT OF ORGANIZATION PRIOTIES:** Not Applicable ☐

CPSM's Mandate is:

> *We protect the public and promote the safe and ethical delivery of quality medical care by registrants in Manitoba.*

In September 2023, Council approved the following 3 goals for CPSM to achieve its Mandate:

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

Addressing Anti-Indigenous Racism was a Deliverable for each of these goals. CPSM **cannot** achieve its Mandate if it does not address Anti-Indigenous racism in the practice of medicine.

Indigenous Peoples experience unique harm because of racism they are subjected to in the healthcare system. Eventually, lesson learned by the Restorative Practices Program in addressing anti-Indigenous racism will be applied to address issues related to inclusivity, diversity, equity and accessibility in the ethical delivery of quality medical care by registrants for all Manitobans. The starting point will be addressing anti-Indigenous racism. Lessons learned and skills developed will then be applied to the larger challenge.

**PATIENT SAFETY:**

As stated in the Preamble to the Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism:

> *It is an undeniable fact that racism exists in the provision of health care to Indigenous Peoples via personal interactions and systemic contexts. Racism against Indigenous Peoples in the health care system has been researched, reported, and acknowledged both regionally and nationally. (see Contextual Information and Resources Practicing Medicine to Prevent Anti-Indigenous Racism).*
>
> *Racism in health care causes harm that has both short and long-term impacts, and in the worse cases results in patients' death.*

Indigenous Peoples will continue to be harmed if positive action is not taken to address anti-Indigenous racism in the practice of medicine.

**RISK ANALYSIS:**

Failure to operationalize the:

- implementation of the Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism,
- establishment of Restorative Justice Approach to Complaints and Investigations/Create a Culture for Receiving and Addressing Complaints by Indigenous Patients
- deployment of Mandatory Indigenous-Specific Anti-Racism Training
- Mentorship/Leadership & Create Open Culture to Support Indigenous Physicians

will result in an ineffective superficial adoption of the 7 TRC Recommendations.

**Public Risk** Not Applicable ☐

Failure to provide sound guidance to registrants will maintain the status quo of Indigenous Peoples experiencing harm.

**Reputational Risk** Not Applicable ☐

CPSM has made public statements and apologies regarding the negative impact of anti-Indigenous racism in the practice of medicine on the health of Indigenous Peoples. CPSM has publicly stated the steps it will take to address this problem.

Failure to act will undermine, if not destroy, CPSM and the medical profession's reputation with the Indigenous Peoples of Manitoba.

Failure to act will also undermine CPSM's reputation with registrants who are looking for leadership to address this issue.

Failure to act will most likely be seen by the Government as a failure to meet the mandate it entrusted to CPSM.

**Regulatory Risk**

The fact that racism exists in the provision of health care to Indigenous Peoples is evidence that the medical profession has not complied with its ethical and legal obligations. Simply applying the Code of Ethics and Professionalism and the proposed new Standard of Practice – Practicing Medicine to Prevent Anti-Indigenous Racism will improve patient safety. CPSM needs to take steps to ensure that the Code of Ethics and the Standard of Practice are followed.

**Operational Risk** Not Applicable ☐

Budgetary considerations can impact CPSM and registration fees.

## REGULATORY IMPACT ON REGISTRANTS:

Registrants care about the well-being of patients. The Restorative Practices Program will work with registrants to build knowledge and self-awareness in a non-judgmental educational format. The Program will also work to develop mentorship opportunities for Indigenous registrants.

Registrants have a negative perception of CPSM because of the "blame and shame" culture associated with the enforcement of Standards of Practice. The Restorative Practice Program will focus on preventing harm through coaching, positive proactive communication, and encouraging lifelong learning.

## FINANCIAL IMPACT:

The Restorative Practices Program is a new concept, but its development will follow how the Prescribing Practices Program was developed. The Prescribing Practices Program began with one medical consultant (0.6 EFT) and expanded since 2018 to include a pharmacist and an occupational therapist (total of 2.3 FTE positions).

The first step will be the hiring of a Program Director (ideally a medical consultant) with expertise in Indigenous health related racism and restorative practices. A Coordinator position will also be required to assist the Program Director. As the program develops additional staff may be required. Detailed budget included in Appendix A.

**Human Resources:** Not Applicable ☐

Current staff will allocate time and internal resources to initially recruit and onboard the Program Director and Coordinator.

**Financial:** Not Applicable ☐

Budget for additional salary and benefits will be required. The annual estimated costs for the Program are $328,346. Accordingly, approximately $82,000 will be required for the current 2024/25 fiscal year. This amount will be absorbed within the current budget funding. Ongoing annual fee increases for registrants will commence November 1, 2025; the amount of these increases is currently being calculated (approximately $100/registrant).

**Infrastructure:** Not Applicable ☐

Space/IT/furniture - one-time costs of approximately $24,000.

**Transition Budget:** Not Applicable ☐

Estimate of an additional $25,000 for an operating budget. TRC currently has $50,000 allocated for advisory expenses that can be reallocated to this new operating budget for a total operating budget of $75,000/annum.

**ALTERNATIVES OR STATUS QUO:** Not Applicable ☐

The alternative would be for current staff to take on the responsibility of operationalizing the TRC Advisory Circle recommendations; unfortunately, current staff do not have the knowledge, skill or judgment to do so. The status quo will result in non-operationalization of the recommendations, which is contrary to Council direction.

**EVALUATION AND OUTCOMES:** Not Applicable ☐

The design of the Restorative Practices Program will include development of metrics to assess the effectiveness of the program and the impact it has on CPSM's reputation for meeting its mandate.

**ADDITIONAL INFORMATION:** Not Applicable ☐

Further program data can be presented as required.

**RECOMMENDATION:**

Secure funding to hire a Program Director and a Coordinator to develop the Restorative Practices Program for the purpose of operationalizing the TRC Advisory Circle recommendations.

**MOTION:**

**NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 25, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:**

> Council authorize CPSM management to commence the development and implementation of the Restorative Practices Program as outlined herein.
>
> Council further directs CPSM management to provide detailed program cost projections and fee implications when determined.

**Appendix A – Budget**

| **Staff Expenses** | **EFT** | **Total** |
|---|---|---|
| Medical Consultant | 0.6 | $ 185,973 |
| Coordinator | 1 | $ 109,613 |
| Parking | | $ 2,760 |
| Membership fees | | $ 7,000 |
| **subtotal** | | **$ 305,346** |
| **Operating Expenses** | | |
| Travel | | |
| in Province | | $ 10,000 |
| Out of Province | | $ 10,000 |
| Professional Fees | | $ 15,000 |
| TRC Advisory Group to Council | | $ 18,000 |
| Materials | | $ 5,000 |
| Training | | $ 10,000 |
| Misc | | $ 5,000 |
| Existing budget | | -$ 50,000 |
| **Subtotal** | | $ 23,000 |
| **Total** | | **$ 328,346** |

# COUNCIL MEETING
# SEPTEMBER 25, 2024
# BRIEFING NOTE

**SUBJECT:** Practice Direction – Practice Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students Contextual Information and Resources Document

**BACKGROUND:**

At its March 20, 2024 meeting, Council approved the Practice Direction – Practice Supervision for Clinical & Physician Assistants and Physician Assistant Students.

Included in the Practice Direction materials circulated for consultation was the Contextual Information & Resources Document. Although the Contextual Information & Resources Document does not require Council approval to be published as a CPSM document, the document was discussed at the Council meeting because of feedback received regarding its content.

Council discussion centered on what, if anything, CPSM should be saying about physician billing for work performed by Clinical & Physician Assistants. The Physician's Manual (billing tariffs agreed to by Manitoba Health and Doctors Manitoba) states, *"Insured service claims many only be made for services rendered personally by physicians."*

Discussion on the matter was tabled.

In the past CPSM addressed a significant number of inquiries and complaints related to physician's billing for services provided by Clinical & Physician Assistants. In October 2022, CPSM posted on its website in the section entitled "Clinical and Physician Assistant Contracts of Supervision" a link to an additional information document entitled "Clinical Assistant and Physician Assistant Billing Considerations". This document is the basis for the Contextual Information and Resources Document that was circulated in the Practice Direction materials.

The Contextual Information and Resources Document provided specific examples from the Physician's Manual of services that physicians were not permitted to bill for if the service was provided by a Clinical or Physician Assistant. Doctors Manitoba, in their initial submission on the consultation emphasized their concern that CPSM should not be interpreting the provisions of the Physician's Manual as Manitoba Health may use this interpretation to justify not allowing billing for those services. That said, Doctors Manitoba, could not identify anything incorrect in what CPSM had written.

Additional discussion identified a possible “chilling effect” on physicians not using Clinical & Physician Assistants if they could not bill for these services.

Former Council member, Mr. Chris Barnes, was tasked at the March meeting with gathering additional information. As a result, CPSM and Doctors Manitoba engaged in discussions and agreed upon acceptable language for a revised Contextual Information and Resources Document, see attached Appendix A.

# 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

Registrants who employ Clinical Assistants (ClAs) or Physician Assistants (PAs) need to be aware of potential issues related to billing for the insured medical services the ClA or PA provides under the registrant's supervision.

*The Health Services Insurance Act* (HSIA) and the Manitoba Physician's Manual set out expectations surrounding claims for insured medical services. It is the registrant's responsibility to meet these expectations.

The challenge for registrants is understanding when they cannot bill Manitoba Health for a particular insured medical service. The matter is confusing because if the registrant performed the service themselves, they would be able to bill for it, but the exact same service performed by a ClA or a PA under their supervision may be billable in certain circumstances and not in other circumstances.

The issue arises because the Physician's Manual indicates that claimants cannot submit claims under the HSIA relating to medical services which they had no personal involvement in. The Physician's Manual, states that, *"Insured service claims many only be made for services rendered personally by the physician."*

What constitutes "rendered personally by the physician" will be different from one tariff item to the next. When a registrant bills for insured medical services involving a ClA or PA, the registrant must ensure that their personal involvement in the delivery of the medical services was appropriate for the specific tariff requirement.

The registrant is responsible for knowing if they are permitted to bill for a particular insured medical service that is provided by a ClA or PA under their supervision.

If a registrant has any uncertainty as to whether they are permitted to bill Manitoba Health for an insured medical service performed by a ClA or PA they should contact Manitoba Health or Doctors Manitoba for clarification. Having a clear understanding of billing requirements will not only assist in the processing of accounts but will avoid professionalism complaints and disciplinary matters associated with improper billings.

# COUNCIL MEETING
# SEPTEMBER 25, 2024
# BRIEFING NOTE

**SUBJECT:** International Medical Graduate (IMG) Working Group - Update

**BACKGROUND:**

The IMG Working Group has met twice; on May 13th and July 30th. The Working Group has been oriented to its terms of reference and has discussed priorities for the coming year, which include:

- Developing a Standard of Practice for Entering the Manitoba Practice Environment. It is anticipated this will 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.
- Developing orientation materials and an orientation program for new registrants. It is anticipated this will include information and education relating to:
    - 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.

The Working Group's current focus is on gathering insight, information, and resources relevant to the issues raised by the Terms of Reference. CPSM has reached out to various organization within Manitoba and Canada for this purpose. The Working Group is creating a survey that CPSM will send to all registrants to collect further information and data to support is work.

The theme discussed at the Group's last meeting related to forms of discrimination that occur in Manitoba Practice Environments. This theme will carry forward to the next meeting where possible tools and options to address this topic will be discussed. It is also hoped the survey can be finalized at the next meeting.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

# COUNCIL MEETING
# SEPTEMBER 25, 2024
# BRIEFING NOTE

**SUBJECT:** National Registry Project - Medical Council of Canada (MCC)

**BACKGROUND:**

The Medical Council of Canada (MCC) and the Government of Canada have advocated for a National Registry of Physicians (NRP). See attached slide deck prepared by MCC outlining the purpose and benefits of the NRP.

The purpose of NRP as set out in the Participation Agreement dated February 26, 2024, is to "integrate sources of data on physicians in Canada and will function as a centralized information exchange to allow for improved collaboration across jurisdictions and to consolidate valuable physician data in a centralized location."

All Medical Regulatory Authorities in Canada, except for Ontario and Quebec, signed the Participation Agreement. CPSM has agreed that it will provide data that is currently publicly available on CPSM's website.

Phase 1 of the project, which is currently underway, involves the MRAs pushing their respective publicly available data to the NRP database. The MRA facing database is hoped to be operational within the next 2 months, and the public facing database operational shortly thereafter.

Phase 2 involves the MRAs considering adding new data fields including fields related to Certificates of Professional Conduct. Most of Phase 2 data would only be available to the MRAs and not the public. Discussions at the Data Governance Advisory Committee level (Registrars and CEOs) is at the preliminary stages. Privacy of data (i.e. can MRAs share private registrant data without their consent) is a key factor to be considered. Streamlining the Certificate of Professional Conduct process requires detailed analysis to determine whether a viable system can be developed.

MCC has announced the next funding for the NRP program. Each Medical Regulatory Authority (MRA) will have up to $175,000 available over the 5-year period (April 2024 to March 2029) to support the onboarding of data, system modification and ongoing improvements and enhancements.

The following individuals have formal roles representing CPSM on various committees or subcommittees:

- Dr. Ainslie Mihalchuk – Data Governance Advisory Committee
- Jeremy de Jong – Registration Subcommittee
- Sam Lount and Ray Jobin – Information Technology Subcommittee

NATIONAL REGISTRY of physicians

# *Serving multi-jurisdictional registration and licensure & Canadian physician workforce planning*

# What will the NRP provide?

- Real-time notification and **status of registration and professional conduct** with provincial/territorial regulator to facilitate and **enhance and expedite licensure** in another jurisdiction

- Support for **modeling and research** for local and national health care human resources planning with **potential for integration** with other national services

- Information physicians' credentials and scope of practice **a national locum pool** to support recruitment, retention and **redeployment** to underserved areas and times of need

# Why will NRP benefit the system?

## NRP value for MRAs:

- Enhanced and expedited decision making for physicians licensed in Canada in another jurisdiction
- Improved data accessibility, accuracy, searchability, commonality
- State-of-the-art privacy compliance

## NRP value for stakeholders (governments, CIHI, MINC, public):

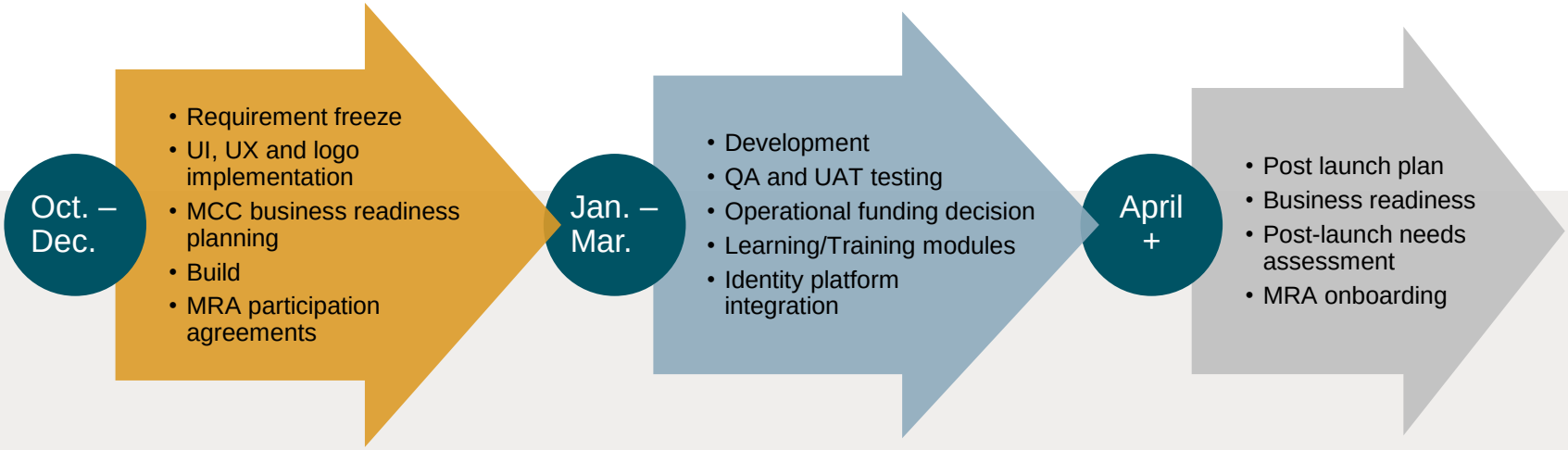
- Health sector planning capabilities
- Disaster preparedness and potential for a national locum pool
- Improve patient access to physicians

# How does NRP function?

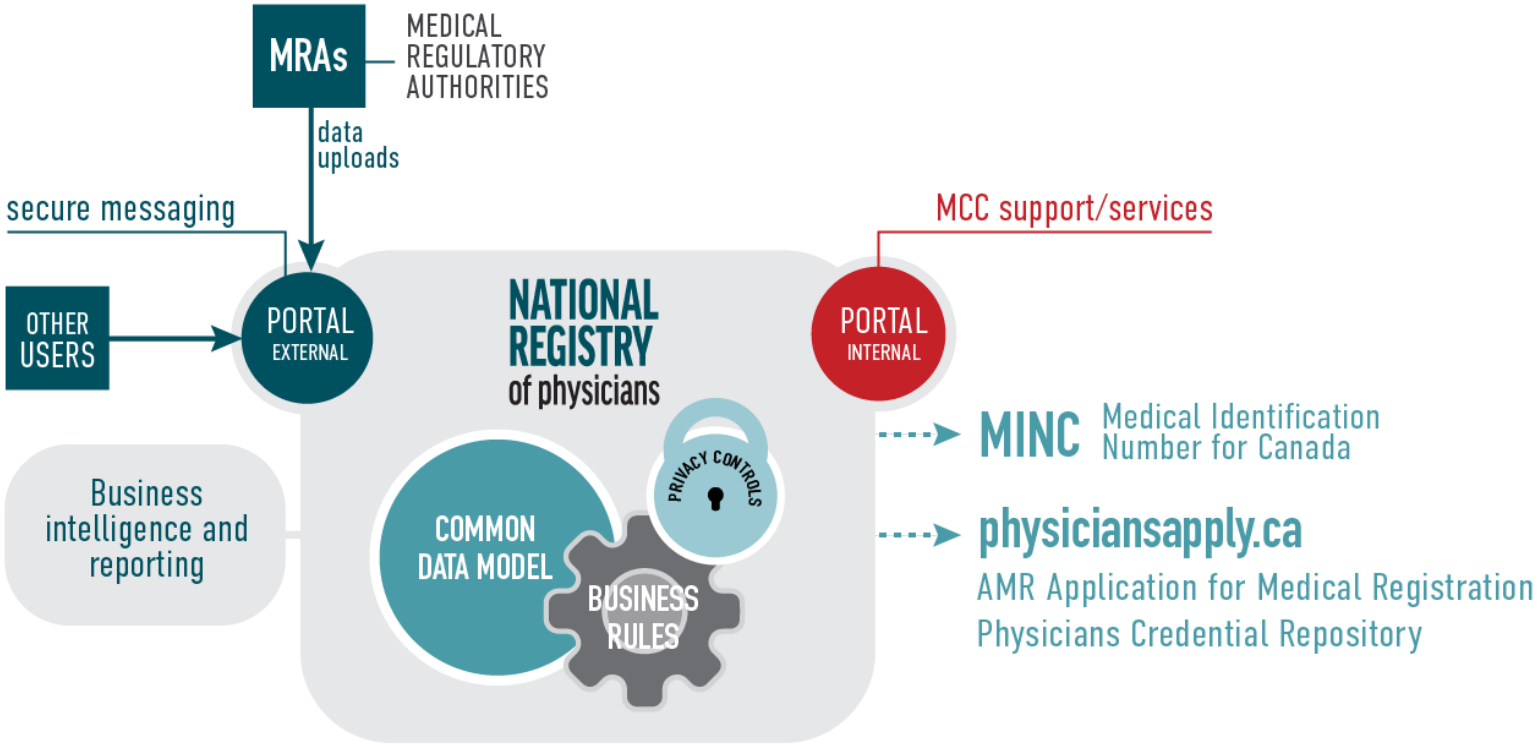
1. **Cloud-based** registry – MCC serves as an agent of the MRAs
2. Defining registry components with NRP working group to ensure **pan-Canadian consistency** while abiding with provincial/territorial regulations
3. “Data Governance Advisory Committee” to inform **strategic directions**
   - Participating MRAs, FMRAC, MCC, HealthCanada, CHW
4. Leverage Medical Identification Number Canada (**MINC**) as primary index
5. Ongoing communication & collaboration with **interested parties**

# Milestones




*Ready for launch starting April 2024 – Starting with MRA access*

# A “First” Nationally Integrated Source of Physician Data



# COUNCIL MEETING
# SEPTEMBER 25, 2024
## BRIEFING NOTE

**SUBJECT:** Performance Metrics Reporting

**BACKGROUND:**

CPSM management continues to review and refine performance metrics. The attached performance scorecard shows data for the fourth quarter of 2023-24 for the metrics where data is available.

You will also note that some departments have provided variance explanations as well as potential mitigation plans. At this point the Quality Department is the most advanced within CPSM and is undergoing further refinements and review. Complaints and Investigations as well as Registration are essentially taking a step back to review what metrics actually speak to performance (outcomes vs output measures). Both departments are to have their metrics fully developed for the March 2025 Council.

For 2024-25, quarterly scorecard updates will be provided to Council as part of the CPSM Operational Reports update.

| CPSM PERFORMANCE SCORE CARD | | | 2023-24 4th Quarter | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Performance Indicator** | **Related goal/objective** | **Target in 2023/24** | **Baseline (last year)** | **2023-24 4th Qtr** | **FIRMS** | ● ● ● | **Variance Explanation** | **Course Correction** |
| **QUALITY DEPARTMENT** | | | | | | | | |
| **Audits & Monitoring** | | | | | | | | |
| **Registrants will demonstrate a measurable improvement on follow-up assessments*** | Demonstrating measurable change after interventions is a powerful indictor of the effectiveness of CPSM's ability to self regulate, act in the public interest and improve care for patients | 50% of registrants will demonstrate a measurable improvement for Category 3 and 4 audits | Not currently measured | Q1-Q4 - 9 Registrants between Age Triggered and Referred Audits had repeat reviews previously using the CSC Audit Decision and Feedback Framework Tool<br>67% stayed in the same CSC Outcome (#3 to #3) with improvement but still required further CPSM action<br>33% moved up from a previous CSC outcome for a total of 100% improvement/stayed the same | Monitor and respond to physician compliance with quality improvements | ● | Exceeded target | Will continue to monitor. As more registrants come through as repeat reviews from previous CSC years using the CSC Audit and Decision Feedback Framework |
| **Audits will be performed a timely and predictable manner** | Registrants typically find engaging with CPSM audits as stressful. Having a timely and predictable process can reduce stress & improve registrant engagement. | 80% of audits will be completed with 30 days | Not currently measured | 16 Audits were completed in Q4 and the average was 30 days. There were 4 reviews that exceeded the 30 days which brings the percentage of audits completed to 75% | Monitor and measure | ● | Not meeting target. May have set overly optimistic target goal. To be reassessed ongoing. Issues for this quarter was during winter with the registrant and/or auditor not being available (vacation, on-call etc.) | Course correction - move timeline to 45 days? To be dicsussed further. Allow for variances during certain times of the year due to holidays etc. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Provisional Registration chart audit reports will be sent to the physician in a timely and predictable manner** | Registrants typically find engaging with CPSM audits as stressful. Having a timely return of the chart audit report can reduce stress & improve registrant engagement. | 3 days from the date of the audit to the date the report is sent to the Provisional Registrant | 6.18 days | 4.56 Days | Monitor and measure | | Target almost met. During Q4 a team member was away. There were a few days where the process was unclear for the person covering. | Process has been updated and discussed between team members and target should be able to be met going forward. |
| **Physician Health** | | | | | | | | |
| **# of referrals coming from registrants about self/colleagues to the PHP** | Increase self referrals from registrants | 50% of all referrals are generated from registrant self referrals | 41% | 65% | Monitor and Measure | | Exceeded target | Will continue to monitor this to assess if target is to low. |
| **Response Time (initial contact) for urgent referrals** | Timely response to new referrals of an urgent nature supports CPSM's mandate to protect the public | 90% within 1 business day | NA | 100% | | | Exceeded target | Will not measure this moving forward. New measure is under development. |
| **Quality Improvement Program** | | | | | | | | |
| **CPSM will complete reviews of 95% of all applicable registrants by the end of the seven year cycle (December 2025)** | Supervising the practice of medicine is critical to CPSM's self regulatory duty and is a legislated requirement | Complete 19% of registrants per annum for the remaining three years | 42% of registrants have completed the program (1056/2529) | 67% of registrants have completed (1735/2594) | Adopt a standardized physician practice/ performance assessment framework | | | |
| **QI process will be completed within targeted timelines 90% of the time for Category I(30 days), II (90 days)& III (240 days)** | CPSM has a duty to supervise the practice of medicine and ensure the competence of its registrants in the interest of patient safety. | 90% completion for<br>Category 1 – 30 days<br>Category 2 – 90 days<br>Category 3 – 240 days | 90% completion for<br>Category 1 – 30 days<br>Category 2 – 90 days<br>Category 3 – 240 days | Category 1: 100%<br>Category 2: 37% (14 in progress)<br>Category 3: 33% (2 in progress) | Monitoring and measuring | | Category 2: seven in progress<br>Category 3: two in progress | As the Category 2 MSF timeline is largely out of our control due to external factors, we will determine a KPI based on when we receive the participants' completed MCC 360 reports as opposed to tracking the entire process. |

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| **Prescribing Practices Program** | | | | | | | | |
| **PPP will respond in a timely manner to general prescribing advice inquiries** | Provide timely advice related to prescribing opioids, benzodiazepines, opioid agonist therapy, and other complex medication regimens, to provide impactful support for safe patient care | PPP will respond to general prescribing advice inquiries within:<br>60% – 1 business day<br><br>90% – 2 business days | Not currently measured | PPP responded to inquiries received Q1-Q4 within:<br><br>82% – 1 business day<br>89% – 2 business days<br>93% – 3 business days<br>100% – ≥ 4 business days | NA | ● | Essentially met target. By prioritizing response to inquires, responded to 58% on the same day! Responded to 89% within 2 days (nearly 90%) and 93% within 3 days. | Will continue to prioritize response to general prescribing advice inquires. For 2024-25 will aim to maintain responsiveness of 80% within 1 business day and reach 90% within 2 business days. |
| **Medical Examiner cases that identify serious prescribing concerns will be completed within 90 days** | Timely completion of case reviews are paramount for high-impact regulation | 75% of ME cases with serious prescribing concerns will be completed within 90 days | Not currently tracked | 4/5 ME cases for Q1-Q4 with serious prescribing concerns closed this fiscal year. Metric not met - all cases with serious concerns took at least ≥120 days to complete. | NA | ● | Metric not met as awaiting responses from registrants implicitly delays ability to close cases (for each correspondence, registrants have up to 30 days to respond). Analyst (assigned to ME portfolio) on parental leave for 6 months. Also limited by Medical Consultant time for multistep case review process. | PPP will continue to prioritize work on ME cases with serious prescribing concerns. However, will not continue to track metrics as too many confounding variables. Additionally, case reviews (therefore metric tracking) halted as consultants have been unable to attend ME office for 11 months now (will resume case reviews ASAP, once Memorandum of Understanding signed with ME office). |
| **Accreditation Programs** | | | | | | | | |

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| **MANQAP will inspect the required number of facilities to be in compliance with the Manitoba Health contract & will ensure all required NHMS facilities are inspected** | Protecting the public and contract compliance | 90% of inspections in both lab & diagnostics as well as NHMSF will be completed by the end of 2023-24 fiscal year | N/A | 33 out of 46 inspections occurred that were listed in the Quarterly Reports to the provincial government (1 April 2023- 31 March 31).<br><br>6 NHMSF inspections were done 1 May 2023 to 30 April 2024. | Monitoring and measuring | | 72% of inspections were completed as indicated in the quarterly reports to the provincial government. 1 was deferred do to equipment replacement. 2 additional inspections occurred due to new equipment/location openings. | Human Resources being our number one limitation for timely site inspections. Action/course correction is the addition of 1 new positions Permanent part time LAB/TM (0.6 FTE) inspector (December 2023). 2024-2025 will see the addition of a permanent part time DI (0.6 FTE) inspector. |
| **Non-emergent Adverse Patient Outcomes (APO's) reports and briefing to the Program review committee will occur within 14 days** | Monitoring APO's is a requirement for ongoing patient safety (CPSM Accredited Facilities By-Law). Core function of the accreditation role in protecting the public and ensuring public safety | 90% - reviews will be completed within 14 days of the receipt of the complete APO file | Not currently measured | All the APOs, where the consultant's review was complete and ready to be reviewed by PRC, were ready for the PRC agenda within the 14 day deadline. | Monitoring and measuring | | | Human Resources is an issue for APO output. 2024-2025 will see the addition of 2 nursing consultants and a permanent part time (0.5 FTE) clerk position to assist in the increasing demand of the APOs. Will be reviewing this metric to assess whether a different metric is more indicative of performance. |
| **Performance Indicator** | **Related goal/objective** | **Target in 2023/24** | **Baseline (last year)** | | **FIRMS** | | **Variance Explanation** | **Course Correction** |
| **COMPLAINTS & INVESTIGATIONS** | | | | | | | | |
| **Complaints screened are completed within 4 business days** | Investigation matters are concluded within timelines | All complaints screened within 4 days<br>Red flag cases with 24 hours | Not currently captured | under review | Adopt a standardized investigation process including a triage mechanism to prioritize complaints | | All Metrics under review for 2024-25 | Significant overhaul in process and measures will be implemented in 2024/25 |

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| **Complaint reviews are Completed within 120 days** | Investigation matters are concluded within timelines | 50% of cases are completed within 120 days | 45% of cases completed within 120 days | 2.7% | Monitoring and measuring performance & case management system | 🔴 | | |
| **Complainants are contacted and connected through the process** | Ensure our processes are helpful, respectful and culturally appropriate | Complainants and Registrants are contacted within 14 days | NA | **Complainants** - **47%** within 14 days **Registrants** - **23%** within 14 days (data capture starting Mar 2024) | Monitoring and measuring performance & case managment | 🔴 | | |
| **% of Complaints resolved through alternative means** | CPSM processes are appropriate and respectful | 5% | 1.30% | 27.6% | Case management system | 🟢 | | |
| **% of Complaints that request referral to Investigations** | CPSM is effective and efficient | 10% or less | 16.90% | 20.0% | Case management system | 🟡 | | |
| **Time to Investigative action taken for serious allegations** | Protection of the Public | Investigative action taken on serious allegations within 3 days | Not currently measured | under review | Monitor Performance and adherence | 🟡 | | |
| **# of Inquiries overturned by Court of Kings Bench** | Inquiry matters are appropriate, and the process is effective | 0 | 0 | 0 | Reliable Complaints and Resolution Process | 🟢 | | |
| **Performance Indicator** | **Related goal/objective** | **Target in 2023/24** | **Baseline (last year)** | | **FIRMS** | 🔴 🟡 🟢 | **Variance Explanation** | **Course Correction** |
| **REGISTRATION** | | | | | | | | |

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| **Support National Registry Initiatives** | Implement project initiatives required to support the National Registry | Complete the National Registry Project by March 2024 (Phase 1) | NA | Initial project has been completed | Adopt standardized registration and licensure policies that address; requirements, source verification, approval processes, and triggers for reconsideration | ● | All Metrics in Registration under review for 2024-25 | Significant overhaul in process and measures will be implemented in 2024/25 |
| **Annual Report - Fair Registration Practices Office** | Protection of the public through regulatory compliance | Implement recommendations made by FRPO | | All recommendations closed | Monitor performance with regulatory compliance | ● | | |
| **Process Metrics – Application turn around times** | Define and publicize applciation turn-around times | Length of time to process applications | | Efficiency maintained* | Monitoring & measuring performance | ● | | |
| **Performance Indicator** | **Related goal/objective** | **Target in 2023/24** | **Baseline** | | **FIRMS** | ●<br>●<br>● | **Variance Explanation** | **Course Correction** |
| **FINANCE** | | | | | | | | |
| **CPSM will maintain adequate reserves** | Ensure the College is appropriately resourced to effectively achieve its mandate | •Debt to Equity ratio <1<br>•Total Reserves at 70% of annual operating expenses | •Debt to Equity ratio of 0.7<br>•Reserves @ 66% of annual operating expenses | •Debt to Equity ratio of 0.81<br>•Reserves @ 64% of annual operating expenses | Transparent reserve policies | ● | Reserves approved to be used on a short term basis to offset fee increases | Will be reviewing in the 2024/25 budgeting process |
| **CPSM will achieve a balanced budget** | Ensure CPSM is financially stable and able to sustain the activities and objectives as set out by CPSM's mandate | Achieve a balanced budget by 2025/26 | NA | CPSM ran a minor surplus for the year ending 2023-24. | Monitoring and measuring financial performance | ● | | |
| **INFORMATION TECHNOLOGY** | | | | | | | | |
| **CPSM's technology and information is protected from both external and internal loss/destruction** | Protect the public, our Registrants and the reputation of CPSM | Improve CPSM's Center for Internet Security Score to 45% or 2.25/5 | 28% or 1.4/5 | 52% or 2.6/5 | Adopt an enterprise wide cyber security policy and monitoring system | ● | Exceeded target | |

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| **Information Systems are considered highly reliable and available** | Maintain high network availability/uptime | >TBD | TBD | 99% uptime recorded | Implement formal strategies to ensure information and business systems support the organizations functions | ● | | Will continue to monitor to assess if this is a valuable metric to be tracking |
| **High IT Accountability and satisfaction** | Implement project documentation, prioritization scores and tracking for all IT projects | Full implementation of projecting tracking and reporting in 2023/24 | NA | Project intake porcess and monitoring process has been implemented - reporting on track for 2024/25 | Monitoring & measuring | ● | Other higher priorities for IT moved this to a later implementation date | Project intake and monitoring process will be implemented in 2024/25 |
| **High IT responsiveness** | Effective issue tracking, management and reporting | Triage all IT issues within 1 business days of receipt | Not currently tracked | 90% of IT tickets triaged within 24 hours | Monitoring & Measuring, reliable IT and infrastructure | ● | | Will continue to monitor to assess if this is a valuable metric to be tracking |
| **HUMAN RESOURCES** | | | | | | | | |
| **Employee satisfaction and engagement with CPSM priorities** | CPSM employees high levels of job satisfaction and are engaged in the delivery of the CPSM mandate | Conduct survey of CPSM staff and report on findings. | NA | engagement survey to be released in Fall of 2024 | Monitoring and measuring | ● | Significant changes in leadership delayed the planning and approval | Engagement survey planned for Sept 2024 |
| **Retention of staff** | CPSM retains its valuable staff in order to delivery on its mandate | •Average Years of Service<br>•# of Employees resigning from CPSM other than retirement | Avg YOS – 8 years<br>Resignations – 0 | Avg YOS - 7.06<br>Resignations - 1 | Human Resource planning | ● | Additional positions will automatically reduce YOS. 2025-26 will see futher drops in YOS due to long service employees | |
| **Employees are productive** | CPSM employees are available to deliver on the goals and objectives of CPSM | Establish absenteeism benchmark (Public sector avg 13.4 days, Private sector 7.5 days) | Average of 6.6 days lost to sick time or approximately 1.3 EFT | May 1 2023-April 30, 2024 - Average of 7.09 Sick days | Monitoring of human resource performance | ● | Implementation of HRMS now allows for more accurate time tracking and reporting | Quarterly reports being distributed to managers starting in Dec 2023. HR providing support to managers where attendance issues are identified |
| **COMMUNICATIONS** | | | | | | | | |

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| **Increase positive sentiment score in media coverage by 20%** | Improve public perception of CPSM. | Increase positive associations of CPSM in media coverage through improved sentiment score. | Media coverage sentiment scores as of December 31, 2021:<br><br>Negative – 8.1%<br><br>Positive – 3.8%<br><br>Neutral – 88.1% | Media coverage sentiment scores as of June 3, 2024:<br><br>Negative 18%<br><br>Positive 24%<br><br>Neutral 59% | Leadership – transparency and disclosure<br><br>Measuring and Monitoring | | While it appears negative mentions have increased, While it appears negative mentions have increased, it is more of the "neutral" mentions have been better vetted and scored as negative. This is because algorithm monitored the sentiment score 2021 (and earlier). By manually monitoring relevant mentions, I was able to get a more accurate score. | The goal is still to increase positive associations.<br><br>Increased positive media interactions will result in increased positive sentiment. Activities to feed into these interactions include: proactively responding to media, building better relationships with media, and outreach from CPSM to media to share positive stories. |
| **# of educational opportunities executed** | Educate the public on CPSM's role to protect the public and how that is accomplished through three core functions. | Launch public awareness campaign. | n/a | Launched 3 explainer videos about CPSM's role. Video launched through online ads and QR codes in the annual report.<br><br>Plan for a public facing newsletter has been developed; launch to occur in Q.2. | Leadership – training/transparency | | Public interaction has been limited.<br><br>New initatives (i.e. public newsletter) has been delayed due to transition & other competing priorities | This performance indicator will be reviewed for 2024-25 |
| **# of engagement targets met** | Boost engagement from the public and registrants. | - Host 4 webinars and/or lead other opportunities to engage the public or registrants.<br>- Assess engagement metrics. | One webinar (for registrants) was hosted in 2022. | Supported webinar development for various audiences:<br>1) January 2024 Webinar hosted by Doctors MB to their members/CPSM registrants on physician | Leadership – training and transparency | | | This performance indicator will be reviewed for 2024-25 to better align with activities led by communications |

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

**COUNCIL MEETING – SEPTEMBER 25, 2024**

**FOR INFORMATION**

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

Dr. Ainslie Mihalchuk assumed the role of CPSM Registrar and CEO on July 1, 2024.

**Internal - People and Culture**

- Several key roles left vacated by retirements effective June 30, have been filled.
  - Dr. Sonja Bruin has taken on the role of interim Director for the Quality department.
  - Jeremy de Jong has taken on the role of interim Director of Registration.
  - Dr. Phillipe Guillaume Poliquin joined CPSM as Assistant Registrar for the Complaints & Investigations Department on August 6.
  - Other roles have been filled, including Legal Counsel and Senior Legal Counsel in Complaints & Investigations.
- With these key roles in place, the transition has successfully been completed. Meetings with each department were invaluable for developing a transition plan that ensured minimal disruption during the transition and gaining a comprehensive understanding of current operations. Following the transition, every staff member has had the opportunity to meet with the Registrar in small teams or individually.
- The first all-staff meeting with the new Registrar was held over the summer. All-staff meetings will occur quarterly in the future.
- A Staff Engagement Survey was launched to provide staff with an opportunity to provide feedback on what we are doing well and identify improvement areas.
- Dialogue with CPSM senior leaders is ongoing to ensure organizational alignment with long-term goals.

**External Relations**

- Assessing expectations and experiences the public and registrants have of CPSM has been a large focus and will inform long-term operational planning.
- Reached out to key stakeholders, including the Minister of Health, Seniors and Long-Term Care, to request meetings to discuss regulatory matters.
- The Registrar participated in inaugural day activities at the University of Manitoba, including the white coat ceremony for the new medical class of 2028, the class of 2026 Master of Physician Assistant Studies and read the Physician's Pledge to the Med 3 (Clerkship) class.

- Issued a media release in July to publicly announce the change in Registrar at CPSM. An article in the Winnipeg Free Press introduced the Registrar to the public.
- Responded to several media inquiries where they aligned with regulatory matters, including questions regarding professional obligations when issuing medical exemption notes.

# COUNCIL MEETING – SEPTEMBER 25, 2024

## FOR INFORMATION

**SUBJECT:** **Operational Reports**

## STAFF MATTERS

The information described below highlights the staffing changes and additions since the June 2024 Council meeting.

**Registration Department** – the department is currently recruiting for a replacement Qualifications & Registration Representative to join the department.

**Complaints & Investigation** – Ms. Kasia Kieloch, Legal Counsel joined the department on August 26 and Ms. Kathleen McCandless, Senior Legal Counsel, joined the department on September 3.

**Quality Department** – With Dr. Sonja Bruin taking the interim Director role, the department has recruited Dr. Liesel Möller who has accepted a 0.4 EFT term position (September to December 2024) as a medical consultant in the Quality Assurance and Quality Improvement program. Dr. Möller will begin her term on September 10, 2024.

**Manitoba Quality Assurance Program** – Christine Muzibao joined the MANQAP team on July 16 as their new Clerk (0.5 EFT) & Ms. Alannah Baker joined on August 8 in the role of Diagnostic Imagining Accreditation Inspector (0.6 EFT).

## COMMUNICATIONS & MEDIA

The communications department oversees corporate communications including email campaigns, managing online platforms including the website, Council updates, launching new or updated Standards of Practice and public consultations, registrant communications, developing assts to support communications campaigns, and media relations.

The communications department supported the leadership transition with several initiatives to meet corporate communications goals including:

- A media release was issued to notify the public of the leadership transition. This was followed by an article in the Winnipeg Free Press highlighting the Registrar's vision, background and experience.
- Announcement of Dr. Guillaume Poliquin joining CPSM as Assistant Registrar for the Complaints & Investigations Department.

- Several communications have been sent to the Manitoba government, registrants, and other stakeholders to enhance relationship-building and collaboration.

Other initiatives this quarter included:

- Launching a public consultation related to amendments to the Accredited Facilities Bylaw.
- Developing a survey for the IMG Working Group.
- Communications issued to registrants over the summer months included Advice to the Profession in three areas: 1) responsible use of AI in medical practice, 2) maintaining professional obligations when engaging on public platforms, and 3) medical exemption notes.
- CPSM responded to several media inquiries where they aligned with regulatory matters, including questions regarding professional obligations when issuing medical exemption notes.
- Developing policies to support the communications function.
- The 2023-24 annual report is nearing completion and will be published by the end of September.

## FINANCE

First quarter results show a $270,000 net surplus. The surplus is driven primarily by lower than expected expenses which were $162,000 favorable. Approximately half of the positive variance is related to one-time staff savings. The other 50% is due to timing difference from pending vendor invoices not yet received/recorded and planned projects not yet implemented.

CPSM Finance is transitioning from cheque payments to electronic funds transfer (EFT) to improve internal controls involving vendor payments. A partial roll-out limited to non-salary payments to staff was implemented in August. The next phase will target external vendors and is set to roll-out on October 1, 2024. The final phase will involve honoraria recipients and is planned to roll-out on December 1, 2024.

## INFORMATION TECHNOLOGY

Work continues to provide improved automation and productivity to all areas of CPSM. Major projects currently underway include CPSM Portal and SharePoint enhancements for Standards/Quality Assurance and the Manitoba Quality Assurance Program as well as validation of all CPSM data reports. Below are a few of the improvements that have been implemented:

- Enhanced online security posture including enabling multi-factor authentication on all CPSM on premise servers.
- A “Return to Practice” application has been added to the CPSM Portal for Registrants returning to practice.

- Many CPSM Portal enhancements including improved navigation and new features including showing important messages to registrants in their Home Page (M3P Information).

## QUALITY DEPARTMENT

**Physician Health Program (PHP)**

- Since the beginning of July 2024, the PHP has had 13 new referrals with 7 of those referrals remaining open for more follow-up/PHP involvement.
- Since the start of the fiscal year (May 1), we have had 30 new referrals with 14 of those referrals still open for more follow-up/PHP involvement.
- 2 of the 22 registrant files who were carried over to the 2024-2025 for follow-up, have been closed.
- We currently have 41 active PHP undertakings.
- **PHP caseload: 110 registrants** (this includes anyone with an active undertaking, potential undertakings, new referrals, active referrals not yet closed, and anyone who requires follow/up either periodically or at a specific time in future).
- There are 12 physicians who have been inactive for 3+ years that will require approval from PHP before they can take the next steps in returning to practice.

**Quality Assurance Program (QAP)**

- Current number of audits to be scheduled in 2024 is: 147.
- Currently there are 100 open files in various stages of the process:
    - Newly initiated - 16
    - Waiting for Pre-audit Questionnaire - 10
    - Waiting for Manitoba Health - 3
    - Difficult Review Process - 22
    - Audit Scheduled – 10
    - Alternative Review Process - 15
    - Going to CSC – 14
    - Retired or planning to retire by the end of 2024 - 10
- The 22 cases that are difficult to review are due to:
    - No Manitoba Health information
    - Difficult to access charts (nursing stations, salaried positions etc.)
    - Physician away (LOA, Vacation, etc.)
    - Auditor availability
- Some participants will require an alternative or equivalency review in place of a chart audit such as performance reviews and/or action plans and multi-source feedback.
- Currently working on Age Triggered cohorts 72 and 71 years of age with a small number of previous cohorts that QAP was unable to review due to no available auditor or were deferred due to recent Quality Improvement involvement.

**Quality Improvement Program (QIP)**

- Program operations continue at a normal pace.
- A work plan is being finalized to meet the end of the first cycle (which ends in December 2025).
- All specialties will begin participation by the end of 2025.
- Auditor Training Workshop to be held October 29, 2024.
- 0.40 FTE Medical Consultant, Dr. Liesel Möller, to start on Sept 10, 2024.

**Prescribing Practices Program (PPP)**

- **Registrant Advice & Support**: responded to **57 general prescribing advice** inquires Jun-Sep 2024 (160 GPA cases thus far in 2024). KPI metrics: 56% responded to the same day, 81% within 1 business day, and 89% within 2 business days.
- **Outcome Evaluation**: Sending (anonymous) surveys to registrants/other HCPs who seek prescribing advice, to evaluate the impact of PPP interventions. **55% response rate** (21 responded/38 surveys sent since March). Will evaluate data this in fall (quarterly).
- **Prescribing Approvals**: Issued **6 Suboxone** & **1 methadone** prescribing approvals for OAT since June (current total 234 OAT prescribers). **6 pain/palliative methadone** approvals since June (current total 69 P&P prescribers).
- **CME Death Review**: Working with CME Office on Memorandum of Understanding to resume CPSM consultant attendance for case review.
- **Quality Prescribing Review Working Group**: Collaborated with Communications and Leadership to implement the prescribing rules changes effective June 1, 2024, and responded to 14 related inquires since June.
- **High Dose Morphine Milligram Equivalents (MME) Reviews**: Preparing to review cases identified by MB Health DPIN dataset, involving very high-dose opioid prescribing. Current data involves 23 patients prescribed doses > 900 MME per day, by 31 physicians, up to 2,167 MME per day. Designing review process and trialing with first case identified for review. Risk stratification will be used to design intervention toward quality assurance and safer prescribing practices.

**Manitoba Quality Assurance Program (MANQAP)**

- Currently reviewing Continuing Service Agreement (CSA) with Manitoba Health- surplus request still pending.
- Clinical review panel summary complete, to be presented to September PRC meeting for approval to implement new WCAA DI standards in Jan 2025.
- Collaboration with Manitoba Dental Association continues, MOU in draft stages.
- Working in collaboration with PPP to review business case reviews for new pain management services in Manitoba.
- Reviewing new applications NHMSF for surgical and hyperbaric care within Winnipeg.
- Continue to evaluate implementation of WCAA Laboratory standards.
- Continue to build relationships with Shared Health Privileging committee.

## COMPLAINTS & INVESTIGATIONS DEPARTMENT

- The Complaints & Investigations Department has undergone significant personnel changes over the summer months, including the start of the new Assistant Registrar, a new Senior Legal Counsel (Kathleen McCandless) and a new legal Counsel (Kasia Kieloch).
- As an extension of staffing changes, the Department is undergoing a strategic review of processes and metrics, with a view to incorporate principles of restorative justice and positive change as part of the complaints process.
- A key goal of the upcoming months will be to identify root causes for the back log and delays in Complaints & Investigations and chart a path for resolution.
- The Complaints & Investigations team is looking forward to working internally and with other departments within the CPSM in achieving an integrated vision for the future.

## REGISTRATION DEPARTMENT

The Registration Department is in a period of transition following the departure of the previous Director and the new Interim-Director's transition into their role. Consequently, the administration of the department has not been at full capacity and numerous policy initiates have been on hold.

Updates to the Registration section of the website continue. The site has been updated to present step by step information for all classes of registration. Information and resources have been added for physicians who cease practice, retire, or relocate their practice. We are engaged in a process of clarifying and posting clearer and more accessible information about provisional registration and practice readiness assessment. This work is being done in partnership with Shared Health and the IMG Program.

A review of all registration related Council Policies, Registrar's Policies, and Practice Directions continues. 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 Registration Policies and Practice Directions. The latest revised policies relate to English language proficiency and certificates of professional conduct.

The Board of Assessors had its inaugural meeting in August of 2024. It is supported in its work by staff in the registration department.

Other significant ongoing initiatives include:

- Supporting the development of the National Registry of Physicians.
- Developing enhanced performance metrics for the department, including for the purposes of quality assurance tracking.
- Establishing a record retention and destruction policy.

# COUNCIL MEETING – SEPTEMBER 25, 2024

## BRIEFING NOTE

**SUBJECT:** **2023-24 Annual Report**

**BACKGROUND:**

Section 142(1) of the Regulated Health Professions Act requires:

> "A college must submit an annual report to the minister within four months after the end of the college's fiscal year."

The 2023-34 Annual Report will be submitted to the Minister of Health and published no later than September 30, 2024. Copies of the Annual Report will be provided to Council members when they are available.

The legislative requirements of the content of the annual report are set out in section 142(2) of the RHPA:

(a) a description of the structure of the college, including the names and a description of the committees of the council and their functions;

(b) the names of the council members and of the members of the committees of the council;

(c) a copy of the by-laws and any amendments to by-laws that were made;

(d) the number of members by registration category;

(e) the number of members who hold a certificate of practice;

(f) the number of applications for registration that were received and their disposition;

(g) the number of applications for certificates of practice that were received and their disposition;

(h) the number of complaints that were received and their disposition;

(i) the number of members disciplined, the reasons for the discipline and the sanctions imposed;

(j) the number of practice audits conducted and the results of the audits;

(k) a description of the continuing competency program of the college and other methods used to maintain the competence of the members;

(l) a financial report on the operation of the college;

(m) any other information the minister requires.

# COUNCIL MEETING – SEPTEMBER 25, 2024
# COMMITTEE REPORTS
# FOR INFORMATION

## EXECUTIVE COMMITTEE REPORT:

The Executive Committee met in-person with virtual option on September 4, 2024. Most matters discussed at the meetings appear on this Council agenda.

The Executive Committee held an Appeal Panel on July 24, 2024 and heard 6 appeals of the Investigation Committee decisions.

Respectfully submitted by
Dr. Nader Shenouda
President, CPSM and Chair of the Executive Committee

## FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

The committee did not meet but was asked to virtually review and approve the reinvestment of $2.2 million of GIC's that expired in July 2024. The committee approved the recommendation to re-invest the $2.2 million into 1-year and 2-year GIC's. The full investment portfolio is currently at $5.4 million comprising of $3.2 million GIC's and $2.2 million Principal Protected Notes. The portfolio maintains a 60:40 long-term to short-term investment ratio to meet its liquidity readiness requirement.

Respectfully submitted by
Dr. Charles Penner
Chair, Audit & Risk Management Committee

## PROGRAM REVIEW COMMITTEE REPORT:

**Diagnostic Facilities:**
The WCAA Diagnostic Imaging standards have been reviewed by subject matter experts. Feedback is currently being compiled and reviewed. Implementation with the diagnostic imaging facilities and inspections using the new standards is anticipated for next year.

**Non-Hospital Medical Surgical Facilities (NHMSF):**
Two nursing consultants have been engaged to facilitate the adverse patient outcome process. They will assist MANQAP with the initial review of the adverse patient outcomes and finalizing the physician consultant's review for the Committee.
Work has also begun to implement Hyperbaric Oxygen Therapy standards.

Respectfully submitted by
Ms. Leanne Penny
Chair, Program Review Committee

## COMPLAINTS COMMITTEE REPORT:

The Complaints Committee met on June 6, 2024 at 1:30 p.m. 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
00 cases resulted if endorsement of an informal resolution
01 case resulted in a referral to the Investigation Committee

The Complaints Committee met on August 1, 2024 at 1:30 p.m. and reviewed 16 complaints.
Of those complaints considered, they were disposed as follows:
01 cases resulted in a letter of criticism
01 cases resulted in a letter of advice
11 cases resulted in a decision that no further action was required
00 cases resulted if endorsement of an informal resolution
03 cases resulted in a referral to the Investigation Committee

Respectfully submitted by
Ms. Lynette Magnus
Chair, Complaints Committee

## INVESTIGATION COMMITTEE REPORT:

The Investigation Committee has met three times since our last Council meeting (June 19, July 31 and September 4).

We have reviewed 28 cases during those meetings. The results of those discussions include the following decisions;
No Further Action = 10
Advice = 7
Criticism = 9
Defer for Audit = 1
Defer for further investigation = 1

There have been two new lawyers hired in the department whom I've met at our last meeting. At the moment, we have approximately 155 cases outstanding in the Investigation department.

Respectfully submitted by
Dr. Kevin Convery
Chair, Investigations Committee

## STANDARDS COMMITTEE REPORT:

**Central Standards Committee (CSC) Activities for the year 2024**

The CSC met March 15 and June 20, 2024.

**AGE TRIGGERED/REFERRED AUDITS REVIEWED IN 2023**

The CSC reviewed:

- 23 Age Triggered Audits
- 22 Referred Audits

The following outcomes were determined at CSC.

| | |
|---|---|
| 28 + *3 | #1 Outcomes (*Multiple doctors from one review three total) |
| 7 + *1 | #2 Outcomes (*Multiple doctors from one review one total) |
| 7 | #3 Outcomes |
| 2 | #4 Outcomes |
| 0 | #5 Outcomes |
| 1 | Other – Full Practice Audit, Interactive Audit and More Information Requested |
| 45 + *4 | Total outcomes |


Standards Sub-Committee Reporting.

The Central Standards Committee continues to request and receive quarterly reports from the various Standards Committees within the province. The following table represents the active committees by region and status.

Current active Committees by Region:

| Committee | RHA | Chair | Current Status |
|---|---|---|---|
| **Interlake-Eastern ASC** | Interlake-Eastern | Dr. Habtu Demsas | Up to date |
| **Northern ASC** | Northern | Dr. Shadi Mahmoud | Up to date |
| **Prairie Mountain Health ASC** | Prairie Mountain | Dr. Shannon Prud'homme | Q2 reminder sent July 4 |
| Brandon Regional Health Centre ASC | Prairie Mountain | Dr. Brian Bookatz | Up to date |
| **Southern ASC** | Southern | Dr. Shayne Reitmeier | Up to date |

| Committee | RHA | Chair | Current Status |
|---|---|---|---|
| Portage ASC | Southern | Dr. Jim Ross | Up to date |
| Boundary Trails Health Centre | Southern | Dr. Kevin Convery | Up to date |
| C.W. Wiebe Medical Centre | Southern | Dr. Louw Greyling | Q2 reminder sent July 4 |
| Eden Mental Health Centre | Southern | Dr. William Miller | Up to date |
| CancerCare Provincial | Provincial | Dr. Chantalle Menard | Up to date |
| Endoscopy Provincial | Provincial | Dr. Ross Stimpson | Up to date |
| Orthopedic Surgery Provincial | Provincial | Dr. Eric Bohm | Q2 reminder sent July 4 |
| Winnipeg Regional Health Standards Committee | WRHA | Dr. Elizabeth Salamon | Q 2 reminder sent July 4 |

Cumulative Reporting by Area/Region.

The following cumulative report includes total numbers from all quarterly reports received from the Provincial Standards Committees and Area Standards Committees by region for the months of January – August 2024.

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: Adverse Patient occurrences (APO) totals.

Respectfully submitted by
Dr. Roger Süss
Chair, Central Standards Committee

## BOARD OF ASSESSORS REPORT:

The Board of Assessors had its inaugural meeting on August 14, 2024, and has established a schedule for regular quarterly meetings going forward. Two policies were reviewed and endorsed by the Board; the first for English language proficiency, and the second for Certificates of Professional Conduct issued by CPSM. These now appear on Council's agenda. The Board also consider one (1) application for registration referred to it by the Registrar.

Respectfully Submitted by
Dr. Alewyn Vorster
Chair, Board of Assessors